

2017 Ambulatory Health Care National Patient Safety Goals

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

Identify patients correctly

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

Use medicines safely

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

Prevent infection

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

Prevent mistakes in surgery

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

SURGERY CENTER OF RENO

Section: 5.3

Policy: Quality Management and Improvement

Subject: SENTINEL EVENT REPORTING

Effective Date: 2-06

Revised: 2-07, 2-08

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

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PURPOSE:

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

DEFINITIONS:

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

SURGERY CENTER OF RENO

Section: 5.3

Policy: QUALITY MANAGEMENT AND IMPROVEMENT

Subject: SENTINEL EVENT REPORTING

Effective Date: 2-06

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PROCEDURAL DOCUMENTATION:

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

SURGERY CENTER OF RENO

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Who Should Know This Policy

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

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

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

SURGERY CENTER OF RENO

Section 8, D Environment of Care Management Plan

Policy: Facilities and Environment

Subject: Environment of Care Emergency Management Plan, Codes

Effective Date: 2-06

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

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ENVIRONMENT OF CARE MANAGEMENT PROGRAMS AND EMERGENCY PLAN

POLICY:

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

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

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

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

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PROCEDURE:

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

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

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

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

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

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

SURGERY CENTER OF RENO

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

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

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

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

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K. In the event of a community wide disaster and the ASC is safe to continue services, the Administrator will be responsible for contacting the local hospitals to verify if the transfer agreement is valid during an extended community recovery phase.

Who Should Know This Policy

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

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

- Governing Body Administrator Medical Director Clinical Managers
 Director of Nursing

SURGERY CENTER OF RENO

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

Policy: Emergency Preparedness Plan

Subject: Cardiopulmonary Arrest, Code Blue

Effective Date: 2-06

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

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3-16, 4-16, 3-17

IV. CARDIOPULMONARY ARREST – CODE BLUE

POLICY:

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

PROCEDURE:

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

SURGERY CENTER OF RENO

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

Policy: Emergency Preparedness Plan

Subject: Cardiopulmonary Arrest, Code Blue

Effective Date: 2-06

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

Who Should Know This Policy

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

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

- Governing Body Administrator Medical Director Clinical Managers
 Director of Nursing

SURGERY CENTER OF RENO

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

Policy: Emergency Preparedness Plan

Subject: Bomb Threat, Code Black

Effective Date: 2-06

Revised: 6-08, 8-11

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IV.B.2 BOMB THREAT –Code Black

POLICY:

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

PROCEDURE:

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

A. Employee receiving the call will:

1. Make every effort to obtain detailed information from the caller using the *SCOR's Bomb Threat Checklist* as a guide.
2. Notify the Administrator immediately if he/she is in SCOR; otherwise notify the next person in the chain of command.
3. Dial *911* and notify the local authorities. Answer all questions and stay on the line until they tell you to hang up.
4. Once you are off the phone with the authorities, immediately relay any instructions to the Administrator or person in charge.
5. Call Welltower to notify the other building occupants at 916-682-4492 or after hours service at 866-568-5855.

B. Administrator or Acting Person in Charge will:

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

C. All Personnel:

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

D. Following the evacuation:

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

SURGERY CENTER OF RENO

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

Policy: Emergency Preparedness Plan

Subject: Bomb Threat, Code Black

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c) Cooperate with all agencies present.

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

Who Should Know This Policy

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

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

- Governing Body Administrator Medical Director Clinical Managers
 Director of Nursing

SURGERY CENTER OF RENO

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

Policy: Emergency Preparedness Plan

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

Effective Date: 2-06

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

POLICY:

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

PROCEDURE:

The Administrator, Director/Clinical Manager, and the Safety Officer and their designated help will coordinate the activities during internal disasters in order to maintain and promote an organized, safe, and calm situation. HAVBED will be updated in the event of a community wide disaster with available resources. In the event of an internal disaster, HAVBED can be accessed to notify the community and State of Nevada via web address:
<https://www4.emsystem.com/EMSystem>.

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

A. During the earthquake:

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

a) If you are indoors:

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

b) If you are outdoors:

- (1) Stay away from buildings, power lines, towers, poles, trees, etc.
- (2) Lie flat on the ground until shaking stops.
- (3) Remain in a clear area and do not enter buildings until they are inspected and declared safe to enter.
- (4) Don't use open flames until you are advised that is safe to do so.

SURGERY CENTER OF RENO

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

Policy: Emergency Preparedness Plan

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

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(5) Stay calm.

2. Staff should protect patients:

- a) Keep patients calm and prevent hysteria.
- b) Instruct ambulatory patients to move as little as possible to a nearby safe place - stand in hallways near center of building or in a doorway and away from windows.
- c) If patients unable to get out of gurneys, pull privacy curtains around beds and either pull covers completely over themselves (including face and head) to protect from flying glass and objects. Both staff and patients should protect their eyes by pressing their faces against their arm.
- c) For patients in the O.R. staff will cover any open incisions with a sterile towel or sheet until quake has ceased.
- d) At that time the O.R. team will evaluate status of facility to determine safety in continuing procedure. All attempts will be made to close as soon as possible.
- e) The O.R. staff will remain in the O.R. suite with their team until evaluation and determination has been given by one of those 3 people in charge (the Safety Officer, Clinical Manager, or Administrator) will report to each O.R. room to give instructions on how to proceed.
- f) In the event the facility/situation is deemed unstable the staff and surgeon will close the patient and begin waking patient.

B. After an earthquake:

1. Immediately check for injuries. Staff are to check themselves for injuries and check patients for injuries.
2. Give first aid for serious injuries. If necessary, transfer staff or patients to the hospital for life threatening emergencies. Look for and extinguish small fires. Eliminate fire hazards.
3. Listen for alerts and/or instructions via cellular phones, if available.
4. Expect after shocks. Every time a shock is felt, follow procedures for an active earthquake.

C. Take aftershock precautions for at least seventy-two (72) hours:

1. Keep all privacy curtains closed around all beds (unoccupied as well as occupied).
2. Remove all loose objects from shelving, walls, sills, etc. in all patient areas of the building.
3. Restrict patient and visitor movements to areas where precautions are being enforced.

D. Inspect facilities and prevent further damage:

1. Check utility connections for damage or leaks. Repair essential utilities if possible. Secure and tag all non-essential utilities.
2. Take steps to restore essential services, if necessary.

SURGERY CENTER OF RENO

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

Policy: Emergency Preparedness Plan

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

Effective Date: 2-06

Revised: 6-08, 8-11

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

3. Establish communication channels with authorities and advise of:
 - a) Numbers and types of casualties, internally.
 - b) Extent of damage to SCOR's facilities.
 - c) Determine possible options for the most efficient use of available facilities and services in the open.
4. Inspect SCOR to determine if evacuation of patients and staff is necessary.
5. Minimize required traveling and transport needs.

E. Reduce post-quake environmental hazards:

1. Secure areas in or around building which pose a danger to pedestrians because of falling objects or other damage.

II. Floods:

A. When a Flood Watch is issued and it affects the SCOR:

1. Be alert to signs of flash flooding
2. Listen to local radio and TV stations for information and advice.

B. When a Flood Warning is issued:

1. Be prepared to evacuate staff and patients if evacuation for the area is issued by the State Emergency System. Depending on the progress of the surgery or procedure, the physician will abort or complete the on-going surgery or procedure. All patients in PACU will be recovered until the discharge criteria has been met and the patient can safely be discharged. All remaining surgeries or procedures will be cancelled.

III. Heat Wave:

A. If the State Emergency System issues a heat wave advisory, the occupants of the SCOR will be warned of the Advisory and are instructed on safety measures when leaving the SCOR. Water and non caffeinated fluids are offered to occupants as they leave.

B. Window coverings in the SCOR will be drawn to help decrease the penetration of the heat into the facility.

IV. Thunderstorms:

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

B. Unused and unnecessary equipment will be unplugged. Avoid using the telephone, including cell phones, unless absolutely necessary. Avoid using electrical appliances.

SURGERY CENTER OF RENO

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

Policy: Emergency Preparedness Plan

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

Effective Date: 2-06

Revised: 6-08, 8-11

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

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

Who Should Know This Policy

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

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

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

SURGERY CENTER OF RENO

Section 8, D-IV. B.4

Policy: Facilities and Environment

Subject: Emergency Preparedness –Malignant Hyperthermia

Effective Date: 2-06

Revised: 2-08

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

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

POLICY:

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

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

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

PROCEDURES:

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

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

B. Patient with MH Crisis

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

2. The SCOR keeps 36 vials of Dantrolene on hand for the purposes of treating malignant hyperthermia.

The patient will be transferred once the malignant hyperthermia treatment has been initiated and the patient has been stabilized.

C. Responsibility

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

SURGERY CENTER OF RENO

Section 8, D-IV. B.4

Policy: Facilities and Environment

Subject: Emergency Preparedness –Malignant Hyperthermia

Effective Date: 2-06

Revised: 2-08

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- e. Circulator or available nurse to call MH Hotline for additional management advice as instructed by the anesthesiologist.
5. PACU Nurse:
 - a. Retrieve Crash Cart and MH cart (if not already present)
 - b. Designate/delegate duties according to color coded assignment cards:
White cards= non clinical staff and Pink cards= licensed clinical staff.
 - c. Assist in mixing Dantrolene.
 - d. Start cooling measures (ice to groin and axilla, cold IVs, cold saline irrigation-provide cold saline to anesthesiologist for nasal gastric irrigation). **DO NOT OVERCOOL** (stop active cooling measures when patient reaches a core temp of 38°C or 100.4°F.)
6. OR personnel or designee
 - a. Call Administrator and Director/Clinical Managers for additional help in OR.
 - b. OR cases in progress will proceed if an MH crisis is in progress, but no further cases will be started until after the MH crisis has stabilized.
 - c. Assist in making ice packs; bring bags of ice from lounge freezer; check with circulator and, if necessary, obtain more bags of ice as instructed.
 - d. Call 911 as instructed by the anesthesiologist when transfer arrangements have been completed.
7. The licensed nurse will follow transfer policy and copy chart appropriately.
8. An Occurrence Report is to be filled out in the event of an MH episode.
9. A meeting will be scheduled by Nursing Leadership including those present during MH episode to critique and evaluate the response.

D. Equipment

1. Malignant hyperthermia cart; see list for inventory, retrieve cold Saline solutions from PACU MH refrigerator and ice.

E. Signs and Symptoms

1. Unanticipated doubling or tripling of end-tidal carbon dioxide.
2. Skeletal muscle rigidity (even in presence of neuromuscular blockage).
*NOTE: Masseter muscle spasm after use of Succinylcholine may be associated with malignant hyperthermia.
3. Tachypnea, tachycardia, unstable blood pressure, cyanosis
4. Hypoxemia
5. Myoglobinuria (cola-colored urine)
6. Increased temperature, fever (may be a late sign)

F. Treatment

1. As outlined in Emergency Treatment for Malignant Hyperthermia (See below)
2. Documentation: On-going documentation will be completed by an RN

General Outline of Emergency Treatment for Malignant Hyperthermia

PROCEDURE: Acute Phase

1. Notify the Surgeon
 - Discontinue all volatile agents and Succinylcholine.
 - Hyperventilate with 100% oxygen. Increase O₂ to 10L/minute.
 - Halt the procedure as soon as possible; if emergent, use non-triggers.
2. Administer Dantrolene Sodium 2.5mg/kg rapidly IV through large bore IV, if possible

SURGERY CENTER OF RENO

Section 8, D-IV. B.4

Policy: Facilities and Environment

Subject: Emergency Preparedness –Malignant Hyperthermia

Effective Date: 2-06

Revised: 2-08

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

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

Who Should Know This Policy

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

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

- Governing Body Administrator Medical Director Clinical Managers Director of Nursing

SURGERY CENTER OF RENO

Section Appendix Medication Management

Policy: Medication Management

Subject: Adverse Drug Reaction

Effective Date: 2-06

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

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POLICY:

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

Definition:

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

PROCEDURE:

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

Who Should Know This Policy

- All licensed Nurses Clinical Managers Medical Director Administrator
 Contracted Pharmacist

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

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

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

SURGERY CENTER OF RENO

Section: Appendix OSHA

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

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

Effective Date: 2-06

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

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Attachment A Methods of Compliance

A. Universal Blood and Body Fluid Precautions:

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

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

B. Engineering and Work Practice Controls:

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

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

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

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

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

SURGERY CENTER OF RENO

Section: Appendix OSHA

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

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

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

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Section: Appendix OSHA

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

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

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

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Section: Appendix OSHA

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

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

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

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

4. Laundry:

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

5. Environmental Controls:

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

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Section: Appendix OSHA

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

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

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- e. Blood or body fluids in pleuravacs, blood bags, suction liners, materials dripping or saturated with blood, etc., are regulated waste and must be terminally placed in biohazard boxes.
- f. Contaminated, reusable equipment must be decontaminated with an EPA approved tuberculocidal or microbacterial viral disinfectant.
- g. Biohazard signs must be placed on containers of regulated medical waste, containing blood or OPIM and other containers used to store or transport contaminated materials.
- h. Contaminated Equipment to be serviced: Unless SCOR demonstrates decontamination of the equipment or portions of the equipment is not feasible, equipment which may become contaminated with blood or other potentially infectious materials will be examined prior to servicing or shipping and a readily observable tag or label will be attached to the equipment stating which portions remain contaminated. SCOR will ensure that this information is conveyed to all affected employees, the servicing representative, and/or the manufacturer, as appropriate, and prior to handling, servicing, or shipping so that appropriate precautions will be taken.
- i. All buckets, bins, cans, and similar receptacles intended for reuse which have a reasonable likelihood for becoming contaminated with blood or other potentially infectious materials will be inspected and decontaminated on a weekly basis and cleaned and decontaminated immediately as soon as feasible upon visible contamination.

6. Personal Protective Equipment (PPE):

- a. Employees must use appropriate PPE and precautions to prevent skin and mucous membrane contact with any blood or any body fluid.
- b. Training will be provided to each employee as to the appropriate selection, location, use, and disposal of PPE during their clinical orientation.
- c. The type of PPE available to employees are as follows: Gloves, gowns, masks, goggle, eye shields, foot protection, head protection.
- d. Each employee is instructed to critically review their work responsibilities to make informed decisions or recommendations regarding appropriate use of PPE.
- e. When there is an occupational exposure, the SCOR will provide, at no cost to the employee, appropriate personal protective equipment.

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Section: Appendix OSHA

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

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

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

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Section: Appendix OSHA

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

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

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

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

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

7. Hepatitis B Vaccination:

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

8. Post Exposure Evaluations:

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

1. Post Exposure Evaluation Procedures:

A. First aid. Clean/rinse exposed area.

B. Report incident to supervisor.

C. Supervisor to ask source patient to be tested.

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

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

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

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

Who Should Know This Policy

All Employees Clinical Managers Administrator Medical Director

SURGERY CENTER OF RENO

Section: Appendix OSHA

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

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

Effective Date: 2-06

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

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

Governing Board Administrator Medical Director Clinical Managers

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

Date: _____ Employee Signature: _____

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

SURGERY CENTER OF RENO

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

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

Effective Date: 2-06

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

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Policy:

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

Purpose:

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

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

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

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

SURGERY CENTER OF RENO

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

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

Effective Date: 2-06

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

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

SURGERY CENTER OF RENO

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

Subject: Bloodborne Pathogens Exposure Control Plan, Attachment C:

Determination of Employee's Exposure Category

Effective Date: 2-06

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

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Attachment C

Determination of Employee's Exposure Category

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

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

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

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

SURGERY CENTER OF RENO

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

Subject: Bloodborne Pathogens Exposure Control Plan, Attachment C:

Determination of Employee's Exposure Category

Effective Date: 2-06

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

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

Name of employee (Print), Job Title

Date

Signature of employee

Date

Signature of Director, Clinical Manager or Administrator

Date

SURGERY CENTER OF RENO

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

Subject: Bloodborne Pathogens Exposure Plan, Attachment D:

Sharps Injury Log

Effective Date: 2-06

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

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Exposure to Blood/Body Fluids

Employee: Name, Last: _____ First: _____ Middle: _____ Gender: <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> Other Date of Birth: ____ / ____ / ____ Work Location: _____ Occupation: _____ If occupation is physician, indicate clinical specialty: _____		
Section I – General Exposure Information		
1. Date of exposure: ____ / ____ / ____		
2. Number of hours on duty: _____		3. Time of exposure: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM
6. Location where exposure occurred: _____		5. Is exposed person a temp/agency employee? <input type="checkbox"/> Y <input type="checkbox"/> N
7. Type of exposure: (Check all that apply)		
<input type="checkbox"/> 7a. Percutaneous: Did exposure involve a clean, unused needle or sharp object? <input type="checkbox"/> Y <input type="checkbox"/> N (If No, complete Q8, Q9, Section II and Section V-XI)		
<input type="checkbox"/> 7b. Mucous membrane (Complete Q8, Q9, Section III and Section V-XI)		
<input type="checkbox"/> 7c. Skin: Was skin intact? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown (If No, complete Q8, Q9, Section III & Section V-XI)		
<input type="checkbox"/> 7d. Bite (Complete Q9 and Section IV-XI)		
8. Type of fluid/tissue involved in exposure: (Check one)		
<input type="checkbox"/> Blood/blood products		<input type="checkbox"/> Body fluids: (Check one)
<input type="checkbox"/> Solutions (IV fluid, irrigation, etc.): (Check one)		<input type="checkbox"/> Visibly bloody
<input type="checkbox"/> Visibly bloody		<input type="checkbox"/> Not visibly bloody
<input type="checkbox"/> Not visibly bloody		<input type="checkbox"/> Tissue
<input type="checkbox"/> Tissue		<input type="checkbox"/> Other (specify): _____
<input type="checkbox"/> Other (specify): _____		<input type="checkbox"/> Unknown
<input type="checkbox"/> Unknown		If body fluid, indicate one body fluid type:
9. Body site of exposure: (Check all that apply)		
<input type="checkbox"/> Hand/finger	<input type="checkbox"/> Foot	<input type="checkbox"/> Amniotic
<input type="checkbox"/> Eye	<input type="checkbox"/> Mouth	<input type="checkbox"/> CSF
<input type="checkbox"/> Arm	<input type="checkbox"/> Nose	<input type="checkbox"/> Pericardial
<input type="checkbox"/> Leg	<input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> Peritoneal
		<input type="checkbox"/> Pleural
		<input type="checkbox"/> Semen
		<input type="checkbox"/> Synovial
		<input type="checkbox"/> Vaginal fluid
		<input type="checkbox"/> Saliva
		<input type="checkbox"/> Sputum
		<input type="checkbox"/> Tears
		<input type="checkbox"/> Urine
		<input type="checkbox"/> Feces/stool
		<input type="checkbox"/> Other (Specify): _____

Section II – Percutaneous Injury

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

2. Depth of the injury: (Check one)

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

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

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

Hollow-bore needle

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

Suture needle

Suture needle

Other solid sharps

- | | | |
|---|---|--|
| <input type="checkbox"/> Bone cutter | <input type="checkbox"/> Bur | <input type="checkbox"/> Electrocautery device |
| <input type="checkbox"/> Elevator | <input type="checkbox"/> Explorer | <input type="checkbox"/> Extraction forceps |
| <input type="checkbox"/> File | <input type="checkbox"/> Lancet | <input type="checkbox"/> Microtome blade |
| <input type="checkbox"/> Pin | <input type="checkbox"/> Razor | <input type="checkbox"/> Retractor |
| <input type="checkbox"/> Rod (orthopedic) | <input type="checkbox"/> Scaler/curette | <input type="checkbox"/> Scalpel blade |
| <input type="checkbox"/> Scissors | <input type="checkbox"/> Tenaculum | <input type="checkbox"/> Trocar |
| <input type="checkbox"/> Wire | | |

Glass

- | | | |
|---|--|--|
| <input type="checkbox"/> Capillary tube | <input type="checkbox"/> Blood collection tube | <input type="checkbox"/> Medication ampule/vial/bottle |
| <input type="checkbox"/> Pipette | <input type="checkbox"/> Slide | <input type="checkbox"/> Specimen/test/vacuum tube |

Plastic

- | | | |
|---|--|--|
| <input type="checkbox"/> Capillary tube | <input type="checkbox"/> Blood collection tube | <input type="checkbox"/> Specimen/test/vacuum tube |
|---|--|--|

Non-sharp safety device

- | | | |
|--|---|---|
| <input type="checkbox"/> Blood culture adapter | <input type="checkbox"/> Catheter securement device | <input type="checkbox"/> IV delivery system |
| <input type="checkbox"/> Other known device (specify): _____ | | |

4. Manufacturer and Model: _____

Exposure to Blood/Body Fluids

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

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

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

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

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

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

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

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

Obtaining a blood specimen percutaneously

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

Giving a percutaneous injection

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

Performing a line related procedure

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

Performing surgery/autopsy/other invasive procedure

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

Performing a dental procedure

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

Handling a specimen

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

Other

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

Exposure to Blood/Body Fluids

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

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

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

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

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

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

Exposure to Blood/Body Fluids

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Section III – Mucous Membrane and/or Skin Exposure

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

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

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

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

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

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

Section IV – Bite

1. Wound description: (Check one)

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

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

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

Exposure to Blood/Body Fluids

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

Section V – Source Information

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

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

Section VI – For HIV Infected Source

1. Stage of disease: (Check one)

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

Section VII – Initial Care Given to Healthcare Worker

1. HIV postexposure prophylaxis:

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

Exposure to Blood/Body Fluids

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Section VIII – Baseline Lab Testing

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

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

Section IX – Follow-up

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

Section X – Narrative

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

Section XI – Prevention

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

Custom Fields

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

Comments

SURGERY CENTER OF RENO

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

Subject: Bloodborne Pathogens Exposure Plan, Attachment F:

Consent or Declination for Hepatitis B vaccination

Effective Date: 2-06

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

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Attachment F

INFORMED CONSENT FOR HEPATITIS B VACCINE

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

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

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

Signature of Employee

Date

Department

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

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

#1 Signature of employee: _____

#2 Signature of employee: _____

#3 Signature of employee: _____

SURGERY CENTER OF RENO

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

Subject: Bloodborne Pathogens Exposure Plan, Attachment F:

Consent or Declination for Hepatitis B vaccination

Effective Date: 2-06

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

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DECLINATION

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

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

Signature of Employee

Date

Witness

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

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

Maintenance Requirements Testing

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

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

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

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

Maintenance Requirements Monthly Testing

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

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

Maintenance Requirements Annual Load Bank Testing

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

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

Maintenance Requirement 36 Month Load Bank Testing

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

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

Maintenance Requirements Time Delays

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

Time Delays should be set as follows:

On start: 1 second minimum

Transfer to emergency: no minimum

Return to normal: 5 minutes minimum

Shutdown: 5 minutes minimum

Transfer switches shall be operated monthly (8.4.6)

Maintenance Requirements

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

Transfer Time

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

Fire Extinguisher

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

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

PATIENT LABEL _____

BRIEF DESCRIPTION (Attach additional sheet, if needed)

Patient/Family aware of incident? Yes ___ No ___

A. LOCATION OF INCIDENT: _____

Type of Incident (Check only one that most applies)

B. FALLS

- Slip/fall Found on floor Other

C. MEDICATION VARIANCE

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

D. TREATMENT OR PROCEDURE VARIANCE

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

E. INFECTION SURGERY CENTER

- Infection/Nosocomial confirmed

F. EQUIPMENT/PRODUCT-RELATED INCIDENT

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

LOT # _____

EQUIPMENT TYPE: _____ MODEL #: _____

MANUFACTURER: _____ SERIAL #: _____

G. MISCELLANEOUS

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

H. MEDICAL TREATMENT

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

Physician Name: _____

Notified Date: _____ Time: _____

Address: _____

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

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

J. RELATED FACTORS (check all that apply)

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

K SEVERITY LEVEL

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

WITNESSES

Name: _____ Name: _____

EMPLOYEE PREPARING REPORT

Name _____ Date/Time: _____ Title: _____

L. HOW COULD THIS EVENT HAVE BEEN PREVENTED?

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

Signature: _____ Title: _____

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

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

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

Administrator Signature: _____ Date/Time: _____

Medical Director: _____ Date/Time: _____

Governing Board: _____ Date/Time: _____

(Original with signatures in QI Book)

Effective as of: _____

Quality Improvement Plan

SURGERY CENTER OF RENO, LLC

Approved by the Medical Staff

By: _____ Dated: _____

Its President

Adopted by the Governing Board of Directors

By: _____ Dated: _____

Authorized Representative

Surgery Center of Reno

Quality Improvement Plan

Purpose:

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

QI Indicators to be monitored may include but are not limited to:

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

Quality Improvement Issues:

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

Routine monitoring will also include:

Emergency Cart / Defibrillator checks

Refrigerator and Fluid warmer temperature checks.

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

QUALITY IMPROVEMENT, RISK MANAGEMENT, AND PATIENT SAFETY PLAN

Las Vegas Surgery Center 2018

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

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

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

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

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

HCA Patient Safety Organization (PSO), LLC

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

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

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

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

Quality Improvement Plan

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

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

Risk Management and Patient Safety

Definitions of Potential Risk Issues:

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

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

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

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

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

- Death
- Permanent harm
- Severe temporary harm

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ORGANIZATION STRUCTURE AND PROCEDURE

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

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

These functions include, but not limited to:

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

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

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

Key Goals:

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

Key Activities:

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

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

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

Quality Improvement Committee Chair:



Risk Manager:



Infection Control Coordinator:



Patient Safety Committee Chair:



Radiation Safety Officer

Key activities:

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

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

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

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

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

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

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

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

Assessment is automatically triggered for any of the following:

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

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

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

ONGOING QUALITY AND RISK MANAGEMENT - PERFORMANCE MEASUREMENTS

Customer Satisfaction Surveys

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

Patient Flow

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

Anesthesia Care

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

Pre-op Care

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

Intra-op Care and Processes

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

Complications

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

Resuscitation / Emergency Response

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

Diagnostics Results

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

Medication Usage

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

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

Infection Control

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

Provision of Care/ Medical Record Review

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

Equipment

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

Safety

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

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

Emergency Preparedness

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

Radiation Safety

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

Patient Safety

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

EVALUATION OF THE 2017 QUALITY PROGRAM

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

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

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

A. Division Goals

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

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

B. Center specific Goals

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

2018 QUALITY / RISK GOALS

2018 ASD Clinical Agenda

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

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

2018 Division Goals

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

2018 Center Goals

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

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

REFERENCED ORGANIZATIONS

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

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

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

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

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

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

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

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

WHO- World Health Organization, WHO.Int

QUALITY IMPROVEMENT, RISK MANAGEMENT, AND PATIENT SAFETY PLAN

FLAMINGO SURGERY CENTER 2017

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

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

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

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

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

HCA Patient Safety Organization (PSO), LLC

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

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

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

Quality Improvement Plan

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

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

Risk Management and Patient Safety

Definitions of Potential Risk Issues:

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

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

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

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

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

- Death
- Permanent harm
- Severe temporary harm

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

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

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

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

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

action plan is reported at the quality meetings, MEC and GB meetings. In 2016 the ASD will be move toward an online program for analysis of serious events called Serious Event Analysis (SEA).

Risk Management

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

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

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

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

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

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

Medication Safety

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

- Conducting medication rounds and audits providing feedback on areas of opportunities
- Collaborating with the center on choice of pharmaceutical vendors and formularies
- Collaborating with the center on policy review and development
- Participating in review of any medication error or diversion

- Assuring controlled substance ordering and monitoring is in accordance to state and federal regulations
- All relevant activities are reported through QI/MEC/GB committees

Radiation Safety

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

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

Infection Control

The center conducts an annual infection control risk assessment to identify areas of opportunities to reduce the risk of infections. (See Infection Control Plan) All infection control activities are reported though QI/MEC/GB.

Peer Review

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

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

Confidentiality

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

ORGANIZATION STRUCTURE AND PROCEDURE

Role of Leadership

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

Governing Board/Medical Executive Committee

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

committees and teams. Quarterly, the Governing Body shall receive a report on the activities of the quality and risk management programs. These functions include, but not limited too:

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

Administration

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

Key Goals:

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

Key Activities:

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

Quality Improvement/ Risk/Infection Control/Patient Safety Committee

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

The following staff members will be assuming the following roles for the year 2017, upon approval from the MEC and Governing Body:

Quality Improvement Committee Chair:



Risk Manager:

Infection Control Coordinator:

Patient Safety Committee Chair:

Radiation Safety Officer



Key activities:

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

Quality Studies

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

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

Staff Education

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

Ongoing Measurement

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

Design of New Processes

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

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

Periodic Assessment and Improvement

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

Assessment is automatically triggered for any of the following:

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

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

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

ONGOING QUALITY AND RISK MANAGEMENT PERFORMANCE MEASUREMENTS

Customer Satisfaction Surveys

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

Patient Flow

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

Anesthesia Care

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

Pre-op Care

- Completion of One Medical Passport prior to day of procedure
- Appropriate follow through on obtaining pre-op diagnostic studies per anesthesia guidelines and follow up on abnormal reports
- Pre op instructions
- DVT assessment –including use of SCD when indicated
- Falls Assessment
- Sleep Apnea assessment and Incentive Spirometer started on designated patient population (if applicable)

Intra-op Care and Processes

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

Complications

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

Resuscitation / Emergency Response

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

Diagnostics Results

- Pre-op diagnostic studies clinically reviewed and documented.

- Pre- and post operative diagnosis agreement

Medication Usage

- Utilize "One Source" truth for allergy documentation
- Medication Reconciliation process
- Use of Medication Administration Record (MAR) for consistency in medication documentation
- Medication errors
- Adverse drug reactions
- Appropriate labeling of high alert and look alike/sound alike medications
- Independent double checks with administration of designated high risk medications
- Controlled substance audits
- External pharmacy audits
- Surveillance of security of medications and needles
- Verbal and telephone orders are read back and verified
- Appropriate medication ordering, preparation and administration of medications.
- Utilizing approved compounding pharmacies and continual monitoring for FDA alerts.

Infection Control

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

Provision of Care/ Medical Record Review

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

Equipment

- Routine preventive maintenance
- Compliance with process of notification and removal of malfunctioning equipment.
- Initial and annual competencies

Safety

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

Radiation Safety

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

Patient Safety

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

EVALUATION OF THE 2016 QUALITY PROGRAM

1. Evaluation of 2016 Quality/Risk/Patient Safety Plan

- 0 % Grievances entered into Risk Management workbook **and addressed** within time frame dictated by policy in 2016. (# grievances within time frame / #total grievances entered)
- 100 % staff that received annual Risk Management In-service in 2016. (# staff with in-service/ total number staff at time of in-service)
- 100 % compliance with 2016 Risk Reduction Program (#components completed/#components required)
- 100 % of the HCA High Level Disinfection & Central Sterile Processing Boosterpak deliverables met
- 1 (#) Sentinel Events in 2016 and SEA completed.
- Comments:

2. Goals – met / not met (if not met – Explain)

Division Goals

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

Center specific Goals

- All 2016 Center specific goals have been met

2017 QUALITY / RISK GOALS

2017 Clinical Agenda -- see attached.

2017 Division Goals

- To continue to reduce the number of sharp occurrences by implementing the sharps safety toolkit. In 2016 the Division reported an increase in sharp occurrences, in 2015 the Division reported 15 sharp occurrences.
- To decrease the Direct Hospital Admission rate per thousand by identifying commonalities/trends and increasing the use of One Medical Passport at the centers
- To sustain 100% compliance with IV Prophylactic Antibiotic Administration during 2017
- To complete the 2017 Clinical Safety Improvement (CSIP) Plan (Risk Reduction Program Initiatives).
- To meet the 2017 ASD Clinical Objectives

• **2017 Center Goals**

- **To reduce falls**
- **To reduce the amount of IUSS**
- **To continue to monitor the processing time of intraocular instruments**
- **To complete the CSIP components by their deadlines**
- **Re-Syndication of Partnerships**

QUALITY IMPROVEMENT, RISK MANAGEMENT, AND PATIENT SAFETY PLAN

Sahara Surgery Center 2018

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

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

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

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

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

HCA Patient Safety Organization (PSO), LLC

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

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

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

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

Quality Improvement Plan

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

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

Risk Management and Patient Safety

Definitions of Potential Risk Issues:

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

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

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

Adverse Event: Any deviation from usual medical care that causes an injury to the patient or poses a risk of harm. Events include errors, preventable adverse events and hazards. An incident in which a patient is

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

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

- Death
- Permanent harm
- Severe temporary harm

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

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

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

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

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

Risk Management: The Center maintains an ongoing risk management program that is designed to protect the life, safety and welfare of the patients and employees. Risk management addresses strategies from the

organizational, operational, human resource and liability areas of the organization. Goals of the program include:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ORGANIZATION STRUCTURE AND PROCEDURE

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

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

These functions include, but not limited to:

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

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

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

Key Goals:

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

Key Activities:

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

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

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

- | | |
|--------------------------------------|--------------|
| Quality Improvement Committee Chair: | Name Here RN |
| Risk Manager: | Name Here RN |
| Infection Control Coordinator: | Name Here RN |
| Patient Safety Committee Chair: | Name Here RN |

Key activities:

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

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

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

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

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

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

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

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

Assessment is automatically triggered by any of the following:

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

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

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

ONGOING QUALITY AND RISK MANAGEMENT - PERFORMANCE MEASUREMENTS

Customer Satisfaction Surveys

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

Patient Flow

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

Anesthesia Care

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

Pre-op Care

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

Intra-op Care and Processes

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

Complications

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

Resuscitation / Emergency Response

- Code blue drill(s) - Adult and Pediatric
- Malignant Hyperthermia drill
- Emergent Blood drill
- Lipid rescue drill
- Crash carts, Malignant Hyperthermia carts checked according to policy

Diagnostics Results

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

Medication Usage

- Utilize “One Source” of truth for allergy documentation
- Medication Reconciliation process
- Use of Medication Administration Record (MAR) for consistency in medication documentation
- Medication errors
- Adverse drug reactions
- Appropriate labeling of high alert and look alike/sound alike medications
- Independent double checks with administration of designated high risk medications
- Controlled substance audits
- External pharmacy audits

- Surveillance of security of medications and needles
- Verbal and telephone orders are read back and verified
- Appropriate medication ordering, preparation and administration of medications.
- Utilizing approved compounding pharmacies and continual monitoring for FDA alerts.

Infection Control

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

Provision of Care/ Medical Record Review

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

Equipment

- Routine preventive maintenance
- Compliance with process of notification and removal of malfunctioning equipment.
- Initial and annual competencies

Safety

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

Emergency Preparedness

- Develop a Hazardous Vulnerability Analysis (HVAC) grid

- Written emergency preparedness plan that incorporates community resources

Radiation Safety

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

Patient Safety

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

EVALUATION OF THE 2017 QUALITY PROGRAM

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

- 100% Grievances entered into Risk Management workbook **and addressed** within time frame dictated by policy in 2017.
- 89 % staff that received annual Risk Management In-service in 2017.
- 100 % compliance with 2017 Clinical Safety Improvement Program - CSIP
- 100 % of the HCA High Level Disinfection & Central Sterile Processing Boosterpak deliverables met
- 0 (#) Sentinel Events in 2017.
- List Quality Studies completed in 2017:
 - Daily OR Narcotic Logs
 - "OR IN" Time
 - Throat Pack Insertion and Removal for Dental Procedures
- Comments: Completion of Daily OR Narcotic Logs study in the first quarter of 2018.

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

A. Division Goals

- To continue to reduce the number of sharp occurrences by implementing the sharps safety toolkit.
All FWD centers reported a sharp occurrence in 2017 – 37 total occurrences. All but one occurred in the OR. Sahara Surgery Center had a 40% decrease in sharps occurrences. Met.
- To decrease the Direct Hospital Admission rate per thousand by identifying commonalities/trends and increasing the use of One Medical Passport at the centers. Sahara Surgery Center had a 73% decrease in Direct Hospital Admissions. Met. Staff has been educated to encourage patients during the pre-op phone call, to go online to complete One

Medical Passport. Sahara Surgery Center has 100% compliance with the use of One Medical Passport.

- To sustain 100% compliance with IV Prophylactic Antibiotic Administration during 2017. Met.
- To complete the 2017 Clinical Safety Improvement (CSIP) Plan (Risk Reduction Program Initiatives). Met.
- To meet the 2017 ASD Clinical Objectives. Met.

B. Center specific Goals

- Update the Central Sterile Processing Department by adding an instrument washer/disinfector. Not met. Washer not purchased.
- Improve temperature and humidity monitoring in all required departments. Met.
- Enroll a PACU staff member in the AORN Perioperative 101 for ASC's course. Not met. New OR personnel were hired. The PACU staff member who expressed an interest in the program was needed to staff Pain/PACU. He also had an extended (5 week) vacation in 2017.

2018 QUALITY / RISK GOALS

2018 ASD Clinical Agenda

- Industry leading quality and service
 - Assessment and promotion of a patient safety culture through the Culture of Safety Survey (CSIP)
 - Continued verification of clinical standards through perpetual Survey Readiness
 - Prevention of serious events through ASD wide shared learning calls (CSIP)
- Profitable growth through distinctive MD and patient relationships and value
 - Support and develop physician leaders through the Medical Directors' engagement program (CSIP)
 - Provide specific clinical guidance to expand service lines through:
 - Total Joint Replacement Program Workbook
 - Partner with local GME programs
 - Initiate Professional Performance Evaluation Program for medical staff and advanced practice providers
- Efficiency levels that continue to lead the industry
 - Facilitate safe Medication Management strategies (CSIP)
 - Ensure accurate and timely Clinical Records
 - Analysis/transparency of data through:
 - Quarterly Clinical Operations calls (Division)
 - SQL enhancements (Division)
- A well-informed response to evolving market environment
 - Assessment and support of post-operative Normothermia to reduce untoward outcomes
 - Evaluate ophthalmologic outcomes through reporting and assessment of unplanned vitrectomies
 - Enhance Patient Experience by utilization of a standardized patient experience of care survey
- Unparalleled development of future leaders
 - Expedite the development of new leaders through:
 - CSP and Endoscopy Reprocessing ongoing certification
 - CSG ASD Orientation (3 times: February, May, August)
 - Quality and Risk Management Manual

2018 Division Goals

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

2018 Center Goals

- To continue to identify areas of opportunity to reduce the IUSS rate, and to sustain the IUSS rate \leq 10% (as per HCA recommendation).
- To complete the 2018 Clinical Safety Improvement (CSIP) Program.
- To meet the 2018 ASD Clinical Objectives
- Update the Central Sterile Processing Department by adding an instrument washer/disinfector.
- Add "One Source" to Central Sterile Processing for immediate access to MIFU's.
- Sustain lower Direct Hospital Admission rates by continuing the current process of pre-op phone calls and use of One Medical Passport.
- Under the guidance of the Regional Pharmacist continue to refine the accountability process of controlled substances in the OR and Pain departments.
- Increase Risk Management in-service participation to 100%

REFERENCED ORGANIZATIONS

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

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

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

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

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

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

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

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

WHO- World Health Organization, WHO.Int

Safety

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FALLS PREVENTION

POLICY:

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

PROCEDURE:

Standard Fall Risk Interventions:

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

Reporting Patient Falls:

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

SECURITY

POLICY

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

PROCEDURE

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

SMOKING

POLICY:

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

PROCEDURE:

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

RECALL- EQUIPMENT, SUPPLIES AND FOOD

OVERVIEW

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

POLICY

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

PROCEDURE

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

HAZARDOUS MATERIALS AND WASTE-INVENTORY OF HAZARDOUS SUBSTANCES

POLICY:

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

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

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

APPROPRIATE ATTIRE-PPE

POLICY

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

PROCEDURE

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

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

HAZARDOUS MATERIALS AND WASTE-BIOHAZARDOUS WASTES – HANDLING OF

BACKGROUND AND DEFINITIONS

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

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

Biohazardous waste includes the following materials:

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

Responsibilities of Biohazardous Waste Generators

Surgery centers that generate biohazardous waste are responsible for:

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

Biohazard Waste Minimization

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

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

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

BIOHAZARDOUS WASTES - HANDLING OF

Page 2

POLICY:

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

PROCEDURE:

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

BIOHAZARDOUS WASTES - RED BAG CONTENTS

(WHAT MUST I PUT INTO THE RED BAG?)

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

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

II. **SHARPS:**

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

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

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

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

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

DEFINITION:

Sharps include:

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

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

SHARPS WASTE MINIMIZATION:

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

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

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

SHARPS WASTE DISPOSAL PROCEDURES:

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

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

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

POLICY:

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

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

BLADES, GLASS, NEEDLES, SHARPS, AND SYRINGES – HANDLING AND DISPOSAL OF
Page 2

PROCEDURE:

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

SPILLS POLICY

PURPOSE:

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

POLICY:

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

PROCEDURE:

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

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

Reference: CDC Sterilization and Disinfection in Healthcare Facilities, 2008

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

RADIATION SAFETY

Purpose:

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

Policy:

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

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

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

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

Procedure:

Protecting the Patient from Unnecessary Exposure

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

Minimizing Occupational Exposure

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

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

Pregnant Health Care Personnel

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

Radiation Monitors

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

Documentation

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

Shielding Devices

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

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

Spacer Cone

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

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

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

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

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

ANNUAL OCCUPATIONAL DOSE LIMITS

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

FIRE SAFETY-FIRE IN THE OPERATING ROOM

GENERAL INFORMATION

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

POLICY

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

PROCEDURE

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

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

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

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

Fiberoptic Light Sources

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

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

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

Fighting Fires Involving an Endotracheal Tube

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

Fighting Fires On or In Equipment

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

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

Reference: Fire Prevention in the Perioperative Practice Setting 2013

FIRE SAFETY-FIRE WATCH/SYSTEM IMPAIRMENT

PURPOSE

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

CAUSES

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

POLICY

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

PROCEDURES

I. Implementation

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

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

II. Closeout

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

MEDICAL EQUIPMENT- ELECTRICAL EQUIPMENT - SAFE USE OF

POLICY:

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

PROCEDURE:

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

MEDICAL EQUIPMENT - ELECTROSURGICAL UNIT (ESU) SAFETY

POLICY:

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

PROCEDURE:

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

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

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

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

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

MEDICAL EQUIPMENT MANAGEMENT, MAINTENANCE & REPAIR

POLICY:

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

PROCEDURE:

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

MEDICAL EQUIPMENT MALFUNCTION

POLICY:

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

PROCEDURE:

At the moment of a medical device failure or malfunction:

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

MEDICAL EQUIPMENT – USE OF DIRTY EQUIPMENT

POLICY

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

PROCEDURE

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

MEDICAL EQUIPMENT - SUCTIONING EQUIPMENT

POLICY:

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

PROCEDURE:

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

STORAGE AND HANDLING OF MEDICAL GASES POLICY

POLICY

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

PROCEDURE:

Delivery

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

Storage

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

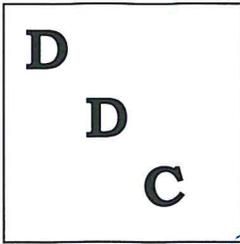
Handling

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

Usage

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

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



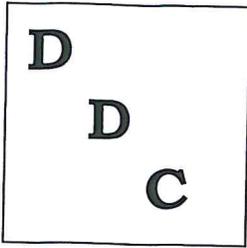
**P A T I E N T S A F E T Y
P O L I C Y & P R O C E D U R E**

Policy:

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

Procedure:

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



Digestive Disease Center

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

Policy:

The policy set forth by the Digestive Disease Center (DDC) is to ensure that staff, physicians, vendors, and contracted employees are compliant with patient safety including checklists, policies & procedures established by the DDC.

Procedure:

- A. All staff, physicians, vendors & contracted services are required to read and comply with the safety checklists, policies & procedures prior to working in the center.
- B. Policies & checklists will be provided to vendors & contracted services to provide to their employees.
- C. Staff educated upon hire & annually thereafter on the process for reporting violations to the Director of Nursing Services.
- D. Audits performed monthly utilizing the Infection Control Surveillance Tool to ensure compliancy & sanitation.
- E. The safety committee will meet monthly to discuss patient safety issues, review audits & monitor & document effectiveness of the patient identification policy.
- F. Safety Policies & Procedures, checklists will be reviewed at least annually & more often if needed.

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

POLICY:

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

PURPOSE:

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

PROCEDURE:

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

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

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

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

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

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

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

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

Implementing an orientation and education plan that addresses:

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

Conducting ongoing monitoring of performance to asses:

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

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

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

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

POLICY:

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

PURPOSE:

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

SCOPE:

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

RISK MANAGEMENT COMPONENTS:

The Risk Management Program incorporates the following components:

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

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

May not be valid after 1/22/2018

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

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

C. Claims Management

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

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

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

Litigation Matters

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

RESPONSIBILITY:

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

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

May not be valid after 1/22/2018

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

The Center Director’s Risk Management duties are to:

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

Employees’ duties:

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

QAPI Committee is responsible to:

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

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

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

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

Insurance and Quality Department:

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

EXTERNAL REPORTING: *(if applicable in ASC state)

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

CONFIDENTIALITY:

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

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

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

EDUCATION:

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

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

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

(See also HR in-servicing)

ANNUAL REVIEW AND GOALS:

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

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POLICY

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

PURPOSE/OBJECTIVES

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

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

MISSION

The QAPI program supports the center purpose/mission statement.

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

SCOPE OF CARE

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

Services include: GI Endoscopy

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

RESPONSIBILITY FOR QAPI PROGRAM

Governing Board – The Northern NV Endoscopy ASC, LLC

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

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

Center Director and Management Team

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

- Ensure patient care is delivered safely,

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

Quality Assessment Performance Improvement (QAPI) Committee

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

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

Specific functions of the Committee include:

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

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

Quality Improvement Teams

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

QI Teams may be initiated based on the following priorities:

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

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

Employees

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

QUALITY MEASURES/PERFORMANCE INDICATORS

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

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

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

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

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

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

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

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

BENCHMARKING

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

QUALITY STUDIES (FOCUS STUDIES)

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

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

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

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

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

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

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

INTEGRATION WITH RISK MANAGEMENT

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

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

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

REPORTING

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

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CONFIDENTIALITY

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

PROGRAM EVALUATION

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

ANNUAL GOALS

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

PROGRAM APPROVAL

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

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

POLICY:

The Center maintains a Life Safety Management Plan.

PURPOSE:

To provide safety from fire hazards

PROCEDURE:

The Center has processes for:

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

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

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The Life Safety Management Plan has procedures to address:

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

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

Policy Type:	FE_FACILITIES - ENVIRONMENT
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Policy Title:	INFECTION CONTROL PROGRAM		
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POLICY:

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

PURPOSE:

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

SCOPE OF THE INFECTION CONTROL PROGRAM:

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

COMPONENTS OF THE INFECTION CONTROL PROGRAM:

RESPONSIBILITY:

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

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

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

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

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

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INFECTION CONTROL COORDINATOR

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

SURVEILLANCE:

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

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

OUTBREAK INVESTIGATION

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

PATIENT ASSESSMENT AND TRIAGE

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

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

HAND HYGIENE

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

LAUNDRY SERVICES

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

ENVIRONMENT of CARE

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

- Workflow to prevent cross contamination
- Sterilization and reprocessing procedures and documentation
- Ventilation
- Temperature and humidity of rooms
- Appropriate ventilation and maintenance of systems
- Housekeeping responsibilities
- Disinfection of surfaces between patients
- Cleaning schedules, and pest management

EDUCATION

Orientation and training regarding infection prevention and control is conducted by the designated Infection Control Professional and includes the topics:

- hand hygiene
- high level disinfection/sterilization
- waste management procedures
- infection prevention principles and practices

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Information related to employee health is also included.

Documented education in Infection Control Policies and processes is provided to all staff within 10 days of commencement of employment, annually thereafter, and when there is an identified need.

Credentialed providers receive ongoing or, at a minimum, annual infection control training.

QUALITY ASSURANCE/PERFORMANCE IMPROVEMENT STRATEGIES (QAPI)

Monitoring of infection control measures is conducted and variances are reported for specific occurrences. Corrective and preventive measures for improvement are undertaken immediately as needed. Infection Control is a component of the facility's Quality Assurance Performance Improvement Program (QAPI) and infection control reports are made to the QAPI committee. In addition, infection control audits are performed to assess the level of quality provided and actions for improvement are taken as needed.

The QAPI Committee meets on a regular basis and provides input and direction for the Infection Prevention Program. Policies and procedures relating to Infection Prevention are approved by the committee. Reports of infections are presented to the committee which recommends actions and control measures when needed.

REPORTING MECHANISMS FOR INFECTION CONTROL

Patient infection cases are monitored by the ICC. The ICC completes a list of infections, the monthly report forms and:

- Reports to the QAPI Committee
- Reports to the Governing Board
- Reports to health authorities, if appropriate
- Provides feedback to staff as needed.

Employee infections are reported by the employee to the Supervisor and Center Leader, then to the ICC. The ICC completes the employee infection report form and reports:

- Compliance with infection control practices is monitored and documented by:
 - Staff evaluation
 - Observation of Practices
 - The ICC and Center Leader review the compliance monitoring and initiate appropriate actions.

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UPDATING THE INFECTION CONTROL PLAN:

The Infection Control Plan is reviewed annually by the Infection Control Committee/QAPI Committee. Revisions, if needed, will be made to the plan based on review.

POLICIES AND PROCEDURES

Policies and procedures for infection prevention are reviewed on a regular schedule and updated as needed.

The following Infection Control policies and procedures are maintained and made part of the Center Infection Control Plan:

- Airborne Precautions
- Annual Evaluation of Infection Control Program
- Asepsis Principles of
- Cleaning New-Repaired or Loaner Equipment
- Cleaning Procedure Room
- Communicable-Infectious Diseases Personnel
- Communicable-Infectious Diseases Patients
- Consent Form to Draw Blood
- Contact Precautions
- Disinfection High-Level
- Disinfection of Non-Critical Devices
- Droplet Precautions
- Exposure Control Plan
- Hand Hygiene
- Hepatitis B Immunization Documentation for employees
- Hepatitis B Vaccine General Information

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- Hepatitis B Vaccine Immunization Program for employees
- Infection Control Agents Center Approved*
- Infection Control Annual Risk Assessment
- Infection Control Committee
- Infection Control Meeting Minutes Template-QAPI
- Infection Control Multi-Drug Resistant Organisms (MDRO)
- Infection Control Orientation Checklist
- Infection Control Orientation Outline
- Infection Control Program
- Infection Control Standard Precautions and Practices
- Infection Control Surveillance Plan
- Infection Control Training-Orientation
- Influenza Vaccine Availability for Employees
- Influenza Vaccine Consent
- Outbreak Investigation
- Reprocessing Endoscope
- Reprocessing Instruments
- Sharps Injury Log
- Sharps Injury Protection Plan
- Skin Preparation
- Sterile Supplies Opening
- Sterilization Monitoring Process

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- Sterilization Packaging
- Sterilization-Disinfection Products Center Approved*
- Storage Sterile
- Traffic Control
- Tuberculin Skin Tests Competency
- Tuberculosis Screening for Employees

REFERENCES:

Association for Professionals in Infection Control and Epidemiology, Inc. (APIC)

2005 APIC Text of Infection Control and Epidemiology/Ambulatory Care
 1275 K Street, NW Suite 100
 Washington, DC 20005-4006
 Phone 202-789-1890
 Fax 202-789-1899
 E-mail apicinfo@apic.org
 Internet www.apic.org

Society of Gastrointestinal Nurses and Associates

www.sгна.org

Centers for Disease Control and Prevention (CDC)

www.cdc.gov

Occupational Safety and Health Administration

<http://www.osha.gov>

Accreditation Association for Ambulatory Health Care, Inc.

2016 Accreditation Handbook for Ambulatory Health Care
 STANDARD 7.I.b
www.aaahc.org

Centers for Medicare and Medicaid Services

<http://www.cms.hhs.gov>

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EYE SURGERY CENTER OF NEVADA

QUALITY AND PATIENT SAFETY PLAN

PATIENT SAFETY COMMITTEE/PROGRAM

EYE SURGERY CENTER OF NEVADA
3839 N CARSON STREET
CARSON CITY NEVADA 89706

CONTACT INFORMATION:



This plan was created and revised by the Eye Surgery Center of Nevada Patient Safety committee. Implementation of this plan is intended to optimize the healthcare quality and patient safety outcomes, encourage recognition, reporting and acknowledgement of risks to patient, visitor and employee safety, as well as reduce the medical/healthcare errors and/or preventable events.

It was last reviewed and revised as needed on March 1, 2018.

EYE SURGERY CENTER OF NEVADA

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EYE SURGERY CENTER OF NEVADA

COMMITMENT TO PATIENT SAFETY

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

MISSION, VISION AND VALUES

In support of our mission, vision and values, the Eye Surgery Center of Nevada Patient Safety and Quality Improvement program promotes:

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

SCOPE AND PURPOSE

The scope of this Quality and Patient Safety Plan is organization wide which includes but is not limited to:

- Patient safety
- Visitor safety
- Employee safety

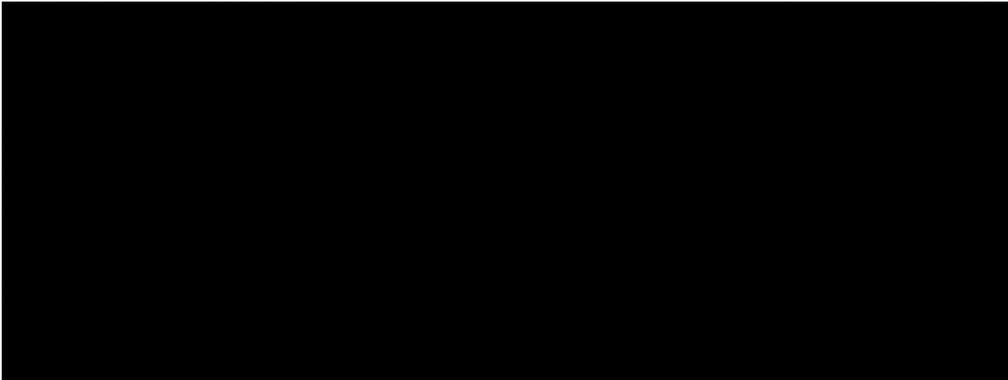
All staff at the Eye Surgery Center of Nevada are required to fully support and participate in this plan and devote their expertise to the patient safety and healthcare quality improvement process. The plan is action oriented and solution focused. The purpose of this plan is to address patient safety related concerns, challenges and revise as needed to better serve the patients and their families. To this end, the Eye Surgery Center of Nevada has developed this Patient Safety Plan.

EYE SURGERY CENTER OF NEVADA

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

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

ROLES AND RESPONSIBILITIES



PATIENT SAFETY COMMITTEE RESPONSIBILITIES

- Monitor and document effectiveness of the patient identification policy
- Receive reports from Patient Safety Officer
- Evaluate actions of the Patient Safety Officer in connection with reports of sentinel events alleged to have occurred.
- Review and evaluate the quality of measures carried out to prevent and control infection.
- Review and evaluate the quality of measures carried out to improve the safety of patients.
- Make recommendations to the governing body to reduce the number of sentinel events and infections that occur.
- Meet quarterly in conjunction with Quality Assurance committee to report any sentinel event or infection occurring in the last quarter and measures taken.
- Adopt and review patient safety checklists and policies annually; revise as needed.

EYE SURGERY CENTER OF NEVADA

PATIENT SAFETY OFFICER RESPONSIBILITIES

- Serve on patient safety committee.
- Supervise the reporting of all sentinel events.
- Take action he determines to be necessary to ensure the safety of patients as a result of investigation into sentinel event.
- Report such investigations to Patient Safety Committee.

INFECTION CONTROL OFFICER RESPONSIBILITIES

- Serve on Patient Safety Committee.
- Monitor the occurrences of infections at the facility to determine the number and severity of infections.
- Report to patient safety committee concerning the number and severity of infections.
- Take action as necessary to prevent and control infections at facility.
- Carry out the provision of the infection control program and ensure compliance of staff.

RCA LEADER RESPONSIBILITIES

- Organize and coordinate the RCA process.
- Assign investigative and implementation tasks to staff members
- Conduct the RCA, investigation and corrective action plan implementation process.
- Communicate the progress of the investigation and finalized plan to leadership.
- Monitor the goals and progress of the corrective action plans.
- Provide training, education and direction to staff that incorporate the Patient Safety and Quality Improvement elements.

GOVERNING BODY RESPONSIBILITIES

- Provide vision and leadership to Patient Safety and Quality Improvement process, develop and foster a safe learning and improving culture.
- Provide oversight to the quality improvement process.
- Plan, discuss and generate the facility patient safety goals and activities in conjunction with the patient safety action plans.

COMPONENTS AND METHODS

The Eye Surgery Center of Nevada as a licensed facility in the State of Nevada is responsible for reporting any Sentinel event within 45 days. The facility will then conduct an investigation concerning the causes or contributing factors or both of the sentinel event and implement a plan to remedy the causes or contributing factors or both, of the sentinel event.

EYE SURGERY CENTER OF NEVADA

The Eye Surgery Center of Nevada will use the root cause analysis process to determine the contributing factors and the underlying reasons for the deficiencies or failures. The Plan-Do-Study-Act (PDSA) is the model, which was developed by the Institute of Health Care Improvement, that we will use to test the changes.

ROOT CAUSE ANALYSIS

A Root Cause Analysis is a process for identifying the root causes of the problem. It focuses on the process instead of the individuals.

Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

Root cause analysis and action plan framework table, which was introduced by the Joint Commission, contains 24 analysis questions. It is a guide to the steps in RCA, not all of the questions will apply to all of the events or cases. It will be used with the fishbone diagram.

The 5 Whys techniques will be used at the Eye Surgery Center of Nevada to explore the cause and effect relationship underlying a problem. One can identify the root causes by asking "why" no less than five times. It will be used as part of the fishbone diagram along with the action plan framework table.

MODEL FOR IMPROVEMENT

The Model for Improvement is a collaborative and ongoing effort to improve the product and services quality and process. It provides guidance in identifying the root causes; conducting tests to assess possible changes; and for implementation of the new approaches and solutions. It guides the test of change to determine if the change is an improvement.

PLAN	Develop plan based on the identified root causes
DO	Implement the change
STUDY	Study process and results
ACT	Adjust, adopt or abandon

EYE SURGERY CENTER OF NEVADA

DEFINITION OF PDSA CYCLE

PLAN--Collect data and establish goals. Identify problem and possible root causes, answer the following questions.

- What is the objective of the test?
- What are the steps for the test-who, what, when?
- How will you measure the impact of the test?
- What is your plan for data collection?
- What do you predict will happen?

DO-- Make changes designed to correct or improve the situation.

- What were the results of the test?
- Was the cycle carried out as planned?
- What did you observe that was unplanned or expected?

STUDY--Study the effect of the changes on the situation. Data should be collected on the new process and compared to the baseline or expected results.

- Did the results match your prediction?
- What did you learn?
- What do you need to do next?

ACT-- If the result is successful or desirable, standardize the changes and then work on the next prioritized problem or further improvements. If the outcome is not successful look for different ways to identify the causes or change the testing process.

DATA COLLECTION AND REPORTING

Data should drive any quality and patient safety effort. The Eye Surgery Center of Nevada will use the data collected from our Quality Improvement Measures for tracking the sentinel and infection events for internal data collection.

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

- NHSN: National Healthcare Safety Network
- NQF: National Quality Forum
- CDC: Centers for Disease Control and Prevention

EYE SURGERY CENTER OF NEVADA

ONGOING REPORTING AND REVIEW

The Eye Surgery Center of Nevada is an independently physician owned and operated ambulatory surgical facility for ophthalmology related procedures only. It operates only twice a month on Wednesdays for a twelve hour or less surgical day. Data will be collected and reported as follows:

MONTHLY

- 1) Sentinel Event Report
- 2) Infection Report
- 3) RCA assessment

QUARTERLY

- 1) Sentinel event report update
- 2) Severity of infection report
- 3) Review and evaluate the measure of improvement of patient safety
- 4) Review and evaluate the measurement to prevent and control infection

ANNUALLY

- 1) Quality and Patient Safety Plan
- 2) Checklists and Policies review/revise

ASSESSMENT OF THE QUALITY AND PATIENT SAFETY PLAN

The assessment of the Patient Safety plan and Quality Improvement measures will be ongoing and continuous. It will have four essential elements; management, patient safety program, procurement & equipment and safety policies and checklists. Important factors of a quality program include building trust through active listening skills, identifying issue through improved questioning skills and resolving issues with feedback obtained in open environment without instilling blame.

EYE SURGERY CENTER OF NEVADA

PATIENT SAFETY CHECKLISTS AND POLICIES

The Eye Surgery Center of Nevada Patient Safety Plan includes a Patient Safety Checklist and patient safety policies. The Patient Safety policies are developed for the use of Providers of healthcare who provide treatment to patients at the facility and to employees of the facility who provide treatment and who do not provide treatment but whose duties affect the health and welfare of the patients at the facility. The policies are also developed for persons or entities whom the facility contracts with for services which may affect the health or welfare of patients including Pharmacy, BioMed, Laundry and Sanitation.

The patient safety policies include but are not limited to policies on patient identification; hand hygiene; compliance policy; discharge policy.

The patient safety checklists are included as part of the patient permanent record and address treatment specific issues; sanitary environment issues and discharge instructions. They are verified and completed by the registered nurse, timed and dated.

APPROVAL OF PATIENT SAFETY PLAN

The Eye Surgery Center of Nevada will submit its patient safety plan to the governing board for approval. After initial approval the facility is responsible for notifying all providers of healthcare who provide treatment to patients of the existence and requirements of the plan.

The patient safety plan will be reviewed and updated annually and a copy of the plan will be submitted to the Division of Public and Behavioral Health.

Ford Center for Foot Surgery

January 1, 2015

Reviewed

1-1-14

1-4-17

1-1-18

Policy: Safety Plan

Purpose: To provide a safe environment for all patients, employees, and physicians.

Procedure: 1. All electrical equipment is in optimal condition.

2. No frayed cords or loose plugs.
3. Emergency power has been checked.
4. Air conditioner filters will be serviced quarterly.
5. Temperature and humidity checked to be at a comfortable level for the patients and staff.
6. Bio-Med person will check equipment and electrical safety annually.
7. O.R. rooms and electrical equipment checked on surgical days.
8. Emergency call systems are located in O.R., Changing rooms, Pre-Op room, and Post-op Room. They are checked to be in working condition on operative days.
9. Wheelchair is in working condition.
10. Crutches are in working condition.
11. All walkways are clear of debris, and cleared of ice snow, and water.

Signatures:

A series of five horizontal lines representing redacted signatures. Each line is completely blacked out, obscuring the names and any handwritten notes.

**NEVADA ENDOSCOPY MANAGEMENT INC
GASTROENTEROLOGY CONSULTANTS LTD
RENO ENDOSCOPY CENTER LLC
SOUTH MEADOWS ENDOSCOPY CENTER LLC
CARSON ENDOSCOPY CENTER LLC**

POLICY AND PROCEDURE MANUAL

Policy: Patient Safety Plan
Owner: Center
Date last updated: Revised 4/2016

Purpose: Gastroenterology Consultants, Ltd (GIC) and affiliated Endoscopy Centers are committed to ensuring the ongoing safety of our patients. To ensure the ongoing safety and care of our patients we follow specific guidelines and policies which, at a minimum, include:

I Infection Control (IC): Refer also to the Infection Control (IC) Policy

Guidelines followed include:

- a. American Society for Gastrointestinal Endoscopy (ASGE) Multisociety Guideline on Reprocessing Flexible Gastrointestinal Endoscopes 2011
- b. Society of Gastroenterology Nurses and Associates, Inc. (SGNA) Standards of Infection Prevention in Reprocessing Flexible Gastrointestinal Endoscopes 2015
- c. Society of Gastroenterology Nurses and Associates, Inc. (SGNA) Standard of Infection Prevention in the Gastroenterology Setting 2015
- d. Society of Gastroenterology Nurses and Associates, Inc. (SGNA) Guideline for Use of High Level Disinfectants and Sterilants for Reprocessing Flexible Gastrointestinal Endoscopes 2013
- e. American Society for Gastrointestinal Endoscopy (ASGE) Infection Control during GI Endoscopy 2008
- f. Center for Disease Control (CDC) Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings 2007
- g. CDC Guide to Infection Prevention for Outpatient Settings 2014
- h. Association for Professionals in Infection Control and Epidemiology (APIC) Guide to the Elimination of Clostridium difficile in Healthcare Settings 2013
- i. CDC Safe Injection Practices

The IC Policy includes at a minimum processes or guidelines for:

- a. Patient selection and placement within the facility
- b. Infection Control Monitoring and Surveillance, Reporting
- c. Standard and Transmission Precautions, Hand Hygiene, Personal Protective Equipment, Respiratory Hygiene / Cough Etiquette and General Infection Control Practices in Healthcare Facilities as developed by the CDC and APIC
- d. Environmental and Terminal Cleaning
- e. Infection Control Officer

Approved Board of Managers REC/SEC/ CEC 10/11/11; Revised 8/9/12, Approved Board of Managers REC/SEC 1-31-16; CEC 1-25-16; Approved Medical Directors 4/2016

The proceedings and records of a patient safety committee are subject to the same privilege and protection from discovery as the proceedings and records described in NRS 49.117 - 49.123 and NRS 49.265.

- f. Equipment Processing: Cleaning, Disinfection, High Level Disinfection and Sterilization

II □ Patient Selection and Screening: Refer also to the Criteria for Scheduling Patients at ASC Policy.

1. To ensure patients are appropriate for the planned procedure in the planned setting patients undergo:
 - a. Pre-procedure scheduling evaluation with referral for office visit or consultation as appropriate
 - b. Pre-procedure assessment which includes at a minimum:
 - i. Review of past medical & surgical history
 - ii. Medication reconciliation, review
 - iii. Allergy and reaction, review of
 - iv. Physical assessment; assessment for communicable diseases
 - v. Vital signs

III □ Patient Identification: Refer to Patient Identification Policy. Patient identity is verified with at minimum two (2) identifiers at check-in and at multiple points throughout care.

IV □ Safe Surgery Checklist: Refer to Safe Surgery Checklist Policy. Patient and procedure are verified immediately prior to procedures.

V □ Discharge Teaching: Patients are provided with written discharge instructions which are reviewed with patient and driver, as applicable, prior to discharge. Medications are reconciled prior to discharge if any new medications are ordered. Information specific to diagnosis, as best as known, is given to the patient. Patients are educated about signs and symptoms to report and given a twenty-four (24) hour telephone number to call in event of questions or concerns.

VI □ Post Procedure Callbacks: Patients are contacted one (1) to two (2) business days post-procedure for follow up of any concerns and questions regarding discharge instructions.

VII □ Pathology follow up: Patients are notified of pathology results and given information and follow up orders as applicable within two (2) weeks.

VIII □ Pharmaceutical Services: Refer to Pharmaceutical Services Policy. Safe injection practices are strictly followed. Pharmaceutical services are overseen by a contracting pharmacist on a monthly basis.

I □ Quality Assurance and Benchmarking: Refer to the Quality Management Plan. More than one hundred (100) quality assurance checkpoints are monitored on per patient, per case, per day, per week or per month basis as applicable. Benchmarking of multiple facility and nursing care factors are completed on an ongoing basis. In addition, multiple procedure-related factors are tracked and trended in aggregate and specific to individual

Approved Board of Managers REC/SEC/ CEC 10/11/11; Revised 8/9/12, Approved Board of Managers REC/SEC 1-31-16; CEC 1-25-16; Approved Medical Directors 4/2016

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physicians on an ongoing basis. Incidents, procedure complications/events, adverse and sentinel events are investigated tracked and trended by facility, staff and physician. All data is reported to the Quality Management Committee.

- **Staff Training:** Extensive staff training is done at time of hire. Annual staff retraining is mandatory; ongoing training is provided as applicable. Staff are evaluated for customer service and performance on an ongoing basis.
- I□ **Checklists:** All items above are monitored via specific checklists, logs and or chart documentation.

Refer to:

- Infection Control Policy
- Criteria for Scheduling Patients at ASC Policy
- Identification of Patient Policy
- Pharmaceutical Services Policy
- Quality Management Plan
- Safe Surgery Checklist Policy
- Incident Reports Policy
- Complications: Procedure Event, Adverse and Sentinel Events Policy
- Staff Training Competencies and Logs
- NRS 439.865; 439.877

Approved Board of Managers REC/SEC/ CEC 10/11/11; Revised 8/9/12, Approved Board of Managers REC/SEC 1-31-16; CEC 1-25-16; Approved Medical Directors 4/2016

The proceedings and records of a patient safety committee are subject to the same privilege and protection from discovery as the proceedings and records described in NRS 49.117 - 49.123 and NRS 49.265.

Please revise and expand this template to meet your facility's needs.

Facility Name: Shepherd Eye Surgicenter

QUALITY AND PATIENT SAFETY PLAN Template



This plan was created and revised by the Shepherd Eye Surgicenter Patient Safety committee/team. Implementation of this plan is intended to optimize the healthcare quality and patient safety outcomes, encourage recognition, reporting, and acknowledgment of risks to patient, visitor, and employee safety, as well as reduce the medical/healthcare errors and /or preventable events.

Patient Safety Committee/Program

Facility name:

Facility Address

Facility contact information

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Commitment to Patient Safety

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

Mission, Vision, and Values

In support of our mission, vision, and values, Shepherd Eye Surgicenter Patient Safety and Quality Improvement program promotes:

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

Scope and Purpose

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

- Patient safety
- Visitor safety
- Employee safety

All staff in Shepherd Eye Surgicenter are required to fully support and participate in this plan, and devote their expertise to the patient safety and healthcare quality improvement process.

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

The plan focuses on the process rather than the individual, and recognizes both internal and external customers, as well as facilitates the need of analyzing and improving processes. The *Patient Safety and Quality Improvement Plan*

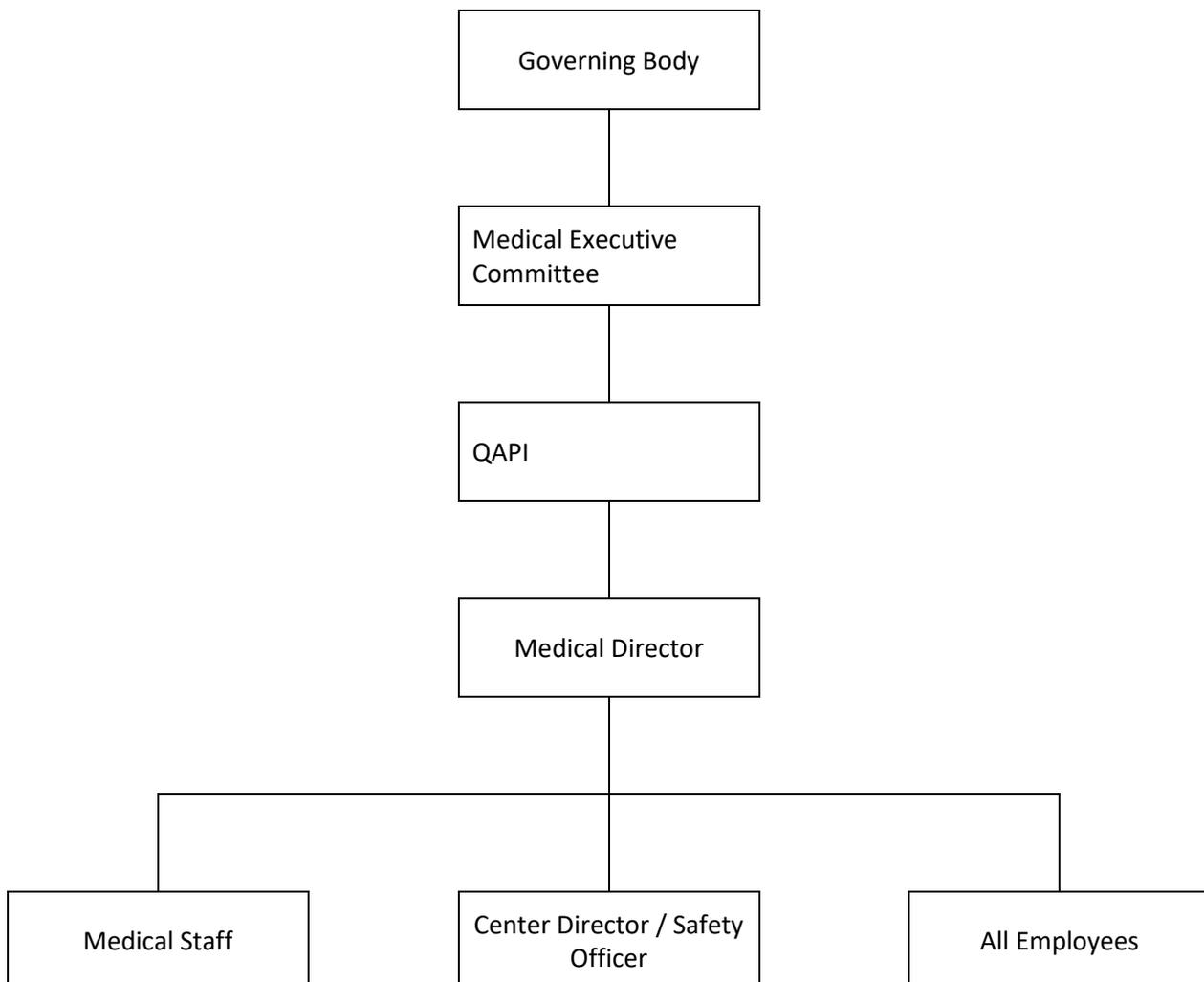
core principles of this plan include:

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

Roles and Responsibilities

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

The Patient Safety Committee Organization



Roles and Responsibilities

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

Based on [NAC 439.920](#), a medical facility that has fewer than 25 employees and contractors must establish a patient safety committee comprised of:

- The patient safety officer of the medical facility;
- At least two providers of healthcare who treat patients at the medical facility, including but without limitation, one member of the medical staff and one member of the nursing staff of the medical facility; and
- The Chief Executive Officer (CEO) or Chief Financial Officer (CFO) of the medical facility.

The roles and responsibilities are defined below (Please modify them as needed.)

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

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

Root Cause Analysis (RCA) Team Responsibilities (please revise as needed)*Patient Safety and Quality Improvement Plan*

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

Patient Safety Officer Responsibilities (based on [NRS 439.870](#))

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

(Additional responsibilities here if needed)

Infection Control Officer Responsibilities (based on [NRS 439.873](#))

- Serve on the patient safety committee.
- Monitor the occurrences of infections at the facility to determine the number and severity of infections.
- Report to the patient safety committee concerning the number and severity of infections at the facility.
- Take such action as determines is necessary to prevent and control infections alleged to have occurred at the facility.
- Carry out the provisions of the infection control program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program.

(Additional responsibilities here if needed)

RCA team leader Responsibilities (please revise as needed)

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

RCA Facilitator Responsibilities

(Please provide the responsibilities here)

Executive or Governing Body Staff Responsibilities (please revise as needed)

Patient Safety and Quality Improvement Plan

- Provide vision and leadership to Patient Safety and Quality Improvement process, and develop and foster a safe learning and improving culture.
- Provides oversight to the healthcare quality improvement processes and teams.
- Plan, discuss, and generate the organization patient safety goals and activities, in conjunction with the patient safety action plans

(Please provide additional responsibilities here if needed)

The Patient Safety Committee will meet monthly (or quarterly) to accomplish the following:

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

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

- Define the healthcare issues or potential risks.
- Conduct Root Cause Analysis
 - Reviewing and analyzing the data.
 - Reviewing the RCA process and quality improvement related activities and timelines.
 - Brainstorming issues or the potential risks by using the fishbone diagrams.
 - Identify the contributing factors and conduct the Root Cause Analysis.
- Conduct Corrective Action Plan
 - Identifying the Plan-Do-Study-Act (PDSA) topics.
 - Discussing corrective action process and activities.
 - Discussing and presenting possible changes in procedure to improve areas indicated.
 - Identifying strengths and areas that need improvement.
 - Developing strategies, solutions, and steps to take next.
- Identify barriers and technical assistance needs for supporting the RCA efforts.

A meeting agenda and minutes noting follow-up tasks will be kept.

Objectives and Goals of the Quality and Patient Safety Plan

Objective	Goals	Plan	Planned Completion Date	Responsible Party

Components and Methods

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

(Facility name) will use RCA process to determine the contributing factors and the underlying reasons for the deficiencies or failures. The Plan-Do-Study (check)-Act (PDSA or PDCA) is the model, which was developed by the Institute of Health Care Improvement, that we will use to test the changes.



Root Cause Analysis

A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals.

Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

Root cause analysis and action plan framework table, which was introduced by the Joint Commission. It contains 24 analysis questions. It guides the organization to the steps in a root cause analysis. Not all the questions apply to all the events or cases. This table can be used individually or with the fishbone diagram.

5 Whys technique will be used in Shepherd Eye Surgicenter to explore the cause and effect relationship underlay a problem. One can find the root causes by asking “why” no less than five times. This technique can be used individually or as a part of the fishbone diagram.

Fishbone Diagram

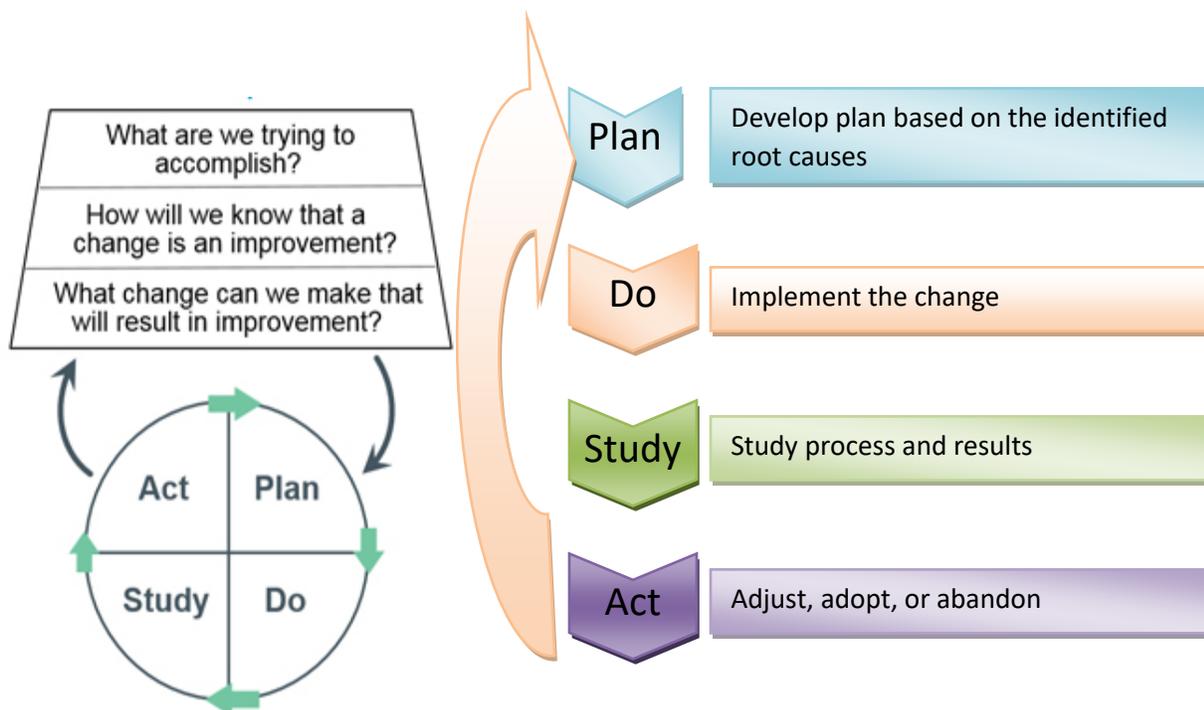
Patient Safety and Quality Improvement Plan

Once the problems are identified, a Fishbone Diagram (Appendix C) will be used for analyzing the problems. You can use the fishbone diagram individually to analyze the root causes, or use it with the root cause analysis and action plan framework table.

A Fishbone Diagram, also called a Cause-and-Effect diagram, is a useful tool for a team to structurally brainstorm by discovering possible underlying factors or root causes from different major categories for the chosen problems. General categories used include: people, methods, materials, measurements, education, procedures, process, location, environment, etc. RCA team members will brainstorm and ask multiple times, “why did this happen?” for each cause until all ideas are exhausted. The highest priority root causes will be chosen for PDSA topics. Once all the categories are established on the fishbone diagram, 5 Why’s technique also can be used to drill down the problem and find the root causes.

Model for Improvement

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



The cycle is defined as follows:

- Plan--collect data and establish appropriate goals. Identify the problem and the possible root causes, and answer the following questions.
 - What is the objective of the test?

- What are the steps for the test - who, what, when?
 - How will you measure the impact of the test?
 - What is your plan to collect the data needed?
 - What do you predict will happen?
- Do--make changes designed to correct or improve the situation. Use the following questions for the guidance.
 - What were the results of the test?
 - Was the cycle carried out as designed or planned?
 - What did you observe that was unplanned or expected?
 - Study -- Study the effect of the changes on the situation. Data should be collected on the new process and compared to the baseline or expected results. Results should be evaluated and by using the following questions as guidance.
 - Did the results match your prediction?
 - What did you learn?
 - What do you need to do next?
 - Act--If the result is successful or desirable, standardize the changes and then work on the next prioritized problem or the further improvements. If the outcome is not yet successful, look for different ways to identify the causes or change the testing process.

PDSA worksheet will be used to map the potential change strategies and to establish a course of action. The PDSA worksheet and the PDSA progress report are attached in Appendix D-1.

Data Collection and Reporting

Data should drive any quality and patient safety effort. (Facility name) is using (data system names) for tracking the sentinel events, healthcare infection data, and (any other database) for internal data collection.

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

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



Ongoing Reporting and Review

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

Monthly	Quarterly	Annually
1) Sentinel event monthly report 2) Severity of infection report 3) RCA assessment	1) Sentinel event quarterly report 2) Severity of infection report 3) Review and evaluate the measure of improvement of patient safety 4) Review and evaluate the measurement to prevent and control infections	1) Quality and Patient Safety Plan update 2) Checklists and Policies reviewing and revising

Assessment of the Quality and Patient Safety Plan

Please see the Patient Safety Assessment Tool (PSAT) from the VA National Center for Patient Safety for your reference.

Patient Safety Checklists and Patient Safety Policies

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

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

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

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

The patient safety policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include, the name and date of birth of the patient.

- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.
- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

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

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

The patient safety checklists are listed in Appendix E. (The following links provide some patient safety checklists for your reference— a checklist example is shown in **Appendix E.**)

http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf

<http://www.who.int/patientsafety/implementation/checklists/en/>

The patient safety policies are listed in Appendix F. (The following link provides you some patient safety policies for your reference—a policy example is shown in **Appendix F.**)

<https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>

Approval of Patient Safety Plan

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

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

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

Reference

- Root Cause Analysis Toolkit <http://www.health.state.mn.us/patientsafety/toolkit/>
- Quality and Service Improvement Tools http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html
- CQI 101 An Introduction to Continuous Quality Improvement: <https://www.coursehero.com/file/13827355/CQI-Overviewppt/>
- Quality Improvement <http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/>
- Root Cause Analysis <http://www.patientsafety.va.gov/professionals/onthejob/rca.asp>
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2 https://www.jointcommission.org/sentinel_event.aspx
- Hospital Policies <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>
- Checklists to Improve Patient Safety http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf
- Patient Safety Checklists <http://www.who.int/patientsafety/implementation/checklists/en/>
- Minutes of the Meeting of the Quality and Patient Safety Committee <http://www.cookcountyhhs.org/wp-content/uploads/2013/12/09-23-14-QPS-scan-Minutes.pdf>
- Title 40 – Public Health and Safety <https://www.leg.state.nv.us/NRS/NRS-439.html>

Appendix A: Terms and Definitions

Patient Safety: The Agency for Healthcare Research Quality (AHRQ) defines patient safety as “a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.”
http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

Sentinel event ([NRS 439.830](#))

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

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

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

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

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

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

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

Facility-Associated Infection: ([NRS 439.802](#))

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

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

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

Medical facility ([NRS 439.805](#))

“Medical facility” means:

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

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

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

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

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

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

Catheter Associated Urinary Tract Infection (CAUTI): A urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CUR_RENT_b.pdf.)

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

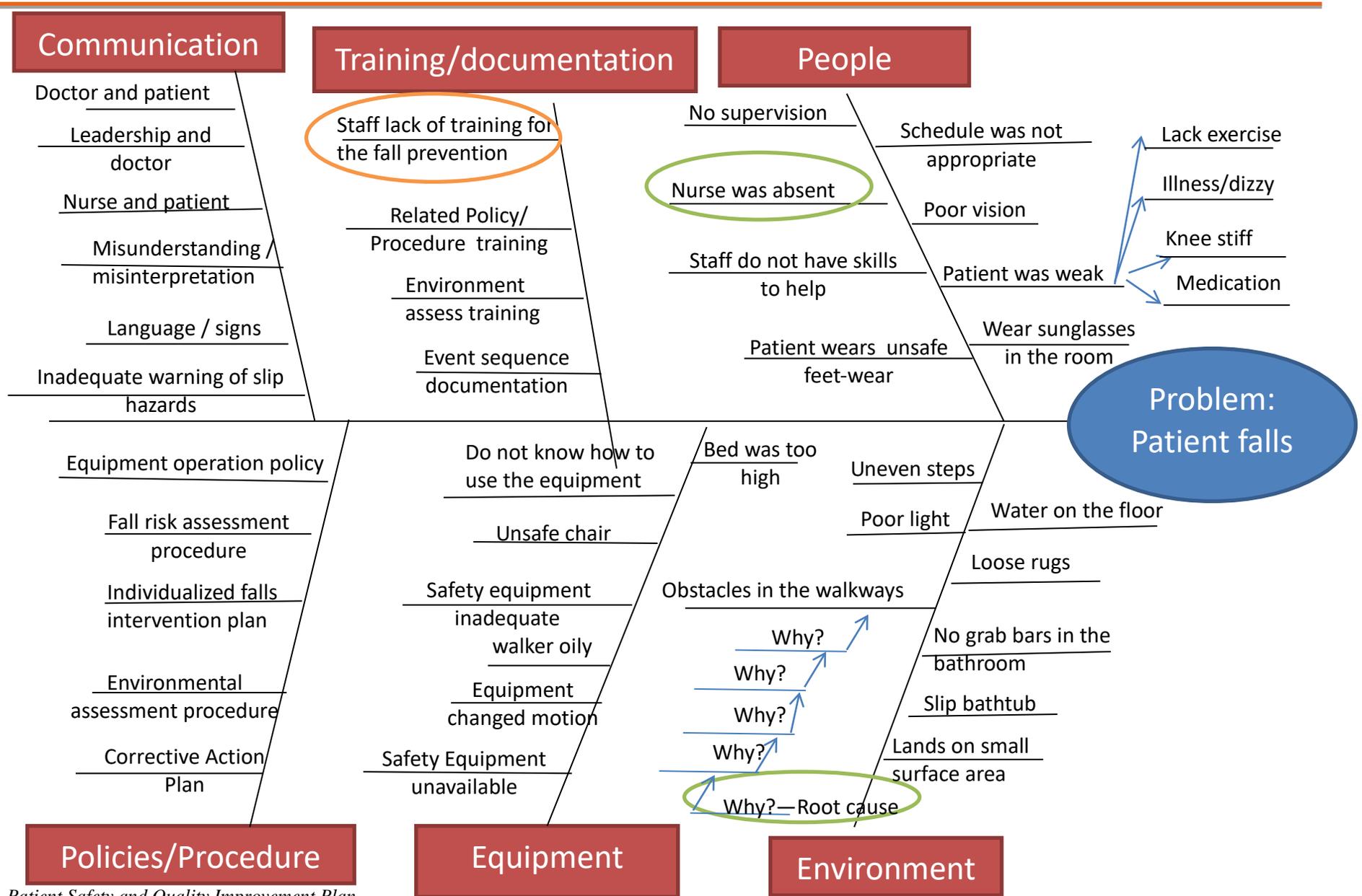
Appendix B: Patient Safety Goals

OBJECTIVE:	GOAL:	Q3 2014	Q4 2014	Q1 2015
ACTION PLAN:				
1. Create Systems that anticipate errors & either prevent or catch them before they cause harm.	a. Enhance retrospective chart review process. b. Establish an automated surveillance process. c. Conduct a proactive risk assessment in a high risk area.		Complete an in-depth analysis of risk point utilizing the methods of FMEA.	Implement Trigger Tools. Develop automated surveillance reports in Cerner.
		Implemented e-MERS & PSO with UHC.	Create process for reviewing & closing reports in e-MERS. Increase number of events reported by 10%. Create process for communicating outcome of reported events.	
2. Establish Structures for reporting and a process for managing reports in the event reporting system.	a. Implement new electronic Voluntary Reporting System & participate in Patient Safety Organization. b. Develop a structure to educate employees system-wide of the process for reporting hazards, errors and adverse events. c. Establish a process for providing feedback regarding reported events.			
3. Develop a Culture of Safety where providers feel safe and supported when they report medical errors or near misses & voice concerns about patient safety.	a. Provide education on patient safety plan that emphasizes importance of blending a systems focus with appropriate individual accountability. b. Establish a recognition program that rewards safe practices. c. Improve overall perceptions of safety as measured by the Culture of Safety Survey.		Educate Medical staff, Hospital Wide Oversight & the Quality Committees on the objectives and goals of the patient safety plan. Include patient safety presentation in monthly New Employee Orientation. Develop 'Great Catch' awards program.	Re-evaluate culture of safety and develop action plan.
4. Establish Safety Priorities & Targets.	a. Develop Patient Safety Dashboard that includes national measures and benchmarks. b. Facilitate the development of action plans associated with measures not meeting benchmarks. c. Assess and improve processes related to hand-off, transition and communication	Complete 2014 Leapfrog Safety Survey.	Present Patient Safety Dashboard monthly to Hospital Wide Oversight Committee. Establish & implement a plan to improve performance of each leap.	
		Develop method to track & report departmental progress and compliance of RCA action plans.		
5. Charter Safety Programs through teams, workgroups or projects.	a. Coordinate Improvement Efforts in order to ensure that capital, people, facilities & technologies are matched to strategic priorities for safe practices. b. Reduce and eliminate variation in care.		Establish Patient Safety Council. Establish workgroups focused on medication safety, reducing patient falls & hospital acquired pressure ulcers.	
			Revise or develop policies, procedures and protocols.	

Reference: Patient Safety Plan and Its Applicable Goals. 2014. Cook County Health and Hospitals System.

Patient Safety and Quality Improvement Plan

Appendix C: Fishbone Diagram



Appendix D-1: PDSA Worksheet

PDSA Worksheet

Topic:			
Person Completing Worksheet:		Date:	
Telephone/ Email:		Cycle:	
Patient Safety Committee Members			
CEOs/CFOs			
Patient Safety Officer			
Infection Control Officer			
Other Medical Staff			
Other team members			
Aim: (Describe the overall SMART goal that your team wishes to achieve.)			
Plan:			
1. List the tasks needed to set up this test of change.			
2. Predict what will happen when the test is carried out.			

3. List the steps to develop the test-who, what, and when.			
Steps	By Whom	By When	Desired Outcome
Do: (Describe what actually happened when you ran your test, including any problems and unexpected findings.)			
Study: (Describe what you learned and did you meet your measurement goal?)			
Did you meet your measurement goal? Explain.		Summarize what was learned: success, failure, unintended consequences, etc.	
Act: (Describe what you concluded from this cycle.)			
Based on what was learned, please indicate what action will be considered.		Describe what modifications to the plan will be made for the next cycle based on what you learned.	
<input type="checkbox"/> Adapt: modify changes and repeat PDSA Cycle			
<input type="checkbox"/> Adopt: expanding changes throughout organization			
<input type="checkbox"/> Abandon: change approach and repeat PDSA cycle			

Appendix D-2: PDSA Monthly / Quarterly Progress Report

Event:			
Person Complete Report:		Date:	
Patient Safety Officer		Contact Information:	
Monthly / Quarterly Report			
Items	Description		
1. What is your goal?			
2. Report on the PDSA cycle			
3. What system and practices are working well? Explain.			
4. What areas for improvement did the data identify?			
5. What barriers or system issues have been encountered implementing action activities?			
6. Action plans to address the barriers or system issues			
7. Lesson learned			
8. Support needed			
9. Additional discussion			
Notes:			

Appendix E: Checklist Example: Injuries from Falls and Immobility

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

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

Appendix F: Policy Example

[Reference: Hospital Policies. MERCY Hospital. <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>]

	HOSPITAL POLICY AND INFORMATION MANUAL	
<p>PERSONAL PROTECTIVE EQUIPMENT POLICY Page 1 of 2</p>	<p>Date Issued: 07/01 08/14 Date Last Revised: 08/17 Next Review Date: Approved By: Policy Committee</p>	

Key Words: personal protective equipment, PPE, safety equipment,

Policy Applies to:

- All staff employed by Mercy Hospital;
- Credentialed Specialists, Allied Health Professionals, patients, visitors and contractors will be supported in meeting policy requirements.

Related Standards:

- Infection and Prevention and Control Standards NZS 8134.3:2008
- Health and Safety in Employment Act 1992
- EQulP5 - 1.5.1 and 1.5.2 Infection Control
- EQulP5 - Standard 3.2 Criterion 3.2.1 Health and Safety

Rationale:

Mercy Hospital will provide suitable personal protective equipment (PPE) when the risk to health and safety cannot be eliminated or adequately controlled by other means.

Definitions:

Personal protective equipment (PPE) means all equipment which is intended to be worn or held by a person to protect them from risk to health and safety while at work.

Examples of PPE include: protective footwear, gloves, hard hats/helmets, clothing affording protection from the weather, visibility clothing, eye and face protection.

Objectives:

- To ensure appropriate PPE is identified to minimize hazards not able to be controlled by elimination or isolation;
- To ensure fit for purpose PPE is provided at Mercy Hospital for use by staff;
- To ensure adequate training in the use of PPE is provided;
- To monitor the use of PPE and evaluate effectiveness.

	HOSPITAL POLICY AND INFORMATION MANUAL	
<p>PERSONAL PROTECTIVE EQUIPMENT POLICY Page 2 of 2</p>	Date Issued: Date Last Revised: Next Review Date: Approved By:	07/01 08/14 08/17 Policy Committee

Implementation:

Risk Management

Department Managers, the Occupational Health/ Infection Prevention and Control Nurse (OH/IPC Nurse) and Health and Safety/ Infection Control Representatives (HSIC reps) will in consultation with staff:

Ensure PPE requirements are identified when carrying out risk assessments of activities;

- Regularly review the risk assessment of activities if substances or work processes change;
- Identify the most suitable type of PPE that is required;
- Ensure PPE is available to those who need it;
- Inform staff of the risks involved in their work and why PPE is required;
- Monitor compliance.

Process

Manager’s Responsibilities

Must ensure that:

- PPE requirements are considered when risks are assessed;
- Suitable PPE is provided and made accessible to employees;
- PPE is properly stored, maintained, cleaned repaired and replaced when necessary;
- Adequate information and training is provided to those who require PPE;
- PPE is properly used;
- Use of PPE is monitored and reviewed.

Employee’s Responsibilities All employees must ensure that:

- They use PPE whenever it is required;
- Attend and comply with training, instruction and information;
- Check the condition of their PPE;
- Store, clean and maintain their PPE;
- Report losses, defects or other problems with PPE to their manager.

Evaluation:

- Staff health and safety orientation
- Environmental audits
- Incident reports

**Sierra Center for Foot Surgery's
Patient Safety Plan
Patient Safety Committee**

The goal of the Sierra Center for Foot Surgery's internal patient safety plan is to improve the health and safety of patients who are treated at the medical facility. It is developed in consultation with the actual providers of health care to the facility's patients. The center's safety plan is delineated in the center's policy and procedure manual and includes policies and procedures related to:

Surgical Time Out
Surgical Site Marking
Emergency Call System
Safe Use of Electrical Equipment
Facility Safety Checklist
Facility Maintenance and Safety
Equipment Safety Log
Emergency Drills:

- Fire Drills
- Earthquake Drills
- Bomb Threats
- Medical Emergency Drills

Patient Positioning

The center's Program for The Prevention and Control of Infections and Communicable Diseases, includes policies and procedures related to:

Medication Safety

- Single Dose vials
- Multi-dose vials
- Anesthesia Services

Syringe and Needle Use
IV Infusions
Disinfection
Sterilization
Aseptic Technique
Communicable Diseases and Resistant Infections
Hand Hygiene
Gloves

The center's infection control and patient safety policies and procedures are reviewed and approved at least annually. Infection control, patient safety and communicable disease policies and procedures are also reviewed and reinforced via annual face to face in-services. If new and improved infection control practices, patient safety practices or new information on communicable disease control and/or prevention are discovered before that time they are discussed and reviewed with the Director of Nursing, medical director and any pertinent staff members, in-serviced and put into effect at that time.

The Sierra Center for Foot Surgery has designated Jessica Bell, RN to serve as the center's Patient Safety Officer. She has the responsibility to serve on the patient safety committee, supervise the reporting of all sentinel events, take action as deemed necessary to ensure patient safety at the facility and report any action taken to the patient safety committee.

Patient Safety Committee:

The center's patient safety committee is comprised of all the staff members of the center, including the Director of Nursing and the Medical Director who is considered the "CEO" of the center.

The committee shall meet once annually.

The patient safety committee shall:

Receive reports from the patient safety officer pursuant to NRS 439.870

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

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

**Southwest Medical,
Part of Optum Care**

PATIENT SAFETY PLAN

MARCH 1 2018



The Southwest Medical Patient Safety committee/team created the plan and revises/updates it annually. Implementation of this plan is intended to optimize healthcare quality and patient safety outcomes, encourage recognition, reporting, and acknowledgment of risks to patient, visitor, and employee safety, and reduce the medical/healthcare errors and /or preventable events

Patient Safety Committee/Program
Southwest Medical, Part of Optum Care
Las Vegas, Nevada

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Commitment to Patient Safety

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

Mission, Vision, and Values

In support of our mission, vision and values, Southwest Medical's Patient Safety and Quality Improvement program promotes:

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

Plan Scope and Purpose

The scope of the Patient Safety Committee organizational-wide and includes but is not limited to

- Patient safety
- Visitor safety
- Employee safety

The Committee provides oversight for patient safety activities, infection control activities, initiatives to promote patient safety and monitoring and review of medical/healthcare errors/potential errors involving patients, visitors, SMA staff, students and volunteers

All staff members at Southwest Medical are expected to fully support and participate in this plan and devote their expertise, knowledge, vision, skill, and insight to the patient safety and healthcare quality improvement process

Leadership assumes a role in establishing a culture of safety that minimizes hazards and patient harm by focusing on processes of care. The leaders of the organization are responsible for fostering a culture of safety through personal example by:

- Emphasizing patient safety as an organizational priority
- Providing education to medical and facility staff regarding the commitment to reduction of medical errors
- Supporting proactive reduction in medical/health care errors
- Integrating patient safety priorities into the new design and redesign of all relevant organization processes, functions and services

The purpose of the Patient Safety Plan is:

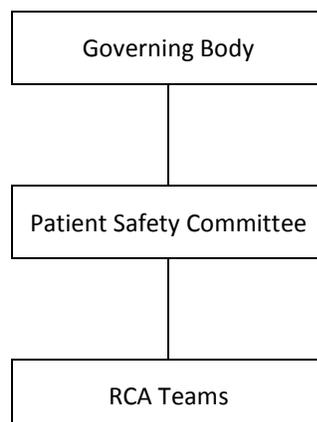
- To address patient safety related concerns and challenges
- To reduce risk
- To respect the dignity of those Southwest Medical serves by assuring a safe environment
- To periodically evaluate and revise the program to better serve patients and their families

Roles and Responsibilities

Southwest Medical created an organization-wide Patient Safety Plan that includes the medical facilities (Surgery Centers) as directed by [NRS 439.875](#) a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plan is promoted and executed successfully

The Southwest Medical Patient Safety Committee

- Is a standing confidential interdisciplinary committee formed to manage the Southwest Medical’s Patient Safety Program and Infection Prevention and Control Program through a systematic, coordinated, continuous approach
- Will meet monthly to assure maintenance and improvement of patient safety with the establishment of plans, processes and mechanisms involved in the provision of the patient care
- Will report and discuss events including:
 - Number of sentinel events from previous calendar quarter
 - Number of severe infections from previous calendar quarter
 - Corrective action plans
 - Corrective action plan evaluation
 - Patient safety policies and checklists
- Will monitor and document the effectiveness of the patient safety policy
- Will evaluate patient safety policies and checklists at least annually
- Will revise patient safety policies and checklists as needed
- Will convene a RCA meeting/team as necessary
- Review the RCA process and quality improvement related activities and timelines
- Identify barriers and technical assistance needs for supporting the RCA efforts
- Discuss corrective action process and activities



Patient Safety Committee Membership

In accordance with [NRS 439.875](#), the Patient Safety Committee will include:

- The Patient Safety Officer
- The Infection Prevention and Employee Health Medical Director

- At least three providers of healthcare who treat patients , including but, without limitation, at least one member of the medical, nursing and pharmaceutical staff
 - Medical Director Specialties
 - Medical Director Primary Care
 - Medical Director On Demand Medicine
 - Medical Director Clinical Education Programs
 - Medical Director Surgery Centers
 - Associate Vice President Surgery Centers (RN and Administrator)
 - Chief Nursing Officer
 - RN Executive Director On-Demand Medicine
 - RN Director Specialties
 - Director Imaging Services
 - Pharmacy Consultant (PharmD)
 - RN Managers Surgery Centers
 - RN Clinical Quality
 - Infection Prevention RN
- One member of the governing body
- Optum Legal
- Vice Presidents Clinic Operations
- UHG Safety Regional Manager

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

The Patient Safety Committee is a standing confidential interdisciplinary committee formed that manages the Southwest Medical’s Patient Safety Program and Infection Prevention and Control Program through a systematic, coordinated, continuous approach

- Evaluating and improving the quality of care rendered by Southwest Medical
- Collecting data and evaluating aggregate data related to individual occurrences in order to utilize performance improvement methodologies to promote patient safety and infection prevention
- Maintaining and improving patient safety with the establishment of plans, processes and mechanisms involved in the provision of the patient care
- Monitoring and documenting the effectiveness of the patient identification policy
- On or before July 1 of each year, submitting a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#)
- Receiving reports from the Patient Safety Officer pursuant to [NRS 439.870](#)
- Evaluating actions of the Patient Safety Officer in connection with all reports of potential or actual sentinel events
- Reviewing and evaluating the quality of measures carried out by Southwest Medical to improve the safety of patients who receive treatment
- Reviewing and evaluating the quality of measures carried out by Southwest Medical to prevent and control infections
- Making recommendations to the governing body to reduce the number and severity of sentinel events and infections that occur
- At least once each quarter, reporting to the governing body regarding
 - The number of sentinel events at the medical facility (Surgery Centers) during the preceding calendar quarter
 - The number and severity of infections at the medical facility (Surgery Centers) during the preceding calendar quarter
 - Any recommendations to reduce the number and severity of sentinel events and infections

- Adopting patient safety checklists and patient safety policies as required by [NRS 439.877](#), reviewing checklists and policies annually and revising the checklists and policies as necessary
- Directing root cause analysis teams when indicated
- Providing oversight/direction for Surgery Centers QAPI program and quality studies
- Providing oversight/direction for the Surgery Centers participation in NHSN
- Providing oversight and monitoring for the Optum Practice Health and Safety Clinical Assessment Process

Patient Safety Officer Responsibilities ([based on NRS 439.870](#))

- Chair the Patient Safety Committee
- Supervise the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#)
- Take such action as necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility
- Report to the Patient Safety Committee regarding any action taken in accordance with the responsibilities above
- Promote compliance with patient safety standards and initiatives
- Reinforce expectations of the Patient Safety Plan
- Accept accountability for measurably improving safety and reducing errors
- Liaison with Southwest Medical clinical leadership including surgery center leadership, other quality committees and the Board of Directors

Infection Prevention Officer Responsibilities ([based on NRS 439.873](#))

- Serve on the Patient Safety Committee
- Liaison with Southwest Medical clinical leadership including surgery center leadership, other quality committees and the Board of Directors
- Provide medical direction as indicated (for both patient and employee infection control issues)
- Monitor the occurrences of infections to determine the number and severity of infections
- Report to the Patient Safety Committee concerning the number and severity of infections
- Take such action as necessary to prevent and control infections alleged to have occurred
- Carry out the provisions of the infection control program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program
- Ensure compliance with current infection prevention and control standards
- Direct infection prevention initiatives
- Reinforce expectations of the Infection Control program
- Complete at least four hours of continuing education each year on topics relating to current practices in infection control and prevention
- Be a certified Infection Preventionist or complete a nationally recognized basic training program in infection control

RCA Team/Meeting

Will meet as needed to:

- Define the healthcare issues or potential risks
- Conduct Root Cause Analysis
- Review and analyze data
- Brainstorm issues or the potential risks by using the fishbone diagrams
- Identify the contributing factors
- Develop Corrective Action Plan
- Identify Plan-Do-Check -Act (PDCA) topics

- Discuss and present possible changes in procedure to improve areas indicated
- Identify strengths and areas that need improvement
- Develop strategies, solutions, and next steps

RCA Team Leader Responsibilities

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

Root Cause Analysis (RCA) Team Responsibilities

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

Governing Body Staff Responsibilities

- Provide vision and leadership to Patient Safety and Quality Improvement process
- Develop and foster a safe learning and improving culture
- Provide oversight to healthcare quality improvement processes and teams
- Plan, discuss and generate patient safety goals and activities

Quality Studies -Process Analysis (Surgery Centers)

The Surgery Centers will complete quality studies each year that include:

1. A statement of the purpose of the QI activity that includes a description of the known or suspected problem and explained significance to the SSC
2. Identification of the performance goal against which SSC will compare current performance
3. Description of the data that will be collected in order to determine the SSC's current performance
4. Evidence of Data Collection
5. Data analysis that describes findings about the frequency, severity and source of issue
6. Comparison of the SSC's current performance against identified performance goal
7. Implementation of corrective action
8. Re-measurement to objectively determine whether corrective actions achieved and sustained improvement
9. Implementation of any additional corrective action to achieve and/or sustain improved performance (and plan for on-going re-measurement)
10. Communication of findings to SSC Leadership, The Patient Safety Committee, the Board of Directors and SSC staff and incorporating findings into educational activities

For quality studies, the Surgery Center(s) may base topic selection on information published by accrediting bodies, National Patient Safety Goals and/or other sources of information including risk management, performance improvement, quality assurance, infection prevention and control, patient/family suggestions/expectations or process outcomes

The Surgery Centers quality studies will focus on redesign or implementation of new processes to incorporate patient safety principles and will place an emphasis on the important facility and patient care functions of:

- Rights of Patients
- Governance
- Administration
- Quality of Care
- Quality Management and Improvement
- Clinical Records and Health Information
- Infection Prevention and Control and Safety
- Facilities and Environment
- Anesthesia Services
- Surgical and Related Services
- Pharmaceutical Services
- Pathology and Medical Laboratory Services
- Diagnostic and Other Imaging Services

Infection Prevention Program

- The purpose of the Infection Control Programs is to prevent and control infections
- The Infection Control Program and the surgery Centers Infection Control Program (SSC and SCT 1600-3 Infection Control Program for Southwest Medical Surgery Center) are components of the Patient Safety Plan
- The Infection Control Programs are based on current guidelines developed by nationally recognized infection control organizations
- The Infection Control Professionals will report regularly on the number and severity of infections that occurred in the prior quarter

Infection Prevention RN

Southwest Medical will maintain at least one Registered Nurse with training and education in infection prevention and control. While supporting the entire organization, the Infection Prevention RN will dedicate specific hours to the SSC

NHSN

- The medical facilities (Surgery Centers) will participate in the CDC's National Healthcare Surveillance Network
- Infection Prevention staff will report aggregate data and patient follow-up to the Patient Safety Committee at regularly scheduled intervals

Medical/Health Care Error

- Staff will immediately report the event to supervisor

The supervisor will:

- Immediately communicate the event through appropriate channels to the Patient Safety Officer; should this occur during off-hours, the supervisor/designee will leave a voice mail message for the Patient Safety Officer
- Initiate investigation and follow-up actions
- Staff will complete the Incident/Occurrence Report or Quality of Care form
- Staff will obtain required orders to support the patient's clinical condition
- Staff/supervisor will notify the UHG Safety Liaison of any situations of potential risk to others
- The Patient Safety Officer will follow usual protocols to investigate the error and coordinate the factual information/investigation for presentation, review and action by the Patient Safety Committee and/or other quality committees as applicable

Identification and Reporting

- SMA Policy # 1600-29 (Sentinel Event Policy) and SMA Policy 190-4 (Incident Occurrence Reporting Policy) will describe the mechanism for identification and reporting a Sentinel Event/other medical error
- Southwest Medical will promote willingness of staff to report and will support a Just Culture that focuses on process not individuals

Root Cause Analysis

- The Patient Safety Committee/Patient Safety Officer will provide oversight and direction for any root cause analysis of facility processes conducted for either Sentinel Events or near miss events
- The Patient Safety Officer will act as the liaison to quality committees and the Board of Directors for review/recommendations

Staff Involvement

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

- A non-punitive approach and without fear of reprisal
- Voluntary participation in the root-cause analysis for educational purposes and prevention of further occurrences

Reporting Requirements/Sentinel Event Reporting

- The Patient Safety Officer will report sentinel events to the Patient Safety Committee
- The Patient Safety Officer will direct reporting of any sentinel event at a medical facility per state of Nevada requirements as defined in NRS (Nevada Revised Statutes) and NAC (Nevada Administrative Code)
- The Patient Safety Officer will report the number of sentinel events and recommendations to reduce the number or severity of sentinel events to the SMA Board of Directors
- The Patient Safety Officer/Committee will provide education and support to providers to ensure providers report the occurrence of a sentinel event resulting from any surgery to the Board within fourteen days after the occurrence of the sentinel event
- The Patient Safety Committee shall evaluate the actions of the Patient Safety Officer in connection with the reporting of sentinel events
- The Patient Safety Committee shall make recommendations to the SMA Board of Directors to reduce the number and severity of sentinel events and infections that occur at the facility

HealthCare Acquired Infections (HAI) Reporting

The Patient Safety Officer/Committee will provide education and support to providers to ensure if a provider identifies a patient with an infection, the provider will notify, within five days or as soon as practicable, the patient or the legal guardian or other person authorized by the patient to receive such information that the patient has an infection

The Patient Safety Officer/Committee will provide education and support to providers so that providers understand the notification may be delayed if the patient does not have a legal guardian, has not authorized any other person to receive such information and:

- Is not capable of understanding the information
- Is not conscious
- In the provider's judgment, the notification is likely to result in the patient harming himself

The Patient Safety Officer/Committee will provide education and support to providers so that providers understand if the notification is delayed, the information must be provided as soon as practicable after:

- The patient is capable of understanding the information

- The patient regains consciousness
- In the judgment of the provider, the patient is not likely to harm himself if informed about the infection
- A legal guardian or other person authorized to receive such information is available

Internal Reporting

The Patient Safety Committee will report internally to provide a comprehensive view of both the clinical and operational safety activity of the organization by submitting Patient Safety Committee minutes/reports to the SMA Board of Directors

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

External Reporting

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

- On or before March 1 of each year, The Patient Safety Committee will submit an annual sentinel event report to the Office of Public Health Informatics and Epidemiology, Bureau of Health Statistics, Planning, Epidemiology and Response, Nevada State Health Division
- The Surgery Centers will participate in the CDC National Healthcare Surveillance Network per State of Nevada NRS and NAC

Annual Report

The Patient Safety Officer will report to the SMA Board of Directors and will include:

- Defining the scope of occurrences including sentinel events, near misses and serious occurrences
- Demonstrating a pro-active component of the patient safety program through selection of high risk or problem prone processes for ongoing measurement and analysis
- Reporting results ongoing measurement and analysis of the high-risk or error-prone processes
- Describing how the function of process design incorporates patient safety using specific examples of process design or redesign that include patient safety principles
- Describing the process for soliciting and obtaining input for improving patient safety from patient/families
- Describing staff willingness to report medical/health care errors
- Describing the procedures for communication with patients/families about adverse events or unanticipated outcomes of care
- Describing examples of ongoing in-service, education and training programs to maintain and improve staff competence and support an interdisciplinary approach to patient care

Medical Facility (Surgery Centers) Reporting Requirements

The Patient Safety Officer/Committee will report to the appropriate licensing Board, within five days, after a change in the privileges of a physician, perfusionist, physician assistant or practitioner of respiratory care that is based on:

- An investigation of the mental, medical or psychological competency of the physician, perfusionist, physician assistant or practitioner of respiratory care
- Suspected or alleged substance abuse in any form by a physician, perfusionist, physician assistant or practitioner of respiratory care

Public Disclosure

The Surgery Centers will provide the name of each physician who performed a surgical procedure at the Surgery Centers, the total number of surgical procedures performed by the physician, reported by type of medical treatment, principal diagnosis, if the information is available, by principle surgical procedure and secondary surgical procedure (SB340)

Objectives Patient Safety Plan

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

Components and Methods

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

Southwest Medical will use RCA process to determine the contributing factors and the underlying reasons for the deficiencies or failures. Southwest Medical will use the Plan-Do-Study (check)-Act (PDSA or PDCA) model, developed by the Institute of Health Care Improvement, to test changes



Root Cause Analysis

- A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals
- Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis
- Root Cause Analysis and action plan framework table was introduced by the Joint Commission. It contains 24 analysis questions. It guides the organization to the steps in a root cause analysis. Not all the questions apply to all the events or cases. This table can be used individually or with the fishbone diagram.

5 Whys technique will be used at Southwest Medical to explore the cause and effect relationship underlay a problem. One can find the root causes by asking “why” no less than five times. This technique can be used individually or as a part of the fishbone diagram.

Fishbone Diagram

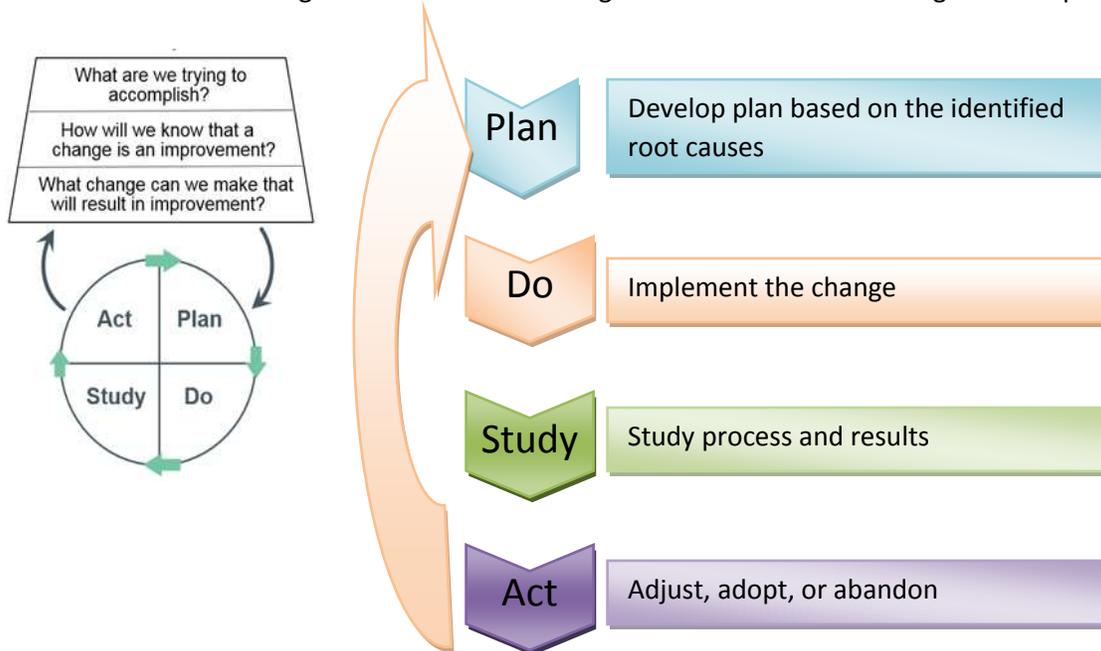
Once the problems are identified, a Fishbone Diagram can be used for analyzing the problems. Southwest Medical can use the fishbone diagram individually to analyze the root causes or can use it with the Root Cause Analysis and action plan framework table

A Fishbone Diagram, also called a Cause-and-Effect diagram, is a useful tool for a team to structurally brainstorm by discovering possible underlying factors or root causes from different major categories for the chosen problems. General categories include: people, methods, materials, measurements, education, procedures, process, location and environment.

RCA team members will brainstorm and ask multiple times, “why did this happen?” for each cause until all ideas are exhausted. The highest priority root causes will be chosen for PDSA topics. Once all the categories are established on the fishbone diagram, 5 Why’s technique also can be used to drill down the problem and find the root causes

Model for Improvement

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



The cycle is defined as follows:

- Plan--collect data and establish appropriate goals. Identify the problem and the possible root causes, and answer the following questions:
- Do--make changes designed to correct or improve the situation. Use the following questions for the guidance:
- Study -- Study the effect of the changes on the situation. Data should be collected on the new process and compared to the baseline or expected results. Results should be evaluated and by using the following questions as guidance:
- Act--If the result is successful or desirable, standardize the changes and then work on the next prioritized problem or the further improvements. If the outcome is not yet successful, look for different ways to identify the causes or change the testing process.

Data Collection and Reporting

Data should drive any quality and patient safety effort. Southwest Medical will track sentinel events, healthcare infection data and other internal data collection

External data sources are those data sources which are collected outside the supervisory structure of the case. Southwest Medical may use external data from:

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

Ongoing Reporting and Review

The Patient safety committee will review Elements of the Patient Safety Plan at scheduled intervals

Monthly	Quarterly	Annually
<ol style="list-style-type: none"> 1. Sentinel event monthly report 2. Severity of infection report 3. RCA assessment 4. Optum Practice Health and Safety Clinical Compliance and Infection Prevention Clinic Assessments 	<ol style="list-style-type: none"> 1. Incidents-including sentinel event quarterly report 2. Severity of infection report 3. Review and evaluate the measure of improvement of patient safety 4. Review and evaluate the measurement to prevent and control infections 5. Quality reports including: <ul style="list-style-type: none"> • Environment of Care Standards • GI Staff Performance and HLD • Hand Hygiene • Infection Prevention • Sterilization • Pharmacy Standards 	<ol style="list-style-type: none"> 1. Quality and Patient Safety Plan update 2. Checklists and Policies reviewing and revising

Assessment of the Quality and Patient Safety Plan

Southwest Medical will review and evaluate the Patient Safety Plan at least annually

Patient Safety Checklists and Patient Safety Policies

By [NRS 439.865](#), the Patient Safety Plan must include the patient safety checklists and patient safety policies for use by:

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

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

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

The patient safety policies must include, without limitation:

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

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

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

Prevention (CDC), the World Health Organization (WHO) and the Society for Healthcare Epidemiology of America (SHEA)

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

Approval of Patient Safety Plan

According to [NRS 439.865](#), Southwest Medical will submit its Patient Safety Plan to the Governing Board for approval. After the patient safety plan is approved, Southwest Medical will notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan

Southwest Medical will review and update the plan annually in accordance with State of Nevada requirements

Southwest Medical, according to [NRS 439.843](#), will submit the most current copy of the Patient Safety Plan on or before March 1 of each year, to the Division of Public and Behavioral Health

References

- Root Cause Analysis Toolkit <http://www.health.state.mn.us/patientsafety/toolkit/>
- Quality and Service Improvement Tools http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html
- CQI 101 An Introduction to Continuous Quality Improvement: <https://www.coursehero.com/file/13827355/CQI-Overviewppt/>
- Quality Improvement <http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/>
- Root Cause Analysis <http://www.patientsafety.va.gov/professionals/onthejob/rca.asp>
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2 https://www.jointcommission.org/sentinel_event.aspx
- Hospital Policies <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>
- Checklists to Improve Patient Safety http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf
- Patient Safety Checklists <http://www.who.int/patientsafety/implementation/checklists/en/>
- Minutes of the Meeting of the Quality and Patient Safety Committee <http://www.cookcountyhhs.org/wp-content/uploads/2013/12/09-23-14-QPS-scan-Minutes.pdf>
- Title 40 – Public Health and Safety <https://www.leg.state.nv.us/NRS/NRS-439.html>

Terms and Definitions

Patient Safety

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

http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

Sentinel event (NRS 439.830)

1. Except as otherwise provided in subsection 2, “sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum
2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:
 - January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or
 - July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published
3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist

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

Medical Harm

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

Facility-Associated Infection: (NRS 439.802)

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

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

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

Medical Facility (NRS 439.805)

“Medical facility” means:

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

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

Near Miss

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

Mandatory Reporting

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

Risk

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

Preventable Event

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

Catheter Associated Urinary Tract Infections (CAUTI)

A CAUTI is a urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CURRENT_b.pdf.)

Central Line Associated Bloodstream Infections (CLABSI)

A CLABSI is a primary bloodstream infection that is associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection

**BATTLE MOUNTAIN GENERAL HOSPITAL
CRITICAL ACCESS HOSPITAL**

535 S. Humboldt Street
Battle Mountain, NV 89820

Developed By: Risk Manager
Department: All Department
Effective: April 9, 2014
Revised: June 30, 2016
Reviewed: February 7, 2018

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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 that provide treatment to patients at the medical facility, an internal patient safety plan to improve the health and safety of patients who are treated at this medical facility.

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

The BMGH Patient Safety Plan must include, without limitation:

- The patient safety checklists and patient safety policies most recently adopted pursuant to **NRS 439.877**.
- An infection control program to prevent and control infections within the medical facility. To carry out the program, the medical facility shall adopt an infection control policy. The policy must consist of:
 - The current guidelines appropriate for the facility's scope of service developed by a nationally recognized infection control organization as approved by the State Board of Health which may include, without limitation, the Association for Professionals in Infection Control and Epidemiology, Inc., the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the World Health Organization and the Society for Healthcare Epidemiology of America.
 - Facility-specific infection control developed under the supervision of a the person who has successfully completed a nationally recognized basic training program in infection control, which may include, without limitation, the program offered by the Association for Professionals in Infection Control and Epidemiology, Inc.

Reviewed by AA/hh

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

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

BMGH shall designate an officer or employee of the facility to serve as the patient safety officer of the medical facility. The person who is designated as the patient safety officer shall:

- Serve on the Patient Safety Committee.
- Supervise the reporting of all sentinel events alleged to have occurred at the medical facility, including, without limitation, performing the duties required pursuant to **NRS 439.835**.
- Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the medical facility.
- Report to the patient safety committee regarding any action taken in accordance with paragraph (c).

BMGH shall establish a patient safety committee.

- The BMGH Patient Safety Committee must be composed of:
 - The patient safety officer of the medical facility.
 - The infection control officer of the medical facility.
 - At least three providers of health care who treat patients at BMGH, including, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility.
 - One member of the executive or governing body of the medical facility.
- A patient safety committee shall meet at least once each month.
- The patient safety committee shall:
 - Receive reports from the patient safety officer pursuant to **NRS 439.870**.
 - Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred at the medical facility.
 - Review and evaluate the quality of measures carried out by BMGH to improve the safety of patients who receive treatment at the medical facility.

- Make recommendation to the executive or governing body of the medical facility to reduce the number and severity of sentinel events that occur at BMGH.
 - At least once each calendar quarter, report to the BMGH executive or governing body of the medical facility regarding
 - The number of sentinel events that occurred at BMGH during the preceding calendar quarter;
 - The number and severity of infections that occurred at the medical facility during the preceding calendar quarter; and
 - Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
 - Adopt patient safety checklists and patient safety policies as required by **NRS 439.877**, review the checklists and policies annually and revise the checklists and policies as the patients safety committee determines necessary.
- The proceedings and records of a patient safety committee are subject to the same privilege and protection from discovery as the proceedings and records described in **NRS 49.265**

The Patient Safety Committee, established pursuant to **NRS 439.875** by a medical facility, shall adopt patient safety checklists and patient safety policies for use by:

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

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

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

- Any other checklists which may be appropriate to ensure the safety of patients at the medical facility

The patient safety policies must include, without limitation:

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

The patient safety committee shall:

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

No person is subject to any criminal penalty or civil liability for libel, slander or any similar cause of action in tort if the person, without malice:

- Reports a sentinel event to a governmental entity with jurisdiction or another appropriate authority
- Notifies a governmental entity with jurisdiction or another appropriate authority of a sentinel event;
- Transmits information regarding a sentinel event to a governmental entity with jurisdiction or another appropriate authority;
- Compiles, prepares or disseminates information regarding a sentinel event to a governmental entity with jurisdiction or another appropriate authority; or
- Performs any other act authorized to **NRS 439.800-439.890** inclusive.



2018 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.
- Complete Patient Safety Survey

OBJECTIVES

The objectives of the Patient Safety Plan are to:

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

- Report internally to the Patient Safety Council/ Committee, MEC and the Governing Board.

PRIORITIES

Priorities for 2018 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 2017 National Patient Safety Goals
5. Analysis of one high-risk process for proactive risk assessment
6. Review annually checklists or policy to ensure the most current standards in patient safety protocols are being adhered to with audit revision.
7. Implement all risk alerts to incorporate best practices to the greatest degree possible into the patient safety process and systems already in place.
8. Review, revise and promote patient-safety orientation and education for employees
9. Communicate WHH patient safety commitment to customers, patients and visitors
10. Report quarterly to the WHH Medical Staff (MEC) and at a minimum of annually to the Governing Board the 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 2018 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.
 - 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.
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 2018 as evidenced by:
 1. Orienting new staff members to WHH values and patient safety commitment and providing information on reporting mechanisms in the orientation training
 2. Providing ongoing education through education sessions, departmental meetings and/or other administrative communications, in-services and meetings
 3. Evaluating staff knowledge levels of patient safety principles through Health stream program and contributions to patient safety in annual performance appraisals
 9. Internal accountability for an effective patient safety program will be demonstrated via reporting to and oversight of the activities and results of the Patient Safety Council to the Medical Executive Committee and to the Governing Board.
 10. A separate Environment of Care committee that addresses EOC safety considerations was instituted as a separate group in 2013 and will continue in 2018.
 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 2017 and to continue in 2018.*

- b. The scope of occurrences including sentinel events, near misses and serious occurrences and the effectiveness of actions taken to prevent recurrence. *Completed in 2017 and to continue in 2018.*
 - 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 2017 and to continue in 2018.*
 - e. The results of input are solicited and participation from patients and families in improving patient safety is obtained and incorporated into the patient safety program. *Completed in 2017 and to continue in 2018.*
 - 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 2017 and to continue in 2018.*
 - 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 in 2017 and to continue in 2018.*
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 in 2017 and to continue in 2018.*

 Boulder City Hospital <small>Quality care close to home</small>	Patient/Resident Safety Plan	
	DEPARTMENT: Administration	
APPROVED BY:	REFERENCE # SEP 015	PAGE: 1 OF: 6
EFFECTIVE: 9/18/2007	REVISED: 01/26/10; 12/21/2010, 6/1/11; 10/13/14; 9/20/16	

Policy Statement:

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

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

- II. The PRSP provides a systematic, coordinated and continuous approach to the maintenance and improvement of patient safety through:
 - a. The establishment of mechanisms that support effective responses to actual occurrences;
 - b. Ongoing proactive reduction in medical / health care errors; and
 - c. Integration of patient safety priorities into the new design and redesign of all relevant organization processes, functions and services.
 - d. Zero tolerance for workplace violence. BCH strives to maintain a harmonious work environment free from violence and intimidation. Weapons of any kind are prohibited. Violent acts, threatening, harassing, discriminating, disruptive behavior (conflict that disrupts the work and jeopardizes the safety of individuals) and/or coercing behavior are prohibited and may result in disciplinary action up to and including termination (for employees) and/or legal action as warranted.

- III. As patient care and therefore the maintenance and improvement of patient safety, is a coordinated and collaborative effort, the approach to optimal patient safety involves multiple departments and disciplines in establishing the plans, processes and mechanisms that comprise the activities to maintain patient safety. This plan works in conjunction with the facility-wide Safety/Emergency Preparedness Manual which has inter-facility and department specific policies as necessary to address safety concerns such as Fire, Emergency Preparedness for Internal and External Disasters, Pandemic Events, etc.
 The PRSP was developed by the interdisciplinary Safety Committee and approved by the Medical Staff, Board of Trustees and Administration and outlines the components of the organization's PRSP.

Procedure:

- I. Scope of Activities
 - a. Ongoing assessment, monitoring, tracking and trending with analysis using internal and external knowledge and experience to:
 - i. Prevent error occurrence
 - ii. Maintain and improve patient safety
 - b. Patient/resident Safety Occurrence Information:
 - i. Collected from aggregated data reports and individual occurrence reports.
 - ii. Will be reviewed by the Safety Committee.
 - iii. Is used to prioritize organizational patient safety activity efforts.

- II. Types of Patient/resident Safety or Medical/Health Care Errors
 - a. No Harm Errors
 - i. Unintended acts, either of omission or commission;

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

III. Scope of Program

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

Ethics, Rights & Responsibility	Management of the Environment of Care
Provision of Care	Management of Human Resources
Medication Management	Management of Information
Improving Organization	Surveillance, Prevention and Control of
Performance	Infection
Leadership	
- c. Assures:
 - i. All departments have current Safety Manual available on-line
 - ii. Emergency Preparedness Quick Reference Guide “Red Book” is available in high traffic areas
 - iii. Senior Leaders are FEMA trained and NIMS compliant
 - iv. Hospital Decontamination Program (and related equipment) is available and compliant with current regulations
 - v. Enforced Hand Hygiene policy
 - vi. Adherence to Standard Precautions with implementation of Isolation Precautions when necessary

- vii. Maintenance of a sanitary environment through interdepartmental collaboration, product and service evaluation and monitoring effectiveness

IV. Methodology

a. Responsibility

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

b. Membership will include but not be limited to:

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

c. Communication

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

V. Review of Internal and External Reports

a. To include, but not be limited to:

- i. Sentinel event report information;
- ii. HAI statistical report;
- iii. Fire and Disaster Drill reports;
- iv. Occurrence reporting;
- v. Injury Report;
- vi. Information from state and federal sources;
- vii. Current literature;
- viii. Performance Improvement reports.
- ix. Safety Survey results (performed at least annually)

b. The Committee will select at least one high-risk safety process for an annual proactive risk assessment.

c. The proactive risk assessment will include:

- i. Assessment of the intended and actual implementation of the process.
- ii. Identify the steps in the process if there may be any undesirable variations.
- iii. Identification of possible effects of the undesirable variation on patient/residents.
- iv. How serious the possible effects on the patient/resident could be.
- v. For the most critical effects, conduct a failure mode event analysis (FMEA) to determine why the undesirable variation leading to that effect may occur.
- vi. Redesign the process and/or underlying systems to:
 1. Minimize the risk of that undesirable variation; or

2. Protect patient/residents from the effects of that undesirable variation.
- vii. Test and implement the redesigned process.
- viii. Identify and implement measures of the effectiveness of the redesigned process.
- ix. Implement a strategy for maintaining the effectiveness of the redesigned process over time.

VI. Identification of a Medical/Health Care Error

- a. Note that the following Quality Improvement Policies are pertinent to this section: Medication Errors [HWN 139], Decreasing Medication Errors [HWN 142] and Safe Medication Practices [HWN 145]
- b. The staff member will immediately:
 - i. Perform and/or obtain necessary healthcare interventions to protect and support the patient's clinical condition;
 - ii. As appropriate to the occurrence, perform necessary healthcare interventions to contain the risk to others – example: immediate removal of any recalled item from stock.
 - iii. Contact the patient's attending physician and other physicians, as appropriate, to report the error, carrying out any physician orders as necessary;
 - iv. Preserve any information related to the error including physical information such as:
 1. Removal and preservation of blood unit for a suspected transfusion reaction;
 2. Preservation of IV tubing, fluids bags and/or pumps for a patient/resident with a severe drug reaction from IV medication;
 3. Preservation of medication label for medications administered to the incorrect patient/resident;
 4. Documenting the facts regarding the error on an occurrence report and medical record as appropriate to organizational policy and procedure;
 5. Reporting the medical/health care error to Department Director; and
 6. Enter the occurrence report into the Quality Review Report system. Risk Manager will review.
- c. Any individual in any department identifying a potential patient safety issue will:
 - i. Immediately notify his/her supervisor; and
 - ii. Document the findings on an occurrence report.
 - iii. Submit occurrence report to the Risk Manager per policy.
- d. Patient, and family member as appropriate; and officiating agency will be notified timely of safety concerns and/or medical errors including HAI, ADR, SE, etc.

VII. Response

- a. Staff response to medical/health care errors is dependent upon the type of error identified.
- b. Error types:
 - i. Near miss
 1. Report the near miss event to immediate supervisor;
 2. Describe the facts of the near miss on an occurrence report; and
 3. Submit report to the Risk Manager/designee.
 - ii. No harm errors (including "no harm" medication errors)
 1. Document appropriately in the medical record according to policy;
 2. Document the circumstances regarding the no harm error on an occurrence report form;
 3. Submit the report to the Risk Manager; and
 4. Notify the immediate supervisor.
 - iii. Mild to moderate adverse outcome errors (including medication errors)
 1. Perform any necessary clinical interventions to support and protect the patient/resident;
 2. Notify the physician and staff responsible for the patient/resident;
 3. Carry out any necessary physician orders;
 4. Preserve any physical evidence as appropriate;
 5. Notify immediate supervisor;
 6. Document facts appropriately in the medical record and on an occurrence report;
 7. Submit report to the Risk Manager per policy; and
 8. Notify the Pharmacy Manager of medication errors at the time of occurrence/discovery.
 - iv. Adverse Drug Reaction
 1. Perform any necessary clinical interventions to support and protect the patient;
 2. Notify the physician staff responsible for the patient;
 3. Execute any necessary physician orders;
 4. Preserve any physical evidence as appropriate;

5. Notify immediate supervisor;
 6. Document facts appropriately in the medical record and notify patient/resident;
 7. Report ADR to Pharmacy via an ADR form or phone call
- v. Transfusion Reaction
1. Perform any necessary clinical interventions to support and protect the patient;
 2. Notify the physician responsible for the patient;
 3. Carry out any necessary physician orders.
 4. Follow the Administration of Blood and/or Blood Products and the Adverse Reaction to Blood Transfusion policies in House Wide P & P Manual including completion of a QRR
- vi. Hazardous Condition Patient Safety Issue
1. As appropriate, and if possible, staff will:
 - a. Contain the hazardous condition or patient safety issue;
 - b. Immediately notify supervisor;
 - c. Document the findings on an occurrence report;
 - d. Submit report to Risk Manager or designee.
 - e. Notify patient
 - f. Notify agencies as appropriate
 2. BCH has identified three significant clinical safety concerns based on the age of the population we serve and the historical data analyzed:
 - a. Falls with injuries
 - b. Aspiration
 - c. Hospital Acquired Infection
 3. For significant safety concerns, BCH has established:
 - a. A mechanism to identify individuals at risk
 - b. Plans to prevent the occurrence of these safety concerns
 - c. A reporting mechanism using the Quality Review and Report system (internal) to track , trend and analyze data reporting to the appropriate internal committees including the Safety Committee, Quality Improvement Committee, Medical Quality Improvement Committee, Medical Executive Committee, and the Board of Trustees
 - d. Timely forward reporting of pertinent information to applicable agencies including but not limited to the State of Nevada Bureau of Health Care Quality and Compliance, the Ombudsman, the Sentinel Event Registry, the Southern Nevada Health District, etc.
 - e. At a minimum annual staff education regarding these safety concerns
- vii. Sentinel Event
1. Perform any necessary clinical interventions to support and protect the patient;
 2. Notify the physician and staff responsible for the patient;
 3. Carry out any necessary physician orders; and
 4. Notify the patient documenting notification;
 5. Follow the Sentinel Event Policy and Procedure (see BCH Policy “Sentinel Events” in House Wide P & P Manual).
 6. Report event to the appropriate committees including Safety, Quality Improvement and Medical Quality Improvement, Medical Executive and Board of Trustees

VIII. Organizational Response

- a. Established policy and/or the Hospital Quality Improvement Committee will determine the organizational response to medical/health care errors and occurrences.
- b. Sentinel events and “Near Misses” will have a root-cause analysis conducted.
- c. The Committee, based on internal and external data analysis and prioritizing of patient safety criticality, will determine:
 - i. Further remedial action activities necessary for identified occurrences;
 - ii. Proactive occurrence reduction activities; and
 - iii. Necessity and benefit of root cause analysis performance for identified occurrences or proactive reduction activities.
- d. Resolution
 - i. Non-Punitive Approach
 1. An effective Patient/resident Safety Program cannot exist without optimal reporting of medical/health care errors and occurrences.

2. The intent of this institution is to adopt a non-punitive approach in its management of errors and occurrences.
 3. All personnel are *required* to report suspected and identified medical/health care errors, and should do so without the fear of reprisal in relationship to their employment.
 4. This organization supports the concept that errors occur due to a breakdown in systems and processes.
 5. Focus will be given on improving systems and processes rather than disciplining those responsible for errors and occurrences.
 6. A focus will be placed on remedial actions to *assist* rather than punish staff members.
 7. The Committee and the individual department Managers will determine the appropriate course of action to prevent error recurrence.
- ii. Sentinel Events
 1. Staff members involved in a sentinel event occurrence will receive support to facilitate the staff member's professional and emotional reconciliation of the sentinel event.
 2. The staff member will be allowed an active role in process resolution as well as the root-cause analysis and action plan processes.
 3. Any staff member involved in a sentinel event or other medical/health care error may request and receive supportive personal counseling as per the Sentinel Event Policy and Procedure and Employee Assistance Program.
- e. Evaluation
- i. The Patient/Resident Safety Program includes an annual survey of patients, their families, volunteers and staff (including medical staff) opinions, needs and perceptions of risks to patients and requests suggestions for improving patient/resident safety.
 - ii. In keeping with a non-punitive philosophy designed to encourage reporting and resolution of errors, the staff will be queried annually regarding safety concerns including their willingness to report medical/health care errors.
- f. Education
- i. Staff will receive education and training:
 1. During their initial orientation process; and
 2. On an ongoing basis regarding job-related aspects of patient safety.
 - ii. Education and training will include:
 1. The need and method to report medical/health care errors and other safety concerns;
 2. Providing the optimal provision of healthcare in an interdisciplinary manner; and
 3. An interdisciplinary approach to patient care.
- g. Reporting
- i. BCH values transparency working together as an organization accountable to the licensing and quality agencies as well as to our patients, staff, medical staff, volunteers and our community
 - ii. Medical/health care errors and occurrences, including sentinel events, will be reported internally and externally per hospital policy and through the channels established by this plan.
 - iii. External reporting will be performed in accordance with all state, federal and regulatory body rules, laws and requirements. Refer to House wide policy HWN 135 Reportable Events.
 - iv. Patient safety reports from the Safety Committee will be submitted to the Medical Executive Committee and the Quality Improvement Committee.
 - v. The Board of Trustees has the opportunity to review and ask questions during the monthly meeting as the minutes of committees are contained within the Medical Executive Committee minutes for approval by the board.

Title: Banner Health System Quality and Safety Plan	
Number: 778, Version: 15	Original Date: 09/19/2002
Effective: 10/10/2017	Last Review/Revision Date: 10/10/2017
Next Review Date: 06/23/2018	Author: Mikaela Mackey (Care Management Performance Improvement Team) Rona Paritsky
Approved by: Banner Health Board of Directors Quality Committee, Banner Health Board of Directors, Care Management Council, Chief Clinical Officer, Document Control Administrators 10/10/2017	

Discrete Operating Unit/Facility:

Banner Baywood Medical Center
 Banner Behavioral Health
 Banner Boswell Medical Center
 Banner Casa Grande Medical Center
 Banner Churchill Community Hospital
 Banner Del E Webb Medical Center
 Banner Desert Medical Center
 Banner Estrella Medical Center
 Banner Fort Collins Medical Center
 Banner Gateway Medical Center
 Banner Goldfield Medical Center
 Banner Heart Hospital
 Banner Ironwood Medical Center
 Banner Lassen Medical Center
 Banner Payson Medical Center
 Banner Thunderbird Medical Center
 Banner—University Medical Center Phoenix
 Banner—University Medical Center South
 Banner—University Medical Center Tucson
 Community Hospital
 East Morgan County Hospital
 McKee Medical Center
 North Colorado Medical Center
 Ogallala Community Hospital
 Page Hospital
 Platte County Memorial Hospital
 Sterling Regional MedCenter
 Washakie Medical Center

Banner Corporate
 Banner Health Clinics
 Banner MD Anderson Cancer Center
 Banner Health Network
 Banner Home Care and Hospice
 Banner Plan Administration
 Banner Pharmacy Services
 Banner Surgery Centers
 Banner Urgent Care Centers
 Occupational Health/Employee Services
 Post-Acute Care Services
 Research
 Rural Health Clinics
 University Physicians Health Plans

I. Purpose/Population:

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

- a. Fosters strong and authentic relationships in every interaction by demonstrating honestly respect and assuming positive intent.
- b. Actively listens to the needs of others, and follows through on commitments
- c. Creates an open culture of communication that honors the truth and values diverse input

E. Purpose:

1. Banner can and will create a new model that answers America's health care challenges today and in the future.
2. Inspired to change the health care landscape in our communities – big and small – our talented and passionate teams care deeply about individuals who are responsive for the needs of their extended families.
3. Taking access and delivery from complex to easy, from costly to affordable and from unpredictable to reliable, we give every individual we serve confidence in their health care experience and its outcome.

II. **Definitions:**

- A. Facility – Any Banner Health hospital, ambulatory surgery center, physician/provider office, home health, hospice, skilled nursing facility, clinic or other setting where care is provided.
- B. Process Owner – A process owner is an individual responsible for their respective level of business operations. A level of business operation could include a whole Facility, a department or a specific service within a department or across a Facility or the organization.
- C. Process Improvement (PI) – Process Improvement is a series of actions taken to identify, analyze and improve existing processes to meet new goals and objectives.
- D. Quality Assurance/Quality Improvement/Clinical Process Improvement/Quality Management Program Activities – For the purpose of this plan, “Quality Assurance/Quality Improvement/Clinical Process Improvement/Quality Management Program” means activities designed and implemented to improve the delivery of care and services.

III. **Policy:**

- A. Banner Health bases its decisions on its values and applies the Guiding Principles throughout the organization in its Quality Management Model. (See **Figure 1: Banner Quality and Safety Management Model**)
- B. Quality Authority/Responsibility
 1. Governance.
 - a. The Banner Health Board of Directors has the ultimate responsibility and accountability for quality of care and services provided by Banner Health. The Clinical Leadership Team and the Care Management and Quality Committee of the Board serve as the oversight bodies for quality management and have the following duties and delegated responsibilities:
 - i. Monitor non-financial measures of organizational quality performance.
 - ii. Ensure use of a systematic approach to quality management and assess ongoing improvement in the quality of services delivered by the corporation.
 - iii. Review and make recommendations to the Board regarding a system-wide quality plan.

- iv. Evaluate and make recommendations to the Board concerning healthcare technologies including, but not limited to, genomics, biotechnology, future clinical services delivery and therapeutics.
 - v. Evaluate and make recommendations to the Board with respect to ethical implications relating to the activities and services of the corporation, including quality and clinical innovation.
 - vi. Act for the Board with respect to proposals of management and the local institutions and their medical staffs concerning medical staff policies, patient care policies, and compliance with standards of government and accreditation agencies having jurisdiction over the corporations' institutions as to such policies which require the involvement of the Board of Directors.
 - vii. Act for the Board of Directors on matters and activities pertaining to the medical staffs of each local institution operated by the corporation to the extent permitted by law and applicable accreditation standards, including any matter which requires action by the Board of Directors, including the adoption, amendment or repeal of medical staff bylaws, rules and regulations, and medical credentialing criteria.
 - viii. Act for the Board of Directors to the extent permitted by law and applicable accreditation standards, and otherwise make recommendations to the Board of Directors on any matter affecting medical staff membership or privileges, including application for appointment to the medical staff; application for reappointment to a medical staff; request for delineated clinical privileges; and denial, curtailment, limitation or revocation of any of the foregoing.
 - ix. Review reports regarding the quality of care being provided in respective Facilities.
 - x. Perform such other duties and responsibilities as the Board may assign to the Committee from time to time.
- b. In some communities, Advisory Boards provide advice and counsel to management and medical staff leadership on a variety of issues, including quality and safety activities and outcomes.
2. Leadership.
- a. Leadership is responsible for setting organizational direction and does this through the establishment of mission, values, and purpose, including annual initiatives. These are turned into actions through the development and execution of the strategic and operational plans that include quality of services and patient safety. Senior leadership communicates organizational direction, reviews and approves plans, provides resources and structure for the execution of the plans, and reviews performance to meet the goals of the plan.
 - b. At Banner Health, Care Management provides oversight for improvement of clinical care and patient safety coordinated across the system. The Clinical Leadership Team, a group of Banner Health Leaders representing patient care and supporting functions, makes decisions related to system-wide quality and safety goals and activities to achieve those goals.
 - c. Leadership for Facility activities related to quality of services and patient safety is directed by Facility administrative teams working with leaders under the oversight of the Quality Council structure. (See **Figure 2: Banner Facility Quality and Safety Structure Template**)
 - d. Quality Councils are responsible for the oversight of:
 - i. Quality leadership:
 - (i) Development and prioritization of Facility quality and patient safety goals and targets in an annual work plan.

- (ii) Facilitation of ongoing quality and patient safety education
 - (iii) Communication of the quality and patient safety commitment, goals, targets and performance.
 - (iv) Alignment of policies with quality and patient safety commitment.
 - (v) Establishment of an engaged workforce.
 - ii. Quality management:
 - (i) Identification of patients and other customer needs.
 - (ii) Identification of key processes; standardization and simplification.
 - (iii) Establishment of measures and monitoring.
 - (iv) Assessment and analysis of processes and outcomes.
 - (v) Identification of improvement opportunities.
 - iii. Performance improvement:
 - (i) Evaluation and prioritization of improvement opportunities.
 - (ii) Identification and replication of proven or evidence-based practices.
 - (iii) Clinical Innovation through the rapid identification and deployment of strategies based on the science of care delivery.
 - (iv) Allocation of resources for improvement.
 - (v) Celebration of success.
 - iv. Evaluation
 - (i) Evaluation of this plan occurs at the local and system levels. Locally, each Facility reviews its progress towards goals identified in the annual work plan using data that measures clinical, financial, resource utilization, and service performance. To assure sustained improvement, this process includes a review of how improvements have been made and will be maintained. Additionally, leaders evaluate their own performance in supporting sustained improvement. Areas failing to meet targets become areas of focused improvement activities. At the system level, performance information is regularly aggregated for review by leadership and governance.
- 3. Process Owner/Department Managers.
 - a. Process owners, individuals who serve in a leadership role in the performance of a process, are responsible for understanding patient and other customer needs, analyzing the processes used to meet those needs, standardizing and simplifying them to reduce variation and waste, measuring important indicators, and using this data to determine appropriate improvement actions based on the organization's goals.
- 4. Employees, Contacted Staff and Volunteers.
 - a. To assure that the organization meets the needs of its patients and other customers as they interact with nursing and other clinical staff as well as support staff, leadership has committed to developing an engaged workforce (staff, contracted staff and volunteers) who:
 - i. Understand job expectations and responsibilities, including service standards;
 - ii. Have access to information to determine if patient and other customer needs are being met, and understand how to respond quickly to resolve problems.
 - iii. Are provided opportunities and skills for meaningful involvement in improving operations;
 - iv. Recognize the need to work together to meet patient and other customer needs; and
 - v. Know how to identify and report incidents.
- 5. Medical Staff

- a. Providers fulfill their Medical Staff delegated peer review responsibilities and take a leadership role in quality and patient safety activities. Medical Staff Departments and Committees routinely review clinical performance measures and identify improvement opportunities. Medical Staff leaders partner with administration in the leadership of quality management through routine interaction with administrative leaders and also serve on Quality Councils. In addition, providers serve in various capacities as team members, collaborating with other members of the health care team, to monitor and improve processes.
 - b. The Board of Directors has delegated responsibility for review of professional practices to the medical staffs as set forth in the Medical Staff Bylaws. The Medical Executive Committees report on their performance of these responsibilities to the Board through the Medical Staff Subcommittee of the Care Management and Quality Committee of the Banner Health Board.
6. Risk Management
- a. Risk Management conducts activities intended to improve the quality of care and reduce errors and omissions. Risk Management may report trends and concerns relating to individual physicians and allied health providers to the appropriate Medical Staffs to determine whether peer review is warranted. Risk Management may report other trends and concerns to the appropriate subcommittee of the Clinical Leadership Team.
- C. Quality management is initiated as leadership sets organizational direction by planning and developing goals, including quality, patient safety and risk priorities that are based on continuous efforts to understand the needs of those we serve as well as improving current levels of performance, utilizing evidence-based and best practices and industry benchmarks. Areas identified for improvement and for achievement of the vision are called strategic initiatives. Strategic and operational planning processes as well as proactive risk assessment and gap analyses are used to identify desired outcomes and actions to achieve those goals at various levels of the organization. Criteria used for establishing priorities may include, but are not limited to, clinical quality, patient safety, customer satisfactions, strategic direction, financial sustainability, regulatory and accreditation compliance, resource utilization, high volume, high risk, or problem prone areas and external forces.
- D. Process owners are expected to identify patient and other customer needs and expectations, understand key processes and safe practices, and establish performance measures for their areas of responsibility. Performance measures encompass different dimensions, including clinical outcomes, patient safety, evidence-based practice, utilization management, and patient satisfaction as well as financial sustainability, and are aligned from the system level (e.g., quarterly patient satisfaction with inpatient care) to the process level (e.g., daily feedback from patients in a nursing unit).
- E. Appropriate improvement action is determined by analyzing and interpreting 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, payers, and others, along with current comparative information/data from other organizations.
- K. Data for monitoring the effectiveness and safety of services and the quality of care at each Facility, including clinical outcomes, patient safety, evidence-based practice, utilization management and patient satisfaction, are collected and evaluated on an ongoing basis and reported up to governance for recommendations and actions on at least a quarterly basis.
- L. When performance issues may be related to the professional practice of an individual medical staff member, medical staff committees review such professional practices and determine appropriate action, if any.
- M. All proceedings, records, and materials related to Quality Assurance/Quality Improvement/Clinical Process Improvement/Quality Management and peer review activities are confidential in accordance with federal and state laws. Meetings will be held in confidence and minutes will be maintained separately. Dedicated portals with restricted access will be created to allow the sharing of confidential information.
- N. When performance issues may be related to the performance of a staff member, they will be handled through the appropriate Banner Health Human Resources policies and/or procedures.
- O. New committees and new organization structures may be formed from time to time and the work performed by these groups is intended to be covered under the auspices of the Quality Plan and the protections afforded by federal and state law.

IV. Procedure/Interventions:

- A. N/A

V. Procedural Documentation:

- A. N/A

VI. Additional Information:

- A. N/A

VII. References:

- A. Arizona Statutes: A.R.S. § 36-441 et seq. A.R.S. § 36-2401 et seq., A.R.S. § 36-445 et seq.
- B. California Statutes: Cal.Health & Safety Code § 101848.9D.
- C. Colorado Statutes: C.R.S.A. § 25-3-109
- D. Nebraska Statutes: Title 172 NAC, Chapter 5
- E. Nevada Statutes: NRS 439.865
- F. Wyoming Statutes: W.S. 35-2-910
- G. CMS Conditions of Participation
- H. The Joint Commission

VIII. Other Related Policies/Procedures:

- A. Banner Health Strategic Initiatives/Plan
- B. Facility Work Plans
- C. Event Reporting Policy (#9062)
- D. Patient Complaint, Discrimination and Grievance (#2865)
- E. Peer Review Policy (#15535)

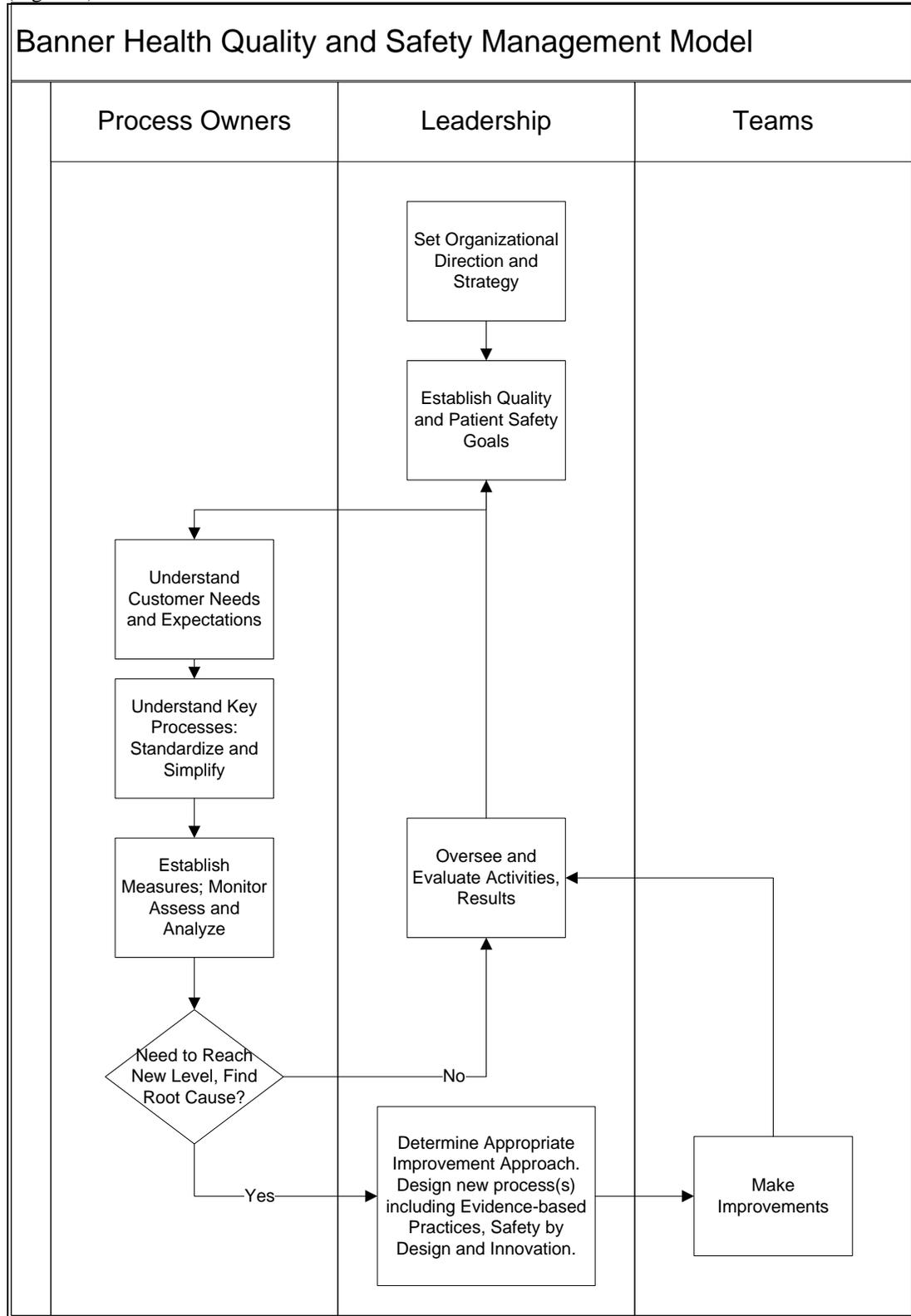
IX. Keywords and Keyword Phrases:

- A. Board
- B. Care Management
- C. Mission
- D. Quality Management
- E. Quality Plan
- F. Vision
- G. Safety Plan
- H. Patient Safety Plan

X. Appendix:

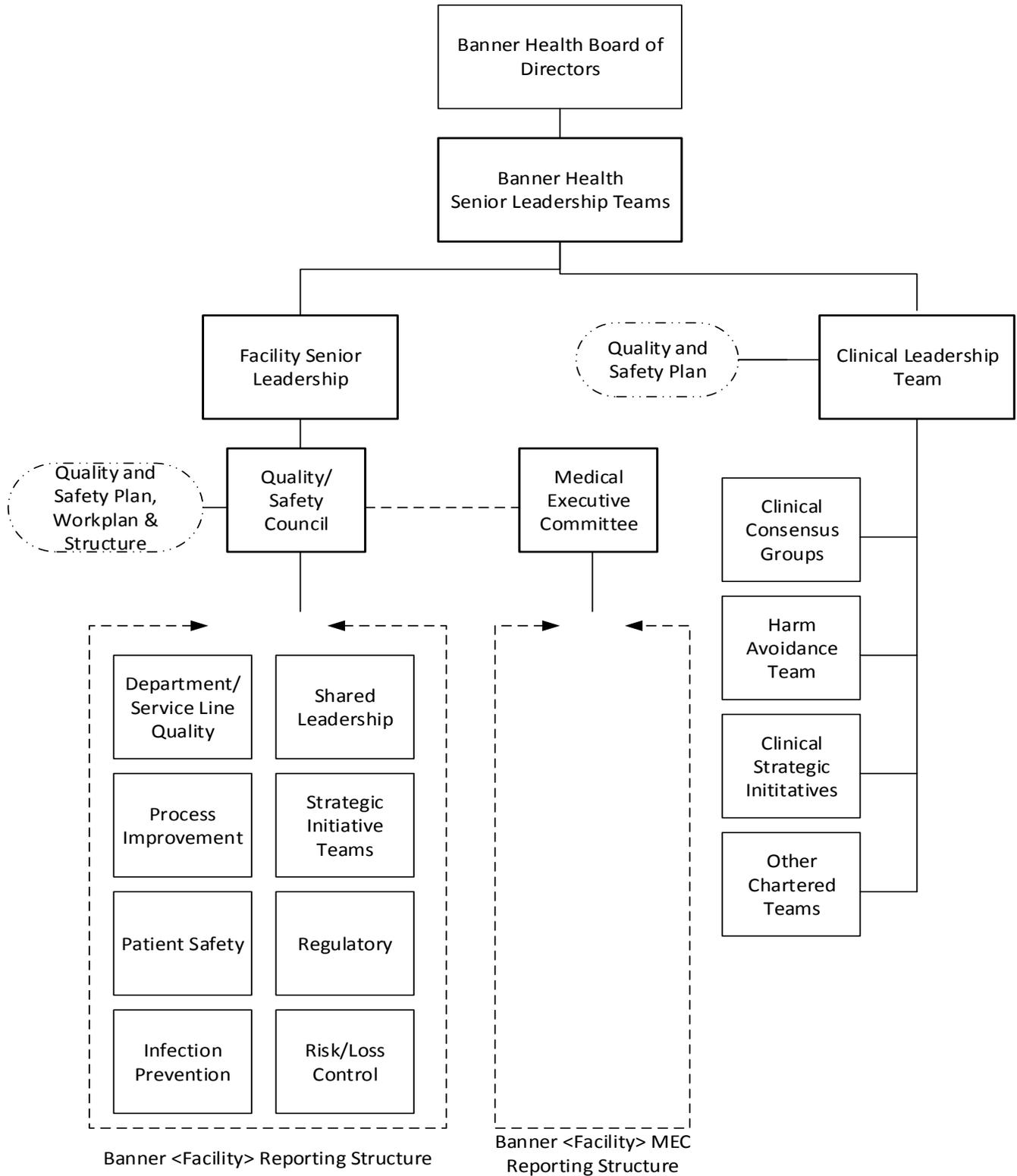
- A. Figure 1: Banner Quality and Safety Management Model (See Section III.A: Appendix below)
- B. Figure 2: Banner Facility Quality and Safety Structure Template (See Section III.B.2: Appendix below)

(Figure 1)



(Figure 2)

Banner Health <Facility> Quality and Safety Structure Template



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2018 PERFORMANCE IMPROVEMENT AND PATIENT SAFETY PLAN



Last Review Date: 02/2018
Origination Date: 04/2007
Submitted By: Cinthya S. Cook,
Director of Risk
Management/Patient Safety
Officer

Patient Safety Committee 02/2018
Policy Council 02/2018
Medical Executive Committee 02/2018
Board of Trustees 02/2018

PURPOSE

Sunrise Hospital and Medical Center and Sunrise Children’s Hospital develops, implements, and maintains an effective, ongoing, hospital-wide, data-driven quality and patient safety assessment and performance improvement program.

SCOPE

Housewide

POLICY/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 (3) leadership groups: the Board of Trustees (BOT), the organized medical staff which is represented by the Medical Executive Committee (MEC), and Senior Leadership.

A. BOT

The BOT 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 MEC 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 and patient safety is defined, implemented, and maintained.
9. Establishes clear expectations for safety.
10. Provides the organized medical staff, represented by the MEC with the opportunity to participate in governance and the opportunity to be represented at BOT meetings.
11. Assumes full legal authority and responsibility for operations of 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 CSIP Appraisal.
17. Approves the annual Performance Improvement and Patient Safety Plan.

B. Medical Staff and 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 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 and safety of the medical care provided to the patients.
2. Operates under Medical Staff Bylaws and Rules and Regulations approved by the BOT.
3. Oversees the quality of care, treatment and services provided by those individuals with clinical privileges.
4. Approves the 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 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 CEO, MEC, the Chief Nurse Officer (CNO), and the Vice-President (VP) of Quality Management (QM) work together to make certain that the hospital-wide PI and CSIP along with training programs address identified problems.
4. Discuss issues that affect the hospital and the population(s) it serves, including the following:
 - a) PI and Clinical Safety Improvement activities.
 - b) Reported safety and quality issues.
 - c) Proposed solutions and their impact on 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 response to sentinel events.

See:

http://fwdvwpwebpmgr01.hca.corpad.net/Policies/Components/PnP/DocTree_ViewFile.aspx?ModuleID=1786&ID=3AA40203-846D-41EB-AC78-88DE4DE2A003

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 (Nevada Revised Statutes [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.

See:

http://fwdvwpwebpmgr01.hca.corpad.net/Policies/Components/PnP/DocTree_ViewFile.aspx?ModuleID=1786&ID=3AA40203-846D-41EB-AC78-

4. Reports all sentinel events and the actions taken to ensure the event does not reoccur.
5. Takes action as deemed to be necessary to ensure the safety of patients as a result of an investigation of the event.

E. Department Directors

The Department Directors of each ancillary/nursing service area is responsible for all PI 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 PI or Patient Safety activities will be reported through the appropriate channels.

F. Patient Safety Committee (PSC) and Quality Care Committee (QCC)

The PSC and the QCC are responsible to the BOT, MEC, and Senior Leaders for the overall operation of the PI and Patient Safety Plan. These interdisciplinary committees include but are not limited to, representatives from the BOT, Senior Leaders, Medical Staff, QM, Pharmacy, Nursing Leadership, Infection Control, Ancillary Services Directors, Patient Safety Officer and Facility Safety Officer. On an annual basis the PSC and QCC performs an annual 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 PSC and QCC 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 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 use of standardized Time Out practices before any treatments or procedures.
 - d. Use of medication safety as it relates to the prevention of significant medication errors.
 - e. Evaluate the effectiveness of all fall reduction activities including assessment, interventions, and education.
 - f. Evaluate the effectiveness of the reduction of all 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 infections 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. 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. 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. Checklists to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - i. Proper instructions concerning prescription medications;
 - ii. Instructions concerning aftercare; and
 - iii. Any other instructions concerning his or her care upon discharge.
 - f) Ensure that a policy for appropriately identifying a patient before providing treatment the policy will require the patient to be identified with at least two (2) personal identifiers before each interaction with a provider of healthcare. 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.
 - h) Monitor and document the effectiveness of the patient identification policy.
 - i) At least annually, review and revise the patient safety checklists and patient safety policies adopted and consider any additional patient safety checklists and patient safety policies that may be appropriate for adoption for use at the medical facility as necessary to ensure that the checklist or policy, as applicable, reflects the most current standards in patient safety protocols.
 - 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) Compiles data in usable formats.
 - f) Uses statistical tools and techniques to analyze and display data.
 - g) Analyzes and compares internal data over time to identify levels of performance, patterns,

- trends, and variations.
- h) Compares data with external sources, when available.
 - i) Analyzes its organ procurement conversion rate data as provided by the organ procurement organization (OPO).
 - j) Uses the results of data analysis to identify improvement opportunities.
 - k) 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.
 - l) The QCC considers participation in Quality Improvement Organization (QIO) cooperative projects.
 - m) 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 MEC and the BOT. 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 Hospital Corporation of America (HCA) Patient Safety Organization (PSO), LLC ("HCA PSO, LLC"), a federally certified PSO, to receive assistance in conducting a wide variety of patient safety activities intended to reduce medical errors in a legally protected environment.

Generally speaking, patient safety work product (PSWP) is not subject to subpoena or discovery in state or federal court, in administrative proceedings, or pursuant to the Freedom of Information Act (FOIA), and cannot be disclosed except as permitted under the Patient Safety and Quality Improvement Act (PSQIA) and its associated regulations. (See 42 [code of federal regulations] CFR § 3.204, *Privilege of patient safety work product*; and 42 CFR § 3.206, *Confidentiality of patient safety work product*.)

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-Plan-Do-Check-Act (PDCA) is the methodology used for PI projects. Using this methodology data are systematically aggregated and analyzed on an ongoing basis. Statistical tools used are displayed in diagram II below.

A. FOCUS

1. Find an improvement opportunity:
 - a) Review results of measurement activities and input from staff, patients, medical staff, and other customers.
 - b) How are we doing compared to ourselves/external benchmarks over time?
 - c) What situation yields an opportunity for improvement?
 - d) What processes should be addressed first?
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 track the process change?
 - c) Identify those forces that assist or prevent change-force field analysis.
2. Do Improvement:

- a) Implement change
3. Check Results:
 - a) Do results match the expectations?
 - b) What was learned?
 - c) What does the team want to continue to do?
 - d) What would the team do differently?
 4. Act (to sustain improvement and continue to improve or abandon change and start cycle again)
 - a) What part of the process needs to be standardized?
 - b) What policies/procedures need to be revised?
 - c) Who needs to be trained?
 - d) Determine method for ongoing measurement.

Serious Event Analysis is the primary Performance Improvement methodology utilized for analysis of significant unanticipated outcomes and/or Sentinel Events.

See:

http://fwdvwpwebpmgr01.hca.corpad.net/Policies/Components/PnP/DocTree_ViewFile.aspx?ModuleID=1786&ID=3AA40203-846D-41EB-AC78-

EXTERNAL DATA SOURCES

Data is also collected as indicated for participation in the following external databases or for participation with the following organizations:

Lavanta

The Centers for Medicare & Medicaid (CMS) contracted Quality Improvement Organization (QIO) has developed Healthcare QI 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 medical staff to compare their performance with what may be optimal levels of practice.

Comprehensive Health Outcomes Information System (CHOIS) Reports

CHOIS 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 medical staff focus groups. The data is risk and severity adjusted using CMS's Refined diagnosis-related group (DRG)s and economic cycle research institute (ECRI), a risk index used to adjust complication rates, Risk Adjusted Mortality Index (RAMI) and the risk adjustment specialty algorithm (RASPEC) as appropriate. 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.

The Joint Commission (TJC) Measurement System (ORYX)

This is TJC initiative to integrate performance measures into the accreditation process. It involves a collection of service, process and outcome indicators related to specific patient populations. . Data for this initiative is collected through the Comprehensive Outcomes Measurement Evaluation and Transmission (COMET) database. The information is collected at the facility level and transmitted directly to TJC 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 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.

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

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 grams). 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 Administrative Code (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 Commission of Cancer (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 QI 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, using the national comparisons and benchmarking as an integral part of the PI program for Cardiovascular Services.

American College of Cardiology (ACC)/National Cardiovascular Data Registry (NCDR)

NCDR is the recognized resource for measuring and quantifying outcomes and identifying gaps in the delivery of quality cardiovascular patient care in the United States. 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 (ED). 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.

ACTION Registry®–GWTG™

ACTION Registry is a risk-adjusted, outcomes-based quality improvement program that focuses exclusively on high-risk STEMI/NSTEMI patients. It helps hospitals apply ACC/AHA clinical guideline recommendations in their facilities and provides invaluable tools to measure care and achieve quality improvement goals.

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 nine (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 CMS.

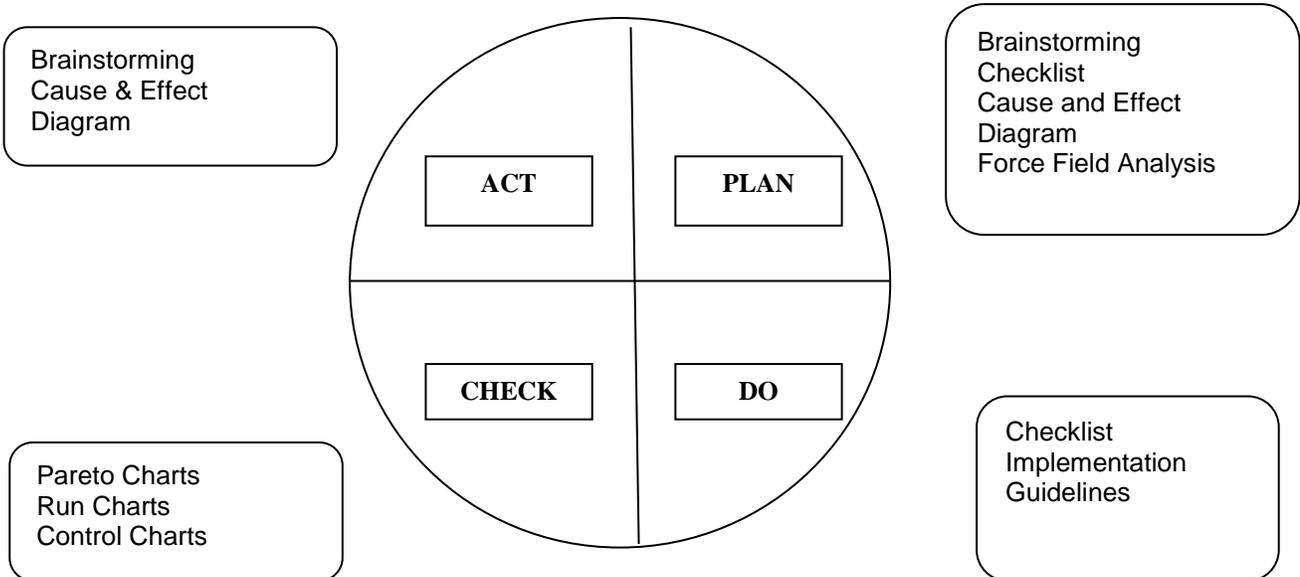
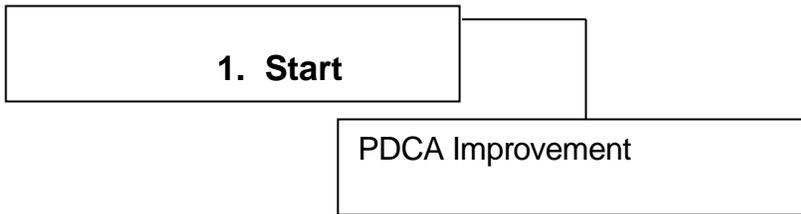
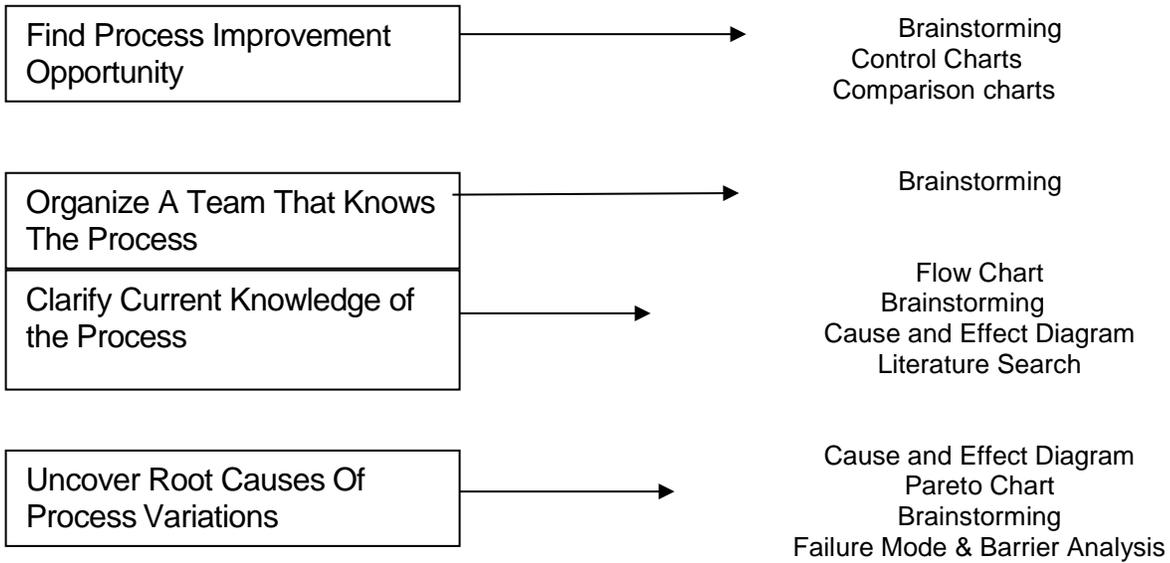
National Healthcare Safety Network (NHSN) Database

The NHSN is a secure, internet-based surveillance system that integrates former Center for Disease Control (CDC) surveillance systems, including the National Nosocomial Infections Surveillance System (NNIS), National Surveillance System for Healthcare Workers (NaSH), and the Dialysis Surveillance Network (DSN). 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

FOCUS - PDCA



MOUNTAINVIEW HOSPITAL



PATIENT SAFETY PLAN

CY 2018

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CY 2016 Patient Safety Program

I. Introduction

Purpose, Scope and Responsibility

- ✓ Purpose:
 - To define the essential components of the Patient Safety Program at MountainView Hospital, which is committed to ensuring a safe environment and reliable care processes.
 - To cultivate a culture of patient safety through the ongoing promotion of a safe practices and personal accountability.
- ✓ Scope: Patient safety is everyone's responsibility. The MountainView Hospital Patient Safety Program covers all activities and functions relating to patient safety at all sites and services within the organization.
- ✓ Responsibility: Leaders, employees, members of the medical staff, students and volunteers are to be familiar with and involved in the Patient Safety Program.

Participation in Patient Safety Organization

- ✓ MountainView Hospital is committed to an organizational environment aimed at improving patient safety and the quality of healthcare provided to the Hospital. To further this objective, the Hospital contracted with HCA Patient Safety Organization, LLC ("HCA PSO, LLC"), a federally certified Patient Safety Organization ("PSO"), to receive assistance in conducting a wide variety of patient safety activities intended to reduce medical errors in a legally protected environment.

Generally speaking, patient safety work product ("PSWP") is not subject to subpoena or discovery in state or federal court, in administrative proceedings, or pursuant to the Freedom of Information Act ("FOIA"), and cannot be disclosed except as permitted under the Patient Safety and Quality Improvement Act ("PSQIA") and its associated regulations. (*See 42 CFR § 3.204, Privilege of patient safety work product; and 42 CFR § 3.206, Confidentiality of patient safety work product.*)

The Hospital will be receiving and exchanging patient safety information with the PSO, including event or incident reports and investigations, analytic tools such as root cause analyses, patient safety communications, quality reviews, and other documents aimed at improving patient safety. Documents will be submitted in a standardized format to allow for comparison with like providers. As part of this effort, the Hospital will operate a Patient Safety Evaluation System ("PSES") designed to encourage internal reporting of adverse events, near misses, and unsafe conditions for purposes of reporting to HCA PSO, LLC. The PSES will be the vehicle for collecting, managing, and analyzing information for patient safety purposes. Designated Hospital personnel will collect patient safety information and report it to HCA PSO, LLC on an ongoing basis for analysis and feedback.

Definition of Terms

Accountability:

An obligation or willingness to accept responsibility for one's actions.

Adverse Event:

Event under the control of a provider which has caused harm and requires a new or modified

physician order for management of the patient's health care. See Policy RM19: Sentinel Event for specific event list and RM13: Disclosure of Adverse Events.

Hazardous condition:

Any set of circumstances (exclusive of the disease or condition in which the patient is being treated), which significantly increases the likelihood of serious adverse outcome.

Healthcare FMEA:

Healthcare Failure Mode and Effects Analysis: A proactive model for addressing potential risks within the organization.

Human Error:

An unintended act, or failure to act, that results in actual or potential patient injury, harm or adverse event in the process of care delivery.

Near miss:

Any process variation that did not affect the patient outcome, but for which a recurrence carries a significant chance of serious adverse outcome.

Non-punitive:

No punishment or disciplinary action imposed for specific error.

Patient injury:

Major permanent loss of function, sensory, motor, or intellectual impairment not present at admission, requiring continued treatment or lifestyle change. When "major permanent loss of function" cannot be immediately determined, patient injury is not established until either the patient is discharged with continued major loss of function, or two weeks have elapsed with persistent major loss of function, whichever occurs first.

Patient safety event:

All adverse events or potential adverse events that are deemed preventable and Healthcare associated infections as defined by the CDC that are deemed to be preventable.

PSQIA

The Patient Safety and Quality Improvement Act (PSQIA) of 2005, Pub. L. 109-41, 42 U.S.C. 299b-21-b-26 (for which the final rule implementing the regulations became effective on January 19, 2009), was enacted in response to growing concern about patient safety in the United States and the Institute of Medicine's 1999 report, *To Err is Human: Building a Safer Health System*. The goal of the Act is to improve patient safety by encouraging voluntary and confidential reporting of events that adversely affect patients.

PSO

A Patient Safety Organization (PSO) means a private or public entity or component thereof that is listed as a PSO by the Secretary of Health and Human Services. A health insurance issuer or a component organization of a health insurance issuer may not be a PSO. The PSO enters into bona fide contracts, each of a reasonable period of time, each with a different provider for the purpose of receiving and reviewing patient safety work product.

PSES

A Patient Safety Evaluation System (PSES) means the collection, management, or analysis of information for reporting to or by a PSO.

PSWP

Patient Safety Work Product (PSWP) (1) Except as provided in (2) below, patient safety work product means any data, reports, records, memoranda, analyses (such as root cause analyses), or written or oral statements (or copies of any of this material) (i) Which could improve patient safety, health care quality, or health care outcomes; and (A) Which are assembled or developed by a provider for reporting to a PSO and are reported to a PSO, which includes information that is documented as within a patient safety evaluation system for reporting to a PSO, and such documentation includes the date the information entered the patient safety evaluation system; or (B) Are developed by a PSO for the conduct of patient safety activities; or (ii) Which identify or constitute the deliberations or analysis of, or identify the fact of reporting pursuant to, a patient safety evaluation system. (2)(i) Patient safety work product does not include a patient's medical record, billing and discharge information, or any other original patient or provider information; nor does it include information that is collected, maintained, or developed separately, or exists separately, from a patient safety evaluation system. Such separate information or a copy thereof reported to a PSO shall not by reason of its reporting be considered patient safety work product. (ii) Patient safety work product assembled or developed by a provider for reporting to a PSO may be removed from a patient safety evaluation system and no longer considered patient safety work product if: (A) The information has not yet been reported to a PSO; and (B) The provider documents the act and date of removal of such information from the patient safety evaluation system. (iii) Nothing in this part shall be construed to limit information that is not patient safety work product from being: (A) Discovered or admitted in a

criminal, civil or administrative proceeding; (B) Reported to a Federal, State, local or Tribal governmental agency for public health or health oversight purposes; or (C) Maintained as part of a provider's recordkeeping obligation under Federal, State, local or Tribal law.

Reliability:

The extent of consistent performance over time.

Sentinel Event:

A patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in death, permanent harm, and/or severe temporary harm (TJC, 2016). (A permanent loss of function related to the natural course of the patient's illness or underlying condition is not a Sentinel Event.) The State of Nevada defines a sentinel event as an event included in Appendix A of "Serious Reportable Events in Healthcare – 2011 Update: A Consensus Report," published by the National Quality Forum (Nevada Revised Statutes NRS §439.830 – effective October 1, 2013).

Sentinel Event Alert Gap Analysis:

A model for prioritizing and addressing potential risks related to publish external sentinel or warning alerts.

Unusual Occurrence:

Any event or condition not consistent with the normal or usual operation of the hospital or department and which has the potential for causing patient or visitor injury or property damage. (See policies – RM19: Sentinel Event and RM13: Disclosure of Adverse Events).

II. Policy

The Board of Trustees delegates responsibility for oversight of the patient safety program to the Patient Safety Committee. The Patient Safety Committee monitors and evaluates the effectiveness of the Patient Safety Program and generates feedback and actions as appropriate. The Patient Safety Committee prepares an annual report to the Quality Council, Medical Executive Committee (MEC), and the Board of Trustees (BOT). The report includes at a minimum, occurrence or trending of patient safety indicators and actions taken in response to actual occurrences as well as proactive assessments of high-risk activities. The Environment of Care Committee oversees non-clinical safety related processes and system issues that affect patients, employees, and visitors in the environment of care.

Risk Management maintains the hospital-wide occurrence reporting system for patients, employees, and visitor occurrences and a referral system for hospital staff and physicians to report potential claims. Risk Management in conjunction with Hospital Quality and Patient Safety Leaders investigate actual and potential safety risk within the organization. They also evaluate occurrences to identify those that may require immediate follow up actions or meet the Sentinel Event, the Safe Medical Device Act, or regulatory agency reporting criteria, including CMS, FDA, OSHA, State of Nevada DHHS, or Joint Commission. Notification is

made to Administration, Risk Management, appropriate regulatory and accrediting agencies, equipment manufacturers and other appropriate individuals as necessary.

The Organization ensures timely coordination and dissemination of reporting and data management of patient safety information at the appropriate medical staff/organizational committees for review and discussion.

III. Culture of Safety

MountainView Hospital is committed to creating a culture of safety by designing or redesigning systems and processes geared to prevent, detect, and minimize the hazards and likelihood of error. MountainView Hospital is focused on prevention, not blaming individuals. Patient safety events are viewed as an opportunity to learn. The Hospital believes in balancing the organization's accountability and the individual's accountability for assuring safe practices and a safe environment to care for patients.

IV. Structure, Roles and Responsibilities

The philosophy guiding the promotion of a culture of patient safety is accountability. To achieve a culture of patient safety the following accountabilities are expected at MountainView Hospital:

<i>Role</i>	<i>Accountability</i>	<i>Specific Tasks</i>
Board of Trustees, with Senior Leadership	Set goals, monitor performance & require accountability.	<ul style="list-style-type: none"> • Receive regular and thorough reports on patient safety risks, hazards and progress towards performance improvement objectives from the MEC and Patient Safety Committee. • Receive regular and thorough briefings regarding the results of culture measurement and performance improvement initiatives • Require multi-cause analysis of errors that lead to injury. • Set performance improvement goals for safety improvement. • Hold hospital leaders accountable for achieving the integrated patient safety agenda. • Receive systematic and regular assessment of resource and budget allocations to key systems (patient safety systems, human resources, quality systems, technology) related to the patient safety agenda.

Role	Accountability	Specific Tasks
Administrative (CEO, COO, CNO, VP's, Directors, & Physician Leaders	Set the agenda for the rest of the team	<ul style="list-style-type: none"> • Ensure that an integrated patient safety program is implemented throughout the hospital. • Set performance improvement priorities and identify how the hospital adjusts priorities in response to unusual or urgent events. • Allocate adequate resources for measuring, assessing and improving the hospital's performance and improving patient safety. • Measure and assess the effectiveness of the performance improvement and safety improvement activities. • Monitor implementation for of corrective action of patient safety events. • Ensure remedial activities, identified through analysis of reported patient safety events, are implemented, effective, and do not cause unintended adverse consequences. • Develop a proactive approach to reducing errors. • Encourage an environment of openness & collaboration. • Support a dialogue about outcomes between patients and clinicians including systems to obtain direct feedback from patients regarding performance of the organization • Educate staff about safety. • Support staff and lead by example.
Patient Safety Officer / (Chief of Staff)	Lead patient safety initiatives with the medical staff and organizational staff	<ul style="list-style-type: none"> • Lead an integrated patient safety program. • Serve as the primary point of contact for questions about patient safety, and coordinate patient safety for education and deployment of system changes. • Execute performance improvement priorities and adjusts priorities in response to unusual or urgent events. • Assure effectiveness in measuring, assessing and improving the hospital's performance and improving patient safety. • Lead a proactive approach to reducing errors and make recommendation to reduce patient safety events. • Lead in an environment of openness & collaboration. • Assure dialogue about patient safety issues occurs effectively between patients and clinicians. • Report progress regularly, and educate about patient safety • Support staff and lead by example.

Role	Accountability	Specific Tasks
Patient Safety Coordinators	Day to day coordination and facilitation of safety initiatives	<ul style="list-style-type: none"> • Implement operational aspects of the patient safety program throughout the hospital. • Implement proactive patient safety management that assures immediate, appropriate response to unusual or urgent events. • Participate in measuring, assessing and improving the hospital's performance and improving patient safety. • Be accountable for patient safety initiatives and strengthening a culture of safety in day to day practice. • Support an environment of openness & collaboration. • Support a dialogue about patient safety issues between patients and clinicians. • Report progress regularly, and educate about patient safety. • Support staff and lead by example.
Pharmacists	Ensure safe medication usage	<ul style="list-style-type: none"> • Ensure that authoritative, up-to-date drug information is available in reference form in patient care areas and prescribers' offices. • Periodically examine all drug products stored in patient care areas and procedures on drug storage/distribution to patient care areas. • Minimize the need for nurses to calculate, manipulate, or mix medications. • Establish a pharmacy led interdisciplinary team to spearhead medication safety activities. • Provide leadership to develop safe medication delivery systems.
Clinicians & Medical Staff	Monitor, report, & learn.	<ul style="list-style-type: none"> • Medical staff and other employee job descriptions and competency evaluations incorporate accountability for safety. • Medical staff & employees participate in education on the importance of safety, surveillance, and expectations for reporting safety concerns, beginning with orientation. • Medical staff & employees evaluations include an individual's contributions to safety for the organization. • Medical staff & employees are positively acknowledged for disclosing errors, near-misses, and safety concerns. • Employees and physicians work collaboratively assuring responsibilities of the team to the patients are met, and noticing errors before they cause harm. • Participate in the facility reporting system for PS events, both actual and potential event.

Role	Accountability	Specific Tasks
Patients/visitors	Involved partners in prevention.	<ul style="list-style-type: none"> • Inform doctors and nurses about medications they take, including prescriptions, over-the-counter drugs and dietary supplements. • Ask for written information about possible side effects. • Inform the doctors and nurses about allergies & adverse reactions. • Ask a relative or friend to be an advocate. • Learn about their medical condition by asking their doctor, nurse, and other reliable sources. • Upon hospital discharge, ask doctors for an explanation of the treatment plan to be used at home. • Provide feedback regarding performance of the organization • Report safety concerns through the Patient Safety hotline and other venues available.

V. Mechanisms for Coordination

MountainView Hospital Patient Safety Committee

The MVH Patient Safety Committee (PSC) or equivalent is a multidisciplinary team involving department representatives that meets not less than monthly. The Patient Safety committee or equivalent committee, is comprised of various health care professionals including but not limited to physicians, 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 or retribution for reporting mistakes.
2. An accessible multifaceted non-punitive, just culture reporting system exists .
3. Errors and accidents are tracked in an attempt to establish trends and patterns, to learn from them and prevent reoccurrence.
4. Healthcare providers participate in reporting and developing improved processes to effectively evaluate errors and near misses.
5. Reporting errors and near misses are a critical component of the MountainView Hospital Patient Safety Program.

The Meditech on-line incident reporting system is a tool for the documentation, investigation, and correction of patient safety issues as described in the organizational policy: RM21 Facility Event and Close Call Reporting. The Director of Risk Management coordinates this process.

Organization or Medical Staff committees refer patient safety issues to the Patient Safety Officer for review at the PSC and corrective action.

NRS 439.877 – Monitoring and Compliance

Nevada statute NRS 439.877 requires medical facilities to adopt patient safety checklists and patient safety policies. These patient safety checklists are protocols used to improve the outcomes of patients at the hospital to include:

1. Patient Discharge Process (CP120 – Discharge Planning)
2. Patient Identification Process (CP70 – Patient Identification)
3. Patient room/environment sanitation and cleaning (Sodexo 7-Step Cleaning Process)
4. Additional patient safety checklists which may be appropriate to ensure the safety of patients in the facility. These include, but are not limited to the following:
 - a. Universal Protocol (CP195 – Safe Procedural and Surgical Verification)
 - b. Central Line Insertion Bundle (CP131 – Adult Central Line/PICC (Non-Implanted_ Management)

Monitoring and oversight for compliance with these policies and checklists will be the ongoing responsibility of the Patient Safety Committee.

NRS 439.865– Infection Control Program

Nevada statute NRS 439.865 requires medical facilities have an infection control program to prevent and control infections within the medical facility, as well as an infection control policy. The Hospital's Infection Control Plan is attached as an addendum to the Patient Safety Plan and is reviewed annually. (See Appendix 3 – Infection Prevention and Control Plan)

Proactive Risk Identification and Reduction:

1. Opportunities for improvement regarding patient safety issues and hazardous conditions are identified through trending of actual or potential occurrences involving patients or visitors and/or evidence-based literature (e.g. The Joint Commission Sentinel Event Alerts).
2. When an identified opportunity for improvement is identified, it is analyzed by the involved care providers according to level of severity, frequency of occurrence, potential for harm and liability.
3. At least every 18 months, one high-risk or error-prone process is selected for Failure Mode Effect Analysis (FMEA) process. The underlying systems are examined and modified or redesigned to minimize the risk of the identified failure mode.
4. Trending of adverse events, environmental safety issues, aggregate data collection, and review of intensive assessments are part of the identification and management of risks to safety and are used to prevent reoccurrences.
5. Serious unusual occurrences and sentinel events are reviewed with determination made for intensive assessment and root cause analysis according to the Facility Event and Close Call Reporting and SPAE policies.
6. Near miss events are reviewed and root cause analysis conducted as deemed appropriate.
7. Regular communication about patient safety and risk management is conducted with designated Quality Committee, Medical Executive Committee, and the Board of Trustees. Disclosure of an adverse event to a patient is in accordance with policy. RM13: Disclosure of Adverse Events and the SPAE policy

IX. Reporting Patient Safety Results:

To the PSC:

The Patient Safety Committee reviews and recommends actions on the following reports:

- Audits on Patient Safety

- National Patient Safety Goals and Safe Practices compliance (including accordance with NRS 439.877)
- Culture of Patient Safety Survey
- Leapfrog Survey

To organization staff and medical staff:

Organizational staff receives patient safety results and information on:

- Lessons Learned summaries
- Culture of Safety Survey
- Patient experience survey results on patient safety components.
- National Patient Safety Goals and Safe Practices compliance (including accordance with NRS 439.877)
- Leapfrog Survey

To executive leadership and Board of Trustees:

The Board of Trustees and Executive Leadership receives periodic reports on:

- Culture of Safety Survey
- Leapfrog Survey
- Risk Management dashboard
- Patient Safety dashboard

X. EVALUATION OF CY 17 PSC / Organizational Goals

GOAL	GOAL MET	GOAL NOT MET
Attain ≥ 90% compliance with NPSG / Patient Safety Audit Tool.	Goal Met. Maintained ≥90% compliance with NPSG audits.	
Reduce preventable falls with injury to zero (utilize daily falls report for data). Re-institute Patient Safety Rounds to identify safety opportunities from front line nursing and support staff.		Goal not met. Continue to strive for green compliance and/or improvement by 10% for 2018 goals.
Attain 3Q17 SHARP Metric “DVT and PE on All Inpatients” in green or improve by 10% from 3Q16 results		Goal not met. Continue to strive for green compliance and/or improvement by 10% for 2018 goals.

XI. CY 18 PSC / Organizational Goals:

1. Maintain ≥ 90% compliance with NPSG/Patient Safety Audits.
2. Reduce preventable falls with injury to zero (utilize daily falls report for data). Re-institute Patient Safety Rounds to identify safety opportunities from front line nursing and support staff.
3. Attain 3Q18 SHARP Metric “DVT and PE on All Inpatients” in green or improve by 10% from 3Q17 results.
4. Achieve ≥80% hospital participation in the AHRQ Patient Safety Culture Survey. Assess survey results and develop facility specific action plan(s) based upon opportunities identified.

5. Implement weekly Executive Leadership Safety rounding that encourages discussion of safety issues and fosters a culture of safety through building respect, trust and inclusion in the organization.

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.

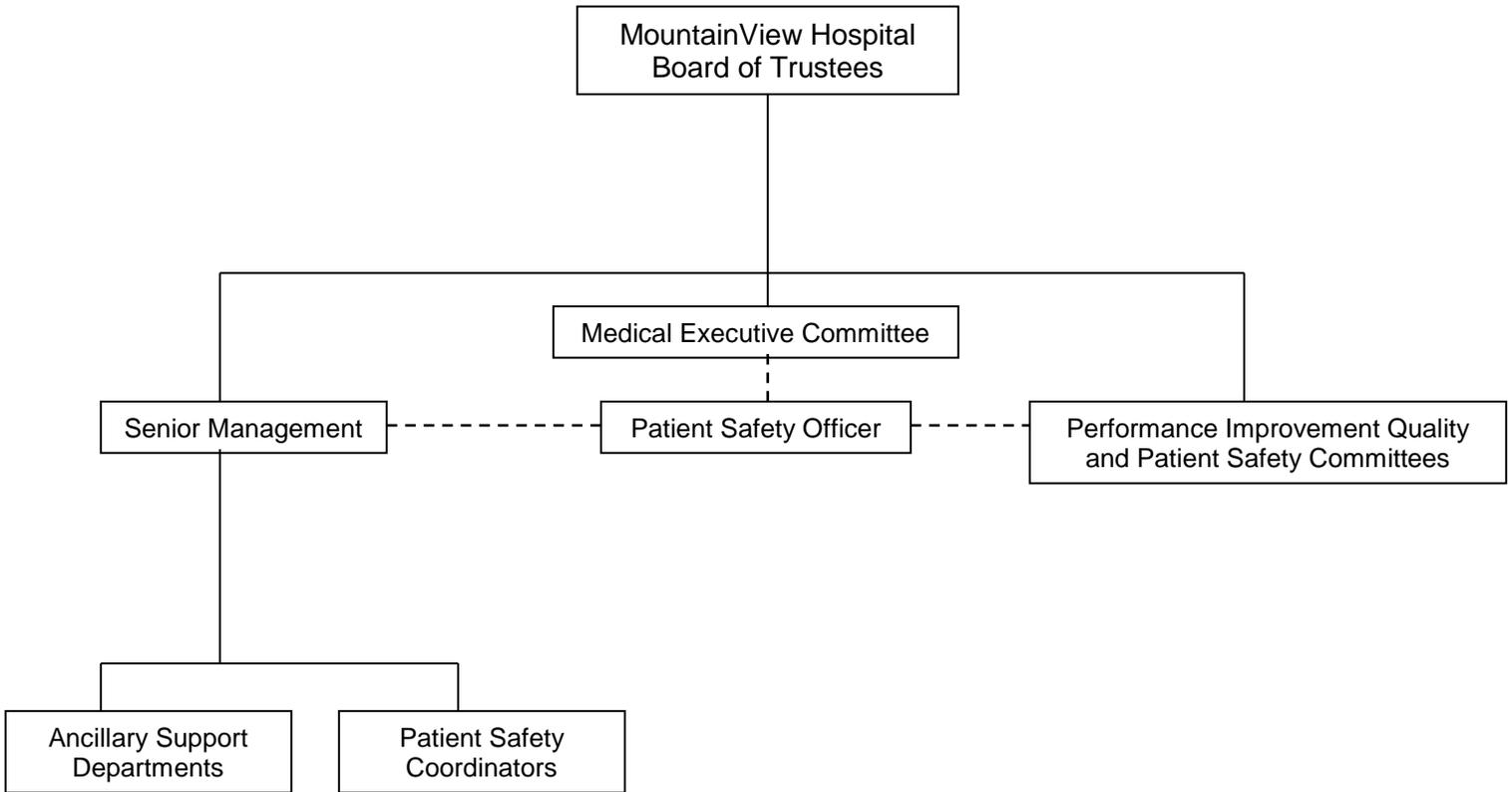
XII. The MountainView Hospital Patient Safety Program

The components of the patient safety program are outlined in Appendix One:

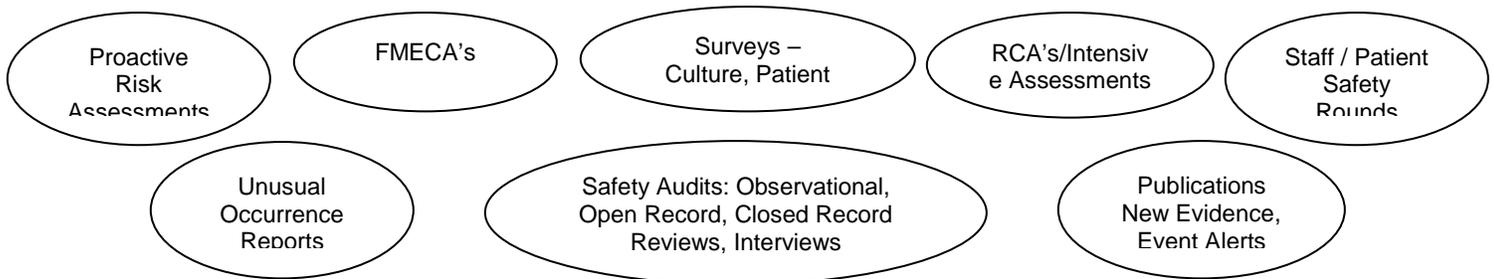
XIII. References/Authority

- The Joint Commission 2018 NPSG's
- HCA Patient Safety Organization PSO Operating Policy and Procedure
- Federal Register - Department of Health and Human Services 42 CFR Part 3 – Patient Safety and Quality Improvement

Patient Safety Program



Sources of Patient Safety Data



2018 National Patient Safety Goals Overview

The Joint Commission NPSG's	Specific Elements Within Broad Goal (Note #'s same as per The Joint Commission's NPSG's for Hospitals)	Key Content Expert Links to PSC	Audit Methodology (Cross-reference to Patient Safety Dashboard)
#1: Improve the accuracy of patient identification	A: Use at least two patient identifiers when providing care, treatment or services		
	A1 Blood draw and other lab specimen collection	Blood Bank Laboratory Nursing	Random observation audits (Quarterly)
	A2 Label containers in presence of patient	Blood Bank Laboratory Nursing	Random observation audits (Quarterly)
	B: Eliminate Transfusion Errors		
	B1. Blood transfusion process: match blood or blood component to the order; match the patient to the blood or blood component; use a two-person verification process	Blood Bank Laboratory Nursing	Blood Bank Audits (Quarterly)
	B2. Qualified transfusionist part of two-person verification process	Blood Bank Laboratory Nursing	Blood Bank Audits (Quarterly)
	B3. Second qualified individual part of two-person verification process	Blood Bank Laboratory Nursing	Blood Bank Audits (Quarterly)
#2: Improve the effectiveness of communication among caregivers	A. Report critical results of tests and diagnostic procedures on a timely basis.		
	A1. Evaluate the timeliness of reporting the critical results of tests and diagnostic procedures.	Lab Nursing	Random charts and log audits (Quarterly)

The Joint Commission NPSG's	Specific Elements Within Broad Goal (Note #'s same as per The Joint Commission's NPSG's for Hospitals)	Key Content Expert Links to PSC	Audit Methodology (Cross-reference to Patient Safety Dashboard)
#3: Improve the safety of using medications	A. Label all medications, medication containers (for example, syringes, medicine cups, basins), or other solutions on and off the sterile field.	Cardiac Imaging OR Nursing	Random observations and audits, all procedure areas (Quarterly)
	B. Reduce the likelihood of patient harm associated with the use of anticoagulation therapy.	Pharmacy Nursing	Random chart audits (Quarterly)
	C. Maintain and communicate accurate patient medication information.	Pharmacy Nursing	Random chart audits (Quarterly)
#6: Improve the safety of clinical alarm systems.	A. Leaders establish alarm safety as a hospital priority.	Patient Safety Officer / PS Plan	Random observations and audits (Quarterly)
	B. Identify the most important alarm signals to manage.	Patient Safety Committee	Random observations and audits (Quarterly)
	C. Establish policies and procedures for managing alarms as listed above in #B.	Patient Safety Committee	Random observations and audits (Quarterly)
	D. Educate staff and LIP's about the purpose and proper operation of alarm systems for which they are responsible.	Patient Safety Committee	Random observations and audits (Quarterly)
#7: Reduce the risk of health	A. Comply with current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines	Infection Prevention Nursing	Random observations (Quarterly)

The Joint Commission NPSG's	Specific Elements Within Broad Goal (Note #'s same as per The Joint Commission's NPSG's for Hospitals)	Key Content Expert Links to PSC	Audit Methodology (Cross-reference to Patient Safety Dashboard)
care-associated infections	B. Implement evidence-based practices to prevent healthcare associated infections due to multiple drug-resistant organisms (MDRO's)	Infection Prevention	MDRO Tracker (Quarterly)
	C. Implement evidence-based practices to prevent central line-associated bloodstream infections (CLABSI's).	Infection Prevention	Targeted Surveillance (Quarterly)
	D. Implement evidence-based practices to prevent surgical site infections (SSI's).	Infection Prevention	Targeted Surveillance (Quarterly)
	E. Implement evidence-based practices to prevent catheter associated urinary tract infections. (CAUTI's)	Infection Prevention	Targeted Surveillance (Quarterly)
#15: The organization identifies safety risks inherent in its patient population	A. The organization identifies patients at risk for suicide. [Applicable to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals.]	Nursing Risk Management	(Structural process) Random chart audits (Quarterly)
Universal Protocol	A. Pre-op verification B. Site marking C. Time-out	Cardiac Medical Imaging Nursing OR	Random observations & chart audits (Quarterly)

**DESERT SPRINGS HOSPITAL
MEDICAL CENTER**

**Risk Management/
Patient Safety Plan**

Nevada Acute Care Division

I. Overview

Desert Springs Hospital Medical Center endorses an integrated, system-wide patient safety program designed to improve patient safety and reduce risk to patients. Patient safety is a cornerstone of quality care and is a leadership priority. Desert Springs Hospital Medical Center operates as a Patient Safety Organization to further its commitment in promoting patient safety and assuring that Desert Springs Hospital Medical Center remains at the forefront in the delivery of safe and effective clinical care. The Member Patient Safety Evaluation System (PSES) is utilized by Desert Springs Hospital Medical Center to track safety information, generate Patient Safety Work Product (PSWP) analysis of safety and clinical performance, and promote best practices. This Acute Care Division Risk Management/Patient Safety Plan ("Plan") provides the general framework to identify, manage, reduce, and eliminate patient safety risks.

The Plan identifies the mechanisms to continually assess and improve the patient safety systems at Desert Springs Hospital Medical Center. It is our strategy to utilize statistical tools and defined project work to achieve breakthrough gains in patient safety. Performance improvement tools are used in developing and delivering consistent processes and services. The cultural aspect of the Plan is to promote a non-punitive approach to identifying and reporting adverse events. This is consistent with the "Just Culture" concept to promote patient safety practices by instituting a culture of safety and embracing concepts of teamwork and communication.

Most patient safety events are due to a failure of systems; therefore, a systems analysis approach is utilized in evaluations. The goal is to identify and track errors, deficiencies, and problematic trends in order to continuously improve the underlying systems and to intervene as necessary to improve system processes. Although a non-punitive culture is promoted, this approach is balanced by holding caregivers personally responsible for at-risk behaviors and failures to meet the standard of care. When warranted, discipline measures will be initiated as needed consistent with Desert Springs Hospital Medical Center policies. Desert Springs Hospital Medical Center employees, contractors, vendors, and members of each facility's medical staff share responsibility to participate in detection, reporting, and remediation to prevent errors.

GENERAL STATEMENTS ON GOALS AND OBJECTIVES

To support, maintain and enhance the quality of patient care delivered by:

- Systematic and objective monitoring and evaluation of reports of injuries, accidents, patient safety issues, safety hazards, and/or clinical services findings.
- Identification and assessment of general areas of actual or potential risk in the clinical aspects of the delivery of patient care and safety.

- Implementation of appropriate corrective action, to the extent possible, to alleviate and resolve identified problems or concerns with patient safety issues.
- Evaluation and documentation of the effectiveness of actions implemented.
- Aggregation of data/information collected for integration in information management systems and use in managerial decisions and operations.

II. Mission and Vision

Desert Springs Hospital Medical Center mission, vision and values drive the Plan and serve as the foundation in identifying strategic goals, objectives and priorities. Our mission is to improve patient safety and the quality of health care delivery through the provision of excellence in clinical care while fostering safe care to our communities, that our patients will recommend to their families and friends, physicians prefer for their patients, purchasers select for their clients, employees are proud of, and investors seek for long-term results. The vision is to be recognized as the provider of choice for healthcare services in the local community where we are trusted by our patients, families and physicians to create a safe, caring and compassionate experience.

In support of our mission, vision, and values, the Plan promotes:

- Collaboration of administrative leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high quality healthcare.
- Communicate honestly and openly to foster trusting and cooperative relationships among healthcare providers, staff members, and patients along with their families, to ensure accountability for the patient safety priorities.
- Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.
- Accountability for every healthcare related decision and action based on the level of risk-taking or egregious behavior identified.
- A focus on continuous learning and improving, system design, and the management of choices and changes, bringing the best possible outcomes or performances to the facility.
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare.
- Education of staff and physicians to assure coordination and integration of care across disciplines and specialties.

Desert Springs Hospital Medical Center recognizes that providing safe patient care requires significant coordination and collaboration. The optimal approach to patient safety involves multiple departments and disciplines to establish and effectively implement the processes and mechanisms that comprise this plan.

III. ROLES AND RESPONSIBILITIES

A. Risk Management/Patient Safety Officer

Desert Springs Hospital Medical Center has a designated risk director/manager responsible for patient safety risk identification and reduction for their respective facilities. The designated Risk Director/Manager is also the Patient Safety Officer. Each facility is required to submit scheduled reports to the Board of Governors describing risk reduction efforts associated with facility specific, or industry identified risk exposures, including environmental risks and emergency management. Reports are thoroughly reviewed and analyzed by the risk staff to determine effectiveness and follow-through of identified corrective action plans.

The Patient Safety Officer responsibilities based upon [NRS 439.870](#) includes:

- Serving on the Patient Safety Committee (PSC)
- Supervising the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Taking action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the PSC regarding any action taken in accordance with the responsibilities above.

B. Infection Control Officer

The infection control officer designated for each facility, based on [NRS 439.873](#), responsibilities include:

- Serving on the Patient Safety Committee
- Monitoring the occurrences of infections at the facility to determine the number and severity of infections.
- Reporting to the PSC concerning the number and severity of infections at the facility each month.
- Taking such action as determined necessary to prevent and control infections alleged to have occurred at the facility.
- Carrying out the provisions of the Infection Control Program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program.

Based on [NRS 439.865](#), the patient safety plan must also include an infection control program that carries out the infection control policy. The policy must consist of:

- The current guidelines appropriate for the facility's scope of service developed by a nationally recognized infection control organization as approved by the State Board of

Health which may include, the Association for Professionals in Infection Control and Epidemiology (APIC), the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO) and the Society for Healthcare Epidemiology of America (SHEA); and

- Facility-specific infection control developed under the supervision of a certified Infection Preventionist.

C. Patient Safety

Desert Springs Hospital Medical Center has an established Patient Safety Councils (PSC) to support patient safety activities. The PSC should ensure that its Patient Safety Plan is promoted and executed successfully. Desert Springs Hospital Medical Center has also assembled participants to serve in the Member Workforce and to utilize the Member PSES to generate PSWP and exchange analysis and recommendations with the Acute Care PSO Workforce. The main vehicles for these analytic activities occurring within the Member PSES and the member facility Patient Safety Council meetings. The Member PSES is made up of both electronic and physical spaces for the reporting, storing, and generation of PSWP, including secure SharePoint site, and other electronic databases (including but not limited to ClearSight (STARS) and Midas) to maintain and manage PSWP.

According to [NRS 439.875](#), a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plans are promoted and executed successfully.

I. Facility Patient Safety Committee

Each facility establishes a Patient Safety Committee (PSC) that meets on a regular basis and at least monthly.

Membership:

In accordance with [NRS 439.875](#), the committee core membership consists of the following Key Members: (CEO, CNO, Physician, Risk/ Patient Safety Officer, Infection Prevention Nurse, Pharmacy, and Quality). The COO, CMO and Regional CMO attend, as applicable. NRS requires that at least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing, and pharmaceutical staff of the medical facility. In addition, the infection control officer, patient safety officer, and one member of the executive or governing body of the medical facility.

Based on [NAC 439.920](#), a medical facility that has fewer than 25 employees and contractors must establish a patient safety committee comprised of: the Patient Safety Officer, at least two providers of healthcare who treat patients at the medical facility, including but without limitation, one member of the medical staff and one member of

the nursing staff of the medical facility; and the Chief Executive Officer (CEO) or Chief Financial Officer (CF) of the medical facility.

Meetings:

The required members attend the meetings on a monthly basis. If a required member is absent, the facility makes a suitable replacement with someone that has authority to implement actions identified by the PSC.

Duties and Responsibilities:

Desert Springs Hospital Medical Center PSC is charged with the assessment and improvement of high-risk processes related to patient safety. This is to be carried out using a four-step methodology.

- **Issue Identification:** The primary issue is the most important risk issue facing the facility and is determined by reviewing the facility’s claims history, claims history unique to the facility, patient safety concerns, industry claims, and through discussions with the risk staff. Other issues may be related to process initiatives.
- **Best Practice:** Once identified, the primary issue is dissected to determine its component issues. For each component issue, a best practice is selected. Best practices represent the most appropriate method for performing the delineated process and should not be selected until the PSC is assured that it is truly the “Best Practice.”
- **Implementation:** Implementation strategies are those methods used to put the best practices into place. Often this includes revising policies, education, newsletters, phone calls, meetings, formal training, etc. Responsible parties and dates for completion are identified to ensure success.
- **Monitoring and Accountability:** Monitoring is essential to ensure that the strategies identified have been effective. Improvement should be demonstrated statistically whenever possible.

Additional Patient Safety Committee Responsibilities, based upon [NRS 439.875](#) and [NRS 439.877](#), include:

- Monitor and document the effectiveness of the Patient Identification Policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the Patient Safety Officer pursuant to [NRS 439.870](#).
- Evaluate actions of the Patient Safety Officer in connection with all reports of sentinel events alleged to have occurred.

- The Quality member of the PSC will review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- The Quality member in conjunction with the Infection Control Officer will review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- Make recommendations to the Board of Directors of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the Board of Directors of the facility regarding:
 - (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);
 - (2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and
 - (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
 - Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

In addition to the work done on the primary issue, the PSC is charged with addressing issues identified through claims reporting, Safety Watch Newsletters, the Joint Commission (Sentinel Event Alerts) and others, HRUs and from the TERM evaluation or other surveys, such as the OBHRU Site Assessments. Feedback is provided on an ongoing basis as to the functioning of the Patient Safety Committee.

II. Patient Safety Advisories

When an untoward event occurs at a facility or in the industry, it is important that we respond in a positive manner. Systems that lead to failure at one facility can be assessed at other facilities to avoid the same or similar occurrence. To this end, the Acute Care PSO distributes Safety Watch newsletters. These alerts detail the circumstances that lead to the negative outcome and facilities are charged with assessment and improvement of their own processes.

Desert Springs Hospital Medical Center is required to address the Safety Watch newsletters via their Patient Safety Council and this is evidenced in their monthly minutes. Responses to the Safety Watch are reviewed for the opportunity to generate a best practice to implement.

C. TERM Program

The facility has utilized its formalized risk management program identified as TERM: the Technical Elements of Risk Management. Each element focuses on a separate organizational function and details specific strategies for managing risk in these areas. These elements are summarized as follows:

Element I. Administration of the Risk Management Program: The tenets outlined in Element 1 lay the foundation for an effective risk management program. The Risk Manager/Director must be seen as a resource to administration, facility, and medical staff. Written plans, goals, and objectives provide a clear vision to meet the purpose of the risk program. Although the TERM program uses the title “Risk Manager,” this applies equally to Risk Directors.

Element II. Risk Identification: Risk identification is essential in order to avoid, mitigate, and eliminate risk-generating practices. This Element focuses on those steps taken to identify exposures faced by the facility.

Element III. Risk Education: Education is a cornerstone of the TERM program. Risk management education is intended to reduce and eliminate risk-generating practices and to promote best practices that enhance the provision of safe patient care.

Element IV. Patient Safety Initiative: Imperative to a comprehensive RM program is one that focuses on the improvement of patient and staff safety through the creation of an environment that maximizes safety and reduces liability claims exposure. The mechanism used to drive the culture of safety is the Patient Safety Committee (PSC) at each facility. The PSC operates using a four-step process. These steps include: identification of the problem, determining best practice, implementing the recommendations, and monitoring and accountability. Corrective actions are discussed, monitored, and validated by the PSC.

Element V. Patient Safety Priority: Root Cause Analysis (RCA): The cornerstones of an effective Patient Safety and Risk Management Program are (i) the performance of a thorough and credible RCA when a serious, sentinel, never event or a significant near miss event occurs; and (ii) implementation of systemic improvements to enhance patient safety and improve healthcare outcomes going forward.

Element VI. Environment of Care; Safety and Security Programs: The safety and security programs in the facility serve to protect and preserve both life and property. Areas of safety include licensing, accreditation and federal, state, and local safety practices and programs, including the EPA, TJC, etc.

Element VII. Claims and Litigation Management: The risk manager serves as the on-site representative of the insurance program in the management of general and professional claims and litigation.

Element VIII. Patient Safety Organization (PSO): Participants of the Member Workforce are expected to perform identified patient safety activities and to be trained in their responsibilities. They must also understand and acknowledge their obligations, including maintaining the confidentiality of PSWP, as required by the Patient Safety and Quality Improvement Act (PSQIA), and of Protected Health Information, as required by the Health Insurance Portability and Accountability Act (HIPAA) and its regulations, and other federal and state laws.

Element IX. Measuring the Effectiveness of the Risk Management Program: In order to assure the effectiveness of the Risk Management Program, certain activities should be conducted to ensure that implementation of the TERM program has been successful. This includes, but is not limited to, data analysis and trending of events and potential claims, which are shared with the respective oversight committees.

D. MIDAS

The MIDAS system is the electronic event reporting system utilized by the facilities to report patient and visitor safety events. The risk management module allows for the collection, categorization, and analysis of incident data using electronic reporting functions (Remote Data Entry - RDE). The facility enters incidents into MIDAS through identification of the type of incident and characteristics of the event using risk parameters and outcomes. Additional information can be attributed to a department, physician, or individual, along with further details of the event. This allows the retrieval of information in a variety of ways for analysis and review.

E. ClearSight (STARS)

STARS is an integrated claims management program that allows for complete claims management, including extensive analysis of reportable fields associated with reported claims. STARS also provides for the electronic submission of potential claims by user facilities.

Delineation of issues featured in the probable claim module allows for the facility staff to identify causation factors associated with any reported event. The system also provides for the entry of details that will describe the event and liability concerns.

Trending of claim information is performed on a scheduled basis to operations leadership metrics to form strategies on facilitating risk reduction efforts. Previous examples of this function include the formation of an OB HRU and Perioperative

concepts. Quarterly reports should be provided by the Facility's RM to the Governing Board of all claims activities.

F. Event Notification Site

The Risk Department developed the Event Notification Site or ENS, a web-based system that allows for contemporaneous reporting of serious adverse events and key near miss sentinel events to facility and corporate management. The ENS also provides an environment in which stakeholders can post questions and additional information to the facility reporting the event. Updates to the event are reported in real-time to all identified facility and stakeholders via the ENS. The Risk Management staff reviews each ENS to determine if follow-up is needed; if follow-up is indicated, it is to be completed within 45 days.

G. Root Cause Analysis (RCA)

Pursuant to [NRS 439.837](#), a medical facility shall, upon reporting a sentinel event pursuant to [NRS 439.835](#), conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both of the sentinel event.

A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals. Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

It is recommended that the Joint Commission's root cause analysis and actions plan framework table are utilized. It contains analysis questions and guides the organization in the steps of a root cause analysis. Not all of the questions apply to all of the events or cases.

Utilization of the "5 Whys" technique should be used to explore the cause and effect relationship underlying a problem. One can find the root causes by asking "why" no less than five times.

RCA Responsibilities

- Organize and coordinate the RCA process. For Serious OB events, RCAs are to be done within 72Hrs. of the event.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA and corrective action plan implementation process.
- Communicate the progress of the investigation, institutional barriers and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.



H. Patient Safety Checklists

By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

The patient safety checklists must follow protocols to improve the health outcomes of patients at the medical facility and must include, without limitation:

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.

- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - Proper instructions concerning prescription medications;
 - Instructions concerning aftercare;
 - Any other instructions concerning his or her care upon discharge; and
 - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety checklists are listed in Appendix E. (The following links provide some patient safety checklists for your reference— a checklist example is shown in **Appendix B.**)

http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf

<http://www.who.int/patientsafety/implementation/checklists/en/>

I. Patient Safety Policies

The patient safety policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include, the name and date of birth of the patient.
- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.
- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

J. MEMBER PATIENT SAFETY EVALUATION SYSTEM (PSES)

The Patient Safety and Quality Improvement Act of 2005 (PSQIA) and its regulations govern the operations and activities of the UHS Acute Care PSO and its Members. This includes assembling a “workforce” of employees, volunteers, trainees, contractors, and other persons who carry out patient safety activities on behalf of the Members within the Member Patient Safety Evaluation System (“Member PSES”). Participants in the Member Workforce are expected to perform identified patient safety activities and to be well trained in their responsibilities. They must also understand and acknowledge their obligations, including maintaining the confidentiality of PSWP, as required by the PSQIA, and of Protected Health Information, as required by the Health Insurance Portability and Accountability Act (HIPAA) and its regulations, and other federal and state laws. The Member PSES serves as a means by which patient safety information is collected, maintained, reported, and analyzed for the UHS Acute Care PSO for the purposes of improving patient safety.

K. Training and Education

Training is essential to successful implementation of the Patient Safety and TERM program. All facility risk managers undergo extensive orientation and education related to Patient Safety, TERM program and other healthcare, risk-related topics. Newly hired risk managers receive both on-site and collaborative corporate-based education and training to afford them the requisite skills to manage their facility assignment. Each risk manager is provided a copy of the TERM source documents and other reference materials that guide the risk management function. In addition, formalized supplemental training is provided to all facility risk managers as needed, including quarterly risk management meetings. Risk leadership provides ongoing support and consultation to their assigned facility to facilitate the minimization of liability exposures and enhancement of safe patient care.

The leadership risk management staff provides consultative services to each facility and as members of designated projects. These activities include on-site assistance, research, and consulting from off-site. Examples of designated projects are as follows.

- Facility specific risk Issues
- Safety Watch newsletters
- MIDAS Focus advisories

IV. Risk Management Goals and Objectives 2018

- Surgical and Procedural Safety
 - Monitor compliance through tracer methodology and report monthly with oversight by leadership.

- Goal: Zero harm events: Prevent mistakes in surgeries and procedures
- OB HRU-Zero Preventable Harm
 - Goal: Reduction/ Elimination of Maternal Hemorrhage
 - Goal: Reduction/ Elimination of Serious Harm from Shoulder Dystocia
 - Goal: Reduction/ Elimination of Serious Harm by decreasing response time to changes in Fetal Monitoring Tracings
- Emergency Department
 - Goal: Reduction/ Elimination of Workplace Violence
- Medication Safety
 - Goal: Implement an effective Opioid – Pain Management strategy, as evidenced by compliance with Assembly Bill 474, NRS 233B.066, regarding prescribing of controlled substances and reporting of controlled substance overdoses.
- Perform monthly *Safety Watch* Gap Analysis and complete within 90 days.
- Reduce 2018 Patient Falls by 10% of 2017 Total Patient Falls
- Increase monthly reporting of Medication Events to at least 8%

V. Monitoring and Accountability

A. Evaluation of TERM Program

These evaluations consist of both a core risk and clinical risk review. The facility is required to submit a written corrective action plan for noted deficiencies determined during the TERM evaluation. All information is shared with senior staff and monitored through the facility PSC.

B. Patient Safety Council Coaching

As detailed above, each facility is required to post their monthly reports or minutes that details the work conducted by their Patient Safety Committee to the facility PSES site. These are then reviewed minutes and detailed feedback is provided to coach the committee on their form and function.

C. Dashboards

The Risk Management/Patient Safety Dashboard and the Environment of Care Dashboard include multiple indicators to demonstrate the facility's performance as to these markers. These include: event reporting statistics, fall rate including harmful event rate, medication event rate including harmful medication events, timeliness of event review and closure, risk management education, events that meet the ECRI Top Patient Safety Concerns, and environment of care concerns.

VI. Evaluation/Review:

The risk staff reviews the effectiveness of the Patient Safety/Risk Management Plan to ensure activities are appropriately focused on improving patient safety, decreasing harmful errors, decreasing rate of compensable events, facility risk program consistency/functionality and support of clinical delivery in the field. Evaluation will include the following:

- The culture supports the identification and reporting of “Near Miss” events
- There is a framework that advances a “Just Culture”
- Accountability is promoted when acts of “at risk” or “reckless behavior” occur resulting in potential/actual adverse outcomes;
- Comparison of trended incident data to include analysis of performance to stated targets, submission of incident data in compliance to SOX stipulations and review of trended data submitted to the PSC for potential action;
- Review of annualized and prior year’s probable claim reports to determine needs for corporate-based projects designed to improve outcomes in an identified service line;
- Review of educational products distributed for the concluding operating year that were intended to improve outcomes associated with a particular clinical emphasis;
- Review information, analyses and reports from the Acute Care PSO for integration into the Patient Safety Evaluation System.

VII. Confidentiality

All patient safety/risk management work products are considered Patient Safety Work Products (PSWP) as defined by federal guidelines governing Patient Safety Organizations (PSO). All PSWP reported, stored, or generated in the Member PSES is confidential and privileged under Federal law. The Member PSES will only be accessed by authorized staff. Workforce participants will be trained on policies and procedures governing their patient safety activities and responsibilities.

VIII. Approval of Patient Safety Plan

According to [NRS 439.865](#), a medical facility shall submit its patient safety plan to the governing board of the facility for approval. After a facility’s patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan.

The patient safety plan must be reviewed and **updated annually** in accordance with the requirements for approval set forth in this section.

According to [NRS 439.843](#), on or before March 1 of each year, a copy of the most current patient safety plan established to [NRS 439.865](#) must be submitted to the Division of Public and Behavioral Health.

Appendix A: Terms and Definitions

Patient Safety: The Agency for Healthcare Research Quality (AHRQ) defines patient safety as “a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.”

http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

Sentinel event ([NRS 439.830](#))

1. Except as otherwise provided in subsection 2, “sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum.

2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:

(a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or

(b) July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published.

3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.

(Added to NRS by [2002 Special Session, 13](#); A [2005, 599](#); [2013, 217](#))

Institute for Healthcare Improvement (IHI) defines **medical harm** as “unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death.”

Facility-Associated Infection: ([NRS 439.802](#))

“Facility-acquired infection” means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections;
- Ventilator-associated pneumonia;

- Central line-related bloodstream infections;
- Urinary tract infections; and
- Other categories of infections as may be established by the State Board of Health by regulation pursuant to [NRS 439.890](#).

(Added to NRS by [2005, 599](#); A [2009, 553](#))

Medical facility ([NRS 439.805](#))

“Medical facility” means:

- A hospital, as that term is defined in [NRS 449.012](#) and [449.0151](#);
- An obstetric center, as that term is defined in [NRS 449.0151](#) and [449.0155](#);
- A surgical center for ambulatory patients, as that term is defined in [NRS 449.0151](#) and [449.019](#); and
- An independent center for emergency medical care, as that term is defined in [NRS 449.013](#) and [449.0151](#).

(Added to NRS by [2002 Special Session, 13](#))

Near miss: An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Mandatory reporting: Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985;254(6):796-800.)

Risk: Possibility of loss or injury. (Merriam-Webster’s Online Dictionary, Risk, Available at <http://www.merriamwebster.com/dictionary/risk>. Last Accessed August 2009.)

Preventable event: Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Catheter Associated Urinary Tract Infection (CAUTI): A urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at

http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CUR_RENT_b.pdf.)

Central Line Associated Bloodstream Infections (CLABSI): Primary bloodstream infections that are associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection.

Appendix B: Checklist Example: Injuries from Falls and Immobility

Process Change	In Place	Not Done	Will Adopt	Notes (Responsible & By When?)
Conduct fall and injury risk assessment upon admission				
Reassess risk daily and with changes in patient condition				
Implement patient-specific intervention to prevent falls and injury				
Communicate risk across the team; use handoff forms, visual cues, huddles				
Round every 1 to 2 hours for high-risk patients; address needs (e.g., 3Ps: pain, potty, position-pressure). Combine with other tasks(vital signs)				
Individualize interventions. Use non-skid floor mats, hip protectors, individualized toileting schedule; adjust frequency of rounds				
Review medications (by pharmacist); avoid unnecessary hypnotics, sedatives				
Incorporate multidisciplinary input for falls				
Prevention from PT, OT, MD, RN and PharmD				
Include patients, families and caregivers in efforts to prevent falls. Educate regarding fall prevention measures; stay with patient				
Hold post-fall huddles immediately after event; analyze how and why; implement change to prevent other falls				

Reference: Checklists to Improve Patient Safety. June 2013. Health Research & Educational Trust.



Current Status: Active

PolicyStat ID: 3056388



**NORTHEASTERN NEVADA
REGIONAL HOSPITAL**

Effective: 06/2002

Approved: 02/2017

Last Revised: 02/2017

Next Review: 02/2018

Owner: [REDACTED]

Policy Area: Leadership

References: 439.800, 439.855, 439.860,
439.865, 439.870, 439.875,
439.877, 439.890, CMS CFR
§482.21(e)(1), LD.03.01.01, NRS
439.835, TJC LD.04.04.05

Applicability: Northeastern Nevada Regional
Hospital

Patient Safety Plan

SCOPE:

House Wide

PURPOSE:

To build a system for providing safe patient care and for preventing adverse patient outcomes.

DEFINITIONS:

Adverse Event: Harm to a patient as a result of medical care or harm that occurs in a healthcare setting. Although an adverse event often indicates that the care resulted in an undesirable clinical outcome and may involve medical errors, adverse events do not always involve errors, negligence, or poor quality of care and may not always be preventable.

Error: An unintended act, either of omission or commission, or an act that does not achieve its intended outcome.

Facility-acquired Infection: A localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

1. Surgical site infections;
2. Ventilator-associated pneumonia;
3. Central line-related bloodstream infections;
4. Urinary tract infections; and
5. Other categories of infections as may be established by the State Board of Health by regulation pursuant to NRS 439.890.

Hazardous Condition: Any set of circumstances (exclusive of the disease or condition for which the patient is being treated), which significantly increases the likelihood of a serious adverse outcome.

Failure Mode and Effects Analysis (FMEA): A systematic, proactive method for evaluating a process to identify where and how it might fail, and to assess the relative impact of different failures in order to identify the parts of the process that are most in need of change.

Medical Error: Any event (unanticipated outcome) within the control of a provider that results in harm and requires a new or modified practitioner order for management of the patient's medical care.

"Near Miss": Used to describe any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome. Near misses fall within the scope of the definition of a sentinel event, but outside the scope of those sentinel events that are subject to review by The Joint Commission under its Sentinel Event Policy.

"Sentinel Events": Episodes of care that should never happen in any facility, at any time. Examples include patient abduction, wrong site procedure, and procedure on wrong patient.

Root Cause Analysis: A credible process for identifying the basic or causal factors that underlie variation in performance, including the risk of possible occurrence of a sentinel event.

Hospital Acquired Conditions: Conditions that result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis and could reasonably have been prevented through the application of evidence based guidelines. These include, but are not limited to:

1. Catheter-associated urinary tract infections
2. Central line-associated blood stream infection
3. Hospital acquired infections
4. Surgical site infections

Patient Safety Officer (PSO): The person who is designated as such by a medical facility pursuant to NRS 439.870. Northeastern Nevada Regional Hospital (NNRH) shall designate an officer or employee of the facility to serve as the PSO. The PSO will:

- Supervise reporting of sentinel events
- Serve on the patient safety committee
- Take such actions as he/she determines necessary to insure safety of patient as a result of sentinel event activity
- Report any action taken to Patient Safety Committee
- Work under the direction of the Director of Quality, Risk & Safety

POLICY:

The Safety Plan at NNRH is implemented to provide a collaboratively planned, systematic, organization-wide approach to process design and performance measurement, assessment and improvement of patient safety. With a goal of delivering the safest and highest quality health care to the residents of the community, the plan is designed and organized to support the mission, vision and values of the hospital and LifePoint Healthcare Inc.

In formulating the plan, it is recognized that the implementation of an effective patient safety plan is dependent on a participative management approach, including all organization leaders, the Governing Board, senior management, the Patient Safety Committee, departmental management, and medical staff. We believe our plan provides our organization with the mechanisms to achieve patient safety that is expected by our customers and the community we serve.

Senior management is fully committed to the belief that improving patient safety is the most important challenge that we face in the healthcare industry and in our hospital. The purpose of the plan is to develop mechanisms to integrate and coordinate the activities of all of our healthcare staff so that patient safety is the foremost concern at every stage of every process that we conduct. Patient safety is to be the number one priority in the design of new processes, in the evaluation of existing processes and in the re-design of existing processes. The hospital-wide goal is to be proactive in preventing errors and complications.

To accomplish this goal, we are committed to comparing ourselves to national databases, searching for "best practices", studying designs of systems, and always searching for methods of strengthening our existing system designs by adding risk reduction strategies. Senior leaders regularly evaluate the culture of safety and quality using valid and reliable tools and prioritize and implement changes based on such evaluations. All individuals who work in the hospital are able to participate in safety and quality initiatives, either on an individual basis or a team approach. Staff, including the medical staff, is encouraged to discuss any areas of concern that impact patient safety and quality. Relevant literature concerning patient and staff safety is distributed throughout the hospital in the form of flyers, posters, newsletters and through staff meetings. Patients and their family members are encouraged to speak with the hospital staff concerning any safety and quality issues.

PROCEDURE:

INFECTION CONTROL

The patient safety plan 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 439.835 mandates that
 - a. Within 24 hours after becoming aware of a sentinel event, an employee of NNRH will notify the PSO of the event.
 - b. Within 13 days after receiving notification, the PSO shall report the date, time, and a brief description of the sentinel event to the Health Division using their occurrence reporting form.
 - c. If the PSO personally discovers or becomes aware of a sentinel event in the absence of notification by another employee, the PSO shall report the date, time, and a brief description of the sentinel event to the Health Division within 14 days after becoming aware of the sentinel event using their occurrence form.

National Quality Forum List of Serious Reportable Events:

- A. Foreign object retained after surgery
- B. Wrong surgical procedure performed on a patient
- C. Surgery performed on the wrong patient
- D. Intraoperative or immediately postoperative death in an ASA Class I patient
- E. Death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the healthcare facility
- F. Death or disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended
- G. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility
- H. Infant discharged to the wrong person
- I. Patient death or serious disability associated with patient elopement
- J. Suicide, or attempted suicide, resulting in serious disability while being cared for in a healthcare facility
- K. Death or serious disability associated with a medication error
- L. Death or serious disability associated with a hemolytic reaction to the administration of ABO/HLA incompatible blood or blood products
- M. Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare facility
- N. Stage 3 or 4 pressure ulcers not present on admission
- O. Death or serious disability due to spinal manipulative therapy
- P. Artificial insemination with the wrong donor sperm or wrong egg
- Q. Patient death or serious disability associated with an electric shock while being cared for in a healthcare facility
- R. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances
- S. Patient death or serious disability associated with a burn incurred from any source while being cared for in a healthcare facility

- T. Patient death or serious disability associated with a fall while being cared for in a healthcare facility. This includes but is not limited to fractures, head injuries, and intracranial hemorrhage.
- U. Patient death or serious disability associated with the use of restraints or bed rails while being cared for in a healthcare facility
- V. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider.
- W. Abduction of a patient of any age
- X. Sexual assault on a patient within or on the grounds of a healthcare facility
- Y. Death or significant injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds of a healthcare facility.

NRS439.837 mandates that the facility shall, upon reporting a sentinel event, conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event. A Root Cause Analysis (RCA) will be performed, with all staff involved with the sentinel event, with an ultimate goal of preventing a recurrence.

Once opportunities for improvement are identified, strategies for change can be developed using evidence based practice. Measures are used to determine the effectiveness of the improvement and ongoing feedback is provided to staff, the Patient Safety Committee and Quality Council.

DISCLOSURE OF EVENT TO PATIENT AND/OR FAMILY

When a sentinel event, hospital acquired condition, or an outcome that differs significantly from the anticipated outcome occurs, the patient, and when appropriate, the patient's family or the patient's designee shall be informed as soon as reasonably possible but within 7 days (NRS 439.855). The disclosure of facts of an event should occur after determination of the surrounding facts and after consultation with the Chief Executive Officer (CEO) or designee or Risk Management.

In most instances, disclosure should be handled by the attending physician who has responsibility for the overall care of the patient. The physician or his/her designee should communicate:

- Acknowledgement of the event
- Data known to date
- That a full analysis will take place
- What is currently taking place as a result of the event
- Additional data on an ongoing basis
- Measures taken to prevent recurrence
- Apologize that an event occurred.

PATIENT SAFETY COMMITTEE

The Patient Safety Committee is the interdisciplinary committee designated to manage the organization-wide patient safety program and shall be organized with strict adherence to NRS 439.875.

The Governing Board is responsible for the oversight of the Patient Safety Plan. The Patient Safety Committee functions under the guidance and with the oversight of the CEO and Quality Council, with the PSO, or designee, serving as Chairperson. The meetings, records, data gathered, and reports generated by the Patient

Safety Committee are protected by the peer review privilege set forth by the Health Care Quality Improvement Act of 1986 (Title IV of Public Law 99-660, as amended, and other applicable Nevada Statutes).

The committee shall be composed of the following members and others as the committee may from time to time add to accomplish specific goals and objectives within the authorized scope of activities outlined herein:

- A. Facility Patient Safety Officer
- B. Chief Nursing Officer and/or Member representing the Governing Board
- C. Director, Quality, Risk & Safety
- D. 2-3 clinical staff members
- E. Nursing Staff member
- F. 2-3 non-clinical staff members
- G. Member representing Pharmacy services
- H. Infection Prevention and Control Practitioner
- I. 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 whom the medical facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients at the facility
 - Patient safety checklists must follow best practice protocols to improve the health outcome of patients at NNRH according to NRS 439.877 and must include without limitation:
 - Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of health care
 - Checklist to ensure employees and contractors follow protocols to ensure that the room and environment of the patient is sanitary

- Checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received discharge instructions regarding medication management
- Instructions concerning aftercare and any other instructions concerning patient's care after discharge
- Checklists adopted by NNRH include:
 - Central Line Insertion (with prompt for practitioner order)
 - Universal Protocol and Surgical Site Fire Risk Assessment/Time Out
 - Safe Surgery Checklist
 - Discharge Instructions (prescription medication instructions, aftercare instructions, any other instructions related to discharge such as follow-up appointments)
 - Daily Room Cleaning (room and environment sanitation)
 - CDC Environmental Checklist for Monitoring Terminal Cleaning
 - Pre-Oxytocin Checklist (with prompt for practitioner order)
- In addition, the Patient Safety Committee will adopt and monitor compliance with our policy for the use of two patient identifiers, hand hygiene and any other patient safety checklist and policy adopted pursuant to this section. This may include active surveillance, a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.
- The Patient Safety Committee shall monitor and document the effectiveness of the patient identification policy and at least annually, review the patient safety checklists and patient safety policies adopted and consider any additional patient safety checklist and patient safety policies that may be appropriate for adoption at NNRH.
- On or before July 1st of each year, the committee submits a report to the Director of the Legislative Council Bureau for transmittal to the Legislative Committee on Health Care. The report is to include information regarding the development, revision, and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to paragraph above outlining checklist review (NRS 439.800).
- At least once each calendar quarter, report to the Governing Board 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 (2015): Patient Safety Program Components and Governing Body Report

TJC Standard LD.03.01.01 (2015): Patient Safety Culture Regular Evaluation (survey)

CMS CFR §482.21(e)(1): Patient Safety as a component of Performance Improvement Program

Nevada Revised Statutes §439.800 and any implementing Health Division and/or State Board of Health rules and regulations: Patient Safety Plan, Program, Officer and Committee; event reporting, investigation and action plan implementation; and an annual summary of events.

Nevada Revised Statutes §439.860 and any implementing agency rules and regulations pertaining to inadmissibility of report, document or other information compiled or disseminated pursuant to the provisions of §439.800 through §439.890, inclusive, in administrative or legal proceedings.

Attachments:

No Attachments

Approval Signatures

Approver	Date
[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]

COPY



October 3, 2017

Received reports on 10/02/2017 that patient; Dorla Crothers had fallen out of bed and was found on the floor by CNA, T. Barton. Patient was found lying parallel to the bed. No blood on the patient. Vital signs were taken by charge nurse K.C. Luchessi, RN; assessment showed bruising on left leg and arm. Patient stated she was in no pain and was placed back into bed by staff and monitored. Patient did state that her spouse was trying to help her get out of bed at the time of the fall. Approximately 2 hours later, patient reported pain in hip at which time Dr. Jensen was again contacted and he did place orders for a hip x-ray which revealed a mildly displaced left subcapital femoral neck fracture.

Both Dr. Jensen and Dr. Katschke have met with the patient and family and have determined that surgery may cause more harm. Determined to keep the patient here, stabilized and proper management of pain.

Plan:

The patient and patients spouse will be monitored closely when spouse is in the room as they do not share a room. Continue to orient the patients by telling them that the patient cannot be removed from her bed, staff to monitor every 10-15 minutes when spouse is in the room. Because both have a diagnosis of dementia we have reminded all staff that we must be very aware of when the spouse enters the room. Side rails were requested by the family and after education and consent was signed, the rails were placed on the bed.

Grover C. Dils Medical Center • Name Here, Chief Operating Officer

E-mail: missie@gcdmc.org

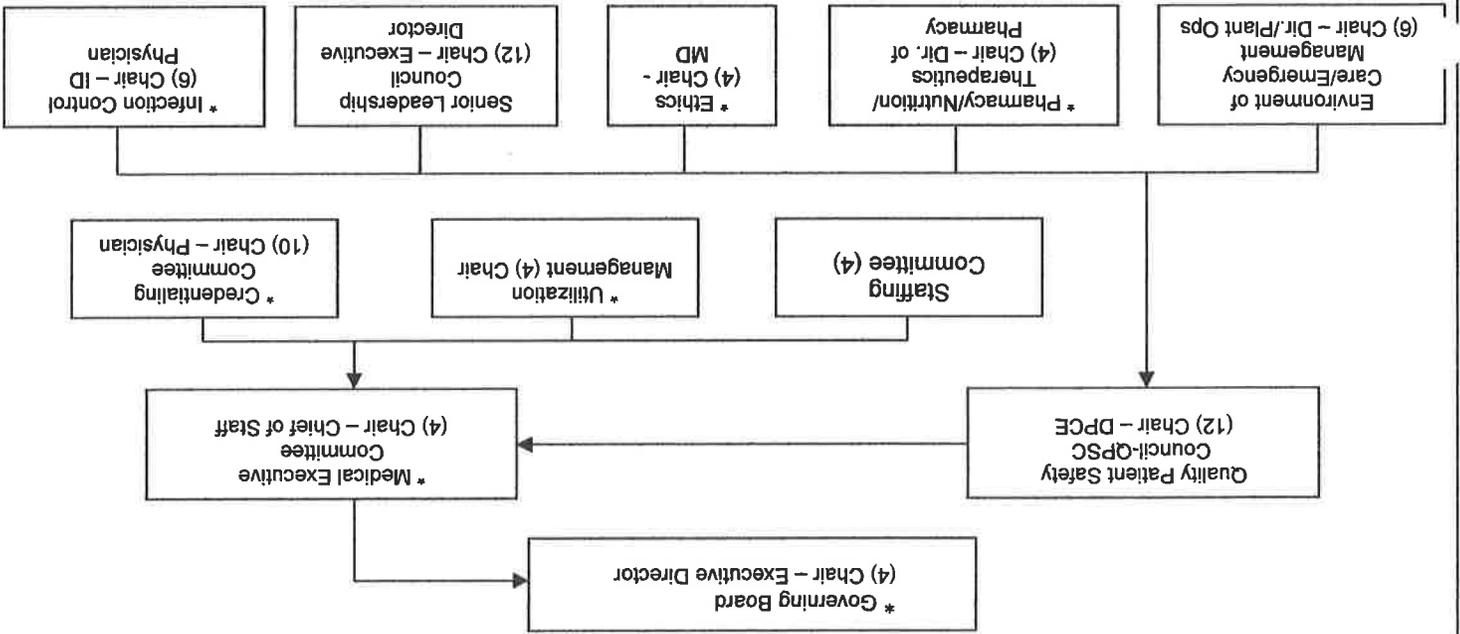
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Las Vegas and Henderson

**HORIZON SPECIALTY HOSPITAL
COMMITTEE ORGANIZATIONAL
CHART**



*MD on Committee

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PLAN

PURPOSE

The Governing Body, Administration, Medical Staff, and staff of Horizon Specialty Hospitals will demonstrate a consistent endeavor to deliver optimal care to all patients through the establishment of a hospital-wide continuous Quality Assessment and Performance Improvement (QAPI) plan. The organization's leaders will plan and implement a hospital-wide continuous Quality Assessment and Performance Improvement Plan in accordance with our mission, vision, and values as well as applicable laws and regulations. QAPI is incorporated into each aspect of our patient care delivery process. Quality is multidisciplinary and the processes for monitoring, analyzing, and improving quality involve various methodologies. Multiple tools and techniques are used to gather data, analyze information, evaluate solutions, and demonstrate improvement. Organizational functions and processes that most significantly impact patient care and outcomes will be evaluated in accordance with clinically valid criteria, indicators, and standards. Data can be obtained through a variety of sources (Appendix A). Performance measures may include efficacy, appropriateness, availability, timeliness, effectiveness, continuity, safety efficiency, respect, and caring. Continuously monitoring, analyzing, and improving performance of clinical and other processes are the focus of the QAPI Plan.

OBJECTIVES

The objective of the plan is to provide an optimal, uniform level of care through reduction and/or elimination of unnecessary and correctable risks, hazards, and expense within the hospital by:

- Establishing a planned and systematic approach to monitor, analyze, and improve performance to optimize patient outcomes
- Coordinating the integration of all quality improvement activities throughout the organization
- Implementing a system for evaluation of information collected through ongoing monitoring/evaluation and utilization of comparative data sources to identify trends, risks, or opportunities for improvement
- Objectively assessing the cause and scope of identified risks and variations
- Implementing appropriate processes for improvement and sustaining improved performance
- Documenting improved patient care and improved patient outcomes through quality improvement initiatives
- Assuring communication and reporting of quality improvement activities between hospital staff and administration, Medical staff, and the Governing Body

AUTHORITY AND ACCOUNTABILITY

The normal operation and administrative structure of the hospital and its Medical Staff are not altered by this plan.

A. Governing Body

The Governing Body of Horizon Specialty Hospital has the responsibility for the QAPI Plan. The Governing Body has delegated these functions to be carried out by the medical and hospital staff.

B. Medical Staff

The Medical Executive Committee (MEC) has the authority and responsibility to take necessary corrective action based on findings and recommendations of the quality improvement activities. This action could be in the form of, but is not limited to the following:

- a. New or revised policies and procedures
- b. Changes in privileges and assignments
- c. Educational and training programs
- d. Recommendations for equipment or facility changes
- e. Counseling of hospital or Medical staff
- f. Recommending a Performance Improvement Team

C. Quality Patient Safety Council (QPSC) Committee

The QPSC shall have the responsibility for coordinating and integrating the hospitals QAPI Plan and shall be accountable to the MEC of the Medical Staff, Administration, and the Governing Body. The council will monitor all quality improvement activities of the Medical Staff and hospital departments/programs.

D. Administration and Hospital Staff

The Executive Director (ED) has the responsibility for assuring that necessary action is taken in the administrative area based on findings of quality improvement activities.

The department and program directors shall be responsible for the implementation of quality improvement activities within their department/program. The quality department and program directors shall be accountable to the ED for taking necessary corrective action based on findings of the quality improvement activities as related to their area of responsibility.

CONFLICT OF INTEREST

In quality improvement activities which include Medical Staff ongoing Professional Practice Review (OPPE) and Focused Professional Practice Review (FPPPE), no physician shall have primary review responsibility for any case in which he/she is involved. This does not preclude the physician from participating in the case presentation process which facilitates education.

CONFIDENTIALITY

When monitoring, analyzing, and reporting quality improvement data, all reasonable steps shall be taken to ensure the confidentiality rights of patients, physicians, and staff that are affected by the data reviewed. All information related to quality improvement activities performed by the Medical Staff or hospital staff in accordance with this plan is confidential. Some information may be disseminated on a "need to know" basis as required by agencies, such as federal review agencies, regulatory bodies, the National Practitioners Data Bank, or others approved by the MEC, Hospital Administration, and/or the Governing Body. QPSC meeting minutes and reports generated are considered confidential. Official actions pertinent to individual clinical performance are personal and confidential.

QUALITY PATIENT SAFETY COUNCIL (QPSC) COMMITTEE

A. Membership/Organization

The membership of the QPSC Committee will be composed to all hospital departments, both internal and contracted. Meetings will be held on a monthly basis. More frequent meetings may be called at the discretion of the Committee Chairperson.

B. Responsibilities

The QPSC shall coordinate all quality improvement activities, having the responsibility for the following functions:

1. Setting priorities for hospital-wide quality improvement activities designed to provide quality outcomes and improved efficiency. Prioritizations of quality improvement activities is based on the following:

- a. Impact on patient care
- b. Urgency
- c. Information on unanticipated adverse occurrences affecting patients
- d. Potential for resistance to change, manageability and measurability
- e. Special attention will be given to those activities that are determined to involve high volume, high risk, and/or problem-prone aspects of care
- f. Quality improvement priorities will be established annually and specified in Appendix B of this plan

2. Chartering Performance Improvement Teams (PIT) as recommended and reviewing team activities. Proposed action from PIT's will be reviewed by the QPSC Committee for approval.

3. Ensuring that directors, staff, and teams have appropriate education, time, and resources for quality improvement activities.
4. Reviewing all performance improvement reports and data from hospital departments and committees as well as contracted services.
5. Assisting in the development of goals and selecting criteria to be used for ongoing monitoring and quality improvements activities.
6. Assisting in determining methods for review and assessment of identified concerns.
7. Requesting reports of performance improvement activities.
8. Recommending corrective action for identified concerns as appropriate.
9. Determining if further review should be done prospectively, concurrently, or retrospectively.
10. Monitoring corrective action through resolution.
11. Selecting and reviewing performance of comparative indicators and core measures.
12. Reviewing the results Sentinel Event or Near Miss investigations, including any analysis of the adequacy of staffing. Making recommendations based on event and investigation conducted.
13. Forwarding findings to the MEC and Governing Body as appropriate.
14. Performing an annual review of each clinical department's performance improvement indicators.
15. Performing an annual evaluation of the Hospital-wide QAPI Plan.

C. QPSC Committee Chairperson

The Chairperson is the vital link to ensure communication between the QPSC Committee, the ED, MEC, Governing Board, IP Committee, Environment of Care/Emergency Management and the medical and hospital staff. The chairperson is responsible for the administration of the QAPI and Safety Plan. His/her responsibilities include, but are not limited to:

1. Chairmanship of multidisciplinary QPSC Committee.
2. Presents final PSC activities and reports to the MEC and Governing Board.

- Performance improvement priorities identified by hospital administration
 - Invasive procedure monitoring
 - Adverse events related to the use of procedural sedation
 - Blood and blood component use, including reported and confirmed transfusion reactions.
- A. Ongoing monitoring and assessment of important aspects of care, processes, and functions, as well as review of occurrences identified through the medical record screening process and incident reporting. Monitoring will be carried out utilizing objective criteria and indicators that reflect current knowledge and clinical experience. Performance measurement data will be collected on the following as appropriate:

REVIEW PROCESS/SCOPE OF ACTIVITIES

Quality assessment and performance improvement shall be complete through:

1. Assuring that all quality improvement activities are documented with a focus on effective communication of conclusions, recommendations, actions, and follow-up evaluation.
2. Keeping the QPSC Committee informed of the results of all ongoing quality improvement activities and initiatives.
3. Assisting departments and services in developing a monitoring and assessment system to evaluate patient outcomes and important processes of the department or service in a continuous manner
4. Facilitation and training of Performance Improvement Teams as needed.
5. Informing ancillary and contracted services of quality improvement activities in process or completed that may be relevant to their respective areas.
6. Storing and retaining all departmental, committee, and team reports presented to the QPSC Committee.
7. Evaluation of the QAPI Plan annually.
8. Requesting follow-up information on concerns from hospital administration and Medical staff members.

D. Director of Patient/Customer Experience (DPCE)

3. Screening of sensitive information that should be referred to the appropriate authority other than the QPSC Committee because of the urgent or privileged nature of the information.
4. Reviewing medical staff and departmental quality improvement activities with the Senior Leadership Council, MEC, and Governing Board to determine patterns/trends, integration of information and compliance with CMS and The Joint Commission standards.
5. Providing input to the Credentials Committee as needed.
6. Participation in identification of multidisciplinary or departmental issues or concerns.

A. **Blood Usage Measurement**- Blood usage measurement shall be conducted on an ongoing basis. Blood usage data is reviewed and analyzed quarterly by the MEC. Clinically valid criteria and indicators will be used in the screening process and in the more intensive evaluation of any identified or suspected concerns in blood usage. Blood usage measurement will include the following:

MEDICAL STAFF AND/OR QUALITY IMPROVEMENT FUNCTIONS

Reports of the Medical Staff department quality improvement activities are reviewed by the MEC, Governing Board, the Executive Director (ED), and the Chief Nursing Officer (CNO). As part of the annual evaluation of the hospital's QAPI Plan, the effectiveness of the quality assessment and improvement activities by the Medical Staff department shall be evaluated.

- B. Periodic analysis of the data collected through ongoing monitoring and assessment including information collected by appointed Medical Staff committees, task forces, and PTT's to identify trends or opportunities for improvement.
- C. Taking action when concerns regarding patient care and clinical performance or opportunities for improvement have been identified.
- D. Evaluation of the effectiveness of action taken.
- E. Documentation of the results of monitoring and assessment activities, including conclusions, recommendations, actions taken, and follow-up and evaluation of the effectiveness of actions taken in the minutes of the departmental or committee meetings.

- The results of resuscitation
- Restraint utilization and safety
- Medication Management, including significant medication errors and adverse drug reactions
- Patient perception of the safety and quality of care, treatment, and services
- Staff perception of hospital safety culture (surveys to be completed no less than every two years)
- Fall reduction and Safety activities
- Effectiveness of response to a change or deterioration of a patient's condition
- Review of Rapid Response Team response
- Organ Procurement conversion rate
- Infection Prevention activities
- Mortality and Morbidity reviews including use of autopsy criteria
- Utilization Management
- Timeliness of reporting critical test results and compliance with all National Patient Safety Goals (NPSG)

- Monitoring the use of whole blood and blood components
 - Evaluation of all reported and confirmed transfusion reactions
 - Development/approval of policies and procedures relating to the distribution, handling, and administration of blood and blood components
 - Measuring, assessing, and improving the ordering, distribution, handling, dispensing, administration, and monitoring of the effects of blood and blood components
 - Review of the adequacy of transfusion services
- B. Credentials Committee-** The Credentials Committee shall meet monthly, but no less than quarterly. This committee shall ensure that each medical staff member is qualified for membership, and shall strive to maintain the optimal level of professional performance of the medical staff through the appointment/reappointment process, the specific delineation of privileges, the approval of physician assistant/nurse practitioner, and physician employees, and the periodic review of each staff member.
- C. Medical Executive Committee (MEC)-** The Medical Staff Executive Committee is delegated the primary authority over activities related to functions of quality assessment and performance improvement of the professional services provided by individuals with clinical privileges. The MEC shall meet quarterly to receive and act upon reports and recommendations from medical staff committees, clinical departments, assigned activity groups, and the QPSC Committee.
- D. Quality Patient Safety Council Committee (QPSC) -** The QPSC shall meet monthly. There shall be representation from the Medical Staff, hospital Administration and all hospital departments, services and programs as well as contracted services. The committee shall adopt, implement, and monitor a comprehensive hospital-wide Quality, Risk, and Safety Program. The committee is responsible for the oversight of the Patient Safety Program and to evaluate effectiveness and recommend changes in equipment, policies & procedures, and processes as appropriate for the safe, effective delivery of care. The committee shall oversee the Patient Complaint and Grievance process and all adverse occurrences.
- In addition, the QPSC shall review and evaluate The Joint Commission Sentinel Event Alerts and National Patient Safety Goals as they are published, make recommendations regarding further action and determine which areas within the hospital shall be involved with review/evaluation of each alert/goal and implementation of risk reduction strategies to ensure compliance.
- E. Infection Prevention Committee-** The Infection Prevention committee shall meet bi-monthly to review and evaluate the hospital-wide infection control activities. The committee shall have representation from the Medical Staff, Hospital Administration, the person directly responsible for management of infection surveillance, prevention

- Based on clinical experience, it is known or suspected that the drug causes adverse reactions or interacts with another drug(s) in a manner that represents significant health risk
- following reasons:
- monitoring of medications. Drugs may be selected for evaluation for one or more of the selection, ordering and transcribing, preparing and dispensing, administering, and meet quarterly and oversee the measurement, assessment, and improvement of the **G. Pharmacy, Nutrition, and Therapeutics Committee (PNT)**- The PNT Committee shall
- to patients, hospital staff, and visitors.
- characteristics and practices, and to eliminate or reduce, to the extent possible, hazards and utility systems of the hospital, which shall be designed to produce safe security, hazardous materials, emergency management, life safety, medical equipment, The committee shall adopt, implement, and monitor requirements related to safety, management, clinical leader, Human Resource Director, and Central Supply Manager. person directly responsible for all aspects of plant operations and emergency at least quarterly. Committee representation shall include Hospital Administration, the **F. Environment of Care/Emergency Management Committee**- The committee shall meet
- Control, OSHA, APIC and other agencies as indicated.
 - Current literature and/or new recommendations from the Centers for Disease
 - Procedures and practices of new services instituted and any problems identified
 - Prevalence and incidence studies
 - above the usual baseline infection rates
 - Unusual epidemics, clusters of infections, unusual pathogens, and occurrences of antimicrobial susceptibility/resistance trend studies
 - Annual program evaluation of risk assessments and outcomes using the results hospital.
 - proposals for special infection control studies conducted throughout the employee infection surveillance and environmental sampling. This includes other
 - Special collection of surveillance data directed by the committee such as
 - Data trend analyses generated by surveillance activities
- The surveillance activities and system are selected by reviewing:
- targeted surveillance, problem-oriented surveillance, or a combination of these systems. the detection of nosocomial infection will be selected from total house surveillance, approve the type and scope of surveillance activities. The type of surveillance system for hospital from the community. The committee will evaluate, revise as indicated, and prevent, identify, and control infections acquired in the hospital or brought into the function will include the use of pre-established criteria and will be performed to and control program, and, as appropriate, other department and services. The review

The quality and appropriateness of patient care will be monitored and evaluated in all important aspects of care, key processes, and important functions of clinical departments and support services. This review may include the following dimensions of performance:

HOSPITAL AND/OR CONTRACTED SERVICES

Results of quality improvement activities are considered when evaluating each physician at the time of reappointment. As part of the annual evaluation of the hospital's QAPI Plan, the effectiveness of quality assessment and performance improvement activities by medical staff committees shall be evaluated.

Documentation of the results of monitoring and evaluation activities shall be included in the minutes of the committee meetings. The minutes will reflect all conclusions, recommendations, follow-up, and actions taken. All concerns and review activities are presented to the MEC and Governing Board.

H. **Utilization Management (UM) Committee**- The UM Committee shall meet quarterly to address over-utilization, under-utilization, and inefficient scheduling of resources for federal (QIO) and non-federal patients. This shall be accomplished through screening of admissions, evaluation of ancillary services as to inappropriate utilization, evaluation of "avoidable days", and evaluation of the results of discharge planning.

Department-specific information is forwarded to the appropriate medical staff department for review and follow-up.

- The drug is used in the treatment of patients who may be at high risk for adverse drug reactions because of age, disability, or unique, metabolic characteristics
- The drug has unusual toxicity or potential for causing serious complications from their pharmacologic effects if not prescribed correctly
- The drug has been designated, through the hospital's Antibiotic Stewardship Program or other continuous quality improvement activities for monitoring and evaluation
- The drug is one of the most frequently prescribed drugs; and/or The drug has greater cost than other drugs of comparable pharmacologic effect
- Monitor medication errors and adverse drug reaction and take appropriate follow-up actions
- Develop and approve policies and procedures related to the selection and procurement, storage, ordering and transcribing, preparing and dispensing, administering and monitoring of medications
- Develop and maintain a drug formulary or drug list

Performance Improvement Teams and/or Task Forces are comprised of individuals from cross-functional groups. Teams are chartered to improve systems and operational processes involved

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT TEAMS & TASK FORCES

and/or contracted services shall be evaluated. the hospital's QAPI Plan, the effectiveness of the quality improvement activities by clinical the office of the Director of Patient/Customer Experience. As part of the annual evaluation of evaluation activities of the medical staff. All evaluation activities will be coordinated through Where possible, clinical and/or support services evaluation activities will be integrated with the effectiveness of actions taken shall be documented and submitted to the QPSC Committee. Results of the quality improvement activities including evaluation, actions taken, and the QPSC on a quarterly basis. Laboratory, Diagnostic Imaging, Dialysis, and Rehabilitation quality data will be reported to the issues/concerns impacting system processes and functions which affect patient care and safety; Each department/service is also responsible for identifying and participating in the analysis

- **Nursing Services- Chief Nursing Officer**
- **Respiratory Care Services- Director of Ancillary Services**
- **Dietary Services- Registered Dietician via PNT Committee**
- **Wound Care Services- Wound Care Services Registered Nurse**
- **ABG Laboratory Services- Director of Ancillary Services**
- **Pharmacy Services- Director of Pharmacy via the PNT Committee**
- **Patient & Family Services- Chief Nursing Officer**

responsible individual listed: Each department/service is responsible for establishing specific quality improvement indicators or projects which are reflective of the hospital-wide plan and prioritizes aspects of care to be studied. The indicator results will be presented to the QPSC at least quarterly by the

documentation of quality improvement activities) will be used. The same process as outlined for the medical staff and clinical departments (ongoing monitoring, periodic evaluation, the use of objective criteria, establishing thresholds, taking action for identified concerns, evaluation of the effectiveness of actions taken, and

- **Efficacy**
- **Appropriateness**
- **Availability**
- **Timeliness**
- **Effectiveness**
- **Continuity**
- **Safety**
- **Efficiency**
- **Respect and caring**

**HUMBOLDT GENERAL HOSPITAL
CRITICAL ACCESS HOSPITAL
118 East Haskell St.
Winnemucca, Nevada 89445**

POLICY/PROCEDURE

Date:
Revised:

**Developed by: Quality Services Director
Revised by:
Department: All HGH Departments
Page 1 of 1 Page**

**Reviewed by: _____
Approved: _____
Approved: _____
Effective: _____**

POLICY: PATIENT SAFETY PLAN

In compliance with NRS 439.800-439.890, Humboldt General Hospital shall develop, in consultation with the providers of health care who provide treatment to patients at the medical facility, an internal patient safety plan to improve the health and safety of patients who are treated at this medical facility.

HGH shall develop a patient safety plan to include without limitation:

- a) The patient safety checklists and patient safety policies most recently adopted pursuant to NRS 439.877.
- b) An infection control program to prevent and control infections within the medical facility. To carry out the program, HGH shall adopt an infection control policy. The policy must consist of:
 - 1) The current guidelines appropriate for HGH’s scope of service developed by a nationally recognized infection control organization as approved by the State Board of Health which may include, without limitation, the Association for Professionals in Infection control and Epidemiology, Inc., the Centers for Disease Control and Prevention of the United State Department of Health and Human Services, The World Health Organization and the society for Healthcare Epidemiology of America: and
 - 2) Facility-specific infection control developed under the supervision of a certified infection preventionist.

HGH shall designate the house supervisors as the person who is responsible for infection control when the infection control officer is absent to ensure that someone is responsible for infection control at all times.

The Patient Safety Plan shall be submitted to the governing board for approval in accordance with the requirements of NRS 439.865. After the HGH Patient Safety Plan is approved, all providers of health care who provide treatment to patients at HGH shall be notified of the plan and of the requirements of the plan. Compliance with the HGH Patient Safety Plan shall be required.

The Patient Safety Plan shall be reviewed and updated annually in accordance with the requirements for approval set forth in this section.

HGH shall designate an employee to serve as the patient safety officer. The person who is designated as the patient safety officer shall:

- a) Serve on the Patient Safety Committee

- b) Supervise the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to NRS 439.835.
- c) Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at HGH.
- d) Report to the patient safety committee regarding any action taken in accordance with paragraph (c).

HGH shall designate an employee to serve as the infection control officer. The infection control officer shall:

- a) Serve on the patient safety committee.
- b) Monitor the occurrences of infections at Humboldt General Hospital to determine the number and severity of infections
- c) Report to the patient safety committee concerning the number and severity of infections at HGH. Take such action as he or she determines is necessary to prevent and control infections alleged to have occurred at HGH.
- d) Carry out the provisions of the infection control program adopted pursuant to NRS 439.865 and ensure compliance with the program.

HGH will ensure that the infection control officer has successfully completed a nationally recognized basic training program in infection control, which may include, without limitation, the program offered by the Association for Professionals in Infection Control and Epidemiology, Inc., or a successor organization. The infection control officer shall complete at least 4 hours of continuing education each year on topics relating to current practices in infection control and prevention. HGH shall maintain records concerning the certification and training required by this section.

HGH shall establish a patient safety committee.

- a) The HGH Patient Safety Committee must be composed of:
 - 1) The patient safety officer of the medical facility.
 - 2) The infection control officer of the medical facility.
 - 3) At least three providers of health care who treat patients at HGH, including, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility.
 - 4) One member of the executive or governing body of the medical facility.
- b) A patient safety committee shall meet at least once each month.
- c) The patient safety committee shall:
 - 1) Receive reports from the patient safety officer pursuant to NRS 439.870.
 - 2) Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred at the medical facility.
 - 3) Review and evaluate the quality of measures carried out by HGH to improve the safety of patients who receive treatment at the medical facility.
 - 4) Review and evaluate the quality of measures carried out by HGH to prevent and control infections at the medical facility.
 - 5) Make recommendation to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur at HGH.
 - 6) At least once each calendar quarter, report to the HGH executive or governing body of the medical facility regarding

- i. The number of sentinel events that occurred at HGH during the preceding calendar quarter;
 - ii. The number and severity of infections that occurred at the medical facility during the preceding calendar quarter; and
 - iii. Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
- 7) Adopt patient safety checklists and patient safety policies as required, review the checklists and policies annually and revise the checklists and policies as the patients safety committee determines necessary.
- d) The proceedings and records of a patient safety committee are subject to the same privilege and protection from discovery as the proceedings and records described in NRS 49.265

The Patient Safety Committee, established pursuant to NRS 439.875 by a medical facility, shall adopt patient safety checklists and patient safety policies for use by:

- a) Providers of health care who provide treatment to patients at HGH;
- b) Other personnel of the medical facility who provide treatment or assistance to patients;
- c) Employees of the HGH who do not provide treatment to patients but whose duties affect the health or welfare of the patients at HGH, including, without limitation, a janitor or HGH; and
- d) Person with whom HGH enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients at HGH.

The patient safety checklists must follow protocols to improve the health outcomes of patients at the medical facility and must include, without limitation:

- a) Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of health care.
- b) Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of health care follow protocols to ensure that the room and environment of the patient is sanitary.
- c) A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - 1) Proper instructions concerning prescription medications;
 - 2) Instructions concerning aftercare; and
 - 3) Any other instruction concerning his or her care upon discharge.
- d) Any other checklists which may be appropriate to ensure the safety of patients at the medical facility

The patient safety policies must include, without limitation:

- a) A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of health care. The personal identifiers may include, without limitation, the name and date of birth of the patient.

- b) A policy regarding the nationally recognized standard of precautionary protocols to be observed by providers of health care at the medical facility including, without limitation, protocols relating to hand hygiene.
- c) A policy to ensure compliance with the patient safety checklists and patient safety policies, which may include, without limitation, active surveillance. Active surveillance may include, without limitation, a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

The Patient Safety Committee shall:

- a) Monitor and document the effectiveness of the patient identification policy adopted.
- b) At least annually, review the patient safety checklists and patient safety policies adopted pursuant to this section as necessary to ensure that the checklist or policy, as applicable, reflects the most current standards in patient safety protocols.
- c) On or before July 1 of each year, submit a report to the Director of the Legislative Counsel Bureau for transmittal to the Legislative Committee on Health Care. The report must include information regarding the development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted.

No person is subject to any criminal penalty or civil liability for libel, slander or any similar cause of action in tort if the person, without malice:

- a) Reports a sentinel event to a governmental entity with jurisdiction or another appropriate authority;
- b) Notifies a governmental entity with jurisdiction or another appropriate authority of a sentinel event;
- c) Transmits information regarding a sentinel event to a governmental entity with jurisdiction or another appropriate authority;
- d) Compiles, prepares or disseminates information regarding a sentinel event to a governmental entity with jurisdiction or another appropriate authority; or
- e) Performs any other act authorized pursuant to [NRS 439.800](#) to [439.890](#), inclusive.

If Humboldt General Hospital:

- (a) Commits a violation of any provision of [NRS 439.800](#) to [439.890](#), inclusive, or for any violation for which an administrative sanction pursuant to [NRS 449.163](#) would otherwise be applicable; and
- (b) Of its own volition, reports the violation to the Administrator, such a violation must not be used as the basis for imposing an administrative sanction pursuant to [NRS 449.163](#).

If HGH commits a violation of any provision of [NRS 439.800](#) to [439.890](#), inclusive, and does not, of its own volition, report the violation to the Administrator, the Division may, in accordance with the provisions of subsection 3, impose an administrative sanction:

- (a) For failure to report a sentinel event, in an amount not to exceed \$100 per day for each day after the date on which the sentinel event was required to be reported pursuant to [NRS 439.835](#);
- (b) For failure to adopt and implement a patient safety plan pursuant to [NRS 439.865](#), in an amount not to exceed \$1,000 for each month in which a patient safety plan was not in effect; and
- (c) For failure to establish a patient safety committee or failure of such a committee to meet pursuant to the requirements of [NRS 439.875](#), in an amount not to exceed \$2,000 for each violation of that section.



TAHOE FOREST HEALTH SYSTEM

Origination Date: 12/2005
Last Approved: 01/2018
Last Revised: 02/2017
Next Review: 01/2019
Department: *Quality Assurance /
Performance Improvement -
AQPI*
Applies To: *System*

Patient Safety Plan, AQPI-02

PURPOSE:

To develop, implement, and evaluate a patient safety program for the Tahoe Forest Health System which includes Tahoe Forest Hospital (TFH) and Incline Village Community Hospital (IVCH), (hereinafter referred to as the "organization").

The Tahoe Forest Hospital District (TFHD) Board of Directors makes a commitment to provide for the safe and professional care of all patients, and also to provide for the safety of visitors, employees and health care practitioners. The commitment is made through the provision of this Patient Safety Plan that will identify, evaluate, and take appropriate action to prevent unintended patient care outcomes (adverse events), as well as protect the TFHD's financial resources, tangible assets, personnel and brand. Leadership structures and systems are established to ensure that there is organization-wide awareness of patient safety performance, direct accountability of leaders for that performance and adequate investment in performance improvement abilities, and that actions are taken to ensure safe care of every patient served.

This policy is integrated with a companion policy, Risk Management Plan AQPI-04.

The Tahoe Forest Hospital District endorses the National Quality Forum set of "34 Safe Practices for Better Healthcare." Further, the District ascribes to the tenets and practices of the Just Culture program in the investigation of near-misses, adverse events and unexpected/unintended outcomes.

A. SCOPE & APPLICABILITY

1. This is a Health System program empowered and authorized by the Board of Directors of Tahoe Forest Hospital District. Therefore, it applies to all services and sites of care provided by the organization.

B. RECITALS

1. The organization recognizes that a patient has the right to a safe environment, and strives to achieve an error-free healthcare experience. Therefore, the Health System commits to undertaking a proactive approach to the identification and mitigation of unexpected/unintended outcomes.
2. The organization also recognizes that despite best efforts, errors can occur. Therefore, it is the intent of the Health System to respond quickly, effectively and appropriately when an error does occur.
3. The organization also recognizes that the patient has the right to be informed of the results of treatments or procedures whenever those results differ significantly from anticipated results. Patients and patient representatives are informed of unexpected/unintended outcomes as described in 4.8.1

below.

C. AUTHORITY & RESPONSIBILITY

1. **Governing Body**

- a. The Governing Body, through the approval of this document, authorizes a planned and systematic approach to preventing adverse events and implementing a proactive patient safety plan. The Governing Body delegates the implementation and oversight of this program to the Chief Executive Officer (hereinafter referred to as the "Senior Leader") and request that the Medical Staff approve the creation of a Patient Safety Committee. The Medical Staff Quality Committee will serve as the Patient Safety Committee for TFHD and the IVCH Medical Staff Committee will serve as the Patient Safety Committee for IVCH.

2. **Senior Leader**

- a. The Senior Leader is responsible for assuring that this program is implemented and evaluated throughout the organization. As such, the Senior Leader will establish the structures and processes necessary to accomplish this objective. The Senior Leader delegates the day-to-day implementation and evaluation of this program to the Medical Staff Quality Committee and the Management Team.

3. **Medical Staff**

- a. The meetings, records, data gathered and reports generated by the Patient Safety Committee shall be protected by the peer review privilege set forth at California evidence Code Section 1157 relating to medical professional peer review and for the State of Nevada subject to the same privilege and protection from discovery as the proceedings and records described in NRS 49.265.
- b. The Patient Safety Committee shall take a coordinated and collaborative approach to improving patient safety. The Committee shall seek input from and distribute information to all departments and disciplines in establishing and assessing processes and systems that may impact patient safety in the organization. The Patient Safety Committee shall recognize and reinforce that the members of the Medical Staff are responsible for making medical treatment recommendations for their patients.

4. **Management Team**

- a. The Management Team, through the Director of Quality and Regulations, is responsible for the day-to-day implementation and evaluation of the processes and activities of this Patient Safety Plan.

5. **Patient Safety Officer (The Patient Safety Officer's standing committee assignments, chain-of-command and reports/reporting structure are attached as Attachment C)**

- a. The Director of Quality & Regulations or the Quality & Regulations staff designee shall be the Patient Safety Officer for the organization. The Patient Safety Officer shall be accountable directly to the Senior Leader, through the supervision of the Director of Quality and Regulations, and shall participate in the Patient Safety/Medical Staff Quality Committee.

6. **Patient Safety/Medical Staff Quality Committee**

1. The Patient Safety Committee shall:
 1. Receive reports from the Director of Quality and Regulations and/or the Patient Safety Officer

-
2. Evaluate actions of the Director of Quality and Regulations and/or Patient Safety Officer in connection with all reports of adverse events, near misses or unexpected/unintended outcomes alleged to have occurred
 3. Review and evaluate the quality of measures carried out by the organization to improve the safety of patients who receive treatment in the Health System
 4. Make recommendations to the executive committee or governing body of the Health System to reduce the number and severity of adverse events that occur
 5. Report quarterly, and as requested, to the executive committee and governing body
 6. The Patient Safety Committee members shall include, at least, the following individuals:
 1. Director of Quality and Regulations or the Patient Safety Officer designee, if not one and the same
 2. Members of the medical staff
 3. One member of the nursing staff (CNO or designee)
 4. Director of Pharmacy
 5. Medical Director of Quality
 6. Risk Manager, if not one and the same as the Patient Safety officer
 7. Chief Operating Officer

D. PROGRAM ELEMENTS, GOALS AND OBJECTIVES

1. Assess patient safety risk, identify threats, prevent occurrence or mitigate frequency and severity of harm when unexpected/unintended outcomes occur
2. Promote a safe environment in the Health Systems to alleviate injuries, damages or losses
3. Foster communication with patients, employees, medical staff and administration when patient safety issues are identified
4. Contribute to PI activities and plans to resolve patient safety issues
5. Participate and/or consult on all patient disclosure conferences regarding unexpected/unintended outcomes
6. Manage losses, claims or litigation when adverse events occur.
7. **Designing or Re-designing Processes**
 - a. When a new process is designed (or an existing process is modified) the organization will use the Patient Safety Officer to obtain information from both internal and external sources on evidence-based methods for reducing medical errors, and incorporate best practices into its design or re-design strategies.
8. **Identification of Potential Patient Safety Issues**
 - a. As part of its planning process, the organization regularly reviews the scope and breadth of its services. Attendant to this review is an identification of care processes that, through the occurrence of an error, would have a significant negative impact on the health and well being of the patient. Areas of focus include:
 - i. Processes identified through a review of the literature
 - ii. Processes identified through the organization's performance improvement program

- iii. Processes identified through Safety Risk Management Reports ([Event Reporting AQPI-06](#)) and sentinel events ([Sentinel/Adverse Event/Error or Unanticipated Outcome, AGOV-35](#))
- iv. Processes identified as the result of findings by regulatory and/or accrediting agencies
- v. The National Quality Forum: "Safe Practices for Better Healthcare – 02/2013 Update"
- vi. Adverse events or potential adverse events as described in HSC 1279.1. (Attachment A)
- vii. Health-care-associated infections (HAI) as defined in the federal CDC National Healthcare Safety Network. (Attachment B)
- viii. Adverse events associated with misconnecting intravenous lines, enteral feeding tubes, and epidural lines.
- ix. TFHD specific results from the AHRQ Patient Safety Culture Survey

9. Performance Related to Patient Safety

- a. Once potential issues have been identified, the organization will establish performance measures to address those processes that have been identified as "high risk" to patient safety. In addition, the following will be measured:
- b. The perceptions of risk to patients and suggestions for improving care.
 - i. The level of staff reluctance to report errors in care and staff perceptions of the organization's culture of safety as assessed through an industry-recognized external survey.
- c. Opportunities to reduce errors that reflect system issues are addressed through the organization's performance improvement program.
- d. Opportunities to reduce errors that reflect the performance of the individual care provider are addressed, as appropriate, through the Medical Staff peer review process or through the organization's human resource policy(s) using the practices and tenets of the Just Culture.

10. Proactive Risk Assessments

- a. Through implementation of this Patient Safety Plan, and integrated with the Risk Management Plan and other performance improvement processes, the Department of Quality and Regulations will systemically identify and mitigate patient safety risks and hazards with an integrated approach in order to continuously reduce preventable patient harm. Identified opportunities for improvement will then undergo redesign (as necessary) to mitigate any risks identified. A patient safety risk assessment by an external resource will be performed at least every 24 months and reported to the organization as described herein under "reporting structure." A focused patient safety risk assessment will be performed annually by the Patient Safety Officer and reported to the organization as described herein under "reporting structure."

11. Responding to Errors

- a. The organization is committed to responding to known errors in care or unexpected/unintended outcomes in a manner that supports the rights of the patient, the clinical and emotional needs of the patient, protects the patient and others from any further risk, and preserves information critical to understanding the proximal and – where appropriate – root cause(s) of the error. The organization's response will include care for the involved caregivers as noted below in 4.6.1. To that end, the organization has established a variety of policies and procedures to address these

issues,

- b. Errors that meet the organization's definition of a potential sentinel event will be subjected to an intensive assessment or root cause analysis using the tenets and practice of the Just Culture. Management of these types of errors is described in [Sentinel/Adverse Event/Error or Unanticipated Outcome, AGOV-35](#).

12. Supporting Staff Involved in Errors

- a. Following serious unintentional harm due to systems failures and/or errors that result from human performance failures, the involved caregivers shall receive timely and systematic care which may include: supportive medical/psychological care, treatment that is compassionate, just and respectful and involved staff shall have the opportunity to fully participate in the event investigation, risk identification and mitigation activities that will prevent future events. To that end, the organization has defined processes to provide care for the caregivers: ([Support for Employee Caregivers Involved in Sentinel or Adverse Events AHR-110](#))

13. Educating the Patient on Error Prevention

- a. The organization recognizes that the patient is an integral part of the healthcare team. Therefore, patients will be educated about their role and responsibility in preventing medical errors.

14. Informing the Patient of Errors in Care

- a. The organization recognizes that a patient has the right to be informed of results of care that differ significantly from that which was anticipated, known errors and unintended outcomes. Following serious unanticipated outcomes, including those that are clearly caused by systems failures, the patient, and family as appropriate, will receive timely, transparent and clear communication concerning what is known about the adverse event. Management of disclosure to patients/families is described in the Administrative policy, [Disclosure of Unanticipated Adverse Outcome to Patients/Families AGOV-15](#).

15. Reporting of Medical Errors

- a. The organization has established mechanisms to report the occurrence of medical errors both internally and externally.
- b. Errors will be reported internally to the appropriate administrative or medical staff entity.
- c. Errors will be reported to external agencies in accordance with applicable local, state, and federal law, as well as other regulatory and accreditation requirements. For reporting process, see the Administrative policy, [Sentinel/Adverse Event/Error or Unanticipated Outcome, AGOV-35](#).

16. Evaluating the Effectiveness of the Program

1. On an annual basis, the organization will evaluate the effectiveness of the patient safety program. A report on this evaluation will be provided to the Patient Safety/Medical Staff Quality Committee, Medical Staff, Senior Leader(s), and to the Governing Body.

Related Policies/Forms: [Sentinel/Adverse Event/Error or Unanticipated Outcome, AGOV-35](#); [Event Reporting AQPI-06](#); [Disclosure of Unanticipated Adverse Outcome to Patients/Families AGOV-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"

All revision dates:

02/2017, 12/2016, 03/2014, 02/2014, 11/2013, 10/

2013, 01/2012, 01/2009

Attachments:

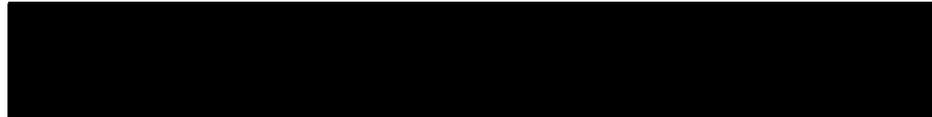


image1.jpeg

Process Flow for Risk Manager-Patient Safety.pdf

Approval Signatures

Step Description	Approver	Date
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COPY

Harmon Hospital

**Patient Safety
Plan**

Patient Safety Plan

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Patient Safety Plan

Commitment to Patient Safety

Harmon Hospital is committed to a comprehensive approach to improving healthcare quality and patient safety by aligning with our Mission, Vision, and Values, creating an environment that supports a dynamic, proactive, and safe culture for patients, family members, visitors, and employees, through continuous learning and improving patient safety policies, systems, and processes.

Mission, Vision, and Values

In support of our mission, vision, and values, Harmon Hospital's Patient Safety function as part of the Quality Assessment Quality Improvement program promotes:

- ✦ Collaboration of healthcare, leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high quality healthcare.
- ✦ Communicate honestly and openly to foster trusting and cooperative relationships among healthcare providers, staff members, and patients and their families, to ensure accountability for the patient safety priorities.
- ✦ Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.
- ✦ Responsibility for every healthcare related decision and action.
- ✦ A focus on continuous learning and improving, system design, and the management of choices and changes, bringing the best possible outcomes or performances to the facility.
- ✦ Incorporation of evidence-based practice guidelines to deliver high quality healthcare.
- ✦ Education of staff and physicians to assure participation of healthcare providers.

Scope and Purpose

The scope of this Quality and Patient Safety Plan is organizational-wide/hospital-wide/agency-wide which includes but is not limited to

- ✦ Patient safety
- ✦ Visitor safety
- ✦ Employee safety

All staff in Harmon Hospital are required to fully support and participate in this plan, and devote their expertise to the patient safety and healthcare quality improvement process.

This plan is action oriented and solution focused. The purpose of this plan is to address patient safety related concerns, challenges and revise the program to better serve the patients and their families. To this end, Harmon Hospital has developed this Patient Safety Plan.

The plan focuses on the process rather than the individual, and recognizes both internal and external customers, as well as facilitates the need of analyzing and improving processes. The core principles of this plan include:

- ✦ All staff have the same goal and contribute their knowledge, vision, skill, and insight to improve the process of the Patient Safety Plan.
- ✦ Decisions will be based on data and facts, and staff will be encouraged to learn from the experiences.
- ✦ Customer based including patients, families, and visitors.

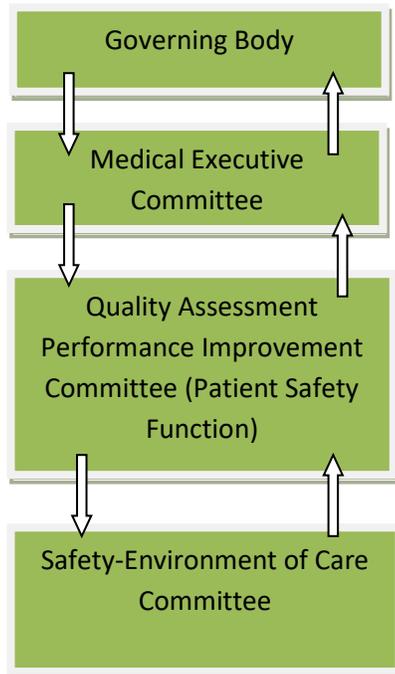
Patient Safety Plan

- ✚ Promote systems thinking.
- ✚ Employ well-trained and competent staff maintaining high healthcare quality.

Roles and Responsibilities

According to NRS 439.875, a medical facility shall establish a Patient Safety Committee (PSC). This Committee should ensure that the Patient Safety Plan is promoted and executed successfully. The Patient Safety Function is incorporated into the Quality Assessment Performance Improvement Committee (QAPI)

The Patient Safety Function Organization



Patient Safety Plan

Roles and Responsibilities

In accordance with NRS 439.875, a patient safety committee must be comprised of:

- ✚ The infection control officer of the medical facility;
- ✚ The patient safety officer of the medical facility, if he or she is not designated as the infection control officer;
- ✚ At least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility; and
- ✚ One member of the executive or governing body of the medical facility.
- ✚ The Chief Executive Officer (CEO) or Chief Financial Officer (CFO) of the medical facility.

Patient Safety Committee Responsibilities (based on NRS 439.875 and NRS 439.877)

- ✚ Monitor and document the effectiveness of the patient identification policy.
- ✚ **On or before July 1 of each year**, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to NRS 439.877(4)(b).
- ✚ Receive reports from the patient safety officer pursuant to NRS 439.870.
- ✚ Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred.
- ✚ Review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- ✚ Review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- ✚ Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- ✚ At least once each calendar report to the executive or governing body of the facility regarding:
 - ✓ The number of sentinel events that occurred at the medical facility during the preceding calendar month

Patient Safety Plan

R (2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and

(3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.

- ✚ Adopt patient safety checklists and patient safety policies as required by NRS 439.877,
- ✚ review the checklists and policies annually and
- ✚ revise the checklists and policies as the patient safety committee determines necessary.

Root Cause Analysis (RCA) Team Responsibilities

- ✚ Root Cause interviews,
- ✚ analysis,
- ✚ investigation, and
- ✚ corrective action plan implementations
- ✚ Participates in the RCA meetings and discussions.
- ✚ Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders.

Patient Safety Officer Responsibilities (based on NRS 439.870)

- ✚ Serve on the QAPI meeting for the patient function.
- ✚ Supervise the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to NRS 439.835.
- ✚ Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- ✚ Report to the patient safety function of the QAPI committee regarding any action taken in accordance with the responsibilities above.

Infection Control Officer Responsibilities (based on NRS 439.873)

- ✚ Serve on the QAPI Committee and report on infections and practices impacting patient safety.
- ✚ Monitor the occurrences of infections at the facility to determine the number and severity of infections.
- ✚ Report to the QAPI committee concerning the number and severity of infections at the facility.
- ✚ Take such action as determines is necessary to prevent and control infections alleged to have occurred at the facility.
- ✚ Carry out the provisions of the infection control program adopted pursuant to NRS 439.865 and ensure compliance with the program.

RCA team leader Responsibilities

Patient Safety Plan

- ✚ Organize and coordinate the RCA process.
- ✚ Assemble and encourage a supportive and proactive team.
- ✚ Assign investigative and implementation tasks to the team members.

Patient Safety Plan

- ✚ Conduct and be actively involved in the investigation, RCA, and corrective action plan implementation process.
- ✚ Communicate the progress of the investigation, institutional barriers, and finalized action plan to executive leadership.
- ✚ Monitor goals and progress towards completion of the Corrective Action Plans.
- ✚ Provide training, education and direction to create RCA processes that incorporate the Patient Safety and Quality Improvement elements.

Executive or Governing Body Staff Responsibilities

- ✚ Provide vision and leadership to Patient Safety and Quality Improvement process, and
- ✚ Develop and foster a safe learning and improving culture.
- ✚ Provides oversight to the healthcare quality improvement processes and teams.
- ✚ Plan, discuss, and generate the organization patient safety goals and activities, in conjunction with the patient safety action plans

The Quality Assessment and Performance Improvement Committee (including the Patient Safety function) will meet monthly to accomplish the following:

- ✚ Report and discuss sentinel events which include:
 - ✓ Number of sentinel events from previous calendar month.
 - ✓ Number of severe infections that occurred in the facility.
 - ✓ Corrective Action Plan for the sentinel events and infections
 - ✓ Evaluate the corrective action plan.
- ✚ Patient safety policies and checklists
- ✚ At least annually evaluate Patient Safety policies and checklists
- ✚ Revise the patient safety policies and checklists as needed.
- ✚ Monitor and document the effectiveness of the patient safety policy.

A RCA Team and meeting will meet as needed to accomplish the following:

- ✚ Define the healthcare issues or potential risks.
- ✚ Conduct Root Cause Analysis
 - ✓ Reviewing and analyzing the data.
 - ✓ Reviewing the RCA process and quality improvement related activities and timelines.
 - ✓ Brainstorming issues or the potential risks by using the fishbone diagrams.
 - ✓ Identify the contributing factors and conduct the Root Cause

- ✚ A meeting agenda and minutes noting follow-up tasks will be kept.

Patient Safety Plan

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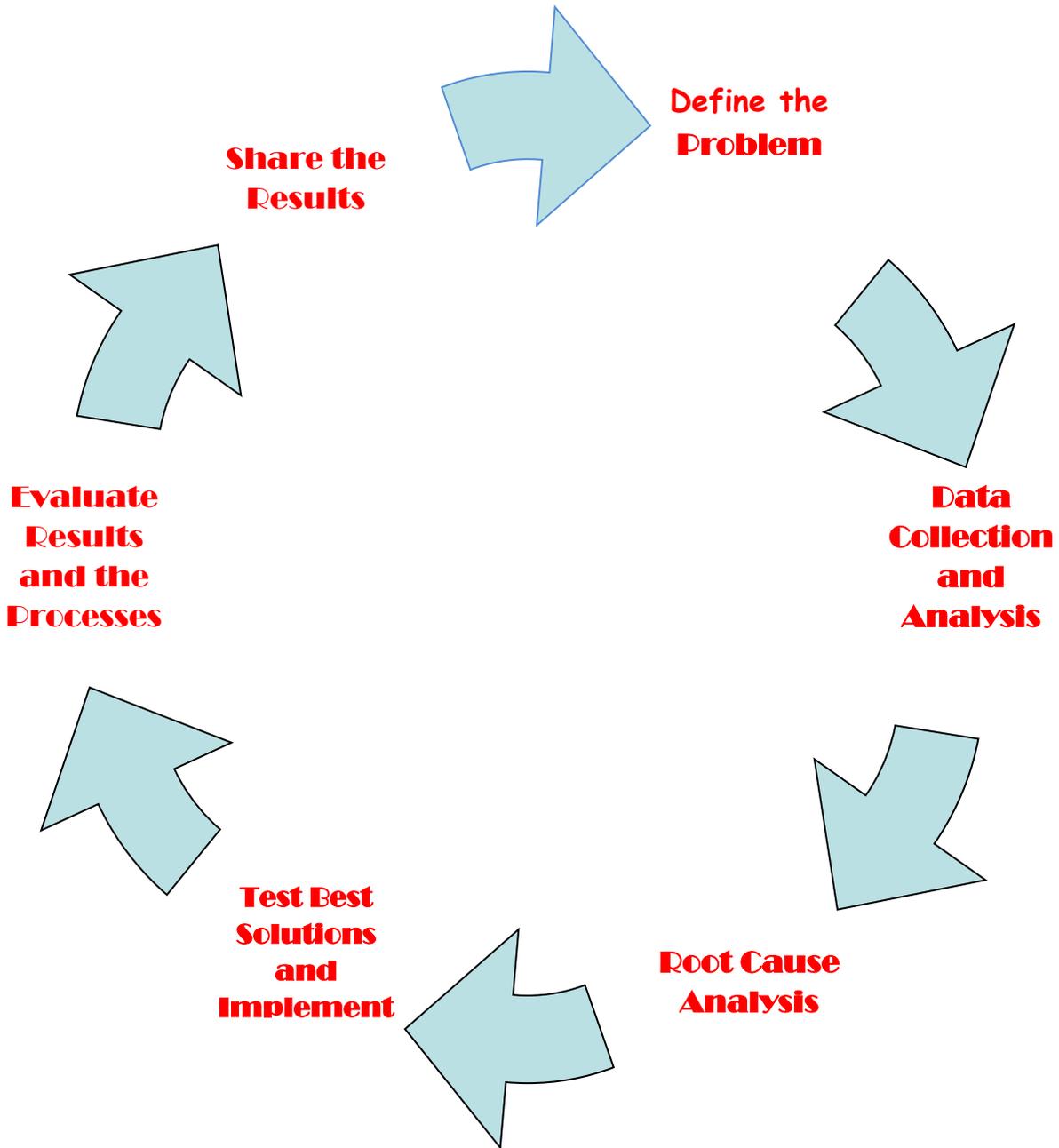
Components and Methods

- ✚ Pursuant to NRS 439.837 and NAC 439.917, within 45 days after reporting a sentinel event pursuant to NRS 439.835, the medical facility shall conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event.”
- ✚ Harmon Hospital will use RCA process to determine the contributing factors and the underlying reasons for the deficiencies or failures. The Plan-Do-Study-Act (PDSA) is the model, which was developed by the Institute of Health Care Improvement that we will use to test the changes.

Root Cause Analysis

- ✚ A **Root Cause Analysis** is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals. Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.
- ✚ **Root cause analysis and action plan framework table**
 - ✓ Introduced by the Joint Commission.
 - ✓ It contains 24 analysis questions.
 - ✓ It guides the organization to the steps in a root cause analysis.
 - ✓ Not all the questions apply to all the events or cases.
 - ✓ This table can be used individually or with the fishbone diagram.
- ✚ **5 Whys**
 - ✓ Technique will be used by Harmon Hospital to explore the cause and effect relationship underlay a problem.
 - ✓ One can find the root causes by asking “why” no less than five times.
 - ✓ This technique can be used individually or as a part of the fishbone diagram.

RCA Improvement Process



Fishbone Diagram

Once the problems are identified, a Fishbone Diagram (Appendix C) will be used for analyzing the problems. You can use the fishbone diagram individually to analyze the root causes, or use it with the root cause analysis and action plan framework table.

A Fishbone Diagram, also called a Cause-and-Effect diagram, is a useful tool for a team to structurally brainstorm by discovering possible underlying factors or root causes from different major categories for the chosen problems.

General categories used include:

- ✓ people,
- ✓ methods
- ✓ materials,
- ✓ measurements,
- ✓ education,
- ✓ procedures,
- ✓ process,
- ✓ location,
- ✓ environment, etc.

RCA team members will brainstorm and ask multiple times, “why did this happen?” for each cause until all ideas are exhausted. The highest priority root causes will be chosen for PDSA topics. Once all the categories are established on the fishbone diagram, 5 Why’s technique also can be used to drill down the problem and find the root causes.

Model for Improvement

The Model for Improvement is a collaborative and ongoing effort model to improve the product and services quality and process. It provides multi-disciplinary quality team guidance from identifying the root causes; conducting the best tests to assess possible changes, and working in collaboration for implementation of the new approaches and solutions. It guides the test of a change to determine;

- ✓ if the change is an improvement.
- ✓ Adjust, adopt, or abandon
- ✓ Study process and results
- ✓ Implement the change
- ✓ Develop plan based on the identified root causes

Patient Safety Plan

What are we trying to accomplish?

How will we know a change is an improvement?

What change can we make that will result in an improvement?

Plan--Do-- Study-- Act

Plan

Develop Plan based on identified root causes

Do

Implement the change

Study

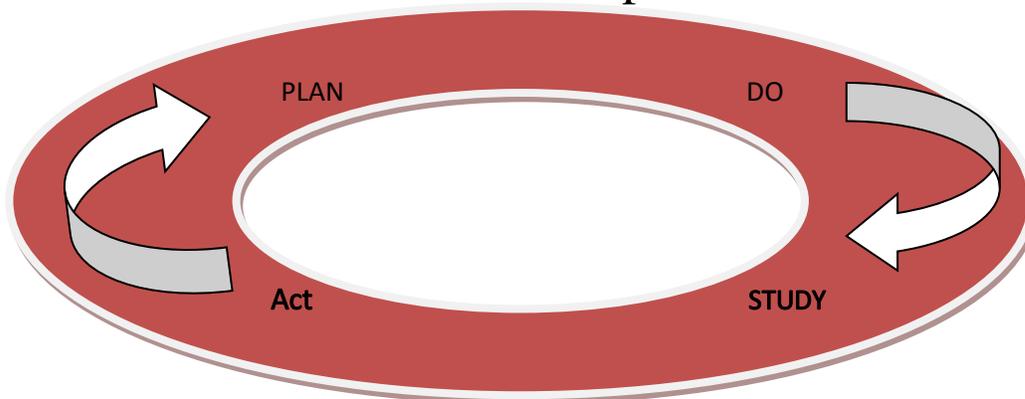
Analyze process and results

Act

Adjust, adopt or abandon to repeat cycle as needed

□

Cycle continues until maximum improvement is achieved



The cycle is defined as follows:

- ✚ **Plan**--Collect data and establish appropriate goals. Identify the problem and the possible root causes, and answer the following questions.
 - ✓ What is the objective of the test?
 - ✓ What are the steps for the test - who, what, when?
 - ✓ How will you measure the impact of the test?
 - ✓ What is your plan to collect the data needed?
 - ✓ What do you predict will happen?

Patient Safety Plan

- ✚ **Do-**
 - ✓ Make changes designed to correct or improve the situation.
 - ✓ Use the following questions for the guidance.
 - What were the results of the test?
 - Was the cycle carried out as designed or planned?
 - What did you observe that was unplanned or expected?

- ✚ **Study–**
 - ✓ Study the effect of the changes on the situation.
 - Data should be collected on the new process and compared to the baseline or expected results.
 - Results should be evaluated by using the following questions as guidance.
 - ✓ Did the results match your prediction?
 - ✓ What did you learn?
 - ✓ What do you need to do next?

- ✚ **Act–**
 - ✓ If the result is successful or desirable, standardize the changes
 - ✓ Then work on the next prioritized problem or the further improvements.
 - ✓ If the outcome is not yet successful, look for different ways to identify the causes or
 - ✓ Change the testing process.

Data Collection and Reporting

Data should drive any quality and patient safety effort. Harmon Hospital is using a Fundamental LTC corporate database for tracking the sentinel events and other incidents such as falls, hospital acquired pressure ulcers and medication variations for internal data collection.

External data sources are those data sources which are collected outside the supervisory structure of the case. External data which will be utilized for Quality and Patient Safety plan include the data from:

- ✚ AHRQ: Agency for Healthcare Research & Quality
- ✚ CDC: Centers for Disease Control and Prevention
- ✚ CMS: Centers for Medicare & Medicaid Services
- ✚ NQF: National Quality Forum
- ✚ NHSN:

Patient Safety Plan

Ongoing Reporting and Review Data points such as the following will be reviewed according to the schedule prescribed:

Monthly	Quarterly	Annually
1) Sentinel event monthly report	1) Sentinel event quarterly report	1) Quality and Patient Safety Plan update
2) Severity of infection report	2) Severity of infection report	2) Checklists
3) RCA assessment	3) Review and evaluate the measure of improvement of patient safety	3) Policies reviewing and revising
4) Infection reports	4) Review and evaluate the measurement to prevent and control infections	

Patient Safety Checklists and Patient Safety Policies

By NRS 439.865, the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- ✚ Providers of healthcare who provide treatment to patients at the facility;
- ✚ Other personnel of the facility who provide treatment or assistance to patients;
- ✚ Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; a
- ✚ Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

The patient safety checklists must follow protocols to improve the health outcomes of patients at the medical facility and must include, without limitation:

- ✚ Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.
- ✚ Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- ✚ A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - ✚ Proper instructions concerning prescription medications;
 - ✚ Instructions concerning aftercare;
 - ✚ Any other instructions concerning his or her care upon discharge; and
 - ✚ Any other checklists which may be appropriate to ensure the safety of patients at the facility.
- ✚ The patient safety policies must include, without limitation:
 - ✓ A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include, the name and date of birth of the patient.
 - ✓ A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.

Patient Safety Plan

- ✓ A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

Based on NRS 439.865, the patient safety plan must also include an infection control program that carries out the infection control policy.

The policy must consist of:

- ✚ The current guidelines appropriate for the facility's scope of service developed by a nationally recognized infection control organization as approved by the State Board of Health which may include, the Association for Professionals in Infection Control and Epidemiology (APIC), the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO) and the Society for Healthcare Epidemiology of America (SHEA); and
- ✚ Facility-specific infection control developed under the supervision of a certified Infection Preventionist.

Patient Safety Plan

Approval of Patient Safety Plan

According to NRS 439.865, a medical facility shall submit its patient safety plan to the governing board of the facility for approval. After a facility's patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan.

The patient safety plan must be reviewed and **updated annually** in accordance with the requirements for approval set forth in this section.

According to NRS 439.843, on or before March 1 of each year, a copy of the most current patient safety plan established to NRS 439.865 must be submitted to the Division of Public and Behavioral Health.

References

- ✓ Root Cause Analysis Toolkit <http://www.health.state.mn.us/patientsafety/toolkit/>
- ✓ Quality and Service Improvement Tools http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html
- ✓ CQI 101 An Introduction to Continuous Quality Improvement: <https://www.coursehero.com/file/13827355/CQI-Overviewppt/>
- ✓ Quality Improvement <http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/>
- ✓ Root Cause Analysis <http://www.patientsafety.va.gov/professionals/onthejob/rca.asp>
- ✓ Patient Safety Systems Chapter, Sentinel Event Policy and RCA2 https://www.jointcommission.org/sentinel_event.aspx
- ✓ Hospital Policies <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>
- ✓ Checklists to Improve Patient Safety http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf
- ✓ Patient Safety Checklists <http://www.who.int/patientsafety/implementation/checklists/en/>
- ✓ Minutes of the Meeting of the Quality and Patient Safety Committee <http://www.cookcountyhhs.org/wp-content/uploads/2013/12/09-23-14-QPS-scan-Minutes.pdf>
- ✓ Title 40 – Public Health and Safety <https://www.leg.state.nv.us/NRS/NRS-439.html>

APPENDIX A

DEFINITIONS

Patient Safety Plan

Sentinel Event

1. Except as otherwise provided in subsection 2, “sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum.
2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:
 - (a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or
 - (b) July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published.

** If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.

(Added to NRS by 2002 Special Session, 13; A 2005, 599; 2013, 217)

Medical Harm

Institute for Healthcare Improvement (IHI) defines **medical harm** as “unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death.”

Facility-Associated Infection: (NRS 439.802)

- ✚ “Facility-acquired infection” means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:
 - ✓ Surgical site infections;
 - ✓ Ventilator-associated pneumonia;
 - ✓ Central line-related bloodstream infections;
 - ✓ Urinary tract infections; and
 - ✓ Other categories of infections as may be established by the State Board of Health by regulation pursuant to NRS 439.890.

(Added to NRS by 2005, 599; A 2009, 553)

Medical facility (NRS 439.805) Medical facility” means:

- ✚ A hospital, as that term is defined in NRS 449.012 and 449.0151;
- ✚ An obstetric center, as that term is defined in NRS 449.0151 and 449.0155;
- ✚ A surgical center for ambulatory patients, as that term is defined in NRS 449.0151 and 449.019; and
- ✚ An independent center for emergency medical care, as that term is defined in NRS 449.013 and 449.0151.

(Added to NRS by 2002 Special Session, 13)

Near miss:

Patient Safety Plan

- ✚ An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Mandatory reporting:

- ✚ Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985;254(6):796-800.)

Risk:

- ✚ Possibility of loss or injury. (Merriam-Webster's Online Dictionary, Risk, Available at <http://www.merriamwebster.com/dictionary/risk>. Last Accessed August 2009.)

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- ✚ **Catheter Associated Urinary Tract Infection (CAUTI):** A urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CURRENT_b.pdf.)

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- ✚ **Catheter Associated Urinary Tract Infection (CAUTI):** A urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CURRENT_b.pdf.)

 **Central Line Associated Bloodstream Infections (CLABSI):** Primary bloodstream infections that are associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection.

Appendix B PDSA WORKSHEET

PDSA WORKSHEET
Harmon Hospital

TOPIC:		
PERSON COMPLETING WORK SHEET		Date:
Telephone:	e-mail	Quarter:
QAPI Committee Members		
Medical Director		
Physician Member		
Physician Member		
CEO		
DQM-Patient Safety Officer		
Infection Control Officer		
Facility Safety Officer		
Team Members:		
AIM: Describe the Overall Goal team wishes to achieve		
Plan		
1. List the tasks needed to set up this test of change		
2. Predict what will happen when the test is carried out		

3. List the steps to develop the test-who what and when

Steps	By whom	By when	Desired outcome

DO: (Describe what actually happened when you ran the test including any problems and unexpected findings)

--

STUDY: (Describe what you learned and did you meet your measurement role?)

Did you meet measurement goal? Explain:	Summarize what was learned: success, failure, unintended consequences etc.

Act: (Describe what you concluded from this cycle)

Based on what your learned, Pleas indicate the action to be considered.	Describe what modifications to the plan will be made for the next cycle based on what you have learned
<input type="checkbox"/> Adapt: modify changes and repeat the PDSA cycle	
<input type="checkbox"/> Adopt: standardize and expand changes throughout org.	
<input type="checkbox"/> Abandon: change approach and repeat PDSA cycle	
<input type="checkbox"/> Other:	

APPENDIX C

Patient Safety

Goals

Patient Safety Goals Objectives and Action Plan

Goal	Objectives	QTR 1	QTR 2	QTR 3
Safety and Quality method for improvement educations for all staff	<ul style="list-style-type: none"> ✓ Utilize Institute of Healthcare Improvement free online training <ul style="list-style-type: none"> ▪ On Demand: An Introduction to the Model for Improvement ▪ On Demand: Building Skills in Data Collection and Understanding Variation ▪ On Demand: Using Run and Control Charts to Understand Variation ▪ On Demand: Improvement Skills to Empower Front-Line Nurses 			
Design systems/processes to anticipate errors and prevent or identify them before they cause harm	<ul style="list-style-type: none"> ✓ Conduct proactive risk assessment areas identified as high risk ✓ Utilize retrospective chart review to identify areas of concern ✓ Establish an automatic surveillance process 			
Establish structures for reporting events and a process for managing reports in the event reporting system	<ul style="list-style-type: none"> ✓ Educate and train staff to utilized incident reporting process for all events with potential for patient harm ✓ Establish standardized reports based on events that occurred as well as near missed ✓ Evaluate the potential and actual harm caused by these events. ✓ Develop processes to prevent actual and potential harm 			

Goal	Objectives	QTR 1	QTR 2	QTR 3
Develop a culture of safety within the organization	<ul style="list-style-type: none"> ✓ Ensure staff feels safe and supported when they report medical errors/ near misses or when they voice concern about patient safety ✓ Conduct a Culture of Safety Survey with all staff ✓ Identify key areas for improvement based on the Culture of Safety Survey 			
Establish Safety Priorities and benchmarks	<ul style="list-style-type: none"> ✓ Establish a Patient Safety Dashboard with national measures and benchmarks ✓ Facilitate the development of action plans for safety measures not meeting benchmarks 			
Improve all levels of communication and particularly with handoff and transition patient information	<ul style="list-style-type: none"> ✓ Ensure a standardized process for handoff communication at change of shift ✓ Utilize checklists for key transition processes such as RTA and Discharge ✓ Educate staff on key measures to improve communication such as Huddles and post event assessments 			
Initiate Monitoring process for National Patient safety goals	<ul style="list-style-type: none"> ✓ Focus on the following 5 until solidly in place: <ul style="list-style-type: none"> • Two identifiers • Critical value management • Suicide assessment • Hand washing, PPE • Fall prevention 			

Appendix D

Leadership Policy

for Patient Safety

Patient Safety Program

PURPOSE

To establish guidelines and processes supporting a comprehensive, effective, organization-wide Patient Safety Program designed to improve patient safety by preventing medical/healthcare errors and reducing risks to patients.

POLICY

The Patient Safety Program is a coordinated and systematic approach to create an information infrastructure and build a better evidence base for patient safety critical to reducing medical/healthcare errors and improving patient safety. The program meets the requirements of Patient Safety Standard, and integrates with the Quality Assessment and Performance Improvement (QAPI) Plan and the Sentinel Event Policy, and is endorsed by the medical staff and Leadership.

Patient Safety Program:

Harmon Hospital is committed to making the safety of all patients, employees, physicians and visitors a leadership priority for organizational performance improvement. The Patient Safety Program is an integral part of the QAPI Plan that includes processes to:

- Establish and maintain a just culture of safety throughout the hospital;
- Promote safety by recognizing and reducing risks and hazardous conditions that result in medical/healthcare errors and patient injury;
- Support a strong internal non-punitive reporting mechanism;
- Facilitate the rapid redesign of unsafe care processes and systems in response to actual and potential adverse events;
- Support ongoing proactive efforts through implementation of known safe practices;
- Promote communication and coordination among individuals and departments to minimize risk to patients;
- Support sharing of knowledge to effect behavior change and organizational improvement to reduce risk and improve patient safety;
- Support notification of patients and when appropriate, their family, of unplanned outcomes;
- Establish a data collection system to monitor performance of new or revised processes including patient, family, and staff input, needs, perceptions of risk to patients, and suggestions for improvement.

Organizational Culture:

An organizational culture has been established by the leaders that support the effective reduction of medical/health care errors and other factors that contribute to unintended adverse patient outcomes. This culture is based on the principles of organization-wide cooperation and communication and encourages:

- The recognition and acknowledgement that preventing errors and improving safety for patients requires a systems approach in order to modify the conditions that contribute to errors;
- A focus on processes and systems;
- Minimization of individual blame or retribution for involvement in a medical/health care error;
- The internal reporting of what has been found and the actions taken to reduce risk; and
- Organizational learning about medical/health care to effect behavioral changes in order to improve patient safety.

The organizational culture is also reflective of Harmon Hospital's Philosophy, which supports the patient's right to be informed about the outcomes of their care, including unanticipated outcomes.

An effective Patient Safety Program cannot exist without optimal reporting of actual or potential medical/healthcare errors and occurrences. Therefore, it is the intent of Harmon Hospital to adopt a just, non-punitive approach in its management of errors and occurrences. All personnel will report suspected or actual medical/healthcare errors and may do so without fear of reprisal.

Scope of Activities:

The Patient Safety Program at Harmon Hospital is an organization-wide program that includes not only facility staff and medical staff, but is inclusive of patients, family and visitors. The Patient Safety program supports and encourages the active participation of each person in order to have an effective program.

When processes, functions or services are designed or redesigned, information internal and external to the organization regarding potential risks to patient safety will be considered and where appropriate, utilized to minimize the risk to patients affected by the new or redesigned process, function or service.

Undesirable patterns or trends in performance and sentinel events will be intensively analyzed to determine where best to focus changes for improvement. Intensive analysis will be initiated when:

- Levels of performance, patterns, or trends vary significantly and undesirably from those expected;
- Performance varies significantly and undesirably from that of other organizations;
- Performance varies significantly and undesirably from recognized standards; or
- When a sentinel event has occurred.

Minimally, data from the following areas will be analyzed and action plans developed reflective of the findings:

- Initial risk assessment
- On-going proactive risk assessments utilizing internal and external resources
- Aggregate event report reflective of all medical/healthcare errors, with and without adverse outcomes, including but not limited to:
 - Medication errors, to include delays in administration
 - Adverse drug reactions
 - Transfusion reactions
 - Patient falls
 - Sentinel events, actual and near misses
 - Hazardous conditions
 - Restraint issues
 - Medical record legibility issues

- Patient/family/staff opinions, needs, perceptions of risks to patients, and suggestions for improving patient safety
- Others as defined by Harmon Hospital

Leadership:

Hospital leadership has overall responsibility for the implementation of an integrated, organization-wide Patient Safety Program. These responsibilities include the following:

- Fostering an environment in which patients, their families and organization staff and leaders can identify and manage actual and potential risks to patient safety through personal example and the provision of resources to establish proactive mechanisms to reduce risk.
- Establishing a culture in which communication flows freely regardless of authority gradient;
- Ensuring that a defined, on-going, proactive program for identifying risks to patient safety and reducing medical/health care errors is fully implemented and includes responses to actual and potential events, as well as addresses two high risk processes for proactive intensive assessment based on internal data and information published in JCAHO Sentinel Event Alerts and other literature sources;
- Ensuring that patient safety issues are given a high priority and addressed when processes, functions or services are designed or redesigned;
- Providing for mechanisms to measure, analyze and manage variations in the performance of defined processes that affect patient safety;
- Allocating adequate resources, including personnel, time, information systems, data management support and staff training to support the performance improvement processes associated with reducing risk and improving patient safety; and
- Annually evaluating the patient safety plan for its effectiveness in reducing risk and improving patient safety.

Patient Safety Coordinator:

The Risk Manager has been designated the *Patient Safety Coordinator* and as such, has the administrative responsibility for the Program. Specific responsibilities include:

- Day to day responsibility for the ***Patient Safety Program***
- Along with the Safety Officer, collection, trending and analysis of data
- Quarterly reporting of trended data and actions taken to improve the quality and safety of patient care to the Patient Safety Committee and senior leadership
- Working with Patient Safety Committee to achieve the goals of the Patient Safety Program

Patient Safety Committee:

The Patient Safety Committee, in collaboration with the chair of the committee and the Patient Safety Coordinator, has oversight responsibility to ensure that the responsibilities and functions outlined in this program are carried forward throughout the organization. The following responsibilities are assigned:

- Serve as champions of the Patient Safety Program within the organization;
- Establish and evaluate data to identify patient safety performance indicators;
- Evaluate other sources of patient safety data utilizing internal and external resources including, but not limited to, risk assessments, sentinel event report/alert information, and event reporting information from a variety of available resources including the event reporting system;
- Selection of at least two high-risk patient safety processes (one related to medication errors and one related to mistake management) for proactive risk assessment and improvement annually; and
- Annual review of the Patient Safety Program to ensure its appropriateness of focus and effectiveness of efforts.

Physicians:

Physicians are responsible, as participants in the patient safety program, for reporting errors or near misses, and participating on teams to reduce identified patient safety risks. Whenever patient care outcomes differ significantly from the anticipated outcomes, the primary care provider and/or responsible licensed independent practitioner (or comparable designee), shall clearly explain these outcomes to the patient, and when appropriate, the family.

Patients/Families/Visitors:

Patients and families are responsible for:

- Providing, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to the patient's health;
- Reporting perceived risks in their care and unexpected changes in the patient's condition to the responsible practitioner;
- Asking questions when they do not understand what they have been told about the patient's care or what they are expected to do.

Patients and visitors will be provided with educational materials explaining these expectations and their role in reducing risk and improving patient safety at the time of admission. Some patients may also be included in the process to obtain their opinions, needs, perceptions of risks to patients and their suggestions for improving patient care.

Hospital Departments and Staff:

Hospital departments and staff have the following responsibilities:

- Active participation in the Patient Safety Program;
- Participation in all education activities and process implementation;
- As appropriate, the provision of accurate, timely and complete verbal and written communication among care givers, including test results relevant to the management of the patient's condition, and to all others involved in the utilization of data; and
- Participation in the information needs assessment, staff surveys and other processes that request information regarding the Patient Safety Program.
- Participate in the measurement activities for process and outcomes which will be utilized for data driven decisions and improve quality of care and services.

PROCEDURE

1. Proactive Risk Assessment Activities

- 1.1. The Risk Manager, in collaboration with the Patient Safety Committee, will conduct proactive risk assessments to identify hazards/risks that may affect patient safety. Risk assessment activities will include, but not be limited to the following:
 - 1.1.1. An initial patient safety risk assessment evaluating known high risk processes/procedures that have associated risks;
 - 1.1.2. On-going risk assessments based on internal and external data, including sentinel event alerts;

- 1.1.2.1. Focused risk assessments as determined by the Patient Safety Committee, senior leadership and/or Quality Council
 - 1.1.2.2. Selection of patient safety process improvements and risk reduction activities utilizing the priority setting criteria of Gerald Champion RMC.
 - 1.1.2.3. The information needs assessment conducted by Harmon Hospital will include identification of barriers to effective communication among caregivers.
 - 1.1.2.4. Patient satisfaction surveys will include a question determining how the patient/family thinks the facility can improve patient safety. Results from this question shall be analyzed and responded to in a manner that supports risk reduction.
 - 1.1.2.5. Staff surveys will be conducted to assess for staff opinions, needs, perceptions of risks to patients and suggestions for improving patient safety as well as the staff's willingness to report medical/health care errors.
- 1.2. Risk assessment activity results will be aggregated and analyzed. Appropriate action plans will be developed in response to the results with the goal of reducing the actual, potential or perceived risk to patient safety.

2. Event Reporting

- 2.1. When an unplanned event occurs, the patient care provider will do the following:
- 2.1.1. Perform the necessary healthcare interventions to support the patient's clinical condition
 - 2.1.2. Perform the necessary interventions to contain the risks to others
 - 2.1.3. Notify the patient's attending physician
 - 2.1.4. Preserve any information related to the event including physical evidence.
 - 2.1.5. Preservation of the information includes the documentation of facts regarding the event or complication of event on the Event Reporting form and in the medical record
 - 2.1.6. Notify immediate supervisor of the event
 - 2.1.7. Submit the Event Report form to the medical center's Risk Manager
- 2.2. Identification of potential unsafe condition that may affect patient safety:
- 2.2.1. Individuals identifying such a condition will immediately report such to their supervisor, and document on the Event Report form
 - 2.2.2. Take the necessary actions to ensure that any potential risks to patient care and safety are mitigated
 - 2.2.3. Submit the Event Report form to the medical center's Risk Manager

3. Event Monitoring/Risk Assessment Analysis, Action Planning and Intervention

- 3.1. Patient safety related event reporting data within the scope of the Patient Safety Program and all risk assessment results will be aggregated and presented to the Executive Safety Committee for analysis quarterly. Based on the analysis of this data, any actual or potential sentinel events and other internal and external data including JCAHO Sentinel Event Alerts and other current literature, proactive action plans will be developed to include the following:
 - 3.1.1. Assessment of the intended and actual implementation of processes to identify the steps in where there is, or may be, undesirable variation;
 - 3.1.2. Identification of the possible effects of the undesirable variations on patients and how serious the effect or outcome on the patient might be;
 - 3.1.3. For critical effects/outcomes, a root cause analysis will be conducted to determine why the variation leading to the effect may occur;
 - 3.1.4. Redesign of the process and/or underlying systems to minimize the risk of that variation or to protect patients from the effects of the variation;
 - 3.1.5. Test and implement the redesign process;
 - 3.1.6. Identification and implementation of measures of the effectiveness of the redesigned process;
 - 3.1.7. Implementation of a strategy for maintaining the effectiveness of the process over time.

4. Response to Reported Adverse/Sentinel Events

- 4.1. Harmon Hospital shall respond to all reported potential and actual adverse/sentinel events as described in the sentinel event policy.
- 4.2. Minimally, all significant adverse events will be analyzed utilizing a team of individuals to conduct a root cause analysis and/or a failure mode and effects analysis, implement an action plan to reduce further risk to patients and establish measures of effectiveness as described above in Section III A.
 - 4.2.1. The following events always elicit an intense analysis:
 - 4.2.1.1. Confirmed transfusion reactions;
 - 4.2.1.2. Significant adverse drug reactions;
 - 4.2.1.3. Significant medication errors and hazardous conditions;
 - 4.2.1.4. Major discrepancies, or patterns of discrepancies, between preoperative and postoperative (including pathologic) diagnoses, including those identified during the pathologic review of specimens removed during surgical or invasive procedures; and
 - 4.2.1.5. Significant adverse events associated with anesthesia use.
 - 4.2.2. A root cause analysis is performed when a sentinel event occurs.

- 4.3. Staff involved in an adverse/sentinel event shall be treated with respect and dignity.
 - 4.3.1. A non-punitive approach shall be taken in order to facilitate changes in systems and processes to prevent further risk to patient safety, as well as promote future reporting by other staff.
 - 4.3.2. Involved staff should be involved in the root cause analysis process.
 - 4.3.3. The department manager will provide on-going support to the staff member as needed.
 - 4.3.4. Whenever necessary, Employee Assistance Programs will be offered as support to the involved employee.
- 4.4. Harmon Hospital will notify patients and/or family members, when appropriate, of unplanned outcomes.
Staff will follow the policy and procedure on "Disclosure of Unanticipated Adverse Outcomes to Patients/Families."

5. Facility Education

5.1. Staff Education

- 5.1.1. General orientation, on-going in-service and other education and training programs will emphasize specific job-related aspects of patient safety.
- 5.1.2. Specific Patient Safety Program training at orientation and annually thereafter will include:
 - 5.1.2.1. An overview of the Patient Safety Program
 - 5.1.2.2. Staff's role and responsibilities in the Patient Safety Program
 - 5.1.2.3. Event reporting, including the events requiring reporting and the process for reporting events.
 - 5.1.2.4. Methods to support and foster an interdisciplinary and collaborative approach to the delivery of patient care;
 - 5.1.2.5. Examples of specific job-related aspects of patient safety.
- 5.1.3. Staff participating at a higher level of the Patient Safety Program will receive appropriate training necessary to understand and complete their assigned responsibilities.

5.2. Physician Education

- 5.2.1. An overview of the Patient Safety Program will be provided to physicians at time of initial appointment and periodically thereafter that describes the program, emphasizes their role and responsibilities in the program and informs them of the event reporting mechanism.
- 5.2.2. Specific physicians may receive additional training to support their involvement at a higher level in the Patient Safety Program.

6. Patient Safety Program Reporting and Review

- 6.1. Patient Safety related data and information reports will be provided at least quarterly to the Patient Safety Committee.
- 6.2. A summary report of data, other internal and external information, as well as all actions taken by the Patient Safety Committee and/or specific patient safety related teams will be submitted to the Quality Council, Quality and Utilization Management Committee the Medical Executive Committee and Governing Board.
- 6.3. Annually, the Patient Safety Program will be evaluated for effectiveness and the program updated to reflect the results of risk assessments of patients, families and staff. The review shall include a summary of the occurrence of medical/health care errors and actions taken to improve patient safety, both in response to actual occurrences and proactive efforts.

- 6.3.1. The review will be approved by Patient Safety Committee, Medical Staff Executive Committee
 - 6.3.2. Will be submitted to the governing body for review and approval.

REFERENCES:

Conditions of Participation- (CMS) Standards
The Joint Commission Standards
Sentinel Event Policy

Addendum A
Patient Safety Policy and Procedure
Definitions

Error: An unintended act, either of omission or commission, or an act that does not achieve its intended outcome.

Sentinel Event: An unexpected occurrence involving death or serious physical or psychological injury or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or risk thereof" includes any process variation for which a recurrence would carry a significant chance of serious adverse outcome.

Near Miss: Used to describe any process variation which did not affect the outcome, but for which recurrence carries a significant chance of a serious adverse outcome. Such a near miss falls within the scope of the definition of a sentinel event, but outside the scope of those sentinel events that are subject to review by the Joint Commission under its Sentinel event Policy.

Hazardous Condition: Any set of circumstances (exclusive of the disease or condition for which the patient is being treated) which significantly increases the likelihood of a serious adverse event.

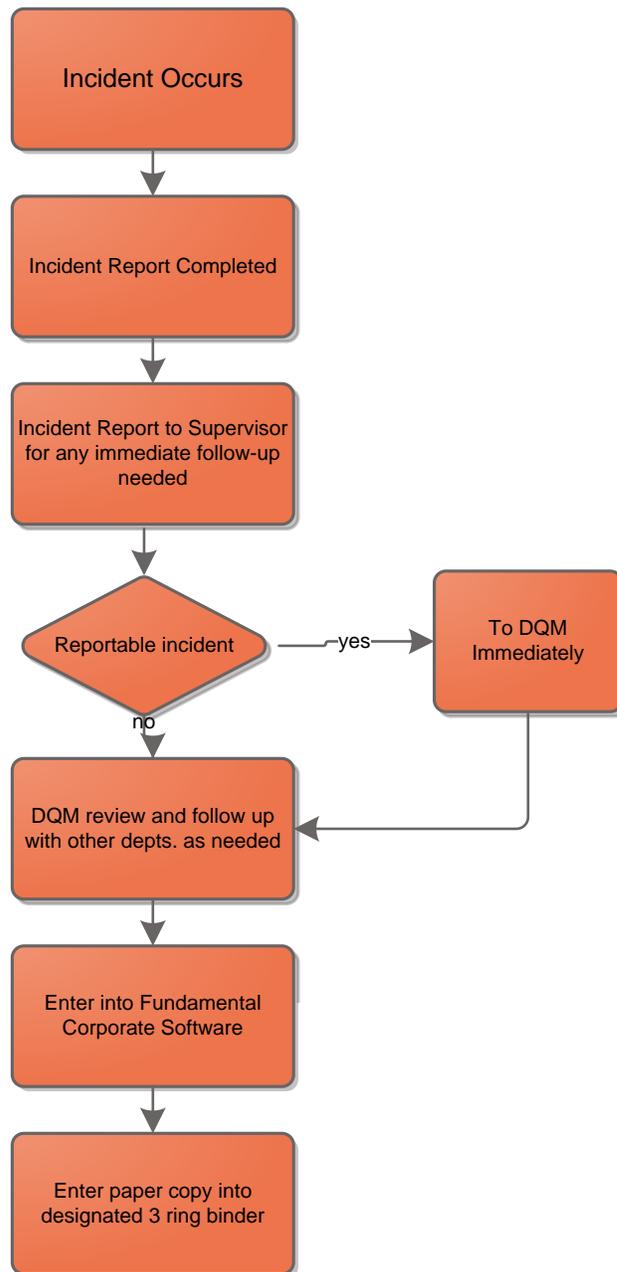
APPENDIX E

INCIDENT REPORTING

Incident Report Process (Non-Medication incident)

1. Incident is identified by Hospital staff
2. Incident report is completed
3. Incident Report is given to Nursing Supervisor for immediate review and follow up as needed.
4. Any additional assessment and investigation is completed and documented. Supporting documentation is attached to the Incident Report.
5. After incident information and follow up Completed the information and incident report is given to the Director of Quality Management (DQM).
6. DQM reviews for any immediate actions/notifications including interface with other departments involved.
7. DQM gives incident report to Patient Advocate for entering into Fundamental incident reporting software on Fundamental site.
8. Patient Advocate enters the Incident into the Incident Reporting Module.
9. Patient Advocate then has the paper copy of the incident with supporting documentation filled in 3 ring binders for maintaining incident reports.
10. Incidents are filed in binder by date. The binder is kept in the DQM office when filing is completed.
11. Reports are maintained on site for 3 years and then filed and sent to Iron Mountain for a total of 7 years.

Incident
Process
Flow Chart

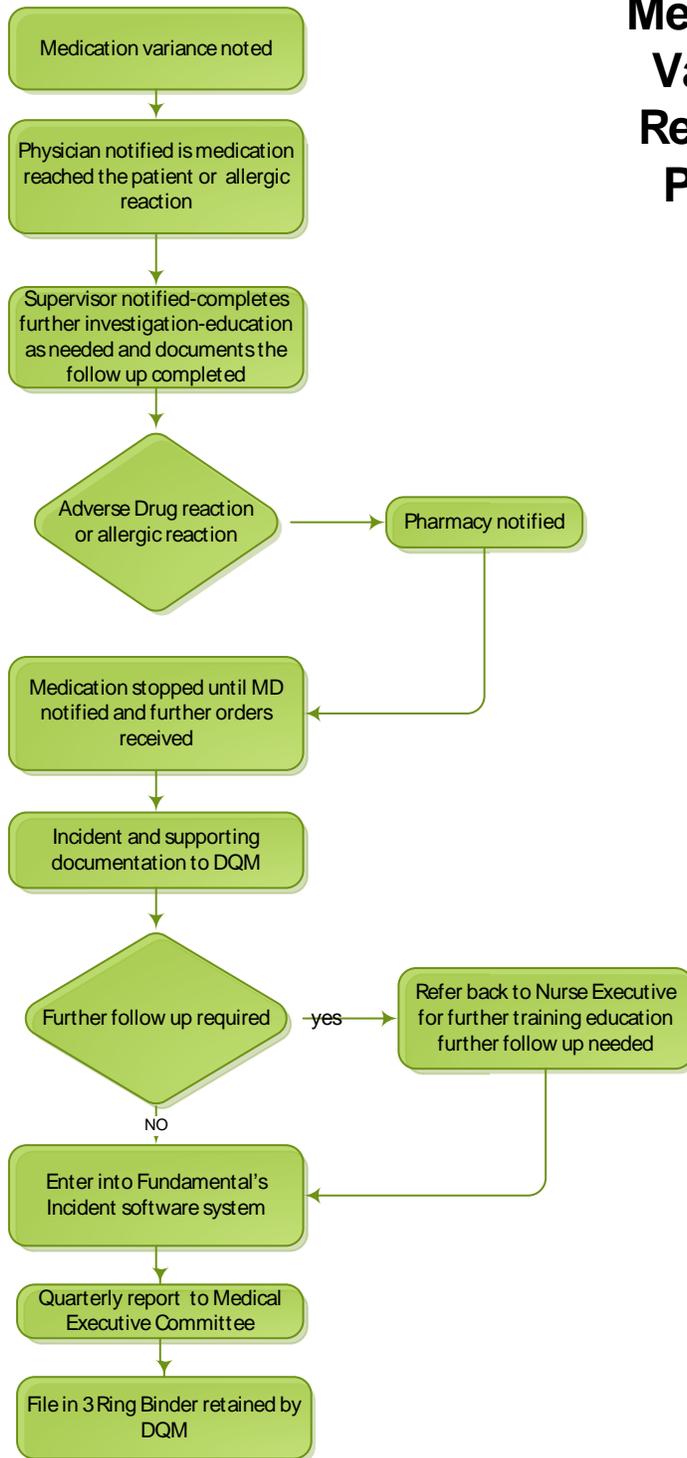


Incident Reporting Process

Medication Variances

1. Medication Variation is noted. (error, transcription error, medication not available, adverse drug reaction, etc.)
2. Individual noting the error completes the incident report.
3. Physician notified of medication error (only if wrong medication reached the patient, route, reached the patient or an obvious allergic reaction)
4. If the medication error reached the patient the physician notifies the patient, guardian or Power of Attorney of the error and any impact this had on the patient. This interaction must be documented in the patient's medical record.
5. Nursing Supervisor notified.
6. Nursing Supervisor investigates the medication variation issue and ensures all required follow up is completed.
7. Nursing Supervisor documents all and follow-up in a report to the nurse executive.
8. Staff education is completed at the time of the incident with the nurses involved. (Nursing Supervisor). Nurse Executive may do further education or further follow –up as appropriate at a later date.
9. Pharmacy is notified promptly for Adverse Drug Reactions and or allergic reactions.
10. Incident Report and all supporting investigative data are sent to the Director of Quality Management (DQM).
11. DQM will review medication variation, investigation and follow-up. Notifies the Nurse Executive if more follow-up or further investigation is needed.
12. DQM or designee enters the medication error into the Fundamental Corporate Software program.
13. Medication variations are reported to the Pharmacy and Therapeutics function at the Medical Executive Committee Quarterly.

Medication Variance Reporting Process



Appendix E

Checklist and Action Plan for Safety

Process Change	In Place	Not done	Will adopt	Responsible-By when
Conduct Fall Risk Injury Assessment upon admission	✓			
Reassess risk daily and when change in condition occurs	✓			
Implement patient specific interventions to prevent falls/injuries	✓			
Communicate risk across the team, handoff forms, visual cues, huddles	✓		improve	Forms, Quality Risk-Mar 14th
Rounds every 1-2 hrs for high-risk patients, address needs, (e.g. 4 Ps – pain- potty –position change pressure relief- personal needs) Combine w/ other tasks	✓		improve	Nursing Service April 30. 2017
Individualize interventions,. Use non-skid floor mats, float heels, hip protectors, individualized toileting schedule, adjust rounds to patient needs	✓			
Medication Review by pharmacy, avoid unnecessary hypnotics, sedatives			✓	Pharmacy Department-April 19th
Multidiscipline input for falls	✓			
Prevention measures from PT, OT, MD, RN, Pharm D	✓			Pharmacy Department-April 19th
Include patients and families in efforts to prevent falls/injury. Educate regarding fall/injury prevention measures, stay with patient	✓			
Hold post-fall huddles immediately after falls, analyze how and why, implement changes in intervention to prevent further falls	✓		improve	

Reference: Checklist to Improve Patient Safety. June 2013 Health Research & Educational Trust

Action Plan for Improvement

Improvement item	Findings	Actions to be taken	Responsible - timeframe
Communicate risk across the team, handoff forms, visual cues, huddles	<p>Information is communicated but forms would increase quality and accuracy of reports.</p> <p>Patient specific visual cues in place</p> <p>Huddles are not consistently conducted immediately post fall-no form utilized for consistent review. Analysis forms but are not conducted by team.</p>	<ol style="list-style-type: none"> 1. Develop hand off form for patients who have history of falls and have fallen HH, 2. Develop, educate and implement use of Post Fall Huddle form to improve consistency of change needed post fall 	
Rounds every 1-2 hrs for high-risk patients, address needs, (e.g. 4 Ps –pain- potty – position change pressure relief- personal needs) Combine w/ other tasks	Inconsistency in timeliness and consistency with 4 Ps	<ol style="list-style-type: none"> 1. Reeducate to rounds process 2. Re-implement process 3. Measure and report compliance 	
Hold post-fall huddles immediately after falls, analyze how and why, implement changes in intervention to prevent further falls	Inconsistency with post fall huddles-Form not used to ensure consistency of review	<ol style="list-style-type: none"> 1. Develop Post Fall Huddle form 2. Educate and train staff on use of form 3. Implement process 4. Measure and Report compliance 	

Compliance Checklist

Organization: _____ Department/Unit: _____

Date of Review: _____ Reviewer: _____

Environment of Care [CAH, HAP, NCC]

✓ N/A

- All equipment on one side of hall
- No equipment plugged in within hallways
- Nothing parked in hall longer than 30 minutes
- Top of linen cart covered; solid bottom on cart
- Nothing other than linen on linen carts

Clean Utility or Storage Room [AHC, CAH, HAP, NCC, OBS]

✓ N/A

- Oxygen tanks upright, in holder, full and empty tanks separated with signage
- Top of linen cart covered when not in use; solid bottom on cart
- Door to hall closed (not propped open)

Soiled/Dirty Utility Holding Room [AHC, BHC, CAH, HAP, NCC, OBS, OME]

✓ N/A

- Biohazard trash contained
- Nothing under sink

Housekeeping and Security [AHC, BHC, CAH, HAP, NCC, OBS]

✓ N/A

- Trash contained
- Drawers locked, as appropriate

Crash Cart [AHC, CAH, HAP, NCC, OBS]

✓ N/A

- Daily checklist completed
- No clutter on top
- Locked (including extra locks secured)
- No expired medications or supplies noted

Medication Carts/Storage Areas [AHC, BHC, CAH, HAP, NCC, OBS, OME]

✓ N/A

- No open single-use vials; all discarded after use
- Opened multidose vials dated
- MAR/eMAR closed when not in use
- Pill crushers/splitters cleaned
- All doors/drawers locked when unused

Medication Refrigerator/Freezer [AHC, BHC, CAH, HAP, NCC, OBS, OME]

✓ N/A

- Temperature checks completed; response to variances recorded

- Opened multidose vials dated
- Discharged patient medications managed
- No expired medications

Medications/Solutions [AHC, BHC, CAH, HAP, NCC, OBS, OME]

✓ N/A

- No unsecured medications, sharps, or syringes
- No expired medications or solutions
- No predrawn syringes

Point-of-Care Glucose Meters [AHC, BHC, CAH, HAP, NCC, OME]

✓ N/A

- Cleaned
- Controls and strips dated when opened
- QC performed, per manufacturer's guidelines

Patient Care [AHC, CAH, HAP, NCC, OBS]

✓ N/A

- All patients wearing correct ID band
- Fall-risk patients wearing bracelets; signage up
- Any nonambulatory patients (on gurneys or in wheelchairs) in hall covered with dignity
- Trays and snacks delivered
- Call lights functional and within patient reach
- Alarms answered
- Confirmed confidentiality of medical records
- Isolation precautions implemented if ordered
- Reviewed hand hygiene policy with staff and ensured sanitizer dispensers are full
- Reminded staff to perform time-out for any invasive procedures
- Reviewed medication administration with staff

Chart Review (New Admits) [CAH, HAP, NCC]

✓ N/A

- Home medication record completed
- Administration database completed
- TO/VO/critical value documentation completed

Appendix F

ICRA

Infection Control Risk Assessment

INFECTION CONTROL RISK ASSESSMENT (ICRA) FORM

Project Name: _____

Project Location: ..

Project Manager:

IDENTIFY THE TYPE --

Step 2: Identify the Area Risk Group

Identify the locations of all groups/spaces that are potentially impacted from the project. This should include all areas surrounding the project. If there is more than one risk group that will be affected, use the higher risk group.

- **Low Risk:** No patient care or occupancy. No laboratory research or materials present.
- **Medium Risk:** Most active laboratories, outpatient areas, patient occupancy and support service areas.
- **High Risk:** Clean Rooms, areas with high value equipment subject to damage from dust, High Risk Outpatient and all inpatient areas.

IDENTIFY THE RISK-

Step 3: Determine Class (I – IV) of Risk Mitigation Measures Required

Project Type

Area Risk Group	Type A	Type B	Type C	Type D
Low Risk	I	I	II	IV
Medium Risk	I	II	III	IV
High Risk	II	III/IV	III/IV	IV

All work/construction projects that require Class II, III or IV risk mitigation measures will require approval of a dust control plan prior to the start of work.

Step 4: Risk Mitigation Measures

Class	During Construction Project	Upon Completion of Project
I	<ol style="list-style-type: none"> Execute work using methods to minimize raising dust from construction operations. Immediately replace a ceiling tile displaced for visual inspection. 	<ul style="list-style-type: none"> Contractors will conduct cleaning with approved disinfectant.
II	<ol style="list-style-type: none"> Provide enclosure to control dust migration using portable tent (control cubes) or sheetrock, plywood, plastic (6 mil poly) to seal area from non-work area with a HEPA vacuum continuously running to create negative pressure (Monitoring airflow direction is not required). Provide active means as described below to prevent airborne dust from dispersing: <ul style="list-style-type: none"> Water mist work surfaces to control dust while cutting. Seal unused doors with tape if high risk site adjacent to construction site. Place sticky mat at entrance and exit of work area and change sticky mat when covered with dust. Provide dampen walk off mats at fixed location. If used must be kept damp. Contain construction debris (e.g. seal with plastic) prior to removal from site Use only designated route/elevator to transport materials or construction debris. 	<ul style="list-style-type: none"> Vacuum with HEPA filtered vacuum prior to removing barrier.

<p>III</p>	<ol style="list-style-type: none"> 1. Disconnect or isolate HVAC system in area in consultation with Engineering & Maintenance where work is being done to prevent contamination of duct system or adjacent spaces. 2. Complete all critical barriers i.e. sheetrock, plywood, plastic (6 mil poly), to seal area from non-work area, or implement control cube method (cart with plastic covering and sealed connection to work site with HEPA vacuum for vacuuming prior to exit) before construction begins. 3. Place dust mat at entrance and exit of work area and replace or clean when no longer effective. 4. Maintain negative air pressure (>0.01" water) within work site utilizing HEPA equipped air filtration units or other methods to maintain negative pressure. 5. Re-circulating HEPA units may supplement dust control measures inside the work area. 6. Additional HEPA filtration unit should be installed near all entrances and exits to the work area. 7. The contractor will inspect all dust control equipment daily and log the results. 8. Keep work area broom clean and remove debris daily. 9. Contain construction debris (e.g. seal with plastic) prior to removal from site 10. Use only designated route/elevator to transport. 	<ul style="list-style-type: none"> • Do not remove barriers from work area until completed project is inspected by Environmental Health and Safety. • Contractor to clean area with HEPA filtered vacuum or wet mop as appropriate to the satisfaction of the Project Manager. • Remove isolation of HVAC system in areas where work was being performed.
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IV	<ol style="list-style-type: none"> 1. Disconnect or isolate HVAC system in area in consultation with Engineering & Maintenance where work is being done to prevent contamination of duct system or adjacent spaces. 2. Complete all critical barriers i.e. sheetrock, plywood, plastic (6 mil poly), to seal area from non-work area, or implement control cube method (cart with plastic covering and sealed connection to work site with HEPA vacuum for vacuuming prior to exit) before construction begins. 3. Place dust mat at entrance and exit of work area and replace or clean when no longer effective. 4. Maintain negative air pressure (>0.01" water) within work site utilizing HEPA equipped air filtration units or other methods to maintain negative pressure. 5. Re-circulating HEPA units may supplement dust control measures inside the work area. 6. Additional HEPA filtration unit should be installed near all entrances and exits to the work area if appropriate. 7. The contractor will inspect all dust control equipment daily and log the results. 8. Keep work area broom clean and remove debris daily. 9. Contain construction debris (e.g. seal with plastic) prior to removal from site 10. Seal holes, pipes, conduits, and punctures appropriately. 11. Construct anteroom and require all personnel to pass through this room. Wet mop or HEPA vacuum the anteroom daily. 12. During demolition, dust producing work, or work in the ceiling, disposable shoe covers and coveralls are to be worn and removed in the anteroom when leaving the work area. 13. Use only designated route to transport materials or construction debris. 	<ul style="list-style-type: none"> • Do not remove barriers from work area until completed project is inspected by Plant operations • Contractor to clean area with HEPA filtered vacuum or wet mop as appropriate to the satisfaction of the Project Manager. • Remove isolation of HVAC system in areas where work was being performed. • Housekeeping Service will conduct cleaning with approved disinfectant before re-occupation of the area.
----	---	---

Step 5: Life Safety Assessment

Life Safety Assessment	Answer (Yes, No)	Alternative Measures If "YES" is answered for any questions in the life safety assessment, alternative life safety measures must be indicated
1. Will any existing required path of egress be obstructed or impacted by planned work or construction?	yes	The newly identified path of egress has been posted and staff educated. Fire drills will be completed weekly on each shift. Exit signs temporarily removed.
2. Will any existing exit signs need to be covered; removed or relocated?	yes	This has been accomplished
3. Will new exit signage be required due to rerouting of a path or egress?	yes	New signage has been placed.
4. Will fire suppression system (wet/dry/pre-action sprinklers) be impaired during any part of planned work or construction?	no	
5. Will any component of a fire alarm system be impaired during any part of planned work or construction?	yes	Smoke detectors disabled. See plan
6. Will any existing fire/smoke rated separation be impacted by planned work or construction?	no	
7. Will existing fire extinguishers be removed from the space during planned work or construction?	no	

Step 6: Sign-Off:

Project Team/Hiring Department Supervisor must complete this form to document the results of the assessment of the planned work/construction project.

PROJECT NAME/DESCRIPTION: _____

Construction Project Type (A-D): _____

Risk Group Classification (Low-Medium-High): _____

Risk Mitigation Measures Class (I – IV): _____

Have any life safety issues been identified through the Life Safety Assessment? ____ Yes ____ No

The Project Team / Hiring Department Supervisor must submit a written plan detailing how dust/fume control and Interim Life Safety Measures (ILSM) if required, will be achieved to the CEO for any work:

1. That requires Class II, III, or IV risk mitigation measures, and/or
2. That requires interim life safety measures

Work cannot commence until the plan is approved by both CEO and the Project Manager.

Sign-Off:

Project Manager/Supervisor: _____ Date:

CEO: _____ Date:

Dust Control Plan and Interim Life Safety Measures

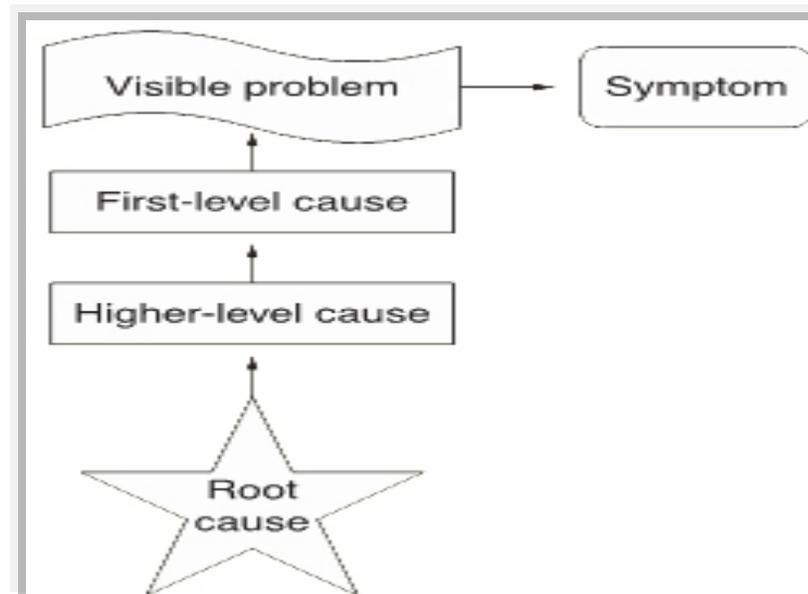
Dust Control:

Interim Life Safety

Appendix G

ROOT CAUSE ANALYSIS

The highest-level cause of a problem is called the root cause:



The root cause is “the evil at the bottom” that sets in motion the entire cause-and-effect chain causing the problem(s) and or adverse outcome.

Some root cause analysis approaches are geared more toward identifying true root causes than others; some are more general problem-solving techniques, while others simply offer support for the core activity of root cause

At the start of your fact finding team meeting list the sequence of events (flowchart) as they happened that lead to the problem, issues, or Sentinel Event.

If there is a defined procedure for the process that resulted in an adverse outcome list the sequence of steps in the approved procedure.

Compare the actual sequence of events to the steps outlined in the procedure. Identify any areas in the event sequence where approved procedure was not followed.

These areas may become the basis to develop a Cause and Effect Diagram to identify Root Cause.

Root causes analysis using the Cause and Effect methods.

What's the Problem?



Define the issue by its impact to overall goals. People often disagree over how to define the problem. You can get alignment when the problem is defined by the impact to the goals.

Why did it happen?



Break the problem down into a visual map. Using a Cause and Effect Diagram to provide a thorough explanation revealing all of the causes required to produce the problem.

What will be done?



Prevent or mitigate any negative impact to the goals by selecting the best solutions. Effective solutions should make a change to how people execute work process.

Better Communication, Better Analysis



The Sequence of Events identifies areas needing more investigation.

The Cause and Effect Diagram creates a visual dialogue, making it easier to communicate what's known and what needs a little more digging.

People can see how all of the pieces fit together to produce a particular incident.

The better an organization gets at explaining its problems, the better it becomes at finding smart solutions.

How to Use the Cause and Effect (Fishbone) Tool for Root Cause Analysis

Overview:

Root cause analysis is a structured team process that assists in identifying underlying factors or causes of an adverse event or near-miss. Understanding the contributing factors or causes of a system failure can help develop actions that sustain the correction.

A cause and effect diagram, often called a “fishbone” diagram, can help in brainstorming to identify possible causes of a problem and in sorting ideas into useful categories. A fishbone diagram is a visual way to look at cause and effect. It is a more structured approach than some other tools available for brainstorming causes of a problem (e.g., the Five Whys tool). The problem or effect is displayed at the head or mouth of the fish. Possible contributing causes are listed on the smaller “bones” under various cause categories. A fishbone diagram can be helpful in identifying possible causes for a problem that might not otherwise be considered by directing the team to look at the categories and think of alternative causes. Include team members who have personal knowledge of the processes and systems involved in the problem or event to be investigated.

Directions:

The team using the fishbone diagram tool should carry out the steps listed below.

- Agree on the problem statement (also referred to as the effect). This is written at the mouth of the “fish.” Be as clear and specific as you can about the problem. Beware of defining the problem in terms of a solution (e.g., we need more of something).
- Agree on the major categories of causes of the problem (written as branches from the main arrow). Major categories often include: equipment or supply factors, environmental factors, rules/policy/procedure factors, and people/staff factors.
- Brainstorm all the possible causes of the problem. Ask “Why does this happen?” As each idea is given, the facilitator writes the causal factor as a branch from the appropriate category (places it on the fishbone diagram). Causes can be written in several places if they relate to several categories.
- Again asks “Why does this happen?” about each cause. Write sub-causes branching off the cause branches.
- Continues to ask “Why?” and generate deeper levels of causes and continue organizing them under related causes or categories. This will help you to identify and then address root causes to prevent future problems.

Tips:

- Use the fishbone diagram tool to keep the team focused on the causes of the problem, rather than the symptoms.
- Consider drawing your fish on a flip chart or large dry erase board.
- Make sure to leave enough space between the major categories on the diagram so that you can add minor detailed causes later.
- When you are brainstorming causes, consider having team members write each cause on sticky notes, going around the group asking each person for one cause. Continue going through the rounds, getting more causes, until all ideas are exhausted.

- Encourage each person to participate in the brainstorming activity and to voice their own opinions.
- Note that the “five-whys” technique is often used in conjunction with the fishbone diagram – keep asking why until you get to the root cause.
- To help identify the root causes from all the ideas generated, consider a multi-voting technique such as having each team member identify the top three root causes. Ask each team member to place three tally marks or colored sticky dots on the fishbone next to what they believe are the root causes that could potentially be addressed.

Examples:

Here is an example of the start of a fishbone diagram that shows sample categories to consider, along with some sample causes.

Here is an example of a completed fishbone diagram, showing information entered for each of the four categories agreed upon by this team. Note, as each category is explored, teams may not always identify problems in each of the categories.

Facts gathered during preliminary investigation:

- Time of fall: change of shift from days to evenings
- Location of fall: resident’s bathroom
- Witnesses: resident and aide
- Background: the plan of care stipulated that the resident was to be transferred with two staff members, or with one staff member using a sit-to-stand lift.
- Information from interviews: the resident was anxious and needing to use the bathroom urgently. The aide was helping the resident transfer from her wheelchair to the toilet, without using a lift, and the resident fell, sustaining an injury. The aide stated she did not use the lift because the battery was being recharged, and there was no extra battery available. The aide stated she understood that the resident could be transferred with assist of one.

With this information, the team proceeded to use the fishbone diagram to better understand the causes of the event.

The value of using the fishbone diagram is to dig deeper, to go beyond the initial incident report, to better understand what in the organization’s systems and processes are causing the problem, so they can be addressed.

In this example, the root causes of the fall are:

- There is no process in place to ensure that every lift in the building always has a working battery. (One battery for the lift on this unit is no longer working, and the other battery was being recharged.)
- There is no process in place to ensure timely communication of new care information to the aides. (New transfer information had not yet been conveyed to the aide. The aide’s “care card” still indicated transfer with assist of one for this resident.)

The root causes of the event are the underlying process and system problems that allowed the contributing factors to culminate in a harmful event. As this example illustrates, there can be more than one root cause. Once you have identified root causes and contributing factors, you will then need to address each root cause and contributing factor as appropriate.

➤ **Root Causes are Identified**

➤ **Develop Action Plan for each Root Cause.**

➤ **Identify a Goal for each Root Cause.**

➤ **List the Steps needed to accomplish the Goal.**

➤ **What Resources are needed to complete the action steps?**

➤ **Who is Responsible for the Goal's steps?**

➤ **What is the anticipated Timeframe for completion?**

➤ **How will you Measure the effectiveness of the action steps?**

Planning is preparatory to action. Analytically at least, planning must be separated from implementation so that the major policy decisions can be taken and their implications understood prior to action

8 Steps to Develop a Plan for Action

1 Express your solution as a series of goals

Having agreed on a root cause to a particular problem within your organization, you first need to define that solution in terms of a goal. For example, each goal could be expressed as follows: "For us to, we would need to" Record each goal at the top of a whiteboard or sheet of paper

2 Generate a list of Actions for each goal

Use brainstorming to compile a list of actions to achieve a particular goal and record these below the goal. Arrange this list of suggested actions in sequential order. Include training and education, P&P changes, approvals.

3 Prepare a timeline

Beginning with a time point labeled "now" and ending with a point labeled "goal achieved", build a timeline on which you allocate dates by which you intend to complete each of the sequential actions listed under a particular goal. It is important that you get both sequence and timing right if you are to reach "goal achieved" effectively.

4 Allocate resources

Financial, physical and human resources must be allocated to each action step. If resources are limited, or fall short of requirements at any stage, it may be necessary to return to an earlier step and revise the action plan.

5 Identify possible problems

Consider all of the things that could go wrong in the process of achieving a particular goal. List these problems and identify causes and suitable actions to resolve them. If necessary, these actions might need to be added to appropriate slots in the timeline

6 Develop strategies for monitoring progress

List ways in which progress of the action plan can be monitored. These monitoring stages should also be included on the timeline.

7 Assign tasks

Take each point on the timeline in turn and ask : "Who will do what, by the date set, to bring about the specified action? Allocate these tasks to appropriate individuals or teams.

8 Implement the plan

Translate all your information to a clean copy, listing the actions required, the person responsible for a particular task, and when that task is to be completed. Having now finalized the plan for action in specific terms, this information can now be made available to all involved.

Corrective Action Plan

Root Cause:

Goal:

Potential Obstacles:

Action Steps	Required Resources	Projected timeframes	Responsible
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Corrective Action Plan

Root Cause:

Goal:

Potential Obstacles:

Action Steps	Required Resources	Projected timeframes	
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Executive Summary Report

<p>Brief incident description:</p> <p>Incident date:</p> <p>Incident type:</p> <p>Actual effect on patient and/or service:</p> <p>Actual severity of incident:</p>
<p>Level of investigation conducted</p>
<p>Involvement and support of the patient and/or relatives</p>
<p>Detection of the incident</p>
<p>Care and service delivery problems</p>
<p>Contributory factors</p>
<p>Root causes</p>

Lessons learned
Recommendations
Arrangements for sharing learning
Outcome of Measurement

Name Title Date

Root Cause Analysis Investigation Report

Incident Investigation Title:	
Incident Date:	

Incident Number:	
Author(s) and Job Titles	
Investigation Report Date:	

Executive Summary Report

Brief incident description:

Incident date:

Incident type:

Actual effect on patient and/or service:

Actual severity of incident:

Level of investigation conducted

Involvement and support of the patient and/or relatives

Detection of the incident

Care and service delivery problems

Contributory factors

Root causes

Lessons learned

Recommendations

Arrangements for sharing learning

Outcome of Measurement

Name

Title

Date

Sentinel Event Investigation

Purpose To identify the root causes and key learning from an incident and use this information to significantly reduce the likelihood of future harm to patients
Objectives <ul style="list-style-type: none">• To establish the facts i.e. what happened (<i>effect</i>), to whom, when, where, how and why (<i>root causes</i>)• To establish whether failings occurred in care or treatment• To look for improvements rather than to apportion blame• To establish how recurrence may be reduced or eliminated• To formulate <i>recommendations and an action plan</i>• To provide a <i>report and record</i> of the investigation process & outcome• To provide a means of <i>sharing learning</i> from the incident• To identify routes of <i>sharing learning</i> from the incident
Key questions/issues to be addressed <ul style="list-style-type: none">• ...specific to this incident or incident type
Key Deliverables <ul style="list-style-type: none">• Investigation• Report,• Action Plan,• Implementation of Actions
Scope (investigation start & end points)
Investigation type, process and methods used <ul style="list-style-type: none">• Single or Multi-incident investigation• Gathering information e.g. <i>Interviews</i>• Incident Mapping e.g. <i>Tabular timeline</i>• Identifying Care and service delivery problems e.g. <i>Change analysis</i>• Identifying contributory factors & root causes e.g. <i>Fishbone diagrams</i>• Generating solutions e.g. <i>Barrier analysis</i>
Arrangements for communication, monitoring, evaluation and action
Investigation team Names, Roles, Qualifications, Departments
Resources
Involvement of other organizations
Stakeholders/audience
Investigation timescales/schedule

Level of investigation

Add text here

Involvement and support of patient and relatives

Add text here

Involvement and support provided for staff involved

Add text here

Information and evidence gathered

Add text here

CONCLUSIONS:

Recommendations

Add text here

Arrangements for Shared Learning

Add text here

Distribution List

Add text here

Appendices

Add text here

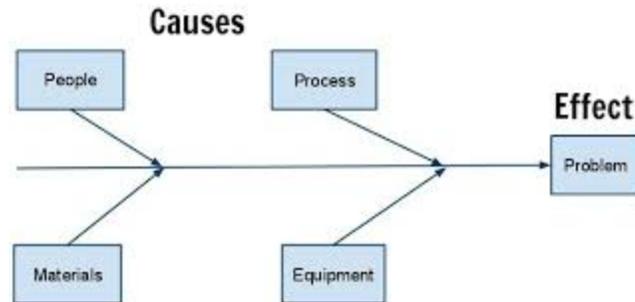
Data Collection

Measure of Success Indicators	How data collected	By Whom	Timeframe	Follow up

APPENDIX H

FISHBONE DIAGRAM

The Cause and Effect Diagram is used to explore all real, possible and potential causes of the single effect/outcome you are now experiencing.



Creating a cause and effect diagram is fun and educational. These diagrams are usually constructed as a team or group activity to get ideas from as many people as possible. As a result of everyone working on the diagram together, everyone tends to gain some new knowledge. Cause and effect diagrams encourage new ideas about causes of problems by helping the group think about different categories of causes. The cause and effect diagram also indicates how much we know about our process. If the diagram is full, we know a lot about our process. If it is sketchy, chances are we don't have a good understanding of our process. Cause and effect diagrams should be living documents. That is, we should actively seek causes of problems and add to the diagram as time goes on.

A cause and effect diagram is a tool that shows the relationship between an effect and possible sources of variation for this effect (causes). As shown in the figure the effect could be a problem that needs to be solved. The causes of the problem would then be listed on the cause and effect diagram. The effect could also be a goal. In this case, what needs to be done to reach the goal would be listed on the cause and effect diagram.

The causes are most commonly categorized as machines, methods, environment, materials, measurement, and people (the 4 M's, a P and an E). This is particularly true for manufacturing applications. You can pick your own categories. See above for 4 categories that may be used in healthcare. (People, Process, Materials, Equipment)

Cause and effect diagrams are also called fishbone diagrams (because of their appearance) and Ishikawa diagrams (because of their developer). Cause and effect diagrams can be used for any problem in any area

The cause and effect diagram is one of many root cause analysis tools. Root cause analysis should be thorough enough to "root" out the deep and hidden causes that are often missed with quick fixes to problems. It provides a method of taking all the jumbled-up ideas we have and arranging them so we can use a systematic approach to improvement.

How to Construct a Fishbone Diagram

1. Pinpoint the problem you want to fix or the goal you want to reach.
2. Write the problem or goal (effect) on the right hand side of a large sheet of paper taped to the wall and draw a horizontal line to the left.
3. Select the categories for the causes of the problem or for what needs to be done to reach the goal. These categories will be the main factors of the cause and effect diagram. Each main factor forms a branch off the horizontal line.
4. Brainstorm detailed causes for each main factor. These detailed causes are written on branches off those of the main factors. Use the brainstorming rules shown below to maximize the number of causes your group develops.
 - Go for quantity of ideas.
 - Everyone participates.
 - Encourage creativity.
 - Don't discuss/criticize/evaluate ideas.
 - Build off other ideas.
 - Pass if you don't have an idea to contribute.
5. Always try to branch further by continuously asking, "What causes variation in this branch?" In this way, you can add to the cause and effect diagram until it fully shows all the possible causes of variation.

A summary of the general rules for constructing a cause and effect diagram is given below.

1. Get everyone to participate.
2. Don't forget that this is a brainstorming session; brainstorming rules apply.
3. Give ideas one at a time to encourage creative ideas.
4. Have the person giving the idea tell which "bone" of the fish the idea goes on. For example, say "My idea is the truck tire pressure. That goes on the Materials bone."
5. Allow any idea to go on more than one bone. Allow other team members to use the same idea on multiple bones.

6. Never analyze or criticize suggestions while creating the fishbone. This includes nonverbal criticism such as shaking your head or drawing back from the group.
7. Piggyback one suggestion into another, let ideas suggest other ideas.
8. Use the major bones to help you come up with ideas. For example, think to yourself, "How could our methods or procedures cause this problem?"
9. Ask yourself for each idea that has already been given, "Why does that happen? How does that happen?" to develop branches or "smaller bones" off each major bone.
10. Be open and honest. Have the courage to give the idea that everyone is thinking about, but doesn't want to state.
11. Never use the suggestion that someone came up with in a fishbone session against the person outside the meeting. For example, never leave the meeting saying, "You'll never guess what Sam thought the problem was...He thinks that it's all Harvey's fault!"

Appendix I

LINK TO SENTINEL EVENT REGISTRY TOOLKIT.
Use Control /enter while holding cursor over title
below.

Access to the complete manual for using the
registry and Redcap.

[The Sentinel Event Registry Toolkit](#)

 North Vista Hospital			Page(s):	10
			Saved As:	Patent Safety Plan 2018
Subject:	PATIENT SAFETY PLAN 2018		Formulated:	2009
Manual:	ADMINISTRATIVE MANUAL		Reviewed:	02/18
GOVERNING BOARD APPROVAL		Date:	Revised:	02/18

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
- 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. 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 and summarized in the Patient Safety Dashboard. These reports will be reported to appropriate hospital and Medical Staff committees and to the Governing Board. The aggregate data will be used to prioritize organization-wide patient safety efforts.
- 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: <ul style="list-style-type: none"> ▪ Diagnostic errors (misdiagnoses leading to an incorrect choice of therapy or treatment, failure to use an indicated diagnostic test, misinterpretation of test results, failure to properly act on abnormal test results) ▪ Equipment failures (defibrillator without working batteries, or inadvertent dosing of medications in a short time frame due to IV pumps with valves that are easily dislodged) ▪ Infections (HAI, post-op wound infections) ▪ Blood transfusion-related injuries ▪ Deaths due to seclusion / restraint use
Medical Accident, “near miss”	Any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome. May include a clinical event.
Sentinel Event	An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase “or the risk thereof” includes any process variation for which a recurrence would be a significant chance of serious adverse outcome.
Root Cause Analysis	A process for identifying the basic or causal factor(s) that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event.
Intensified Analysis	An examination of factors or elements that contribute to undesirable trends in performance to determine where best to focus changes for improvement.

Adverse Drug Event	A patient injury resulting from a medication, either because of a pharmacological reaction to a normal dose or because of a preventable adverse reaction to a drug resulting from an error.
Medication Error	Any preventable event that may cause or lead to inappropriate medication use or patient harm.
Hazardous condition	Any set of circumstances (exclusive of the disease or condition for which the patient is being treated) which significantly increased the likelihood of a serious adverse event.

V. AUTHORITY/ROLES & 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.

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 leader who can operationalize this plan such as the Patient Safety Officer who may be supported by the Director/Manager, Performance Improvement.

Director/Manager, Performance Improvement, Patient Safety Officer and Infection Control Officer

The Patient Safety Officer is the Risk Manager at North Vista Hospital. The Patient Safety Officer is responsible for the day to day implementation and evaluation of the processes and activities noted in this program. The Patient Safety Officer will work collaboratively with the Director/Manager of Performance Improvement and the Infection Control Officer in establishing the Patient Safety framework and a culture of patient safety. The leadership including Senior Administration and the Chief of Staff will provide support as needed to assure the Patient Safety Plan is fully implemented and effective in positively impacting patient safety issues.

Patient Safety Officer Duties Include (As indicated in [NRS 839.870](#)):

1. Serve on the Patient Safety Committee (Chair of the Committee)
2. Supervise the reporting of all sentinel events alleged to have occurred at the medical facility, including, without limitation, performing duties required pursuant to [NRS 439.835](#).
3. Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the medical facility.
4. Report to the patient safety committee regarding any action taken in accordance with number 3.

Other 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 12-18 months. Coordinates the process throughout this period.
3. Presents Patient Safety reports to all departments.
4. Develops, and recommends new policies and procedures for patient safety based on analysis of data from events, and other relevant information.
5. 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.
6. Maintains the confidentiality and legal privilege, as appropriate, of all data and information.
7. Facilitates patient safety orientation and in-service education programs.
8. Measures and evaluates effectiveness of the patient safety program using the established goals and prepares an annual report for the Governing Board, which includes events related to staffing complement.
9. 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 Patient Care and Services”.)

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. (Medical staff defined as those physicians who have been granted recognition as members of the medical staff pursuant to the terms of the Medical Staff Bylaws.)

Quality/Utilization Management Committee

Quality/Utilization Management Committee is assigned to oversee Patient Safety Committee at North Vista Hospital. Duties include:

1. Review Patient Safety Dashboard for trends, performance and improvement and make recommendations where necessary.
2. Review, provide input and recommend approval of Patient Safety Plans & evaluations where necessary.
3. Review all sentinel event / root cause analyses and intensified analyses if/as requested by Patient Safety Committee.
4. Review risk assessments and FMEA and make recommendations where necessary.

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 (Risk Manager) 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 Responsibilities (based on [NRS 439.875](#) and [NRS 439.877](#)):

1. Monitor and document the effectiveness of the patient identification policy.
2. On or before July 1st of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
3. Receive reports from the patient safety officer pursuant to [NRS 439.870](#).
4. 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.
5. At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the executive or governing body of the facility regarding:
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 patient safety committee determines necessary.

- a. The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter).
- b. The number and severity of infections that occurred at the facility during the preceding calendar month or quarter.
- c. Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.

7. Provide regular reports to the Quality/Utilization Management Committee.
8. Implement and monitors the National Patient Safety Goals compliance within the facility.

VI. OBJECTIVES AND GOALS FOR THE PATIENT SAFETY PLAN

Goal 1 – Improve the following 3 Patient Safety Culture Domains:

- Nonpunitive Response to Errors-2018 Goal: 20% (scored 14% in 2017)
- Communication Openness-2018 Goal: 55% (scored 47% in 2017)
- Handoffs & Transitions-2018 Goal: 21% (scored 16% in 2017)

Goal 2 – Reduce the number of patient falls in 2018 from 2017 (119)

- Hospital Wide Performance Improvement Indicator (Risk Manager is lead) as listed in the Performance Improvement Plan

Goal 3 – Reduce number of hospital acquired conditions (HACs) in 2018 from 2017

- 7 CAUTIs, 19 C. Diff, 2 SSI's

VII. COMPONENTS AND METHODOLOGY

Pursuant to [NRS 439.837](#), a medical facility shall, upon reporting a sentinel event pursuant to [NRS 439.835](#), conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event.”

North Vista will use RCA process to determine the contributing factors and the underlying reasons for the deficiencies or failures. The FOCUS Plan-Do-Check-Act (PDCA) is the model which North Vista Hospital will use to test the changes.

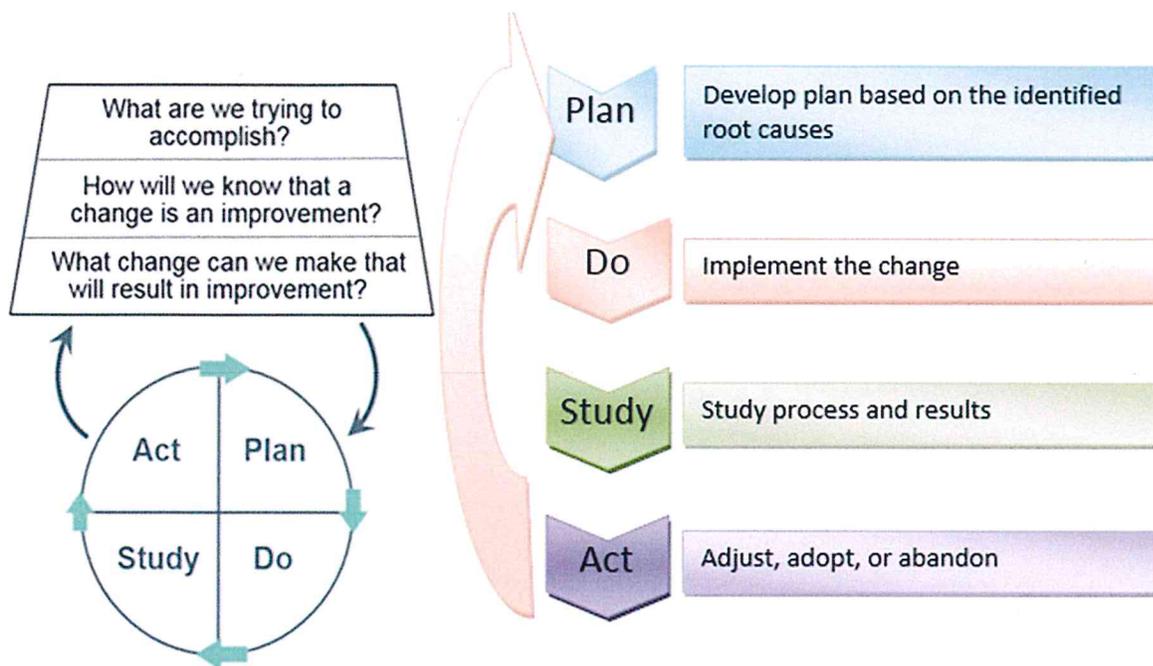


Root Cause Analysis

A Root Cause Analysis (RCA) is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals. Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis. The attached forms in Attachment I will be utilized to conduct RCAs.

Model for Improvement

The Model for Improvement is a collaborative and ongoing effort model to improve the product and services quality and process. It provides multi-disciplinary quality team guidance from identifying the root causes; conducting the best tests to assess possible changes, and working in collaboration for implementation of the new approaches and solutions. It guides the test of a change to determine if the change is an improvement.



This methodology will be accomplished utilizing the RCA forms attached in Attachment I. This methodology is also utilized in the Performance Improvement Plan to select Performance Improvement Indicators for each department.

VIII. DATA COLLECTION AND RISK ASSESSMENT

In order to reduce the likelihood of patient incidents and negative outcomes, North Vista Hospital will track the frequency and type of patient safety issues and compile them in order to learn from and prevent future negative occurrences. Examples of how the hospital collects and analyzes data is listed below.

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 procedures
- Departmental indicators
- Employee surveys (includes perception of risk)

2. External

- 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; assesses actual and potential risk, failure, points of vulnerability; and through a logical process, priorities areas for improvement based on the actual or potential patient care impact (criticality).

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. FOCUS PDCA (Plan, Do, Check, Act) methodology for Performance Improvement will be utilized for all performance improvement activities within the facility. This methodology will not be used when conducting RCAs

IX. PATIENT SAFETY CHECKLISTS & PATIENT SAFETY POLICIES

By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

The patient safety checklists must follow protocols to improve the health outcomes of patients at the medical facility and must include, without limitation:

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.
- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - Proper instructions concerning prescription medications;
 - Instructions concerning aftercare;
 - Any other instructions concerning his or her care upon discharge; and
 - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include, the name and date of birth of the patient.
- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.
- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a

system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

X. CULTURE OF SAFETY SURVEY

North Vista Hospital will utilize the Agency of Healthcare and Research Quality (AHRQ) research survey that is intended to measure the ten dimensions of culture pertaining to patient safety:

1. 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 North Vista Hospital.

XI. CONFIDENTIALITY

The proceedings and records of a patient safety committee are subject to the same privilege and protection from discovery as the proceedings and records described in [NRS 49.265](#)

XII. PLAN EVALUATION

According to [NRS.439.865](#), a medical facility shall submit its patient safety plan to the governing board of the facility for approval. After a facility's patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan. The patient safety plan must be reviewed and updated annually in accordance with the requirements set forth in this section. According to NRS 439.843, on or before March 1st of each year, a copy of the most current patient safety plan (developed according to [NRS 439.865](#)) must be submitted to the Division of Public and behavioral Health.

- 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 quality management system for North Vista Hospital.
- B. The Patient Safety Plan should be considered a "working" document and an interim product to facilitate the development of a "culture of safety". As such, the plan may be modified as the implementation of the patient safety standards takes place and sections of the plan are incorporated into existing plans, policies, procedures and protocols.
- 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, sentinel events, State and Federal regulations, and other applicable patient safety issues and initiatives.

REFERENCES:

- Performance Improvement Plan
- Infection Prevention and Control Plan
- Environment of Care Plan
- Plan for Provision and Patient Care Services
- Title 40 – Public Health and Safety <https://www.leg.state.nv.us/NRS/NRS-439.html>

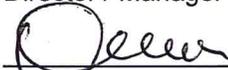
Approvals



Director / Manager Performance Improvement

2/9/2018

Date



Chief Nursing Officer / Administrator

2/9/18

Date



Chief Executive Officer

2/9/18

Date



Chairman, PI Committee

2/21/18

Date

Chief of Staff

Date

Governing Board

Date

DETERMINATION OF SEVERITY

Hospital Name:	Date Identified:
-----------------------	-------------------------

When Did the Event Occur?		
Date:	Day of the week:	Time:
Diagnosis:		

What Type of Incident is this? (See below for definitions)		
<input type="checkbox"/> Error	<input type="checkbox"/> Near Miss / Hazardous Condition	<input type="checkbox"/> Sentinel Event
Explain Error Type (based on definitions below):		

Identified How/Reported by Whom:	Staff Witnesses:

Who were the direct/indirect caregivers involved in the event? (use no personal identifiers, job titles only)

Brief Description (No names or other individual identifiers):

Definitions:

Error:

An unintended act, either of omission or commission, or an act that does not achieve its intended outcome.

Sentinel Event:

An unexpected occurrence involving death or serious physical or psychological injury or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.

Near Miss:

Used to describe any process variation that did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome. Such a near miss falls within the scope of the definition of sentinel event, but outside the scope of those sentinel events that are subject to review by the Joint Commission under its sentinel event policy. Refer to the Sentinel Event Policy for JCAHO reviewable events.

Hazardous Condition:

Any set of circumstances (exclusive of the disease or condition for which the patient is being treated), which significantly increases the likelihood of a serious adverse outcome.

ORGANIZATION OF THE TEAM

Team Leader:	Team Meeting Date:
	Date RCA / IA Completed:

Team Members:	Job Title:

Documents/Policies Gathered (include Timeline, Flowchart, etc.):	

UNDERSTAND THE CURRENT PROCESS
<p>What was intended to happen, normally occur? (steps as defined by the policy, procedure)</p>
<p>What went wrong? (Easily identifiable, proximal causes) (Were there any steps in the process that did not occur as intended?)</p>

ROOT CAUSE ANALYSIS

(Checkoff the appropriate sections. This is the ANALYSIS section where you document the drill down of the event. Remove items rows not applicable)

Process	Analysis
<input type="checkbox"/> Behavioral Assessment Process: Was patient’s mood/ behavior approp assessed upon admission? Were potential mood/behavior problems identified approp/subsequently monitored? Were referrals made to physicians, Social Work, or Behavioral Health? Are current asmt. tools approp. measurement of mood/behavior?	
<input type="checkbox"/> Physical Assessment Process: Was patient approp. assessed upon admission or prior to their procedure? Was the patient approp. re-assessed throughout their stay? Were assessments done timely and according to policy? If conditions identified, did staff act approp. follow up, referrals, etc.?	
<input type="checkbox"/> Patient Identification Process: Was the patient approp. identified by an ID band or by other means? Are there deficits in the patient identification process that permitted the error to occur? Did the patient have approp. patient identifiers in place (i.e. ID bands, chart labels, etc.)?	
<input type="checkbox"/> Patient Observation Procedures: Was the patient approp. observed/monitored during their stay/procedure? Were conditions present that warranted increased observation/monitoring that were not identified by staff?	
<input type="checkbox"/> Care Planning Process: Was the patient’s care planned approp.? Did the patient have a completed History and Physical? Was care deemed to be appropriate as planned? Was the outcome a complication despite appropriate care planning?	
<input type="checkbox"/> Continuum of Care: Was the outcome affected by a breakdown in the continuum of care? Was there a failure to provide adequate information/services from a prior caregiver or other discipline that contributed to the event? Were the appropriate referrals made according to the patient’s assessment? Were the appropriate referrals completed?	
<input type="checkbox"/> Staffing Levels: Are staffing levels high enough to meet demand; limitations overtime? Agency/float staff in use? Are staff members approp. matched to assignments? How many continuous hours had the staff/physician involved been working?	
<input type="checkbox"/> Orientation and Training Of Staff: Is ongoing training available regarding the process involved in the event? Are employees oriented to the process involved in the incident? Are staff members aware of reference resources? If event involved a contingent or agency staff member, was orientation and training sufficient for the delivery of patient care?	
<input type="checkbox"/> Competency Assessment/Credentialing: Have staff completed orientation and training on the process involved? Is assessment of employee performance of this procedure part of the employee review process? When was last competency assessment completed? Need to repeat them? What the process involved a “core ability” of the staff member, if so, should competencies be considered? Include omissions in critical thinking and/or performance variance(s) from defined policy, procedure, protocol and guidelines in effect at time.	

<input type="checkbox"/> Supervision of Staff: Are supervisors readily available to both experienced and new staff? Are performance standards made clear? Are staff members observed in the performance of their daily work? Would direct supervision have resulted in a better outcome in this process?	
<input type="checkbox"/> Communication with Patient/Family: Was communication with the patient hindered in any fashion (i.e. a comatose or demented patient)? Was the family or significant other present to assist with the assessment process? Is the patient a reliable historian?	
Process	Analysis
<input type="checkbox"/> Communication Among Staff Members: Are instructions clear and precise: evaluation of verbal, written, electronic communication or the lack thereof? Timing factor? Handoff? Are human interactions free of intimidation and embarrassment? Was key information communicated from one caregiver to another as appropriate? Were appropriate referrals made?	
<input type="checkbox"/> Availability of Information: To what degree was all the necessary information available when needed? Accurate? Complete? Unambiguous? Does historical information include all pertinent information needed to facilitate care of the patient? Was the sharing of necessary information hindered due to technological reasons?	
<input type="checkbox"/> Adequacy of Technological Support: Did automation actually contribute to this event? Is the right equipment used for the task at hand? Is the equipment up-to-date? Are resources available to answer the operator's questions about the equipment? Does equipment design play a role in causing problems?	
<input type="checkbox"/> Equipment Maintenance/Management: Is machinery/equipment working properly? Are service guidelines being followed? Is backup equipment on hand? Biomed checks done?	
<input type="checkbox"/> Physical Environment: Current environment meets code? Do noise levels make it difficult for staff to communicate? Was there an environmental risk involved in the event that was not previously identified? Was location a factor in causing the event? Was the facility on any special status at the time (e.g. fire drill, Code Blue, etc.)? Lighting issues?	
<input type="checkbox"/> Security Systems and Processes: Were medications/equipment/supplies needed for the delivery of care secured properly? Were medications/equipment/supplies needed for the delivery of care able to be obtained. Was the safety and security of the patient/staff adequate? Were there deficits or breaches in security that contributed to the event?	
<input type="checkbox"/> Control of Medications - Storage/Access: Are medications stored properly? For example, are dangerous drugs stored away from patient-care units? Is storage set up to eliminate confusion? Is access to medications limited to the appropriate personnel?	
<input type="checkbox"/> Labeling of Medications: Are labels clear and legible? Do similarities in packaging cause confusion? Are labels read at least three times – when picking the medication, preparing the dose, and prior to administration?	

ADDITIONAL QUESTIONS

What uncontrollable external factors influenced this outcome? (Identify any factors the organization cannot change that contributed to a breakdown in the internal process, for example natural disasters).

Were there any other factors that directly influenced this outcome? (List any other factors not yet discussed).

What are the other areas in the organization where this could happen? (Ensure planned actions include addition areas as needed).

What barriers were in place but failed to stop the undesirable outcome? What barriers SHOULD have been place but were not to prevent the undesirable outcome?

What uncontrollable, outside factors directly affected the result?

What human factors were relevant to the outcome? (examples: fatigues, personal problems, in-attentional blindness/confirmation bias, substance abuse)

Summary	YES	NO
1. Was the event caused by an inappropriate action?		
2. Do policies/procedures exist for the activities/tasks involved?		
3. Do the policies/procedures related to the tasks have sufficient detail?		
4. Do the policies/procedures have sufficient fail-safe mechanisms?		
5. Do the policies/procedures cover tasks in proper sequence?		
6. Did the time of day have an effect on the event?		
7. Did the event occur at shift change?		

What other pertinent issues were identified not already addressed in the minimum scope of investigation as listed above?

CONCLUSIONS

Pertinent Conclusions	
Proximal Cause (s)	
Systemic Deficiencies	

Improvement Opportunities identified: (add rows as needed)

# 1.	
# 2.	
# 3.	
# 4.	
# 5.	

ACTION PLAN

*Method Key: (A) Policy (B) Education (C) Audit (D) Observation (add rows as needed)

#	Action Plan/Risk Reduction Strategies— Prevent Reoccurrence	*Method				Responsible Party	Target Date
		(A)	(B)	(C)	(D)		
1							
2							
3							
4							

Bibliography: Cite all books and journal articles that were considered in developing this root cause analysis and action plan.

DO NOT WRITE BELOW THIS POINT – RISK MANAGEMENT USE ONLY

Was the analysis completed within forty-five (45) days after determining that the occurrence is a sentinel event?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	If NO, Explain:	
------------------------------	-----------------------------	-----------------	--

Should this analysis be voluntarily reported to DNV?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain:	
------------------------------	-----------------------------	----------	--

Action	Date

Date discussed in Performance Improvement / Quality Council:

--

Performance Improvement Review:

--

Medical Staff Review:

--

Legal Services Review:

--

Final Disposition:

	Date:
--	-------

ATTACHMENT II

Minimum Scope of Root Cause Analysis for Specific Types of Sentinel Events

Detailed inquiry into these areas is expected when conducting a root cause analysis for the specified type of sentinel event. Inquiry into areas not checked (or listed) should be conducted as appropriate to the specific event under review.

ANALYSIS AREAS	EVENT TYPE									
	Suicide (24 hr care)	Med. Error	Proced. Cmplic.	Wrong site surg.	Treatmt Delay	Restraint Death	Elopement Death	Assault/ Rape/hom.	Transfusun Death	Infant abduction
Behavioral assessment process*	X					X	X	X		
Physical assessment process	X		X	X	X	X	X			
Patient identification process		X		X					X	
Patient observation procedures	X					X	X	X	X	
Care planning procedures	X		X			X	X			
Continuum of care	X				X	X				
Staffing levels	X	X	X	X	X	X	X	X	X	X
Orientation and training of staff	X	X	X	X	X	X	X	X	X	X
Competency assessment/ credentialing	X	X	X		X	X	X	X	X	X
Supervision of staff		X	X		X	X			X	
Communication with patient/family	X			X	X	X	X			X
Communication among staff members	X	X	X	X	X	X			X	X
Availability of information	X	X	X	X	X	X			X	
Adequacy of technological support		X	X							
Equipment maintenance/ management		X	X			X				
Physical environment	X	X	X				X	X	X	X
Security systems and processes	X						X	X		X
Control of medications: storage/access		X							X	
Labeling of medications		X							X	

MONTEVISTA

Title: SAFETY PLAN	Policy Number: 800.102
Function: EOC	Approved: 10/17 Revised: 01/18
Manual: ENVIRONMENT OF CARE	Page(s): 13
Developed By: SAFETY COMMITTEE	Attachment(s): N/A

I. Objective and Scope

It will be the policy of Montevista Hospital (MH) to provide a work environment safe for the guest and employees and make every effort to prevent accidents.

II. Risk Assessment

It will be the practice of MH to perform safety risk assessments per policy 800.114.

III. Staff Development

MH will train staff to recognize and keep a safe environment. This will be accomplished through initial orientation safety topics, rounding that identifies safety issues, meetings, and policy familiarization.

IV. Emergency Response and Procedures

MH will have standards that guide safe action during related events such as the emergency preparedness manual.

V. Inspection, Testing, and Maintenance

Proper care of the MH facilities will occur on an ongoing basis through TELS PM and work order systems.

VI. Information Collection and Evaluation

MH records about safety practices and events will be used to improve safety.

VII. Performance Monitoring

MH tracks compliance with safety practices and policies.

VIII. Annual Evaluation

MH reviews its safety plan, policies and procedures.

POLICY:

Montevista Hospital will have an active safety plan to outline operation processes designed to manage staff activities which will reduce health care errors, the risk of human injury, and provide a safe physical environment for patients, personnel and visitors.

DEFINITIONS:

1. Error - an unintentional act either of omission or commission, or an act which does not achieve its intended outcome.
2. Sentinel Event - The sentinel event applies to events which meet the following criteria:
 - The event has resulted in an unanticipated death or major permanent loss of function¹, not related to the natural course of the patient's illness or underlying condition, (note: a distinction is made between an adverse outcome related to the natural course of the patient's illness or underlying condition [not a sentinel event] and a death or major permanent loss of function associated with the treatment, or lack of treatment, of that condition), or,
 - The event is one of the following (even if the outcome was not death or permanent loss of function):
 - Suicide of a patient in a setting where the patient receives around-the-clock care (e.g., hospital, residential treatment center, crisis stabilization center), or
 - Infant abduction or discharge to the wrong family, or
 - Rape, the determination of which is to be based on the hospital's definition consistent with applicable law and regulation. An allegation of rape shall be investigated and the root cause analysis initiated when the determination is made a rape has occurred, or
 - Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities, or

¹ A major permanent loss of function means sensory, motor, physiological, or intellectual impairment not present or admission requiring continued treatment or life-style change. When major permanent loss of function cannot be immediately determined, root cause analysis may not be initiated until either the patient is discharged with continued major loss of function, or two weeks have elapsed with persistent major loss of function, whichever occurs first.

Root Cause Analysis (RCA): An evaluation process structured to attempt to determine underlying causes of the sentinel event and whether there is a reasonable potential for process improvement to reduce the likelihood of such events in the future. The following are characteristics of a root cause analysis:

- Focus primarily on systems and processes, not individual performance;
- Progression from special causes in clinical processes to common causes in organizational processes;
- The use of "Why?" repeatedly as each reason is determined; and

- Identification of changes, if any, should be made in systems and processes, either through redesign or development of new systems or processes, which would reduce the risk of recurrence of that sentinel event.
3. Critical Event - Critical event applies to events which meet the following criteria: The event results in or has the potential to cause serious harm or death (even if the outcome was not serious harm or death):
- Suicide of any patient other than an inpatient or who has been discharged from the facility's inpatient, partial hospitalization, outpatient or other service program within 30 days prior to the suicide, or
 - Attempted suicide of any patient (does not result in a major loss of permanent function), or
 - Any actual or alleged inappropriate sexual contact between staff and current patients or individuals who are patients within two years from discharge, (to include inappropriate verbal or written communication and/or inappropriate physical contact), or
 - Sexual contact between patients involving any touching of genitalia, or
 - Patient elopement, or
 - Staff/patient or patient/patient aggression resulting in injury to the patient, or
 - Medication error resulting in injury to the patient, or
 - Significant adverse drug reaction, including incidents where the correct drug and dosage were administered, yet the patient suffered a major reaction which may have precipitated a medical emergency, or
 - Falls with significant injury, or
 - Any other Class I Incident.

Critical Event Analysis: An evaluative process structure to attempt to determine underlying causes of the critical event and whether there is a reasonable potential for process improvement to reduce the likelihood of such events in the future. The following are characteristics of a critical event analysis:

- Focus primarily on systems and processes, not individual performance;
 - Progression from special causes in clinical processes to common causes in organizational processes;
 - The use of "Why?" repeatedly as each reason is determined; and identification of changes, if any, should be made in systems and processes, either through redesign or development of new systems or processes, would reduce the risk of recurrence of that critical event.
4. Near Miss - use to describe any process variation which did not affect the outcome but for which a recurrence carries a significant chance of a serious adverse outcome. Such a near miss falls within the scope of the definition of a sentinel event but outside the scope of those sentinel events which are subject to review by the Joint Commission on Accreditation of Healthcare Organizations under its Sentinel Event Policy.
5. Hazardous Condition - any set of circumstances (exclusive of the disease or condition for which the patient is being treated) which significantly increases the likelihood of serious adverse outcome.

6. Medication Variance – any preventable event may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, or patient. Such events may be related to professional practice, pharmaceutical products, procedures, & systems, including prescribing; order communication; product labeling; packaging and nomenclature; dispensing; distribution; administration; education; monitoring; and use.
7. Adverse Drug Reactions (ADR): any undesired, unintended, excessive or exaggerated effect of a drug administered to a patient within the facility due to either the drug itself or patient idiosyncrasy (excluding gross overdose and therapeutic failure). These reactions may be expected or unexpected.

SAFETY PLAN PHILOSOPHY:

The focus of this plan is to identify and reduce risks to patient safety and employee safety. The hospital environment is one, which values the highest standards of quality and ethics integrity. Open communication and safety reporting is encouraged and a nonpunitive philosophy presides, focusing on systems and processes rather than individual blame. Individuals involved in a risk event (staff, visitor, patient, family) will be offered an opportunity to process/express feelings in a safe and therapeutic environment.

All departments/personnel are responsible to contribute to data collection, resolution of problems and continued monitoring using the PDCA PI model of safety issues. An interdisciplinary process (formal and informal) is encouraged to enhance positive outcomes. A competent work force is paramount in maintaining a safe practice; therefore every department will develop an employee competency program which is reviewed by Human Resources.

SCOPE:

The Safety Plan includes all buildings and facilities operated by Montevista Hospital and apply to all employees, physicians, and other independent practitioners, patients and visitors. It also applies to all activities conducted by staff members off site while conducting activities required by their position at the Hospital.

The scope of the Plan entails the following operational components: safety policies and procedures, safety education and training, hazard surveillance (including product recall), employee incident reports, security program, hazardous materials and waste Plan, emergency preparedness program, quality improvement program, risk Plan, life safety Plan, medical equipment Plan, utilities Plan and medical/health care errors/factors which contribute to unanticipated patient outcomes.

GOALS:

The Safety Plan functions to create a culture of safety by maintaining a safe environment for patients, personnel, and visitors through compliance with regulations, procedures, and standards set forth by OSHA, The Joint Commission, CMS, HIPAA, National Fire Code, the City of Las Vegas Fire Marshall's office and Standard Building Codes, Clark County, as well any Professional Discipline Regulatory Agencies.

Short-term objectives of the Safety Plan will be identified annually by the Safety Committee. These will be based on annual evaluation results of the Safety Plan and unresolved safety issues.

OBJECTIVES:

The objectives of the Plan are to:

- Establish and implement operational processes which guide, monitor and/or evaluate safety management practices.
- Identify the organizational components responsible for safety management functions at Montevista Hospital and delineate the relationship among these components including lines of authority, responsibility and accountability.
- Identify and resolve safety management issues which result in environmental hazards and unsafe practices with special attention to hazards related to the ages of the patients served.
- Evaluate results of actions taken by individual departments to meet safety recommendations.
- Provide at least monthly reports of safety management activities to Quality Council, Administration, and department heads, including the CEO.
- Provide effective process for supervising all grounds and equipment.
- Provide processes for conducting risk assessments that evaluate the buildings, grounds, equipment, occupants, and other physical systems on patient and public safety.
- Provide processes for reporting and investigating all incidents or abnormal occurrences which involve the building, patients, staff, and visitors.

RESPONSIBILITY AND AUTHORITY:

Chief Executive Officer: The Chief Executive Officer (CEO) has the responsibility, authority, and accountability for requiring, supporting the establishment and maintenance of an effective hospital-wide Safety Plan. The CEO has the responsibility to provide necessary staffing and equipment for the Safety Plan; and require hospital staff participation by all departments. The CEO has authorized the Safety Officer the responsibility for development, implementation, and monitoring of the Safety Plan. The CEO and Medical Director through the Medical Executive Committee authorize the Safety Officer to intervene whenever conditions exist that pose a threat of damage to equipment or building.

Quality Council: The Quality Council monitors the effectiveness of the Safety Plan and is authorized to designate resources and priority levels to the Safety Committee's recommendations. The Quality Council approves the annual Safety Plan.

Safety Committee: The Safety Committee is a standing committee designed to analyze identified safety management issues and to develop recommendations for resolving them. The Safety Committee is responsible for:

- The Safety Committee will meet every month with an agenda and minutes completed for each meeting.
- The Chairman of the Safety Committee will be appointed by the Chief Executive Officer.
- Review and revision of the Safety Plan policies and procedures for accuracy, completeness, and proper implementation.
- Monitoring system user training programs and directing changes as appropriate.
- Monitoring safety systems and processes as it relates to the overall quality of the patient care environment.
- Developing and monitoring Performance Standards for the Safety Plan.
- The Committee will receive on a regular basis summary reports from the following areas:
 - 1) Patient and visitor variances
 - 2) Personnel injuries and occupational illness incidents
 - 3) Personnel and visitor security incidents and property damage
 - 4) Medical equipment and utility management disruptions
 - 5) Hazard surveillance, product recall, fire safety, and all safety and security investigations
 - 6) Fire drill and emergency preparedness evaluation data
 - 7) Life Safety (to include all aspects of fire devices, i.e., sprinkling system, fire Extinguishing systems, etc.)
 - 8) Performance Improvement results of monitoring and evaluation activities related to Hazards and safety practices
 - 9) Risk Management issues related to hazards and safety practices
 - 10) Infection Control activities related to hazards and safety practices

The SAFETY Committee will make recommendations to analyze identified safety management issues and to develop and approve recommendation for solving them and to monitor the effectiveness of the changes to see if correction/improvement occurs.

The SAFETY Committee will receive results of the annual evaluation of the Safety Plan and revise as necessary and forward the plan to Quality Council.

Safety Officer: The Safety Officer has the responsibility to manage an ongoing hospital-wide process to collect and evaluate information about hazards and safety practices used to identify safety management issues to be addressed by the SAFETY Committee. The Safety Officer will:

- Report monthly to the SAFETY Committee on findings, recommendations, actions and monitoring conducted by the Safety Department. This includes but is not limited to hazard surveillance, product recall, fire safety, incident investigation.

- Participate in hazard surveillance, product recall and incident reporting on a regular basis.
- Participate in the development of departmental and organization-wide safety policies and procedures.
- Participate in Safety education orientation program for new employees and in continuing education for all employees.
- Be a member of the SAFETY Committee and Quality Council.
- Work with appropriate staff to implement SAFETY Committee recommendations and to monitor effectiveness of the changes.
- Prepare monthly reports of safety management issues and summaries of SAFETY Committee activities for communication and distribution to Quality Council and designated hospital personnel.
- The Safety Officer will work with the SAFETY Committee and Quality Council to develop and monitor Performance Standards for the Safety Plan.

Compliance Director: The Performance Improvement (PI) Director is responsible for the planning, implementation, monitoring and evaluation of Performance Improvement clinical activities including safety and risk events as well as proactive safety improvements and risk reduction strategies. The PI Director serves as a resource for regulatory compliance and risk management consultation. The PI Director works collaboratively with the Safety Officer to establish a Safety Plan and monitor the effectiveness of the plan. (Refer to PI and Risk Management sections)

Department Heads: Department Heads are responsible for establishing departmental safety programs. Safety precautions applicable to the department will be written form either collectively or inclusive in the various job functions. Each department head is responsible for employee safety awareness/education; monitoring or compliance to safety related policies and procedures; corrections of safety deficiencies and proper reporting of safety incidents/hazardous.

Employees: Hospital employees are responsible for adhering to safety policies and procedures, reporting environmental hazards and safety incidents/variances, and making recommendations for the improvement of the Safety Plan and the overall Environment of Care.

SAFETY RISK/ERROR REDUCTION:

1. Montevista Hospital recognizes a patient has the right to a safe environment therefore the organization is committed to undertaking a proactive program to identify processes which may adversely affect patient safety or be associated with medical errors.
2. Effective reduction of errors and other factors which contribute to unintended adverse patient outcomes in our organization requires an environment in which patients, their families, and organizational staff and leaders can identify and manage actual and potential risks to patient safety. Our environment must encourage:

- a. Recognition and acknowledgement of risks to patient safety.
 - b. Organizational focus on process and systems assessment and improvement related to patient risk and safety.
 - c. Initiation of actions to reduce these risks.
 - d. Internal reporting of what has been found and the actions taken.
 - e. Minimization of individual blame or retribution for involvement in a medical error.
3. Montevista Hospital has delegated oversight of our patient safety and error reduction program to Quality Council.
 4. Quality Council shall report to the Medical Executive Committee. Quality Council will on a regular basis aggregate and assess all organizational data related to adverse events; incident reports; risk management; environmental safety clinical outcome measurements; risk concerns and provide a report to the Medical Executive Committee.
 5. At least annually, Quality Council will select at least two (2) high-risk processes for proactive risk assessment and risk reduction. High-risk process selection shall be based on information published periodically by the Joint Commission or other nationally recognized sources of information on patient safety and medical errors. The processes selected for proactive risk assessment and risk reduction should include those processes known to be associated with sentinel events, significant patient risk or medical errors in other organizations.
 6. Quality Council shall oversee the development of a program to reduce medication related errors. The medication error reduction program shall incorporate the principles of medication error reduction which have been identified by the Joint Commission and by other nationally recognized sources of patient safety and error reduction strategies. Montevista Health recognizes medication errors as medication variances.
 7. Montevista Hospital understands inconsistency in the performance of existing organizational processes frequently leads to unanticipated and/or undesirable results. In order to minimize risk to patient safety due to undesirable process variations, Quality Council will require ongoing monitoring to ensure processes identified as variance prone or high risk regarding patient safety are being performed. Each year the performance of critical steps in at least two (2) processes shall be subject to ongoing measurement and analysis to determine the degree of variation from intended performance. If undesirable process variation is identified Quality Council shall refer their assessment findings to the appropriate committee or team for prioritization of a performance improvement project.
 8. Specific processes which should be considered for performance improvement prioritization. Identification of risk can occur through:
 - Self report
 - Performance Improvement reporting and trending
 - Proactive measurement of high risk, problem prone processes
 - Failure Mode Evaluation (including near misses)
 9. Safety risks will be categorized as Class I, II, III, IV
 - Class I Incidents: Patient event requires forwarding to Corporate Risk Management.

- Class II Incidents: Patient event requires internal tracking and trending.
 - Class III Incidents: Visitor general liability.
 - Class IV Incidents: Worker's Compensation, employee injury or concern.
10. Quality Council will assure knowledge-based information, including journal literature, clinical practice standards or guidelines, reference information and research data, is utilized in process design and process redesign. Quality Council shall assure knowledge based information is used and the development of at least one (1) clinical practice guideline (Best Practice) on an annual basis.

FUNCTIONS TO BE INCLUDED IN PATIENT SAFETY AND ERROR REDUCTION COMMITTEE DUTIES

Performance Improvement

1. Establish measurable objectives for improving patient safety and reducing medical errors. Measurable objectives shall be based on the elements of patient safety and error reduction which are described in this Plan.
2. Review of all sentinel/critical events including the development of a thorough and credible root cause analysis or critical event analysis, appropriate plan of correction, and follow up plan. See Sentinel Event and Critical Event Policies and Procedures #200.12 and #200.121.
3. Review and disseminate available information about sentinel events known to occur in other health care organizations which provide services similar to Montevista Hospital. This includes review of all The Joint Commission sentinel event alerts through Quality Council.
4. Assuring prioritization is given to those events and processes most closely associated with patient safety when developing the organizational measurement program and in selecting specific improvement activities.
5. Assuring the data which the organization considers for collection to monitor performance shall include the following:
 - a. Patient, family and staff opinions, needs, perceptions of risks to patients, and suggestions for improving patient safety.
 - b. Staff willingness to report medical/health care errors/variances.
 - c. Data about the needs, expectations, and satisfaction of individuals and organizations served. Montevista Hospital will ask these groups specifically how the organization can improve patient safety.
6. Aggregating organizational information related to patient safety and medical errors to identify trends or patterns in process or outcome, which may lead toward patient events.
7. Assuring when organizational process is designed or redesigned, information from other organizations related to potential risks to patient safety, including occurrence of sentinel/critical events, is reviewed and risk reduction strategies are implemented in the designed or redesigned process.

Information Management

1. Quality Council shall work with appropriate organizational staff in developing the hospital information management needs assessment. The needs assessment shall include information regarding barriers to effective communication among caregivers. Specific attention will be directed to the processes for assuring accessibility of accurate, timely and complete verbal and written communication among caregivers and all others involved in the utilization of data (including external sources).
2. Working collaboratively with staff to assure the medical record is audited on a regular basis to verify all information necessary to assure patient safety and reduce medical errors is contained in the medical record in a timely manner.
3. Development of program to assure knowledge-based information is available to clinicians to support clinical management and decision making in a timely manner, including internet access, journal subscriptions, corporate and community networking and collaborative efforts.

Environment of Care (EOC)

1. Aggregate and assess organizational data related to environmental issues associated with patient safety and risk. Each of the seven (7) EOC elements have an individual management plan. These plans are reviewed annually by the Safety Committee, Quality Council and Medical Executive Committee. Additionally, departments develop specific safety policies to promote safety practices and reduction of risk opportunities. Refer to the EOC Safety Manual.

Risk Management

1. Provide oversight of all organizational risk management activities.
2. Develop an organizational-wide approach to the reporting and evaluation of potential medical errors.
3. Develop procedures for immediate response to medical errors including care of the affected patient, containment of risk to others and preservation of information for subsequent analysis. Refer to Addendum B.
4. Develop systems for internal and external reporting of information relating to medical errors.
5. Aggregation and trending of all risk management information to identify those events or processes which are associated with patient safety and/or medical errors.
6. Develop procedures to be followed related to the notification of patients and when appropriate their families about unanticipated error outcomes or medical errors. Refer to Addendum A.

Human Resources

1. Ensure each staff member participates in ongoing in-service, education, and training to increase his or her knowledge of job-related aspects of patient safety.
2. Assure ongoing in-service and other education and training programs emphasize specific job-related aspects of patient safety. As appropriate, this training incorporates methods of team training to foster the interdisciplinary collaborative approach to the delivery of patient care and reinforces the need and ways to report medical care errors.
3. Define a mechanism for the support of staff who are involved in medical errors or sentinel/critical events.

Patient and Family Education

1. Work with staff in the development of programs to enhance involvement by the patient and patient's family as appropriate to his or her condition as a partner in the health care process.
2. Oversee the development of programs to educate the patient and families about their role in helping to facilitate the safe delivery of health care.
3. Oversee the development of programs to educate patients and families regarding their responsibility for asking questions when they do not understand what they have been told about the patient's care or what they are expected to do.
4. Work with staff to assure patient education programs are implemented related to safe and effective use of medications.

Safety Risk Continuum of Care

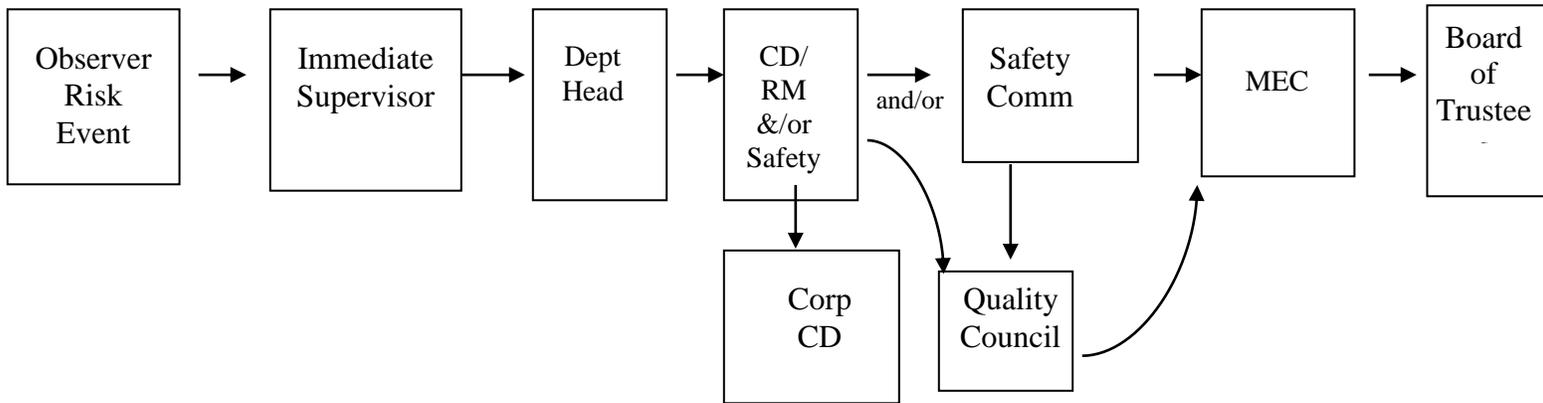
The patient and staff safety standards meet regulatory requirements throughout the continuum of care at Montevista Hospital. Department Heads review standards to ensure compliance for off-campus sites and when providing community services. Safety risk identification and follow through remains intact regardless of level of care or site location.

Safety Risk Event Documentation/Notification

It is the policy of Montevista Hospital that patients and, when appropriate, their families are informed about outcomes of care including unanticipated outcomes. It is the obligation of the responsible licensed independent practitioner or his or her designee to clearly explain the outcome of any treatment or procedure to the patient and, when appropriate, to the patient's family whenever those outcomes differ significantly from anticipated outcomes. Quality Council shall institute monitoring programs to assure information regarding unanticipated outcomes is shared with patients and, when appropriate, their families in a timely manner. Refer to Addendum A.

Risk events are to be accurately documented in the medical record. Patient and non-patient related events are to be documented using appropriate internal reporting tools. Routing of this documentation is diagramed below to ensure preservation of information to appropriate notification of key caregivers (i.e., attending physician, medical physician, therapist, etc.). To encourage accurate reporting the hospital supports the Supervisor's authority to impact changes to avoid similar risk events. This includes: time limited milieu modifications, import additional

staff or modify staffing pattern, notification of vendors or other department personnel to make necessary changes.



Performance Improvement Measurements Clinical Safety

1. Patient Satisfaction Survey: Created as a mechanism to review outcome study and recommend action to improve satisfaction scores.
2. Seclusion/Restraint Indicator: High volume of seclusion and restraints experienced. Corporate policy to reduce seclusion and restraints by 50%.
3. Staffing Effectiveness: Measurement of key indicators as they relate to patient and employee safety and staffing patterns.

Addendum A

The patients and family if applicable are to be informed of unanticipated outcomes by the attending physician/designee unless such information is deemed detrimental to the safety of the individual. Such a sanction requires a second opinion by a psychiatrist and administrative approval.

Patient/family notification is documented in the Progress Notes, signed by the attending physician and witness by an additional care giver attending the meeting. Should information be deemed detrimental, Risk Management is contacted and provides opportunity for the second opinion to be documented and reviewed by Administration. The approval or other direction is noted and followed accordingly.

Addendum B

Immediate response to medical errors:

- Follow communication algorithm for notification
- Provide care per policy and physician orders
- Supervisor to determine risk containment measure including
 - Staffing/personnel changes
 - Equipment replacement
 - Relocation of patients
 - Modification of processes/program
- Preservation of factual information
 - Event is to be documented immediately in Progress Notes and via Risk Management tools.
 - Equipment including videotapes, medical devices, instruments, photos are to be locked in Risk Management.
 - Event analysis is to occur within 24 hours of notification.
 - Events necessitating reporting to outside agencies (i.e., CPS, Adult Protective Services, Police, and insurance carriers) will be handled promptly and with full commitment to the governing regulations by the CEO or designee.

Policy:

It is the policy of MGGH to develop and implement, in consultation with the providers of health care, an internal Patient Safety Program to improve the health and safety of patients/residents who are treated at our facility.

Procedure:

1. The Patient Safety Plan at MGGH encompasses Acute care, Emergency room, surgical services, clinic and Home Maker Services and compliance with the Patient Safety Plan is mandatory.
2. Following approval of the safety plan by the Governing Body, the Medical Staff shall be notified as to the existence and requirements of the plan.
3. The Patient Safety Committee is comprised of a physician, a nurse from SNF, pharmacist, governing board member, risk manager, Infection Control Officer, Patient Safety Officer, and the Administrator

The Committee shall:

- Function under the authority of the Medical Staff
- Submit its patient safety plan to the Governing Board
- Meet monthly
- Investigate, report and formulate corrective actions related to alleged sentinel events
- Review Medical Equipment/devices safety and maintenance inspections
- Review and recommend actions related to medications events
- Review and investigate patient care related incident reports
- Additional tasks as assigned by the Medical Staff
- Annually review patient safety checklists and policies and consider any additional checklists and policies for appropriate adoption
- Revise check lists and policies to ensure they reflect the most current standards in patient safety protocols
- On or before July 1st of each year, submit a report to the Director of the Legislative Bureau for transmittal to the Legislative Committee on Health Care that includes information regarding the development, revision, and usage of the patient safety checklists and policies and a summary of the annual review conducted by the facility.

3. The Administrator shall appoint a Patient Safety Officer with the following responsibilities:

- Serve on the Patient Safety Committee
- Supervise the reporting of all sentinel events alleged to have occurred in the medical facility.
- Shall within 13 days of being notified of a Sentinel event or within 14 days of becoming aware without notification, report the date, time and brief description of the sentinel event to the health division, The Bureau of Licensure, Administrator and the Patient Safety Committee
- Take such actions as he/she determine necessary to ensure the safety of the patients as a result of an investigation of any sentinel event alleged to have occurred at the medical facility
- Report to the Patient Safety Committee regarding any actions taken
- The Patient Safety Officer may designate alternates to act in his/her absence. Kathy The Risk Manager will act as Patient Safety Officer in the absence of the Patient Safety Officer
- The Patient Safety Officer is responsible to review, investigate and act upon patient safety issues other than sentinel events at this facility, including medication errors, environmental issues and equipment and supply malfunction

4. Jan Kollodge RN DON has been appointed by the Administrator as Patient Safety Officer

POLICY: The Patient Safety Committee functions to enhance patient safety through data collection, reporting, investigation and evaluation of patient safety issues prior to an event and when an event occurs. All patient safety information will be confidential and reported through the Medical Staff Quality Assurance process.

PROCEDURE: The Patient Safety Committee shall:

- Receive reports from the Patient Safety Officer (PSO)
- Evaluate actions of the PSO in connection with all reports of sentinel events alleged to have occurred at MGGH
- Review and evaluate the quality of measures carried out to improve the safety of patients who receive treatment at MGGH
- Review and evaluate the quality of measures carried out by MGGH to prevent and control infections
- Make recommendations to the Governing Board of MGGH to reduce the number and severity of sentinel events and infections that occur at MGGH
- Monitor and document the effectiveness of the patient identification policy
- At least annually, review the patient safety checklists and patient safety policies appropriate for adoption for use by MGGH
- Revise a patient safety checklist and patient safety policy as necessary to ensure that the checklist or policy reflects the most current standards in patient safety protocols
- On or before July 1 of each year, submit a report to the Director of the Legislative Counsel Bureau for transmittal to the Legislative Committee on Health Care with information regarding the development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted in #3 above
- Forward Patient Safety Committee minutes/reports to the Medical Staff quarterly. Minutes will summarize MGGH patient safety activities.
- Report on a quarterly basis to the Governing Body of MGGH regarding:
 1. The number of sentinel events that occurred at MGGH during the preceding calendar quarter
 2. The number and severity of infections that occurred at MGGH during the preceding calendar quarter
 3. Any recommendations to reduce the number and severity of sentinel events and infections that occur at MGGH

PATIENT SAFETY DATA COLLECTION:

Patient safety data collection, review and reporting of the following patient safety events is a means of providing the safest patient care possible. Data collection will begin with the completion of a Quality Review Report.

- Sentinel events
- Adverse events
- Near Misses
- Medication errors and falls
- Equipment malfunctions
- Preventive corrective interventions

SUBJECT: MEETING AGENDA

DEPARTMENT: HOSPITAL WIDE

REFERENCE 4002

PAGE: 1 of 1

APPROVED BY: _____ EFFECTIVE: 11/03

REVISED:

Patient Safety Committee Meeting Agenda

The Patient Safety Committee meets on the fourth Tuesday of each month.

Patient Safety officer: Name Here RN

Date:

Members Present:

Standard Agenda Items:

- 1. Sentinel Event**
- 2. Other Events**
- 3. Adverse Drug Events and medication errors**
- 4. Incident Reports**
- 5. Equipment/ Supply issues**
- 6. Root Cause Analyses Evaluation**

Old business:

New business:

Other:

SUBJECT: **EMPLOYEE TRAINING/EDUCATION**

REFERENCE 4003

DEPARTMENT: HOSPITAL WIDE

PAGE: 1 of 1

APPROVED BY: _____ EFFECTIVE: 11/03 REVISED: 6/21/16

POLICY:

It is the policy of MGGH that all employees and individuals contracted for patient care receive Patient Safety Training and are familiar with the job related aspects of patient safety and staff specific roles and responsibilities to actively support patient safety

PROCEDURE:

All staff will receive patient safety education and training during their new employee orientation and on an annual and as needed basis. Contracted individuals will be monitored for compliance with patients safety policies by the supervisor of the department the contracted individual is assigned to.

SUBJECT: INTERNAL EVENT REPORTING

DEPARTMENT: HOSPITAL WIDE

REFERENCE: 4004

PAGE: 1 of 1

APPROVED BY: _____ EFFECTIVE: 11/03 REVISED:

POLICY:

It is the policy of MGGH that prevention and reporting of harm to patients is the responsibility of all employees. Anyone with knowledge of an actual or patient safety event must report it.

PROCEDURE: Near Miss and Adverse Events

- Immediately notify your Department Director and complete a Quality Review Report.
- The supervisor will review and forward it to the Patient Safety Officer within 24 hours of receipt or the first work day following a week-end or holiday
- The Patient Safety Officer will review all reports and determine what specific actions are needed and forward them to Risk Management for review through the Quality Review Process
- All events will be reported to the Patient Safety Committee

SENTINEL EVENT REPORTING

Sentinel events signal the need for immediate investigation and response and any person employed by MGGH shall, within 24 hours after becoming aware that a sentinel event has occurred, notify the Patient Safety Officer of the sentinel event.

PROCEDURE:

- Immediately perform necessary health care interventions
- Notify the patient's Medical Provider and initiate all physician orders. If necessary contain the risk to others and preserve event related material that may require further investigation
- Document the facts in the medical record using concise, factual, objective and complete details
- Notify the appropriate department director and the Patient Safety Officer who will inform the Administrator and Risk Manager and in the case of an intentional unsafe act that results from gross negligence or possible criminal activity, report to the appropriate authorities.
- The Patient Safety Officer will notify the Bureau of Licensure and the Health Department on a form to be developed by them within the prescribed time restraints.
- All Sentinel events will be reported to and investigated by the Patient Safety Committee

POLICY:

It is the policy of MGGH to investigate all patient safety events that occur (actual event) or almost occurred (near miss) that caused or had the potential to cause harm to a patient.

PROCEDURE:

1. Upon notification of a patient safety event the Patient Safety Officer will review all pertinent data related to the event i.e. diagnostic testing, medication orders, medical records and interviews of the parties involved etc
2. Take any action deemed necessary at the time of the investigation
3. Form a plan to prevent recurrence of a similar event
4. In the event of a sentinel event, begin investigation immediately and take such actions necessary to ensure the safety of the patient.
5. Report the event and the results of the review, action taken, and the prevention plan to the Patient Safety Committee for their recommendations
6. The Patient Safety Officer will inform the appropriate supervisor of actions taken and the determinations of the Patient Safety Committee

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

POLICY:

A patient safety event is defined as any incident that occurred (actual event) or almost occurred (near miss) that caused or had the potential to cause harm to a patient and shall be reported to Patient Safety Officer via the Quality Review Report.

- Near Miss: An event or situation that could have resulted in harm to a patient but did not, either by chance or through intervention.
- Adverse Event: An occurrence associated with health care or services that may or may not result in harm to a patient. These include incidents such as medication errors and patient falls even if there is no harm or permanent damage to the patient.
- Sentinel Event: An event included in Appendix A ‘Serious Reportable Events in Health Care__2001 Update: A Consensus Report. Sentinel events signal the need for immediate investigation and proactive response from MGGH.
- Facility –acquired infection: A localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility including: 1. surgical site infections 2. ventilator-associated pneumonia 3. Central line-related bloodstream infections 4. Urinary tract infections

SUBJECT: SAFE MEDICAL DEVICES REPORTING TO THE FDA

REFERENCE 4009

DEPARTMENT: HOSPITAL WIDE

PAGE: 1 of 1

APPROVED BY: _____ EFFECTIVE: 11/03REVISED:

Safe Medical Devices Reporting to the FDA

POLICY:

It is the policy of MGGH to voluntarily report serious adverse events or product problems that are suspected to be associated with a drug or medical device to the FDA. All such events will be reported to the Patient Safety Officer and the Patient Safety Committee for review.

PROCEDURE:

The following reporting procedure will be followed

1. All adverse events or product problems will be reported to the Patient Safety Officer.
2. Department managers will be responsible for completion of the MED WATCH FDA reporting form (form 3500A)
3. The Patient Safety Officer will review and submit the completed form to
4. Forms are available in the Patient Safety Policy and Procedure manual

FDA
MedWatch HFD-410
5600 Fishers Lane
Rockville, MD 20857

POLICY:

Proper patient identification is required in order to prevent errors related to invasive procedures, medication administration, transfusion of blood products, and patient labeling of specimens. The use of patient identifiers improves the reliability of the patient identification process and decreases the chance of performing the wrong procedure on the wrong patient. It is the policy of MGGH to correctly identify patients prior to any procedures and before each interaction with a health care provider/

PROCEDURE:

The use of two patient identifiers is required to confirm a patient's identity.

1. Ask all patients for their NAME and DATE OF BIRTH prior to any treatments, procedures, or medication administration.
2. Label all specimen containers with the patient labels that are generated at admission.

MONITORING AND DOCUMENTATION:

1. Monitor medication errors related to wrong patient and report to Patient Safety Committee
2. Monitor incident reports related to wrong person procedures
3. Review the patient identification policies with the involved staff member
4. Perform a root cause analysis if indicated
5. Report as a sentinel event if indicated

POLICY:

Health Care Workers at MGGH are required to recognize and follow established nationally recognized standards of care.

PROCEDURE:

Nationally recognized standards of care are to be followed by all Health Care Workers relevant to their departments and to standards related to all departments involved in patient care. Established standards of care include, but are not limited to, the following:

1. Implementation of evidence based practice to prevent health care associated infections:
 - A. Hand hygiene based on CDC guidelines
 - B. CAUTI
 - C. Infections caused by multi-drug resistant organisms
 - D. Central line infections
 - E. Surgical site infections
 - F. Blood stream infections
2. Improve the accuracy of patient identification prior to any treatment, care, or services, using 2 patient identifiers
3. Report critical results of tests and diagnostics on a timely basis
4. Prevent pressure ulcers
5. Identify safety risks and prevent falls
6. Prevent wrong site, wrong patient, and wrong surgery
 - A. Mark the site
 - B. Time out before procedures
 - C. Surgical checklists
7. Improve the safety of medications
 - A. Label all IV medications accurately and completely
 - B. Use approved protocols for the initiation and maintenance of anticoagulation therapy
 - C. Maintain and communicate accurate patient medication records
 - E. 2 nurses to verify certain high risk medications before administration i.e. insulin, cardiac drips, heparin, etc.

SUBJECT: INFECTION CONTROL OFFICER

DEPARTMENT: HOSPITAL WIDE

REFERENCE # 4013

PAGE: 1 of 1

APPROVED BY: _____ EFFECTIVE: 10/1/11 REVISED:

POLICY:

MGGH has designated the DON as the Infections Control Officer for the facility which includes ER, OR, acute care, SNF, and the medical clinic. The Infection Control Officer also serves as the Patient Safety Officer at MGGH

RESPONSIBILITIES:

- Serves on the Patient Safety Committee
- Monitors the occurrences of infections to determine the number and severity of infections at the facility
- Reports to the patient safety committee concerning the number and severity of infections at the facility
- Shall take such action as he or she determines is necessary to prevent and control infections alleged to have occurred at MGGH
- Shall carry out the provisions of the infection control program adopted by NRS 439.865 and ensure compliance with the program
- Shall consult with the Health Division for education and technical assistance relating to infection control in medical facilities when indicated
- The Risk Manager will service as the Infection Control Officer in the absence of the Infection Control Officer. If neither one is available, the charge nurse is responsible.

POSITION REQUIREMENTS:

- Must be a Registered Nurse
- Must successfully complete a nationally recognized basic training program in infection control
- Must complete at least 4 hours of continuing education each year on topics relating to current practices in infection control and prevention
- MGGH shall maintain records concerning the required training

POLICY:

It is the policy of MGGH that when a patient at our facility has an infection, the provider of health care or the designee of the provider of health care shall, as soon as practicable, but not later than 5 days after the diagnosis is confirmed, inform the patient or legal guardian or other person authorized by the patient to receive such information that the patient has an infection. Notification of the patient may be delayed only if the patient does not have a legal guardian, has not authorized any other person to receive such information and:

1. Is not capable of understanding the information
2. Is not conscious or
3. In the judgment of the provider of health care, is likely to harm himself or herself if informed about the infection

If the provider of health care or the designee of the provider of health care delays providing information about an infection, such information must be provided as soon as practicable after:

1. The patient is capable of understanding the information
2. The patient regains consciousness
3. In the judgment of the provider of health care the patient is not likely to harm himself or herself if informed about the infection or
4. A legal guardian or other person authorized to receive such information is available

PROCEDURE:

1. At admission, all patients or their legal guardian sign a Release of Protected Health Information that lists who may be given information about their health condition
2. The provider of health care will consult this list when someone other than the patient must be given information about an infection
3. The provider of health care may authorize the Infection Control Officer, Risk Manager or other RN to inform the patient, legal guardian, or another person authorized by the patient of an infection
4. Notification will be verbal and will be documented in the medical record
5. If an infection is known or determined while the patient remains at MGGH, the patient or person authorized by the patient or the legal guardian will be notified whether the infection was acquired at the facility and of the apparent source of the infection

PATIENT LABEL

FOLEY CATHETER INSERTION AND MAINTENANCE CHECK LIST

	Patient identified using 2 identifiers?
	Is it necessary for patient care?
	Is there a doctor's order?
	Hand hygiene performed prior to procedure?
	Sterility of catheter kit verified?
	Sterile gloves applied?
	Area cleansed per protocol?
	Sterile drapes applied?
	Asceptic technique insured? May need assistance for some patients
	Foley bag hung on bed frame below patient's bladder?
	Leg strap on to prevent movement and urethral traction?
	UA obtained?
	Hand hygiene performed after procedure?
	Care Plan on chart?
	Daily catheter care performed?
	Foley to be removed as soon as possible? Assess for need every 24 HOURS
	Closed system maintained and additional UAs taken from sampling port

NURSE SIGNATURE _____ **DATE** _____

PATIENT LABEL

LIVER BIOPSY CHECKLIST

	Patient identified by name and date of birth
	Procedure verified with patient
	Anticoagulants held by patient as ordered by doctor
	Consent signed
	All equipment available
	Hand hygiene prior to procedure
	Sterile technique throughout procedure
	Specimens labeled correctly and delivered to the lab
	Post liver biopsy orders on chart and followed
	Patient given discharge instructions

NURSE SIGNATURE _____ **DATE** ____

APPROVED BY: _____ EFFECTIVE: 07/12/10 REVISED:

POLICY:

Patient Safety policies and check lists have been developed by MGGH to ensure the safety of our patients. Staff compliance with these safety components will be ensured by monitoring, peer-to- peer communication, sanitation audits, education, and when possible video monitoring.

PROCEDURE:

Compliance will be measured using the following methods and reported at the monthly Patient Safety Committee Meeting. Violations will be reported to the appropriate supervisor.

1. Chart audits
2. Staff monitoring by Department Supervisors
3. Staff monitoring by the Patient Safety and Infection Control Officer
4. Environmental sanitation audits
5. Department specific education
6. Video monitoring when possible

PATIENT LABEL

ISOLATION PRECAUTIONS CHECKLIST

	Appropriate isolation precautions selected?
	Isolation bag stocked and hanging outside of patient room
	Linen and red trash bags set up in room?
	Blood pressure cuff, stethoscope, and thermometer in patient room?
	Precaution signs, visitor and patient instructions posted outside of room?
	Visitor and patient instructions posted inside the room?
	Hand hygiene performed before going into room and before leaving?
	Isolation rules enforced with staff and visitors?
	Ancillary departments following isolation rules?
	Appropriate isolation precautions Care Plan in chart?

NURSE SIGNATURE _____ **DATE** _____

PATIENT LABEL

**PATIENT SAFETY
DISCHARGE CHECK LIST**

	Discharge Instructions Form Given?
	After care instructions included?
	Has patient designated a lay caregiver?
	Discharge plan provided to lay caregiver prior to discharge day?
	Is caregiver available at discharge?
	Written training and education given to caregiver at discharge if present?
	Follow up instructions?
	Activity instructions?
	Diet instructions?
	New medications explained and RX given or called to pharmacy
	Medication reconciliation form
	CHF instructions (the carbon copy instructions and diet instructions etc.)
	Teaching materials
	Name and relationship of person discharged to on DC instruction form?
	Telemetry removed?
	Medications from home given to patient at discharge?
	PNEUMONIA SHOT GIVEN (check for criteria being met and consent signed?)
	FLU SHOT GIVEN (during flu season)?
	PORTAL ACCESS COMPLETED WITH PORTAL ACCESS DOCUMENT PRINTED AND GIVEN TO PATIENT- MUST BE COMPLETED ON 100% OF ALL IN-PATIENTS

NURSE SIGNATURE _____ **DATE** _____

This check list to be filed with the Discharge Instruction form in the chart and completed at the time of discharge along with the standard discharge instructions and the CHF instructions

PATIENT LABEL

**PATIENT SAFETY
OBSERVATION DISCHARGE CHECK LIST**

	Discharge Instructions Form Given
	After care instructions included
	Follow up instructions
	Activity instructions
	Diet instructions
	New medications explained and RX given or called to pharmacy
	Medication reconciliation form
	CHF instructions (the carbon copy instructions and diet instructions etc.)
	Teaching materials
	Name and relationship of person discharged to on DC instruction form
	Telemetry removed
	Medications from home given to patient at discharge
	FLU SHOT GIVEN (during flu season)
	Health Information Exchange "Summary of Care" completed

NURSE SIGNATURE _____ **DATE** _____

This check list to be filed with the Discharge Instruction form in the chart and _____ completed at the time of discharge along with the standard discharge instructions and the CHF instructions

DINI-TOWNSEND HOSPITAL

PROTOCOL

SUBJECT: PATIENT SAFETY PROGRAM

NUMBER: DT-PI-02

Page 1 of 8

ORIGINAL DATE: 2/18/10

REVIEW/REVISE DATE: 7/18/13, 11/22/17

APPROVAL: _____ Agency Manager

APPROVAL _____ Local Governing Body



I. PURPOSE

To enhance patient care delivery and prevent adverse outcomes of care by employing a systematic, coordinated, and continuous approach to the improvement of patient safety.

II. PROTOCOL

The Patient Safety Program is supported by leadership’s promotion of a blame-free culture of safety that:

- 1. Facilitates reporting and follow-up on errors, adverse events, risks, and safety concerns.
- 2. Initiates, monitors, and takes action to reduce errors and risks of errors.
- 3. Reports findings and actions taken.

4. Educates employees to ensure their knowledge of and participation in the program.

III. DEFINITIONS

1. Sentinel Event: An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called "sentinel" because they signal the need for immediate investigation and response.
2. Near Miss: Any process variation which did not affect an outcome but for which a recurrence carries a significant chance of a serious adverse outcome.
3. 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.
4. Incident: 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, employee, or visitor; or which may give rise to a claim against the hospital, an employee, or a member of the medical staff.
5. Error: An unintended act, either omission or commission, or an act that does not achieve its outcome such as medication errors and adverse drug events or reactions.

IV. REFERENCES

1. Nevada Revised Statutes (NRS) 439.865 to 439.890 Patient safety plan; patient safety committee; patient safety officer; patient safety checklists and policies.
2. NRS 439.802 Facility-acquired infections defined.
3. Serious Reportable Events in Healthcare, 2011 Update: A Consensus Report, National Quality Forum, www.qualityforum.org.
4. The Joint Commission Accreditation Manual for Hospital, National Patient Safety Goals Chapter.
5. Dini-Townsend Hospital Protocol DT-EC-08 Environmental Safety Management.
6. Dini-Townsend Hospital Protocol DT-IC-06 Hand Hygiene.
7. Dini-Townsend Hospital Protocol DT-IC-07 Standard Precautions.
8. Dini-Townsend Hospital Protocol DT-PI-03 Sentinel Events.
9. Division of Public and Behavioral Health (DPBH) Discharge Interdisciplinary Continuity of Care Form MR 189 Nursing Discharge Instructions.

V. OBJECTIVES

1. To collect and analyze data to evaluate processes for opportunities to proactively reduce risk and correct potential system failures.
2. To respond appropriately to any error, adverse event, or sentinel event.
3. To incorporate recognition of patient safety as an integral job responsibility.
4. To encourage organizational learning about adverse or potential adverse events.
5. To improved hospital safety culture by encouraging reporting, measuring safety culture on a regular basis, and involving employees in addressing needed change.

VI. SCOPE

- A. Areas of focus shall include sentinel events, near misses, errors, and other incidents related to:
 - 1. Facility-acquired infections.
 - 2. Medication errors.
 - 3. Adverse drug events.
 - 4. Drug recalls.
 - 5. Other product recalls.
 - 6. Patient falls.
 - 7. Other patient incidents.
 - 8. Blood and body fluid exposures.
 - 9. Communicable disease exposures.
 - 10. Influenza vaccination program.
- B. Data from external sources, including but not limited to:
 - 1. The Joint Commission.
 - 2. Centers for Medicare and Medicaid Services.
 - 3. Centers for Disease Control and Prevention.
 - 4. Institute for Safe Medication Practices.
 - 5. National Quality Forum.

VII. PATIENT SAFETY COMMITTEE

- A. The Patient Safety Committee provides a multidisciplinary forum for the analysis of risk to patient safety and for the dissemination of information on identified risk for the purpose of improving patient care.
- B. Membership shall include:
 - 1. The Patient Safety Officer – Accreditation and QAPI Manager.
 - 2. The Agency Manager.

3. The Director of Nursing.
 4. The Director of Pharmacy Services.
 5. The Infection Control Officer.
 6. The Clinical Education Coordinator.
 7. The Environmental Safety Officer - Facilities Supervisor.
 8. The Medical Director or other member of the medical staff.
- C. The Patient Safety Committee has adopted patient safety checklists and policies, including, but not limited to:
1. Checklists related to specific types of treatment.
 2. Checklists ensuring that the patient'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 patient safety.
 5. A protocol for appropriately identifying a patient with two personal identifiers.
 6. A hand hygiene protocol regarding standard precautions.
- D. The Patient Safety Committee shall meet monthly and shall:
1. Review reports and evaluate the actions of the Patient Safety Officer on sentinel events and other incidents.
 2. Review, discuss, and evaluate Root Cause Analyses and corrective actions associated with serious incidents.
 3. Review emerging research and best practice standards related to patient safety.
 4. Promote a hospital-wide coordinated effort to comply with The Joint Commission's National Patient Safety Goals.
 5. Review and disseminate information it receives to the appropriate committees or individuals, including, learned lessons from incident reports,

to increase awareness and promote continuous improvement and a just culture.

6. Make recommendations concerning identified risks and evaluate the implementation of corrective action plans.
7. Review the patient safety checklists and policies at least annually and revise as necessary.
8. Ensure compliance with the patient safety checklists and policies, which may include:
 - a. Hand hygiene monitoring.
 - b. Audits of sanitation materials.
 - c. Review of medical records.
 - d. Performance improvement indicator reports.
 - e. Communication to employees.

E. The Patient Safety Officer shall:

1. Serve on the Patient Safety Committee.
2. Manage the agency incident reporting system.
3. Report all sentinel events to the Nevada Sentinel Event Registry, and to The Joint Commission where applicable.
4. Conduct investigations, root cause analyses, and monitor corrective action plans for completion and effectiveness.
5. Take action in collaboration with the Patient Safety Committee and leadership to ensure the safety of patients.
6. Report quarterly, to the Local Governing Body, the number and severity of sentinel events, and any recommendations to reduce the number and severity of sentinel events.
7. On or before July 1 of each year, submit a report to the Director of the Legislative Counsel Bureau for transmittal to the Legislative Committee on

Health Care. The report shall include a summary of any new checklist development, or, revision and use of the checklists and policies.

8. On or before March 1st of each year, submit a report to the Nevada Sentinel Event Registry, summarizing the previous calendar year's sentinel events and Patient Safety Committee activities.

VII. SAFETY IMPROVEMENT ACTIVITIES

- A. Incident reporting trending and analysis.
- B. Medication error reporting and trending.
- C. Other potential errors/prescription interventions tracked by pharmacy.
- D. Infection surveillance and prevention.
- E. Monitoring hand hygiene.
- F. Tracking seclusion and restraint data.
- G. Appropriate implementation of input from patients, families, and employees.
- H. Environmental safety rounds.
- I. Environmental safety monitoring by Environment of Care Committee.
- J. Reactive analysis (root cause analysis) of incidents.
- K. Proactive risk assessment (failure mode effect analysis).
- L. Antibiotic Stewardship Program.
- M. Culture of Safety Employee Survey.

VIII. EMPLOYEE EDUCATION AND TRAINING

- A. Employees are educated on safety issues, policies, 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 protocols or protocol revisions.

- D. Employees participate on teams for proactive or reactive analysis and are, thus encouraged to participate in the improvement of safety.
- E. Employees are provided feedback on the results of the Culture of Safety Survey.
- F. Employees participate with leaders in addressing Culture of Safety Survey data.



**Risk Management/
Patient Safety Plan
Nevada Acute Care Division**

Title: Patient Safety/Risk Management Plan		Policy No. PI-101
		Effective Date: 1/03
Reviewed: 12/07, 3/15, 2/16	Revised: 10/04,10/05, 12/06, 2/09, 10/09, 2/11, 4/13, 2/14, 1/17, 02/18	Page 1 of 20

I. Overview

Northern Nevada Medical Center endorses an integrated, system-wide patient safety program designed to improve patient safety and reduce risk to patients.

Patient safety is a cornerstone of quality care and is a leadership priority. Northern Nevada Medical Center operates as a Patient Safety Organization to further its commitment in promoting patient safety and assuring that Northern Nevada Medical Center remains at the forefront in the delivery of safe and effective clinical care. The Member Patient Safety Evaluation System (PSES) is utilized by Northern Nevada Medical Center to track safety information, generate Patient Safety Work Product (PSWP) analysis of safety and clinical performance, and promote best practices. This Acute Care Division Risk Management/Patient Safety Plan (“Plan”) provides the general framework to identify, manage, reduce, and eliminate patient safety risks.

The Plan identifies the mechanisms to continually assess and improve the patient safety systems at Northern Nevada Medical Center. It is our strategy to utilize statistical tools and defined project work to achieve breakthrough gains in patient safety. Performance improvement tools are used in developing and delivering consistent processes and services. The cultural aspect of the Plan is to promote a non-punitive approach to identifying and reporting adverse events. This is consistent with the “Just Culture” concept to promote patient safety practices by instituting a culture of safety and embracing concepts of teamwork and communication.

Most patient safety events are due to a failure of systems; therefore, a systems analysis approach is utilized in evaluations. The goal is to identify and track errors, deficiencies, and problematic trends in order to continuously improve the underlying systems and to intervene as necessary to improve system processes. Although a non-punitive culture is promoted, this approach is balanced by holding caregivers personally responsible for at-risk behaviors and failures to meet the standard of care. When warranted, discipline measures will be initiated as needed consistent with Northern Nevada Medical Center policies. Northern Nevada Medical Center employees, contractors, vendors, and members of each facility’s medical staff share responsibility to participate in detection, reporting, and remediation to prevent errors.

GENERAL STATEMENTS ON GOALS AND OBJECTIVES

To support, maintain and enhance the quality of patient care delivered by:

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- Systematic and objective monitoring and evaluation of reports of injuries, accidents, patient safety issues, safety hazards, and/or clinical services findings.
- Identification and assessment of general areas of actual or potential risk in the clinical aspects of the delivery of patient care and safety.
- Implementation of appropriate corrective action, to the extent possible, to alleviate and resolve identified problems or concerns with patient safety issues.
- Evaluation and documentation of the effectiveness of actions implemented.
- Aggregation of data/information collected for integration in information management systems and use in managerial decisions and operations.

II. Mission and Vision

Northern Nevada Medical Center mission, vision and values drive the Plan and serve as the foundation in identifying strategic goals, objectives and priorities. Our mission is to improve patient safety and the quality of health care delivery through the provision of excellence in clinical care while fostering safe care to our communities, that our patients will recommend to their families and friends, physicians prefer for their patients, purchasers select for their clients, employees are proud of, and investors seek for long-term results. The vision is to be recognized as the provider of choice for healthcare services in the local community where we are trusted by our patients, families and physicians to create a safe, caring and compassionate experience.

In support of our mission, vision, and values, the Plan promotes:

- Collaboration of administrative leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high quality healthcare.
- Communicate honestly and openly to foster trusting and cooperative relationships among healthcare providers, staff members, and patients along with their families, to ensure accountability for the patient safety priorities.
- Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.
- Accountability for every healthcare related decision and action based on the level of risk-taking or egregious behavior identified.

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- A focus on continuous learning and improving, system design, and the management of choices and changes, bringing the best possible outcomes or performances to the facility.
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare.
- Education of staff and physicians to assure coordination and integration of care across disciplines and specialties.

Northern Nevada Medical Center recognizes that providing safe patient care requires significant coordination and collaboration. The optimal approach to patient safety involves multiple departments and disciplines to establish and effectively implement the processes and mechanisms that comprise this plan.

III. ROLES AND RESPONSIBILITES

A. Risk Management/Patient Safety Officer

Northern Nevada Medical Center has a designated risk director/manager responsible for patient safety risk identification and reduction for their respective facilities. The designated Risk Director/Manager is also the Patient Safety Officer. Each facility is required to submit scheduled reports to the Board of Governors describing risk reduction efforts associated with facility specific, or industry identified risk exposures, including environmental risks and emergency management. Reports are thoroughly reviewed and analyzed by the risk staff to determine effectiveness and follow-through of identified corrective action plans.

The Patient Safety Officer responsibilities based upon [NRS 439.870](#) includes:

- Serving on the Patient Safety Committee (PSC)
- Supervising the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Taking action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the PSC regarding any action taken in accordance with the responsibilities above.

B. Infection Control Officer

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The infection control officer designated for each facility, based on [NRS 439.873](#), responsibilities include:

- Serving on the Patient Safety Committee
- Monitoring the occurrences of infections at the facility to determine the number and severity of infections.
- Reporting to the PSC concerning the number and severity of infections at the facility each month.
- Taking such action as determined necessary to prevent and control infections alleged to have occurred at the facility.
- Carrying out the provisions of the Infection Control Program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program.

Based on [NRS 439.865](#), the patient safety plan must also include an infection control program that carries out the infection control policy. The policy must consist of:

- The current guidelines appropriate for the facility’s scope of service developed by a nationally recognized infection control organization as approved by the State Board of Health which may include, the Association for Professionals in Infection Control and Epidemiology (APIC), the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO) and the Society for Healthcare Epidemiology of America (SHEA); and
- Facility-specific infection control developed under the supervision of a certified Infection Preventionist.

C. Patient Safety

Northern Nevada Medical Center has an established Patient Safety Councils (PSC) to support patient safety activities. The PSC should ensure that its Patient Safety Plan is promoted and executed successfully. Northern Nevada Medical Center has also assembled participants to serve in the Member Workforce and to utilize the Member PSES to generate PSWP and exchange analysis and recommendations with the Acute Care PSO Workforce. The main vehicles for these analytic activities occurring within the Member PSES and the member facility Patient Safety Council meetings. The Member PSES is made up of both electronic and physical spaces for the reporting, storing, and generation of PSWP, including secure SharePoint site, and other

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electronic databases (including but not limited to ClearSight (STARS) and Midas) to maintain and manage PSWP.

According to [NRS 439.875](#), a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plans are promoted and executed successfully.

I. Facility Patient Safety Committee

Each facility establishes a Patient Safety Committee (PSC) that meets on a regular basis and at least monthly.

Membership:

In accordance with [NRS 439.875](#), the committee core membership consists of the following Key Members: (CEO, CNO, Physician, Risk/ Patient Safety Officer, Infection Prevention Nurse, Pharmacy, and Quality). The COO, CMO and Regional CMO attend, as applicable. NRS requires that at least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing, and pharmaceutical staff of the medical facility. In addition, the infection control officer, patient safety officer, and one member of the executive or governing body of the medical facility.

Based on [NAC 439.920](#), a medical facility that has fewer than 25 employees and contractors must establish a patient safety committee comprised of: the Patient Safety Officer, at least two providers of healthcare who treat patients at the medical facility, including but without limitation, one member of the medical staff and one member of the nursing staff of the medical facility; and the Chief Executive Officer (CEO) or Chief Financial Officer (CF) of the medical facility.

Meetings:

The required members attend the meetings on a monthly basis. If a required member is absent, the facility makes a suitable replacement with someone that has authority to implement actions identified by the PSC.

Duties and Responsibilities:

Northern Nevada Medical Center PSC is charged with the assessment and improvement of high-risk processes related to patient safety. This is to be carried out using a four-step methodology.

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- **Issue Identification:** The primary issue is the most important risk issue facing the facility and is determined by reviewing the facility’s claims history, claims history unique to the facility, patient safety concerns, industry claims, and through discussions with the risk staff. Other issues may be related to process initiatives.
- **Best Practice:** Once identified, the primary issue is dissected to determine its component issues. For each component issue, a best practice is selected. Best practices represent the most appropriate method for performing the delineated process and should not be selected until the PSC is assured that it is truly the “Best Practice.”
- **Implementation:** Implementation strategies are those methods used to put the best practices into place. Often this includes revising policies, education, newsletters, phone calls, meetings, formal training, etc. Responsible parties and dates for completion are identified to ensure success.
- **Monitoring and Accountability:** Monitoring is essential to ensure that the strategies identified have been effective. Improvement should be demonstrated statistically whenever possible.

Additional Patient Safety Committee Responsibilities, based upon [NRS 439.875](#) and [NRS 439.877](#), include:

- Monitor and document the effectiveness of the Patient Identification Policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the Patient Safety Officer pursuant to [NRS 439.870](#).
- Evaluate actions of the Patient Safety Officer in connection with all reports of sentinel events alleged to have occurred.
- The Quality member of the PSC will review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- The Quality member in conjunction with the Infection Control Officer will review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- Make recommendations to the Board of Directors of the medical facility to reduce the number and severity of sentinel events and infections that occur.

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- At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the Board of Directors of the facility regarding:
 - (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);
 - (2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and
 - (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.

- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

In addition to the work done on the primary issue, the PSC is charged with addressing issues identified through claims reporting, Safety Watch Newsletters, the Joint Commission (Sentinel Event Alerts) and others, HRUs and from the TERM evaluation or other surveys, such as the OBHRU Site Assessments. Feedback is provided on an ongoing basis as to the functioning of the Patient Safety Committee.

II. Patient Safety Advisories

When an untoward event occurs at a facility or in the industry, it is important that we respond in a positive manner. Systems that lead to failure at one facility can be assessed at other facilities to avoid the same or similar occurrence. To this end, the Acute Care PSO distributes Safety Watch newsletters. These alerts detail the circumstances that lead to the negative outcome and facilities are charged with assessment and improvement of their own processes.

Northern Nevada Medical Center is required to address the Safety Watch newsletters via their Patient Safety Council and this is evidenced in their monthly minutes. Responses to the Safety Watch are reviewed for the opportunity to generate a best practice to implement.

C. TERM Program

The facility has utilized its formalized risk management program identified as TERM: the Technical Elements of Risk Management. Each element focuses on a separate organizational

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function and details specific strategies for managing risk in these areas. These elements are summarized as follows:

Element I. Administration of the Risk Management Program: The tenets outlined in Element 1 lay the foundation for an effective risk management program. The Risk Manager/Director must be seen as a resource to administration, facility, and medical staff. Written plans, goals, and objectives provide a clear vision to meet the purpose of the risk program. Although the TERM program uses the title “Risk Manager,” this applies equally to Risk Directors.

Element II. Risk Identification: Risk identification is essential in order to avoid, mitigate, and eliminate risk-generating practices. This Element focuses on those steps taken to identify exposures faced by the facility.

Element III. Risk Education: Education is a cornerstone of the TERM program. Risk management education is intended to reduce and eliminate risk-generating practices and to promote best practices that enhance the provision of safe patient care.

Element IV. Patient Safety Initiative: Imperative to a comprehensive RM program is one that focuses on the improvement of patient and staff safety through the creation of an environment that maximizes safety and reduces liability claims exposure. The mechanism used to drive the culture of safety is the Patient Safety Committee (PSC) at each facility. The PSC operates using a four-step process. These steps include: identification of the problem, determining best practice, implementing the recommendations, and monitoring and accountability. Corrective actions are discussed, monitored, and validated by the PSC.

Element V. Patient Safety Priority: Root Cause Analysis (RCA): The cornerstones of an effective Patient Safety and Risk Management Program are (i) the performance of a thorough and credible RCA when a serious, sentinel, never event or a significant near miss event occurs; and (ii) implementation of systemic improvements to enhance patient safety and improve healthcare outcomes going forward.

Element VI. Environment of Care; Safety and Security Programs: The safety and security programs in the facility serve to protect and preserve both life and property. Areas of safety include licensing, accreditation and federal, state, and local safety practices and programs, including the EPA, TJC, etc.

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Element VII. Claims and Litigation Management: The risk manager serves as the on-site representative of the insurance program in the management of general and professional claims and litigation.

Element VIII. Patient Safety Organization (PSO): Participants of the Member Workforce are expected to perform identified patient safety activities and to be trained in their responsibilities. They must also understand and acknowledge their obligations, including maintaining the confidentiality of PSWP, as required by the Patient Safety and Quality Improvement Act (PSQIA), and of Protected Health Information, as required by the Health Insurance Portability and Accountability Act (HIPAA) and its regulations, and other federal and state laws.

Element IX. Measuring the Effectiveness of the Risk Management Program: In order to assure the effectiveness of the Risk Management Program, certain activities should be conducted to ensure that implementation of the TERM program has been successful. This includes, but is not limited to, data analysis and trending of events and potential claims, which are shared with the respective oversight committees.

D. MIDAS

The MIDAS system is the electronic event reporting system utilized by the facilities to report patient and visitor safety events. The risk management module allows for the collection, categorization, and analysis of incident data using electronic reporting functions (Remote Data Entry - RDE). The facility enters incidents into MIDAS through identification of the type of incident and characteristics of the event using risk parameters and outcomes. Additional information can be attributed to a department, physician, or individual, along with further details of the event. This allows the retrieval of information in a variety of ways for analysis and review.

E. ClearSight (STARS)

STARS is an integrated claims management program that allows for complete claims management, including extensive analysis of reportable fields associated with reported claims. STARS also provides for the electronic submission of potential claims by user facilities.

Delineation of issues featured in the probable claim module allows for the facility staff to identify causation factors associated with any reported event. The system also provides for the entry of details that will describe the event and liability concerns.

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Trending of claim information is performed on a scheduled basis to operations leadership metrics to form strategies on facilitating risk reduction efforts. Previous examples of this function include the formation of an OB HRU and Perioperative concepts. Quarterly reports should be provided by the Facility’s RM to the Governing Board of all claims activities.

F. Event Notification Site

The Risk Department developed the Event Notification Site or ENS, a web-based system that allows for contemporaneous reporting of serious adverse events and key near miss sentinel events to facility and corporate management. The ENS also provides an environment in which stakeholders can post questions and additional information to the facility reporting the event. Updates to the event are reported in real-time to all identified facility and stakeholders via the ENS. The Risk Management staff reviews each ENS to determine if follow-up is needed; if follow-up is indicated, it is to be completed within 45 days.

G. Root Cause Analysis (RCA)

Pursuant to [NRS 439.837](#), a medical facility shall, upon reporting a sentinel event pursuant to [NRS 439.835](#), conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both of the sentinel event.

A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals. Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

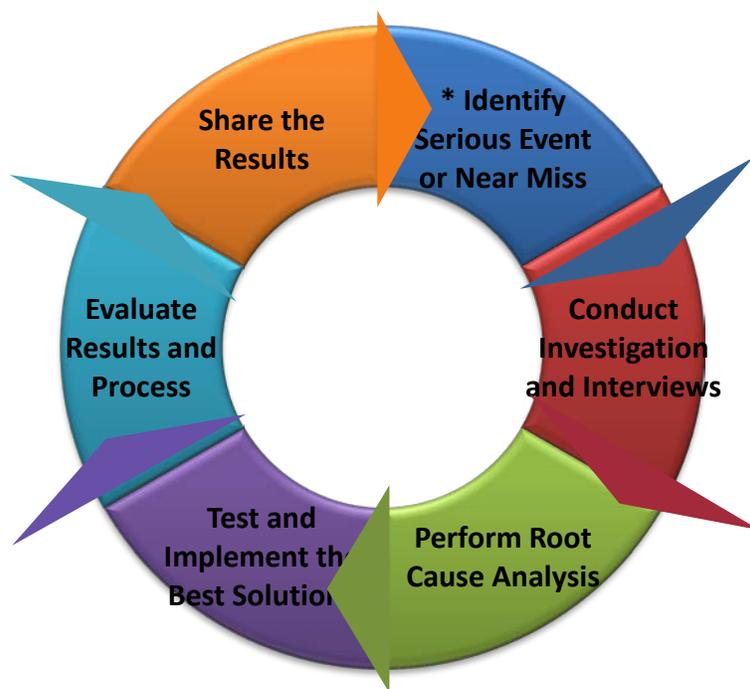
It is recommended that the Joint Commission’s root cause analysis and actions plan framework table are utilized. It contains analysis questions and guides the organization in the steps of a root cause analysis. Not all of the questions apply to all of the events or cases.

Utilization of the “5 Whys” technique should be used to explore the cause and effect relationship underlying a problem. One can find the root causes by asking “why” no less than five times.

RCA Responsibilities

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- Organize and coordinate the RCA process. For Serious OB events, RCAs are to be done within 72Hrs. of the event.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA and corrective action plan implementation process.
- Communicate the progress of the investigation, institutional barriers and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.



H. Patient Safety Checklists

By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

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- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

The patient safety checklists must follow protocols to improve the health outcomes of patients at the medical facility and must include, without limitation:

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.
- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - Proper instructions concerning prescription medications;
 - Instructions concerning aftercare;
 - Any other instructions concerning his or her care upon discharge; and
 - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety checklists are listed in Appendix E. (The following links provide some patient safety checklists for your reference— a checklist example is shown in **Appendix B**.)

http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf

<http://www.who.int/patientsafety/implementation/checklists/en/>

I. Patient Safety Policies

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The patient safety policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include, the name and date of birth of the patient.
- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.
- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

J. MEMBER PATIENT SAFETY EVALUATION SYSTEM (PSES)

The Patient Safety and Quality Improvement Act of 2005 (PSQIA) and its regulations govern the operations and activities of the UHS Acute Care PSO and its Members. This includes assembling a “workforce” of employees, volunteers, trainees, contractors, and other persons who carry out patient safety activities on behalf of the Members within the Member Patient Safety Evaluation System (“Member PSES”). Participants in the Member Workforce are expected to perform identified patient safety activities and to be well trained in their responsibilities. They must also understand and acknowledge their obligations, including maintaining the confidentiality of PSWP, as required by the PSQIA, and of Protected Health Information, as required by the Health Insurance Portability and Accountability Act (HIPAA) and its regulations, and other federal and state laws. The Member PSES serves as a means by which patient safety information is collected, maintained, reported, and analyzed for the UHS Acute Care PSO for the purposes of improving patient safety.

K. Training and Education

Training is essential to successful implementation of the Patient Safety and TERM program. All facility risk managers undergo extensive orientation and education related to Patient Safety, TERM program and other healthcare, risk-related topics. Newly hired

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risk managers receive both on-site and collaborative corporate-based education and training to afford them the requisite skills to manage their facility assignment. Each risk manager is provided a copy of the TERM source documents and other reference materials that guide the risk management function. In addition, formalized supplemental training is provided to all facility risk managers as needed, including quarterly risk management meetings. Risk leadership provides ongoing support and consultation to their assigned facility to facilitate the minimization of liability exposures and enhancement of safe patient care.

The leadership risk management staff provides consultative services to each facility and as members of designated projects. These activities include on-site assistance, research, and consulting from off-site. Examples of designated projects are as follows.

- Facility specific risk Issues
- Safety Watch newsletters
- MIDAS Focus advisories

IV. Risk Management Goals and Objectives 2018

- Surgical and Procedural Safety
 - Monitor compliance through tracer methodology and report monthly with oversight by leadership.
 - Goal: Zero harm events: Prevent mistakes in surgeries and procedures
- Emergency Department
 - Goal: Reduction/ Elimination of Workplace Violence
- Medication Safety
 - Goal: Implement an effective Opioid – Pain Management strategy, as evidenced by compliance with Assembly Bill 474, NRS 233B.066, regarding prescribing of controlled substances and reporting of controlled substance overdoses.
- Perform monthly *Safety Watch* Gap Analysis and complete within 90 days.
 - events
- Retained surgical Items
 - Zero harm events - retained sponges
- Conduct risk management education to staff on identified key risk areas and topics

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- Perform two "deep dive" claims and event analysis report on one high risk area- 4th floor and ED
- Reduce falls by 10% and/or meet goal set forth on dashboard.
- Reduce IV infiltrates by 5%.
- Reduce E-I risk incidents by 5%.
- Increase overall incident reporting by 10%.
- Increase medication bar code scanning to 90% compliance.
- Increase medication variance reporting by 10%.

V. Monitoring and Accountability

A. Evaluation of TERM Program

These evaluations consist of both a core risk and clinical risk review. The facility is required to submit a written corrective action plan for noted deficiencies determined during the TERM evaluation. All information is shared with senior staff and monitored through the facility PSC.

B. Patient Safety Council Coaching

As detailed above, each facility is required to post their monthly reports or minutes that details the work conducted by their Patient Safety Committee to the facility PSES site. These are then reviewed minutes and detailed feedback is provided to coach the committee on their form and function.

C. Dashboards

The Risk Management/Patient Safety Dashboard and the Environment of Care Dashboard include multiple indicators to demonstrate the facility's performance as to these markers. These include: event reporting statistics, fall rate including harmful event rate, medication event rate including harmful medication events, timeliness of event review and closure, risk management education, events that meet the ECRI Top Patient Safety Concerns, and environment of care concerns.

VI. Evaluation/Review:

The risk staff reviews the effectiveness of the Patient Safety/Risk Management Plan to ensure activities are appropriately focused on improving patient safety, decreasing harmful errors, decreasing rate of compensable events, facility risk program

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consistency/functionality and support of clinical delivery in the field. Evaluation will include the following:

- The culture supports the identification and reporting of “Near Miss” events
- There is a framework that advances a “Just Culture”
- Accountability is promoted when acts of “at risk” or “reckless behavior” occur resulting in potential/actual adverse outcomes;
- Comparison of trended incident data to include analysis of performance to stated targets, submission of incident data in compliance to SOX stipulations and review of trended data submitted to the PSC for potential action;
- Review of annualized and prior year’s probable claim reports to determine needs for corporate-based projects designed to improve outcomes in an identified service line;
- Review of educational products distributed for the concluding operating year that were intended to improve outcomes associated with a particular clinical emphasis;
- Review information, analyses and reports from the Acute Care PSO for integration into the Patient Safety Evaluation System.

VII. Confidentiality

All patient safety/risk management work products are considered Patient Safety Work Products (PSWP) as defined by federal guidelines governing Patient Safety Organizations (PSO). All PSWP reported, stored, or generated in the Member PSES is confidential and privileged under Federal law. The Member PSES will only be accessed by authorized staff. Workforce participants will be trained on policies and procedures governing their patient safety activities and responsibilities.

VIII. Approval of Patient Safety Plan

According to [NRS 439.865](#), a medical facility shall submit its patient safety plan to the governing board of the facility for approval. After a facility’s patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan.

The patient safety plan must be reviewed and **updated annually** in accordance with the

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requirements for approval set forth in this section.

According to [NRS 439.843](#), on or before March 1 of each year, a copy of the most current patient safety plan established to [NRS 439.865](#) must be submitted to the Division of Public and Behavioral Health.

Appendix A: Terms and Definitions

Patient Safety: The Agency for Healthcare Research Quality (AHRQ) defines patient safety as “a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.” http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

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Sentinel event ([NRS 439.830](#))

1. Except as otherwise provided in subsection 2, “sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum.

2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:

(a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or

(b) July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published.

3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.

(Added to NRS by [2002 Special Session, 13](#); A [2005, 599](#); [2013, 217](#))

Institute for Healthcare Improvement (IHI) defines **medical harm** as “unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death.”

Facility-Associated Infection: ([NRS 439.802](#))

“Facility-acquired infection” means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections;
- Ventilator-associated pneumonia;
- Central line-related bloodstream infections;
- Urinary tract infections; and

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- Other categories of infections as may be established by the State Board of Health by regulation pursuant to [NRS 439.890](#).

(Added to NRS by [2005, 599](#); A [2009, 553](#))

Medical facility ([NRS 439.805](#))

“Medical facility” means:

- A hospital, as that term is defined in [NRS 449.012](#) and [449.0151](#);
- An obstetric center, as that term is defined in [NRS 449.0151](#) and [449.0155](#);
- A surgical center for ambulatory patients, as that term is defined in [NRS 449.0151](#) and [449.019](#); and
- An independent center for emergency medical care, as that term is defined in [NRS 449.013](#) and [449.0151](#).

(Added to NRS by [2002 Special Session, 13](#))

Near miss: An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Mandatory reporting: Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985;254(6):796-800.)

Risk: Possibility of loss or injury. (Merriam-Webster’s Online Dictionary, Risk, Available at <http://www.merriamwebster.com/dictionary/risk>. Last Accessed August 2009.)

Preventable event: Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Catheter Associated Urinary Tract Infection (CAUTI): A urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available

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http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CURRENT_b.pdf.)

Central Line Associated Bloodstream Infections (CLABSI): Primary bloodstream infections that are associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection.

Appendix B: Checklist Example: Injuries from Falls and Immobility

Process Change	In Place	Not Done	Will Adopt	Notes (Responsible & By When?)
Conduct fall and injury risk assessment upon admission				

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Reassess risk daily and with changes in patient condition				
Implement patient-specific intervention to prevent falls and injury				
Communicate risk across the team; use handoff forms, visual cues, huddles				
Round every 1 to 2 hours for high-risk patients; address needs (e.g., 3Ps: pain, potty, position-pressure). Combine with other tasks(vital signs)				
Individualize interventions. Use non-skid floor mats, hip protectors, individualized toileting schedule; adjust frequency of rounds				
Review medications (by pharmacist); avoid unnecessary hypnotics, sedatives				
Incorporate multidisciplinary input for falls				
Prevention from PT, OT, MD, RN and PharmD				
Include patients, families and caregivers in efforts to prevent falls. Educate regarding fall prevention measures; stay with patient				
Hold post-fall huddles immediately after event; analyze how and why; implement change to prevent other falls				

Reference: Checklists to Improve Patient Safety. June 2013.

	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 439.865, 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. Patient safety occurrence information from aggregated data reports and individual incident occurrence reports will be reviewed by the Risk Manager for presentation to the Safety/QA committee to prioritize organizational patient safety activity efforts. Types of patient safety or medical/health care errors included the data 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 patient 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 threat 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 its 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 department identifying a potential patient safety issue will immediately notify his or her supervisor and document the findings on an occurrence report. The occurrence report will be submitted to the Director of Risk/Quality Management per organizational policy.
 - 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 facts 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 the hazardous condition or potential patient safety issue and 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 be 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 member's professional and emotional reconciliation of the sentinel event. The Safety Committee encourages the staff member's involvement in the root cause analysis and action plan processes, to allow the staff member an active role in process resolution. Additionally, any staff member involved in a sentinel event or other medical/health care error may request and receive supportive personal counseling from the Social Services Department, Human Resources Department and/or his or her department supervisor.
- 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.

HealthSouth Rehabilitation Hospital of Las Vegas

Policy#: 180	Title: Patient Safety Plan	Category: Plans
Policy Status: Published	Effective Date: 09/21/2017	Last Reviewed Date: 09/21/2017

PROCEDURE

PURPOSE:

The purpose of the Patient Safety Program is to improve patient safety and reduce risk to patients, staff and visitors. Recognizing the effective medical/health care error reduction requires an integrated and coordinated approach; HealthSouth Rehabilitation Hospital of Las Vegas has developed an organization-wide safety program. The program supports the creation of an environment in which patients, their families, and organization staff leaders can identify and manage actual and potential risks to patient safety.

OBJECTIVE:

It is the objective of HealthSouth Rehabilitation Hospital of Las Vegas to foster an environment to improve patient safety, establish mechanism to support effective responses to actual occurrences and to be proactive in the reduction of medical/health care errors. Patient safety will be a priority in new design and all relevant organization processes, functions and services.

SCOPE:

The scope of the patient safety program will include compliance with standards identified by external regulatory agencies and accrediting bodies. Program activities will address occurrences ranging from "near misses" to sentinel events with serious adverse outcomes.

DEFINITIONS:

Actual Event-an event occurred that reached the patient or individual (e.g., visitor fall, student injury, etc.).

Near Miss-an event occurred but it did not reach the patient because of chance alone or because of active recovery efforts by caregivers.

Unsafe Condition- circumstances that could cause adverse events (e.g., look-alike medications, confusing equipment, failure to use proper signage when floor is wet).

Sentinel Event- is defined as a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in any of the following:

- Severe temporary harm which is defined as critical, potentially life-threatening harm lasting for a limited time with no permanent residual effect, but requires transfer to a higher level of care/monitoring for a prolonged period of time, transfer to a higher level of care for a life-threatening condition, or additional major surgery, procedure, or treatment to resolve the condition. (Hip fractures are always included)
- Permanent harm
- Death

For additional events also considered "sentinel" reference the HealthSouth Sentinel Event policy

PROCEDURES:

A. The responsibility for management of the organization-wide patient safety program is assigned to the Director of Quality/Risk Management and Patient Safety Officer.

1. The Safety Committee and Quality Council will provide interdisciplinary input related to patient, visitor and staff safety.

2. Reports of safety related activities and issues would be presented to Department Managers, Senior Staff, Medical Staff via the Medical Executive Committee, and the Governing Board. This communication is confidential and for quality assurance purposes only.

B. Staff will report information relating the medical/health care events as outlined in Risk Management Electronic Event Reporting Policy.

1. Staff will be oriented to the Risk Management Policies on hire and through ongoing in-service and other education and training programs.

2. Staff will be oriented to their roles in preventing adverse occurrences as related to their specific job responsibilities and as a part of the organization-wide efforts to improve patient safety.

3. Staff will be oriented to the importance of reporting "near misses," as well as adverse occurrences.

4. Team training to foster an interdisciplinary, collaborative approach to patient care delivery and to reinforce the need and way(s) to report medical/health care errors will be provided as appropriate.

5. The Director of Quality/Risk Management, Department Managers, and Senior Staff are responsible for interacting with staff in a manner that ensures staff do not fear disclosure, embarrassment, blame or punishment for reporting potential or actual events related to patient safety.

6. The Director of Quality/Risk Management, Department Manager and/or Senior Staff member may request the assistance of external resources if a staff member(s) needs support in coping with a sentinel event.

C. Hospital leadership will identify barriers to effective communication among caregivers relative to patient care, redesign the process to

eliminate barriers and monitor for effectiveness. Specific attention will be directed to:

1. Process for ensuring accurate, timely, and complete verbal and written communication among care givers and all others involved in utilization of data, and
2. Test results relative to the management of the patient's condition.

D. All patients are entitled to information about all aspects of their health care, including information about clinically relevant unanticipated outcomes of care.

Patients and, when appropriate, their families are informed about the outcomes of care including unanticipated outcomes (i.e. sentinel events, State reportable events). Responsibility for disclosing unanticipated outcomes typically rests with the physician or designee who has overall responsibility for the patient's care. However, in some situations, other healthcare professionals may be deemed more appropriate to be responsible for disclosing the outcome. A hospital representative, preferably the Quality/Risk Director, Chief Nursing Officer or the Chief Executive Officer should be present for the initial conversation and any follow-up discussions that may occur with the patient and/or patient's representative.

E. The Director of Quality/Risk Management or designee will respond immediately to notification of significant medical/health events to a patient/visitor or staff member.

1. The Nursing Supervisor or Department Manager will contact the Risk Manager and/or Administrator/Administrator-On-Call to report events.
2. Action(s) will be taken to protect the patient/visitor/staff members as indicated per hospital plans and policies.
3. Factual information will be obtained and preserved for subsequent analysis. Such information is confidential for quality assurance purposes.

F. The facility will review historical risk management, Environment of Care (EOC), Program Improvement (PI) and Human Resources (HR) data for high volume, high risk problem trends in medical and care

processes, as well as unanticipated adverse occurrences affecting patients. These will be ranked as:

- A. Unsafe condition (Non-event)
- B1. Near Miss - No Harm/Didn't Reach Patient/Caught by Chance
- B2. Near Miss - No Harm/Didn't Reach Patient b/c of Active Recovery by Caregiver
- C. No Harm – Reached Patient No Monitoring Required
- D. No Harm – Reached Patient Monitoring Required
- E. Harm – Temporary, Intervention Needed
- F. Harm – Temporary, Hospitalization Needed
- G. Harm - Permanent
- H. Harm – Permanent, Intervention Required to Sustain Life
- I. Death

G. The facility will also perform intense analysis consistent with the Root Cause Analysis/Sentinel Event Policies, and reports as required by state, regulatory, and accreditation bodies. The Risk Management designee is responsible for ensuring compliance with reporting.

H. Emerging needs requiring reprioritizing performance improvement activities may be identified through data collection and assessment, unanticipated adverse occurrences affecting patients, changing regulatory requirements, significant patient and staff needs, changes in the environment of care, or changes in the community. Priority consideration in establishing performance improvement teams is given to:

1. Processes that affect a large percentage of patients.
2. Processes that place patients at risk, if not performed well, if performed when not indicated, or if not performed when indicated.

Processes that have been or are likely to be problem prone.

I. When designing/redesigning processes, Department Managers and staff will:

1. Incorporate information from within the organization and from other organizations about potential risks to patients, including the occurrence

of sentinel events in order to minimize risks to patients affected by the new or redesigned process, function or service.

2. Conduct literature searches to obtain evidence based medical and/or care practices to be included in process redesign.

3. Include analysis and or pilot testing to determine whether the proposed design/redesign is an improvement.

J. Hospital leadership will consider the importance of patient safety in:

1. Development of hospital-wide patient care programs, policies and procedures that describe how patients' care needs are assessed and met.

2. Development and implementation of the hospital's plan for the provision of patient care.

3. Decision-making structures and processes.

4. Implementation of an effective and continuous program to measure assesses and improves performance.

5. Development of an interdisciplinary culture that emphasizes cooperation and communication. The leadership role of coaching will be used to promote communication among services, individual staff members and less formal structures such as quality action teams, performance-improvement teams or members of standing committees.

6. Development of a process to involve the patient, as appropriate to his/her condition, as a partner in helping to facilitate the safe delivery of care.

a. Patients/family members are oriented on admission of the importance of reporting perceived risks and concerns about the patient's care per Patient and Customer Complaint and Grievance Policy.

b. Department Managers and Senior Staff will review Press Ganey Patient Satisfaction Survey questions related to patient safety and develop a corrective action plan to patient/family complaints or suggestions for improving safety as appropriate.

7. The Governing Board will appoint the Director of Quality and Risk Management (DQRM) as the Patient Safety Officer. The Patient Safety Officer/Director's role includes:

- Participating in hazard surveillance, event reporting, reviewing, and the development of patient safety policies and procedures.
- Analyzing and seeking resolution of patient safety issues and works with the appropriate staff to implement recommendations and to monitor patient safety improvement activities.
- Report on findings, recommendations, actions taken, and results of measurements through the hospital quality structure.

K. At least one (1) high-risk process is the subject of ongoing measurement and periodic analysis to determine the degree of variation from intended performance, a minimum of 1 proactive risk assessment every 18 months. The process selected will be based, in part, on the information identifying the most frequently occurring sentinel events and patient safety risk factors.

1. Assess the intended and actual implementation of this process to identify steps in the process where there is, or may be, undesirable variation (i.e. called potential "failure modes").
2. For each identified "failure mode, "identify the possible "effect(s)" and how serious the possible effect on the patient could be (i.e. "criticality "of the effect).
3. For the most critical effects, conduct a root cause analysis to determine the variation (failure mode) leading to that effect occur.
4. Redesign the process and/or underlying systems to minimize the risk of that failure mode to protect patients from the effect of that failure mode.
5. Test and implement the redesigned process.

6. Identify and implement measures of the effectiveness of the redesigned process.

7. Implement a strategy for maintaining the effectiveness of the redesigned process over time.

L. Hospital leadership will measure and assess the effectiveness of their contributions to improving patient safety. To accomplish these goals, leaders will.

1. Set measurable objectives for improving patient safety.

2. Actively request staff to periodically discuss their opinions, needs, perceptions of risks to patients and suggestions for improving patient safety. The actions taken as a result of this staff input will be reported to the MEC/GB at bi-annually.

3. Review data on staff willingness to report medical/health events.

4. Review data from Press Ganey Patient Satisfaction Survey related to patient safety.

5. Use pre-established, objective process criteria to assess their effectiveness in improving patient safety.

6. Draw conclusions based on their findings and develop and implement improvement in their activities.

7. Evaluate their performance in supporting sustained improvement.

M. The DQRM will report at a minimum quarterly to the Governing Board occurrences of medical/health events and actions to improve patient safety.



Patient Safety Plan

2017

This plan was created and revised by the Renown Health's Patient Safety Committee. Implementation of this plan is intended to optimize the healthcare quality and patient safety outcomes. In addition the plan is intended to encourage recognition, reporting, and acknowledgment of risks to patients, visitors, and employees as well as reduce medical/healthcare errors and /or preventable events.

Patient Safety Plan

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Commitment to Patient Safety

Renown Health is committed to a comprehensive approach to improving healthcare quality and patient safety by aligning with our Mission, Vision, and Values, creating an environment that supports a dynamic, proactive, and safe culture for patients, family members, visitors, and employees, through continuous learning and improving patient safety policies, systems, and processes.

Mission, Vision, and Values

In support of our mission, vision, and values, Renown Health's Patient Safety program promotes:

- Collaboration of healthcare, leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high quality healthcare.
- Honest, open communication to foster trusting and cooperative relationships among healthcare providers, staff members, and patients and their families, to ensure accountability for the patient safety priorities.
- Preservation of dignity and values for each patient, family member, employee, and other healthcare providers.
- Responsibility for safety related decision and action.
- A focus on continuous learning and improving, system design, and the management of choices and changes, bringing the best possible patient outcomes.
- Incorporation of evidence-based safety practice guidelines to deliver high quality healthcare.
- Education of staff, physicians, patients and their families to promote patient safety and continuous quality improvement.

Scope and Purpose

This Patient Safety Plan applies across the entire Renown Health organization.

All staff and physicians in Renown Health are required to fully support and participate in this plan, and devote their expertise to the patient safety and healthcare performance improvement process.

This plan is action oriented and solution focused. The purpose of this plan is to address patient safety related concerns, challenges and revise the program to better serve patients and their families.

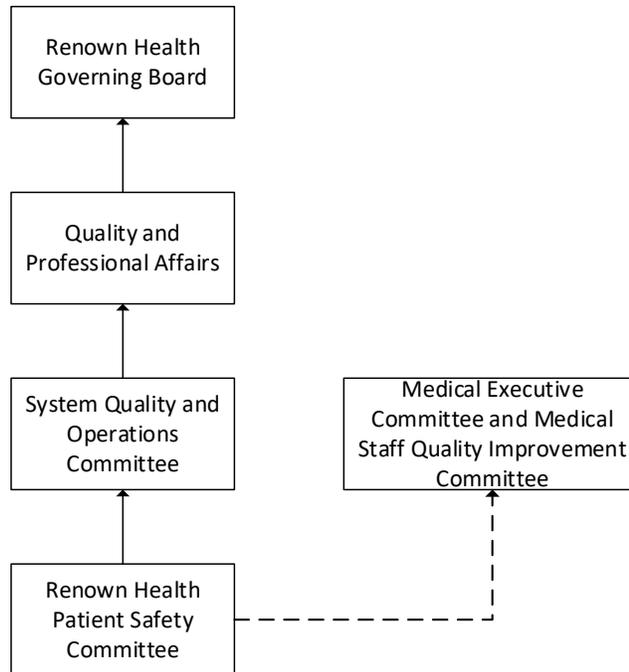
The plan focuses on the process rather than the individual, and recognizes both internal and external customers, as well as facilitates the need of analyzing and improving processes. The core principles of this plan include:

- Staff and physicians contributing their knowledge, vision, skill, and insight to improve the processes of patient safety
- Decisions made based on data and facts, with patient safety being considered
- Customer-focus including patients, families, and visitors
- System-based thinking
- Utilization of trained, expert staff and physicians.

Roles and Responsibilities

The Renown Health Patient Safety Committee ensures that the Patient Safety Plan is promoted and executed successfully as indicated in NRS439.875.

The Patient Safety Committee Organization



Roles and Responsibilities

- In accordance with [NRS 439.875](#), the Renown Health Patient Safety Committee is comprised of:
- The Renown Health Infection Control Officer;
- The Renown Health Patient Safety Officer;
- At least three providers of healthcare who treat patients, including at least one member of the medical, nursing and pharmaceutical staff of the medical organization; and
- One member of the executive or governing body of the medical organization;
- A representative from Executive Leadership.

Patient Safety Committee Responsibilities (based on [NRS 439.875](#) and [NRS 439.877](#))

- Monitor and document the effectiveness of the patient identification policy through event review when applicable.

- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the patient safety officer pursuant to [NRS 439.870](#).
- Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred.
- Review and evaluate the quality of measures carried out by the organization to improve the safety of patients.
- Review and evaluate the quality of measures carried out by the organization to prevent and control infections.
- Make recommendations to the executive or governing body of the organization to reduce the number and severity of sentinel events and infections.
- At least once each calendar quarter, report to the executive or governing body of the organization regarding:
 - (1) The number of sentinel events that occurred;
 - (2) The number and severity of infections that occurred; and
 - (3) Any recommendations to reduce the number and severity of sentinel events and infections.
- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

Patient Safety Officer Responsibilities (based on [NRS 439.870](#))

- Serve on the Renown Health Patient Safety Committee.
- Supervise the reporting of all sentinel events alleged to have occurred, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred.
- Report to the patient safety committee directly or through his/her designee any action taken in accordance with the responsibilities above.

Infection Control Officer Responsibilities (based on [NRS 439.873](#))

- Serve on the Renown Health Patient Safety Committee.
- Monitor the occurrences of infections to determine the number and severity of infections.
- Report to the patient safety committee concerning the number and severity of infections either directly or through his/her designee.
- Take such action as determines is necessary to prevent and control infections alleged to have occurred.
- Carry out the provisions of the infection control program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program.

Quality and Professional Affairs Committee of the Renown Health Board

- Provide vision and leadership to Patient Safety process, and develop and foster a safe learning and improving culture.
- Ensures the priorities of patient safety are aligned with the strategic priorities of the health system.

The Patient Safety Committee will meet monthly to accomplish the following:

- Report and discuss sentinel events and hospital acquired infections including:

- Number of sentinel events from previous calendar month
- Number of hospital acquired infections that occurred in the organization
- Corrective action plans for the sentinel events and infections.
- Patient safety policies and checklists
 - At least annually evaluate Patient Safety policies and checklists
 - Revise the patient safety policies and checklists as needed
 - Monitor and document the effectiveness of patient safety policies.

A meeting agenda and minutes noting follow-up tasks will be kept.

Components and Methods

Pursuant to [NRS 439.837](#), a medical facility shall, upon reporting a sentinel event pursuant to [NRS 439.835](#), conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event.”

Root Cause Analysis

Renown Health will use Root Cause Analysis (RCA) to determine the contributing factors and the underlying reasons for the deficiencies or failures. Transformational Health Care principles and methods are incorporated into Renown Health’s RCA process.

An RCA is a process for identifying the root causes of problems. It follows the principles of Just Culture by focusing on processes, instead of individuals.

Root Cause Analysis (RCA) Team Responsibilities

RCAs are conducted for all identified sentinel events and significant events/near misses involving complex process failure. Results of significant RCAs will be reported and monitored by the Renown Health Patient Safety Committee.

- Root Cause interviews, analysis, investigation, and corrective action plan implementations
- Participates in the RCA meetings and discussions
- Communicate honestly and openly about data and facts to the team members and their supervisors/leaders
- Incorporates the principles of Just Culture in the RCA process.

Causal Chain (5 Whys) technique will be used in Renown Health to explore the cause and effect relationship underlay a problem. One can find the root causes by asking “why” repeatedly.

Data Collection and Reporting

Data drives quality and patient safety efforts. Renown Health uses Midas and other databases for tracking sentinel events, healthcare infections, and other patient safety related data.

External data sources are those data sources which are collected outside the supervisory structure of the case. External data which will be utilized for Patient Safety plan include the data from:

Renown Health Patient Safety Plan

- AHRQ: Agency for Healthcare Research & Quality
- CDC: Centers for Disease Control and Prevention
- CMS: Centers for Medicare & Medicaid Services
- NQF: National Quality Forum
- NHSN: National Healthcare Safety Network
- TJC: The Joint Commission

Patient Safety Checklists and Patient Safety Policies

By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the organization;
- Other personnel who provide treatment or assistance to patients;
- Employees who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the organization; and
- Persons with whom the organization enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

The Renown Health Patient Safety Committee reviews and approves annually patient safety checklists based on policy.

Based on [NRS 439.865](#), the patient safety plan must also include an infection control program that carries out the infection control policy. The policy must consist of:

- The current guidelines appropriate for the scope of service developed by a nationally recognized infection control organization as approved by the State Board of Health which may include, the Association for Professionals in Infection Control and Epidemiology (APIC), the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO) and the Society for Healthcare Epidemiology of America (SHEA); and
- Facility-specific infection control developed under the supervision of a certified Infection Preventionist.

The Renown Health Infection Prevention Plan and Program is established and approved by the Renown Health Infection Control Committee. Regular reports and updates regarding the Infection Prevention Program are provided to the Patient Safety Committee.

Approval of Patient Safety Plan

The Renown Health Patient Safety Plan is reviewed and updated annually and is approved by the Quality and Professional Affairs Committee of the Renown Health Board.

According to [NRS 439.843](#), on or before March 1 of each year, a copy of the most current patient safety plan established to [NRS 439.865](#) must be submitted to the Division of Public and Behavioral Health.

Saint Mary's Regional Medical Center:

PATIENT SAFETY PLAN

DATE: 01/26/2018
VERSION: 01



This plan was created and revised by Saint Mary's Patient Safety committee/team. Implementation of this plan is intended to optimize the healthcare quality and patient safety outcomes, encourage recognition, reporting, and acknowledgment of risks to patient, visitor, and employee safety, as well as reduce the medical/healthcare errors and /or preventable events.

All documents, materials and/or information prepared or created for the purpose of compliance with state law and/or peer review are confidential and deemed protected by the confidentiality provisions of any subsequent federal or state statute providing protection for related activities. Patient Safety files and their entire contents will be clearly marked —CONFIDENTIAL--and should not be copied or distributed without the advice of Legal Counsel.

Patient Safety Committee/Program

Saint Mary's Regional Medical Center:

235 West Sixth Street
Reno, NV 89503
(775)770-3000

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Commitment to Patient Safety

Saint Mary's Regional Medical Center is committed to providing quality healthcare to all patients. The Patient Safety Plan serves as a framework to establish and maintain a safe patient care environment. It expands the organization-wide support for risk management, performance improvement, information management, education, human resources and patient's rights by implementing patient safety standards, measuring and monitoring their effectiveness, and creating a "culture of safety" as part of the overall quality program.

Mission, Vision, and Values

In support of our mission, vision, and values, Saint Mary's Patient Safety program promotes:

- Collaboration of healthcare, leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high quality healthcare.
- Communicate honestly and openly to foster trusting and cooperative relationships among healthcare providers, staff members, and patients and their families, to ensure accountability for the patient safety priorities.
- Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.
- Responsibility for every healthcare related decision and action.
- A focus on continuous learning and improving, system design, and the management of choices and changes, bringing the best possible outcomes or performances to the facility.
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare.
- Education of staff and physicians to assure participation of healthcare providers.

Scope and Purpose

The scope of this Patient Safety Plan is organizational-wide/hospital-wide/agency-wide which includes but is not limited to

- Patient safety
 - Visitor safety
 - Employee safety
- A. Saint Mary's recognizes that patients, staff and visitors have the right to a safe environment. Therefore, the organization commits to undertaking a proactive approach to the identification and mitigation of medical errors through the integration into and participation of all components of the hospital into the hospital wide program. This includes Performance Improvement, Risk, Infection Control and EOC programs.
- B. The Patient Safety Plan promotes the use of internal and external knowledge and experience to identify, analyze, and prevent the occurrence of medical / healthcare errors and identify areas of opportunity to maintain and improve patient safety.
- C. Patient safety information will be analyzed from aggregated data reports. All types of events can be addressed including "no harm", "near misses", and "sentinel events".

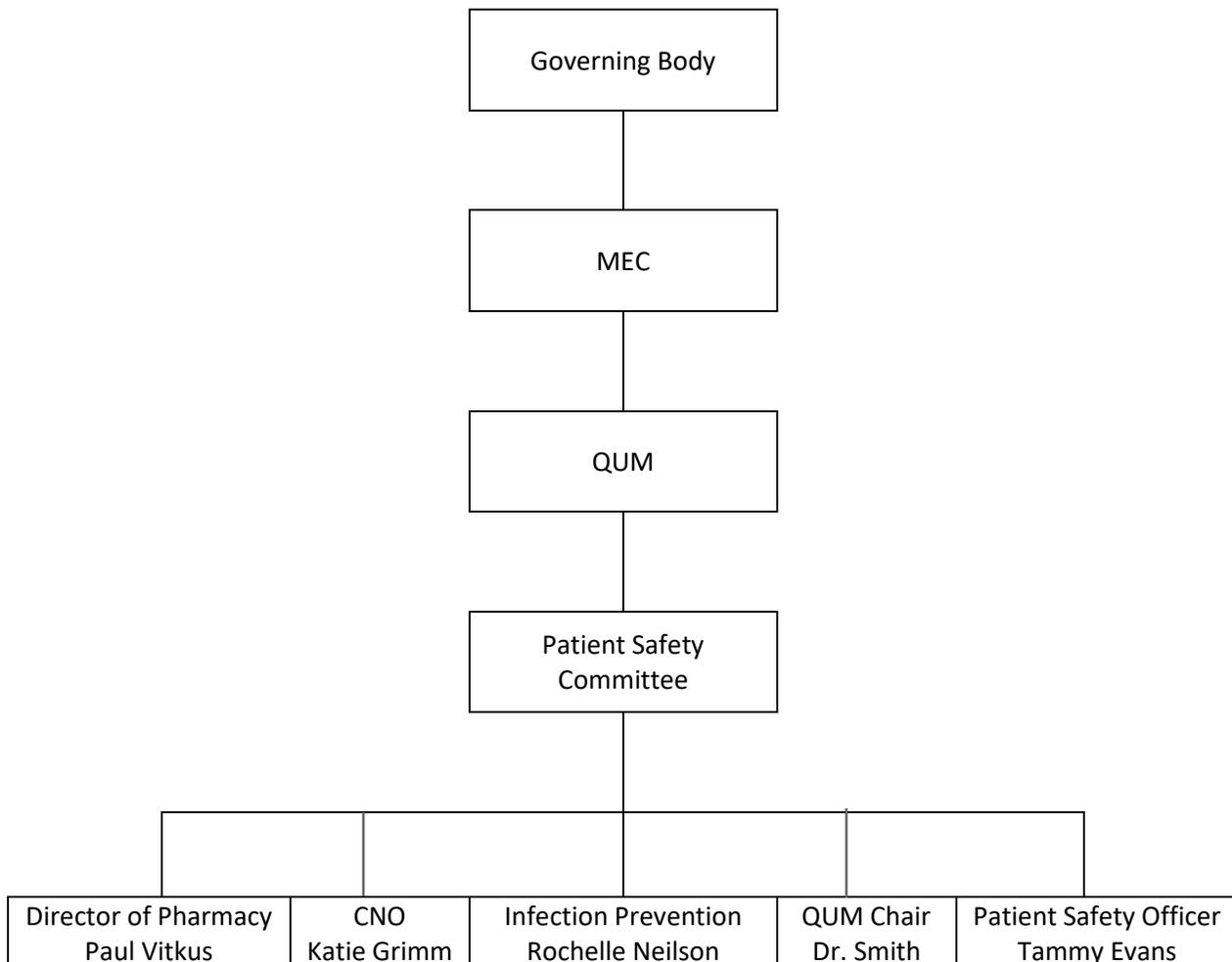
These reports will be reported to appropriate hospital and Medical Staff committees and to the Governing Board at regular intervals. The aggregate data will be used to prioritize organization-wide patient safety efforts.

- D. The organization also recognizes that despite our best efforts, errors can and will occur. Therefore, it is the intent of the organization to respond quickly, effectively, and appropriately when an error does occur.
- E. The organization also recognizes that the patient has the right to be informed of the results of treatment or procedures whenever those results differ significantly from anticipated results.

Roles and Responsibilities

According to [NRS 439.875](#), a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plan is promoted and executed successfully.

The Patient Safety Committee Organization



Roles and Responsibilities

- In accordance with [NRS 439.875](#), a patient safety committee must be comprised of:
- The infection control officer of the medical facility;
- The patient safety officer of the medical facility, if he or she is not designated as the infection control officer;
- At least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility; and
- One member of the executive or governing body of the medical facility.

The roles and responsibilities are defined below

Patient Safety Committee Responsibilities (based on [NRS 439.875](#) and [NRS 439.877](#))

- Monitor and document the effectiveness of the patient identification policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the patient safety officer pursuant to [NRS 439.870](#).
- Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred.
- Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the executive or governing body of the facility regarding:
 - (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);
 - (2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and
 - (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

Patient Safety Officer Responsibilities (based on [NRS 439.870](#))

- Serve on the patient safety committee.
- Supervise the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the patient safety committee regarding any action taken in accordance with the responsibilities above.

- Selects at least one high-risk patient safety process for proactive risk assessment (FMEA) at least every 12-18 months. Coordinates the process throughout this period.
- Presents Patient Safety reports to all departments.
- Develops, and recommends new policies and procedures for patient safety based on analysis of data from events, and other relevant information.
- Works in conjunction with the EOC Chair to prioritize risks, review and analyze data and performs risk analysis as needed to address the safety of the patient environment.
- Maintains the confidentiality and legal privilege, as appropriate, of all data and information.
- Facilitates patient safety orientation and in-service education programs.

Infection Control Officer Responsibilities (based on [NRS 439.873](#))

- Serve on the patient safety committee.
- Monitor the occurrences of infections at the facility to determine the number and severity of infections.
- Report to the patient safety committee concerning the number and severity of infections at the facility.
- Take such action as determines is necessary to prevent and control infections alleged to have occurred at the facility.
- Carry out the provisions of the infection control program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program.

Executive or Governing Body Staff Responsibilities

- Provide vision and leadership to Patient Safety process, and develop and foster a safe learning and improving culture.
- Provides oversight to the healthcare quality improvement processes and teams.

The Patient Safety Committee will meet monthly to accomplish the following:

- Report and discuss sentinel events which include:
 - Number of sentinel events from previous calendar month (or quarter).
 - Number of severe infections that occurred in the facility.
- Corrective Action Plan for the sentinel events and infections
 - Evaluate the corrective action plan.
- Patient safety policies and checklists
 - At least annually evaluate Patient Safety policies and checklists
 - Revise the patient safety policies and checklists as needed.
 - Monitor and document the effectiveness of the patient safety policy.

A meeting agenda and minutes noting follow-up tasks will be kept.

Objectives and Goals of the Patient Safety Plan

Objective	Goals	Plan	Planned Completion Date	Responsible Party
Improve Hospital Handoffs & Transitions	Use TC tools to standardize handoffs within and across hospital departments. Goal: Improve Hospital Handoffs & Transitions by 10% or more by the next Safety Attitude Survey. Current AHRQ value 16%	Saint Mary's will implement a performance improvement team with a bottoms-up approach to problem solving led by bedside employees. We will collaborate with physicians, nurses, and non-clinical staff to address both clinical and non-clinical processes associated with handoff communication. We will have a bias toward action implementing small tests of change utilizing the PDSA model.	July 1, 2018	Name Here
Reduce Misabeled Specimens	Use standardized data collection and process review to determine causation links	Saint Mary's will implement a mislabeled specimens committee to review data and report progress towards zero events to QUM	July 1, 2018	Name Here
Improve response rate of AHRQ Safety Attitude Survey	Increase respondents by 30%	Focus on patient care areas by removing non-clinical departments from denominator	November 30, 2018	Name Here

Components and Methods

Pursuant to [NRS 439.837](#), a medical facility shall, upon reporting a sentinel event pursuant to [NRS 439.835](#), conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event."

Saint Mary's will use RCA process to determine the contributing factors and the underlying reasons for the deficiencies or failures. The Plan-Do-Study (check)-Act (PDSA or PDCA) is the model, which was developed by the Institute of Health Care Improvement, which we will use to test the

changes.



Root Cause Analysis

A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals.

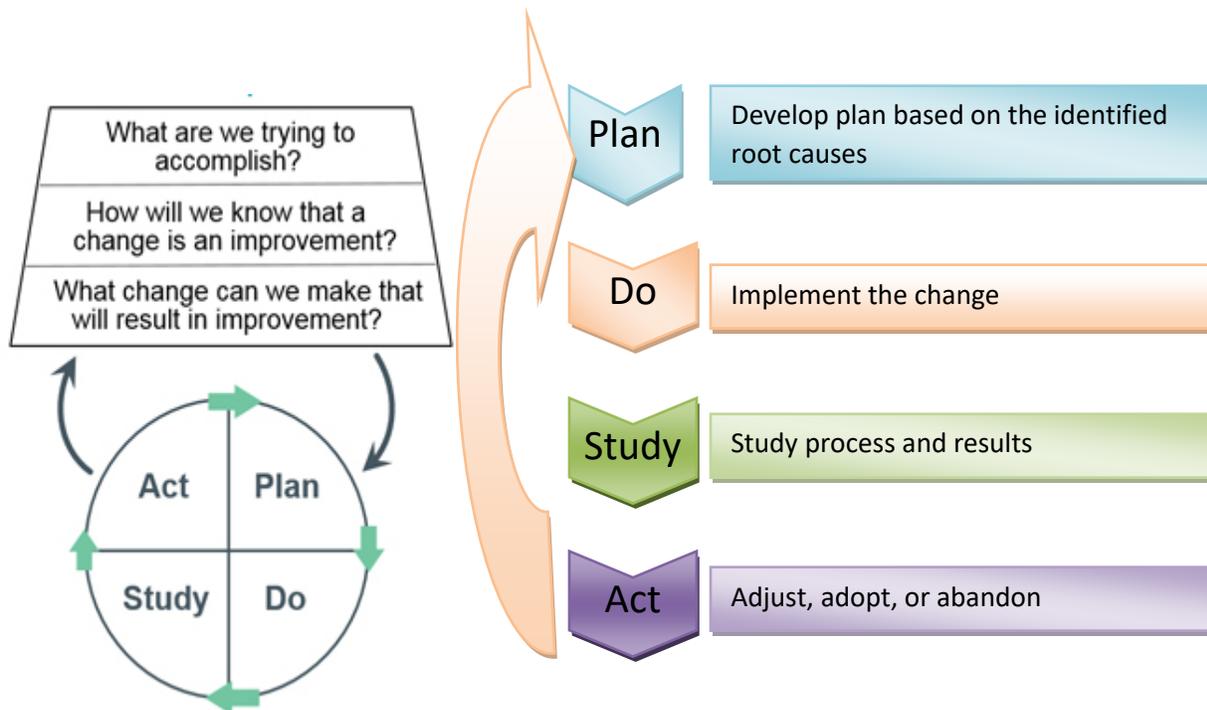
Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

Root cause analysis and action plan framework table, which was introduced by the Joint Commission. It contains 24 analysis questions. It guides the organization to the steps in a root cause analysis. Not all the questions apply to all the events or cases. This table can be used individually or with the fishbone diagram.

5 Whys technique will be used in Saint Mary's to explore the cause and effect relationship underlay a problem. One can find the root causes by asking "why" no less than five times.

Model for Improvement

The Model for Improvement is a collaborative and ongoing effort model to improve the product and services quality and process. It provides multi-disciplinary quality team guidance from identifying the root causes; conducting the best tests to assess possible changes, and working in collaboration for implementation of the new approaches and solutions. It guides the test of a change to determine if the change is an improvement.



The cycle is defined as follows:

- Plan--collect data and establish appropriate goals. Identify the problem and the possible root causes, and answer the following questions.
 - What is the objective of the test?
 - What are the steps for the test - who, what, when?
 - How will you measure the impact of the test?
 - What is your plan to collect the data needed?
 - What do you predict will happen?
- Do--make changes designed to correct or improve the situation. Use the following questions for the guidance.
 - What were the results of the test?
 - Was the cycle carried out as designed or planned?
 - What did you observe that was unplanned or expected?

- Study -- Study the effect of the changes on the situation. Data should be collected on the new process and compared to the baseline or expected results. Results should be evaluated and by using the following questions as guidance.
 - Did the results match your prediction?
 - What did you learn?
 - What do you need to do next?
- Act--If the result is successful or desirable, standardize the changes and then work on the next prioritized problem or the further improvements. If the outcome is not yet successful, look for different ways to identify the causes or change the testing process.

PDSA worksheet will be used to map the potential change strategies and to establish a course of action. The PDSA worksheet and the PDSA progress report are attached in Appendix D-1.

Data Collection and Reporting

In order to reduce the likelihood of patient incidents and negative outcomes, Saint Mary's shall track the frequency and type of medical errors and compile them in order to learn from and prevent future negative occurrences.

1. External data sources are those data sources which are collected outside the supervisory structure of the case. External data which will be utilized for Quality and Patient Safety plan include the data from:
 - a. AHRQ: Agency for Healthcare Research & Quality
 - b. CDC: Centers for Disease Control and Prevention
 - c. CMS: Centers for Medicare & Medicaid Services
 - d. NQF: National Quality Forum
 - e. NHSN: National Healthcare Safety Network
 - f. TJC: The Joint Commission
2. Internal data sources:
 - a. Risk incident reports with database compilation
 - b. Adverse Drug Events and Adverse Drug Reactions
 - c. Data from patient complaints
 - d. Risk Management and Safety findings
 - e. Compliance findings
 - f. PI and special study findings
 - g. Infectious Disease information
 - h. Employee surveys
3. Risk Assessment (Failure Mode and Effect Analysis)

An assessment that examines a process in detail including sequencing of events; accesses actual and potential risk, failure, points of vulnerability; and through a logical process, priorities areas for improvement based on the actual or potential patient care impact (criticality).

4. Data Analysis

Analysis of collected data will be undertaken to monitor and identify levels of performance, trends or patterns that vary significantly from expected outcomes and the need for possible change/improvement in systems or processes.

5. Process Improvement

When undesirable outcomes are identified, the hospital shall involve the personnel, resources, disciplines, and department/services most directly involved with the process to reduce future risk.

Ongoing Reporting and Review

Data points such as the following will be reviewed according to the schedule prescribed:

Monthly	Quarterly	Annually
1) Sentinel event monthly report 2) Severity of infection report 3) RCA assessment	1) Sentinel event quarterly report 2) Severity of infection report 3) Review and evaluate the measure of improvement of patient safety	1) Quality and Patient Safety Plan update 2) Checklists and Policies reviewing and revising

Assessment of the Patient Safety Plan

Please see the Patient Safety Assessment Tool (PSAT) from the VA National Center for Patient Safety for your reference.

Patient Safety Checklists and Patient Safety Policies

By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;

- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

The patient safety checklists must follow protocols to improve the health outcomes of patients at the medical facility and must include, without limitation:

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.
- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - Proper instructions concerning prescription medications;
 - Instructions concerning aftercare;
 - Any other instructions concerning his or her care upon discharge; and
 - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include, the name and date of birth of the patient.
- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.
- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

Based on [NRS 439.865](#), the patient safety plan must also include an infection control program that carries out the infection control policy. Saint Mary's has a separate Infection Prevention Plan developed by our certified Infection Preventionist. This document is available upon request.

The patient safety checklists are listed in Appendix E. (The following links provide some patient safety checklists for your reference— a checklist example is shown in **Appendix E.**)

http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf

<http://www.who.int/patientsafety/implementation/checklists/en/>

The patient safety policies are listed in Appendix F. (The following link provides you some patient safety policies for your reference—a policy example is shown in **Appendix F.**)

<https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>

Approval of Patient Safety Plan

According to [NRS 439.865](#), a medical facility shall submit its patient safety plan to the governing board of the facility for approval. After a facility's patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan.

The patient safety plan must be reviewed and **updated annually** in accordance with the requirements for approval set forth in this section.

According to [NRS 439.843](#), on or before March 1 of each year, a copy of the most current patient safety plan established to [NRS 439.865](#) must be submitted to the Division of Public and Behavioral Health.

Approvals

_____	_____
Director Risk Management	Date
_____	_____
Chief Nursing Officer / Administrator	Date
_____	_____
Chief Executive Officer	Date
_____	_____
Chairman, QUM Committee	Date
_____	_____
Chief of Staff	Date
_____	_____
Governing Board	Date

Reference

- Root Cause Analysis Toolkit <http://www.health.state.mn.us/patientsafety/toolkit/>
- Quality and Service Improvement Tools http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html
- CQI 101 An Introduction to Continuous Quality Improvement: <https://www.coursehero.com/file/13827355/CQI-Overviewppt/>
- Quality Improvement <http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/>
- Root Cause Analysis <http://www.patientsafety.va.gov/professionals/onthejob/rca.asp>
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2 https://www.jointcommission.org/sentinel_event.aspx
- Hospital Policies <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>
- Checklists to Improve Patient Safety http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf
- Patient Safety Checklists <http://www.who.int/patientsafety/implementation/checklists/en/>
- Minutes of the Meeting of the Quality and Patient Safety Committee <http://www.cookcountyhhs.org/wp-content/uploads/2013/12/09-23-14-QPS-scan-Minutes.pdf>
- Title 40 – Public Health and Safety <https://www.leg.state.nv.us/NRS/NRS-439.html>

Appendix A: Terms and Definitions

Patient Safety: The Agency for Healthcare Research Quality (AHRQ) defines patient safety as “a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.”
http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

Sentinel event ([NRS 439.830](#))

1. Except as otherwise provided in subsection 2, “sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum.

2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:

(a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or

(b) July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published.

3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.

(Added to NRS by [2002 Special Session, 13](#); A [2005, 599](#); [2013, 217](#))

Institute for Healthcare Improvement (IHI) defines **medical harm** as “unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death.”

Facility-Associated Infection: ([NRS 439.802](#))

“Facility-acquired infection” means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections;
- Ventilator-associated pneumonia;
- Central line-related bloodstream infections;
- Urinary tract infections; and
- Other categories of infections as may be established by the State Board of Health by regulation pursuant to [NRS 439.890](#).

(Added to NRS by [2005, 599](#); A [2009, 553](#))

Medical facility ([NRS 439.805](#))

“Medical facility” means:

- A hospital, as that term is defined in [NRS 449.012](#) and [449.0151](#);

- An obstetric center, as that term is defined in [NRS 449.0151](#) and [449.0155](#);
- A surgical center for ambulatory patients, as that term is defined in [NRS 449.0151](#) and [449.019](#); and
- An independent center for emergency medical care, as that term is defined in [NRS 449.013](#) and [449.0151](#).

(Added to NRS by [2002 Special Session, 13](#))

Near miss: An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Mandatory reporting: Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985;254(6):796-800.)

Risk: Possibility of loss or injury. (Merriam-Webster's Online Dictionary, Risk, Available at <http://www.merriamwebster.com/dictionary/risk>. Last Accessed August 2009.)

Preventable event: Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Catheter Associated Urinary Tract Infection (CAUTI): A urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CUR_RENT_b.pdf.)

Central Line Associated Bloodstream Infections (CLABSI): Primary bloodstream infections that are associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection.

Appendix B: Patient Safety Goals

Goal 1 - Improve the accuracy of patient identification.

NPSG.01.01.01

Use at least two patient identifiers when providing care, treatment, and services.

NPSG.01.03.01

Eliminate transfusion errors related to patient misidentification.

Goal 2 - Improve the effectiveness of communication among caregivers.

NPSG.02.03.01

Report critical results of tests and diagnostic procedures on a timely basis.

Goal 3 - Improve the safety of using medications.

NPSG.03.04.01

Label all medications, medication containers, and other solutions on and off the sterile field in perioperative and other procedural settings.

Note: Medication containers include syringes, medicine cups, and basins.

NPSG.03.05.01

Reduce the likelihood of patient harm associated with the use of anticoagulant therapy.

Note: This requirement applies only to hospitals that provide anticoagulant therapy and/or long-term anticoagulation prophylaxis (for example, atrial fibrillation) where the clinical expectation is that the patient's laboratory values for coagulation will remain outside normal values. This requirement does not apply to routine situations in which short term prophylactic anticoagulation is used for venous thrombo-embolism prevention (for example, related to procedures or hospitalization) and the clinical expectation is that the patient's laboratory values for coagulation will remain within, or close to, normal values.

NPSG.03.06.01

Maintain and communicate accurate patient medication information.

Goal 6 - Reduce the harm associated with clinical alarm systems.

NPSG.06.01.01

Improve the safety of clinical alarm systems.

Goal 7 - Reduce the risk of health care-associated infections.

NPSG.07.01.01

Comply with either the current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines or the current World Health Organization (WHO) hand hygiene guidelines.

NPSG.07.03.01

Implement evidence-based practices to prevent health care-associated infections due to multidrug-resistant organisms in acute care hospitals.

Note: This requirement applies to, but is not limited to, epidemiologically important organisms such as methicillin-resistant staphylococcus aureus (MRSA), clostridium difficile (CDI), vancomycin-resistant enterococci (VRE), and multidrug-resistant gram-negative bacteria.

NPSG.07.04.01

Implement evidence-based practices to prevent central line-associated bloodstream infections.

Note: This requirement covers short- and long-term central venous catheters and peripherally inserted central catheter (PICC) lines.

NPSG.07.05.01

Implement evidence-based practices for preventing surgical site infections.

NPSG.07.06.01

Implement evidence-based practices to prevent indwelling catheter-associated urinary tract infections (CAUTI).

Note: This NPSG is not applicable to pediatric populations. Research resulting in evidence-based practices was conducted with adults, and there is no consensus that these practices apply to children.

Goal 15 -The hospital identifies safety risks inherent in its patient population.

NPSG.15.01.01

Identify patient at risk for suicide.

1. Conduct a risk assessment that identifies specific patient characteristics and environmental features that may increase or decrease the risk for suicide.
2. Address the patient's immediate safety needs and most appropriate setting for treatment.
3. When a patient at risk for suicide leaves the care of the hospital, provide suicide prevention information (such as a crisis hotline) to the patient and his or her family.

Universal Protocol

UP.01.01.01

Conduct a pre-procedure verification process.

UP.01.02.01

Mark the procedure site.

UP.01.03.01

A time-out is performed before the procedure.

Appendix C: RCA

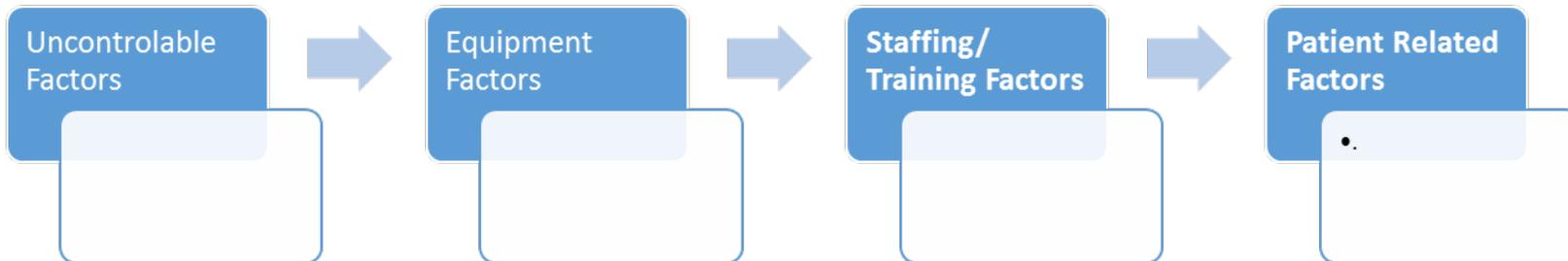
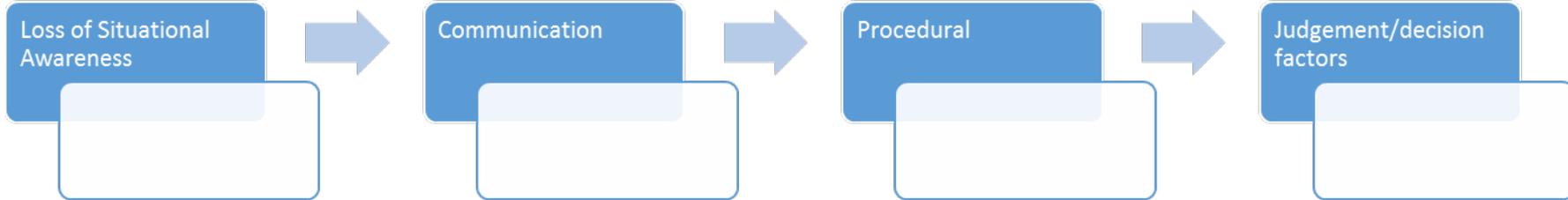
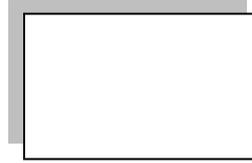
Narrative:

Key Factors:

Timeline:

Date / Time	Description of Event as relates to RCA	Concerns Noted	Employee(s) involved

Cause and Effect Diagram (or process flow chart):



Undesirable Outcome:						
Search for Causes:	Cause Identified	Description of Cause	Human Error	Described Human Error and/or Variance from P/P	Causal Link	Take Action?
Patient Related						
Situational Awareness						
Communication						
Proficiency						
Judgment						
Training						
Leadership						
Staffing						
Mechanical Failure						
Other						

Action Plan

Concerns	Action Plan	Responsible Party	Due Date	Status

Participants:

Literature Review:

Appendix D-1: PDSA Worksheet

PDSA Worksheet

Topic:			
Person Completing Worksheet:		Date:	
Telephone/ Email:		Cycle:	
Patient Safety Committee Members			
CNO/COO			
Patient Safety Officer			
Infection Control Officer			
Other Medical Staff			
Other team members			
Aim: (Describe the overall SMART goal that your team wishes to achieve.)			
Plan:			
1. List the tasks needed to set up this test of change.			
2. Predict what will happen when the test is carried out.			

3. List the steps to develop the test-who, what, and when.			
Steps	By Whom	By When	Desired Outcome
Do: (Describe what actually happened when you ran your test, including any problems and unexpected findings.)			
Study: (Describe what you learned and did you meet your measurement goal?)			
Did you meet your measurement goal? Explain.		Summarize what was learned: success, failure, unintended consequences, etc.	
Act: (Describe what you concluded from this cycle.)			
Based on what was learned, please indicate what action will be considered.		Describe what modifications to the plan will be made for the next cycle based on what you learned.	
<input type="checkbox"/> Adapt: modify changes and repeat PDSA Cycle			
<input type="checkbox"/> Adopt: expanding changes throughout organization			
<input type="checkbox"/> Abandon: change approach and repeat PDSA cycle			

Appendix D-2: PDSA Monthly / Quarterly Progress Report

Event:			
Person Complete Report:		Date:	
Patient Safety Officer		Contact Information:	
Monthly / Quarterly Report			
Items	Description		
1. What is your goal?			
2. Report on the PDSA cycle			
3. What system and practices are working well? Explain.			
4. What areas for improvement did the data identify?			
5. What barriers or system issues have been encountered implementing action activities?			
6. Action plans to address the barriers or system issues			
7. Lesson learned			
8. Support needed			
9. Additional discussion			
Notes:			

Appendix E: Checklist Example: Code Neuro

Code Neuro - New Item ✕

EDIT


Save
Commit


Cancel


Paste
Clipboard


Cut
Clipboard


Copy
Clipboard


Attach File
Actions


ABC
Spelling
Spelling

Last Known Well Time 12 AM 00

Events prior to Code Neuro Call

Total NIHSS Score

Was head CT done

Were Labs ordered

Was Primary MD called

Was Stroke Program Coordinator notified

Name of recorder

Name of primary MD

Name of Primary RN

Name of Code Neuro Team RN

Supervisor

Was Patient transferred

Appendix F: Policy Example

 Saint Mary's <i>Regional Medical Center</i>	Policy and Procedure	Perioperative Services Labor & Delivery/OR Cath Lab Interventional Radiology
Universal Protocol		

POLICY: Universal Protocol (Procedure Verification, Correct Site Management and Time Out For Invasive Procedures)

All patients undergoing a surgery or invasive procedure are to be considered at risk for the potential of a wrong patient, procedure or wrong site surgery/invasive procedure. The process to prevent wrong patient, wrong procedure and wrong site surgery or invasive procedure includes all required elements of the *Universal Protocol*. To assure that the correct procedure (operative or invasive) is performed on the correct patient and body part or site. Certain patients are considered at higher risk for error such as those undergoing multiple procedures with one or more physicians, those undergoing emergency procedures, or those patients that have unusual characteristics such as a physical deformity or massive obesity.

DEFINITIONS:

Procedure Verification: Includes verification of patient, procedure and site and as applicable, any implants, diagnostic/radiology results, blood, devices and special equipment (as appropriate to the type of surgery or procedure) AND is applicable to all departments performing surgical or invasive procedures, inclusive of bedside procedures.

Invasive Procedure: Any procedure performed which involves a puncture or incision of the skin, or insertion of an instrument or foreign material into the body, including but not limited to percutaneous aspirations, biopsies, cardiac and vascular catheterization, central line placements, epidurals and endoscopies. This policy does not apply to certain routine minor procedures such as peripheral IV line placement, insertion of an NG tube or urinary catheter insertion.

Procedure Room: Any room where a surgical or invasive procedure may occur to include the patient's bedside.

Procedure Personnel: The RN or credentialed personnel who are participating in the invasive procedure

PROCEDURE:**A. General Information**

- Procedures NOT within the Scope of the Universal Protocol and this policy:
 - Venipuncture
 - Peripheral intravenous line placement
 - Insertion of nasogastric tube
 - Urinary catheter placement
 - ECT (electroconvulsive therapy)
 - Closed reduction
 - Radiation oncology
 - Lithotripsy (this does have laterality, but the stone is visualized during the procedure)
 - Dialysis (except insertion of the dialysis catheter)

- All other invasive procedures are within the scope of the Universal Protocol and this policy.

- Department staff and physicians participating in a surgical or invasive procedure will actively participate in the Procedure Verification process (to include pre-procedure verification, site marking, and time out) as described in this policy, to assure the correct patient, procedure and site (as applicable) is assessed prior to any surgical or invasive procedure. Staff will document the verification steps in the medical record.

- Anytime there is a discrepancy in the Procedure Verification process, the person discovering the discrepancy will re-verify all the previously completed steps against the surgery schedule, the history and physical, the permit, the patient and notify the physician and department manager. The procedure will not begin until clear verification of the patient, procedure and/or site is completed.

- All actual and "near miss" wrong patient, wrong procedure or wrong site procedures will be reported promptly to the Department Manager or designee and Risk Manager.

B. Pre-Procedure Verification

- Verification of the correct person using two identifiers (patient's name & date of birth), correct site, and correct procedure will occur with the patient/family/legal representative involved, awake and aware, if possible and documented.

- Additionally, persons responsible for scheduling the procedure, completing preadmission testing/assessment and admitting the patient will verify the procedure and site with the physician, physician's office or physician order.

- Pre-procedure verification will occur at the following times:
 - At the time the procedure is scheduled (to include implant information if applicable).
 - At the time of preadmission testing & assessment
 - At the time of admission or entry into the facility for a procedure, whether elective or emergent
 - Before the patient leaves the pre-procedure area (i.e. Same Day Unit or Pre-op Holding) or enters the procedure room

- Anytime the responsibility for care of the patient is transferred to another member of the procedural care team, (including the anesthesia providers), the above information will be communicated during the hand-off
- Additionally, in the pre-procedure area, procedure verification will include the following for patients undergoing a surgical or invasive procedure and be documented. All applicable items will be available in the procedure room/area and matched to the patient:
 - Identification of the procedure scheduled and identified in physician documentation
 - Presence of current, updated and complete History and Physical
 - Consent accurate, complete and signed by patient/representative
 - Provider assessment (MD, Nursing, PA, APN) and pre-anesthesia /procedural sedation assessment completed and documented
 - Marking of the procedure site by the physician prior to the procedure (if applicable)
 - Verification of the correct patient position
 - Availability and documentation of correct and labeled implants, diagnostic/radiology results, blood, devices and special equipment, or special requirements
- Scheduled procedures that involve anatomical sites that have laterality, surface (flexor, extensor), levels or specific digits or lesions, the word(s) left or right or bilateral will be written out fully on the procedure/operating room schedule and on all relevant documentation including the procedural consent or permit.

C. Site Marking

- Site marking is conducted for all procedures involving incision or percutaneous puncture or insertion.
- The marking takes in to consideration anatomical laterality, the surface (flexor, extensor), the level (spine) or specific digit or lesion to be treated.
- In cases where bilateral structures are removed (such as tonsils or ovaries) the site does not need to be marked.
- If one side is definite and the other is possible, only mark the definite site (example: right ovary, possible left ovary, only mark the right side).
- The only exceptions to site marking are:
 - Midline, single organ procedures
 - When both bilateral structures are to be removed.
 - Endoscopies without laterality
 - Procedures when there is no pre-determined site of insertion, such as cardiac catheterization, interventional radiology and amniocentesis.
 - When the use of direct imaging (fluoro x-ray, ultrasound imaging, CT fluoro or MRI imaging) is utilized by a physician present from the time the site is selected through the completion of the procedure. This applies to all cases where the performing physician uses imaging to select and/or navigate and/or complete the procedure.
- The site marking is completed for all procedures involving incision or percutaneous puncture or insertion by the physician or proceduralist performing the procedure prior to the time the patient is moved in to the procedure room/location. The patient/family/legal representative should be involved in the site marking process.

- The physician or proceduralist will identify the patient (using the two patient identifiers) and verify the procedure and site with the patient/family/legal representative.
- In collaboration with the patient or patient's family member, the site will be marked with the initials of the physician performing the procedure using an indelible marker prior to the patient being transferred to the procedure/operating room unless the anatomical site is exempted per policy.
- The site initialed will be made at or adjacent to the incision site, and must be visible after the patient is prepped and draped and positioned in the final position.
- If the procedure involves multiple sides/sites during the same operation, each side and site must be initialed.
- Do not mark any non-operative site(s).
- In limited circumstances, the licensed independent practitioner may delegate site marking to an individual who is permitted by the organization to participate in the procedure, is familiar with the patient, will be present when the procedure is performed, and is either qualified through a medical residency program or is a licensed individual who performs duties requiring collaboration or supervisory agreements with the licensed independent practitioner (i.e., PA, APN).
- For spinal surgery, a two-stage marking process will occur as follows:
 - The general level of the procedure (cervical, thoracic, lumbar, or sacral) will be initialed pre-procedure, along with an indication of the right vs. left if applicable.
 - Intra-operatively, the exact interspace will be precisely marked using the standard intraoperative x-ray.
- The site will not be marked with the letter "X" or the word "No."
- A new marking pen will be used for each patient
- If the patient refuses to be marked, procedural personnel will re-educate the patient regarding the importance of site marking and document. If the patient still declines to be marked, the procedural personnel will notify the physician, document what alternative means was utilized for marking. The patient's refusal to be marked must be resolved between the procedural physician and the patient prior to the invasive procedure.
- If the consent was signed and the patient was marked accordingly, and then it was discovered that the site was incorrect before the incision was made, the procedure can proceed at the discretion of the procedural physician. The procedural personnel as per hospital policy will document an occurrence report.

D. Difficult to Mark Site:

- Sites which are technically difficult or anatomically impossible to mark or minimal access procedures treating a lateralized internal organ, will apply the alternative process below:
- Examples: Arm in cast, ureters through a cystoscope, teeth, or premature infants.

- After verifying with the patient/family/legal representative that the patient identification and procedural information is correct, the procedural personnel will place a patient sticker and the procedural information on an orange band, indicating the 'side' with 'Left' or 'Right'.
- The orange band information will be verified and initialed by the physician, then placed on the patient's ankle. If the patient's anatomy or procedural draping prevents visualization of the band during the time out process then the band will be placed on the patient's wrist.
- The orange band will be removed in the PACU or post-procedure recovery location.
- Teeth. The physician will initial on the dental radiographs or dental diagram each tooth involved in the surgery/procedure. The dental radiograph or diagram will be used during the time-out before the procedure to identify the site during the "time-out".
- Premature Infants: The orange band will be applied as in no. 1 above.

E. Time Out

- The time out is the suspension of all other activities to permit all members of the surgical/ procedural team to focus on active confirmation of the required time out elements. The circulating nurse or technologist will initiate the time out, although any member of the team may do this. These elements include:
 - Correct Patient: Patient identification using the two patient identifiers (patient name & date of birth).
 - Correct Site: Verification/confirmation of procedure site and side as specified on the consent and visualization of site marking that it is correct and agrees with consent
 - Correct Procedure: Accurate procedure and consent form per physician's order.
 - Confirmation of antibiotic administration
 - Consensus with all team members that above information is correct
 - Documentation of the "time out/procedure verification" process
- The procedure will not be initiated until all members agree with all elements included in the time out.
- The time out will be initiated by the procedural personnel after the patient has been prepped and draped and immediately prior to the initiation of the procedure with all team members present in the room or at the bedside.
- Whenever there is more than one procedure performed by separate procedure teams, there will be a time-out completed and documented by the separate procedure teams. The time out will precede each individual procedure.
- If there is any discrepancy among the team members during the time-out, re-verification will occur with a review of the surgical/department procedure schedule, history and physical, procedure consent, radiology films, consultations and any other information available to validate the correct patient, procedure and site.

F. Management Following Discovery of Wrong Patient/ Wrong Site/ Wrong Procedure

- If, after induction of anesthesia, during the course of a surgical/invasive procedure, or after a surgical/ invasive procedure has been completed, it is determined that the procedure being performed or completed is the wrong patient, wrong procedure or at the wrong site, the surgeon/physician and anesthesiologist will:
 - Act in accord with the patient's best interests and to promote the patient's well-being.
 - Record the event accurately in the medical record.

- Procedural personnel will immediately inform the department manager who will immediately notify the Risk Manager per hospital policy.

G. Fire Risk Assessment

- A fire risk assessment shall be done prior to the start of all surgical procedures (Perioperative Areas)
 - Performed before start of procedure
 - All members of the team participating
 - Communicated during the "Time Out"
 - Documented in patient record
 - Fire Risk Assessment Tool:
 - A. Is an alcohol-based prep agent or other flammable solution being used preoperatively?
 - B. Is the surgical procedure being performed above the xiphoid process or in the oropharynx?
 - C. Is open oxygen or nitrous oxide being administered?
 - D. Is an electrosurgical unit, laser, or fiber-optic light being used?
 - E. Are there other possible contributors (i.e. defibrillators, drills, saws, or burrs)?

H. Quality Improvement:

Compliance with the Universal Protocol Policy will be monitored by conducting documentation/observation audits on a monthly basis.

DOCUMENTATION:

Surgical/Procedural Consent

Procedural/Surgical Nursing Record

Preprocedure Safety Checklist

REFERENCE/EVIDENCE BASED PRACTICE:

Prime HealthCare Policy: Universal Protocol: PeriOperative

AORN Position Statement: Preventing Wrong-Patient, Wrong-Site, Wrong-Procedure Events; August 2015

AORN's Fire Safety Tool Kit

The Joint Commission, 2016 National Patient Safety Goals.

The Joint Commission FAQ's 2009 Universal Protocol; November, 2008 Sentinel Event Alert-Wrong Site Surgery

Physician Insurer's Association of America (PIAA). Claims Data
American Academy of Orthopedic Surgeons: Report on Wrong-Site Surgery Feb 1998

Bulletin of the American College of Surgeons, Vol. 87, No. 12, December 2002.

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APPROVAL:

Committee Approvals	Date
Surgical Services Executive Committee	12/13
Procedural Safety Team	12/13
Committee Approvals	Date
Policy Committee	6/16
QUM	6/16
MEC	8/16
BOARD	

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**Dignity Health – St. Rose Dominican
Rose de Lima Campus
PATIENT SAFETY/RISK MANAGEMENT PLAN**

DATE: 01/01/2018
VERSION: 01



This plan was created and revised by the Dignity Health – St. Rose Dominican Patient Safety Officer with review and input from the Patient Safety Committee. Implementation of this plan is intended to optimize the healthcare quality and patient safety outcomes, encourage recognition, reporting, and acknowledgment of risks to patient, visitor, and employee safety, as well as reduce the medical/healthcare errors and /or preventable events.

Patient Safety Committee/Program
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Commitment to Patient Safety

Dignity Health St. Rose Dominican Hospital – Rose de Lima Campus is committed to a comprehensive approach to improving healthcare quality and patient safety by aligning with our Mission, Vision, and Values, creating an environment that supports a dynamic, proactive, and safe culture for patients, family members, visitors, and employees, through continuous learning and improving patient safety policies, systems, and processes.

Mission, Vision, and Values

In support of our mission, vision, and values, Dignity Health – St. Rose Dominican, Rose de Lima Campus' Patient Safety/Risk Management program promotes:

- Honest, open collaboration and partnership of hospital leadership, medical staff, patients and their families, the community and other healthcare providers to deliver compassionate, high-quality, affordable healthcare.
- Promote justice and respect for those we serve.
- Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.
- Responsibility and accountability for every healthcare related decision and action.
- A focus on excellence, teamwork and innovation through continuous learning, improvement in system design, and the management of choices and changes, bringing the best possible outcomes or performances to the facility.
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare.
- Education of staff and physicians to assure participation of healthcare providers.

Scope and Purpose

The Patient Safety/Risk Management Program at St. Rose Dominican is an organization-wide/campus specific strategy that includes not only facility staff and medical staff, but is inclusive of patients, family and visitors. The Patient Safety/Risk Management Program at Rose de Lima Campus supports and encourages the active participation of each person in order to be an effective program. When processes, functions or services are designed or redesigned, information internal and external to the campus and/or organization regarding potential risks to patient safety will be considered and where appropriate, utilized to minimize the risk to patients affected by the new or redesigned process, function or services.

The purpose of this plan is to establish system-wide guidelines and processes supporting a comprehensive, effective, organization-wide Patient Safety/Risk Management Program Plan designed to promote and improve patient safety at Dignity Health – St. Rose Dominican, Rose de Lima Campus, by working to prevent medical/healthcare adverse events and reducing risk to patients and visitors.

Undesirable facility specific and system patterns or trends in performance and sentinel events will be intensively analyzed to determine where best to focus changes for improvement. Intensive analysis will be initiated when:

- Levels of performance, patterns or trends vary significantly and undesirably from those expected including significant near misses;
- Performance varies significantly and undesirable from that of other campuses/organizations;
- Performance varies significantly and undesirably from recognized standards; and/or
- A reportable event has occurred at that campus.

Minimally, data from the following areas will be gathered at each facility and presented at that facility for analysis with action plans developed reflective of the findings:

- Initial and on-going proactive risk assessments utilizing internal and external resources;
- Campus aggregate event reports reflective of all medical/healthcare events, with and without adverse outcomes, including but not limited to:
 - Hospital acquired infections
 - Medication events, to include delays in administration
 - Adverse drug events
 - Transfusion reactions
 - Patient falls
- Actual and near misses
- Hazardous conditions
- Restraint issues
- Medical record legibility issues
- Patient/family/staff opinions, needs, perceptions of risks to patients, and suggestions for improving patient safety;
- Identified data trends and analysis reports from sister facilities, Dignity Health Shared Learnings, etc.
- Others as defined by various campus committees, Leadership and/or Quality Council and Advisory Committee of the Board (QCAC).

Roles and Responsibilities

Per [NRS 439.875](#), a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plan is promoted and executed successfully.

The Patient Safety Committee Organization

Roles and Responsibilities

- In accordance with [NRS 439.875](#), a patient safety committee must be comprised of:
- The infection control officer of the medical facility;

- The patient safety officer of the medical facility, if he or she is not designated as the infection control officer;
- At least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility; and
- One member of the executive or governing body of the medical facility.

The roles and responsibilities are defined below.

Patient Safety Committee Responsibilities (based on [NRS 439.875](#) and [NRS 439.877](#))

The Patient Safety Committee convenes monthly in accordance with NRS 439.875. In collaboration with the Patient Safety Officer, the committee represents the Rose de Lima Campus and includes multidisciplinary team members which has oversight responsibility to ensure that the responsibilities and functions outlined in this program are carried forward throughout the organization. The following are responsibilities assigned:

- Serve as champions of the Patient Safety/Risk Management Program within the facility/organization.
- Establish and evaluate data to identify patient safety performance indicators.
- Evaluate other sources of patient safety data utilizing internal and external resources including but not limited to adopted patient safety checklists, risk assessments, sentinel event report/alert information and event reporting information from a variety of available resources including the event reporting system, APIC, CHPSO, etc.;
- Selection of a high-risk patient safety process for proactive risk assessment and improvement annually;
- Collaborates with each facility's Quality Council to identify, address and conduct follow-up on patient safety related trends, analysis results, changes in processes, and policies.
- Annual review of the Patient Safety Program to ensure its appropriateness of focus and effectiveness of efforts for each campus.
- Monitor and document the effectiveness of the patient identification policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the patient safety officer pursuant to [NRS 439.870](#).
- Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred.
- Review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- Review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur.

- At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the executive or governing body of the facility regarding:
 - (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);
 - (2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and
 - (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

Root Cause Analysis (RCA) Team Responsibilities

- Root Cause interviews, analysis, investigation, and corrective action plan implementations.
- Participates in the RCA meetings and discussions.
- Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders.
- See Quality Department's Performance Improvement Plan

Patient Safety Officer Responsibilities (based on [NRS 439.870](#))

The 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 including:

- Serve on the patient safety committee.
- Supervise the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the patient safety committee regarding any action taken in accordance with the responsibilities above.
- Day to day responsibility for the Patient Safety/Risk Management Program at Rose de Lima Campus.
- Maintenance of related data collected, trended and analyzed at each campus.
- Routine reporting to leadership and QCAC on campus specific trended data and actions taken to improve the quality and safety of patient care.
- Working with QCAC to achieve the goals of the Patient Safety/Risk Management Program.

Infection Control Officer Responsibilities (based on [NRS 439.873](#))

- Serve on the patient safety committee.
- Monitor the occurrences of infections at the facility to determine the number and severity of infections.

- Report to the patient safety committee concerning the number and severity of infections at the facility.
- Take such action as determines is necessary to prevent and control infections alleged to have occurred at the facility.
- Carry out the provisions of the infection control program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program.

RCA team leader Responsibilities

- Organize and coordinate the RCA process.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA, and corrective action plan implementation process.
- Communicate the progress of the investigation, institutional barriers, and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.
- Provide training, education and direction to create RCA process that incorporates the Patient Safety and Quality Improvement elements.

RCA Facilitator Responsibilities

- Identify RCA participants and coordinate a time, date and location of RCA meeting.
- Inform RCA participants of the sentinel event process.
- Explain confidential nature of RCA.
- Explain Just Culture and its application.
- Review event using medical record and any other pertinent materials in preparation for the RCA.
- Provide RCA members access to relevant best practice/research documents/statutes and other literature to include hospital Policy and Procedure documents for reference.
- Conduct RCA in a manner consistent with Just Culture, using principles of human factors, systems theory, etc.

Executive or Governing Body Staff Responsibilities

Provide vision and leadership to Patient Safety and Quality Improvement process, and develop and foster a safe learning and improving culture.

- Provides oversight to the healthcare quality improvement processes and teams.
- Plan, discuss, and generate the organization patient safety goals and activities, in conjunction with the patient safety action plans.

Leadership

The Dignity Health St. Rose Dominican Board and campus Senior Leadership has overall responsibility for the implementation of an integrated, organization-wide Patient Safety/Risk Management Program. These responsibilities are campus specific and include the following:

- Foster an environment in which patients, their families and organization staff and leaders can identify and manage actual and potential risks to patient safety through personal example and the provision of resources to establish proactive mechanisms to reduce risk.
- Establish a culture in which communication flows freely regardless of authority gradient.
- Ensure that a define, on-going, proactive program for identifying risks to patient safety and reducing medical/healthcare adverse events is fully implemented and includes responses to actual and potential events;
- Ensure that patient safety issues are given a high priority and addressed when processes, functions or services are designed or redesigned;
- Provide for mechanisms to measure, analyze and manage variation in the performance of defined processes that affect patient safety;
- Allocate adequate resources, including personnel, time, information systems data associated with reducing risk and improving patient safety, and
- Active participation in the California Hospital Patient Safety Organization (CHPSO).

Physicians

Physicians are responsible, as participants in the Patient Safety/Risk Management Program for reporting events or near misses at each campus, and participating on focus teams to reduce identified patient safety risks. Whenever patient care outcomes differ significantly from the anticipated outcomes, the primary care provider and/or responsible licensed independent practitioner (LIP) or comparable designee shall clearly explain these outcomes to the patient, and when appropriate, the family. (See Disclosure Policy)

Patients/Families/Visitors

Patients, families and patient representatives via written communication are encouraged to be active participants in their care and as such are responsible for:

- Providing, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters relating to the patient's health;
- Reporting their patient and outcome of treatment of that pain
- Reporting perceived risks in their care and unexpected changes in the patient's condition to the responsible practitioner, and
- Asking questions when they do not understand what they have been told about the patient's care, infection control, safety precautions and programs or what they are expected to do etc.

Patients and families/patient representatives/visitors will be provided with educational materials explaining these expectations and their role in reducing risk exposure and improving patient safety at the time of admission and throughout the patient stay utilizing various delivery methods including pamphlets, television

and verbal communication. Some patients may also be included in the development process to obtain their opinions, needs, perceptions of risks to patients and their suggestions for improving patient care.

Hospital Departments and Staff

Rose de Lima staff are key to promoting, identifying, and implementing activities to reduce risk and improve patient safety. Some of the activities include:

- Active participation in the activities to improve patient safety and the quality of healthcare delivered;
- Adherence to Infection prevention measures, the Joint Commission National Patient Safety Goals and other patient safety initiatives;
- Participation in education activities and process implementations;
- As appropriate, the provision of accurate, timely and complete verbal and written communication among caregivers, including test results relevant to the management of the patient's condition, and to all others involved in the utilization of data; and
- Participation in information needs assessment, staff surveys, and other processes that request information regarding the Patient Safety/Risk Management Program.
- Reporting all events and process variances (harm or no harm) even if they do not reach the patient (near miss).

The Patient Safety Committee

The Patient Safety Committee convenes monthly in accordance with NRS 439.875. In collaboration with the Patient Safety Officer, the committee represents the Rose de Lima Campus and includes multidisciplinary team members which have oversight responsibility to ensure that the responsibilities and functions outlined in this program are carried forward throughout the organization. The following responsibilities are assigned:

- Serve as champions of the Patient Safety/Risk Management Program within the facility/organization.
- Establish and evaluate data to identify patient safety performance indicators;
- Evaluate other sources of patient safety data utilizing internal and external resources including, but not limited to adopted patient safety checklists, risk assessments, sentinel event report/alert information and event reporting information from a variety of available resources including the event reporting system, APIC, CHPSO, etc.;
- Selection of a high-risk patient safety process for proactive risk assessment and improvement annually;
- Collaborates with each facility's Quality Council to identify, address and conduct follow up on patient safety related trends, analysis results, changes in processes, policies and other areas to make as a result of identified needs.
- Annual review of the Patient Safety Program to ensure its appropriateness of focus and effectiveness of efforts for each campus.
- Report and discuss sentinel events which include:
 - Number of sentinel events from previous calendar month (or quarter).

- Number of severe infections that occurred in the facility.
- Corrective Action Plan for the sentinel events and infections
 - Evaluate the corrective action plan.
- Patient safety policies and checklists
 - At least annually evaluate Patient Safety policies and checklists
 - Revise the patient safety policies and checklists as needed.
 - Monitor and document the effectiveness of the patient safety policy.

A RCA meeting will meet as needed to accomplish the following:

- Define the healthcare issues or potential risks.
- Conduct Root Cause Analysis
 - Reviewing and analyzing the data.
 - Reviewing the RCA process and quality improvement related activities and timelines.
 - Brainstorming issues or the potential risks by using the fishbone diagrams.
 - Identify the contributing factors and conduct the Root Cause Analysis.
- Conduct Corrective Action Plan
 - Identifying the Plan-Do-Study-Act (PDSA) topics.
 - Discussing corrective action process and activities.
 - Discussing and presenting possible changes in procedure to improve areas indicated.
 - Identifying strengths and areas that need improvement.
 - Developing strategies, solutions, and steps to take next.
- Identify barriers and technical assistance needs for supporting the RCA efforts.

A meeting agenda and minutes noting follow-up tasks will be kept.

Objectives and Goals of the Patient Safety/Risk Management Plan

Goal	Plan	Due Date
Risk Assessments	1. Patient Safety/Risk Management to perform monthly risk assessments and report to PSC. 2. Infection Prevention to report to PSC findings of Risk Assessments.	Monthly PSC
FMEA	PSC to ensure one FMEA is conducted by Risk Management in CY 2018.	December 2018
Checklists	PSC will receive all new and renewed checklists used that impact patient safety whether directly or indirectly.	Monthly and ongoing
National Patient Safety Goals	PSC will support the posting of NPSGs throughout the hospital for staff reference.	Department leaders
Root Cause Analysis	RCAs will be conducted by Risk and Quality Management as soon as possible/practical after an event per Dignity Health policy	Ongoing
Manager orientation	Quality Risk Services will review/update Manager orientation.	March 31, 2018
Grievance Management	Grievances will be reviewed by the Grievance Committee to ensure compliance with CMS CoPs.	Quarterly and ongoing.

Goal	Plan	Due Date
Staff and physician education	Patient Safety education will occur in various forms (e.g. Huddles, Department Meetings, Leadership Meetings, Posters) throughout the year.	Ongoing

Components and Methods

Proactive Risk Assessment Activities

The Patient Safety/Risk Management Department, in collaboration with the various facility committees including Infection Prevention, Quality Council and leadership will conduct proactive risk assessments to identify hazards/risks that may affect patient safety. Risk Assessment activities will include, but not be limited to the following:

- Patient Safety Risk Assessment evaluating known high risk processes/procedures that have associated risks,
- Review employee survey results to identify safety concerns,
- On-going risk assessments based on internal and external data, including sentinel event alerts,
- Focused risk assessments as determined by the Patient Safety Committee, Senior Leadership, external/internal events, etc.
- Selection of patient safety process improvements and risk reduction activities utilizing the priorities set criteria of Rose de Lima campus,
- Any information assessments conducted by St. Rose Dominican will include identification of barriers to effective communication among caregivers.
- Patient Satisfaction surveys will include a question determining how the patient/family thinks the individual facility can improve patient safety. Results from this question shall be analyzed and responded to in a manner that supports risk reduction.
- Infection Prevention Surveillance Program.
- Additional staff surveys may be conducted to assess for staff opinions, needs, perceptions of risks to patients and suggestions for improving patient safety, as well as the staff’s willingness to report medical/healthcare events.

Event Reporting

Rose de Lima actively participates in the CHPSO and its Patient Safety Evaluation System for data collection, monitoring, collaboration and evaluation activities. As provided under the CHPSO (42 Code of Federal Regulations (CFR) Part 3 Section 3.20) the event report is considered a Patient Safety Work Product and as such is privileged and shall not be (1) subject to subpoena; (2) subject to discovery; (3) subject to disclosure and (4) admitted into evidence-provided such information is not subject to disclosure in certain criminal proceedings as described in regulation. (See Event Reporting and Management Policy).

- A. When an unplanned event/process variance occurs, the patient care provider will do the following:
 - a. Perform the necessary healthcare interventions to support the patient’s clinical condition.
 - b. Perform the necessary interventions to contain the risks to others.
 - c. Notify the patient’s attending physician.
 - d. Preserve any information related to the event including physical evidence. Preservation of the information includes the documentation of facts regarding the event or complication of event on the Event Report and in the patients’ medical record.

- e. Notify immediate supervisor of the event.
 - f. Submit electronically an Event Report form or handwritten Event Report form to Risk Management/Patient Safety Services.
- B. Identification of potential unsafe condition that may affect patient safety:
- a. Individual's identifying such a condition will immediately report such to their supervisor, and document in the Event Report.
 - b. Take the necessary actions to ensure that any potential risks to patient care and safety are mitigated.

Event Monitoring/Risk Assessment Analysis, Action Planning and Intervention

- A. Patient safety related event reporting data within the scope of the Patient Safety Program and risk assessment results will be aggregated and presented routinely to various committees including but not limited to Medical Executive Committee (MEC), Medication Safety, Quality Council and Environment of Care for analysis and action. Based on analysis of this data and any actual or potential reviews, sentinel events and other internal and external data including TJC Sentinel Event Alerts, Dignity Health Shared Learnings, CHPSO trends, current literature, proactive action plan will be developed to include the following:
- a. Assessment of the intended and actual implementation of processes to identify the steps in where there is, or may be, undesirable variation.
 - b. Identification of the possible effects of the undesirable variations on patients and how serious the effect or outcome on the patient might be;
 - c. For critical effects/outcomes, a root cause analysis will be conducted to determine why the variation leading to the effect may occur;
 - d. Redesign of the process and /or underlying systems to minimize the risk of that variation or to protect patients from the effects of the variation;
 - e. Test and implement the redesign process;
 - f. Identification and collaboration with Quality Management Systems on implementation of measures of the effectiveness of the redesigned process; and
 - g. Implementation of a strategy for maintaining the effectiveness of the process over time.
 - h. Events that do not require a Root Cause Analysis will have an incident review completed by Quality/Risk Services Department as soon as practicable of becoming aware of the event. The results will be forwarded to leadership for review.

Response to Reported Adverse/Sentinel Events

Reporting of events is an essential component of a Patient Safety/Risk Management program. Through its participation in the CHPSO; all related investigation of events will be securely conducted, collected and documented as Patient Safety Work Product (PSWP) to maintain confidentiality as defined in the Federal Regulation.

- A. Rose de Lima shall respond to all reported potential and actual adverse/sentinel events. (See Sentinel Event policy).
- B. Minimally, all adverse events will be analyzed utilizing a team of individuals including Risk Management/Patient Safety and Quality Departments, to conduct root cause analysis (RCA), incident review and/or a failure mode effects analysis (FMEA), implementation in action plan to reduce further risk to patients and establish measures of effectiveness.
- a. The following events always elicit an intense analysis:
 - i. Confirmed transfusion reactions

- ii. Significant adverse drug reactions
 - iii. Significant medication events and hazardous conditions
 - iv. Manor discrepancies, or patterns of discrepancies, between preoperative and postoperative (including pathologic) diagnoses, including those identified during the pathologic review of specimens removed during surgical or invasive procedures; and
 - v. Significant adverse events associated with anesthesia use.
 - vi. Hospital acquired infections
 - vii. All events meeting the definition of Sentinel Events in the State of Nevada.
 - b. A root cause analysis is performed when a sentinel or State reportable event occurs.
 - c. An incident review is performed when a near miss or other event with significant areas for improvement are identified.
- C. Staff involved in an adverse/sentinel event shall be treated with respect and dignity.
- a. A “JUST CULTURE” approach shall be taken in order to facilitate changes in systems and processes to prevent further risk to patient safety, as well as promote future reporting by other staff.
 - b. Involved staff should be involved in the RCA process.
 - c. The Department Manager will provide ongoing support to the staff member(s) as needed.
 - d. Whenever necessary, Crisis Intervention or Employee Assistance Programs (EAP) will be offered as support to the involved employee.

Education

A. Staff Education

- a. General orientation and other education and training programs as needed will emphasize specific job related aspects of patient safety and risk reduction strategies.
- b. Specific Patient Safety/Risk Management Program training at orientation and annually thereafter will include:
 - i. An overview of the Patient Safety Program
 - ii. Overview of TJC National Patient Safety Goals
 - iii. Staff’s role and responsibilities in the Patient Safety/Risk Management Program
 - iv. Event reporting criteria and process
 - v. Methods to support and foster an interdisciplinary and collaborative approach to the delivery of patient care
 - vi. Examples of specific job related aspects of patient safety.
- c. Staff participating at a higher level of the Patient Safety/Risk Management Program will receive appropriate training necessary to understand and complete their assigned responsibilities.

B. Physician Education

- a. An overview of the Patient Safety/Risk Management Program will be provided to physicians at time of initial appointment and annually thereafter that describes the program, emphasizes their role and responsibilities in the program and informs them of the event reporting mechanism.
- b. Specific physicians may receive additional training to support their involvement at a higher level in the Patient Safety/Risk Management Program.

Pursuant to [NRS 439.837](#), a medical facility shall, upon reporting a sentinel event pursuant to [NRS 439.835](#), conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event.”

Rose de Lima Campus will use RCA process to determine the contributing factors and the underlying reasons for the deficiencies or failures. The Plan-Do-Study (check)-Act (PDSA or PDCA) is the model, developed by the Institute of Health Care Improvement, that we will use to test the changes.



Root Cause Analysis

A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals.

Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

Root cause analysis and action plan framework table, which was introduced by the Joint Commission. It contains 24 analysis questions. It guides the organization to the steps in a root cause analysis. Not all the questions apply to all the events or cases. This table can be used individually or with the fishbone diagram.

5 Whys technique will be used in Rose de Lima Campus to explore the cause and effect relationship underlay a problem. One can find the root causes by asking “why” no less than five times. This technique can be used individually or as a part of the fishbone diagram.

Fishbone Diagram

Once the problems are identified, a Fishbone Diagram will be used for analyzing the problems. You can use the fishbone diagram individually to analyze the root causes, or use it with the root cause analysis and action plan framework table.

A Fishbone Diagram, also called a Cause-and-Effect diagram, is a useful tool for a team to structurally brainstorm by discovering possible underlying factors or root causes from different major categories for the chosen problems. General categories used include: people, methods, materials, measurements, education, procedures, process, location, environment, etc. RCA team members will brainstorm and ask multiple times, “why did this happen?” for each cause until all ideas are exhausted. The highest priority root causes will be chosen for PDSA topics. Once all the categories are established on the fishbone diagram, 5 Whys technique also can be used to drill down the problem and find the root causes.

Model for Improvement

Please refer to the Dignity Health – St. Rose Dominican Performance Improvement Plan.

Data Collection and Reporting

Data should drive any quality and patient safety effort. Rose de Lima is using IVOS_for tracking the sentinel events, healthcare infection data, and Midas for internal data collection.

External data sources are those data sources which are collected outside the supervisory structure of the case. External data which will be utilized for Quality and Patient Safety plan include the data from:

- AHRQ: Agency for Healthcare Research & Quality
- CDC: Centers for Disease Control and Prevention
- CMS: Centers for Medicare & Medicaid Services
- NQF: National Quality Forum
- NHSN: National Healthcare Safety Network
- TJC: The Joint Commission

Ongoing Reporting and Review

Data points such as the following will be reviewed according to the schedule prescribed:

Monthly	Quarterly	Annually
1) Sentinel event monthly report 2) Severity of infection report 3) RCA assessment	1) Sentinel event quarterly report 2) Severity of infection report 3) Review and evaluate the measure of improvement of patient safety 4) Review and evaluate the measurement to prevent and control infections	1) Quality and Patient Safety Plan update 2) Checklists and Policies reviewing and revising

Assessment of the Quality and Patient Safety Plan

Please see the Patient Safety Assessment Tool (PSAT) from the VA National Center for Patient Safety for your reference.

Patient Safety Checklists and Patient Safety Policies

By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

The patient safety checklists must follow protocols to improve the health outcomes of patients at the medical facility and must include, without limitation:

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.
- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - Proper instructions concerning prescription medications;
 - Instructions concerning aftercare;
 - Any other instructions concerning his or her care upon discharge; and
 - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include the name and date of birth of the patient.
- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.

- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

Based on [NRS 439.865](#), the patient safety plan must also include an infection control program that carries out the infection control policy. The policy must consist of:

- The current guidelines appropriate for the facility's scope of service developed by a nationally recognized infection control organization as approved by the State Board of Health which may include, the Association for Professionals in Infection Control and Epidemiology (APIC), the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO) and the Society for Healthcare Epidemiology of America (SHEA); and
- Facility-specific infection control developed under the supervision of a certified Infection Preventionist.

http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf

<http://www.who.int/patientsafety/implementation/checklists/en/>

The following link provides you some patient safety policies for your reference

<https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>

Approval of Patient Safety Plan

According to [NRS 439.865](#), a medical facility shall submit its patient safety plan to the governing board of the facility for approval. After a facility's patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan.

The patient safety plan must be reviewed and **updated annually** in accordance with the requirements for approval set forth in this section.

According to [NRS 439.843](#), on or before March 1 of each year, a copy of the most current patient safety plan established to [NRS 439.865](#) must be submitted to the Division of Public and Behavioral Health.

Patient Safety Program Reporting and Review

All patient safety work product (PSWP) submitted through the CHPSO will be collected in the Patient Safety Evaluation System (PSES) for collection, management and analysis of information pursuant to the Patient Safety and Quality Improvement Act of 2005 (42 U.S.C. 299 et seq.).

- A. Patient safety/Risk Management related data and information reports will be provided routinely to various committees as previously identified including but not limited to medical staff, Quality Council and QCAC.

- B. A summary report of data, other internal and external information, as well as all actions taken by various committees and/or specific patient safety related teams will be submitted to the QCAC and the MEC.
- C. Annually, the Patient Safety/Risk Management Plan will be evaluated for effectiveness and the program updated to reflect the results of risk assessments related to patients, families and staff. The review shall include a summary of the occurrence of medical/healthcare events and actions taken to improve patient safety, both in response to actual occurrences and proactive efforts.
 - a. The review will be approved by QCAC.
 - b. Will be submitted to the Community Board for final review and approval.

References

- Root Cause Analysis Toolkit <http://www.health.state.mn.us/patientsafety/toolkit/>
- Quality and Service Improvement Tools http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html
- CQI 101 An Introduction to Continuous Quality Improvement: <https://www.coursehero.com/file/13827355/CQI-Overviewppt/>
- Quality Improvement <http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/>
- Root Cause Analysis <http://www.patientsafety.va.gov/professionals/onthejob/rca.asp>
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2 https://www.jointcommission.org/sentinel_event.aspx
- Hospital Policies <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>
- Checklists to Improve Patient Safety http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf
- Patient Safety Checklists <http://www.who.int/patientsafety/implementation/checklists/en/>
- Minutes of the Meeting of the Quality and Patient Safety Committee <http://www.cookcountyhhs.org/wp-content/uploads/2013/12/09-23-14-QPS-scan-Minutes.pdf>
- Title 40 – Public Health and Safety <https://www.leg.state.nv.us/NRS/NRS-439.html>

Reviewed/Approved:

Patient Safety Committee, February 2018

Quality Care Advisory Committee of the Board, March 2018

Community Board, March 2018

SOUTH LYON MEDICAL CENTER

PATIENT SAFETY COMMITTEE

SUBJECT: Patient Safety Plan

POLICY NO:

PAGE NO: 1 of 8

EFFECTIVE: 11/2002

REVISED:12/2016

CROSS: Medical Staff

APPROVED:

POLICY: South Lyon Medical Center Patient Safety Plan

PROCEDURE:

1. The Medical Staff, with the approval of the Governing Board shall develop and implement a Patient Safety Plan to encompass all facets of patient care at South Lyon Medical Center. This includes Acute Care, Long Term Care and Rural Health Clinics.
2. The Medical Staff will appoint and submit to the Governing Board for approval the implementation of a Patient Safety Committee which will comprise at a minimum: a physician, a nurse, pharmacist, governing board member and risk manager. This committee shall:
 - a. function under the authority of the Medical Staff
 - b. meet monthly
 - c. investigate, report and formulate corrective actions related to alleged sentinel events
 - d. review medical equipment/devices safety and maintenance inspections
 - e. review and recommend actions related to medication events
 - f. review and investigate patient care related incident reports
 - g. review, investigate and recommend corrective actions for near-miss events
 - h. additional tasks as assigned by the Medical Staff
3. The Administrator shall appoint a Patient Safety Officer whose responsibilities are outlined in the position description.
4. The Patient Safety Plan shall include but not limited to the following items:
 - I. General:
 - a. Patient Safety involves a variety of clinical and administrative activities that health care organizations undertake to identify, evaluate, and reduce the potential for harm to beneficiaries and to improve the quality of health care. Effective medical/health care error reduction requires an integral approach and a supportive environment, in which patients, their families, organization staff and leaders can identify, manage and learn from actual and potential risks.
 - b. A successful patient safety program facilitates non-punitive, interdisciplinary approach to decrease unanticipated adverse health care outcomes. The organizational focus is on continued learning about risks and mitigation strategies and reengineering systems/processes to reduce the chance of human error. South Lyon Medical Center (SLMC) fosters and

supports an organizational environment that recognizes and acknowledges potential risks to patient safety and the occurrence of medical/health care errors. The patient safety program encourages medical error reporting in order to identify system or process failures and to enhance improvement strategies.

II. South Lyon Medical Center (SLMC) Patient Safety Program

- a. The goal of the SLMC Patient Safety Program is to reduce the chance that the adverse effects of human error will harm patients. By creating and promoting a culture in which staff willingly report actual and near-miss patient safety related events without fear of disciplinary action, SLMC is encouraging these events to be freely identified. Once events have been identified, systems and processes can be analyzed and improved in order to prevent future recurrence. Improved systems and processes result in a safer patient care environment.
- b. SLMC Patient Safety Program focuses on system and process design rather than on the individual involved in a given patient safety related mishap. This paradigm is very different from that which prevails in the health care community at large. In the patient safety conscious culture, when an error occurs the response is not to ask “who”, but rather “why”. This new paradigm can exist in light of other organizational expectations associated with risk management, claims management and review of potentially compensable events (PCE) for which the facility may incur financial liability.
- c. All patient safety related reports 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.**
 - a. **On or before July 1 of each year a report will be submitted to the Director of the Legislative Counsel Bureau which includes the**

development, revision and usage of patient safety checklists and policies.

IX Confidentiality of Medical Quality Assurance Information.

As with other medical QA documents, any information, records, reports, minutes, and other documents directly associated with patient safety activities are protected under 10 USC 1102. In discussing medical information with family members, staff shall also comply with other applicable restrictions on nonconsensual disclosures, including those under the Privacy Act, 5 USC 552a. As a general rule under the Privacy Act, information regarding a patient's condition shall not be provided to others without the patient's consent.

SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES

QUALITY AND PATIENT SAFETY PLAN 2018

SNAMHS

DATE: 02/15/2018
VERSION: 01



This plan was created and revised by the SNAMHS Patient Safety committee/team. Implementation of this plan is intended to optimize the healthcare quality and patient safety outcomes, encourage recognition, reporting, and acknowledgment of risks to patient, visitor, and employee safety, as well as reduce the medical/healthcare errors and /or preventable events.

**Patient Safety Committee/Program
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SNAMHS Patient Safety Committee Chair

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Commitment to Patient Safety

SNAMHS is committed to becoming a high reliable organization through a comprehensive approach to improving healthcare quality and patient safety by aligning with our Mission, Vision, and Values, creating an environment that supports a dynamic, proactive, and safe culture for patients, family members, visitors, and employees, through continuous learning and improving patient safety policies, systems, and processes being “aware that safety is an emergent not a static property” (Patient Safety Primer High Reliability November 2017).

Mission, Vision, and Values

In support of our mission, vision, and values, SNAMHS Patient Safety and Quality Improvement programs promote:

- Collaboration of healthcare through collecting and sharing data with leadership, medical staff, our governing board, and other healthcare providers to deliver integrated and comprehensive high-quality healthcare
- Communicate honestly and openly to foster trusting and cooperative relationships among healthcare providers, staff members, and patients and their families, to ensure accountability for the patient safety priorities.
- Preservation of dignity and value for each patient, family member, employee, and other healthcare providers for every healthcare related decision and action.
- A focus on continuous learning and improving, system design, and the management of choices and changes, bringing the best possible outcomes or performances to the facility.
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare.
- Education of staff and physicians to assure participation of healthcare providers.

Scope and Purpose

The scope of this Quality and Patient Safety Plan is organizational-wide/hospital-wide/agency-wide which includes but is not limited to

- Patient safety
- Visitor safety
- Employee safety

All SNAMHS staff are required to fully support and participate in this plan and devote their expertise to the patient safety and healthcare quality improvement process.

This plan is action oriented and solution focused. The purpose of this plan is to address patient safety related concerns, challenges and revise programs to better serve the patients and their families. To this end, SNAMHS has developed this Patient Safety plan.

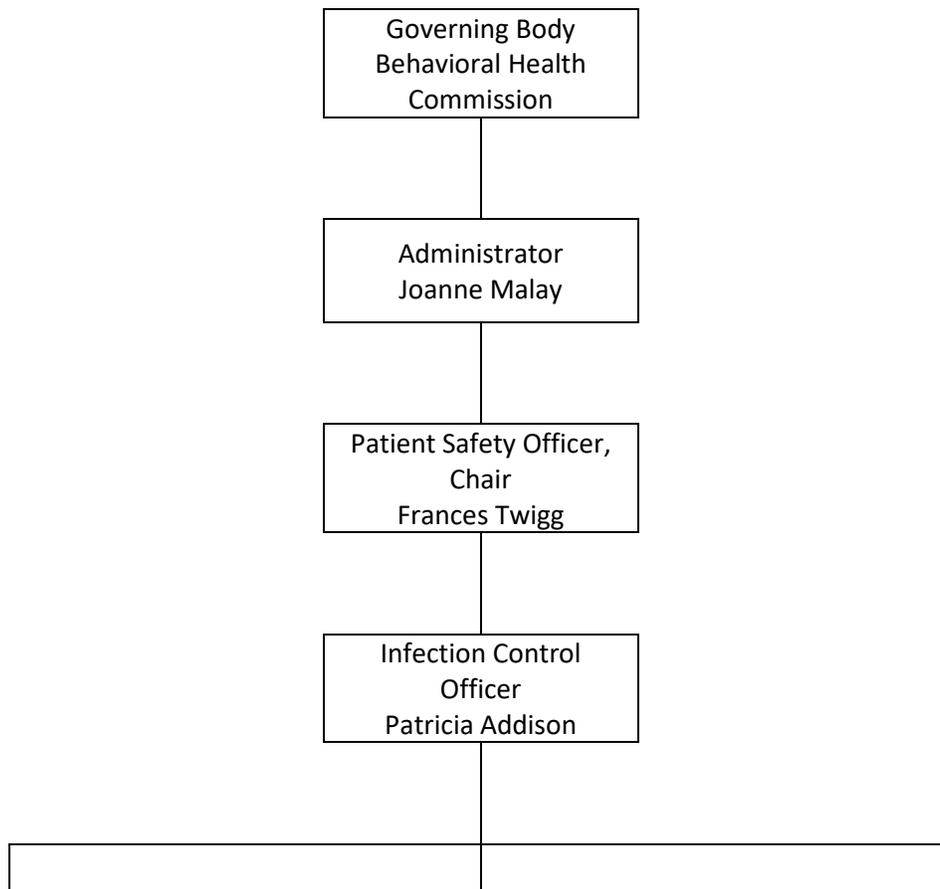
The plan focuses on the process rather than the individual, and recognizes both internal and external customers, as well as facilitates the need of analyzing and improving processes. The core principles of this plan include:

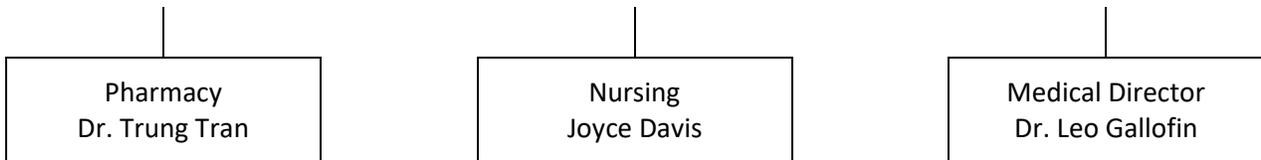
- All staff have the same goal and contribute their knowledge, vision, skill, and insight to improve the process of the Patient Safety Plan.
- Decisions will be based on data and facts, and staff will be encouraged to learn from the experiences.
- Customer based including patients, families, and visitors.
- Promote systems thinking.
- Employ well-trained and competent staff maintaining high healthcare quality.

Roles and Responsibilities

According to [NRS 439.875](#), a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plan is promoted and executed successfully.

The Patient Safety Committee Organization





Roles and Responsibilities

- In accordance with [NRS 439.875](#), a patient safety committee must be comprised of:
 - The infection control officer of the medical facility;
 - The patient safety officer of the medical facility, if he or she is not designated as the infection control officer;
 - At least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility; and
 - One member of the executive or governing body of the medical facility.
- Based on [NAC 439.920](#), a medical facility that has fewer than 25 employees and contractors must establish a patient safety committee comprised of:
 - The patient safety officer of the medical facility;
 - At least two providers of healthcare who treat patients at the medical facility, including but without limitation, one member of the medical staff and one member of the nursing staff of the medical facility; and
 - The Chief Executive Officer (CEO) or Chief Financial Officer (CFO) of the medical facility.

The roles and responsibilities are defined below.

Patient Safety Committee Responsibilities (based on [NRS 439.875](#) and [NRS 439.877](#))

- Monitor and document the effectiveness of the patient identification policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the patient safety officer pursuant to [NRS 439.870](#).
- Evaluate actions of the patient safety officer regarding all reports of sentinel events alleged to have occurred.
- Review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- Review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the executive or governing body of the facility regarding:
 - (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);

(2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and

(3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.

- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

Root Cause Analysis (RCA) Team Responsibilities

- Root Cause interviews, analysis, investigation, and corrective action plan implementations.
- Participates in the RCA meetings and discussions.
- Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders.

Patient Safety Officer Responsibilities (based on [NRS 439.870](#))

- Serve on the patient safety committee.
- Supervise the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the patient safety committee regarding any action taken in accordance with the responsibilities above.
- Participate as a consultant to the RCA teams
- Communicate the progress of the investigation, institutional barriers, and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.
- Provide training, education and direction to create RCA process that incorporate the Patient Safety and Quality Improvement elements

Infection Control Officer Responsibilities (based on [NRS 439.873](#))

- Serve on the patient safety committee.
- Monitor the occurrences of infections at the facility to determine the number and severity of infections.
- Report to the patient safety committee concerning the number and severity of infections at the facility.
- Take such action as determines is necessary to prevent and control infections alleged to have occurred at the facility.
- Carry out the provisions of the infection control program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program.
- Complete and submit the NSHN report to the state Registry and the CDC

RCA Facilitator Responsibilities

- Organize and coordinate the RCA as well as facilitate the RCA process
- Identify team members and alert their supervisors, as well as the staffing department to provide coverage on their units or department
- Assemble and encourage a supportive and proactive team. Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA, and corrective action plan implementation process.

Executive or Governing Body Staff Responsibilities

- Provide vision and leadership to Patient Safety and Quality Improvement process, and develop and foster a safe learning and improving culture.
- Provides oversight to the healthcare quality improvement processes and teams.
- Plan, discuss, and generate the organization patient safety goals and activities, in conjunction with the patient safety action plans

The Patient Safety Committee will meet monthly to accomplish the following:

- Report and discuss sentinel events which include:
 - Number of sentinel events from previous calendar month (or quarter).
 - Number of severe infections that occurred in the facility.
- Corrective Action Plan for the sentinel events and infections
 - Evaluate the corrective action plan.
- Patient safety policies and checklists
 - At least annually evaluate Patient Safety policies and checklists
 - Revise the patient safety policies and checklists as needed.
 - Monitor and document the effectiveness of the patient safety policy.

A RCA meeting will meet as needed to accomplish the following:

- Define the healthcare issues or potential risks.
- Conduct Root Cause Analysis
 - Reviewing and analyzing the data.
 - Reviewing the RCA process and quality improvement related activities and timelines.
 - Brainstorming issues or the potential risks by using the fishbone diagrams.
 - Identify the contributing factors and conduct the Root Cause Analysis.
- Conduct Corrective Action Plan
 - Identifying the Plan-Do-Study-Act (PDSA) topics.
 - Discussing corrective action process and activities.
 - Discussing and presenting possible changes in procedure to improve areas indicated.
 - Identifying strengths and areas that need improvement.
 - Developing strategies, solutions, and steps to take next.
- Identify barriers and technical assistance needs for supporting the RCA efforts.

A meeting agenda and minutes noting follow-up tasks will be kept.

Objectives and Goals of the Quality and Patient Safety Plan

Objective	Goals	Plan	Planned Completion Date	Responsible Party
Implement and train the Bröset Violence Risk Assessment tool to clinical staff	Reduce seclusion and or restraints by 25 %	<ul style="list-style-type: none"> Monitor compliance with training. Audit charts for proper documentation of the Bröset Violence Assessment tool Audit all seclusion and restraints monthly tracking days, time, unit length of event and clients with multiple events 	6/30/18 12/31/18 12/31/18	Restraint Free Committee Restraint Free Committee Patient Safety Officer
		<ul style="list-style-type: none"> 		
Increase staff compliance for seasonal flu vaccines by 10% yearly. Current compliance rate is 69%	100 % staff compliance rates for Flu vaccines	<ul style="list-style-type: none"> Expand formal clinic hours during Flu season. Flu shots during skills week in October. Provide mobile services to the units and other areas of the facility to offer Flu vaccines to staff. Monitor the rates of staff who received the vaccine as well as those who declined due to medical, religious reasons or other reasons. Educate staff on the benefits and risks of flu vaccination. 	July 1, 2020	Infection Control Infection Control Infection Control Infection Control Administration/Chief

		<ul style="list-style-type: none"> Enforce mask policy which has been implemented as of December 1, 2017. 		Medical Officer/Director of Nursing

Components and Methods

Pursuant to [NRS 439.837](#), a medical facility shall, upon reporting a sentinel event pursuant to [NRS 439.835](#), conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event.”

Rawson-Neal will use RCA process to determine the contributing factors and the underlying reasons for the deficiencies or failures. The Plan-Do-Study (check)-Act (PDSA or PDCA) is the model, which was developed by the Institute of Health Care Improvement, which we will use to test the changes.



Root Cause Analysis

A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals.

Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

Root cause analysis and action plan framework table, which was introduced by the Joint Commission. It contains 24 analysis questions. It guides the organization to the steps in a root cause analysis. Not all the questions apply to all the events or cases. This table can be used individually or with the fishbone diagram.

5 Whys technique will be used in Rawson-Neal to explore the cause and effect relationship underlay a problem. One can find the root causes by asking “why” no less than five times. This technique can be used individually or as a part of the fishbone diagram.

Fishbone Diagram

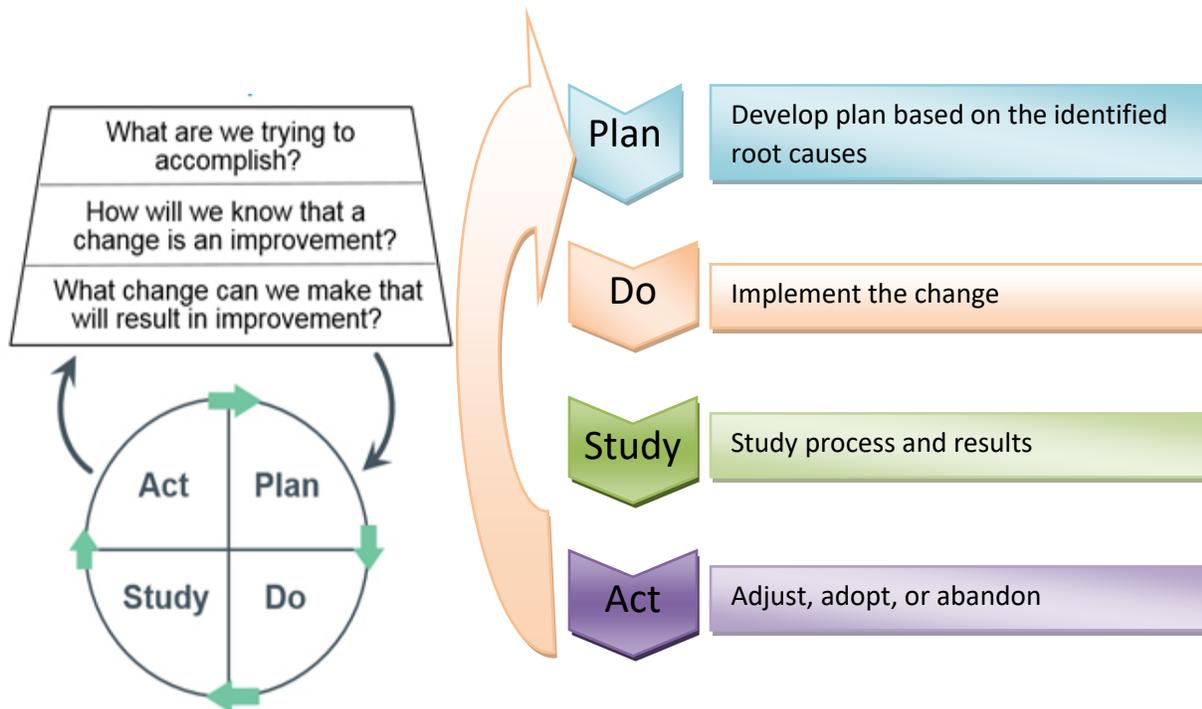
Patient Safety and Quality Improvement Plan

Once the problems are identified, a Fishbone Diagram (Appendix C) will be used for analyzing the problems. You can use the fishbone diagram individually to analyze the root causes, or use it with the root cause analysis and action plan framework table.

A Fishbone Diagram, also called a Cause-and-Effect diagram, is a useful tool for a team to structurally brainstorm by discovering possible underlying factors or root causes from different major categories for the chosen problems. General categories used include: people, methods, materials, measurements, education, procedures, process, location, environment, etc. RCA team members will brainstorm and ask multiple times, “why did this happen?” for each cause until all ideas are exhausted. The highest priority root causes will be chosen for PDSA topics. Once all the categories are established on the fishbone diagram, 5 Why’s technique also can be used to drill down the problem and find the root causes.

Model for Improvement

The Model for Improvement is a collaborative and ongoing effort model to improve the product and services quality and process. It provides multi-disciplinary quality team guidance from identifying the root causes; conducting the best tests to assess possible changes, and working in collaboration for implementation of the new approaches and solutions. It guides the test of a change to determine if the change is an improvement.



The cycle is defined as follows:

- Plan--collect data and establish appropriate goals. Identify the problem and the possible root causes, and answer the following questions.
 - What is the objective of the test?

- What are the steps for the test - who, what, when?
 - How will you measure the impact of the test?
 - What is your plan to collect the data needed?
 - What do you predict will happen?
- Do--make changes designed to correct or improve the situation. Use the following questions for the guidance.
 - What were the results of the test?
 - Was the cycle carried out as designed or planned?
 - What did you observe that was unplanned or expected?
 - Study -- Study the effect of the changes on the situation. Data should be collected on the new process and compared to the baseline or expected results. Results should be evaluated and by using the following questions as guidance.
 - Did the results match your prediction?
 - What did you learn?
 - What do you need to do next?
 - Act--If the result is successful or desirable, standardize the changes and then work on the next prioritized problem or the further improvements. If the outcome is not yet successful, look for different ways to identify the causes or change the testing process.

PDSA worksheet will be used to map the potential change strategies and to establish a course of action. The PDSA worksheet and the PDSA progress report are attached in Appendix D-1.

Data Collection and Reporting

Data should drive any quality and patient safety effort. SNAMHS is using Avatar for tracking the sentinel events, healthcare infection data and seclusion and restraint data.

External data sources are those data sources which are collected outside the supervisory structure of the case. External data which will be utilized for Quality and Patient Safety plan include the data from:

- AHRQ: Agency for Healthcare Research & Quality
- CDC: Centers for Disease Control and Prevention
- CMS: Centers for Medicare & Medicaid Services
- NQF: National Quality Forum
- NHSN: National Healthcare Safety Network
- TJC: The Joint Commission



Ongoing Reporting and Review

Data points such as the following will be reviewed according to the schedule prescribed:

Monthly	Quarterly	Annually
1) Sentinel event monthly report 2) Severity of infection report 3) RCA Report 4) Seclusion and Restraint events monthly report	1) Sentinel event quarterly report 2) Review and evaluate the measurement to prevent and control infections 3) Review and evaluate the plans of correction for RCAs within each quarter 4) Review and evaluate data trending in seclusion and restraint episodes	1) Yearly Quality and Patient Safety Plan update, due March 1, 2018 2) Yearly Sentinel Event Report, due March 1, 2018 2) Yearly AB280 report (Checklists and Policies reviewing and revising) due July 1, 2018

Assessment of the Quality and Patient Safety Plan

Please see the Patient Safety Assessment Tool (PSAT) from the VA National Center for Patient Safety for your reference.

Patient Safety Checklists and Patient Safety Policies

By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

The patient safety checklists must follow protocols to improve the health outcomes of patients at the medical facility and must include, without limitation:

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.
- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - Proper instructions concerning prescription medications;
 - Instructions concerning aftercare;
 - Any other instructions concerning his or her care upon discharge; and
 - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include, the name and date of birth of the patient.

- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.
- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

Based on [NRS 439.865](#), the patient safety plan must also include an infection control program that carries out the infection control policy. The policy must consist of:

- The current guidelines appropriate for the facility's scope of service developed by a nationally recognized infection control organization as approved by the State Board of Health which may include, the Association for Professionals in Infection Control and Epidemiology (APIC), the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO) and the Society for Healthcare Epidemiology of America (SHEA); and
- Facility-specific infection control developed under the supervision of a certified Infection Preventionist.

The patient safety checklists are listed in Appendix E. (The following links provide some patient safety checklists for your reference— a checklist example is shown in **Appendix E.**)

http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf

<http://www.who.int/patientsafety/implementation/checklists/en/>

The patient safety policies are listed in Appendix F. (The following link provides you some patient safety policies for your reference—a policy example is shown in **Appendix F.**)

<https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>

Approval of Patient Safety Plan

According to [NRS 439.865](#), a medical facility shall submit its patient safety plan to the governing board of the facility for approval. After a facility's patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan.

The patient safety plan must be reviewed and **updated annually** in accordance with the requirements for approval set forth in this section.

According to [NRS 439.843](#), on or before March 1 of each year, a copy of the most current patient safety plan established to [NRS 439.865](#) must be submitted to the Division of Public and Behavioral Health.

Reference

- Root Cause Analysis Toolkit <http://www.health.state.mn.us/patientsafety/toolkit/>
- Quality and Service Improvement Tools
http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html
- CQI 101 An Introduction to Continuous Quality Improvement:
<https://www.coursehero.com/file/13827355/CQI-Overviewppt/>
- Quality Improvement <http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/>
- Root Cause Analysis <http://www.patientsafety.va.gov/professionals/onthejob/rca.asp>
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2
https://www.jointcommission.org/sentinel_event.aspx
- Hospital Policies <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>
- Checklists to Improve Patient Safety http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf
- Patient Safety Checklists <http://www.who.int/patientsafety/implementation/checklists/en/>
- Minutes of the Meeting of the Quality and Patient Safety Committee
<http://www.cookcountyhhs.org/wp-content/uploads/2013/12/09-23-14-QPS-scan-Minutes.pdf>
- Title 40 – Public Health and Safety <https://www.leg.state.nv.us/NRS/NRS-439.html>

Appendix A: Terms and Definitions

Patient Safety: The Agency for Healthcare Research Quality (AHRQ) defines patient safety as “a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.”
http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

Sentinel event ([NRS 439.830](#))

1. Except as otherwise provided in subsection 2, “sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum.

2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:

(a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or

(b) July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published.

3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.

(Added to NRS by [2002 Special Session, 13](#); A [2005, 599](#); [2013, 217](#))

Institute for Healthcare Improvement (IHI) defines **medical harm** as “unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death.”

Facility-Associated Infection: ([NRS 439.802](#))

“Facility-acquired infection” means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections;
- Ventilator-associated pneumonia;
- Central line-related bloodstream infections;
- Urinary tract infections; and
- Other categories of infections as may be established by the State Board of Health by regulation pursuant to [NRS 439.890](#).

(Added to NRS by [2005, 599](#); A [2009, 553](#))

Medical facility ([NRS 439.805](#))

“Medical facility” means:

- A hospital, as that term is defined in [NRS 449.012](#) and [449.0151](#);
- An obstetric center, as that term is defined in [NRS 449.0151](#) and [449.0155](#);
- A surgical center for ambulatory patients, as that term is defined in [NRS 449.0151](#) and [449.019](#); and
- An independent center for emergency medical care, as that term is defined in [NRS 449.013](#) and [449.0151](#).

(Added to NRS by [2002 Special Session, 13](#))

Near miss: An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Mandatory reporting: Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985;254(6):796-800.)

Risk: Possibility of loss or injury. (Merriam-Webster’s Online Dictionary, Risk, Available at <http://www.merriamwebster.com/dictionary/risk>. Last Accessed August 2009.)

Preventable event: Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Catheter Associated Urinary Tract Infection (CAUTI): A urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CURRENT_b.pdf.)

Central Line Associated Bloodstream Infections (CLABSI): Primary bloodstream infections that are associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection.

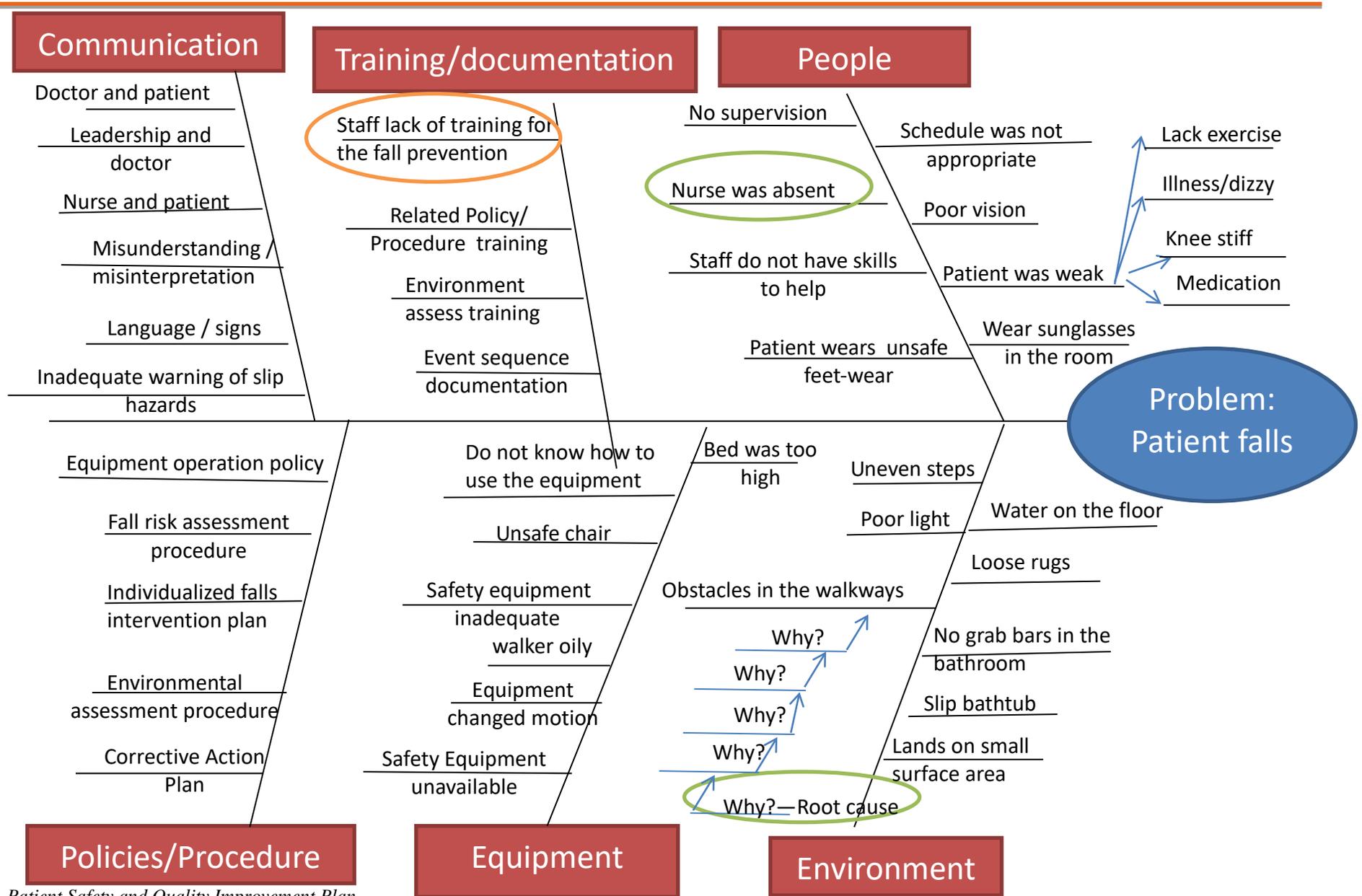
Appendix B: Patient Safety Goals

OBJECTIVE:	GOAL:	Q3 2014	Q4 2014	Q1 2015
ACTION PLAN:				
1. Create Systems that anticipate errors & either prevent or catch them before they cause harm.	a. Enhance retrospective chart review process.			Implement Trigger Tools. Develop automated surveillance reports in Cerner.
	b. Establish an automated surveillance process.		Complete an in-depth analysis of risk point utilizing the methods of FMEA.	
2. Establish Structures for reporting and a process for managing reports in the event reporting system.	a. Implement new electronic Voluntary Reporting System & participate in Patient Safety Organization.	Implemented e-MERS & PSO with UHC.	Create process for reviewing & closing reports in e-MERS.	
	b. Develop a structure to educate employees system-wide of the process for reporting hazards, errors and adverse events.		Increase number of events reported by 10%.	
	c. Establish a process for providing feedback regarding reported events.		Create process for communicating outcome of reported events.	
3. Develop a Culture of Safety where providers feel safe and supported when they report medical errors or near misses & voice concerns about patient safety.	a. Provide education on patient safety plan that emphasizes importance of blending a systems focus with appropriate individual accountability.		Educate Medical staff, Hospital Wide Oversight & the Quality Committees on the objectives and goals of the patient safety plan.	
	b. Establish a recognition program that rewards safe practices.		Include patient safety presentation in monthly New Employee Orientation.	
	c. Improve overall perceptions of safety as measured by the Culture of Safety Survey.		Develop 'Great Catch' awards program.	
				Re-evaluate culture of safety and develop action plan.
4. Establish Safety Priorities & Targets.	a. Develop Patient Safety Dashboard that includes national measures and benchmarks.		Present Patient Safety Dashboard monthly to Hospital Wide Oversight Committee.	
	b. Facilitate the development of action plans associated with measures not meeting benchmarks.	Complete 2014 Leapfrog Safety Survey.	Establish & implement a plan to improve performance of each leap.	
	c. Assess and improve processes related to hand-off, transition and communication		Develop method to track & report departmental progress and compliance of RCA action plans.	
5. Charter Safety Programs through teams, workgroups or projects.	a. Coordinate Improvement Efforts in order to ensure that capital, people, facilities & technologies are matched to strategic priorities for safe practices.		Establish Patient Safety Council.	
	b. Reduce and eliminate variation in care.		Establish workgroups focused on medication safety, reducing patient falls & hospital acquired pressure ulcers.	
			Revise or develop policies, procedures and protocols.	

Reference: Patient Safety Plan and Its Applicable Goals. 2014. Cook County Health and Hospitals System.

Patient Safety and Quality Improvement Plan

Appendix C: Fishbone Diagram



Appendix D-1: PDSA Worksheet

PDSA Worksheet

Topic:			
Person Completing Worksheet:		Date:	
Telephone/ Email:		Cycle:	
Patient Safety Committee Members			
CEOs/CFOs			
Patient Safety Officer			
Infection Control Officer			
Other Medical Staff			
Other team members			
Aim: (Describe the overall SMART goal that your team wishes to achieve.)			
Plan:			
1. List the tasks needed to set up this test of change.			
2. Predict what will happen when the test is carried out.			

3. List the steps to develop the test-who, what, and when.

Steps	By Whom	By When	Desired Outcome

Do: (Describe what actually happened when you ran your test, including any problems and unexpected findings.)

Study: (Describe what you learned and did you meet your measurement goal?)

Did you meet your measurement goal? Explain.

Summarize what was learned: success, failure, unintended consequences, etc.

Act: (Describe what you concluded from this cycle.)

Based on what was learned, please indicate what action will be considered.

Describe what modifications to the plan will be made for the next cycle based on what you learned.

Adapt: modify changes and repeat PDSA Cycle

Adopt: expanding changes throughout organization

Abandon: change approach and repeat PDSA cycle

Appendix D-2: PDSA Monthly / Quarterly Progress Report

Event:			
Person Complete Report:		Date:	
Patient Safety Officer		Contact Information:	
Monthly / Quarterly Report			
Items	Description		
1. What is your goal?			
2. Report on the PDSA cycle			
3. What system and practices are working well? Explain.			
4. What areas for improvement did the data identify?			
5. What barriers or system issues have been encountered implementing action activities?			
6. Action plans to address the barriers or system issues			
7. Lesson learned			
8. Support needed			
9. Additional discussion			
Notes:			

Appendix E: Checklist Example: Injuries from Falls and Immobility

Process Change	In Place	Not Done	Will Adopt	Notes (Responsible & By When?)
Conduct fall and injury risk assessment upon admission				
Reassess risk daily and with changes in patient condition				
Implement patient-specific intervention to prevent falls and injury				
Communicate risk across the team; use handoff forms, visual cues, huddles				
Round every 1 to 2 hours for high-risk patients; address needs (e.g., 3Ps: pain, potty, position-pressure). Combine with other tasks(vital signs)				
Individualize interventions. Use non-skid floor mats, hip protectors, individualized toileting schedule; adjust frequency of rounds				
Review medications (by pharmacist); avoid unnecessary hypnotics, sedatives				
Incorporate multidisciplinary input for falls				
Prevention from PT, OT, MD, RN and PharmD				
Include patients, families and caregivers in efforts to prevent falls. Educate regarding fall prevention measures; stay with patient				
Hold post-fall huddles immediately after event; analyze how and why; implement change to prevent other falls				

Reference: Checklists to Improve Patient Safety. June 2013. Health Research & Educational Trust.

Appendix F: Policy Example

	HOSPITAL POLICY AND INFORMATION MANUAL		[Reference: Hospital Policy]
PERSONAL PROTECTIVE EQUIPMENT POLICY Page 1 of 2	Date Issued: 07/01 08/14 Date Last Revised: 08/17 Next Review Date: Approved By:	Policy Committee	

es. MERCY Hospital. <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>

Key Words: personal protective equipment, PPE, safety equipment,

Policy Applies to:

- All staff employed by Mercy Hospital;
- Credentialed Specialists, Allied Health Professionals, patients, visitors and contractors will be supported in meeting policy requirements.

Related Standards:

- Infection and Prevention and Control Standards NZS 8134.3:2008
- Health and Safety in Employment Act 1992
- EQulP5 - 1.5.1 and 1.5.2 Infection Control
- EQulP5 - Standard 3.2 Criterion 3.2.1 Health and Safety

Rationale:

Mercy Hospital will provide suitable personal protective equipment (PPE) when the risk to health and safety cannot be eliminated or adequately controlled by other means.

Definitions:

Personal protective equipment (PPE) means all equipment which is intended to be worn or held by a person to protect them from risk to health and safety while at work.

Examples of PPE include: protective footwear, gloves, hard hats/helmets, clothing affording protection from the weather, visibility clothing, eye and face protection.

Objectives:

	HOSPITAL POLICY AND INFORMATION MANUAL	
<p>PERSONAL PROTECTIVE EQUIPMENT POLICY Page 2 of 2</p>	Date Issued: Date Last Revised: Next Review Date: Approved By:	07/01 08/14 08/17 Policy Committee

- To ensure appropriate PPE is identified to minimize hazards not able to be controlled by elimination or isolation;
- To ensure fit for purpose PPE is provided at Mercy Hospital for use by staff;
- To ensure adequate training in the use of PPE is provided;
- To monitor the use of PPE and evaluate effectiveness.

Implementation:

Risk Management

Department Managers, the Occupational Health/ Infection Prevention and Control Nurse (OH/IPC Nurse) and Health and Safety/ Infection Control Representatives (HSIC reps) will in consultation with staff:

Ensure PPE requirements are identified when carrying out risk assessments of activities;

- Regularly review the risk assessment of activities if substances or work processes change;
- Identify the most suitable type of PPE that is required;
- Ensure PPE is available to those who need it;
- Inform staff of the risks involved in their work and why PPE is required;
- Monitor compliance.

Process

Manager's Responsibilities

Must ensure that:

- PPE requirements are considered when risks are assessed;
- Suitable PPE is provided and made accessible to employees;
- PPE is properly stored, maintained, cleaned repaired and replaced when necessary;
- Adequate information and training is provided to those who require PPE;
- PPE is properly used;
- Use of PPE is monitored and reviewed.

Employee's Responsibilities All employees must ensure that:

- They use PPE whenever it is required;
- Attend and comply with training, instruction and information;
- Check the condition of their PPE;
- Store, clean and maintain their PPE;
- Report losses, defects or other problems with PPE to their manager.

Evaluation:

- Staff health and safety orientation
- Environmental audits
- Incident reports

SUMMERLIN HOSPITAL MEDICAL CENTER

Risk Management/ Patient Safety Plan

Nevada Acute Care Division

Revised 1/2018

I. Overview

SUMMERLIN HOSPITAL MEDICAL CENTER endorses an integrated, system-wide patient safety program designed to improve patient safety and reduce risk to patients. Patient safety is a cornerstone of quality care and is a leadership priority. **SUMMERLIN HOSPITAL MEDICAL CENTER** operates as a Patient Safety Organization to further its commitment in promoting patient safety and assuring that **SUMMERLIN HOSPITAL MEDICAL CENTER** remains at the forefront in the delivery of safe and effective clinical care. The Member Patient Safety Evaluation System (PSES) is utilized by **SUMMERLIN HOSPITAL MEDICAL CENTER** to track safety information, generate Patient Safety Work Product (PSWP) analysis of safety and clinical performance, and promote best practices. This Acute Care Division Risk Management/Patient Safety Plan (“Plan”) provides the general framework to identify, manage, reduce, and eliminate patient safety risks.

The Plan identifies the mechanisms to continually assess and improve the patient safety systems at **SUMMERLIN HOSPITAL MEDICAL CENTER**. It is our strategy to utilize statistical tools and defined project work to achieve breakthrough gains in patient safety. Performance improvement tools are used in developing and delivering consistent processes and services. The cultural aspect of the Plan is to promote a non-punitive approach to identifying and reporting adverse events. This is consistent with the “Just Culture” concept to promote patient safety practices by instituting a culture of safety and embracing concepts of teamwork and communication.

Most patient safety events are due to a failure of systems; therefore, a systems analysis approach is utilized in evaluations. The goal is to identify and track errors, deficiencies, and problematic trends in order to continuously improve the underlying systems and to intervene as necessary to improve system processes. Although a non-punitive culture is promoted, this approach is balanced by holding caregivers personally responsible for at-risk behaviors and failures to meet the standard of care. When warranted, discipline measures will be initiated as needed consistent with **SUMMERLIN HOSPITAL MEDICAL CENTER** policies. **SUMMERLIN HOSPITAL MEDICAL CENTER** employees, contractors, vendors, and members of each facility’s medical staff share responsibility to participate in detection, reporting, and remediation to prevent errors.

GENERAL STATEMENTS ON GOALS AND OBJECTIVES

To support, maintain and enhance the quality of patient care delivered by:

- Systematic and objective monitoring and evaluation of reports of injuries, accidents, patient safety issues, safety hazards, and/or clinical services findings.
- Identification and assessment of general areas of actual or potential risk in the clinical aspects of the delivery of patient care and safety.
- Implementation of appropriate corrective action, to the extent possible, to alleviate and resolve identified problems or concerns with patient safety issues.
- Evaluation and documentation of the effectiveness of actions implemented.

- Aggregation of data/information collected for integration in information management systems and use in managerial decisions and operations.

II. Mission and Vision

SUMMERLIN HOSPITAL MEDICAL CENTER's mission, vision and values drive the Plan and serve as the foundation in identifying strategic goals, objectives and priorities. Our mission is to improve patient safety and the quality of health care delivery through the provision of excellence in clinical care while fostering safe care to our communities, that our patients will recommend to their families and friends, physicians prefer for their patients, purchasers select for their clients, employees are proud of, and investors seek for long-term results. The vision is to be recognized as the provider of choice for healthcare services in the local community where we are trusted by our patients, families and physicians to create a safe, caring and compassionate experience.

In support of our mission, vision, and values, the Plan promotes:

- Collaboration of administrative leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high quality healthcare.
- Communicate honestly and openly to foster trusting and cooperative relationships among healthcare providers, staff members, and patients along with their families, to ensure accountability for the patient safety priorities.
- Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.
- Accountability for every healthcare related decision and action based on the level of risk-taking or egregious behavior identified.
- A focus on continuous learning and improving, system design, and the management of choices and changes, bringing the best possible outcomes or performances to the facility.
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare.
- Education of staff and physicians to assure coordination and integration of care across disciplines and specialties.

SUMMERLIN HOSPITAL MEDICAL CENTER recognizes that providing safe patient care requires significant coordination and collaboration. The optimal approach to patient safety involves multiple departments and disciplines to establish and effectively implement the processes and mechanisms that comprise this plan.

III. ROLES AND RESPONSIBILITIES

A. Risk Management/Patient Safety Officer

SUMMERLIN HOSPITAL MEDICAL CENTER has a designated risk director/manager responsible for patient safety risk identification and reduction for their respective

facilities. The designated Risk Director/Manager is also the Patient Safety Officer. Each facility is required to submit scheduled reports to the Board of Governors describing risk reduction efforts associated with facility specific, or industry identified risk exposures, including environmental risks and emergency management. Reports are thoroughly reviewed and analyzed by the risk staff to determine effectiveness and follow-through of identified corrective action plans.

The Patient Safety Officer responsibilities based upon [NRS 439.870](#) includes:

- Serving on the Patient Safety Committee (PSC)
- Supervising the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Taking action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the PSC regarding any action taken in accordance with the responsibilities above.

B. Infection Control Officer

The infection control officer designated for each facility, based on [NRS 439.873](#), responsibilities include:

- Serving on the Patient Safety Committee
- Monitoring the occurrences of infections at the facility to determine the number and severity of infections.
- Reporting to the PSC concerning the number and severity of infections at the facility each month.
- Taking such action as determined necessary to prevent and control infections alleged to have occurred at the facility.
- Carrying out the provisions of the Infection Control Program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program.

Based on [NRS 439.865](#), the patient safety plan must also include an infection control program that carries out the infection control policy. The policy must consist of:

- The current guidelines appropriate for the facility's scope of service developed by a nationally recognized infection control organization as approved by the State Board of Health which may include, the Association for Professionals in Infection Control and Epidemiology (APIC), the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO) and the Society for Healthcare Epidemiology of America (SHEA); and

- Facility-specific infection control developed under the supervision of a certified Infection Preventionist.

C. Patient Safety

SUMMERLIN HOSPITAL MEDICAL CENTER has an established Patient Safety Councils (PSC) to support patient safety activities. The PSC should ensure that its Patient Safety Plan is promoted and executed successfully. **SUMMERLIN HOSPITAL MEDICAL CENTER** has also assembled participants to serve in the Member Workforce and to utilize the Member PSES to generate PSWP and exchange analysis and recommendations with the Acute Care PSO Workforce. The main vehicles for these analytic activities occurring within the Member PSES and the member facility Patient Safety Council meetings. The Member PSES is made up of both electronic and physical spaces for the reporting, storing, and generation of PSWP, including secure SharePoint site, and other electronic databases (including but not limited to ClearSight (STARS) and Midas) to maintain and manage PSWP.

According to [NRS 439.875](#), a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plans are promoted and executed successfully.

I. Facility Patient Safety Committee

Each facility establishes a Patient Safety Committee (PSC) that meets on a regular basis and at least monthly.

Membership:

In accordance with [NRS 439.875](#), the committee core membership consists of the following Key Members: (CEO, CNO, Physician, Risk/ Patient Safety Officer, Infection Prevention Nurse, Pharmacy, and Quality). The COO, CMO and Regional CMO attend, as applicable. NRS requires that at least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing, and pharmaceutical staff of the medical facility. In addition, the infection control officer, patient safety officer, and one member of the executive or governing body of the medical facility.

Based on [NAC 439.920](#), a medical facility that has fewer than 25 employees and contractors must establish a patient safety committee comprised of: the Patient Safety Officer, at least two providers of healthcare who treat patients at the medical facility, including but without limitation, one member of the medical staff and one member of the nursing staff of the medical facility; and the Chief Executive Officer (CEO) or Chief Financial Officer (CF) of the medical facility.

Meetings:

The required members attend the meetings on a monthly basis. If a required member is absent, the facility makes a suitable replacement with someone that has authority to implement actions identified by the PSC.

Duties and Responsibilities:

SUMMERLIN HOSPITAL MEDICAL CENTERPSC is charged with the assessment and improvement of high-risk processes related to patient safety. This is to be carried out using a four-step methodology.

- **Issue Identification:** The primary issue is the most important risk issue facing the facility and is determined by reviewing the facility's claims history, claims history unique to the facility, patient safety concerns, industry claims, and through discussions with the risk staff. Other issues may be related to process initiatives.
- **Best Practice:** Once identified, the primary issue is dissected to determine its component issues. For each component issue, a best practice is selected. Best practices represent the most appropriate method for performing the delineated process and should not be selected until the PSC is assured that it is truly the "Best Practice."
- **Implementation:** Implementation strategies are those methods used to put the best practices into place. Often this includes revising policies, education, newsletters, phone calls, meetings, formal training, etc. Responsible parties and dates for completion are identified to ensure success.
- **Monitoring and Accountability:** Monitoring is essential to ensure that the strategies identified have been effective. Improvement should be demonstrated statistically whenever possible.

Additional Patient Safety Committee Responsibilities, based upon [NRS 439.875](#) and [NRS 439.877](#), include:

- Monitor and document the effectiveness of the Patient Identification Policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the Patient Safety Officer pursuant to [NRS 439.870](#).
- Evaluate actions of the Patient Safety Officer in connection with all reports of sentinel events alleged to have occurred.
- The Quality member of the PSC will review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- The Quality member in conjunction with the Infection Control Officer will review and evaluate the quality of measures carried out by the facility to prevent and control infections.

- Make recommendations to the Board of Directors of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the Board of Directors of the facility regarding:
 - (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);
 - (2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and
 - (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

In addition to the work done on the primary issue, the PSC is charged with addressing issues identified through claims reporting, Safety Watch Newsletters, the Joint Commission (Sentinel Event Alerts) and others, HRUs and from the TERM evaluation or other surveys, such as the OBHRU Site Assessments. Feedback is provided on an ongoing basis as to the functioning of the Patient Safety Committee.

II. Patient Safety Advisories

When an untoward event occurs at a facility or in the industry, it is important that we respond in a positive manner. Systems that lead to failure at one facility can be assessed at other facilities to avoid the same or similar occurrence. To this end, the Acute Care PSO distributes Safety Watch newsletters. These alerts detail the circumstances that lead to the negative outcome and facilities are charged with assessment and improvement of their own processes.

SUMMERLIN HOSPITAL MEDICAL CENTER is required to address the Safety Watch newsletters via their Patient Safety Council and this is evidenced in their monthly minutes. Responses to the Safety Watch are reviewed for the opportunity to generate a best practice to implement.

C. TERM Program

The facility has utilized its formalized risk management program identified as TERM: the Technical Elements of Risk Management. Each element focuses on a separate organizational function and details specific strategies for managing risk in these areas. These elements are summarized as follows:

Element I. Administration of the Risk Management Program: The tenets outlined in Element 1 lay the foundation for an effective risk management program. The Risk Manager/Director must be seen as a resource to administration, facility, and medical staff. Written plans, goals, and objectives provide a clear vision to meet the purpose of the risk program. Although the TERM program uses the title “Risk Manager,” this applies equally to Risk Directors.

Element II. Risk Identification: Risk identification is essential in order to avoid, mitigate, and eliminate risk-generating practices. This Element focuses on those steps taken to identify exposures faced by the facility.

Element III. Risk Education: Education is a cornerstone of the TERM program. Risk management education is intended to reduce and eliminate risk-generating practices and to promote best practices that enhance the provision of safe patient care.

Element IV. Patient Safety Initiative: Imperative to a comprehensive RM program is one that focuses on the improvement of patient and staff safety through the creation of an environment that maximizes safety and reduces liability claims exposure. The mechanism used to drive the culture of safety is the Patient Safety Committee (PSC) at each facility. The PSC operates using a four-step process. These steps include: identification of the problem, determining best practice, implementing the recommendations, and monitoring and accountability. Corrective actions are discussed, monitored, and validated by the PSC.

Element V. Patient Safety Priority: Root Cause Analysis (RCA): The cornerstones of an effective Patient Safety and Risk Management Program are (i) the performance of a thorough and credible RCA when a serious, sentinel, never event or a significant near miss event occurs; and (ii) implementation of systemic improvements to enhance patient safety and improve healthcare outcomes going forward.

Element VI. Environment of Care; Safety and Security Programs: The safety and security programs in the facility serve to protect and preserve both life and property. Areas of safety include licensing, accreditation and federal, state, and local safety practices and programs, including the EPA, TJC, etc.

Element VII. Claims and Litigation Management: The risk manager serves as the on-site representative of the insurance program in the management of general and professional claims and litigation.

Element VIII. Patient Safety Organization (PSO): Participants of the Member Workforce are expected to perform identified patient safety activities and to be trained in their responsibilities. They must also understand and acknowledge their obligations, including maintaining the confidentiality of PSWP, as required by the Patient Safety and Quality Improvement Act (PSQIA), and of Protected Health Information, as required by the

Health Insurance Portability and Accountability Act (HIPAA) and its regulations, and other federal and state laws.

Element IX. Measuring the Effectiveness of the Risk Management Program: In order to assure the effectiveness of the Risk Management Program, certain activities should be conducted to ensure that implementation of the TERM program has been successful. This includes, but is not limited to, data analysis and trending of events and potential claims, which are shared with the respective oversight committees.

D. MIDAS

The MIDAS system is the electronic event reporting system utilized by the facilities to report patient and visitor safety events. The risk management module allows for the collection, categorization, and analysis of incident data using electronic reporting functions (Remote Data Entry - RDE). The facility enters incidents into MIDAS through identification of the type of incident and characteristics of the event using risk parameters and outcomes. Additional information can be attributed to a department, physician, or individual, along with further details of the event. This allows the retrieval of information in a variety of ways for analysis and review.

E. ClearSight (STARS)

STARS is an integrated claims management program that allows for complete claims management, including extensive analysis of reportable fields associated with reported claims. STARS also provides for the electronic submission of potential claims by user facilities.

Delineation of issues featured in the probable claim module allows for the facility staff to identify causation factors associated with any reported event. The system also provides for the entry of details that will describe the event and liability concerns.

Trending of claim information is performed on a scheduled basis to operations leadership metrics to form strategies on facilitating risk reduction efforts. Previous examples of this function include the formation of an OB HRU and Perioperative concepts. Quarterly reports should be provided by the Facility's RM to the Governing Board of all claims activities.

F. Event Notification Site

The Risk Department developed the Event Notification Site or ENS, a web-based system that allows for contemporaneous reporting of serious adverse events and key near miss sentinel events to facility and corporate management. The ENS also provides an environment in which stakeholders can post questions and additional information to the

facility reporting the event. Updates to the event are reported in real-time to all identified facility and stakeholders via the ENS. The Risk Management staff reviews each ENS to determine if follow-up is needed; if follow-up is indicated, it is to be completed within 45 days.

G. Root Cause Analysis (RCA)

Pursuant to [NRS 439.837](#), a medical facility shall, upon reporting a sentinel event pursuant to [NRS 439.835](#), conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both of the sentinel event.

A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals. Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

It is recommended that the Joint Commission's root cause analysis and actions plan framework table are utilized. It contains analysis questions and guides the organization in the steps of a root cause analysis. Not all of the questions apply to all of the events or cases.

Utilization of the "5 Whys" technique should be used to explore the cause and effect relationship underlying a problem. One can find the root causes by asking "why" no less than five times.

RCA Responsibilities

- Organize and coordinate the RCA process. For Serious OB events, RCAs are to be done within 72Hrs. of the event.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA and corrective action plan implementation process.
- Communicate the progress of the investigation, institutional barriers and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.



H. Patient Safety Checklists

By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

The patient safety checklists must follow protocols to improve the health outcomes of patients at the medical facility and must include, without limitation:

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.

- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - Proper instructions concerning prescription medications;
 - Instructions concerning aftercare;
 - Any other instructions concerning his or her care upon discharge; and
 - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety checklists are listed in Appendix E. (The following links provide some patient safety checklists for your reference— a checklist example is shown in **Appendix B.**)

http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf

<http://www.who.int/patientsafety/implementation/checklists/en/>

I. Patient Safety Policies

The patient safety policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include, the name and date of birth of the patient.
- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.
- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

J. MEMBER PATIENT SAFETY EVALUATION SYSTEM (PSES)

The Patient Safety and Quality Improvement Act of 2005 (PSQIA) and its regulations govern the operations and activities of the UHS Acute Care PSO and its Members. This includes assembling a “workforce” of employees, volunteers, trainees, contractors, and other persons who carry out patient safety activities on behalf of the Members within the Member Patient Safety Evaluation System (“Member PSES”). Participants in the Member Workforce are expected to perform identified patient safety activities and to be well trained in their responsibilities. They must also understand and acknowledge their obligations, including maintaining the confidentiality of PSWP, as required by the PSQIA, and of Protected Health Information, as required by the Health Insurance Portability and Accountability Act (HIPAA) and its regulations, and other federal and state laws. The Member PSES serves as a means by which patient safety information is collected, maintained, reported, and analyzed for the UHS Acute Care PSO for the purposes of improving patient safety.

K. Training and Education

Training is essential to successful implementation of the Patient Safety and TERM program. All facility risk managers undergo extensive orientation and education related to Patient Safety, TERM program and other healthcare, risk-related topics. Newly hired risk managers receive both on-site and collaborative corporate-based education and training to afford them the requisite skills to manage their facility assignment. Each risk manager is provided a copy of the TERM source documents and other reference materials that guide the risk management function. In addition, formalized supplemental training is provided to all facility risk managers as needed, including quarterly risk management meetings. Risk leadership provides ongoing support and consultation to their assigned facility to facilitate the minimization of liability exposures and enhancement of safe patient care.

The leadership risk management staff provides consultative services to each facility and as members of designated projects. These activities include on-site assistance, research, and consulting from off-site. Examples of designated projects are as follows.

- Facility specific risk Issues
- Safety Watch newsletters
- MIDAS Focus advisories

IV. Risk Management Goals and Objectives 2018

- Surgical and Procedural Safety
 - Monitor compliance through tracer methodology and report monthly with oversight by leadership.

- Goal: Zero harm events: Prevent mistakes in surgeries and procedures
- OB HRU-Zero Preventable Harm
 - Goal: Reduction/ Elimination of Maternal Hemorrhage
 - Goal: Reduction/ Elimination of Serious Harm from Shoulder Dystocia
 - Goal: Reduction/ Elimination of Serious Harm by decreasing response time to changes in Fetal Monitoring Tracings
- Emergency Department
 - Goal: Reduction/ Elimination of Workplace Violence
- Medication Safety
 - Goal: Implement an effective Opioid – Pain Management strategy, as evidenced by compliance with Assembly Bill 474, NRS 233B.066, regarding prescribing of controlled substances and reporting of controlled substance overdoses.
- Perform monthly *Safety Watch* Gap Analysis and complete within 90 days.
- Increase medication reporting from an average of 45 per month to an average of 80 per month.
- Increase overall MIDAS reporting by 20% each month.
- Mandatory Education for Nursing Directors on documentation in the medical record

V. Monitoring and Accountability

A. Evaluation of TERM Program

These evaluations consist of both a core risk and clinical risk review. The facility is required to submit a written corrective action plan for noted deficiencies determined during the TERM evaluation. All information is shared with senior staff and monitored through the facility PSC.

B. Patient Safety Council Coaching

As detailed above, each facility is required to post their monthly reports or minutes that details the work conducted by their Patient Safety Committee to the facility PSES site. These are then reviewed minutes and detailed feedback is provided to coach the committee on their form and function.

C. Dashboards

The Risk Management/Patient Safety Dashboard and the Environment of Care Dashboard include multiple indicators to demonstrate the facility's performance as to these markers. These include: event reporting statistics, fall rate including harmful event rate, medication event rate including harmful medication events, timeliness of event review and closure, risk management education, events that meet the ECRI Top Patient Safety Concerns, and environment of care concerns.

VI. Evaluation/Review:

The risk staff reviews the effectiveness of the Patient Safety/Risk Management Plan to ensure activities are appropriately focused on improving patient safety, decreasing harmful errors, decreasing rate of compensable events, facility risk program consistency/functionality and support of clinical delivery in the field. Evaluation will include the following:

- The culture supports the identification and reporting of “Near Miss” events
- There is a framework that advances a “Just Culture”
- Accountability is promoted when acts of “at risk” or “reckless behavior” occur resulting in potential/actual adverse outcomes;
- Comparison of trended incident data to include analysis of performance to stated targets, submission of incident data in compliance to SOX stipulations and review of trended data submitted to the PSC for potential action;
- Review of annualized and prior year’s probable claim reports to determine needs for corporate-based projects designed to improve outcomes in an identified service line;
- Review of educational products distributed for the concluding operating year that were intended to improve outcomes associated with a particular clinical emphasis;
- Review information, analyses and reports from the Acute Care PSO for integration into the Patient Safety Evaluation System.

VII. Confidentiality

All patient safety/risk management work products are considered Patient Safety Work Products (PSWP) as defined by federal guidelines governing Patient Safety Organizations (PSO). All PSWP reported, stored, or generated in the Member PSES is confidential and privileged under Federal law. The Member PSES will only be accessed by authorized staff. Workforce participants will be trained on policies and procedures governing their patient safety activities and responsibilities.

VIII. Approval of Patient Safety Plan

According to [NRS 439.865](#), a medical facility shall submit its patient safety plan to the governing board of the facility for approval. After a facility’s patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan.

The patient safety plan must be reviewed and **updated annually** in accordance with the requirements for approval set forth in this section.

According to [NRS 439.843](#), on or before March 1 of each year, a copy of the most current patient safety plan established to [NRS 439.865](#) must be submitted to the Division of Public and Behavioral Health.

Appendix A: Terms and Definitions

Patient Safety: The Agency for Healthcare Research Quality (AHRQ) defines patient safety as “a discipline in the healthcare sector that applies safety science methods

toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.”

http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

Sentinel event ([NRS 439.830](#))

1. Except as otherwise provided in subsection 2, “sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum.

2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:

(a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or

(b) July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published.

3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.

(Added to NRS by [2002 Special Session, 13](#); A [2005, 599](#); [2013, 217](#))

Institute for Healthcare Improvement (IHI) defines **medical harm** as “unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death.”

Facility-Associated Infection: ([NRS 439.802](#))

“Facility-acquired infection” means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections;
- Ventilator-associated pneumonia;
- Central line-related bloodstream infections;
- Urinary tract infections; and

- Other categories of infections as may be established by the State Board of Health by regulation pursuant to [NRS 439.890](#).

(Added to NRS by [2005, 599](#); A [2009, 553](#))

Medical facility ([NRS 439.805](#))

“Medical facility” means:

- A hospital, as that term is defined in [NRS 449.012](#) and [449.0151](#);
- An obstetric center, as that term is defined in [NRS 449.0151](#) and [449.0155](#);
- A surgical center for ambulatory patients, as that term is defined in [NRS 449.0151](#) and [449.019](#); and
- An independent center for emergency medical care, as that term is defined in [NRS 449.013](#) and [449.0151](#).

(Added to NRS by [2002 Special Session, 13](#))

Near miss: An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Mandatory reporting: Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985;254(6):796-800.)

Risk: Possibility of loss or injury. (Merriam-Webster’s Online Dictionary, Risk, Available at <http://www.merriamwebster.com/dictionary/risk>. Last Accessed August 2009.)

Preventable event: Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Catheter Associated Urinary Tract Infection (CAUTI): A urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CUR_RENT_b.pdf.)

Central Line Associated Bloodstream Infections (CLABSI): Primary bloodstream infections that are associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection.

Appendix B: Checklist Example: Injuries from Falls and Immobility

Process Change	In Place	Not Done	Will Adopt	Notes (Responsible & By When?)
Conduct fall and injury risk assessment upon admission				
Reassess risk daily and with changes in patient condition				
Implement patient-specific intervention to prevent falls and injury				
Communicate risk across the team; use handoff forms, visual cues, huddles				
Round every 1 to 2 hours for high-risk patients; address needs (e.g., 3Ps: pain, potty, position-pressure). Combine with other tasks(vital signs)				
Individualize interventions. Use non-skid floor mats, hip protectors, individualized toileting schedule; adjust frequency of rounds				
Review medications (by pharmacist); avoid unnecessary hypnotics, sedatives				
Incorporate multidisciplinary input for falls				
Prevention from PT, OT, MD, RN and PharmD				
Include patients, families and caregivers in efforts to prevent falls. Educate regarding fall prevention measures; stay with patient				
Hold post-fall huddles immediately after event; analyze how and why; implement change to prevent other falls				

Reference: Checklists to Improve Patient Safety. June 2013. Health Research & Educational Trust.

Patient Safety Plan
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Purpose

To establish the role of hospital leadership, hospital staff and medical staff in an integrated patient safety program.

Policy

Hospital leaders ensure that an integrated patient safety program is implemented throughout the hospital and ensure the participation of hospital staff and medical staff in the Patient Safety Program.

Procedure

- A. A patient safety program is established throughout the hospital. A qualified individual or team is assigned to manage the hospital safety program.
- B. The scope of the patient safety program encompasses potential negative to actual negative and serious events (near misses to sentinel events).
- C. All components of the hospital participate in the patient safety program.
- D. Patient Safety Program Reports are presented at least annually to the Governing Board regarding system or process failures and actions taken to improve patient safety

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Patient Safety Program

Purpose

Tahoe Pacific Hospital 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 Tahoe Pacific to foster a safe and safety-conscious environment that promotes wellbeing, acknowledges and addresses risks, and encourages interdisciplinary safety and education focusing on process improvement.

Scope

Overall Patient Safety 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:

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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 multidisciplinary in nature with representatives from the hospital and medical staff. Imbedded in each performance improvement team are safety issues relevant to the team's focus. Reports from each performance improvement team are sent to the Quality Council, and reported to the Medical Executive Committee and the Governing Board.

The Patient Safety Committee is also multidisciplinary with representation from the following areas at a minimum: Clinical Departments, Pharmacy and Therapeutics Committee, Safety Committee, Quality/Risk Management and Infection Control.

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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 Tahoe Pacific Lifecare Hospital believes in a non-punitive reporting environment in order to maximize reporting of near misses, adverse outcomes, and sentinel events as it has been demonstrated that many errors are directly related to system and process failures. Disciplinary action may be considered when an involved individual takes action to hide the incident, is malicious or untruthful in reporting, when facts and circumstances suggest that the error was deliberate or in reckless disregard to patient and staff safety, or when the individual consistently fails in the detection, reporting or remedies to prevent mistakes. Reporting of patient safety issues to an outside agency will be done when required by regulation or as determined by the Administrator/CEO

The activities of the Patient Safety Program 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.

Patient Safety Program

Purpose

Tahoe Pacific has developed a Patient Safety Program in conjunction with the Performance Improvement Plan and Program, the Risk Management Plan and Program, and the Hospital Scope of Services, in order to provide guidelines for implementation of an integrated patient safety program throughout the hospital and to comply with the requirements of the state of Nevada. It is the intent of the leadership of the hospital to foster a safe and safety-conscious environment that promotes wellbeing, acknowledges and addresses risks, and encourages interdisciplinary safety and education focusing on process improvement.

Scope

Overall Patient Safety responsibilities include the following:

- 1. Improve the accuracy of patient identification.** 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.

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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 for safe 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

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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.

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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 multidisciplinary in nature with representatives from the hospital and medical staff. Imbedded in each performance improvement team are safety issues relevant to the team's focus. Reports from the performance improvement teams are sent to the Quality Council and reported to the Medical Executive Committee and the Governing Board.

In compliance with State of Nevada Regulations, the Patient Safety Committee is comprised of:

- (1) The patient safety officer of the medical facility.
- (2) At least three providers of health care who treat patients at the medical facility, including, without limitation, at least one member of the medical, nursing, and pharmaceutical staff of the medical facility.
- (3) One member of the executive or governing body of the medical facility.

The Patient Safety Committee is also multidisciplinary with representation from the following areas: Clinical Departments, Pharmacy and Therapeutics Committee, Safety Committee, Quality/Risk Management, and the Hospital's Infection Control Preventionist.

The Patient Safety Committee functions include but are not limited to:

1. Review and evaluate internal and external patient safety data from the following sources for opportunities for improvement in the safety of patient care processes:
 - a. Risk and Safety Management
 - b. External Data Reports
 - c. Sentinel Event Alerts from the Joint Commission

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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 Hospital believe in a non-punitive reporting environment in order to maximize reporting of near misses, adverse outcomes, and sentinel events as it has been demonstrated that many errors are directly related to system and process failures. Disciplinary action may be considered when an involved individual takes action to hide the incident, is malicious or untruthful in reporting, when facts and circumstances suggest that the error was deliberate or in reckless disregard to patient and staff safety, or when the individual consistently fails in the detection, reporting or remedies to prevent mistakes. Reporting of patient safety issues to an outside agency will be done when required by regulation or as determined by the Administrator/CEO.

The activities of the Patient Safety Program and an annual review of the Patient Safety Plan, appropriate policies, forms, checklists and best practices will be reported to the Patient Safety Committee, the Medical Executive Committee, and the Governing Board as outlined in the Performance Improvement Plan and the LifeCare Reporting Calendar. Communication within the hospital and medical staff is the key to a successful patient safety program and will be encouraged.

Education and training is an important and effective tool in assuring that the Patient Safety Program is clearly understood, particularly error identification and reporting and the basic approaches to Patient Safety. Education and training on patient safety is included in new employee general and department orientation and reviewed annually. Additionally, education will be provided to patients and their families about their role in helping to facilitate the safe delivery of care.

Kindred Hospital Las Vegas Sahara Campus

PATIENT SAFETY PLAN

DATE: 02/19/18



This plan was created and revised by the Kindred Hospital Las Vegas Sahara Campus Patient Safety committee/team. Implementation of this plan is intended to optimize the healthcare quality and patient safety outcomes, encourage recognition, reporting, and acknowledgment of risks to patient, visitor, and employee safety, as well as reduce the medical/healthcare errors and /or preventable events.

Patient Safety Committee/Program
Kindred Hospital Las Vegas Sahara Campus
5110 West Sahara Avenue
Las Vegas, Nevada 89146

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Commitment to Patient Safety

Kindred Hospital Las Vegas Sahara Campus is committed to a comprehensive approach to improving healthcare quality and patient safety by aligning with our Mission, Vision, and Values, creating an environment that supports a dynamic, proactive, and safe culture for patients, family members, visitors, and employees, through continuous learning and improving patient safety policies, systems, and processes.

Mission, Vision, and Values

In support of our mission, vision, and values, Kindred Hospital Las Vegas Sahara Campus Patient Safety and Quality Improvement program promotes:

- Collaboration of healthcare, leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high quality healthcare.
- Communicate honestly and openly to foster trusting and cooperative relationships among healthcare providers, staff members, and patients and their families, to ensure accountability for the patient safety priorities.
- Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.
- Responsibility for every healthcare related decision and action.
- A focus on continuous learning and improving, system design, and the management of choices and changes, bringing the best possible outcomes or performances to the facility.
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare.
- Education of staff and physicians to assure participation of healthcare providers.

Scope and Purpose

The scope of this Quality and Patient Safety Plan is organizational-wide/hospital-wide/agency-wide which includes but is not limited to

- Patient safety
- Visitor safety
- Employee safety

All staff in Kindred Hospital Las Vegas Sahara Campus are required to fully support and participate in this plan, and devote their expertise to the patient safety and healthcare quality improvement process.

This plan is action oriented and solution focused. The purpose of this plan is to address patient safety related concerns, challenges and revise the program to better serve the patients and their families. To this end, Kindred Hospital Las Vegas Sahara Campus has developed this Patient Safety Plan.

The plan focuses on the process rather than the individual, and recognizes both internal and external customers, as well as facilitates the need of analyzing and improving processes. The

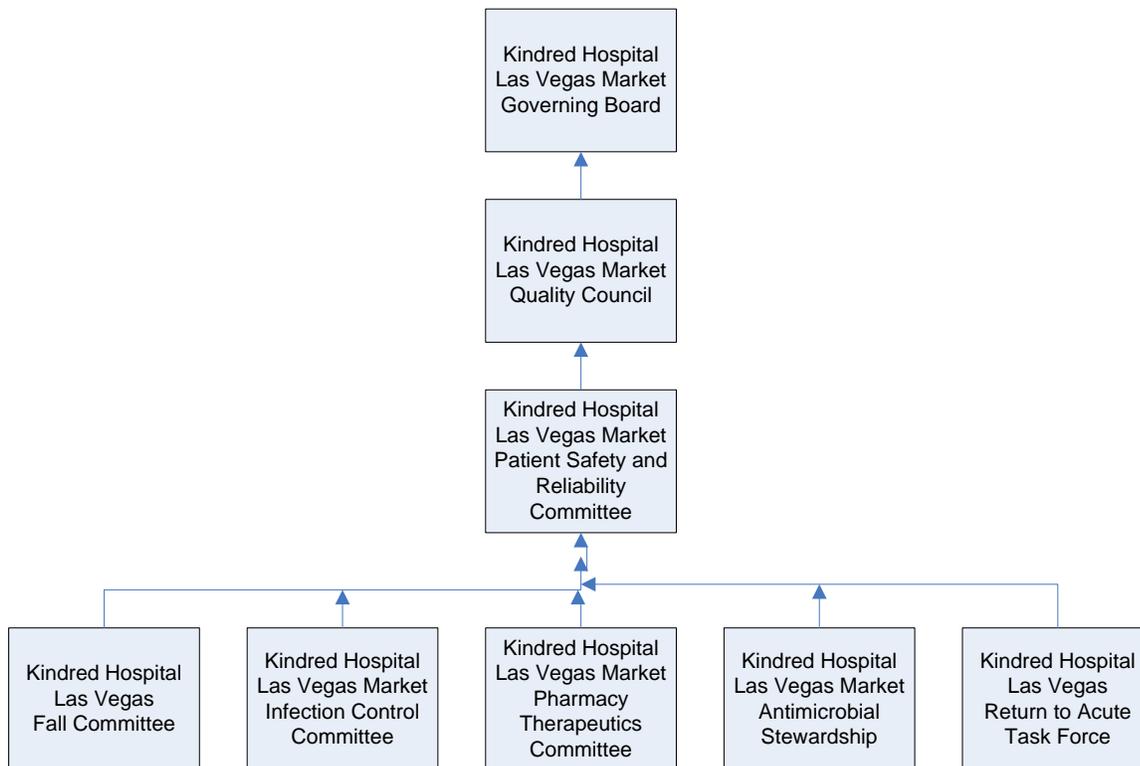
core principles of this plan include:

- All staff have the same goal and contribute their knowledge, vision, skill, and insight to improve the process of the Patient Safety Plan.
- Decisions will be based on data and facts, and staff will be encouraged to learn from the experiences.
- Customer based including patients, families, and visitors.
- Promote systems thinking.
- Employ well-trained and competent staff maintaining high healthcare quality.

Roles and Responsibilities

According to [NRS 439.875](#), a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plan is promoted and executed successfully.

The Patient Safety Committee Organization



Roles and Responsibilities

- In accordance with [NRS 439.875](#), a patient safety committee must be comprised of:
- The infection control officer of the medical facility;

- The patient safety officer of the medical facility, if he or she is not designated as the infection control officer;
- At least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility; and
- One member of the executive or governing body of the medical facility.

Based on [NAC 439.920](#), a medical facility that has fewer than 25 employees and contractors must establish a patient safety committee comprised of:

- The patient safety officer of the medical facility;
- At least two providers of healthcare who treat patients at the medical facility, including but without limitation, one member of the medical staff and one member of the nursing staff of the medical facility; and
- The Chief Executive Officer (CEO) or Chief Financial Officer (CFO) of the medical facility.

The roles and responsibilities are defined below (Please modify them as needed.)

Patient Safety Committee Responsibilities (based on [NRS 439.875](#) and [NRS 439.877](#))

- Monitor and document the effectiveness of the patient identification policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the patient safety officer pursuant to [NRS 439.870](#).
- Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred.
- Review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- Review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the executive or governing body of the facility regarding:
 - (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);
 - (2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and
 - (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

Root Cause Analysis (RCA) Team Responsibilities

- Root Cause interviews, analysis, investigation, and corrective action plan implementations.
- Participates in the RCA meetings and discussions.
- Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders.

Patient Safety Officer Responsibilities (based on [NRS 439.870](#))

- Serve on the patient safety committee.
- Supervise the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the patient safety committee regarding any action taken in accordance with the responsibilities above.

Infection Control Officer Responsibilities (based on [NRS 439.873](#))

- Serve on the patient safety committee.
- Monitor the occurrences of infections at the facility to determine the number and severity of infections.
- Report to the patient safety committee concerning the number and severity of infections at the facility.
- Take such action as determines is necessary to prevent and control infections alleged to have occurred at the facility.
- Carry out the provisions of the infection control program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program.

RCA Team Leader Responsibilities

- Organize and coordinate the RCA process.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA, and corrective action plan implementation process.
- Communicate the progress of the investigation, institutional barriers, and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.
- Provide training, education and direction to create RCA process that incorporate the Patient Safety and Quality Improvement elements.

RCA Facilitator Responsibilities

- Provide vision and leadership to the Root Cause Analysis process
- Work with the Director of Quality Management to assure process changes are implemented
- Guide the staff in the process of discovery and mitigation of future process failures

Executive or Governing Body Staff Responsibilities

- Provide vision and leadership to Patient Safety and Quality Improvement process, and develop and foster a safe learning and improving culture.
- Provides oversight to the healthcare quality improvement processes and teams.
- Plan, discuss, and generate the organization patient safety goals and activities, in conjunction with the patient safety action plans
- Provide fiduciary responsibilities

The Patient Safety Committee will meet monthly to accomplish the following:

- Report and discuss sentinel events which include:
 - Number of sentinel events from previous calendar month.
 - Number of severe infections that occurred in the facility.
- Corrective Action Plan for the sentinel events and infections
 - Evaluate the corrective action plan.
- Patient safety policies and checklists
 - At least annually evaluate Patient Safety policies and checklists
 - Revise the patient safety policies and checklists as needed.
 - Monitor and document the effectiveness of the patient safety policy.

A RCA meeting will meet as needed to accomplish the following:

- Define the healthcare issues or potential risks.
- Conduct Root Cause Analysis
 - Reviewing and analyzing the data.
 - Reviewing the RCA process and quality improvement related activities and timelines.
 - Brainstorming issues or the potential risks by using the fishbone diagrams.
 - Identify the contributing factors and conduct the Root Cause Analysis.
- Conduct Corrective Action Plan
 - Identifying the Plan-Do-Study-Act (PDSA) topics.
 - Discussing corrective action process and activities.
 - Discussing and presenting possible changes in procedure to improve areas indicated.
 - Identifying strengths and areas that need improvement.
 - Developing strategies, solutions, and steps to take next.
- Identify barriers and technical assistance needs for supporting the RCA efforts.

A meeting agenda and minutes noting follow-up tasks will be kept.

Objectives and Goals of the Quality and Patient Safety Plan

Objective	Goals	Plan	Planned Completion Date	Responsible Party
CLABSI Reduction	Reduce CLABSI by 10%	<ol style="list-style-type: none"> 1) Use Tegaderm Dressings 2) CHG Bathing Program 3) Staff education and competencies on hire and annually thereafter 4) Develop nurse-driven protocol for discontinuation of lines 5) RCA performed for each event 	12/31/18	ICP/CCO
CAUTI Prevention	Reduce CAUTI by 10%	<ol style="list-style-type: none"> 1) Staff education and competencies on hire and annually thereafter 2) Evaluate use of external female urine systems 3) RCA performed for each event 	12/31/18	ICP/CCO
NOWPU Prevention	Reduce NOWPU by 10%	<ol style="list-style-type: none"> 1) Use of Patient Safety Index to assure HAPU prevention 2) Braden Scale, Repositioning, Assessment and Wound Education to Patient Family Score 3) RCA done for each event 	12/31/18	Wound Care Coordinator/ Chief Clinical Officer
Employee Health	Improve flu vaccine by 5%	<ol style="list-style-type: none"> 1) Vaccine Education 2) Use of isolation masks by non-vaccinated personnel in clinical areas 	12/31/18	Employee Health Nurse/ Chief Clinical Officer

<p>Antimicrobial Stewardship</p>	<p>Reduce Antibiotic usage to ≤ 35% of total drug cost</p>	<ol style="list-style-type: none"> 1) Enhance the Patient Safety Dashboard for Antimicrobial Therapy Use 2) Incorporate the Pharmacist/ICP/ Infectious Disease MD rounding 3) Staff, physician and Leadership Education 	<p>12/31/18</p>	<p>Director Pharmacy/ICP/CCO/ID Medical Director</p>
<p>Fall Reduction</p>	<p>Reduce falls by 10%</p>	<ol style="list-style-type: none"> 1) Fall risk assessment completed for each patient, each shift 2) Re-implement Market Fall Reduction Performance Improvement Team 3) Staff education on hire and annually thereafter 4) Post-fall assessment completed for each event 	<p>12/31/18</p>	<p>DQM/CCO</p>

Components and Methods

Pursuant to [NRS 439.837](#), a medical facility shall, upon reporting a sentinel event pursuant to [NRS 439.835](#), conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event.”

Kindred Hospital Las Vegas Sahara Campus will use RCA process to determine the contributing factors and the underlying reasons for the deficiencies or failures. The Plan-Do-Study (check)-Act (PDSA or PDCA) is the model, which was developed by the Institute of Health Care Improvement, which we will use to test the changes.



Root Cause Analysis

A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals.

Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

Root cause analysis and action plan framework table, which was introduced by the Joint Commission. It contains 24 analysis questions. It guides the organization to the steps in a root cause analysis. Not all the questions apply to all the events or cases. This table can be used individually or with the fishbone diagram.

5 Whys technique will be used in Kindred Hospital Las Vegas Sahara Campus to explore the cause and effect relationship underlay a problem. One can find the root causes by asking “why” no less than five times. This technique can be used individually or as a part of the fishbone diagram.

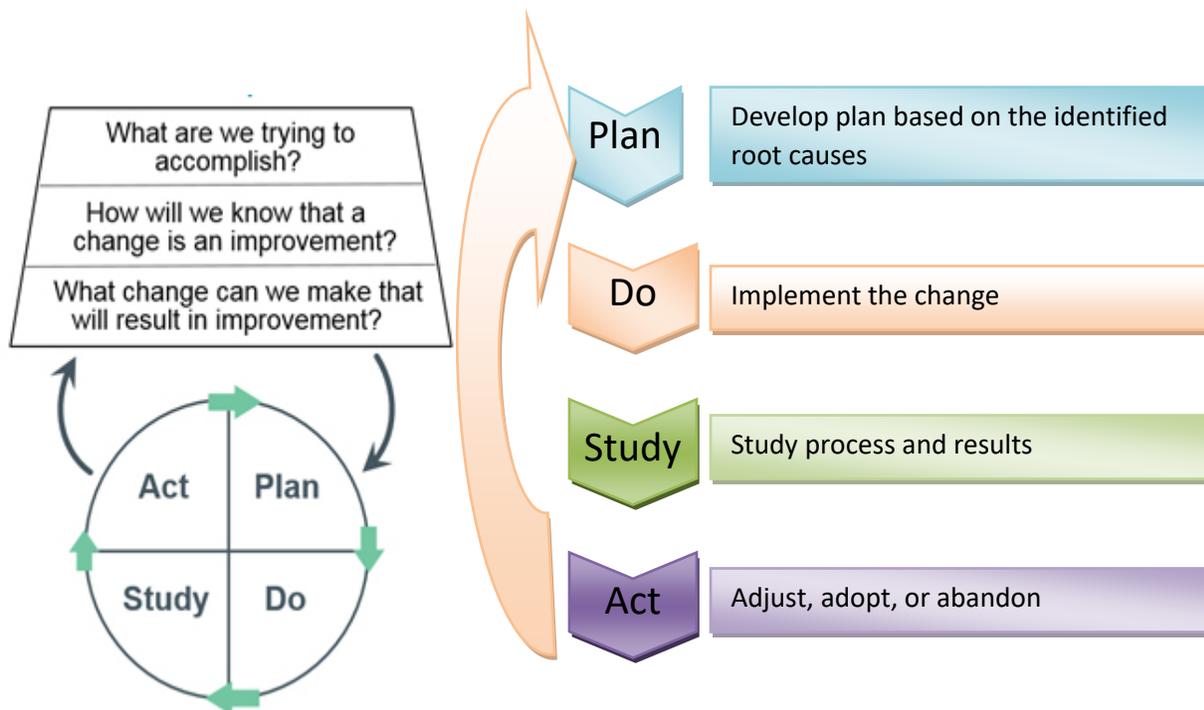
Fishbone Diagram

Once the problems are identified, a Fishbone Diagram (Appendix C) will be used for analyzing the problems. You can use the fishbone diagram individually to analyze the root causes, or use it with the root cause analysis and action plan framework table.

A Fishbone Diagram, also called a Cause-and-Effect diagram, is a useful tool for a team to structurally brainstorm by discovering possible underlying factors or root causes from different major categories for the chosen problems. General categories used include: people, methods, materials, measurements, education, procedures, process, location, environment, etc. RCA team members will brainstorm and ask multiple times, “why did this happen?” for each cause until all ideas are exhausted. The highest priority root causes will be chosen for PDSA topics. Once all the categories are established on the fishbone diagram, 5 Why’s technique also can be used to drill down the problem and find the root causes.

Model for Improvement

The Model for Improvement is a collaborative and ongoing effort model to improve the product and services quality and process. It provides multi-disciplinary quality team guidance from identifying the root causes; conducting the best tests to assess possible changes, and working in collaboration for implementation of the new approaches and solutions. It guides the test of a change to determine if the change is an improvement.



The cycle is defined as follows:

- Plan--collect data and establish appropriate goals. Identify the problem and the possible root causes, and answer the following questions.

- What is the objective of the test?
 - What are the steps for the test - who, what, when?
 - How will you measure the impact of the test?
 - What is your plan to collect the data needed?
 - What do you predict will happen?
- Do--make changes designed to correct or improve the situation. Use the following questions for the guidance.
 - What were the results of the test?
 - Was the cycle carried out as designed or planned?
 - What did you observe that was unplanned or expected?
 - Study -- Study the effect of the changes on the situation. Data should be collected on the new process and compared to the baseline or expected results. Results should be evaluated and by using the following questions as guidance.
 - Did the results match your prediction?
 - What did you learn?
 - What do you need to do next?
 - Act--If the result is successful or desirable, standardize the changes and then work on the next prioritized problem or the further improvements. If the outcome is not yet successful, look for different ways to identify the causes or change the testing process.

PDSA worksheet will be used to map the potential change strategies and to establish a course of action. The PDSA worksheet and the PDSA progress report are attached in Appendix D-1.

Data Collection and Reporting

Data should drive any quality and patient safety effort. Kindred Hospital Las Vegas Sahara Campus is using the Kindred Event Reporting System for tracking the incident and sentinel events, NHSN for reporting healthcare infection data, WebIZ for reporting vaccinations, and Business Warehouse and Meditech for internal data collection.

External data sources are those data sources which are collected outside the supervisory structure of the case. External data which will be utilized for Quality and Patient Safety plan include the data from:

- AHRQ: Agency for Healthcare Research & Quality
- CDC: Centers for Disease Control and Prevention
- CMS: Centers for Medicare & Medicaid Services
- NQF: National Quality Forum
- NHSN: National Healthcare Safety Network
- TJC: The Joint Commission



Ongoing Reporting and Review

Data points such as the following will be reviewed according to the schedule prescribed:

Monthly	Quarterly	Annually
1) Sentinel event monthly report 2) Severity of infection report 3) RCA assessment	1) Sentinel event quarterly report 2) Severity of infection report 3) Review and evaluate the measure of improvement of patient safety 4) Review and evaluate the measurement to prevent and control infections	1) Quality and Patient Safety Plan update 2) Checklists and Policies reviewing and revising

Assessment of the Quality and Patient Safety Plan

Please see the Patient Safety Assessment Tool (PSAT) from the VA National Center for Patient Safety for your reference.

Patient Safety Checklists and Patient Safety Policies

By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

The patient safety checklists must follow protocols to improve the health outcomes of patients at the medical facility and must include, without limitation:

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.
- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - Proper instructions concerning prescription medications;
 - Instructions concerning aftercare;
 - Any other instructions concerning his or her care upon discharge; and
 - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include, the name and date of birth of the patient.

- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.
- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

Based on [NRS 439.865](#), the patient safety plan must also include an infection control program that carries out the infection control policy. The policy must consist of:

- The current guidelines appropriate for the facility's scope of service developed by a nationally recognized infection control organization as approved by the State Board of Health which may include, the Association for Professionals in Infection Control and Epidemiology (APIC), the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO) and the Society for Healthcare Epidemiology of America (SHEA); and
- Facility-specific infection control developed under the supervision of a certified Infection Preventionist.

The patient safety checklists are listed in Appendix E. (The following links provide some patient safety checklists for your reference— a checklist example is shown in **Appendix E.**)

http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf

<http://www.who.int/patientsafety/implementation/checklists/en/>

The patient safety policies are listed in Appendix F. (The following link provides you some patient safety policies for your reference—a policy example is shown in **Appendix F.**)

<https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>

Approval of Patient Safety Plan

According to [NRS 439.865](#), a medical facility shall submit its patient safety plan to the governing board of the facility for approval. After a facility's patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan.

The patient safety plan must be reviewed and **updated annually** in accordance with the requirements for approval set forth in this section.

According to [NRS 439.843](#), on or before March 1 of each year, a copy of the most current patient safety plan established to [NRS 439.865](#) must be submitted to the Division of Public and Behavioral Health.

Reference

- Root Cause Analysis Toolkit <http://www.health.state.mn.us/patientsafety/toolkit/>
- Quality and Service Improvement Tools
http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html
- CQI 101 An Introduction to Continuous Quality Improvement:
<https://www.coursehero.com/file/13827355/CQI-Overviewppt/>
- Quality Improvement <http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/>
- Root Cause Analysis <http://www.patientsafety.va.gov/professionals/onthejob/rca.asp>
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2
https://www.jointcommission.org/sentinel_event.aspx
- Hospital Policies <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>
- Checklists to Improve Patient Safety http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf
- Patient Safety Checklists <http://www.who.int/patientsafety/implementation/checklists/en/>
- Minutes of the Meeting of the Quality and Patient Safety Committee
<http://www.cookcountyhhs.org/wp-content/uploads/2013/12/09-23-14-QPS-scan-Minutes.pdf>
- Title 40 – Public Health and Safety <https://www.leg.state.nv.us/NRS/NRS-439.html>

Appendix A: Terms and Definitions

Patient Safety: The Agency for Healthcare Research Quality (AHRQ) defines patient safety as “a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.”
http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

Sentinel event ([NRS 439.830](#))

1. Except as otherwise provided in subsection 2, “sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum.

2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:

(a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or

(b) July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published.

3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.

(Added to NRS by [2002 Special Session, 13](#); A [2005, 599](#); [2013, 217](#))

Institute for Healthcare Improvement (IHI) defines **medical harm** as “unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death.”

Facility-Associated Infection: ([NRS 439.802](#))

“Facility-acquired infection” means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections;
- Ventilator-associated pneumonia;
- Central line-related bloodstream infections;
- Urinary tract infections; and
- Other categories of infections as may be established by the State Board of Health by regulation pursuant to [NRS 439.890](#).

(Added to NRS by [2005, 599](#); A [2009, 553](#))

Medical facility ([NRS 439.805](#))

“Medical facility” means:

- A hospital, as that term is defined in [NRS 449.012](#) and [449.0151](#);
- An obstetric center, as that term is defined in [NRS 449.0151](#) and [449.0155](#);
- A surgical center for ambulatory patients, as that term is defined in [NRS 449.0151](#) and [449.019](#); and
- An independent center for emergency medical care, as that term is defined in [NRS 449.013](#) and [449.0151](#).

(Added to NRS by [2002 Special Session, 13](#))

Near miss: An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Mandatory reporting: Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985;254(6):796-800.)

Risk: Possibility of loss or injury. (Merriam-Webster’s Online Dictionary, Risk, Available at <http://www.merriamwebster.com/dictionary/risk>. Last Accessed August 2009.)

Preventable event: Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Catheter Associated Urinary Tract Infection (CAUTI): A urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CUR_RENT_b.pdf.)

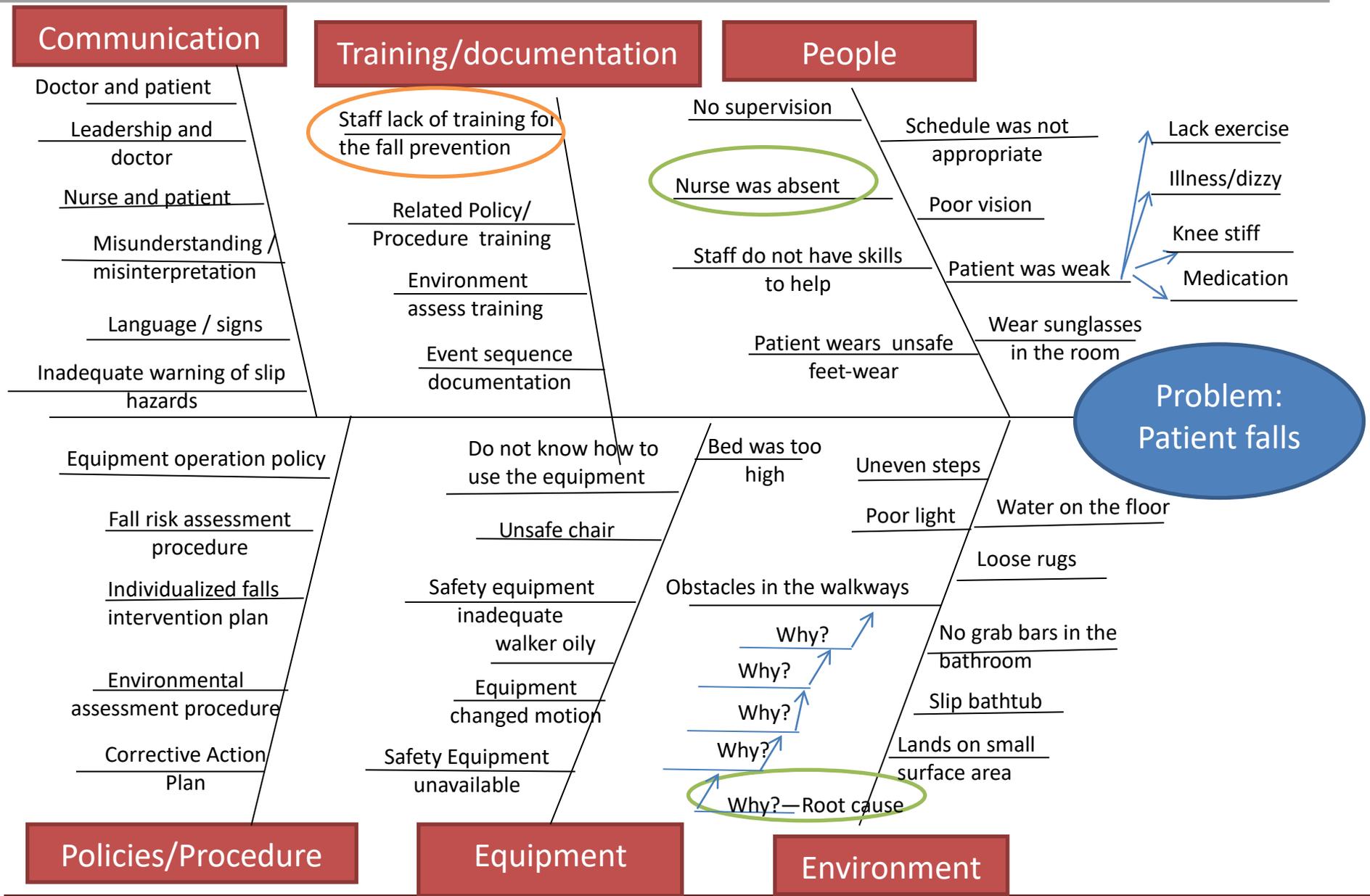
Central Line Associated Bloodstream Infections (CLABSI): Primary bloodstream infections that are associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection.

Appendix B: Patient Safety Goals

OBJECTIVE:	GOAL:	Q3 2014	Q4 2014	Q1 2015
ACTION PLAN:				
1. Create Systems that anticipate errors & either prevent or catch them before they cause harm.	a. Enhance retrospective chart review process.			Implement Trigger Tools. Develop automated surveillance reports in Cerner.
	b. Establish an automated surveillance process.		Complete an in-depth analysis of risk point utilizing the methods of FMEA.	
2. Establish Structures for reporting and a process for managing reports in the event reporting system.	a. Implement new electronic Voluntary Reporting System & participate in Patient Safety Organization.	Implemented e-MERS & PSO with UHC.	Create process for reviewing & closing reports in e-MERS.	
	b. Develop a structure to educate employees system-wide of the process for reporting hazards, errors and adverse events.		Increase number of events reported by 10%.	
	c. Establish a process for providing feedback regarding reported events.		Create process for communicating outcome of reported events.	
3. Develop a Culture of Safety where providers feel safe and supported when they report medical errors or near misses & voice concerns about patient safety.	a. Provide education on patient safety plan that emphasizes importance of blending a systems focus with appropriate individual accountability.		Educate Medical staff, Hospital Wide Oversight & the Quality Committees on the objectives and goals of the patient safety plan.	
	b. Establish a recognition program that rewards safe practices.		Include patient safety presentation in monthly New Employee Orientation.	
	c. Improve overall perceptions of safety as measured by the Culture of Safety Survey.		Develop 'Great Catch' awards program.	
				Re-evaluate culture of safety and develop action plan.
4. Establish Safety Priorities & Targets.	a. Develop Patient Safety Dashboard that includes national measures and benchmarks.		Present Patient Safety Dashboard monthly to Hospital Wide Oversight Committee.	
	b. Facilitate the development of action plans associated with measures not meeting benchmarks.	Complete 2014 Leapfrog Safety Survey.	Establish & implement a plan to improve performance of each leap.	
	c. Assess and improve processes related to hand-off, transition and communication	Develop method to track & report departmental progress and compliance of RCA action plans.		
5. Charter Safety Programs through teams, workgroups or projects.	a. Coordinate Improvement Efforts in order to ensure that capital, people, facilities & technologies are matched to strategic priorities for safe practices.		Establish Patient Safety Council.	
	b. Reduce and eliminate variation in care.		Establish workgroups focused on medication safety, reducing patient falls & hospital acquired pressure ulcers.	
			Revise or develop policies, procedures and protocols.	

Reference: Patient Safety Plan and Its Applicable Goals. 2014. Cook County Health and Hospitals System.

Appendix C: Fishbone Diagram



Appendix D-1: PDSA Worksheet

PDSA Worksheet

Topic:			
Person Completing Worksheet:		Date:	
Telephone/ Email:		Cycle:	
Patient Safety Committee Members			
CEOs/CFOs			
Patient Safety Officer			
Infection Control Officer			
Other Medical Staff			
Other team members			
Aim: (Describe the overall SMART goal that your team wishes to achieve.)			
Plan:			
1. List the tasks needed to set up this test of change.			
2. Predict what will happen when the test is carried out.			

3. List the steps to develop the test-who, what, and when.

Steps	By Whom	By When	Desired Outcome

Do: (Describe what actually happened when you ran your test, including any problems and unexpected findings.)

--

Study: (Describe what you learned and did you meet your measurement goal?)

Did you meet your measurement goal? Explain.	Summarize what was learned: success, failure, unintended consequences, etc.

Act: (Describe what you concluded from this cycle.)

Based on what was learned, please indicate what action will be considered.	Describe what modifications to the plan will be made for the next cycle based on what you learned.
<input type="checkbox"/> Adapt: modify changes and repeat PDSA Cycle	
<input type="checkbox"/> Adopt: expanding changes throughout organization	
<input type="checkbox"/> Abandon: change approach and repeat PDSA cycle	

Appendix D-2: PDSA Monthly / Quarterly Progress Report

Event:			
Person Complete Report:		Date:	
Patient Safety Officer		Contact Information:	
Monthly / Quarterly Report			
Items	Description		
1. What is your goal?			
2. Report on the PDSA cycle			
3. What system and practices are working well? Explain.			
4. What areas for improvement did the data identify?			
5. What barriers or system issues have been encountered implementing action activities?			
6. Action plans to address the barriers or system issues			
7. Lesson learned			
8. Support needed			
9. Additional discussion			
Notes:			

Appendix E: Checklist Example: Injuries from Falls and Immobility

Process Change	In Place	Not Done	Will Adopt	Notes (Responsible & By When?)
Conduct fall and injury risk assessment upon admission				
Reassess risk daily and with changes in patient condition				
Implement patient-specific intervention to prevent falls and injury				
Communicate risk across the team; use handoff forms, visual cues, huddles				
Round every 1 to 2 hours for high-risk patients; address needs (e.g., 3Ps: pain, potty, position-pressure). Combine with other tasks(vital signs)				
Individualize interventions. Use non-skid floor mats, hip protectors, individualized toileting schedule; adjust frequency of rounds				
Review medications (by pharmacist); avoid unnecessary hypnotics, sedatives				
Incorporate multidisciplinary input for falls				
Prevention from PT, OT, MD, RN and PharmD				
Include patients, families and caregivers in efforts to prevent falls. Educate regarding fall prevention measures; stay with patient				
Hold post-fall huddles immediately after event; analyze how and why; implement change to prevent other falls				

Reference: Checklists to Improve Patient Safety. June 2013. Health Research & Educational Trust.

Appendix F: Policy Example

[Reference: Hospital Policies. MERCY Hospital. <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>]

	HOSPITAL POLICY AND INFORMATION MANUAL	
<p>PERSONAL PROTECTIVE EQUIPMENT POLICY Page 1 of 2</p>	<p>Date Issued: 07/01 08/14 Date Last Revised: 08/17 Next Review Date: Approved By: Policy Committee</p>	

Key Words: personal protective equipment, PPE, safety equipment,

Policy Applies to:

- All staff employed by Mercy Hospital;
- Credentialed Specialists, Allied Health Professionals, patients, visitors and contractors will be supported in meeting policy requirements.

Related Standards:

- Infection and Prevention and Control Standards NZS 8134.3:2008
- Health and Safety in Employment Act 1992
- EQulP5 - 1.5.1 and 1.5.2 Infection Control
- EQulP5 - Standard 3.2 Criterion 3.2.1 Health and Safety

Rationale:

Mercy Hospital will provide suitable personal protective equipment (PPE) when the risk to health and safety cannot be eliminated or adequately controlled by other means.

Definitions:

Personal protective equipment (PPE) means all equipment which is intended to be worn or held by a person to protect them from risk to health and safety while at work.

Examples of PPE include: protective footwear, gloves, hard hats/helmets, clothing affording protection from the weather, visibility clothing, eye and face protection.

Objectives:

- To ensure appropriate PPE is identified to minimize hazards not able to be controlled by elimination or isolation;
- To ensure fit for purpose PPE is provided at Mercy Hospital for use by staff;
- To ensure adequate training in the use of PPE is provided;
- To monitor the use of PPE and evaluate effectiveness.

	HOSPITAL POLICY AND INFORMATION MANUAL	
<p>PERSONAL PROTECTIVE EQUIPMENT POLICY Page 2 of 2</p>	<p>Date Issued: Date Last Revised: Next Review Date: Approved By:</p>	<p>07/01 08/14 08/17 Policy Committee</p>

Implementation:

Risk Management

Department Managers, the Occupational Health/ Infection Prevention and Control Nurse (OH/IPC Nurse) and Health and Safety/ Infection Control Representatives (HSIC reps) will in consultation with staff:

Ensure PPE requirements are identified when carrying out risk assessments of activities;

- Regularly review the risk assessment of activities if substances or work processes change;
- Identify the most suitable type of PPE that is required;
- Ensure PPE is available to those who need it;
- Inform staff of the risks involved in their work and why PPE is required;
- Monitor compliance.

Process

Manager’s Responsibilities

Must ensure that:

- PPE requirements are considered when risks are assessed;
- Suitable PPE is provided and made accessible to employees;
- PPE is properly stored, maintained, cleaned repaired and replaced when necessary;
- Adequate information and training is provided to those who require PPE;
- PPE is properly used;
- Use of PPE is monitored and reviewed.

Employee’s Responsibilities All employees must ensure that:

- They use PPE whenever it is required;
- Attend and comply with training, instruction and information;
- Check the condition of their PPE;
- Store, clean and maintain their PPE;
- Report losses, defects or other problems with PPE to their manager.

Evaluation:

- Staff health and safety orientation
- Environmental audits
- Incident reports

**UNIVERSITY MEDICAL CENTER
PATIENT SAFETY PLAN 2018**

I. PURPOSE

University Medical Center of Southern Nevada (UMC) is committed to a comprehensive approach to improving healthcare quality and patient safety by aligning with our Mission, Vision, and Values, creating an environment that supports a dynamic, proactive, and safe culture for patients, family members, visitors, and employees, through continuous learning and improving patient safety policies, systems, and processes.

This is achieved through:

- Collaboration of healthcare, leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high quality healthcare.
- Honest and open communication that fosters trusting and cooperative relationships among healthcare providers, staff members, and patients and their families, to ensure accountability for the patient safety priorities.
- Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.
- Responsibility for every healthcare related decision and action.
- A focus on continuous learning and improving, system design, and the management of choices and changes, bringing the best possible outcomes and performances to the facility.
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare.
- Education of staff and physicians to assure participation of healthcare providers.

II. SCOPE OF ACTIVITIES

The scope of this Patient Safety Plan is organizational-wide which includes but is not limited to

- Patient safety
- Visitor safety
- Employee safety

All staff in University Medical Center of Southern Nevada is able to fully support and participate in this plan, and devote their expertise to the patient safety and healthcare quality improvement process.

The purpose of this plan is to address patient safety related concerns, challenges and revise the program to better serve the patients and their families. To this end, UMC has developed this Patient Safety Plan.

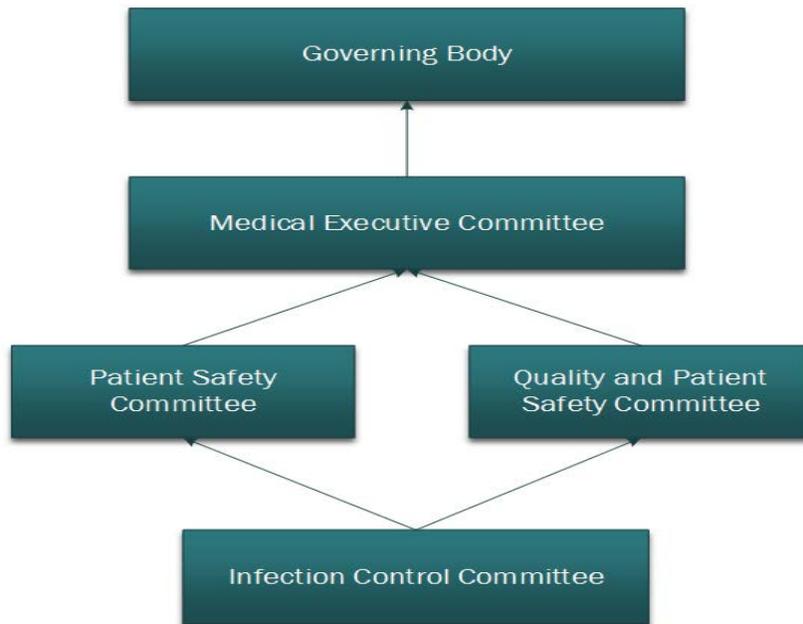
The plan focuses on the process and systems rather than the individual, and recognizes both internal and external customers, as well as facilitates the need for analyzing and improving processes. The core principles of this plan include:

- All staff are encouraged to contribute their knowledge, vision, skill, and insight to improve the process of the Patient Safety Plan.
- Decisions will be based on data and facts, and staff will be encouraged to learn from the experiences.
- Customer based including patients, families, and visitors.
- Promote systems thinking.
- Employ well-trained and competent staff maintaining high healthcare quality.
- One Failure Mode Effect Analysis (FMEA) completed each year

III. ROLES AND RESPONSIBILITIES

In accordance with [NRS 439.875](#), UMC has established a Patient Safety Committee (PSC). The PSC is responsible to oversee UMC’s Patient Safety Program. As directed by the Board of Governors, the Patient Safety Committee will act as the hospital’s Grievance Committee.

Patient Safety Committee Organization



Roles and Responsibilities

- In accordance with [NRS 439.875](#), a patient safety committee must be comprised of:
- The infection control officer of the medical facility;
- The patient safety officer of the medical facility
- At least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility; and
- One member of the executive or governing body of the medical facility.

Patient Safety Committee Responsibilities (NRS 439.875 and NRS 439.877):

- The Patient Safety Committee will meet at least monthly
- Receive reports from the patient safety officer pursuant to [NRS 439.870](#)
- Review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment, including the effectiveness of patient identification policy.
- Review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least once each calendar quarter, report to the executive or governing body of the facility regarding:
 - (1) The number of sentinel events that occurred at the medical facility during the previous calendar quarter;
 - (2) The number and severity of infections that occurred at the facility during the preceding calendar quarter; and
 - (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.
- The Patient Safety Committee shall be responsible for generating, evaluating and reviewing proactive risk assessments for the use of such documents and records in its proceedings. All risk assessments and associated documentation and records shall be subject to the applicable privileges under NRS 49.265 and NRS 439.875 provided that it is generated or produced during the Patient Safety Committee's review process.

Patient Safety Officer Responsibilities (NRS 439.870)

At UMC the Patient Safety Director is designated as the Patient Safety Officer. The Patient Safety Officer shall perform all duties and responsibilities required under Nevada law, including, without limitation:

- Serve on the Patient Safety Committee;
- Supervise the reporting of all sentinel events alleged to have occurred at UMC;
- Investigating the occurrence of Sentinel Events and implementing developed action plans;
- Report to the Patient Safety Committee

IV. COMPONENTS AND METHODS

Reporting of patient safety events:

All medical, nursing and support clinical staff are required to report any event, situation or circumstance that is significant or potentially significant to patient safety. These events will be reviewed and investigated as needed

This is accomplished by:

- Completing an event report in accordance with UMC policy
- Area manager/clinical supervisor review and completion of the manager's section of the event report
- Quality review by the Center for Quality and Patient Safety
- Review of significant/potentially significant events by the Patient Safety Officer
- Unit review of event types with action plan delivered at the Patient Safety Committee

Mandatory Reporting of Sentinel Events:

Pursuant to [NRS 439.835](#):

- A person who is employed by UMC shall, within 24 hours after becoming aware of a sentinel event, notify the Patient Safety Officer of the event.
- Within 13 days after receiving notification, the patient safety officer shall report the event to the Nevada Division of Public and Behavioral Health (DPBH).
- If the Patient Safety Officer personally discovers or becomes aware of a sentinel event, in the absence of notification by another employee, the patient safety officer shall report the event to DPBH within 14 days of discovery of the event must submit a report to The Health Division.

Disclosure of event to patient/family

Notification of patients who have been involved in a sentinel event will occur no later than 7 days after discovering or becoming aware of an event that occurred at the facility. Serious events should

be disclosed by the attending physician who has responsibility for overall care of the patient. If that is not possible, the Risk Manager or designee will disclose the event to the patient.

Pursuant to [NRS 439.837](#), UMC, upon reporting a sentinel event will conduct an investigation concerning the causes and/or contributing factors of the sentinel event and implement a plan to remedy the causes and/or contributing factors of the sentinel event.

Data Collection and Risk Assessment

Data should drive any quality and patient safety effort. UMC utilizes both internal and external sources for data collection.

Internal sources include but are not exclusive:

- Patient Safety Reporting system
- Patient and Family complaints
- Risk Management findings
- Morbidity/Mortality reviews
- Infection Control information
- Compliance findings
- Operative/procedural data
- Staff verbal reporting

External sources include but are not exclusive:

- AHRQ: Agency for Healthcare Research & Quality
- CDC: Centers for Disease Control and Prevention
- CMS: Centers for Medicare & Medicaid Services
- NQF: National Quality Forum
- NHSN: National Healthcare Safety Network
- TJC: The Joint Commission

V. Patient Safety Checklists and Patient Safety Policies:

Patient Safety Checklists must follow protocols, are utilized to improve the health outcomes of patients at UMC and include, without limitation:

- Specific types of treatment, which include documentation that the treatment provided was properly ordered by the provider of healthcare.
- Ensuring that the patient's room and overall environment is sanitary.

- Discharge instructions that must include: proper instructions concerning prescription medications, aftercare instructions, and any individualized patient instructions.

Patient Safety Policies include, without limitation:

- Appropriate identification of patient prior to providing treatment requiring at least two personal patient identifiers
- Nationally recognized standard precaution protocols, including protocols relating to hand hygiene
- Compliance with the patient safety checklists and patient safety policies

Pursuant to [NRS 439.865](#), Policy # I-270, Patient Safety Checklists and Patient Safety Policies, is an extension of the Patient Safety Plan.

VI. Annual Patient Safety Plan and Evaluation:

The Patient Safety Officer reviews and updates the Patient Safety Plan annually. The Patient Safety Committee reviews the Patient Safety Plan annually and submits it to the Governing Board.

The Patient Safety Officer prepares a written annual evaluation of the patient safety program. The annual report assesses patient safety events and actions taken to improve patient safety. The report will be submitted through the performance improvement structure and to the Governing Board.

At a minimum, the written report includes the following:

- All system and process failures
- The number and types of sentinel events
- Whether patients and family were notified of events
- All actions taken to improve safety
- All actions taken in response to analyses related to the adequacy of staffing

VII. Approval of Patient Safety Plan

According to [NRS 439.865](#), a medical facility shall submit its patient safety plan to the governing board of the facility for approval. After a facility's patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan.

The patient safety plan must be reviewed and updated annually in accordance with the requirements for approval set forth in this section.

In compliance with [NRS 439.843](#), on or before March 1 of each year, a copy of the most current patient safety plan established to [NRS 439.865](#) will be submitted to the Division of Public and Behavioral Health.

Terms and Definitions

Patient Safety: The Agency for Healthcare Research Quality (AHRQ) defines patient safety as “a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.”

http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

Sentinel event (NRS 439.830)

1. Except as otherwise provided in subsection 2, “sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum.

2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:

(a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or

(b) July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published.

3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.

(Added to NRS by [2002 Special Session, 13](#); A [2005, 599](#); [2013, 217](#))

Institute for Healthcare Improvement (IHI) defines **medical harm** as “unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death.”

Near miss: An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Mandatory reporting: Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985;254(6):796-800.)

References

- Root Cause Analysis Toolkit <http://www.health.state.mn.us/patientsafety/toolkit/>
- Quality and Service Improvement Tools http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html
- CQI 101 An Introduction to Continuous Quality Improvement: <https://www.coursehero.com/file/13827355/CQI-Overviewppt/>
- Quality Improvement <http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/>
- Root Cause Analysis <http://www.patientsafety.va.gov/professionals/onthejob/rca.asp>
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2 https://www.jointcommission.org/sentinel_event.aspx
- Framework for conducting a Root Cause Analysis and Action Plan https://www.jointcommission.org/framework_for_conducting_a_root_cause_analysis_and_action_plan/
- Hospital Policies <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>
- Checklists to Improve Patient Safety http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf
- Patient Safety Checklists <http://www.who.int/patientsafety/implementation/checklists/en/>
- Minutes of the Meeting of the Quality and Patient Safety Committee <http://www.cookcountyhhs.org/wp-content/uploads/2013/12/09-23-14-QPS-scan-Minutes.pdf>
- Title 40 – Public Health and Safety <https://www.leg.state.nv.us/NRS/NRS-439.html>
- UMC Policy # I-270, Patient Safety Checklist and Policies <http://umc-polandproc/pp6.nsf/d948c925637427b9872566260054a8a2/2ad0126143283b0788257fef0059151e?OpenDocument>
- UMC Infection Prevention/Control Risk Assessment, Plan and Authority Statement <http://umc-polandproc/pp6.nsf/d948c925637427b9872566260054a8a2/b80ee5a6a929c63b88257f940064d794?OpenDocument>
- UMC Policy # I-69.1, Safety Intellivence (SI) Event Reporting [http://umc-polandproc/pp6.nsf/d948c925637427b9872566260054a8a2/5BDF4AAC322CB4BB8825812C00591607/\\$file/I-69_1_Safety_Intelligence.docx](http://umc-polandproc/pp6.nsf/d948c925637427b9872566260054a8a2/5BDF4AAC322CB4BB8825812C00591607/$file/I-69_1_Safety_Intelligence.docx)

VALLEY HOSPITAL MEDICAL CENTER

Risk Management/ Patient Safety Plan

Nevada Acute Care Division

Revised 1/2018

I. Overview

Valley Hospital Medical Center endorses an integrated, system-wide patient safety program designed to improve patient safety and reduce risk to patients.

Patient safety is a cornerstone of quality care and is a leadership priority. **Valley Hospital Medical Center** operates as a Patient Safety Organization to further its commitment in promoting patient safety and assuring that **Valley Hospital Medical Center** remains at the forefront in the delivery of safe and effective clinical care. The Member Patient Safety Evaluation System (PSES) is utilized by **Valley Hospital Medical Center** to track safety information, generate Patient Safety Work Product (PSWP) analysis of safety and clinical performance, and promote best practices. This Acute Care Division Risk Management/Patient Safety Plan (“Plan”) provides the general framework to identify, manage, reduce, and eliminate patient safety risks.

The Plan identifies the mechanisms to continually assess and improve the patient safety systems at **Valley Hospital Medical Center**. It is our strategy to utilize statistical tools and defined project work to achieve breakthrough gains in patient safety. Performance improvement tools are used in developing and delivering consistent processes and services. The cultural aspect of the Plan is to promote a non-punitive approach to identifying and reporting adverse events. This is consistent with the “Just Culture” concept to promote patient safety practices by instituting a culture of safety and embracing concepts of teamwork and communication.

Most patient safety events are due to a failure of systems; therefore, a systems analysis approach is utilized in evaluations. The goal is to identify and track errors, deficiencies, and problematic trends in order to continuously improve the underlying systems and to intervene as necessary to improve system processes. Although a non-punitive culture is promoted, this approach is balanced by holding caregivers personally responsible for at-risk behaviors and failures to meet the standard of care. When warranted, discipline measures will be initiated as needed consistent with **Valley Hospital Medical Center** policies. **Valley Hospital Medical Center** employees, contractors, vendors, and members of each facility’s medical staff share responsibility to participate in detection, reporting, and remediation to prevent errors.

GENERAL STATEMENTS ON GOALS AND OBJECTIVES

To support, maintain and enhance the quality of patient care delivered by:

- Systematic and objective monitoring and evaluation of reports of injuries, accidents, patient safety issues, safety hazards, and/or clinical services findings.
- Identification and assessment of general areas of actual or potential risk in the clinical aspects of the delivery of patient care and safety.
- Implementation of appropriate corrective action, to the extent possible, to alleviate and resolve identified problems or concerns with patient safety issues.
- Evaluation and documentation of the effectiveness of actions implemented.

- Aggregation of data/information collected for integration in information management systems and use in managerial decisions and operations.

II. Mission and Vision

Valley Hospital Medical Center mission, vision and values drive the Plan and serve as the foundation in identifying strategic goals, objectives and priorities. Our mission is to improve patient safety and the quality of health care delivery through the provision of excellence in clinical care while fostering safe care to our communities, that our patients will recommend to their families and friends, physicians prefer for their patients, purchasers select for their clients, employees are proud of, and investors seek for long-term results. The vision is to be recognized as the provider of choice for healthcare services in the local community where we are trusted by our patients, families and physicians to create a safe, caring and compassionate experience.

In support of our mission, vision, and values, the Plan promotes:

- Collaboration of administrative leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high quality healthcare.
- Communicate honestly and openly to foster trusting and cooperative relationships among healthcare providers, staff members, and patients along with their families, to ensure accountability for the patient safety priorities.
- Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.
- Accountability for every healthcare related decision and action based on the level of risk-taking or egregious behavior identified.
- A focus on continuous learning and improving, system design, and the management of choices and changes, bringing the best possible outcomes or performances to the facility.
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare.
- Education of staff and physicians to assure coordination and integration of care across disciplines and specialties.

Valley Hospital Medical Center recognizes that providing safe patient care requires significant coordination and collaboration. The optimal approach to patient safety involves multiple departments and disciplines to establish and effectively implement the processes and mechanisms that comprise this plan.

III. ROLES AND RESPONSIBILITIES

A. Risk Management/Patient Safety Officer

Valley Hospital Medical Center has a designated risk director/manager responsible for patient safety risk identification and reduction for their respective facilities. The

designated Risk Director/Manager is also the Patient Safety Officer. Each facility is required to submit scheduled reports to the Board of Governors describing risk reduction efforts associated with facility specific, or industry identified risk exposures, including environmental risks and emergency management. Reports are thoroughly reviewed and analyzed by the risk staff to determine effectiveness and follow-through of identified corrective action plans.

The Patient Safety Officer responsibilities based upon [NRS 439.870](#) includes:

- Serving on the Patient Safety Committee (PSC)
- Supervising the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Taking action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the PSC regarding any action taken in accordance with the responsibilities above.

B. Infection Control Officer

The infection control officer designated for each facility, based on [NRS 439.873](#), responsibilities include:

- Serving on the Patient Safety Committee
- Monitoring the occurrences of infections at the facility to determine the number and severity of infections.
- Reporting to the PSC concerning the number and severity of infections at the facility each month.
- Taking such action as determined necessary to prevent and control infections alleged to have occurred at the facility.
- Carrying out the provisions of the Infection Control Program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program.

Based on [NRS 439.865](#), the patient safety plan must also include an infection control program that carries out the infection control policy. The policy must consist of:

- The current guidelines appropriate for the facility's scope of service developed by a nationally recognized infection control organization as approved by the State Board of Health which may include, the Association for Professionals in Infection Control and Epidemiology (APIC), the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO) and the Society for Healthcare Epidemiology of America (SHEA); and

- Facility-specific infection control developed under the supervision of a certified Infection Preventionist.

C. Patient Safety

Valley Hospital Medical Center has an established Patient Safety Councils (PSC) to support patient safety activities. The PSC should ensure that its Patient Safety Plan is promoted and executed successfully. **Valley Hospital Medical Center** has also assembled participants to serve in the Member Workforce and to utilize the Member PSES to generate PSWP and exchange analysis and recommendations with the Acute Care PSO Workforce. The main vehicles for these analytic activities occurring within the Member PSES and the member facility Patient Safety Council meetings. The Member PSES is made up of both electronic and physical spaces for the reporting, storing, and generation of PSWP, including secure SharePoint site, and other electronic databases (including but not limited to ClearSight (STARS) and Midas) to maintain and manage PSWP.

According to [NRS 439.875](#), a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plans are promoted and executed successfully.

I. Facility Patient Safety Committee

Each facility establishes a Patient Safety Committee (PSC) that meets on a regular basis and at least monthly.

Membership:

In accordance with [NRS 439.875](#), the committee core membership consists of the following Key Members: (CEO, CNO, Physician, Risk/ Patient Safety Officer, Infection Prevention Nurse, Pharmacy, and Quality). The COO, CMO and Regional CMO attend, as applicable. NRS requires that at least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing, and pharmaceutical staff of the medical facility. In addition, the infection control officer, patient safety officer, and one member of the executive or governing body of the medical facility.

Based on [NAC 439.920](#), a medical facility that has fewer than 25 employees and contractors must establish a patient safety committee comprised of: the Patient Safety Officer, at least two providers of healthcare who treat patients at the medical facility, including but without limitation, one member of the medical staff and one member of the nursing staff of the medical facility; and the Chief Executive Officer (CEO) or Chief Financial Officer (CF) of the medical facility.

Meetings:

The required members attend the meetings on a monthly basis. If a required member is absent, the facility makes a suitable replacement with someone that has authority to implement actions identified by the PSC.

Duties and Responsibilities:

Valley Hospital Medical Center PSC is charged with the assessment and improvement of high-risk processes related to patient safety. This is to be carried out using a four-step methodology.

- **Issue Identification:** The primary issue is the most important risk issue facing the facility and is determined by reviewing the facility's claims history, claims history unique to the facility, patient safety concerns, industry claims, and through discussions with the risk staff. Other issues may be related to process initiatives.
- **Best Practice:** Once identified, the primary issue is dissected to determine its component issues. For each component issue, a best practice is selected. Best practices represent the most appropriate method for performing the delineated process and should not be selected until the PSC is assured that it is truly the "Best Practice."
- **Implementation:** Implementation strategies are those methods used to put the best practices into place. Often this includes revising policies, education, newsletters, phone calls, meetings, formal training, etc. Responsible parties and dates for completion are identified to ensure success.
- **Monitoring and Accountability:** Monitoring is essential to ensure that the strategies identified have been effective. Improvement should be demonstrated statistically whenever possible.

Additional Patient Safety Committee Responsibilities, based upon [NRS 439.875](#) and [NRS 439.877](#), include:

- Monitor and document the effectiveness of the Patient Identification Policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the Patient Safety Officer pursuant to [NRS 439.870](#).
- Evaluate actions of the Patient Safety Officer in connection with all reports of sentinel events alleged to have occurred.
- The Quality member of the PSC will review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- The Quality member in conjunction with the Infection Control Officer will review and evaluate the quality of measures carried out by the facility to prevent and control infections.

- Make recommendations to the Board of Directors of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the Board of Directors of the facility regarding:

(1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);

(2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and

(3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.

- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

In addition to the work done on the primary issue, the PSC is charged with addressing issues identified through claims reporting, Safety Watch Newsletters, the Joint Commission (Sentinel Event Alerts) and others, HRUs and from the TERM evaluation or other surveys, such as the OBHRU Site Assessments. Feedback is provided on an ongoing basis as to the functioning of the Patient Safety Committee.

II. Patient Safety Advisories

When an untoward event occurs at a facility or in the industry, it is important that we respond in a positive manner. Systems that lead to failure at one facility can be assessed at other facilities to avoid the same or similar occurrence. To this end, the Acute Care PSO distributes Safety Watch newsletters. These alerts detail the circumstances that lead to the negative outcome and facilities are charged with assessment and improvement of their own processes.

Valley Hospital Medical Center is required to address the Safety Watch newsletters via their Patient Safety Council and this is evidenced in their monthly minutes. Responses to the Safety Watch are reviewed for the opportunity to generate a best practice to implement.

C. TERM Program

The facility has utilized its formalized risk management program identified as TERM: the Technical Elements of Risk Management. Each element focuses on a separate organizational function and details specific strategies for managing risk in these areas. These elements are summarized as follows:

Element I. Administration of the Risk Management Program: The tenets outlined in Element 1 lay the foundation for an effective risk management program. The Risk Manager/Director must be seen as a resource to administration, facility, and medical staff. Written plans, goals, and objectives provide a clear vision to meet the purpose of the risk program. Although the TERM program uses the title “Risk Manager,” this applies equally to Risk Directors.

Element II. Risk Identification: Risk identification is essential in order to avoid, mitigate, and eliminate risk-generating practices. This Element focuses on those steps taken to identify exposures faced by the facility.

Element III. Risk Education: Education is a cornerstone of the TERM program. Risk management education is intended to reduce and eliminate risk-generating practices and to promote best practices that enhance the provision of safe patient care.

Element IV. Patient Safety Initiative: Imperative to a comprehensive RM program is one that focuses on the improvement of patient and staff safety through the creation of an environment that maximizes safety and reduces liability claims exposure. The mechanism used to drive the culture of safety is the Patient Safety Committee (PSC) at each facility. The PSC operates using a four-step process. These steps include: identification of the problem, determining best practice, implementing the recommendations, and monitoring and accountability. Corrective actions are discussed, monitored, and validated by the PSC.

Element V. Patient Safety Priority: Root Cause Analysis (RCA): The cornerstones of an effective Patient Safety and Risk Management Program are (i) the performance of a thorough and credible RCA when a serious, sentinel, never event or a significant near miss event occurs; and (ii) implementation of systemic improvements to enhance patient safety and improve healthcare outcomes going forward.

Element VI. Environment of Care; Safety and Security Programs: The safety and security programs in the facility serve to protect and preserve both life and property. Areas of safety include licensing, accreditation and federal, state, and local safety practices and programs, including the EPA, TJC, etc.

Element VII. Claims and Litigation Management: The risk manager serves as the on-site representative of the insurance program in the management of general and professional claims and litigation.

Element VIII. Patient Safety Organization (PSO): Participants of the Member Workforce are expected to perform identified patient safety activities and to be trained in their responsibilities. They must also understand and acknowledge their obligations, including maintaining the confidentiality of PSWP, as required by the Patient Safety and Quality Improvement Act (PSQIA), and of Protected Health Information, as required by the

Health Insurance Portability and Accountability Act (HIPAA) and its regulations, and other federal and state laws.

Element IX. Measuring the Effectiveness of the Risk Management Program: In order to assure the effectiveness of the Risk Management Program, certain activities should be conducted to ensure that implementation of the TERM program has been successful. This includes, but is not limited to, data analysis and trending of events and potential claims, which are shared with the respective oversight committees.

D. MIDAS

The MIDAS system is the electronic event reporting system utilized by the facilities to report patient and visitor safety events. The risk management module allows for the collection, categorization, and analysis of incident data using electronic reporting functions (Remote Data Entry - RDE). The facility enters incidents into MIDAS through identification of the type of incident and characteristics of the event using risk parameters and outcomes. Additional information can be attributed to a department, physician, or individual, along with further details of the event. This allows the retrieval of information in a variety of ways for analysis and review.

E. ClearSight (STARS)

STARS is an integrated claims management program that allows for complete claims management, including extensive analysis of reportable fields associated with reported claims. STARS also provides for the electronic submission of potential claims by user facilities.

Delineation of issues featured in the probable claim module allows for the facility staff to identify causation factors associated with any reported event. The system also provides for the entry of details that will describe the event and liability concerns.

Trending of claim information is performed on a scheduled basis to operations leadership metrics to form strategies on facilitating risk reduction efforts. Previous examples of this function include the formation of an OB HRU and Perioperative concepts. Quarterly reports should be provided by the Facility's RM to the Governing Board of all claims activities.

F. Event Notification Site

The Risk Department developed the Event Notification Site or ENS, a web-based system that allows for contemporaneous reporting of serious adverse events and key near miss sentinel events to facility and corporate management. The ENS also provides an environment in which stakeholders can post questions and additional information to the

facility reporting the event. Updates to the event are reported in real-time to all identified facility and stakeholders via the ENS. The Risk Management staff reviews each ENS to determine if follow-up is needed; if follow-up is indicated, it is to be completed within 45 days.

G. Root Cause Analysis (RCA)

Pursuant to [NRS 439.837](#), a medical facility shall, upon reporting a sentinel event pursuant to [NRS 439.835](#), conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both of the sentinel event.

A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals. Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

It is recommended that the Joint Commission's root cause analysis and actions plan framework table are utilized. It contains analysis questions and guides the organization in the steps of a root cause analysis. Not all of the questions apply to all of the events or cases.

Utilization of the "5 Whys" technique should be used to explore the cause and effect relationship underlying a problem. One can find the root causes by asking "why" no less than five times.

RCA Responsibilities

- Organize and coordinate the RCA process. For Serious OB events, RCAs are to be done within 72Hrs. of the event.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA and corrective action plan implementation process.
- Communicate the progress of the investigation, institutional barriers and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.



H. Patient Safety Checklists

By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

The patient safety checklists must follow protocols to improve the health outcomes of patients at the medical facility and must include, without limitation:

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.

- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - Proper instructions concerning prescription medications;
 - Instructions concerning aftercare;
 - Any other instructions concerning his or her care upon discharge; and
 - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety checklists are listed in Appendix E. (The following links provide some patient safety checklists for your reference— a checklist example is shown in **Appendix B.**)

http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf

<http://www.who.int/patientsafety/implementation/checklists/en/>

I. Patient Safety Policies

The patient safety policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include, the name and date of birth of the patient.
- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.
- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

J. MEMBER PATIENT SAFETY EVALUATION SYSTEM (PSES)

The Patient Safety and Quality Improvement Act of 2005 (PSQIA) and its regulations govern the operations and activities of the UHS Acute Care PSO and its Members. This includes assembling a “workforce” of employees, volunteers, trainees, contractors, and other persons who carry out patient safety activities on behalf of the Members within the Member Patient Safety Evaluation System (“Member PSES”). Participants in the Member Workforce are expected to perform identified patient safety activities and to be well trained in their responsibilities. They must also understand and acknowledge their obligations, including maintaining the confidentiality of PSWP, as required by the PSQIA, and of Protected Health Information, as required by the Health Insurance Portability and Accountability Act (HIPAA) and its regulations, and other federal and state laws. The Member PSES serves as a means by which patient safety information is collected, maintained, reported, and analyzed for the UHS Acute Care PSO for the purposes of improving patient safety.

K. Training and Education

Training is essential to successful implementation of the Patient Safety and TERM program. All facility risk managers undergo extensive orientation and education related to Patient Safety, TERM program and other healthcare, risk-related topics. Newly hired risk managers receive both on-site and collaborative corporate-based education and training to afford them the requisite skills to manage their facility assignment. Each risk manager is provided a copy of the TERM source documents and other reference materials that guide the risk management function. In addition, formalized supplemental training is provided to all facility risk managers as needed, including quarterly risk management meetings. Risk leadership provides ongoing support and consultation to their assigned facility to facilitate the minimization of liability exposures and enhancement of safe patient care.

The leadership risk management staff provides consultative services to each facility and as members of designated projects. These activities include on-site assistance, research, and consulting from off-site. Examples of designated projects are as follows.

- Facility specific risk Issues
- Safety Watch newsletters
- MIDAS Focus advisories

IV. Risk Management Goals and Objectives 2018

- Surgical and Procedural Safety
 - Monitor compliance through tracer methodology and report monthly with oversight by leadership.

- Goal: Zero harm events: Prevent mistakes in surgeries and procedures
- OB HRU-Zero Preventable Harm
 - Goal: Reduction/ Elimination of Maternal Hemorrhage
 - Goal: Reduction/ Elimination of Serious Harm from Shoulder Dystocia
 - Goal: Reduction/ Elimination of Serious Harm by decreasing response time to changes in Fetal Monitoring Tracings
- Emergency Department
 - Goal: Reduction/ Elimination of Workplace Violence
- Medication Safety
 - Goal: Implement an effective Opioid – Pain Management strategy, as evidenced by compliance with Assembly Bill 474, NRS 233B.066, regarding prescribing of controlled substances and reporting of controlled substance overdoses.
- Perform monthly *Safety Watch* Gap Analysis and complete within 90 days.
- Falls: Goal: Valley Hospital and Medical Center would like to reduce patient falls with injuries by 20%. The methodology for attainment is incorporating daily rounds by clinical supervisors to confirm all fall reduction strategies have been implemented on high risk for fall patients. Also, patients that require closer monitoring will be placed in camera rooms and/or, a sitter will be utilized as necessary.
- Increase Risk management education to all staff by attending daily huddles, monthly on-site staff meetings, Safety Fair, and conducting open house in the Risk Office. Key patient safety concerns, topics, Midas questions will be addressed. Valley Hospital Risk Management will increase this by 30%.

V. Monitoring and Accountability

A. Evaluation of TERM Program

These evaluations consist of both a core risk and clinical risk review. The facility is required to submit a written corrective action plan for noted deficiencies determined during the TERM evaluation. All information is shared with senior staff and monitored through the facility PSC.

B. Patient Safety Council Coaching

As detailed above, each facility is required to post their monthly reports or minutes that details the work conducted by their Patient Safety Committee to the facility PSES site. These are then reviewed minutes and detailed feedback is provided to coach the committee on their form and function.

C. Dashboards

The Risk Management/Patient Safety Dashboard and the Environment of Care Dashboard include multiple indicators to demonstrate the facility's performance as to these markers. These include: event reporting statistics, fall rate including harmful event rate, medication event rate including harmful medication events, timeliness of event review and closure, risk management education, events that meet the ECRI Top Patient Safety Concerns, and environment of care concerns.

VI. Evaluation/Review:

The risk staff reviews the effectiveness of the Patient Safety/Risk Management Plan to ensure activities are appropriately focused on improving patient safety, decreasing harmful errors, decreasing rate of compensable events, facility risk program consistency/functionality and support of clinical delivery in the field. Evaluation will include the following:

- The culture supports the identification and reporting of "Near Miss" events
- There is a framework that advances a "Just Culture"
- Accountability is promoted when acts of "at risk" or "reckless behavior" occur resulting in potential/actual adverse outcomes;
- Comparison of trended incident data to include analysis of performance to stated targets, submission of incident data in compliance to SOX stipulations and review of trended data submitted to the PSC for potential action;
- Review of annualized and prior year's probable claim reports to determine needs for corporate-based projects designed to improve outcomes in an identified service line;
- Review of educational products distributed for the concluding operating year that were intended to improve outcomes associated with a particular clinical emphasis;
- Review information, analyses and reports from the Acute Care PSO for integration into the Patient Safety Evaluation System.

VII. Confidentiality

All patient safety/risk management work products are considered Patient Safety Work Products (PSWP) as defined by federal guidelines governing Patient Safety Organizations (PSO). All PSWP reported, stored, or generated in the Member PSES is confidential and privileged under Federal law. The Member PSES will only be accessed by authorized staff. Workforce participants will be trained on policies and procedures governing their patient safety activities and responsibilities.

VIII. Approval of Patient Safety Plan

According to [NRS 439.865](#), a medical facility shall submit its patient safety plan to the governing board of the facility for approval. After a facility's patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan.

The patient safety plan must be reviewed and **updated annually** in accordance with the requirements for approval set forth in this section.

According to [NRS 439.843](#), on or before March 1 of each year, a copy of the most current patient safety plan established to [NRS 439.865](#) must be submitted to the Division of Public and Behavioral Health.

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http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

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2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:

(a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or

(b) July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published.

3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.

(Added to NRS by [2002 Special Session, 13](#); A [2005, 599](#); [2013, 217](#))

Institute for Healthcare Improvement (IHI) defines **medical harm** as “unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death.”

Facility-Associated Infection: ([NRS 439.802](#))

“Facility-acquired infection” means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections;
- Ventilator-associated pneumonia;
- Central line-related bloodstream infections;
- Urinary tract infections; and
- Other categories of infections as may be established by the State Board of Health by regulation pursuant to [NRS 439.890](#).

(Added to NRS by [2005, 599](#); A [2009, 553](#))

Medical facility ([NRS 439.805](#))

“Medical facility” means:

- A hospital, as that term is defined in [NRS 449.012](#) and [449.0151](#);
- An obstetric center, as that term is defined in [NRS 449.0151](#) and [449.0155](#);
- A surgical center for ambulatory patients, as that term is defined in [NRS 449.0151](#) and [449.019](#); and
- An independent center for emergency medical care, as that term is defined in [NRS 449.013](#) and [449.0151](#).

(Added to NRS by [2002 Special Session, 13](#))

Near miss: An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Mandatory reporting: Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985;254(6):796-800.)

Risk: Possibility of loss or injury. (Merriam-Webster’s Online Dictionary, Risk, Available at <http://www.merriamwebster.com/dictionary/risk>. Last Accessed August 2009.)

Preventable event: Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Catheter Associated Urinary Tract Infection (CAUTI): A urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and

Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CURRRENT_b.pdf.)

Central Line Associated Bloodstream Infections (CLABSI): Primary bloodstream infections that are associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection.

**REPORT TO THE DIRECTOR OF THE LEGISLATIVE COUNSEL BUREAU PURSUANT TO
NRS 439.877(4)(d) – SUBMITTED BY:**

Valley Hospital Medical Center
620 Shadow Lane, Las Vegas NV 89106
702-388-4000
July 1, 2017– June 30 , 2018

Check Lists Developed Include:	Revisions*	Usage**	Review***
7 Step Cleaning Process		Environmental Services	X
Admission History Adult		Outpatient Surgery (OPS), Emergency Room (ER), Intensive Care Units (ICUs), Intermediate Care Unit (IMC), Medical/Surgical Units (M/S), Behavioral Health (BH) and Rehabilitation (Rehab)	X
Adult Electrolyte PRN Replacement Orders	X	ER, OPS, Recovery Room (PACU), ICUs, IMC, Rehab and M/S.	
Adult Nutrition Initial Assessment/Plan		ICUs, IMC, M/S, and Rehab	X
Adult Post PAT Admission History		Pre-admission testing (PAT), ER, BH, ICUs, IMC, and M/S	X
Adult SAD Persons Scale		BH, ER, ICUs, IMC, and M/S	X
Arrival-Departure		ER, ICUs, IMC, and M/S	X
Basic Admission History Adult		ER, ICUs, IMC, BH and M/S	X
Bridge		PACU, OPS, ER, ICUs, IMC, and M/S	X
Core Measure Prompter		ER, ICUs, IMC, M/S, and Rehab	X
Discharge Needs		BH, ER, ICUs, IMC, and M/S	X
Document Medication by History		BH, PAT, OPS, ER, ICUs, IMC, and M/S	X
ED Abuse/Neglect Adult		ER	X
ED Social History		ER	X
ED Triage General/Screening Adult		ER	X
Education Cardiac		PAT, PACU, OPS, ER, ICUs, IMC, and M/S	X
Education Diabetes		PAT, PACU, OPS, ER, ICUs, IMC, and M/S	X
Education Fall Risk Prevention		PAT, PACU, OPS, ER, ICUs, IMC, and M/S	X

Education Herat Failure		PAT, PACU, OPS, ER, ICUs, IMC, and M/S	X
Education Pain		PAT, PACU, OPS, ER, ICUs, IMC, and M/S	X
Education PCA		PACU, ER, ICUs, IMC, and M/S	X
Education Stroke		PAT, PACU, OPS, ER, ICUs, IMC, and M/S	X
Function and Safety		PAT, PACU, OPS, ER, ICUs, IMC, and M/S	X
Heart Score for Major Cardiac Events		ED, MICU, and SICU	X
Heparin Infusion Low and Standard Dose	X	PACU, OPS, ER, ICUs, IMC, and M/S	
Invasive Line Checklist/PICC Insertion		OPS, ER, ICUs, IMC, M/S, and Rehab	X
IPOC CAUTI – Urinary Catheter Needs Assessment		ER, PACU, ICUs, IMC, and M/S	X
IPOC COPD		ER, ICUs, IMC, and M/S	X
MED Argatroban		ER & ICUs	X
MED Sepsis Module		ER, Recovery Room, ICUs, IMC, and M/S.	X
Modified Rankin Scale (MRS)		ER and ICU	X
NEURO Ischemic Stroke (CVA) IV Thrombolysis Module		ER and ICUs	X
NIH Stroke Scale		ER, ICUs, IMC, and 3 Tower M/S	X
Notification Form		PAT, PACU, OPS, ER, ICUs, IMC, and M/S	X
Nursing Discharge Summary		BH, ER, ICUs, IMC, and M/S	X
Patient Care Dashboard		ER, ICUs, IMC, M/S, and Rehab	X
Post Fall Assessment		PACU, OPS, ER, ICUs, IMC, M/S, and Rehab	X
Preadmission Visit Assessment		PAT	X
Preoperative Doc		Operating Room	X
Preprocedure Checklist/PICC Insertion		OPS, ER, ICUs, IMC, M/S, and Rehab	X
Quality Measures Dashboard		PACU, OPS, ER, ICUs, IMC, M/S, and Rehab	X
Readmission Risk Assessment		ER, ICUs, IMC, M/S, and Rehab	X
Re-admission Risk Assessment		ER, ICUs, IMC, M/S, and Rehab	X
Restraint – Non-violent and Violent	X	PACU, OPS, ER, ICUs, IMC, M/S, and Rehab	

SCIP Core Measure Prompter		OPS, PACU, ER, ICUs, IMC, M/S, and Rehab	X
Sedation (Iview with IO)		ER and ICUs	X
ST Bedside Swallow Eval		ED, IMC, and M/S	X
Stoke Core Measure Prompter		ER, ICUs, IMC, M/S, and Rehab	X
Substance Use		ER	X
Ticket to Ride		ER, ICUs, IMC, M/S, Radiology, and Rehab	X
TPN Advisor		ER, ICUs, IMC, M/S, and Rehab	X
Universal Protocols/Time Out	X	OR, OPS, ER, ICUs, IMC, M/S, Cardiology, Radiology, Special Procedures, Radiology, and Rehab	
Valuables Belongings		PACU, OPS, ER, ICUs, IMC, M/S, and Rehab	X
Vascular Access		PACU, OPS, ER, ICUs, IMC, M/S, and Rehab	X
VTE Prophylaxis Guidelines		PACU, OPS, ER, ICUs, IMC, M/S, and Rehab	X
Wet-dry Process for Mopping		Environmental Services	X
Patient Safety Policies developed include:	Revisions	Usage	Review
Active Surveillance		ED, ICUs, IMC, M/S and Rehab	X
Bar Coding Scanning		BH, OR, OPS, PACU, Radiology, Therapy Services, Respiratory Therapy, Admitting, ER, ICUs, Cardiology, Special Procedures, IMC, M/S, and Rehab	X
Culture of Patient Safety		BH, OR, OPS, PACU, Radiology, Therapy Services, Respiratory Therapy, Admitting, ER, ICUs, Cardiology, Special Procedures, IMC, M/S, and Rehab	X
Discharge Planning	X	ED, ICUs, IMC, M/S, and Rehab	
Education Communication Patient and Family	X	PACU, OPS, ER, ICUs, IMC, M/S, and Rehab	
Functional Screening Assessments		Behavioral Health	X
VHS Hand Hygiene Guidelines	X	All Departments	

Isolation Guidelines	X	BH, OR, OPS, PACU, Radiology, Therapy Services, Respiratory Therapy, Admitting, ER, ICUs, Cardiology, Special Procedures, IMC, M/S, and Rehab	
Patient Access to Protective Services		BH, ER, ICUs, IMC, M/S, and Rehab	X
Patient Identification	X	BH, OR, OPS, PACU, Radiology, Therapy Services, Respiratory Therapy, Admitting, ER, ICUs, Cardiology, Special Procedures, IMC, M/S, and Rehab	X
Public Guardian		BH, ER, ICUs, IMC, M/S, and Rehab	X
Safety of the Patient at Risk for Suicide – Behavioral Health		BH	X
Use of Patient Safety Checklists		BH, OR, OPS, PACU, Radiology, Therapy Services, Respiratory Therapy, Admitting, ER, ICUs, Cardiology, Special Procedures, IMC, M/S, and Rehab	X

Summary of Review	Total # developed	Total # revised	Total # Reviewed
Patient Safety Checklists		4	52
Patient Safety Policies		4	9

*Checklists and Patient Safety Policies were reviewed for the stated time period. Need for revision is noted by the date the revision was made.

**Usage outlines the units/departments the checklists are used in.

***As part of the annual review any required revisions will be identified. If revisions are required this is noted in the revision box. Any additional patient safety checklists or policies identified will be noted in this (review) column. If the annual review reveals no changes are required this box will be marked with an "X". An "X" means that the checklists and policies were reviewed but no changes were required.

❖ Reports are due on or before July 1 of each year, address report to:

Director LCB

Name Here

director@lcb.state.nv.us

Copy to: Redacted

Carson City, NV 89701



Patient Safety Plan

2017

This plan was created and revised by the Renown Health's Patient Safety Committee. Implementation of this plan is intended to optimize the healthcare quality and patient safety outcomes. In addition the plan is intended to encourage recognition, reporting, and acknowledgment of risks to patients, visitors, and employees as well as reduce medical/healthcare errors and /or preventable events.

Patient Safety Plan

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Commitment to Patient Safety

Renown Health is committed to a comprehensive approach to improving healthcare quality and patient safety by aligning with our Mission, Vision, and Values, creating an environment that supports a dynamic, proactive, and safe culture for patients, family members, visitors, and employees, through continuous learning and improving patient safety policies, systems, and processes.

Mission, Vision, and Values

In support of our mission, vision, and values, Renown Health's Patient Safety program promotes:

- Collaboration of healthcare, leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high quality healthcare.
- Honest, open communication to foster trusting and cooperative relationships among healthcare providers, staff members, and patients and their families, to ensure accountability for the patient safety priorities.
- Preservation of dignity and values for each patient, family member, employee, and other healthcare providers.
- Responsibility for safety related decision and action.
- A focus on continuous learning and improving, system design, and the management of choices and changes, bringing the best possible patient outcomes.
- Incorporation of evidence-based safety practice guidelines to deliver high quality healthcare.
- Education of staff, physicians, patients and their families to promote patient safety and continuous quality improvement.

Scope and Purpose

This Patient Safety Plan applies across the entire Renown Health organization.

All staff and physicians in Renown Health are required to fully support and participate in this plan, and devote their expertise to the patient safety and healthcare performance improvement process.

This plan is action oriented and solution focused. The purpose of this plan is to address patient safety related concerns, challenges and revise the program to better serve patients and their families.

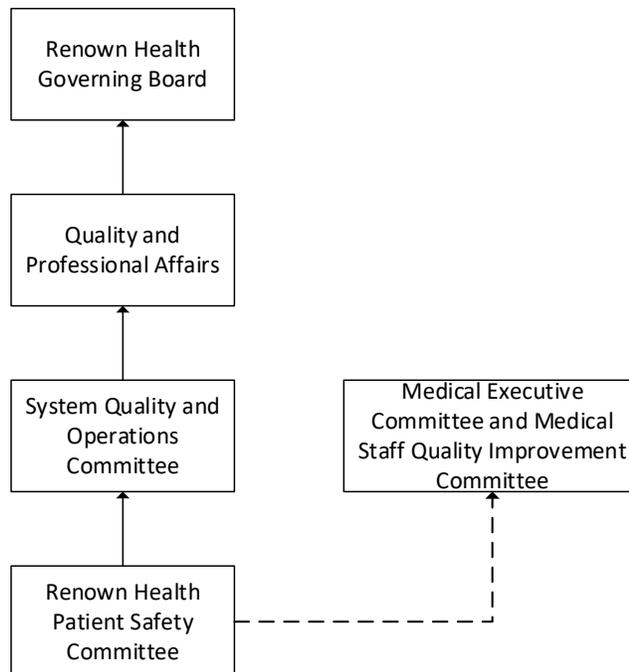
The plan focuses on the process rather than the individual, and recognizes both internal and external customers, as well as facilitates the need of analyzing and improving processes. The core principles of this plan include:

- Staff and physicians contributing their knowledge, vision, skill, and insight to improve the processes of patient safety
- Decisions made based on data and facts, with patient safety being considered
- Customer-focus including patients, families, and visitors
- System-based thinking
- Utilization of trained, expert staff and physicians.

Roles and Responsibilities

The Renown Health Patient Safety Committee ensures that the Patient Safety Plan is promoted and executed successfully as indicated in NRS439.875.

The Patient Safety Committee Organization



Roles and Responsibilities

- In accordance with [NRS 439.875](#), the Renown Health Patient Safety Committee is comprised of:
- The Renown Health Infection Control Officer;
- The Renown Health Patient Safety Officer;
- At least three providers of healthcare who treat patients, including at least one member of the medical, nursing and pharmaceutical staff of the medical organization; and
- One member of the executive or governing body of the medical organization;
- A representative from Executive Leadership.

Patient Safety Committee Responsibilities (based on [NRS 439.875](#) and [NRS 439.877](#))

- Monitor and document the effectiveness of the patient identification policy through event review when applicable.

- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the patient safety officer pursuant to [NRS 439.870](#).
- Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred.
- Review and evaluate the quality of measures carried out by the organization to improve the safety of patients.
- Review and evaluate the quality of measures carried out by the organization to prevent and control infections.
- Make recommendations to the executive or governing body of the organization to reduce the number and severity of sentinel events and infections.
- At least once each calendar quarter, report to the executive or governing body of the organization regarding:
 - (1) The number of sentinel events that occurred;
 - (2) The number and severity of infections that occurred; and
 - (3) Any recommendations to reduce the number and severity of sentinel events and infections.
- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

Patient Safety Officer Responsibilities (based on [NRS 439.870](#))

- Serve on the Renown Health Patient Safety Committee.
- Supervise the reporting of all sentinel events alleged to have occurred, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred.
- Report to the patient safety committee directly or through his/her designee any action taken in accordance with the responsibilities above.

Infection Control Officer Responsibilities (based on [NRS 439.873](#))

- Serve on the Renown Health Patient Safety Committee.
- Monitor the occurrences of infections to determine the number and severity of infections.
- Report to the patient safety committee concerning the number and severity of infections either directly or through his/her designee.
- Take such action as determines is necessary to prevent and control infections alleged to have occurred.
- Carry out the provisions of the infection control program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program.

Quality and Professional Affairs Committee of the Renown Health Board

- Provide vision and leadership to Patient Safety process, and develop and foster a safe learning and improving culture.
- Ensures the priorities of patient safety are aligned with the strategic priorities of the health system.

The Patient Safety Committee will meet monthly to accomplish the following:

- Report and discuss sentinel events and hospital acquired infections including:

- Number of sentinel events from previous calendar month
- Number of hospital acquired infections that occurred in the organization
- Corrective action plans for the sentinel events and infections.
- Patient safety policies and checklists
 - At least annually evaluate Patient Safety policies and checklists
 - Revise the patient safety policies and checklists as needed
 - Monitor and document the effectiveness of patient safety policies.

A meeting agenda and minutes noting follow-up tasks will be kept.

Components and Methods

Pursuant to [NRS 439.837](#), a medical facility shall, upon reporting a sentinel event pursuant to [NRS 439.835](#), conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event.”

Root Cause Analysis

Renown Health will use Root Cause Analysis (RCA) to determine the contributing factors and the underlying reasons for the deficiencies or failures. Transformational Health Care principles and methods are incorporated into Renown Health’s RCA process.

An RCA is a process for identifying the root causes of problems. It follows the principles of Just Culture by focusing on processes, instead of individuals.

Root Cause Analysis (RCA) Team Responsibilities

RCAs are conducted for all identified sentinel events and significant events/near misses involving complex process failure. Results of significant RCAs will be reported and monitored by the Renown Health Patient Safety Committee.

- Root Cause interviews, analysis, investigation, and corrective action plan implementations
- Participates in the RCA meetings and discussions
- Communicate honestly and openly about data and facts to the team members and their supervisors/leaders
- Incorporates the principles of Just Culture in the RCA process.

Causal Chain (5 Whys) technique will be used in Renown Health to explore the cause and effect relationship underlay a problem. One can find the root causes by asking “why” repeatedly.

Data Collection and Reporting

Data drives quality and patient safety efforts. Renown Health uses Midas and other databases for tracking sentinel events, healthcare infections, and other patient safety related data.

External data sources are those data sources which are collected outside the supervisory structure of the case. External data which will be utilized for Patient Safety plan include the data from:

Renown Health Patient Safety Plan

- AHRQ: Agency for Healthcare Research & Quality
- CDC: Centers for Disease Control and Prevention
- CMS: Centers for Medicare & Medicaid Services
- NQF: National Quality Forum
- NHSN: National Healthcare Safety Network
- TJC: The Joint Commission

Patient Safety Checklists and Patient Safety Policies

By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the organization;
- Other personnel who provide treatment or assistance to patients;
- Employees who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the organization; and
- Persons with whom the organization enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

The Renown Health Patient Safety Committee reviews and approves annually patient safety checklists based on policy.

Based on [NRS 439.865](#), the patient safety plan must also include an infection control program that carries out the infection control policy. The policy must consist of:

- The current guidelines appropriate for the scope of service developed by a nationally recognized infection control organization as approved by the State Board of Health which may include, the Association for Professionals in Infection Control and Epidemiology (APIC), the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO) and the Society for Healthcare Epidemiology of America (SHEA); and
- Facility-specific infection control developed under the supervision of a certified Infection Preventionist.

The Renown Health Infection Prevention Plan and Program is established and approved by the Renown Health Infection Control Committee. Regular reports and updates regarding the Infection Prevention Program are provided to the Patient Safety Committee.

Approval of Patient Safety Plan

The Renown Health Patient Safety Plan is reviewed and updated annually and is approved by the Quality and Professional Affairs Committee of the Renown Health Board.

According to [NRS 439.843](#), on or before March 1 of each year, a copy of the most current patient safety plan established to [NRS 439.865](#) must be submitted to the Division of Public and Behavioral Health.

WILLIAM BEE RIRIE CRITICAL ACCESS HOSPITAL/RURAL HEALTH CLINIC

ADMINISTRATION POLICY & PROCEDURES

Department: Facility Wide

Program/Manual: Administration

Policy Subject: Patient Safety Plan

Section Number: P

Effective Date: 01/1990

Revision Date: 09/26/2011; 2/17/2015; 3/14/2018

Approved: _____
Name Here, CEO

Name Here, Board Chairman

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 and findings and actions taken to reduce risk
- Support sharing of knowledge to effect change
- Supplying support systems to health care workers who are involved in sentinel events.
- Have a sufficient number and mix of individuals to support safe, quality care, treatment, and services.

V. RESPONSIBILITIES/DUTIES

It is William Bee Ririe Hospital and Rural Health Clinic's responsibility to designate an officer or employee of the facility to serve as the patient safety officer of the medical facility.

The duties of the designated patient safety officer are:

- To serve as the patient safety officer of WBRH and RHC
- Serve on the Enterprise Safety Committee
- Supervise the reporting of all 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.
- Upon discovery notify the CEO immediately.

The Enterprise Safety Committee shall meet each month

The Patient Safety Plan and any changes thereafter shall be presented to the governing board of WBRH and RHC for approval.

The Patient Safety Plan must include, without limitation, the patient safety checklists and patient safety policies most recently adopted in regards to the patient safety plan.

After the WBRH and RHC's patient safety plan is approved, WBRH and RHC shall notify all providers of health care who provide treatment to patients at WBRH and RHC of the existence of the plan and of the requirements of the plan. WBRH and RHC shall require compliance with the patient safety plan.

The Enterprise safety Committee shall

- Receive reports from the Patient Safety Officer
- Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred at the facility
- Review and evaluate the quality of measures carried out by WBRH and RHC to improve the safety of patients who receive treatment at WBRH and RHC
- Make recommendations to the governing body of WBRH and RHC to reduce the number and severity of sentinel events that occur at WBRH and RHC.

The Enterprise Safety Committee provides a multidisciplinary forum for the collection and analysis of risk to patient safety and the dissemination of information on identified risk for the purpose of improving patient care. It shall review reports on occurrences including near misses to sentinel events. It shall identify those individuals or groups best situated to perform a root cause analysis and develop and implement an action plan for identified issues. It shall review, analyze and disseminate the information it receives, as appropriate, to the designated individuals and/or committees. It shall provide recommendations concerning identified risks, approve plans for corrective actions and evaluate the implantation of corrective actions taken.

Membership will include: CEO, CNO, CIO, Pharmacist, QIC, Infection Control, Materials Manager, Environmental Safety Officer, Patient Safety Officer, a Medical Staff Member, and 1 member of the governing body.

VI. SCOPE

The types of occurrences to be addressed include, but are not limited to, sentinel events, near misses, and actual events related to:

- a) Patient safety
- b) Adverse drug events (medication errors and adverse drug reactions)
- c) Health acquired infections
- d) Patient Falls
- e) Other patient incidents/unexpected clinical/medical events
- f) Unsafe conditions
- g) Visitor safety
 - Visitor incidents
- h) Employee safety
 - Blood/body fluid exposures
 - Occupational diseases
 - Communicable disease exposures
 - Musculoskeletal injuries
 - Immunization programs
 - Other employee incidents
- i) Environmental safety
 - Product recalls
 - Drug recalls
 - Product/equipment malfunction
 - Construction –Infection Control Risk Assessment
 - Water Quality
 - Air Quality
 - Disaster Planning
 - Security incidents
 - Workplace violence

Data from external sources, including but not limited to:

- Centers for Disease Control and Prevention (CDC)
- Joint Commission
- Institute for Healthcare Improvement (IHI)
- Institute for Safe Medication Practices (ISMP)

- Occupational Safety and Health Administration (OSHA)
- Nevada State Health Division
- Published literature

VII. DEFINITIONS

Adverse (Sentinel) Event is defined as an unexpected occurrence that involving facility-acquired infection, death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb function. The phrase “or the risk thereof” includes any process variation for which recurrence would carry a significant chance of a serious adverse outcome.

Facility-acquired infection means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections
- Ventilator-associated pneumonia
- Central line-related bloodstream infections
- Urinary tract infections; and
- Other categories of infections as may be established by the Administrator.

Medical Error is defined as failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim. Medical errors may or may not cause harm.

Serious Error is an error resulting in patient injury including the potential to cause permanent injury or transient but potentially life-threatening harm

Minor Error is an error that does not cause harm or have the potential to do so

Near Miss is an error that could have caused harm but did not reach the patient because it was intercepted.

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. allergy information current
- Telephone response time to callers
- Occurrence review

Give consideration to measures that facilitate safe practices; (Examples are listed below)

- Involve patients in their health care; consider literacy issues and cultural values, partner with patients in developing and planning their care plan.
- Use a team approach to safety; hold focused safety meetings

- Endorse open, effective communication; identify shared values and attitudes among all members. Interview and/or survey staff for attitudes, perceptions and communication barriers.
- Encourage error reporting to include near miss events. Institute a non-punitive reporting that is confidential and timely.
- Ensure employee and patient information or event reports shared with staff for educational purposes do not identify individuals.
- Facilitate communication skills learning (teamwork)
- Examine physical premises to identify and correct potential hazardous conditions.
- Orient physicians and new employees to risk management and patient safety concepts
- Conduct patient safety rounds
- Provide education and training on high risk processes.

XII. METHODOLOGY

A. Structure

- Proactive risk prevention strategies
- Identification of High Risk Areas
- General Incidences (Patient Injuries)
- Potential or actual adverse events (medication errors)

B. Method – Establish a process for;

- Identification, Selection, Prioritization
- Data Collection and Analyses
- Development of Actions
- Implementation
- Reporting
- Follow-up

C. Process Improvement – Establish teams/individual staff members to implement processes and to monitor for effectiveness.

Utilize applicable tools to facilitate improvement; for example

- PDCA: Plan, Do Check Act with focus on process improvement
- FMEA: Failure Mode Effect Analysis a systematic process for identifying potential process failures before they occur with the intent to eliminate or minimize risk.
- RCA: Root Cause Analysis is a retrospective approach to error analysis that identifies what and how the event occurred and why it happened. The focus is on the process and systems not individuals.

XIII. PROGRAM EVALUATION

The Patient Safety Officer will submit monthly a report the Enterprise Safety Committee, Medical Staff and the Board of Directors.

1. Definition of the scope of occurrence including sentinel events, near misses and serious occurrences that occurred at WBRH and RHC during the preceding month including;
 - Employee injuries
 - Potential lawsuits
 - Resolutions
 - Recommendations to the decrease of the number and severity of Sentinel Events

Yearly the Patient Safety Officer will submit to the Enterprise Safety Committee, Medical Staff and the Governing Board the following;

- a. Detail of activities that demonstrate the enterprise safety program has a proactive component by identifying the high-risk process selected.
- b. Results of the high-risk or error-prone processes selected for ongoing measurement and analysis.
- c. A description of how the function of process design that incorporates patient safety has been carried out using specific examples of process design or redesign that include patient safety principles.
- d. The results of how input is solicited and participation from patients and families in improving patient safety is obtained.
- e. The results of the program that assesses and improves staff willingness to report errors.
- f. A description of the examples of ongoing education and training programs that are maintaining and improving staff competence and supporting an interdisciplinary approach to patient care.

Yearly the Enterprise Safety Committee shall;

1. Monitor and document the effectiveness of the patient identification policy.
2. Review the patient safety checklists and patient safety policies adopted and consider any additional patient safety checklists and patient safety policies that may be appropriate for adoption for use at the medical facility.
3. Revise a patient safety checklist and patient safety policy adopted as necessary to ensure that the checklist or policy reflects the most current standards in patient safety protocols.
4. On or before July 1 of each year, submit a report to the Director of the Legislative Counsel Bureau for transmittal to the Legislative Committee on Health Care. This report must contain;
 - Information regarding the development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted.

XIV. NO CRIMINAL 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 IN EVIDENCE IN ANY ADMINISTRATIVE OR LEGAL PROCEEDING CONDUCTED IN THE STATE OF NEVADA.



Willow Springs Center

A Residential Treatment Center for Children and Adolescents

Risk Management/Patient Safety Plan

2018

1. Overview

- A. Willow Springs has established a Risk Management/Patient Safety Plan that is supported by Senior Leadership to prevent, reduce, modify and eliminate conditions and practices that may create or cause loss. The safety and wellbeing of patients, personnel and the public is of the highest priority.

Mission and Vision

At Willow Springs, we are compassionate, committed and caring people, dedicated to inspire hope, as well as the ability to achieve and celebrate success through the power of relationships developed with children, families, and the communities we support. Willow Springs promotes clinical excellence, an environment of collaboration and trust while maintaining fiscal responsibility and integrity for patients, customers and the communities we serve.

2. Roles and Responsibilities

A. Risk Management/Patient Safety Officer

1. Behavioral Health Facilities designate Risk Managers to be responsible for risk identification and risk reduction.
2. The designated Risk Manager/Director is also the Patient Safety Officer
3. The Patient Safety Officer responsibilities based on [NRS 439.870](#) includes:
 1. Serve on the patient safety committee.
 2. Supervise the reporting of all sentinel events alleged to have occurred at the medical facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
 3. Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the medical facility.
 4. Report to the patient safety committee regarding any action taken in accordance with paragraph iii.

B. Infection Control Officer

1. The Infection Control Officers responsibilities based on [NRS 439.873](#) includes:
 1. Shall serve on the patient safety committee.
 2. Shall monitor the occurrences of infections at the medical facility to determine the number and severity of infections.
 3. Shall report to the patient safety committee concerning the number and severity of infections at the medical facility.

4. Shall take such action as he or she determines is necessary to prevent and control infections alleged to have occurred at the medical facility.
 5. Shall carry out the provisions of the infection control program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program.
2. Based on [NRS 439.865](#), the patient safety plan must also include an Infection Control Plan/Program that carries out the infection control policy. The policy must consist of:
 1. The patient safety checklists and patient safety policies most recently adopted pursuant to [NRS 439.877](#).
 2. An infection control program to prevent and control infections within the medical facility. To carry out the program, the medical facility shall adopt an infection control policy. The policy must consist of:
 1. The current guidelines appropriate for the facility's scope of service developed by a nationally recognized infection control organization as approved by the State Board of Health which may include, without limitation, the Association for Professionals in Infection Control and Epidemiology, Inc., the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the World Health Organization and the Society for Healthcare Epidemiology of America; and
 2. Facility-specific infection control developed under the supervision of a certified infection preventionist.
- C. Patient Safety Council (PSC)
1. The Patient Safety Council meets monthly and ensures
 2. According to [NRS 439.875](#), a medical facility shall establish a patient safety committee.
 1. A patient safety committee established pursuant to subsection 1 must be composed of:
 1. The infection control officer of the medical facility.
 2. The patient safety officer of the medical facility, if he or she is not designated as the infection control officer of the medical facility.
 3. At least three providers of health care who treat patients at the medical facility, including, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility.

4. One member of the executive or governing body of the medical facility.
2. A patient safety committee shall meet at least once each month.
 1. A patient safety committee shall meet at least once each month.
 2. The Administrator shall adopt regulations prescribing the composition and frequency of meetings of patient safety committees at medical facilities having fewer than 25 employees and contractors.
3. A patient safety committee shall:
 1. Receive reports from the patient safety officer pursuant to [NRS 439.870](#).
 2. Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred at the medical facility.
 3. Review and evaluate the quality of measures carried out by the medical facility to improve the safety of patients who receive treatment at the medical facility.
 4. Review and evaluate the quality of measures carried out by the medical facility to prevent and control infections at the medical facility.
 5. Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur at the medical facility.
 6. At least once each calendar quarter, report to the executive or governing body of the medical facility regarding:
 - a. The number of sentinel events that occurred at the medical facility during the preceding calendar quarter;
 - b. The number and severity of infections that occurred at the medical facility during the preceding calendar quarter; and
 - c. Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
 7. Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.
 8. The proceedings and records of a patient safety committee are subject to the same privilege and protection from

discovery as the proceedings and records described in [NRS 49.265](#).

4. Additional Patient Safety Committee Responsibilities, based on [NRS 439.877](#) includes Patient safety checklists and patient safety policies: Adoption by patient safety committee; required provisions; duties of patient safety committee.
 1. The patient safety committee established pursuant to [NRS 439.875](#) by a medical facility shall adopt patient safety checklists and patient safety policies for use by:
 - a. Providers of health care who provide treatment to patients at the medical facility;
 - b. Other personnel of the medical facility who provide treatment or assistance to patients;
 - c. Employees of the medical facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
 - d. Persons with whom the medical facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients at the facility.
 2. The patient safety checklists adopted pursuant to subsection 1 must follow protocols to improve the health outcomes of patients at the medical facility and must include, without limitation:
 - a. Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of health care.
 - b. Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of health care follow protocols to ensure that the room and environment of the patient is sanitary.
 - c. A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - i. Proper instructions concerning prescription medications;
 - ii. Instructions concerning aftercare; and
 - iii. Any other instructions concerning his or her care upon discharge.
 - d. Any other checklists which may be appropriate to ensure the safety of patients at the medical facility.

3. The patient safety policies adopted pursuant to subsection 1 must include, without limitation:
 - a. A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of health care. The personal identifiers may include, without limitation, the name and date of birth of the patient.
 - b. A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of health care at the medical facility including, without limitation, protocols relating to hand hygiene.
 - c. A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, without limitation, active surveillance. Active surveillance may include, without limitation, a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.
4. The patient safety committee shall:
 - a. Monitor and document the effectiveness of the patient identification policy adopted pursuant to paragraph (a) of subsection 3.
 - b. At least annually, review the patient safety checklists and patient safety policies adopted pursuant to this section and consider any additional patient safety checklists and patient safety policies that may be appropriate for adoption for use at the medical facility.
 - c. Revise a patient safety checklist and patient safety policy adopted pursuant to this section as necessary to ensure that the checklist or policy, as applicable, reflects the most current standards in patient safety protocols.
 - d. On or before July 1 of each year, submit a report to the Director of the Legislative Counsel Bureau for transmittal to the Legislative Committee on Health Care. The report must include information regarding the development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to paragraph (b).

D. Patient Safety Advisories/Alerts.

1. Advisories/Alerts are issued to facilities for the purpose of sharing pertinent information regarding a system or event that led to failure. Assessing these systems, can to lead to positive outcome so facilities can reduce the risk and avoid the same or similar outcome.
2. Each facility should review the advisory and assure that processes are safe and appropriate.

E. TERM Program.

1. WSC utilizes a risk management program identified as TERM, The Technical Elements Related to the Management of Patient Safety. The TERM document identifies expectations for our facility similar to a standard of care.
2. Elements of TERM include:
 1. Administration of the RM and Patient Safety Program.
 2. Risk Identification.
 3. Patient Safety Orientation and Education.
 4. Risk Prevention Techniques.
 5. Contract Services.
 6. Risk Profiling.
 7. Patient Safety Council.
 8. Environment of Care.
 9. Claims and Litigation.
 10. Measuring the Effectiveness of the Patient Safety Program.

F. MIDAS.

1. The entering of the facility's Healthcare Peer Review Reports (HPRs) for patients and non-patients into MIDAS+ as Risk Management Event Entries is the responsibility of the facility Risk Manager. They are entered on a regular basis and the Risk Manager utilizes the system to collect data through the various Risk Management Reports, which are written based on data from the event reports (HPRs) and MIDAS+.

G. ENTERPRISE.

1. Enterprise is an electronic platform used to enter and track probable claims reports. A PCR is the facility's method of communicating the event and related findings/facts to Corporate Insurance staff.

H. RCA – Root Cause Analysis.

1. The Root Cause Analysis and Action Plan tool has 24 analysis questions. The framework is intended to provide a template for answering the analysis questions and aid organizing the steps in a root cause analysis. All possibilities and questions should be fully considered in seeking "root cause(s)" and opportunities for risk reduction. Not all questions will apply in every case and there may be findings that emerge during the course of the analysis. For each finding we continue to ask "Why?" and drill down further to uncover why parts of the process occurred or didn't occur when they should have. Significant findings that are not identified as root causes themselves have "roots".
2. According to [NRS 439.837](#), states that a Mandatory investigation of sentinel event by medical facility:

1. A medical facility shall, upon reporting a sentinel event pursuant to [NRS 439.835](#), conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event.

I. Risk Management Goals and Objectives 2018:

1. Demonstrate compliance with the Centers for Disease Control and Prevention (CDC) and compliance with National Patient Safety Goal NPSG.07.01.10, demonstrating our compliance with hand hygiene guidelines.”
2. Educate new staff and facility adheres to the National Patient Safety Goals to improve patient safety.
3. Senior leadership conducts audit observation rounds which leads to maintaining patient safety and preventing harm to the patient.
4. Patient safety orientation and education for all new hires creates risk reducing practices.
5. Good Catch Program recognizes an event that could have been harmful to a patient, but was prevented. This creates and maintains an environment of non-punitive reporting

J. Approval of Patient Safety Plan.

1. According to [NRS 439.865](#), a medical facility shall submit its patient safety plan to the governing board of the medical facility for approval in accordance with the requirements of this section.
 1. After a medical facility’s patient safety plan is approved, the medical facility shall notify all providers of health care who provide treatment to patients at the medical facility of the existence of the plan and of the requirements of the plan. A medical facility shall require compliance with its patient safety plan.
 2. The patient safety plan must be reviewed and updated annually in accordance with the requirements for approval set forth in this section.

References:

<https://www.leg.state.nv.us/NRS/NRS-439.html>

<https://www.cdc.gov/handwashing/index.html>

<https://www.jointcommission.org/>

https://www.jointcommission.org/standards_information/npsgs.aspx

WILDCREEK SURGERY CENTER

QUALITY AND PATIENT SAFETY PLAN

DATE: 02/15/2017
VERSION: 01



This plan was created and revised by the Wildcreek Surgical Center Patient Safety committee/team. Implementation of this plan is intended to optimize the healthcare quality and patient safety outcomes, encourage recognition, reporting, and acknowledgment of risks to patient, visitor, and employee safety, as well as reduce the medical/healthcare errors and /or preventable events.

**Patient Safety Committee/Program
Wildcreek Surgical Center**

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Sparks, NV 89431
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Commitment to Patient Safety

Wildcreek Surgical Center is committed to a comprehensive approach to improving healthcare quality and patient safety by aligning with our Mission, Vision, and Values, creating an environment that supports a dynamic, proactive, and safe culture for patients, family members, visitors, and employees, through continuous learning and improving patient safety policies, systems, and processes.

Mission, Vision, and Values

In support of our mission, vision, and values, Wildcreek Surgical Center's Patient Safety and Quality Improvement program promotes:

- Collaboration of healthcare, leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high quality healthcare.
- Communicate honestly and openly to foster trusting and cooperative relationships among healthcare providers, staff members, and patients and their families, to ensure accountability for the patient safety priorities.
- Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.
- Responsibility for every healthcare related decision and action.
- A focus on continuous learning and improving, system design, and the management of choices and changes, bringing the best possible outcomes or performances to the facility.
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare.
- Education of staff and physicians to assure participation of healthcare providers.

Scope and Purpose

The scope of this Quality and Patient Safety Plan is organizational-wide/hospital-wide/agency-wide which includes but is not limited to

- Patient safety
- Visitor safety
- Employee safety

All staff in Wildcreek Surgical Center are required to fully support and participate in this plan, and devote their expertise to the patient safety and healthcare quality improvement process.

This plan is action oriented and solution focused. The purpose of this plan is to address patient safety related concerns, challenges and revise the program to better serve the patients and their families. To this end, Wildcreek Surgical Center has developed this Patient Safety plan.

The plan focuses on the process rather than the individual, and recognizes both internal and

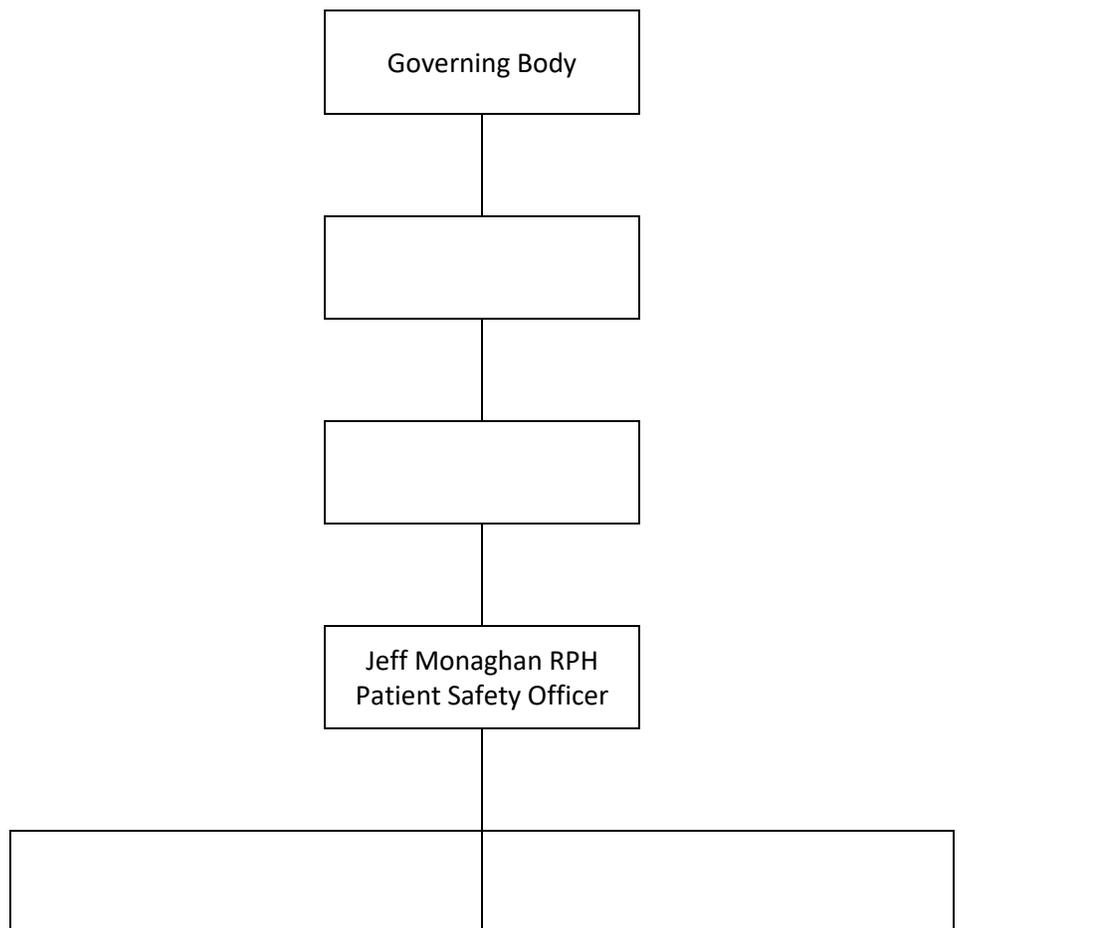
external customers, as well as facilitates the need of analyzing and improving processes. The core principles of this plan include:

- All staff have the same goal and contribute their knowledge, vision, skill, and insight to improve the process of the Patient Safety Plan.
- Decisions will be based on data and facts, and staff will be encouraged to learn from the experiences.
- Customer based including patients, families, and visitors.
- Promote systems thinking.
- Employ well-trained and competent staff maintaining high healthcare quality.

Roles and Responsibilities

According to [NRS 439.875](#), a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plan is promoted and executed successfully.

The Patient Safety Committee Organization



Paul Hiss MD

Douglas Devries OD

Kathryn Brewer RN

Roles and Responsibilities

- In accordance with [NRS 439.875](#), a patient safety committee must be comprised of:
- The infection control officer of the medical facility;
- The patient safety officer of the medical facility, if he or she is not designated as the infection control officer;
- At least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility; and
- One member of the executive or governing body of the medical facility.

Based on [NAC 439.920](#), a medical facility that has fewer than 25 employees and contractors must establish a patient safety committee comprised of:

- The patient safety officer of the medical facility;
- At least two providers of healthcare who treat patients at the medical facility, including but without limitation, one member of the medical staff and one member of the nursing staff of the medical facility; and
- The Chief Executive Officer (CEO) or Chief Financial Officer (CFO) of the medical facility.

The roles and responsibilities are defined below (Please modify them as needed.)

Patient Safety Committee Responsibilities (based on [NRS 439.875](#) and [NRS 439.877](#))

- Monitor and document the effectiveness of the patient identification policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the patient safety officer pursuant to [NRS 439.870](#).
- Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred.
- Review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- Review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the executive or governing body of the facility regarding:
 - (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);
 - (2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and
 - (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.

- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

Root Cause Analysis (RCA) Team Responsibilities (please revise as needed)

- Root Cause interviews, analysis, investigation, and corrective action plan implementations.
- Participates in the RCA meetings and discussions.
- Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders.

Patient Safety Officer Responsibilities (based on [NRS 439.870](#))

- Serve on the patient safety committee.
- Supervise the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the patient safety committee regarding any action taken in accordance with the responsibilities above.

(Additional responsibilities here if needed)

Infection Control Officer Responsibilities (based on [NRS 439.873](#))

- Serve on the patient safety committee.
- Monitor the occurrences of infections at the facility to determine the number and severity of infections.
- Report to the patient safety committee concerning the number and severity of infections at the facility.
- Take such action as determines is necessary to prevent and control infections alleged to have occurred at the facility.
- Carry out the provisions of the infection control program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program.

(Additional responsibilities here if needed)

RCA team leader Responsibilities (please revise as needed)

- Organize and coordinate the RCA process.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA, and corrective action plan implementation process.
- Communicate the progress of the investigation, institutional barriers, and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.

- Provide training, education and direction to create RCA process that incorporate the Patient Safety and Quality Improvement elements.

RCA Facilitator Responsibilities

(Please provide the responsibilities here)

Executive or Governing Body Staff Responsibilities (please revise as needed)

- Provide vision and leadership to Patient Safety and Quality Improvement process, and develop and foster a safe learning and improving culture.
- Provides oversight to the healthcare quality improvement processes and teams.
- Plan, discuss, and generate the organization patient safety goals and activities, in conjunction with the patient safety action plans

(Please provide additional responsibilities here if needed)

The Patient Safety Committee will meet monthly (or quarterly) to accomplish the following:

- Report and discuss sentinel events which include:
 - Number of sentinel events from previous calendar month (or quarter).
 - Number of severe infections that occurred in the facility.
- Corrective Action Plan for the sentinel events and infections
 - Evaluate the corrective action plan.
- Patient safety policies and checklists
 - At least annually evaluate Patient Safety policies and checklists
 - Revise the patient safety policies and checklists as needed.
 - Monitor and document the effectiveness of the patient safety policy.

A RCA meeting will meet as needed to accomplish the following:

- Define the healthcare issues or potential risks.
- Conduct Root Cause Analysis
 - Reviewing and analyzing the data.
 - Reviewing the RCA process and quality improvement related activities and timelines.
 - Brainstorming issues or the potential risks by using the fishbone diagrams.
 - Identify the contributing factors and conduct the Root Cause Analysis.
- Conduct Corrective Action Plan
 - Identifying the Plan-Do-Study-Act (PDSA) topics.
 - Discussing corrective action process and activities.
 - Discussing and presenting possible changes in procedure to improve areas indicated.
 - Identifying strengths and areas that need improvement.
 - Developing strategies, solutions, and steps to take next.
- Identify barriers and technical assistance needs for supporting the RCA efforts.

A meeting agenda and minutes noting follow-up tasks will be kept.

Objectives and Goals of the Quality and Patient Safety Plan

Objective	Goals	Plan	Planned Completion Date	Responsible Party

Components and Methods

Pursuant to [NRS 439.837](#), a medical facility shall, upon reporting a sentinel event pursuant to [NRS 439.835](#), conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event.”

Wildcreek Surgical Center will use RCA process to determine the contributing factors and the underlying reasons for the deficiencies or failures. The Plan-Do-Study (check)-Act (PDSA or PDCA) is the model, which was developed by the Institute of Health Care Improvement, that we will use to test the changes.



Root Cause Analysis

A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals.

Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

Root cause analysis and action plan framework table, which was introduced by the Joint Commission. It contains 24 analysis questions. It guides the organization to the steps in a root cause analysis. Not all the questions apply to all the events or cases. This table can be used individually or with the fishbone diagram.

5 Whys technique will be used in Wildcreek Surgical Center to explore the cause and effect relationship underlay a problem. One can find the root causes by asking “why” no less than five times. This technique can be used individually or as a part of the fishbone diagram.

Fishbone Diagram

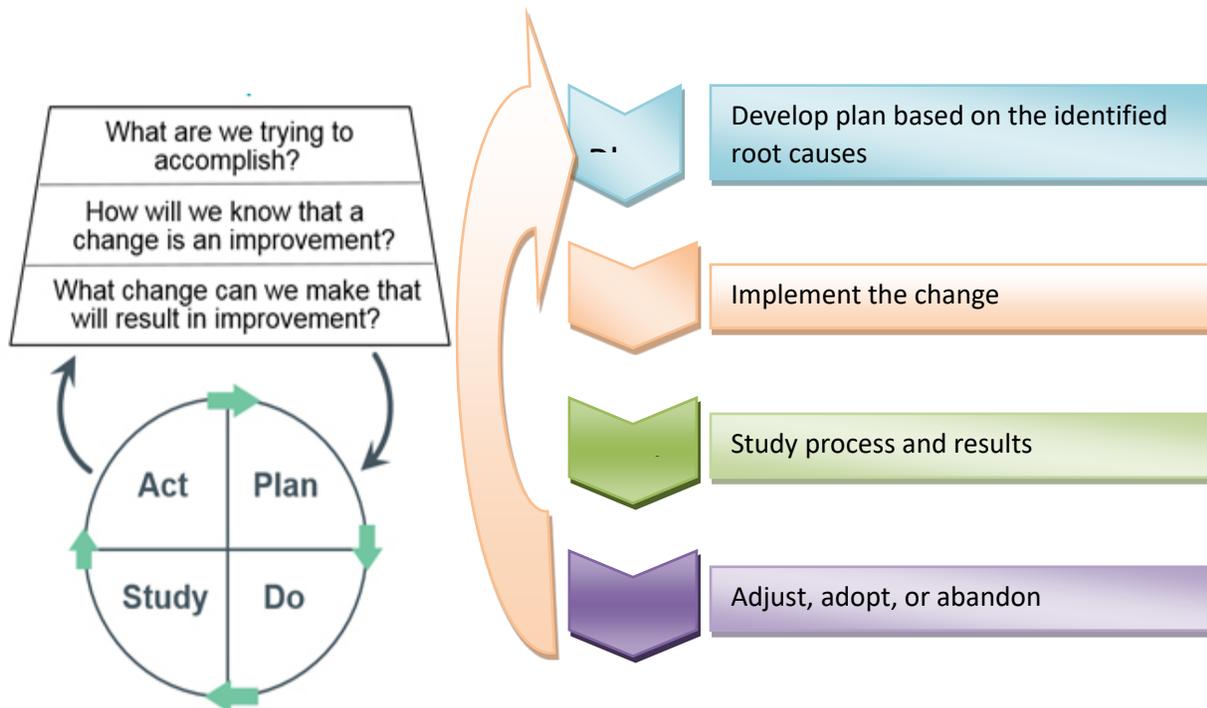
Patient Safety and Quality Improvement Plan

Once the problems are identified, a Fishbone Diagram (Appendix C) will be used for analyzing the problems. You can use the fishbone diagram individually to analyze the root causes, or use it with the root cause analysis and action plan framework table.

A Fishbone Diagram, also called a Cause-and-Effect diagram, is a useful tool for a team to structurally brainstorm by discovering possible underlying factors or root causes from different major categories for the chosen problems. General categories used include: people, methods, materials, measurements, education, procedures, process, location, environment, etc. RCA team members will brainstorm and ask multiple times, “why did this happen?” for each cause until all ideas are exhausted. The highest priority root causes will be chosen for PDSA topics. Once all the categories are established on the fishbone diagram, 5 Why’s technique also can be used to drill down the problem and find the root causes.

Model for Improvement

The Model for Improvement is a collaborative and ongoing effort model to improve the product and services quality and process. It provides multi-disciplinary quality team guidance from identifying the root causes; conducting the best tests to assess possible changes, and working in collaboration for implementation of the new approaches and solutions. It guides the test of a change to determine if the change is an improvement.



The cycle is defined as follows:

- Plan--collect data and establish appropriate goals. Identify the problem and the possible root causes, and answer the following questions.
 - What is the objective of the test?

- What are the steps for the test - who, what, when?
 - How will you measure the impact of the test?
 - What is your plan to collect the data needed?
 - What do you predict will happen?
- Do--make changes designed to correct or improve the situation. Use the following questions for the guidance.
 - What were the results of the test?
 - Was the cycle carried out as designed or planned?
 - What did you observe that was unplanned or expected?
 - Study -- Study the effect of the changes on the situation. Data should be collected on the new process and compared to the baseline or expected results. Results should be evaluated and by using the following questions as guidance.
 - Did the results match your prediction?
 - What did you learn?
 - What do you need to do next?
 - Act--If the result is successful or desirable, standardize the changes and then work on the next prioritized problem or the further improvements. If the outcome is not yet successful, look for different ways to identify the causes or change the testing process.

PDSA worksheet will be used to map the potential change strategies and to establish a course of action. The PDSA worksheet and the PDSA progress report are attached in Appendix D-1.

Data Collection and Reporting

Data should drive any quality and patient safety effort. Wildcreek Surgical Center is using, [NHSN: National Healthcare Safety Network](#), for tracking the sentinel events, healthcare infection data, and internal data collection.

External data sources are those data sources which are collected outside the supervisory structure of the case. External data which will be utilized for Quality and Patient Safety plan include the data from:

- AHRQ: Agency for Healthcare Research & Quality
- CDC: Centers for Disease Control and Prevention
- CMS: Centers for Medicare & Medicaid Services
- NQF: National Quality Forum
- NHSN: National Healthcare Safety Network
- TJC: The Joint Commission



Ongoing Reporting and Review

Data points such as the following will be reviewed according to the schedule prescribed:

Monthly	Quarterly	Annually
1) Sentinel event monthly report 2) Severity of infection report 3) RCA assessment	1) Sentinel event quarterly report 2) Severity of infection report 3) Review and evaluate the measure of improvement of patient safety 4) Review and evaluate the measurement to prevent and control infections	1) Quality and Patient Safety Plan update 2) Checklists and Policies reviewing and revising

Assessment of the Quality and Patient Safety Plan

Please see the Patient Safety Assessment Tool (PSAT) from the VA National Center for Patient Safety for your reference.

Patient Safety Checklists and Patient Safety Policies

By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

The patient safety checklists must follow protocols to improve the health outcomes of patients at the medical facility and must include, without limitation:

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.
- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - Proper instructions concerning prescription medications;
 - Instructions concerning aftercare;
 - Any other instructions concerning his or her care upon discharge; and
 - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include, the name and date of birth of the patient.

- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.
- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

Based on [NRS 439.865](#), the patient safety plan must also include an infection control program that carries out the infection control policy. The policy must consist of:

- The current guidelines appropriate for the facility's scope of service developed by a nationally recognized infection control organization as approved by the State Board of Health which may include, the Association for Professionals in Infection Control and Epidemiology (APIC), the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO) and the Society for Healthcare Epidemiology of America (SHEA); and
- Facility-specific infection control developed under the supervision of a certified Infection Preventionist.

The patient safety checklists are listed in Appendix E. (The following links provide some patient safety checklists for your reference— a checklist example is shown in **Appendix E.**)

http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf

<http://www.who.int/patientsafety/implementation/checklists/en/>

The patient safety policies are listed in Appendix F. (The following link provides you some patient safety policies for your reference—a policy example is shown in **Appendix F.**)

<https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>

Approval of Patient Safety Plan

According to [NRS 439.865](#), a medical facility shall submit its patient safety plan to the governing board of the facility for approval. After a facility's patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan.

The patient safety plan must be reviewed and **updated annually** in accordance with the requirements for approval set forth in this section.

According to [NRS 439.843](#), on or before March 1 of each year, a copy of the most current patient safety plan established to [NRS 439.865](#) must be submitted to the Division of Public and Behavioral Health.

Reference

- Root Cause Analysis Toolkit <http://www.health.state.mn.us/patientsafety/toolkit/>
- Quality and Service Improvement Tools http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html
- CQI 101 An Introduction to Continuous Quality Improvement: <https://www.coursehero.com/file/13827355/CQI-Overviewppt/>
- Quality Improvement <http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/>
- Root Cause Analysis <http://www.patientsafety.va.gov/professionals/onthejob/rca.asp>
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2 https://www.jointcommission.org/sentinel_event.aspx
- Hospital Policies <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>
- Checklists to Improve Patient Safety http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf
- Patient Safety Checklists <http://www.who.int/patientsafety/implementation/checklists/en/>
- Minutes of the Meeting of the Quality and Patient Safety Committee <http://www.cookcountyhhs.org/wp-content/uploads/2013/12/09-23-14-QPS-scan-Minutes.pdf>
- Title 40 – Public Health and Safety <https://www.leg.state.nv.us/NRS/NRS-439.html>

Appendix A: Terms and Definitions

Patient Safety: The Agency for Healthcare Research Quality (AHRQ) defines patient safety as “a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.”
http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

Sentinel event ([NRS 439.830](#))

1. Except as otherwise provided in subsection 2, “sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum.
2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:
 - (a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or
 - (b) July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published.
3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.
(Added to NRS by [2002 Special Session, 13](#); A [2005, 599](#); [2013, 217](#))

Institute for Healthcare Improvement (IHI) defines **medical harm** as “unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death.”

Facility-Associated Infection: ([NRS 439.802](#))

“Facility-acquired infection” means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections;
- Ventilator-associated pneumonia;
- Central line-related bloodstream infections;
- Urinary tract infections; and
- Other categories of infections as may be established by the State Board of Health by regulation pursuant to [NRS 439.890](#).

(Added to NRS by [2005, 599](#); A [2009, 553](#))

Medical facility ([NRS 439.805](#))

“Medical facility” means:

- A hospital, as that term is defined in [NRS 449.012](#) and [449.0151](#);
- An obstetric center, as that term is defined in [NRS 449.0151](#) and [449.0155](#);
- A surgical center for ambulatory patients, as that term is defined in [NRS 449.0151](#) and [449.019](#); and
- An independent center for emergency medical care, as that term is defined in [NRS 449.013](#) and [449.0151](#).

(Added to NRS by [2002 Special Session, 13](#))

Near miss: An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Mandatory reporting: Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985;254(6):796-800.)

Risk: Possibility of loss or injury. (Merriam-Webster’s Online Dictionary, Risk, Available at <http://www.merriamwebster.com/dictionary/risk>. Last Accessed August 2009.)

Preventable event: Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Catheter Associated Urinary Tract Infection (CAUTI): A urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CUR_RENT_b.pdf.)

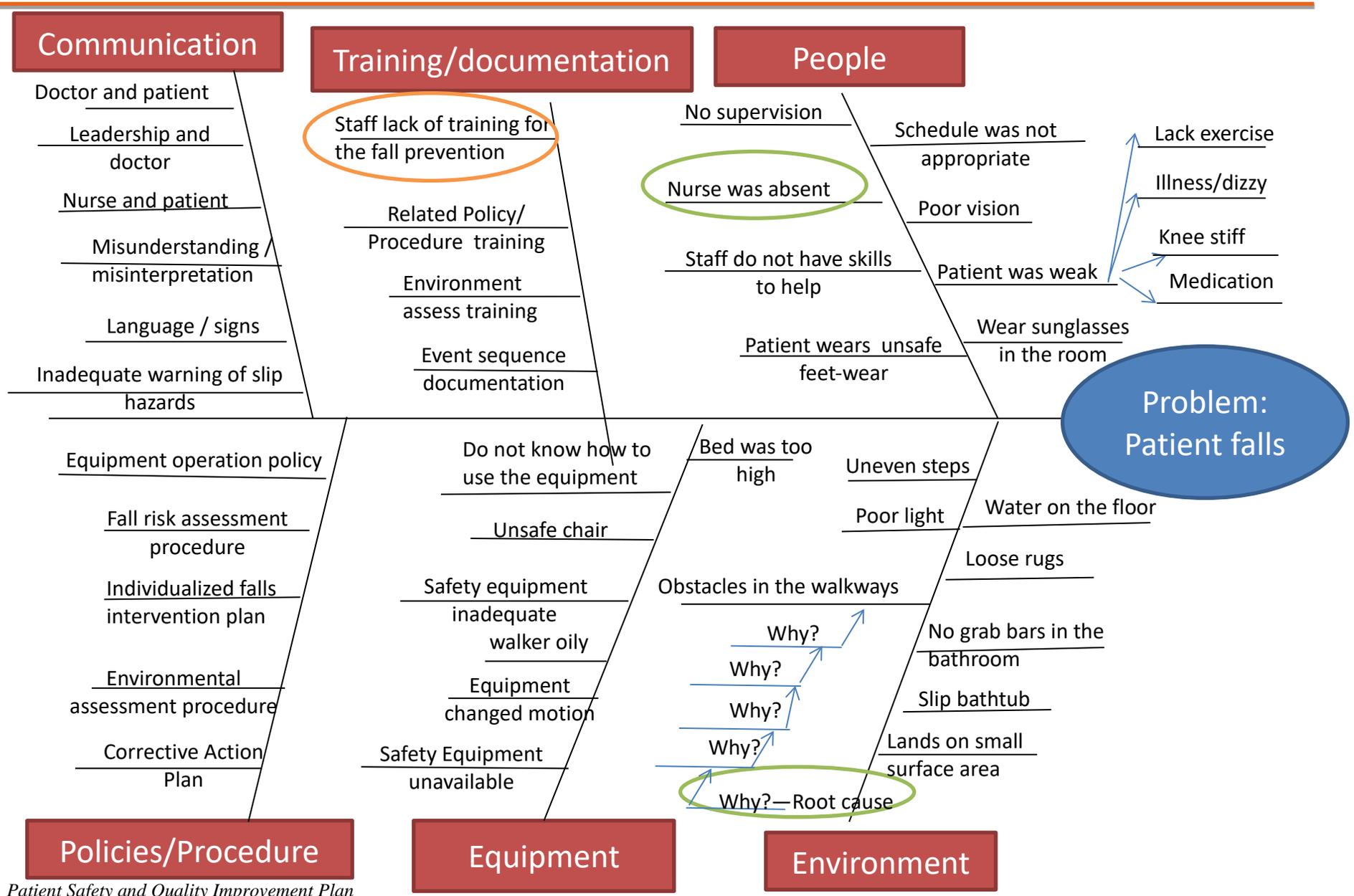
Central Line Associated Bloodstream Infections (CLABSI): Primary bloodstream infections that are associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection.

Appendix B: Patient Safety Goals

OBJECTIVE:	GOAL:	Q3 2014	Q4 2014	Q1 2015
ACTION PLAN:				
1. Create Systems that anticipate errors & either prevent or catch them before they cause harm.	a. Enhance retrospective chart review process.			Implement Trigger Tools. Develop automated surveillance reports in Cerner.
	b. Establish an automated surveillance process.		Complete an in-depth analysis of risk point utilizing the methods of FMEA.	
2. Establish Structures for reporting and a process for managing reports in the event reporting system.	a. Implement new electronic Voluntary Reporting System & participate in Patient Safety Organization.	Implemented e-MERS & PSO with UHC.	Create process for reviewing & closing reports in e-MERS.	
	b. Develop a structure to educate employees system-wide of the process for reporting hazards, errors and adverse events.		Increase number of events reported by 10%.	
	c. Establish a process for providing feedback regarding reported events.		Create process for communicating outcome of reported events.	
3. Develop a Culture of Safety where providers feel safe and supported when they report medical errors or near misses & voice concerns about patient safety.	a. Provide education on patient safety plan that emphasizes importance of blending a systems focus with appropriate individual accountability.		Educate Medical staff, Hospital Wide Oversight & the Quality Committees on the objectives and goals of the patient safety plan.	
	b. Establish a recognition program that rewards safe practices.		Include patient safety presentation in monthly New Employee Orientation.	
	c. Improve overall perceptions of safety as measured by the Culture of Safety Survey.		Develop 'Great Catch' awards program.	
				Re-evaluate culture of safety and develop action plan.
4. Establish Safety Priorities & Targets.	a. Develop Patient Safety Dashboard that includes national measures and benchmarks.		Present Patient Safety Dashboard monthly to Hospital Wide Oversight Committee.	
	b. Facilitate the development of action plans associated with measures not meeting benchmarks.	Complete 2014 Leapfrog Safety Survey.	Establish & implement a plan to improve performance of each leap.	
	c. Assess and improve processes related to hand-off, transition and communication		Develop method to track & report departmental progress and compliance of RCA action plans.	
5. Charter Safety Programs through teams, workgroups or projects.	a. Coordinate Improvement Efforts in order to ensure that capital, people, facilities & technologies are matched to strategic priorities for safe practices.		Establish Patient Safety Council.	
	b. Reduce and eliminate variation in care.		Establish workgroups focused on medication safety, reducing patient falls & hospital acquired pressure ulcers.	
			Revise or develop policies, procedures and protocols.	

Reference: Patient Safety Plan and Its Applicable Goals. 2014. Cook County Health and Hospitals System.

Appendix C: Fishbone Diagram



Appendix D-1: PDSA Worksheet

PDSA Worksheet

Topic:			
Person Completing Worksheet:		Date:	
Telephone/ Email:		Cycle:	
Patient Safety Committee Members			
CEOs/CFOs			
Patient Safety Officer			
Infection Control Officer			
Other Medical Staff			
Other team members			
Aim: (Describe the overall SMART goal that your team wishes to achieve.)			
Plan:			
1. List the tasks needed to set up this test of change.			
2. Predict what will happen when the test is carried out.			

3. List the steps to develop the test-who, what, and when.			
Steps	By Whom	By When	Desired Outcome
Do: (Describe what actually happened when you ran your test, including any problems and unexpected findings.)			
Study: (Describe what you learned and did you meet your measurement goal?)			
Did you meet your measurement goal? Explain.		Summarize what was learned: success, failure, unintended consequences, etc.	
Act: (Describe what you concluded from this cycle.)			
Based on what was learned, please indicate what action will be considered.		Describe what modifications to the plan will be made for the next cycle based on what you learned.	
<input type="checkbox"/> Adapt: modify changes and repeat PDSA Cycle			
<input type="checkbox"/> Adopt: expanding changes throughout organization			
<input type="checkbox"/> Abandon: change approach and repeat PDSA cycle			

Appendix D-2: PDSA Monthly / Quarterly Progress Report

Event:			
Person Complete Report:		Date:	
Patient Safety Officer		Contact Information:	
Monthly / Quarterly Report			
Items	Description		
1. What is your goal?			
2. Report on the PDSA cycle			
3. What system and practices are working well? Explain.			
4. What areas for improvement did the data identify?			
5. What barriers or system issues have been encountered implementing action activities?			
6. Action plans to address the barriers or system issues			
7. Lesson learned			
8. Support needed			
9. Additional discussion			
Notes:			

Appendix E: Checklist Example: Injuries from Falls and Immobility

Process Change	In Place	Not Done	Will Adopt	Notes (Responsible & By When?)
Conduct fall and injury risk assessment upon admission				
Reassess risk daily and with changes in patient condition				
Implement patient-specific intervention to prevent falls and injury				
Communicate risk across the team; use handoff forms, visual cues, huddles				
Round every 1 to 2 hours for high-risk patients; address needs (e.g., 3Ps: pain, potty, position-pressure). Combine with other tasks (vital signs)				
Individualize interventions. Use non-skid floor mats, hip protectors, individualized toileting schedule; adjust frequency of rounds				
Review medications (by pharmacist); avoid unnecessary hypnotics, sedatives				
Incorporate multidisciplinary input for falls				
Prevention from PT, OT, MD, RN and PharmD				
Include patients, families and caregivers in efforts to prevent falls. Educate regarding fall prevention measures; stay with patient				
Hold post-fall huddles immediately after event; analyze how and why; implement change to prevent other falls				

Reference: Checklists to Improve Patient Safety. June 2013. Health Research & Educational Trust.

Appendix F: Policy Example

[Reference: Hospital Policies. MERCY Hospital. <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>]

	HOSPITAL POLICY AND INFORMATION MANUAL	
<p>PERSONAL PROTECTIVE EQUIPMENT POLICY Page 1 of 2</p>	<p>Date Issued: Date Last Revised: Next Review Date: Approved By:</p>	<p>07/01 08/14 08/17 Policy Committee</p>

Key Words: personal protective equipment, PPE, safety equipment,

Policy Applies to:

- All staff employed by Mercy Hospital;
- Credentialed Specialists, Allied Health Professionals, patients, visitors and contractors will be supported in meeting policy requirements.

Related Standards:

- Infection and Prevention and Control Standards NZS 8134.3:2008
- Health and Safety in Employment Act 1992
- EQulP5 - 1.5.1 and 1.5.2 Infection Control
- EQulP5 - Standard 3.2 Criterion 3.2.1 Health and Safety

Rationale:

Mercy Hospital will provide suitable personal protective equipment (PPE) when the risk to health and safety cannot be eliminated or adequately controlled by other means.

Definitions:

Personal protective equipment (PPE) means all equipment which is intended to be worn or held by a person to protect them from risk to health and safety while at work.

Examples of PPE include: protective footwear, gloves, hard hats/helmets, clothing affording protection from the weather, visibility clothing, eye and face protection.

Objectives:

- To ensure appropriate PPE is identified to minimize hazards not able to be controlled by elimination or isolation;
- To ensure fit for purpose PPE is provided at Mercy Hospital for use by staff;
- To ensure adequate training in the use of PPE is provided;
- To monitor the use of PPE and evaluate effectiveness.

	HOSPITAL POLICY AND INFORMATION MANUAL	
<p>PERSONAL PROTECTIVE EQUIPMENT POLICY Page 2 of 2</p>	Date Issued: Date Last Revised: Next Review Date: Approved By:	07/01 08/14 08/17 Policy Committee

Implementation:

Risk Management

Department Managers, the Occupational Health/ Infection Prevention and Control Nurse (OH/IPC Nurse) and Health and Safety/ Infection Control Representatives (HSIC reps) will in consultation with staff:

Ensure PPE requirements are identified when carrying out risk assessments of activities;

- Regularly review the risk assessment of activities if substances or work processes change;
- Identify the most suitable type of PPE that is required;
- Ensure PPE is available to those who need it;
- Inform staff of the risks involved in their work and why PPE is required;
- Monitor compliance.

Process

Manager’s Responsibilities

Must ensure that:

- PPE requirements are considered when risks are assessed;
- Suitable PPE is provided and made accessible to employees;
- PPE is properly stored, maintained, cleaned repaired and replaced when necessary;
- Adequate information and training is provided to those who require PPE;
- PPE is properly used;
- Use of PPE is monitored and reviewed.

Employee’s Responsibilities All employees must ensure that:

- They use PPE whenever it is required;
- Attend and comply with training, instruction and information;
- Check the condition of their PPE;
- Store, clean and maintain their PPE;
- Report losses, defects or other problems with PPE to their manager.

Evaluation:

- Staff health and safety orientation
- Environmental audits
- Incident reports

Patient Safety Plan

2018

Barton Health

██████████, MSN, RN, PHN, CPPS
Director Patient Safety & Clinical Education

Executive Summary

The purpose of the Patient Safety Plan is to set the foundation for patient safety at Barton Health in accordance with state and regulatory requirements. The breadth of Patient Safety is vast and includes event reporting, review, follow up on errors and harm that impact or have the potential to impact patients, hazard mitigation through evidence-based tools, and reporting to internal committees and external agencies. The Patient Safety Plan addresses the processes to correct opportunities for improvement and prevent identified hazards from recurrence. 2017 high priorities are reviewed which included: tubing connections, reducing falls, enhancement of teamwork through TeamSTEPPS, clinical alarms, and sepsis. 2018 high priorities include reducing falls across the organization, tubing connections, teamwork enhancement through TeamSTEPPS in the outpatient clinics, assessing communication in relation to patient hand-offs/hand overs, and clinical alarms. The Patient Safety Plan grants authority for Patient Safety oversight across the organization to the Chief Medical Officer and the Director of Patient Safety and Clinical Education. This plan is revised and updated annually or more often as needed.

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Section A

2018 Patient Safety Plan

Purpose

Barton Health is committed to continuously improving patient safety and reducing health care errors. This Patient Safety Plan ensures that Barton Health implements and maintains a patient safety program in accordance with The Joint Commission standards, guidelines from the California Department of Public Health (CDPH), Nevada Revised Statutes (NRS), Patient Safety and Quality Improvement Act of 2005, and other regulatory agencies.

Introduction

The Patient Safety Plan supports and promotes the mission, vision, values, and strategic plan of Barton Health. This Plan implements continuous integration and coordination of patient safety activities for all medical staff, clinical departments, support service departments and service lines including trauma at Barton Health. A culture of safety inherently implies the continued attention, refinement and progression of the patient safety plan and program.

Barton Health's patient safety goal is to foster an environment and culture where patients, families, staff and leaders within the organization identify and manage actual and potential risks to patient safety thereby resulting in zero harm. All patients and staff are strongly encouraged and supported with multiple avenues/programs to speak up when safety concerns are identified. As an organization, Barton Health has the obligation to listen and respond to these concerns.

The Patient Safety Plan is designed to reduce patient safety errors and improve patient care delivery processes by utilizing a systematic, coordinated and continuous approach to the improvement of patient safety. This approach centers on the establishment of mechanisms that support effective responses to actual occurrences; ongoing proactive reductions in health related errors including near miss and good catch events; and integration of patient safety priorities in the design and redesign of all relevant organizational processes, functions, and services. Patient safety is emphasized in areas such as patient's rights, patient and family education, continuity of care, risk reduction, and managing performance improvement.

Each employee performs a critical role in patient safety and thus, Barton Health's journey to becoming a high reliability organization. All Barton Health team members are focused on providing consistently exceptional care through an environment that supports teamwork, collaboration and respect for other people, regardless of their position in the organization. Leaders demonstrate their commitment to quality and safety while setting expectations for those who work in the organization. Leadership evaluates the culture of safety on a regular basis.

The Chief Medical Officer and Director of Patient Safety & Clinical Education, provide oversight to the integrated patient safety program. These individuals ensure alignment of patient safety activities, compliance with regulations, and provide opportunities for all Barton Health team members to be educated and involved in patient safety initiatives.

The Director of Patient Safety & Clinical Education and Patient Safety Department have the authority to intervene in any clinical or non-clinical activity which poses an actual or potential negative outcome to a patient's well-being. The Patient Safety Department provides leadership in the creation, initiation and evaluation of corrective action measures for event resolution.

The Governing Body, Board Quality Committee, and Patient Safety Committee, described below, are committed to patient safety. These bodies shall assure an environment that encourages error identification, remediation, non-punitive reporting, and prevention through education, system redesign, or process improvement for any potential or actual adverse event.

In accordance with The Joint Commission's Accreditation Participation Requirements, APR.09.02.01, this plan implies Barton Health shall:

- Educate its staff, medical staff, and other individuals who provide care, treatment, and services that concerns about the safety or quality of care provided in the organization may be reported to The Joint Commission.
- Inform its staff and medical staff that Barton Health will take no disciplinary or punitive action because an employee, physician, or other individual who provides care, treatment, and services reports safety or quality of care concerns to The Joint Commission.
- Take no disciplinary or punitive action against employees, physicians, or other individuals who provide care, treatment, and services when they report safety or quality of care concerns to The Joint Commission.

Any employee or medical staff member may contact The Joint Commission if they have a safety or quality of care concern that is not being addressed by Barton Health. All employees or medical staff members are strongly encouraged to bring any safety or quality of care concerns to the Chief Medical Officer, Director of Patient Safety & Clinical Education, Patient Safety Officer, or Director of Quality without fear of punitive or disciplinary action.

In addition, patients are provided information in the patient handbook regarding their right to contact and report a complaint to The Joint Commission.

Scope of the Patient Safety Plan

The Joint Commission, CDPH, NRS, Centers for Medicare and Medicaid Services (CMS) and other regulatory agencies provide the defining framework for patient safety events. The Patient Safety Department is informed of safety event information and hazardous conditions from team members, volunteers, and medical staff practitioners across the organization through completion of event reports and verbal or written communication. This information includes actual or potential (near miss/good catch) occurrences involving inpatients, outpatients, volunteers, employees, physicians, allied healthcare providers, vendors, and visitors.

Risk Assessment

Proactive assessment of high risk activities and hazardous conditions are identified through event reporting, failure mode and effect analysis (FMEA), data collection, audits (tracers), and utilization. In addition, risk reduction strategies are built into the continual process improvement system. Such strategies are obtained from available information regarding sentinel events known to occur in healthcare organizations that provide similar care and services as well as knowledge based information including content from state patient safety organizations as well as other state, national, and international professional organizations.

Event Prioritization

Opportunities for improving patient safety issues are prioritized according to level of severity, frequency of the occurrence, potential for harm to the patient, employee or visitor involvement, and potential for liability. Ongoing review of information is performed to direct administrative and medical staffs' attention to areas of clinical care representing significant sources of actual or potential risk.

Types of medical / health care errors include, but are not limited to:

- **Adverse Event:** Per The Joint Commission, an adverse event is a patient safety event that resulted in harm to a patient. It is also defined as an unexpected occurrence meeting any of the Adverse Event criteria as designated by CDPH.
- **Error:** An unintended omission or commission of an act, or an act that does not achieve its intended outcome.
- **Good Catch/Close Call/Near Miss:** Any patient safety event that did not reach the patient.
- **No-Harm Event-** A patient safety event that reached the patient but did not cause harm.
- **Hazardous Condition:** Any set of circumstances, exclusive of the disease or condition for which the patient is being treated, which increases the probability of an adverse event.
- **Sentinel Event:** A patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in death, permanent harm, or severe temporary harm (Refer to *Sentinel Event* section below) and is reported to The Joint Commission. For Lake Tahoe Surgery Center, located in Nevada, a sentinel event is defined in NRS 439.830 by the National Quality Forum. (Refer to Appendix A)
- **Healthcare Associated Infection (HAI):** A localized or systemic condition resulting from an adverse reaction to the presence of an infectious agent(s) or its toxin(s) as defined by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN) in addition to monthly submission of all surgical site infections associated with different procedures performed at Barton Health. Potential HAIs are reviewed by the HAI Review Committee. Confirmed HAIs are reported to the Patient Safety Committee. HAIs are also reported to Interdisciplinary Collaborative Care Team and Board Quality Committees.

Any patient safety event, incident, or condition that could have resulted or did result in harm to a patient shall be subject for review and further analysis.

Event Reporting

Identification and reporting of adverse events, including those that result from practitioner error are critical to Barton Health's efforts to continuously improve patient safety and reduce harm. To support and encourage this culture of safety, reporting of patient safety events or near misses is highly encouraged. Reporting of events is the responsibility of all employees, volunteers, practitioners, patients, visitors and guests. Events can be reported through many modalities including electronic, verbal, and written communication. Electronic event reporting is available on all Barton Health System computer terminals. An event is reported via the electronic event reporting system by the individual(s) involved with and most knowledgeable about the event. (Refer to Barton Health Organizational Event Reporting Policy.)

Events are reviewed on a daily basis. High severity events are reviewed promptly to ensure immediate action is

taken as warranted.

Regulatory Agency Reporting

Barton Health informs accrediting and licensing bodies when errors and events fall within that agency's reporting requirements. Team members involved in sentinel or adverse events have access to support and are included whenever possible in the root cause analysis process to ensure the potential for recurrence is minimized.

Intensive assessment may be initiated when undesirable patterns or trends are identified or serious, adverse, or sentinel events occur. This includes those events identified as unusual occurrences within the California Code of Regulations section 76551. Sentinel Events reportable to The Joint Commission and Adverse Events reportable to CDPH are delineated below. (Refer to Appendix A for Nevada Sentinel Event reporting.)

Sentinel Event

Patient safety events are determined to fall into the category of a Sentinel Event as defined by The Joint Commission when any of the following occur:

A sentinel event is a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in any of the following:

- Death
- Permanent harm
- Severe temporary harm*

Or

The event is one of the following (even if the outcome was not death, or major permanent loss of function unrelated to the natural course of the patient's illness or underlying condition):

- Suicide of any patient receiving care, treatment and services in a staffed around the clock care setting or within 72 hours of discharge including from the hospital's emergency department (ED)
- Unanticipated death of a full-term infant
- Discharge of an infant to the wrong family
- Abduction of any patient receiving care, treatment, and services
- Any elopement (that is, unauthorized departure) of a patient from a staffed around-the-clock care setting (including ED), leading to death, permanent harm, or severe temporary harm to the patient
- Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities (ABO, Rh, other blood groups)
- Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of any patient receiving care, treatment, and services while on site at the organization
- Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of a staff member, licensed independent practitioner, visitor or vendor while on site at the organization
- Invasive procedure, including surgery, on the wrong patient, at the wrong site, or that is the wrong (unintended) procedure

- Unintended retention of a foreign object in a patient after an invasive procedure, including surgery after the completion of final skin closure
- Severe neonatal hyperbilirubinemia (bilirubin greater than 30 milligrams/deciliter)
- Prolonged fluoroscopy with cumulative dose greater than 1500 rads to a single field or any delivery of radiotherapy to the wrong body region or greater than 25% above the planned radiotherapy dose
- Fire, flame, or unanticipated smoke, heat, or flashes occurring during an episode of patient care
- Any intrapartum (related to the birth process) maternal death
- Severe maternal morbidity (not primarily related to the natural course of the patient's illness or underlying condition) when it reaches a patient and results in permanent harm or severe temporary harm from the intrapartum through postpartum period (24 hours) requiring the transfusion of 4 or more units of packed red blood cells and/or admission to the ICU

*Severe temporary harm is critical, potentially life threatening harm lasting for a limited time with no permanent residual, but requires transfer to a higher level of care/monitoring for a prolonged period of time, transfer to a higher level of care for a life-threatening condition, or additional major surgery, procedure, or treatment to resolve the condition.

It is Barton Health's policy to voluntarily report Sentinel Events to The Joint Commission within their required reporting timeframe (Refer to Barton Health Sentinel Event Policy).

Adverse Event

Barton Health shall report an adverse event as defined within Health and Safety Code §1279.1 (below) to CDPH no later than five calendar days after the event has been detected or, if the event is an ongoing urgent or emergent threat to the welfare, health, or safety of patients, personnel, or visitors, no later than 24 hours after the adverse event has been detected. Events are investigated, mitigation actions initiated, and cooperation with CDPH occurs throughout the process. (Refer to Barton Health Adverse Event policy)

"Adverse event" includes *any* of the following:

1. Surgery performed on a wrong body part that is inconsistent with the documented informed consent for that patient. A reportable event does not include a situation requiring prompt action that occurs in the course of surgery or a situation that is so urgent as to preclude obtaining informed consent.
2. Surgery performed on the wrong patient.
3. The wrong surgical procedure performed on a patient that is inconsistent with the documented informed consent for that patient. A reportable event does not include a situation requiring prompt action that occurs in the course of surgery, or a situation that is so urgent as to preclude the obtaining of informed consent.
4. Retention of a foreign object in a patient after surgery or other procedure, excluding objects intentionally implanted as part of a planned intervention and objects present prior to surgery that are intentionally retained.
5. Death during or up to 24 hours after induction of anesthesia after surgery of a normal, healthy patient who has no organic, physiologic, biochemical, or psychiatric disturbance and for whom the pathologic processes for which the operation is to be performed are localized and do not entail a systemic disturbance.
6. Patient death or serious disability associated with the use of a contaminated drug, device, or biologic provided by the health facility when the contamination is the result of generally

detectable contaminants in the drug, device, or biologic, regardless of the source of the contamination or the product.

7. Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. For purposes of this subparagraph, "device" includes, but is not limited to, a catheter, drain, or other specialized tube, infusion pump, or ventilator.
8. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a facility, excluding deaths associated with neurosurgical procedures known to present a high risk of intravascular air embolism.
9. An infant discharged to the wrong person.
10. Patient death or serious disability associated with patient disappearance for more than four hours, excluding events involving adults who have competency or decision-making capacity.
11. A patient suicide or attempted suicide resulting in serious disability due to patient actions after admission, excluding deaths resulting from self-inflicted injuries that were the reason for admission to the health facility.
12. A patient death or serious disability associated with a medication error, including, but not limited to, an error involving the wrong drug, the wrong dose, the wrong patient, the wrong time, the wrong rate, the wrong preparation, or the wrong route of administration, excluding reasonable differences in clinical judgment on drug selection and dose.
13. A patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products.
14. Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy, including events that occur within 42 days post-delivery and excluding deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy, or cardiomyopathy.
15. Patient death or serious disability directly related to hypoglycemia, the onset of which occurs while the patient is being cared for in a health facility.
16. Death or serious disability, including kernicterus, associated with failure to identify and treat hyperbilirubinemia in neonates during the first 28 days of life. "Hyperbilirubinemia" means bilirubin levels greater than 30 milligrams per deciliter.
17. A Stage 3 or 4 ulcer, acquired after admission, excluding progression from Stage 2 to Stage 3 if Stage 2 was recognized upon admission.
18. A patient death or serious disability due to spinal manipulative therapy performed at the health facility.
19. A patient death or serious disability associated with an electric shock while being cared for in a health facility, excluding events involving planned treatments, such as electric countershock.
20. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by a toxic substance.
21. A patient death or serious disability associated with a burn incurred from any source while being cared for in a health facility.
22. A patient death associated with a fall while being cared for in a health facility.
23. A patient death or serious disability associated with the use of restraints or bedrails while being cared for in a health facility.
24. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider.
25. The abduction of a patient of any age.
26. The sexual assault on a patient within or on the grounds of the facility.
27. The death or significant injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds of a facility.

28. An adverse event or series of adverse events that cause the death or serious disability of a patient, personnel, or visitor.

Provider-Preventable Conditions

Federal law requires Provider-Preventable Conditions (PPCs) that occur during treatment of Medi-Cal and Medicaid patients be reported. These include both healthcare-acquired conditions (HCAC) and other provider-preventable conditions (OPPC). California HCACs and OPPCs are reported to the Department of Health Care Services after discovery and confirmation that the patient is a Medi-Cal beneficiary. Nevada HCACs are reported through the Nevada sentinel event registry.

HCACs are defined as:

- Air embolism
- Blood incompatibility
- Catheter-associated urinary tract infection (UTI)
- Falls and trauma that result in fractures, dislocations, intracranial injuries, crushing injuries, burns and electric shock
- Foreign object retained after surgery
- Iatrogenic pneumothorax with venous catheterization
- Manifestations of poor glycemic control
 - Diabetic ketoacidosis
 - Nonketotic hyperosmolar coma
 - Hypoglycemic coma
 - Secondary diabetes with ketoacidosis
 - Secondary diabetes with hyperosmolarity
- Stage III and IV pressure ulcers
- Surgical site infection following:
 - Mediastinitis following coronary artery bypass graft (CABG)
 - Bariatric surgery, including laparoscopic gastric bypass, gastroenterostomy and laparoscopic gastric restrictive surgery
 - Orthopedic procedures for spine, neck, shoulder, and elbow
 - Cardiac implantable electronic device (CIED) procedures
- Vascular catheter-associated infection
- For non-pediatric/obstetric population, deep vein thrombosis (DVT)/ pulmonary embolism (PE) resulting from:
 - Total knee replacement
 - Hip replacement

OPPCs are defined as:

- Wrong surgical or other invasive procedure performed on a patient
- Surgical or other invasive procedure performed on the wrong body part
- Surgical or other invasive procedure performed on the wrong patient

Patient Safety Organization Reporting

Barton Healthcare System is a member of the California Hospital Patient Safety Organization (CHPSO), which serves as its Patient Safety Organization. Patient Safety Work Product is submitted to CHPSO in accordance with the Patient Safety and Quality Improvement Act of 2005. (Refer to Patient Safety Evaluation System Policy for further details.)

Investigation: Root Cause Analysis and Process Improvements

In any event when an adverse/sentinel event or hazardous condition has occurred, the issue is revisited and the status mitigated through a risk reduction strategy using the Root Cause Analysis (RCA) process. Lesser events are managed through either an RCA or Process Improvement (PI). Reportable Adverse or Sentinel Events shall be subject to an immediate in-depth RCA.

RCAs shall be convened by the Director of Patient Safety & Clinical Education or designee and includes team members either directly or indirectly involved in the event. Members from uninvolved departments may be invited to provide additional information. Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting the RCA. The Root Cause Analysis and Action Plan Framework Table, introduced by the Joint Commission, contains 24 analysis questions that guide the organization through the steps in a root cause analysis. Not all the questions apply to all the events or cases. The 5 Whys technique is utilized to explore the cause and effect relationship underlay a problem. Root causes can be identified by asking “why” no less than five times. During the RCA, events are deconstructed in an effort to identify the key causes that may have contributed to the event. The deconstruction process leads to action items designed to eliminate or control system hazards or vulnerabilities directly related to causal and contributory factors. The Veterans Affairs National Center for Patient Safety Action Hierarchy is used to assure strong corrective action items are identified.

Process Improvement teams are formed when an issue affecting more than one service line is identified and a near miss may or may not be involved. There may be no adverse patient outcome in connection with the event, however, the potential for a patient event should the issue recur is likely. PIs may also result from discussions during RCAs where a system improvement process is identified as a result of a patient event. Team members convene and identify key factors involved in the process through deconstruction that may have contributed to the situation and create action items to mitigate the identified issues.

RCA and PI workgroups construct action items and assign them to appropriate individuals for completion. Staff involvement is considered essential, since they are the team members on the front line with the most knowledge of the actual day-to-day workings of the processes. Individuals assigned action items are required to complete the tasks within a designated amount of time depending upon the breadth of the item. Action items may be forwarded to other appropriate bodies for further in-depth evaluation, review, response, revision, or development of policies or procedures when applicable. Action item progress and completion is reported to the Patient Safety Department.

As a learning organization utilizing Just Culture, Barton Health focuses on systems and processes, not individuals, during RCA or PI event review.

Disclosure

Full disclosure of serious medical errors, reportable events and any unanticipated outcomes are communicated to patients/families by the practitioner with the assistance of the- Risk Management Analyst, Director of Patient Safety & Clinical Education, Patient Safety Officer, or designee as appropriate. (Refer to Barton Health Disclosure of Unanticipated Outcome Policy.)

Patient Safety Committee

The Patient Safety Committee is a multidisciplinary team focused on review and discussion of patient events resulting in a near-miss or an untoward outcome as well as process improvements for the purposes of improving patient safety and the quality of care delivered to Barton Health's patients.

The Patient Safety Committee is a standing committee of the Medical Staff and is comprised of the Chief Medical Officer, Chief of Staff, Physician Director of the Emergency Department, Hospitalist Director, Trauma Medical Director, Administrative Director of Acute Care Services, Director of Patient Safety & Clinical Education, Patient Safety Officer, Director of Pharmacy, , Risk Management Analyst, Chief Nursing Officer, and Director of Quality. Ad Hoc members are invited as appropriate.

The Patient Safety Committee shall review and discuss Code Blues, hospital deaths, Rapid Response Team activations (including near codes), HAIs, serious patient events, and reportable adverse and sentinel patient events. Adverse/sentinel patient events include unanticipated events that affect patient care or patient safety and encompass all service lines of care.

The Committee promotes the application of evidence-based methods in the resolution of patient safety events and reviews RCA and PI workgroup recommendations which ultimately minimize the recurrence of comparable patient events or near misses. Recommendations can be revised, added or deleted through this committee.

The Lake Tahoe Surgery Center Patient Safety Committee is a subcommittee of and reports to the Patient Safety Committee. Refer to Appendix A.

Department Directors or designees are active participants who complete assigned action items within an appropriate timeframe designated by the work group, Director of Patient Safety & Clinical Education, Patient Safety Officer, Chief Medical Officer, or Patient Safety Committee. Directors are responsible for implementing action items and reporting back to the Patient Safety Committee and/or the Patient Safety Department with status updates and upon completion of assigned action items. Directors are responsible to ensure continued compliance exists with their direct reports and implemented process changes are sustained.

Events and PIs shall be closed through the Patient Safety Committee when all assigned action items have been completed, any associated audits exhibit compliance, and all remaining concerns are addressed.

The Director of Patient Safety & Clinical Education or designee shall report patient safety events and process improvements from the Patient Safety Committee to the Board Quality Committee. The Chief Medical Officer

or designee shall report acute events and process improvements from the Patient Safety Committee to the Medical Executive Committee and Governing Board.

Patient Safety Risk Reduction

Several approaches are utilized at Barton Health to reduce the risk of a patient safety event. The Joint Commission's National Patient Safety Goals, National Healthcare Safety Network (NHSN), Institute for Healthcare Improvement (IHI), Agency for Healthcare Research and Quality (AHRQ), National Patient Safety Foundation, and California Hospital Patient Safety Organization (CHPSO) are some examples of utilized resources to prevent and reduce the likelihood of serious patient safety events. Sentinel Event Alerts released through The Joint Commission are also analyzed for compliance.

National Patient Safety Goals

Compliance with The Joint Commission's National Patient Safety Goals are monitored and evaluated on a continual basis through observational audits. Data analyses of these audits shall be reported to and reviewed by Board Quality Committee on a biannual basis. Measure of success for compliance on each standard's requirement is expected to be 90% (ninety percent) or above. Elements falling near or below 90% (ninety percent) are addressed by the appropriate Department Director. The Director shall formulate an action plan with the goal of improving the affected element score within their department.

Patient Safety observational audits (tracers) are conducted on a routine basis. Immediate training is provided to staff when non-compliance with policy elements is observed. (Refer to Patient Safety Observational Tracer Policy.)

Sentinel Event Alerts

Sentinel Event Alerts, published through The Joint Commission, are communicated through the Patient Safety Committee. Compliance status and opportunities for improvement are addressed through workgroups consisting of affected Department Directors, Executive Team Members and others as appropriate to formulate risk reduction strategies and follow up through an action plan. Action items within the action plan are assigned to individuals who are required to complete the tasks within a designated amount of time depending upon the breadth of the item. Action items may be forwarded to other appropriate bodies for further in-depth evaluation, review, response, revision, or development of policies or procedures when applicable. Action item progress and completion is reported to the Patient Safety Department.

Scientific Model Integration

The patient safety program has been developed with scientific knowledge in a foundational aspect including concepts from:

- Shewhart cycle or Model for Improvement (Plan, Do, Study, Act –PDSA)
- Failure Mode and Effects Analysis (FMEA)
- Re-engineering (Human factor re-engineering such as signage for High Alert Medications, Pop up alert in Pyxis medication dispensing system, Tall man lettering for look-alike sound alike drugs in medication usage process, etc.)
- Rapid Cycle Improvement (IHI Collaborative approach termed the 'Breakthrough Series', to bring about rapid cycle improvements. Fundamental to the collaborative approach is the acceptance of a model and

establishment of infrastructure through which collaborating organizations can identify and prioritize aims for improvement and gain access to the methods, tools, materials etc.)

- RCA²: Improving Root Cause Analyses and Actions to Prevent Harm
- Process Improvement such as Lean and Six Sigma concepts
- Evidence-based practice and clinical practice guidelines

Educational Enhancement Activities

The Patient Safety Plan provides the opportunity to reduce patient safety events and hazardous conditions through education, proper and effective orientation, and annual training. Barton Health's clinical orientation program emphasizes medical error reduction and specific job-related aspects of patient safety. Ongoing patient safety training for Barton Health team members including practitioners is offered through various teaching strategies including, but not limited to, bulletin boards, online learning formats, skills labs, and didactic experiences. Program content may include education specific to patient safety related events or advancements in patient safety practice. As appropriate, this training incorporates methods of team training such as TeamSTEPPS by AHRQ to foster an interdisciplinary, collaborative approach to the delivery of patient care and reinforces the need and mechanisms to report patient safety concerns.

Patient Safety Evaluation

Annually, patient safety activities shall be reviewed and presented to the Patient Safety and Board Quality Committees.

Patient Safety Plan Approval, Revision and Review

The Patient Safety Committee shall review and approve this plan at least once a year, but more often as necessary, to evaluate and update the plan, and to incorporate advancements in patient safety practices. The Board Quality Committee shall review and approve this plan at least annually.

Authority

The authority to implement the Patient Safety Plan rests with Barton Health's Governing Body, Board Quality Committee, Medical Executive Committee, and Patient Safety Committee.

Approval

This plan was approved by the following committees:

Patient Safety Committee on 12/19/2017

Board Quality on 1/4/2018

Section B:

2017 Patient Safety Priority Evaluation

In 2017, Barton Health prioritized tubing connections, reducing falls, enhancement of teamwork through TeamSTEPPS, clinical alarms, and sepsis.

Tubing misconnections have been addressed by converting enteral products to meet new standards, continually monitoring for ISO tubing product changes, and awaiting final ISO approval and manufacturer modifications in accordance with California AB 1867, Joint Commission Sentinel Event Alert 53, and California Health and Safety Code 1279.7.

The Fall Prevention Workgroup continued in 2017 with the goal of reducing falls across the organization. Post fall huddle forms were revised and/or developed for patient care areas with emphasis on risk factors relevant to each specific department. Fall risk assessment tools were reviewed. The associated Fall Prevention FMEA will remain active in 2018 with the goal of identifying and mitigating factors that can contribute to patient falls.

TeamSTEPPS tools were introduced to many departments in 2017. Both the Sleep Studies Lab and Pharmacy teams were trained on the CUS tool which focuses on communicating critical information in a specific format. The Medical-Surgical, Orthopedic, Intensive Care Unit, Laboratory/Pathology and Medical Imaging departments were trained on the brief, huddle, and debrief tools and use these tools at the beginning, middle, and end of shifts respectively. System wide Daily Safety Briefs (DSBs) were implemented in the fourth quarter of 2017. The purpose of DSBs are to increase safety awareness and enhance communication among interdepartmental teams in addition to supporting Barton Health's journey to becoming a high reliability organization. The program has been highly successful in a short period of time.

Clinical alarms as related to NPSG.06.01.01 resulted in ongoing review with heightened attention focused on bedside capnography monitor alarms with the intent of reducing nuisance/false alarms. In an effort to mitigate nuisance alarms, work with the capnography vendor resulted in the addition of centralized monitors allowing for enhanced monitoring of patients at risk for respiratory compromise. Data analytics on clinical alarms will continue to be reviewed and assessed in 2018 for further system optimization.

Work on sepsis resulted in increased compliance with core measure requirements. This included the finalization of a sepsis order set and education to hospital based Registered Nurses. The Patient Safety Department will continue to assist with sepsis related concerns in 2018.

Section C:

2018 Patient Safety Priorities

The Patient Safety Plan identifies and defines goals and specific objectives to be accomplished each year. In 2018, Barton Health's high priorities for Patient Safety include reducing falls across the organization, tubing connections, teamwork enhancement through TeamSTEPPS in the outpatient clinic settings, assessing communication in hand-offs/hand overs, and clinical alarms.

Barton Health initiated a Fall Prevention FMEA in late 2016 that will conclude in early 2018. However, the workgroup will continue to focus on risk reduction opportunities related to patient falls. Strategies will be designed and implemented that are specific to addressing identified organizational and department needs with the overall goal of reducing patient falls across the organization.

Measures to prevent adverse events associated with misconnecting intravenous, enteral feeding, and epidural lines will remain a priority in 2018. A complete conversion to the new ISO standard enteral feeding lines occurred in 2015. Manufacturers currently distribute tubing types that can be mistakenly interconnected. However, until connectors are reengineered, approved by the ISO and the FDA, and distributed throughout the healthcare industry, there remains the possibility of human error. Barton Health proactively addresses prevention of adverse events associated with misconnecting IV, enteral and epidural lines through product purchasing and assessment of availability of connectors throughout the organization as well as staff education and awareness. It is anticipated neuraxial connectors with redesigned incompatible connectors will become publicly available in 2018 at which time Barton Health will assess and convert to this new design to ensure compliance with California state law.

TeamSTEPPS teamwork enhancement program implementation will continue across the organization with a focus on bringing the specific tools of briefs, huddles, and debriefs to outpatient clinics in 2018. TeamSTEPPS embraces leadership, communication, situation monitoring and mutual support to enhance team performance and optimize patient outcomes. TeamSTEPPS Master Trainers will continue to integrate tools into departments based upon readiness and need.

In 2018, an FMEA will commence within the organization in association with The Joint Commission's Sentinel Event Alert 58. The overall goal will be to assess and enhance patient hand-off/handover communication among team members.

Barton Health will continue to prioritize NPSG.06.01.01 focusing on clinical alarm system safety in 2018. While alarms in the clinical setting that are non-actionable can result in alarm fatigue for team members, bedside capnography monitoring alarms remain an area for further optimization. Therefore, specific focus will continue to be placed on bedside capnography monitoring data analytics related to nuisance/false alarms.

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Appendix A:

***2018 Lake Tahoe Surgery Center
Patient Safety Plan***

This plan was created and revised by the Lake Tahoe Surgery Center Patient Safety Committee, a subcommittee of Barton Health's Patient Safety Committee. Implementation of this plan is intended to optimize healthcare patient safety outcomes, encourage recognition, reporting, and acknowledgment of risks to patient, visitor, and employee safety, as well as reduce the medical/healthcare errors and /or preventable events. This Patient Safety Plan ensures that Barton Health implements and maintains a patient safety program in accordance with The Joint Commission standards, Nevada Revised Statutes (NRS), Patient Safety and Quality Improvement Act of 2005, and other regulatory agencies.

**Patient Safety Plan
Lake Tahoe Surgery Center**

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Commitment to Patient Safety

Lake Tahoe Surgery Center is committed to a comprehensive approach to improving healthcare quality and patient safety by aligning with our Mission, Vision, and Values, creating an environment that supports a dynamic, proactive, and safe culture for patients, family members, visitors, and employees, through continuous learning and improving patient safety policies, systems, and processes.

Mission, Vision, and Values

In support of the mission, vision, values, and strategic plan of Barton Health, Lake Tahoe Surgery Center's Patient Safety program promotes:

- Collaboration of healthcare, leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high quality healthcare.
- Communicate honestly and openly to foster trusting and cooperative relationships among healthcare providers, staff members, and patients and their families, to ensure accountability for the patient safety priorities.
- Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.
- Responsibility for every healthcare related decision and action.
- A focus on continuous learning and improving, system design, and the management of choices and changes, bringing the best possible outcomes or performances to the facility.
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare.
- Education of staff and physicians to assure participation of healthcare providers.
- An environment and culture where patients, families, staff and leaders within the organization identify and manage actual and potential risks to patient safety thereby resulting in zero harm.
- An ongoing proactive reduction in health-related errors including near miss and good catch events.
- Integration of patient safety priorities in the design and redesign of all relevant organizational processes, functions, and services.

Scope and Purpose

The scope of this Patient Safety Plan is specific to Lake Tahoe Surgery Center, a department of Barton Health, which includes but is not limited to:

- Patient safety
- Visitor safety
- Employee safety

All Lake Tahoe Surgery Center staff are required to fully support and participate in this plan, and devote their expertise to the patient safety and healthcare quality improvement process. Each employee performs a critical role in patient safety and thus, Barton Health's journey to becoming a high reliability organization. All Barton Health-Lake Tahoe Surgery Center team members are focused on providing consistently exceptional care through an environment that supports teamwork, collaboration and respect for other people, regardless of their position in the organization. Leaders demonstrate their commitment to patient safety while setting expectations for those who work in the organization. Leadership evaluates the culture of safety on a regular basis.

This plan is action oriented and solution focused. The purpose of this plan is to address patient safety related concerns, challenges and revise the program to better serve the patients and their families. To this end, Lake Tahoe Surgery Center has developed this Patient Safety plan.

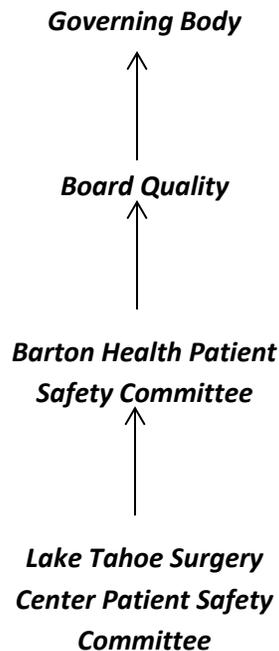
The plan focuses on the process rather than the individual, and recognizes both internal and external customers, as well as facilitates the need of analyzing and improving processes. The core principles of this plan include:

- All staff have the same goal and contribute their knowledge, vision, skill, and insight to improve the process of the Patient Safety Plan.
- Decisions will be based on data and facts, and staff will be encouraged to learn from the experiences.
- Customer based including patients, families, and visitors.
- Promote systems thinking.
- Employ well-trained and competent staff.

Roles and Responsibilities

According to [NRS 439.875](#), a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Patient Safety Plan is promoted and executed successfully.

The Patient Safety Committee reporting hierarchy:



Roles and Responsibilities

- In accordance with [NRS 439.875](#), a patient safety committee must be comprised of:
 - The patient safety officer of the medical facility. At Barton Health, the Director of Patient Safety & Clinical Education has oversight of the Patient Safety Officer and serves in this role;
 - The infection preventionist of the medical facility;
 - At least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility; and
 - One member of the executive or governing body of the medical facility.

The roles and responsibilities are defined below.

Lake Tahoe Surgery Center Patient Safety Committee Responsibilities (based on [NRS 439.875](#) and [NRS 439.877](#))

- Monitor and document the effectiveness of the patient identification policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the patient safety officer pursuant to [NRS 439.870](#).

- Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred.
- Review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- Review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least quarterly, due to the number of employees in the facility, report to the executive or governing body of the facility regarding:
 - (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);
 - (2) The number of infections that occurred at the facility during the preceding calendar month or quarter; and
 - (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

Lake Tahoe Surgery Center Patient Safety Committee will meet quarterly to accomplish the following:

- Report and discuss sentinel events which include:
 - Number of sentinel events from previous calendar month (or quarter).
 - Number of severe infections that occurred in the facility.
- Corrective Action Plan for the sentinel events and infections
 - Evaluate the corrective action plan.
- Patient safety policies and checklists
 - At least annually evaluate Patient Safety policies and checklists
 - Revise the patient safety policies and checklists as needed.
 - Monitor and document the effectiveness of the patient safety policy.
- A meeting agenda and minutes noting follow-up tasks will be kept.

Root Cause Analysis (RCA) Team Responsibilities

- Root Cause interviews, analysis, investigation, and corrective action plan implementations.
- Participates in the RCA meetings and discussions.
- Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders.

RCA Team Leader/Facilitator Responsibilities

- Organize and coordinate the RCA process.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA, and corrective action plan implementation

process.

- Communicate the progress of the investigation, institutional barriers, and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.
- Provide training, education and direction to create a RCA process that incorporates Patient Safety Improvement elements.

Director of Patient Safety & Clinical Education Responsibilities (based on [NRS 439.870](#))

- Provide oversight to the integrated Barton Health patient safety program.
- Serve on the Lake Tahoe Surgery Center patient safety committee.
- Supervise the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the Lake Tahoe Surgery Center Patient Safety Committee, Patient Safety Committee, Board Quality and Governing Board actions taken related to the sentinel event.
- Ensure alignment of patient safety activities, compliance with regulations, and provide opportunities for all Barton Health team members to be educated and involved in patient safety initiatives.
- Oversee, monitor and evaluate safety activities, manage the program that measures and analyzes safety levels, and help identify problem areas for correction
- The Director of Patient Safety & Clinical Education has the authority to intervene in any clinical or non-clinical activity which poses an actual or potential negative outcome to a patient's well-being. The Director of Patient Safety & Clinical Education involves leadership in the creation, initiation and evaluation of corrective action measures for event resolution.
- Report to the Patient Safety Committee regarding any action taken in accordance with the responsibilities above.

Infection Preventionist Responsibilities (based on [NRS 439.873](#))

- Serve on the Lake Tahoe Surgery Center patient safety committee.
- Monitor the occurrences of infections at the facility to determine the number and severity of infections.
- Report to the patient safety committee concerning the number of infections at the facility.
- Take such action as determined necessary to prevent and control infections alleged to have occurred at the facility.
- Carry out the provisions of the infection control program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program.

Chief Medical Officer Responsibilities

- Provide vision and leadership to the Lake Tahoe Surgery Center Patient Safety Committee and develop and foster a safe learning and improving culture.
- Provides oversight to the integrated patient safety program
- Plan, discuss, and generate the organization patient safety goals and activities, in conjunction with the patient safety action plans.

- Ensure alignment of patient safety activities, compliance with regulations, and provide opportunities for all Barton Health team members to be educated and involved in patient safety initiatives.

Objectives and Goals of the Patient Safety Plan

Objective	Goals	Plan	Planned Completion Date	Responsible Party
To control known and potential safety hazards to patients, visitors, and staff.	Strive for zero harm.	Patient Safety Plan as presented	Ongoing	The Director of Patient Safety & Clinical Education and Patient Safety Committee presiding over Barton Health are responsible for managing and coordinating the organization-wide safety program in collaboration with other departments, services and disciplines including Lake Tahoe Surgery Center.
To establish a safety program that incorporates all activities within Lake Tahoe Surgery Center which contribute to the maintenance and improvement of staff and patient safety and reduction of medical/health care errors.	Provide education to all staff on the elements of the Lake Tahoe Surgery Center Patient Safety Plan.	Education provided upon hire	Ongoing	The Director of Patient Safety & Clinical Education and Patient Safety Committee presiding over Barton Health are responsible for managing and coordinating the organization-wide safety program in collaboration with other departments, services and disciplines including Lake Tahoe Surgery Center.

To create a culture in which patients, visitors and employees can identify and manage actual and potential risks to patient and staff safety.	In-service all personnel on the use and completion of event reports.	Education provided upon hire	Ongoing	The Director of Patient Safety & Clinical Education and Patient Safety Committee presiding over Barton Health are responsible for managing and coordinating the organization-wide safety program in collaboration with other departments, services and disciplines including Lake Tahoe Surgery Center.
To develop a culture that encourages recognition and acknowledgement of risks to safety including medical health care errors, facility-acquired infections, initiation of actions to reduce risks, internal minimization of individual blame or retribution, and organizational learning about errors.	Reduce the risk of safety related incidents by proactively evaluating systems in place and making any necessary changes.	Evaluate near-miss events through RCAs and PIs presented at Patient Safety Committee and encourage Just Culture	Ongoing	The Director of Patient Safety & Clinical Education and Patient Safety Committee presiding over Barton Health are responsible for managing and coordinating the organization-wide safety program in collaboration with other departments, services and disciplines including Lake Tahoe Surgery Center.
To develop an environment that supports sharing of knowledge to affect behavioral changes in itself and other healthcare organizations to improve patient safety.	Reduce the risk of safety related incidents by proactively evaluating systems in place and making any necessary changes.	Evaluate near miss events through RCAs and PIs presented at Patient Safety Committee and encourage Just Culture	Ongoing	The Director of Patient Safety & Clinical Education and Patient Safety Committee presiding over Barton Health are responsible for managing and coordinating the organization-wide safety program in collaboration with other departments, services and disciplines including Lake Tahoe Surgery Center.

Empower patients to understand and participate in their healthcare.	Provide communication and education to patients relating to their care.	Provide education through various methods based on learning assessment.	Ongoing	The Director of Patient Safety & Clinical Education and Patient Safety Committee presiding over Barton Health are responsible for managing and coordinating the organization-wide safety program in collaboration with other departments, services and disciplines including Lake Tahoe Surgery Center.
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Components and Methods

Pursuant to [NRS 439.837](#), a medical facility shall, upon reporting a sentinel event pursuant to [NRS 439.835](#), conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event.

Patient Safety Risk Reduction

Several approaches are utilized at Barton Health to reduce the risk of a patient safety event. The Joint Commission's National Patient Safety Goals, National Healthcare Safety Network (NHSN) Institute for Healthcare Improvement (IHI), Agency for Healthcare Research and Quality (AHRQ), Hospital Quality Institute, and California Hospital Patient Safety Organization (CHPSO) are some examples of utilized resources to prevent and reduce the likelihood of serious patient safety events. Sentinel Event Alerts released through The Joint Commission are also analyzed for compliance.

National Patient Safety Goals

Compliance with The Joint Commission's National Patient Safety Goals are monitored and evaluated on a continual basis through observational audits. Data analyses of these audits shall be reported to and reviewed by the Board Quality Committee on a biannual basis. Measure of success for compliance on each standard's requirement is expected to be 90% (ninety percent) and above. Elements falling near or below 90% (ninety percent) are addressed by the Department Director. The Director shall formulate an action plan with the goal of improving the affected element score within their department.

Patient Safety observational audits (tracers) are conducted on a routine basis. Immediate training is provided to staff when non-compliance with policy elements is observed. (Refer to Patient Safety Observational Tracer Policy.)

Sentinel Event Alerts

Sentinel Event Alerts, published through The Joint Commission, are communicated through the Patient Safety Committee. Compliance status and opportunities for improvement are addressed through workgroups consisting of affected Department Directors, Executive Team Members and others as appropriate to formulate risk reduction strategies and follow up through an action plan. Action items within the action plan are assigned

to individuals who are required to complete the tasks within a designated amount of time depending upon the breadth of the item. Action items may be forwarded to other appropriate bodies for further in-depth evaluation, review, response, revision, or development of policies or procedures when applicable. Action item progress and completion is reported to the Patient Safety Department.

Scientific Model Integration

The patient safety program has been developed with scientific knowledge in a foundational aspect including concepts from:

- Shewhart cycle or Model for Improvement (Plan, Do, Study, Act –PDSA)
- Failure Mode and Effects Analysis (FMEA)
- Re-engineering (Human factor re-engineering such as signage for High Alert Medications, Pop up alert in Pyxis medication dispensing system, Tall man lettering for look-alike sound alike drugs in medication usage process, etc.)
- Rapid Cycle Improvement (Institute of Health Care Improvement (IHI)) Collaborative approach termed the ‘Breakthrough Series’, to bring about rapid cycle improvements. Fundamental to the collaborative approach is the acceptance of a model and establishment of infrastructure through which collaborating organizations can identify and prioritize aims for improvement and gain access to the methods, tools, materials etc.)
- RCA²: Improving Root Cause Analyses and Actions to Prevent Harm
- Process Improvement (PI) such as Lean and Six Sigma concepts
- Evidence-based practice and clinical practice guidelines

Educational Enhancement Activities

The Patient Safety Plan provides the opportunity to reduce patient safety events and hazardous conditions through education, proper and effective orientation, and annual training. Barton Health’s clinical orientation program emphasizes medical error reduction and specific job-related aspects of patient safety. Ongoing patient safety training for Barton Health team members including practitioners is offered through various teaching strategies including, but not limited to, bulletin boards, online learning formats, skills labs, and didactic experiences. Program content may include education specific to patient safety related events or advancements in patient safety practice. As appropriate, this training incorporates methods of team training such as TeamSTEPPS by AHRQ to foster an interdisciplinary, collaborative approach to the delivery of patient care and reinforces the need and mechanisms to report patient safety concerns.

Investigation: Root Cause Analysis and Process Improvements

In any event when an adverse/sentinel event or hazardous condition has occurred, the issue is revisited and the status mitigated through a risk reduction strategy using the Root Cause Analysis (RCA) process. Lesser events are managed through either an RCA or Process Improvement (PI). Reportable Adverse or Sentinel Events shall be subject to an immediate in-depth RCA.

RCAs shall be convened by the Director of Patient Safety & Clinical Education or designee and includes team members either directly or indirectly involved in the event. Members from uninvolved departments may be invited to provide additional information. Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting the RCA. The Root Cause Analysis and Action Plan Framework Table, introduced by the Joint Commission, contains 24 analysis questions that guide the organization through

the steps in a root cause analysis. Not all the questions apply to all the events or cases. The 5 Whys technique will be used to explore the cause and effect relationship underlay a problem. One can find the root causes by asking “why” no less than five times. During the RCA, events are deconstructed in an effort to identify the key causes that may have contributed to the event. The deconstruction process leads to action items designed to eliminate or control system hazards or vulnerabilities directly related to causal and contributory factors. The Veterans Affairs National Center for Patient Safety Action Hierarchy is used to assure strong corrective action items are identified.

An RCA meeting will meet as needed to accomplish the following:

Define the healthcare issues or potential risks.

- Conduct Root Cause Analysis
 - Review and analyze the data.
 - Review the RCA process and improvement related activities and timelines.
 - Identify the contributing factors and conduct the Root Cause Analysis.
- Conduct Corrective Action Plan
 - Discuss corrective action process and activities.
 - Discuss and present possible changes in procedure to improve areas indicated.
 - Identify strengths and areas that need improvement.
 - Develop strategies, solutions, and steps to take next.
- Identify barriers and technical assistance needs for supporting the RCA efforts.

Process Improvement teams are formed when an issue affecting more than one service line is identified and a near miss may or may not be involved. There may be no adverse patient outcome in connection with the event, however, the potential for a patient event should the issue recur is likely. PIs may also result from discussions during RCAs where a system improvement process is identified as a result of a patient event. Team members convene and identify key factors involved in the process through deconstruction that may have contributed to the situation and create action items to mitigate the identified issues.

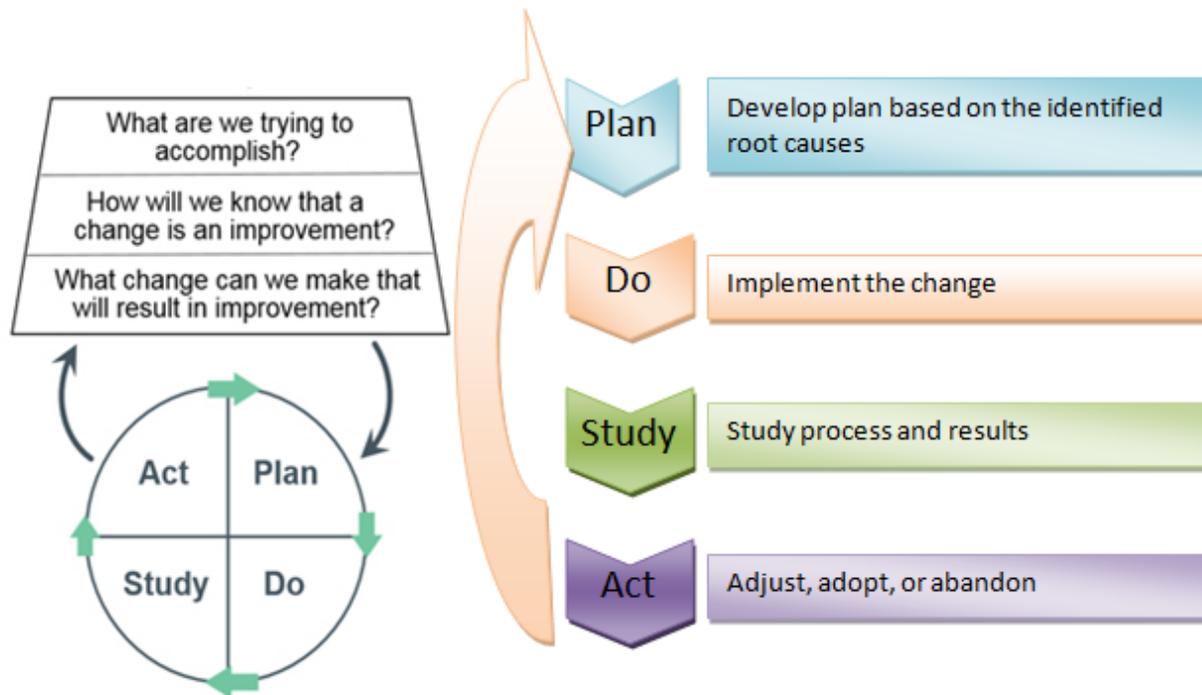
RCA and PI workgroups construct action items and assign them to appropriate individuals for completion. Staff involvement is considered essential, since they are the team members on the front line with the most knowledge of the actual day-to-day workings of the processes. Individuals assigned action items are required to complete the tasks within a designated amount of time depending upon the breadth of the item. Action items may be forwarded to other appropriate bodies for further in-depth evaluation, review, response, revision, or development of policies or procedures when applicable. Action item progress and completion is reported to the Patient Safety Department.

As a learning organization utilizing Just Culture, Barton Health focuses on systems and processes, not individuals, during RCA or PI event review.

Lake Tahoe Surgery Center will use the RCA process to determine the contributing factors and the underlying reasons for the deficiencies or failures. The Plan-Do-Study-Act (PDSA) is the model, which was developed by the Institute of Health Care Improvement that will be utilized to test the changes.

Model for Improvement

The Model for Improvement is a collaborative and ongoing effort model to improve product, services and processes. It provides multi-disciplinary team guidance from identifying the root causes; conducting the best tests to assess possible changes, and working in collaboration for implementation of the new approaches and solutions. It guides the test of a change to determine if the change is an improvement.



The cycle is defined as follows:

- Plan--collect data and establish appropriate goals. Identify the problem and the possible root causes, and answer the following questions.
 - What is the objective of the test?
 - What are the steps for the test - who, what, when?
 - How will you measure the impact of the test?
 - What is your plan to collect the data needed?
 - What do you predict will happen?
- Do--make changes designed to correct or improve the situation. Use the following questions for the guidance.
 - What were the results of the test?
 - Was the cycle carried out as designed or planned?
 - What did you observe that was unplanned or expected?
- Study -- Study the effect of the changes on the situation. Data should be collected on the new process and compared to the baseline or expected results. Results should be evaluated and by using the following questions as guidance.
 - Did the results match your prediction?

- What did you learn?
 - What do you need to do next?
- *Act*--If the result is successful or desirable, standardize the changes and then work on the next prioritized problem or the further improvements. If the outcome is not yet successful, look for different ways to identify the causes or change the testing process.

Data Collection and Reporting

Data should drive patient safety efforts. Lake Tahoe Surgery Center utilizes an electronic event reporting system for tracking events, sentinel events, healthcare infection data, and information for internal data collection.

External data sources are those data sources which are collected outside the supervisory structure of the case. External data which will be utilized for the Patient Safety plan include data from:

- AHRQ: Agency for Healthcare Research & Quality
- CDC: Centers for Disease Control and Prevention
- CMS: Centers for Medicare & Medicaid Services
- NQF: National Quality Forum
- NHSN: National Healthcare Safety Network
- TJC: The Joint Commission

Ongoing Reporting and Review

Data points such as the following will be reviewed according to the schedule prescribed:

Monthly	Quarterly	Annually
1) Sentinel event monthly report 2) Severity of infection report 3) RCA assessment as needed	1) Sentinel event quarterly report 2) Severity of infection report 3) Review and evaluate the measure of improvement of patient safety 4) Review and evaluate the measurement to prevent and control infections	1) Patient Safety Plan update 2) Review and revise Patient Safety checklists and policies

Assessment of the Patient Safety Plan

The Patient Safety Committee shall review and assess/approve this plan at least once a year, but more often as necessary, to evaluate and update the plan, and to incorporate advancements in patient safety practices.

Patient Safety Checklists and Patient Safety Policies

In accordance with [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

The patient safety checklists must follow protocols to improve the health outcomes of patients at the medical facility and must include, without limitation:

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.
- Checklists for ensuring employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure the patient's room and environment is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - Proper instructions concerning prescription medications;
 - Instructions concerning aftercare;
 - Any other instructions concerning his or her care upon discharge; and
 - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include the name and date of birth of the patient. Refer to Barton Health's Patient Identification policy.
- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene. Refer to Barton Health's Hand Hygiene policy.
- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials. Refer to Patient Safety Tracers policy.

Based on [NRS 439.865](#), the patient safety plan must also include an infection control program that carries out the infection control policy. The policy must consist of:

- The current guidelines appropriate for the facility's scope of service developed by a nationally recognized infection control organization as approved by the State Board of Health which may include, the Association for Professionals in Infection Control and Epidemiology (APIC), the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO) and the Society for Healthcare Epidemiology of America (SHEA); and

- Facility-specific infection control developed under the supervision of a certified Infection Preventionist.

The patient safety checklists are listed in LTSC Attachment A.

The patient safety policies are listed in LTSC Attachment B.

Approval of Patient Safety Plan

According to [NRS 439.865](#), a medical facility shall submit its patient safety plan to the governing board of the facility for approval. At Barton Health, this is accomplished by the plan being approved through the Lake Tahoe Surgery Center Patient Safety Committee, the Barton Health Patient Safety Committee, Board Quality and the Governing Board. After a facility's patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan. The patient safety plan must be reviewed and updated annually in accordance with the requirements for approval set forth in this section.

According to [NRS 439.843](#), on or before March 1 of each year, a copy of the most current patient safety plan established to [NRS 439.865](#) must be submitted to the Division of Public and Behavioral Health.

Authority

The authority to implement the Patient Safety Plan rests with Barton Health's Governing Body, Board Quality Committee, Medical Executive Committee, and Patient Safety Committee.

2018 Lake Tahoe Surgery Center Patient Safety Priorities

During 2018, Lake Tahoe Surgery Center will strive to achieve two different priorities to ensure safe patient care. During 2017, the surgical site infection rate was zero. Physician and staff education was provided during the year. In 2018, LTSC would like to maintain a surgical site infection rate of less than 0.5%.

Lake Tahoe Surgery Center had zero never events during 2017. In an effort to reduce the potential for harm, Lake Tahoe Surgery Center will strive to maintain zero harm during 2018. Physician and staff education is ongoing. The patient safety committee reviews all event reports and action items will be assigned to the appropriate staff. Education will occur immediately following an event, near miss or good catch.

References

Agency for Healthcare Research and Quality. (2008). *The patient safety and quality improvement act of 2005*. Retrieved from

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Centers for Disease Control and Prevention's National Healthcare Safety Network. (2014).

Healthcare-associated infections (HAIs). Retrieved from

<http://www.cdc.gov/hai/>

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[http://dpbh.nv.gov/Programs/SER/Sentinel_Events_Registry_\(SER\)-Home/](http://dpbh.nv.gov/Programs/SER/Sentinel_Events_Registry_(SER)-Home/)

Nevada Revised Statutes. Health and safety of patient at certain medical facilities. NRS

439.800-439.890

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The Joint Commission. (2016). *National Patient Safety Goals*. Retrieved

from http://www.jointcommission.org/standards_information/npsgs.aspx

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from http://www.patientsafety.va.gov/docs/joe/rca_tools_2_15.pdf

LTSC Attachment A: Terms and Definitions

Patient Safety: The Agency for Healthcare Research Quality (AHRQ) defines patient safety as “a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.”

http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

Sentinel event ([NRS 439.830](#))

1. Except as otherwise provided in subsection 2, “sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum.

2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:

(a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or

(b) July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published.

3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.

(Added to NRS by [2002 Special Session, 13](#); A [2005, 599](#); [2013, 217](#))

Institute for Healthcare Improvement (IHI) defines **medical harm** as “unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death.”

Facility-Associated Infection: ([NRS 439.802](#))

“Facility-acquired infection” means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections;
- Ventilator-associated pneumonia;
- Central line-related bloodstream infections;
- Urinary tract infections; and
- Other categories of infections as may be established by the State Board of Health by regulation pursuant to [NRS 439.890](#). (Added to NRS by [2005, 599](#); A [2009, 553](#))

Medical facility ([NRS 439.805](#))

“Medical facility” means:

- A hospital, as that term is defined in [NRS 449.012](#) and [449.0151](#);
- An obstetric center, as that term is defined in [NRS 449.0151](#) and [449.0155](#);

- A surgical center for ambulatory patients, as that term is defined in [NRS 449.0151](#) and [449.019](#); and
- An independent center for emergency medical care, as that term is defined in [NRS 449.013](#) and [449.0151](#).

(Added to NRS by [2002 Special Session, 13](#))

Near miss: An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Mandatory reporting: Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985;254(6):796-800.)

Risk: Possibility of loss or injury. (Merriam-Webster's Online Dictionary, Risk, Available at <http://www.merriamwebster.com/dictionary/risk>. Last Accessed August 2009.)

Preventable event: Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Catheter Associated Urinary Tract Infection (CAUTI): A urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place for greater than 2 calendar days on the date of event, with day of device placement being Day 1, and an indwelling urinary catheter was in place on the date of event or the day before. If an indwelling catheter was in place for greater than 2 calendar days and then removed, the date of event for the UTI must be that day of discontinuation or the next day for the UTI to be catheter-associated (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN): Patient Safety Component Manual; 2017. Available at https://www.cdc.gov/nhsn/pdfs/pscmanual/pcsmanual_current.pdf)

Central Line Associated Bloodstream Infections (CLABSI): Primary bloodstream infections that are associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection.

LTSC Attachment B: Patient Safety Patient Safety Checklists & Policies for Lake Tahoe Surgery Center**REPORT TO THE DIRECTOR OF THE LEGISLATIVE COUNSEL BUREAU PURSUANT TO ASSEMBLY BILL 280 OF THE 2011 LEGISLATIVE SESSION – SUBMITTED BY:**

Lake Tahoe Surgery Center
212 Elks Point Rd Suite 201, Zephyr Cove NV 89448

██████████ Director of Nursing

YEAR – June 1, 2017 – June 30, 2018

Check Lists Include:	Developed	Revisions*	Usage**	Review***
Related to the following specific types of treatments*		(date of revision)	(Unit/department)	
Patient Room & Environment Sanitation (Cleaning Checklists)		June 29, 2015	ASC	X
Discharge Checklist		October 28, 2014	PACU	X (on EMR)
Pre-op Checklist		May 2, 2015	PRE-OP/OR	X (on EMR)
Safety Checklist	May 2, 2015	June 1, 2016	OR	X (on EMR)
Sign-In	May 2, 2015	June 1, 2016	OR	X (on EMR)
Fire Safety	May 2, 2015	June 1, 2016	OR	X (on EMR)
Timeout	May 2, 2015	June 1, 2016	OR	X (on EMR)
Sign-out	May 2, 2015	June 1, 2016	OR	X (on EMR)
Environmental Rounds (quarterly)		November 3, 2015	ASC	X
Infection Control Survey (monthly)			ASC	X
Surgical Services Audit		June 29, 2015	ASC	X
Incubation Temperature			STERILIZATION	X
Medication Refrigerator		May 2013	PRE-OP/PACU/OR	X
IVF/Blanket Warmer Temperature		April 25, 2016	PRE-OP/PACU/OR	X
Sage Warmer		February 3, 2016	PRE-OP	X
OR Temperature/Humidity		December 18, 2014	ASC	X

Washer Sterilizer Cleaning			STERILIZATION	X
Daily, weekly, monthly duties		April 21, 2016	PRE-OP/PACU/OR	X
Crash Cart		May 2017	NURSING	
Pediatric Crash Cart		May 2017	NURSING	
Malignant Hyperthermia Cart		January 25, 2016	NURSING	X
Hand Hygiene Audit			ASC	X
Medication Labeling Audit		December 8, 2016	ASC	

Patient Safety Policies Include:	Developed	Revisions	Usage	Review
Patient Identification			ASC	X
Hand Hygiene			ASC	X
Patient Safety Checklist			ASC	X
National Patient Safety Goals		2017	ASC	
Medication Reconciliation			ASC	X
Handoff Communication			ASC	X
Universal Protocol			ASC	X
Safe Preparation and Administration of Medications		May 2017	ASC	
General Safety Policy- Patients/employees			ASC	X
Hazard Communications			ASC	X
Injury and Illness Prevention Program Plan			ASC	X
OSHA Reporting/Injury Reporting			ASC	X
Material Safety Data Sheets			ASC	X
Exposure Control Plan			ASC	X

Abusive Behavior- Patients			ASC	X
Abusive Behavior- Non-patients			ASC	X
Disruptive Physician or Ancillary staff Behavior			ASC	X
Identification of Life Safety Code Deficiency			ASC	X
Fire Risk Assessment			ASC	X
Summary of Review	Total # developed	Total # revised	Total # Reviewed	
Patient Safety Checklists	0	3	20	
Patient Safety Policies	0	2	17	

*Checklists and Patient Safety Policies were reviewed for the stated time period. Need for revision is noted by the date the revision was made.

**Usage outlines the unit/departments the checklists are used in.

***As part of the annual review any required revisions will be identified. If revisions are required this is noted in the revision box. Any additional patient safety checklists or policies identified will be noted in this (review) column. If the annual review reveals no changes are required this box will be marked with an "X". An "X" means that the checklists and policies were reviewed but no changes were required.

Reports are due on or before July 1 of each year

The mission of Desert Willow Treatment Center is to provide quality, individualized mental health services in a safe and culturally sensitive environment collaborating with caregivers, community and other providers to ensure that children and families of Nevada may achieve their full human potential.

Desert Willow Treatment Center

QUALITY AND PATIENT SAFETY PLAN

DATE: 2018
VERSION: 2



This plan was created and revised by the Desert Willow Treatment Center_Patient Safety (Care of Patient) committee/team with coordination with applicable Continuing Quality Improvement Teams. Implementation of this plan is intended to optimize the healthcare quality and patient safety outcomes, encourage recognition, reporting, and acknowledgment of risks to patient, visitor, and employee safety, as well as reduce the medical/healthcare errors and /or preventable events.

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**Patient Safety Committee/Care of Patient
Desert Willow Treatment Center**

6171 W. Charleston Blvd, Building 17
Las Vegas, NV 89146
702-486-8900

Commitment to Patient Safety

Desert Willow Treatment Center is committed to a comprehensive approach to improving healthcare quality and patient safety by aligning with our Mission creating an environment that supports a dynamic, proactive, and safe culture for patients, family members, visitors, and employees, through continuous learning and improving patient safety policies, systems, and processes.

Mission Statement

The mission of Desert Willow Treatment Center is to provide quality, individualized mental health services in a safe and culturally sensitive environment collaborating with caregivers, community and other providers to ensure that children and families of Nevada may achieve their full human potential.

In support of our mission Desert Willow Treatment Center Patient Safety and Quality Improvement program promotes:

- Collaboration of healthcare, leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high quality healthcare.
- Communicate honestly and openly to foster trusting and cooperative relationships among healthcare providers, staff members, and patients and their families, to ensure accountability for the patient safety priorities.
- Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.
- Responsibility for every healthcare related decision and action.
- A focus on continuous learning and improving, system design, and the management of choices and changes, bringing the best possible outcomes or performances to the facility.
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare.
- Education of staff and physicians to assure participation of healthcare providers.

Scope and Purpose

The scope of this Quality and Patient Safety Plan is organizational-wide/hospital-wide/agency-wide which includes but is not limited to

- Patient safety
- Visitor safety
- Employee safety

All staff in Desert Willow Treatment Center are required to fully support and participate in this plan, and devote their expertise to the patient safety and healthcare quality improvement process.

This plan is action oriented and solution focused. The purpose of this plan is to address patient safety related concerns, challenges and revise the program to better serve the patients and their families. To this end, Desert Willow Treatment Center has developed this Patient Safety plan.

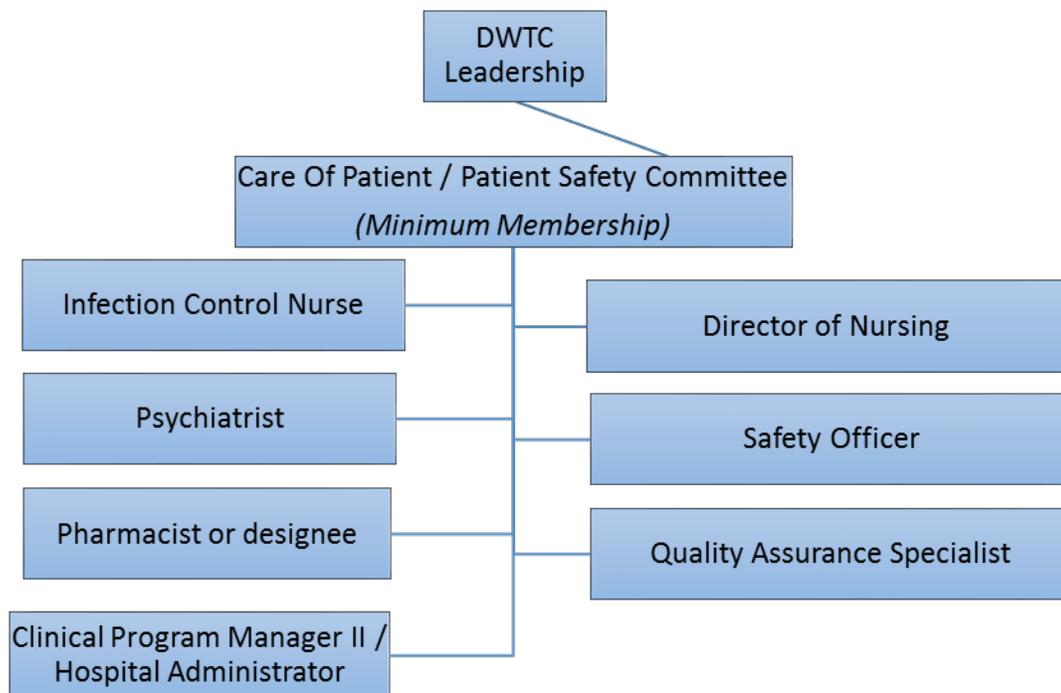
The plan focuses on the process rather than the individual, and recognizes both internal and external customers, as well as facilitates the need of analyzing and improving processes. The core principles of this plan include:

- All staff have the same goal and contribute their knowledge, vision, skill, and insight to improve the process of the Patient Safety Plan.
- Decisions will be based on data and facts, and staff will be encouraged to learn from the experiences.
- Customer based including patients, families, and visitors.
- Promote systems thinking.
- Employ well-trained and competent staff maintaining high healthcare quality.

Roles and Responsibilities

According to [NRS 439.875](#), a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plan is promoted and executed successfully. Desert Willow Treatment Center's Care of Patient Committee serves as the Patient Safety Committee.

The Patient Safety Committee Organization



Roles and Responsibilities

- In accordance with [NRS 439.875](#), a patient safety committee must be comprised of:
- The infection control officer of the medical facility;
- The patient safety officer of the medical facility, if he or she is not designated as the infection control officer;
- At least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility; and
- One member of the executive or governing body of the medical facility.

Patient Safety Committee Responsibilities (based on [NRS 439.875](#) and [NRS 439.877](#))

- Monitor and document the effectiveness of the patient identification policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the patient safety officer pursuant to [NRS 439.870](#).
- Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred.
- Review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- Review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- Make recommendations to Leadership to reduce the number and severity of sentinel events and infections that occur.
- At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the executive or governing body of the facility regarding:
 - (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);
 - (2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and
 - (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

Root Cause Analysis (RCA) Team

A Root Cause Analysis Team will be established following a Sentinel Event or any other event determined by Leadership as requiring a Root Cause Analysis.

Root Cause Analysis (RCA) Team Responsibilities

- Root Cause interviews, analysis, investigation, and corrective action plan implementations.

- Participates in the RCA meetings and discussions.
- Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders.

RCA Team Membership:

- DCFS Administrator will identify a Root Cause Analysis team leader who is not a current employee of Desert Willow Treatment Center
 - RCA team leader Responsibilities:
 - Organize and coordinate the RCA process.
 - Assemble and encourage a supportive and proactive team.
 - Assign investigative and implementation tasks to the team members.
 - Conduct and be actively involved in the investigation, RCA, and corrective action plan implementation process.
 - Desert Willow Treatment Center Quality Assurance Specialist
 - Desert Willow Treatment Center Safety Officer or designee
 - Representation from the following disciplines within Desert Willow Treatment Center
 - Psychiatric Nurse
 - Mental Health Technician
 - Clinical Staff
 - Depending on the event other disciplines may be required
 - DCFS Administrator, Deputy Administrator or Clinical Program Manager II may request additional representation from other agencies, disciplines or programs

Patient Safety Officer Responsibilities (based on [NRS 439.870](#))

- Serve on the patient safety committee.
- Supervise the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the patient safety committee regarding any action taken in accordance with the responsibilities above.
- Serve as chairperson of the Environment of Care Committee

Infection Control Officer Responsibilities (based on [NRS 439.873](#))

- Serve on the patient safety committee.
- Monitor the occurrences of infections at the facility to determine the number and severity of infections.
- Report to the patient safety committee concerning the number and severity of infections at the facility.
- Take such action as determines is necessary to prevent and control infections alleged to have occurred at the facility.

- Carry out the provisions of the infection control program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program.
- Communicate the progress of any infection control investigations, institutional barriers, and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.
- Provide training, education and direction to create RCA process for infection control that incorporates the Patient Safety and Quality Improvement elements.

Executive or Governing Body Staff Responsibilities (Clinical Program Manager II / Hospital Administrator)

- Provide vision and leadership to Patient Safety and Quality Improvement process, and develop and foster a safe learning and improving culture.
- Provides oversight to the healthcare quality improvement processes and teams.
- Plan, discuss, and generate the organization patient safety goals and activities, in conjunction with the patient safety action plans

The Patient Safety Committee/ Care of Patient Team will meet monthly to accomplish the following:

- Report and discuss sentinel events which include:
 - Number of sentinel events from previous calendar month (or quarter).
 - Number of severe infections that occurred in the facility.
- Corrective Action Plan for the sentinel events and infections
 - Evaluate the corrective action plan.
- Patient safety policies and checklists
 - At least annually evaluate Patient Safety policies and checklists
 - Monitor and document the effectiveness of the patient safety policy.
 - Revise the patient safety policies and checklists as needed.
- A meeting agenda and minutes noting follow-up tasks will be kept.

A RCA meeting will meet as needed to accomplish the following:

- Define the healthcare issues or potential risks.
- Conduct Root Cause Analysis
 - Reviewing and analyzing the data.
 - Reviewing the RCA process and quality improvement related activities and timelines.
 - Brainstorming issues or the potential risks by using the fishbone diagrams.
 - Identify the contributing factors and conduct the Root Cause Analysis.
- Conduct Corrective Action Plan
 - Identifying the Plan-Do-Study-Act (PDSA) topics.
 - Discussing corrective action process and activities.
 - Discussing and presenting possible changes in procedure to improve areas indicated.
 - Identifying strengths and areas that need improvement.
 - Developing strategies, solutions, and steps to take next.
- Identify barriers and technical assistance needs for supporting the RCA efforts.

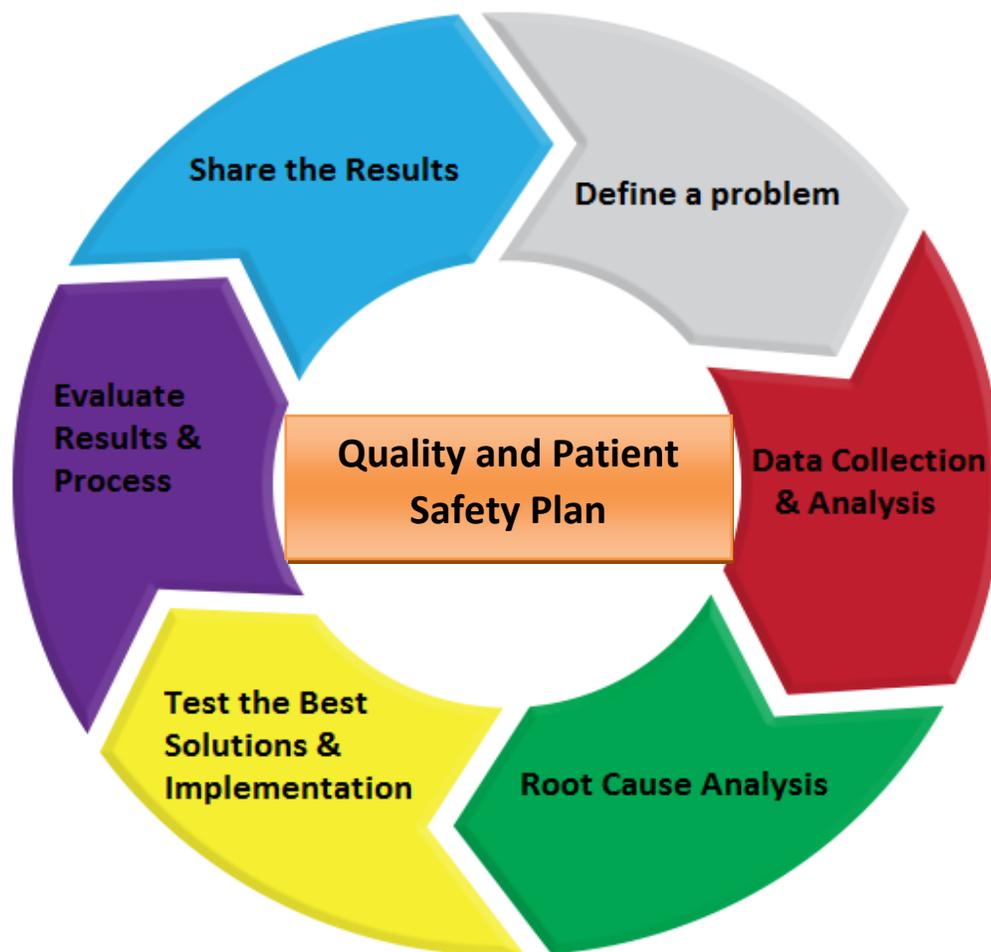
Objectives and Goals of the Quality and Patient Safety Plan

- National Patient Safety Goals guide the service delivery process.
 - Identify Patients Correctly. Use at least two identifiers when providing care, treatment or services. Label specimen containers in the presence of the patient.
 - Use Medications Safely. Maintain and communicate accurate medication information through medication reconciliation. Provide the patient and guardian with written information on the medication (dose, frequency, route, purpose) the patient should be taking and the importance of giving a list to his/her primary care physician.
 - Reduce the risk of health care-associated infections
 - Identify risks for acquiring and spreading infections
 - Comply with the CDC hand hygiene guidelines. Monitor hand hygiene practices. Set goals and improve compliance with hand hygiene guidelines.
 - Increase staff influenza vaccination rates
 - Annually evaluate the effectiveness of the infection control and surveillance plan
 - Identify Patients at risk for suicide. Conduct a risk assessment that identifies specific characteristics of the patient served and environmental features that may increase or decrease the risk for suicide. Assess the immediate safety needs and most appropriate setting for treatment for each patient. Identify patient safety risks. Identify protective factors that decrease risk of suicide. When an individual at risk for suicide leaves the care of the hospital, provide suicide prevention information (such as a crisis hotline) to the patient and family.
- Sentinel Events
 - Identify and Resolve Safety Risks for Patients including Environmental Factors
 - Root cause analysis will be done if sentinel event occurs
- Medication Management to include but not limited to:
 - Monitoring processes for high alert and look-alike/sound-alike medications
 - Reviewing the storage of medication, including expiration and temperatures
 - Reviewing appropriateness of drug order
 - Monitoring medication effects, adverse medication reactions and medication errors
 - Monitoring management of unused/expired medication
 - Monitoring Food/Drug/Drug interaction
 - Reviewing after hours dispensing and administration of medications
 - Providing medication education and handouts
 - Reconciling medication information
- Nutrition Services
 - Provide balanced meals in compliance with the National School Lunch Program
 - Provide all patients with a working knowledge of the basic principles of nutrition and appropriate exercise while addressing potential dietary issues or medical concerns.
- PBIS
 - Continue to implement, evaluate effectiveness and consistency of PBIS program. Update the program as necessary.

Components and Methods

Pursuant to [NRS 439.837](#), a medical facility shall, upon reporting a sentinel event pursuant to [NRS 439.835](#), conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event.”

Desert Willow Treatment Center will use a RCA process to determine the contributing factors and the underlying reasons for the deficiencies or failures. The Plan-Do-Study (check)-Act (PDSA or PDCA) is the model, which was developed by the Institute of Health Care Improvement that we will use to test the changes.



Root Cause Analysis

A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals.

Before analyzing the root causes, defining problems based on facts and data is essential for successfully

conducting root cause analysis.

Root cause analysis and action plan framework table, which was introduced by the Joint Commission. It contains 24 analysis questions. It guides the organization to the steps in a root cause analysis. Not all the questions apply to all the events or cases. This table can be used individually or with the fishbone diagram.

5 Whys technique will be used in Desert Willow Treatment Center to explore the cause and effect relationship underlay a problem. One can find the root causes by asking “why” no less than five times. This technique can be used individually or as a part of the fishbone diagram. 5 Why’s technique also can be used to drill down the problem and find the root causes.

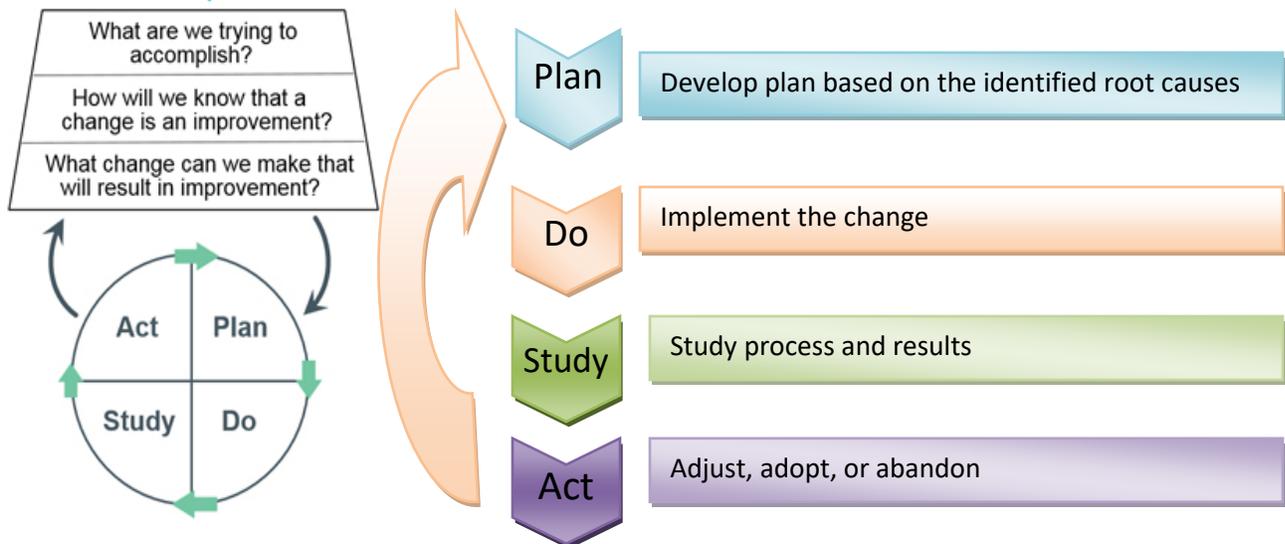
Fishbone Diagram

Once the problems are identified, a Fishbone Diagram (Appendix C) may be used for analyzing the problems. You may use the fishbone diagram individually to analyze the root causes, or use it with the root cause analysis and action plan framework table.

A Fishbone Diagram, also called a Cause-and-Effect diagram, is a useful tool for a team to structurally brainstorm by discovering possible underlying factors or root causes from different major categories for the chosen problems. General categories used include: people, methods, materials, measurements, education, procedures, process, location, environment, etc. RCA team members will brainstorm and ask multiple times, “why did this happen?” for each cause until all ideas are exhausted. The highest priority root causes will be chosen for PDSA topics.

Model for Improvement

The Model for Improvement is a collaborative and ongoing effort model to improve the product and services quality and process. It provides multi-disciplinary quality team guidance from identifying the root causes; conducting the best tests to assess possible changes, and working in collaboration for implementation of the new approaches and solutions. It guides the test of a change to determine if the change is an improvement.



The cycle is defined as follows:

- Plan--collect data and establish appropriate goals. Identify the problem and the possible root causes, and answer the following questions.
 - What is the objective of the test?
 - What are the steps for the test - who, what, when?
 - How will you measure the impact of the test?
 - What is your plan to collect the data needed?
 - What do you predict will happen?

- Do--make changes designed to correct or improve the situation. Use the following questions for the guidance.
 - What were the results of the test?
 - Was the cycle carried out as designed or planned?
 - What did you observe that was unplanned or expected?

- Study -- Study the effect of the changes on the situation. Data should be collected on the new process and compared to the baseline or expected results. Results should be evaluated and by using the following questions as guidance.
 - Did the results match your prediction?
 - What did you learn?
 - What do you need to do next?

- Act--If the result is successful or desirable, standardize the changes and then work on the next prioritized problem or the further improvements. If the outcome is not yet successful, look for different ways to identify the causes or change the testing process.

Data Collection and Reporting

Data should drive any quality and patient safety effort. Desert Willow Treatment Center is using DCFS Incident/ Accident Reports for tracking sentinel events, healthcare infection data, and Microsoft Excel and Access for internal data collection.

Data is submitted to the following external reporting entities:

- BHCQC: Bureau of Health Care Quality and Compliance
- CDC: Centers for Disease Control and Prevention
- CMS: Centers for Medicare & Medicaid Services
- DPBH: Department of Public and Behavioral Health
- Southern Nevada Health District
- State of Nevada Child Death Review Team
- TJC: The Joint Commission
- LCB: Legislative Council Bureau

Ongoing Reporting and Review

Data points such as the following will be reviewed according to the schedule prescribed:

Monthly	Quarterly	Annually
1) Sentinel event monthly report	1) Severity of infection report	1) Quality and Patient Safety Plan update
2) Severity of infection report	2) Review and evaluate the measure of improvement of patient safety	2) Checklists and Policies reviewing and revising
3) RCA assessment	3) Review and evaluate the measurement to prevent and control infections	

Assessment of the Quality and Patient Safety Plan

Quarterly Incident Accident Report including Trigger Identification reported to the Performance Improvement Team and to Leadership

Quarterly Consumer Complaint Report reported to Ethics Rights and Responsibilities Team and to Leadership

Infection Control information reported to Patient Safety Committee/Care of Patient Team and to Leadership

Root Cause Analysis for any Sentinel Event reviewed by all appropriate committees and to Leadership

Corrective Action Plans reviewed by all appropriate committees and Leadership

Patient Safety Checklists and Patient Safety Policies

By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;

- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

The patient safety checklists must follow protocols to improve the health outcomes of patients at the medical facility and must include, without limitation:

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.
- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - Proper instructions concerning prescription medications;
 - Instructions concerning aftercare;
 - Any other instructions concerning his or her care upon discharge; and
 - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include, the name and date of birth of the patient.
- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.
- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

The patient safety checklists are listed in Appendix D.

Approval of Patient Safety Plan

According to [NRS 439.865](#), a medical facility shall submit its patient safety plan to the governing board of the facility for approval. After a facility's patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan.

The patient safety plan must be reviewed and **updated annually** in accordance with the requirements for approval set forth in this section.

According to [NRS 439.843](#), on or before March 1 of each year, a copy of the most current patient safety plan established to [NRS 439.865](#) must be submitted to the Division of Public and Behavioral Health.

Reference

- Root Cause Analysis Toolkit – The Joint Commission
https://www.jointcommission.org/framework_for_conducting_a_root_cause_analysis_and_action_plan/
- Department of Public and Behavioral Health Sentinel Event Reporting
<https://dpbhrdc.nv.gov/redcap/>
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2
https://www.jointcommission.org/sentinel_event.aspx

Appendix A: Terms and Definitions

Patient Safety: The Agency for Healthcare Research Quality (AHRQ) defines patient safety as “a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.”
http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

Sentinel event ([NRS 439.830](#))

1. Except as otherwise provided in subsection 2, “sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum.

2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:

(a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or

(b) July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published.

3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.

(Added to NRS by [2002 Special Session, 13](#); A [2005, 599](#); [2013, 217](#))

Institute for Healthcare Improvement (IHI) defines **medical harm** as “unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death.”

Facility-Associated Infection: ([NRS 439.802](#))

“Facility-acquired infection” means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections;
- Urinary tract infections; and
- Other categories of infections as may be established by the State Board of Health by regulation pursuant to [NRS 439.890](#).

(Added to NRS by [2005, 599](#); A [2009, 553](#))

Medical facility ([NRS 439.805](#))

“Medical facility” means:

- A hospital, as that term is defined in [NRS 449.012](#) and [449.0151](#);
(Added to NRS by [2002 Special Session, 13](#))

Near miss: An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Mandatory reporting: Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985;254(6):796-800.)

Risk: Possibility of loss or injury. (Merriam-Webster's Online Dictionary, Risk, Available at <http://www.merriamwebster.com/dictionary/risk>. Last Accessed August 2009.)

Preventable event: Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Appendix B: National Patient Safety Goals

National Patient Safety Goals 2018

⇒ **Identify Patient Correctly:**

⇒ **NPSG.01.01.01**– Use at least two identifiers (photo and date of birth), to identify each patient when providing care, treatment or services. Label specimen containers in the presence of the patient.

⇒ **Use Medicines Safely: Maintain and communicate accurate medication information for the patient by using proper medication reconciliation to identify and resolve discrepancies**

◆ **NPSG.03.06.01**– Record and pass along accurate information about patient's medicines. Find out what medicines the patient is taking. Compare those medicines to new medicines ordered for the patient to avoid duplications, omissions, interactions and the need to continue current medications. Provide written medication information. Make sure the patient/family knows what medicines to take, dose, frequency, route and purpose prior to being discharged and the importance of giving a list to his/her primary care physician.

⇒ **Prevent Infection: Reduce the risk of health care associated infections**

◆ **NPSG.07.01.01**- Use the hand cleaning guidelines from the CDC to prevent infections. Set goals and improve compliance.

⇒ **Identify Patient Safety Risks: NPSG.15.01.01**– Identify which patients are at risk for suicide and provide suicide prevention information (such as a crisis hotline) to the patient and his or her family. Conduct risk assessments of patients and the environment. Protect patients who are at-risk and keep them safe.

Appendix D: Checklists

Universal Assessments A & B

<S:\DWTC\DWTC FORMS\DWTC 18A Universal Assessment Part A Rev 08-16.doc>

<S:\DWTC\DWTC FORMS\DWTC 18B Universal Assessment Part B Rev 12-08.doc>

Personal Safety Assessment <S:\DWTC\DWTC FORMS\DWTC 163 Personal Safety Assessment 12-17.docx>

Pediatrician History & Physical Examination:

<S:\DWTC\DWTC FORMS\DWTC 19 Pediatrician Admission History and Physical Examination 12-17.docx>

Aftercare Plan Located in Avatar (Electronic Health Record System)

ILSM Assessment Tool <S:\DWTC\DWTC FORMS\DWTC 192 Interim Life Safety Measure Assessment Tool 9-16.docx>

Monitoring Sheet <S:\DWTC\DWTC FORMS\DWTC 31 Patient Monitoring Sheet 6-17.xlsx>

Hygiene Monitoring Form <S:\DWTC\DWTC FORMS\DWTC 183 Hygiene Monitoring form 11-17.docx>

Incident Accident Form <S:\DWTC\DWTC FORMS\DWTC 72 Incident Accident Report 09-11.docx>

Peer Review Forms

<S:\DWTC\DWTC FORMS\DWTC 141C CREDENTIALLED RN PEER REVIEW 09-16.doc>

<S:\DWTC\DWTC FORMS\DWTC 141 - CREDENTIALLED STAFF PEER REVIEW - PSYCHIATRIST 03-09.doc>

Medication Pass Audit <S:\DWTC\DWTC FORMS\DWTC 180 Medication Pass Audit 09-17.docx>

Unit Safety Contraband Checklist <S:\DWTC\DWTC FORMS\DWTC 182 Unit Safety Contraband Checklist 09-16.docx>

Temperature Logs:

<S:\DWTC\DWTC FORMS\DWTC 120 A - Food Refrigerator-Freezer Temperature Log 01-18.doc>

<S:\DWTC\DWTC FORMS\DWTC 120 B - Medication Refrigerator Temperature Log 01-18.doc>

<S:\DWTC\DWTC FORMS\DWTC 120 C - Medication Room Temperature Log 6-17.doc>

Ebola Screening Tool <S:\DWTC\DWTC FORMS\DWTC 184 Ebola Screening Tool 04-16.docx>

Infection Surveillance Report <S:\DWTC\DWTC FORMS\DWTC 73 Infection Surveillance Report 02-17.docx>

Environment of Care Monitors

<S:\DWTC\DWTC Policies & Procedures\DWTC POLICIES\10.0 - ENVIRONMENT OF CARE\10.50 - ENVIRONMENT OF CARE MONITORS 6-16.docx>

Suicide Risk Assessment

[S:\DWTC\DWTC FORMS\DWTC 195A Suicide Risk Assessment & Safety Plan \(Admission\) 11-17.docx](S:\DWTC\DWTC FORMS\DWTC 195A Suicide Risk Assessment & Safety Plan (Admission) 11-17.docx)

[S:\DWTC\DWTC FORMS\DWTC 195B Suicide Risk Assessment \(Weekly\) 11-17.docx](S:\DWTC\DWTC FORMS\DWTC 195B Suicide Risk Assessment (Weekly) 11-17.docx)

[S:\DWTC\DWTC FORMS\DWTC 195C Suicide Risk Assessment & Safety Plan \(Discharge\) 11-17.docx](S:\DWTC\DWTC FORMS\DWTC 195C Suicide Risk Assessment & Safety Plan (Discharge) 11-17.docx)

Appendix E: Related Policies

DWTC Policy 1.19 Risk Management Plan

<S:\DWTC\DWTC Policies & Procedures\DWTC POLICIES\01.0 - ORGANIZATION\1.19 - RISK MANAGEMENT PLAN.doc>

DWTC Policy 4.32 Root Cause Analysis

<S:\DWTC\DWTC Policies & Procedures\DWTC POLICIES\04.0 - QUALITY ASSURANCE\4.32 - ROOT CAUSE ANALYSIS.doc>

DWTC Policy 4.33 Sentinel Events

<S:\DWTC\DWTC Policies & Procedures\DWTC POLICIES\04.0 - QUALITY ASSURANCE\4.33 - SENTINEL EVENTS 6-15.doc>

DWTC Policies included in Chapter 10 - Environment of Care

<S:\DWTC\DWTC Policies & Procedures\DWTC POLICIES\10.0 - ENVIRONMENT OF CARE>

10.01 Guidelines Hepatitis B Vaccine Program	10.53 Security Management Plan
10.02 Influenza Program	10.54 Hazardous Materials and Waste Management Plan
10.03 Occupational Exposure to Bloodborne Pathogens	10.55 Fire Safety Plan (previously Life Safety Management Plan)
10.04 Infection Control of Ice Machine	10.56 Emergency Management Plan
10.05 Health Safety Inspection	10.57 Utility Systems Disruption
10.06 Soiled Linen and Laundry Handling	10.58 Medical Equipment Management Plan
10.07 Interim Life Safety Measures	10.59 Emergency Codes / Public Address System
10.08 Use of Disposable Gloves During Handling of Foods and Fluids	10.60 Distribution of Linens
10.09 Janitor's Closet	10.62 Non-Dairy Beverage Substitutions
10.10 Surveillance, Prevention and Control of Infection Guidelines	10.63 Diets and Food Requisitions
10.11 Personal Protective Equipment	10.64 Meals DWTC
10.12 Housekeeping Procedures for Infection Control	10.66 Nutritional Screening and Assessment
10.13 Work Practice Controls	10.68 Dietetic Services Quality Improvement Plan
10.14 Lice Policy	10.69 Diet Orders
10.15 Hand Washing	10.70 Wellness Policy
10.16 Tuberculosis Screening for Patients	10.73 Nutrition Care Monitoring
10.17 Sanitation and Disinfection	10.74 Nutrition Care Manuals and Menu
10.18 Isolation Techniques	10.75 Nutrition Education
10.19 Nosocomial Detection and Reporting	10.76 Meal Service
10.20 Occupational Illness	10.77 National School Lunch Program
10.21 Infection Control and Surveillance Plan	10.81 Incident-Accident Reporting
10.22 Standard Precautions	10.83 Incidents Involving State Vehicles
10.23 Transmission Based Precautions	10.85 Lockout-Tagout System
10.24 Disinfecting Patients' Recreational Objects	10.86 Employee Lockers
10.25 Emergency Preparedness External Disaster	10.87 Guests of DWTC
10.40 Maintenance Stand-By for After Hours	10.91 911 Emergency Protocol
10.41 Housekeeping/Maintenance	10.92 Building Security
10.42 Maintenance Repair Requests	10.93 Treats / Behavioral Emergencies in the Lobby / Intake Room
10.44 Use of State Vehicles	10.94 Natural Gas Leak
10.46 Non-Smoking/Smoking	10.95 Potentially Dangerous Weapons
10.47 Ordering of Supplies	10.96 Bomb Threats
10.50 Environment of Care Monitors	10.99 Chemical Ingestion by Patient
10.51 Safety Management Plan	10.100 Hostage Situation
10.52 Utility Systems Management Plan	10.101 CCSD / DWTC Evacuation

Facility Name: Parkway Surgery Centers	Policy And Procedure Guideline Name: Safety Management Program (Environment Of Care)	Policy Number: SAFE 104
	Subject Category: SAFETY	Effective Date: 12/01/2016
		Revised Date: 12/14/2017
		Page 1 Of 4 (Update Field)

Policy: The facilities shall provide guidelines and implement proactive practices, which provide a safe environment of care in relation to property, equipment, patients, personnel and the public.

Purpose: The reduction of physical hazards and the implementation of safe practices enhance environmental safety.

Procedure Guidelines:

Responsibility:

1. Employees are responsible for:
 - A. Intervention when, safety conditions pose a threat to life or health, or threaten damage to equipment or buildings.
 - B. The continuing maintenance of the facility property, eliminating hazards upon discovery.
 - C. Reporting equipment or maintenance problems and incidents of property damage to the Safety Officer or Administrator/ Clinical Director upon discovery.
 - D. Reporting injuries and illness to the Administrator/Clinical Director.
 - E. Obtaining the information necessary to perform tasks in a manner that prevents injury to themselves, patients and others.
2. The Administrator/Clinical Director and designated Safety Officer, as agents of the Quality Assurance Committee are responsible for:
 - A. Environment of Care development, implementation and monitoring.

- B. Report of Safety Surveillance and activities to the Quality Assurance Committee.
- C. Annual review of the Environment of Care policies and guidelines for objectives, scope, performance and effectiveness.

Maintenance and Supervision:

1. Comply with the NFPA 101®, Life Safety Code® (LSC) for maintaining and supervising the facility grounds, buildings and equipment.
2. Maintain equipment and utilities following a preventative maintenance schedule.
3. Maintain sufficient light in the parking and entrance areas to reduce the potential for falls and security concerns.
4. Maintain signs and emergency systems to meet the needs of the visual and hearing impaired.
5. Maintain smoke free environment.
6. Provide facility cleaning, maintenance, and inspection, following a schedule for daily, weekly, monthly, semi-annual and annual activities.
7. Construction and Renovation (Interim Life Safety Plan):
 - A. Meet the existing ambulatory health care occupancy health code requirements for construction or renovation.
 - B. Train staff in alternative safety processes including the use of new specialized equipment and space.
 - C. Train staff to compensate for changes in Life Safety Plan.
 - D. Provide increased facility safety monitoring with construction and renovation included reference to the NFPA 101®, Life Safety Code® (LSC).
 - E. Inspect and monitor components of Life Safety Plan weekly or more frequently if indicated.

Risk Assessment:

1. Provide risk assessment and hazard surveillance to evaluate the impact of the center building, grounds, equipment, occupants, and internal physical systems on patient, employee and public safety.
 - A. Assign a Safety Officer to maintain risk and hazard surveillance.
 - B. Record Hazard surveillance.
 - C. Report environmental hazard and safety surveillance to the Quality Assurance Committee. Provide follow-up to staff concerning safety issue recommendations.
2. Report and document patient, personnel or visitor injury, and occupational illness. Document

incidents on a Variance Report, Occurrence Report, or Incident Report.

- A. Investigate and evaluate each report for opportunities to improve performance.
- B. Include injuries and occupational illness in the report to the Quality Assurance Committee.

Product Safety Recalls:

1. Address a product safety recall upon notification.
 - A. Inventory and remove recalled product from possible use.
 - B. Notify affected medical staff and evaluate a substitute product.
 - C. Inventory patients who may have received a recalled medical device from implant logs or records.
 - D. Consult with the Medical Director and/or Quality Assurance Committee to evaluate the situation and determine an appropriate method for patient notification if an implanted medical device has been recalled. The medical director, as an agent of the Quality Assurance Committee reports the incident to the Medical Executive Committee.

Safety Education:

1. Provide Safety Education and Training at orientation and at least annually thereafter. Address general safety processes; area specific safety and job related hazards.
2. Provide Safety Guidelines in the General Orientation including:
 - A. Review of Safety Policies and Guidelines.
 - B. Body Mechanics.
 - C. Hazardous Materials Communication.
 - D. SDS/ Hazardous Waste.
 - E. Safety Risk / Responsibilities.
 - F. Equipment Safety/Operations Manuals.
 - G. Emergency Preparedness.
 - H. Utility Systems and Electrical Safety.
 - I. Infection Control/Exposure OSHA.
 - J. Reporting of Sentinel Events.

- K. Variance, accidents/injuries, Security and Safety concerns.
 - L. Fire and Life Safety.
 - M. Safety Concerns.
 - N. Security.
 - O. OSHA.
3. Include specific safety standards related to safe practices and the safe use, inspection, cleaning and maintenance of specialized equipment in the Department /Job Specific orientation.
 4. Provide updates when new equipment is introduced.
 5. Review General Safety Guidelines annually.

Reference:

Center for Medicare and Medicaid Services (July, 2011). Standard Operations Manual Appendix L – Guidance for Surveyors: Ambulatory Surgery.

The Joint Commission. (2011) Accreditation Standards and Requirements for Ambulatory Surgery Centers

The Accreditation Association for Ambulatory Care. (2011). Accreditation Handbook.

PATIENT SAFETY PLAN

- I. The Patient Safety Committee of Quail Surgical and Pain Management Center has developed this Patient Safety Plan designed to ensure the health and safety of all patients treated at the Center. The Center Administrator and the Management Committee have designated the Operating Room Charge Nurse to serve as Patient Safety Officer. Activities involved in the Patient Safety Plan will be overseen and reported to the Patient Care Committee, the Clinical Review Committee and, ultimately, the Management Committee. The plan encompasses all aspects of patient care, including but not limited to:
 1. Building Security
 - a. Video surveillance to monitor access and the parking lot/grounds
 - b. Door security with coded building entry
 - c. Medical gases and vacuum pump lock-secured
 2. Medication Safety
 - a. Storage
 - b. Administration
 - c. Identification
 - d. Monitoring compliance
 3. Patient Transport
 - a. Gurneys, chairs, cribs, ambulating
 - b. Number of personnel
 4. Patient Positioning
 - a. Number of staff
 - b. Positioning devices
 - c. Recommended practices
 5. Infection Prevention
 - a. See Infection Control Plan
 6. Medical Equipment Safety
 - a. Preventative maintenance
 - b. Proper inservicing
 - c. Safety checks
 - d. Electrical equipment
 - e. Electrosurgical and Laser safety

- f. Radiology safety
 - g. Biomedical checks for new equipment and at scheduled intervals
- 7. Procedure Consents
 - a. Accuracy monitored
- 8. Emergency Management (Code, Fire, Transfer & Disaster Plans)
 - a. Medical emergency equipment, supplies, and medications available
 - b. Clinical alarm systems maintained
 - c. Staff competency maintained (education & drills)
 - d. Emergency power source maintained
 - e. Fire drills
 - f. See disaster plans
- 9. Patient Education
 - a. Pre-admissions instructions, testing, education
 - b. Post-operative discharge instructions
- 10. Protection of Patient Health Information
 - a. Privacy
 - b. IT information protection
 - c. "Red Flag" policy and staff training
- 11. Physical Plant Environment
 - a. Environmental controls monitored and maintained
 - b. Facility Safety Officer observations and reports
 - c. Consistent maintenance of the facility (floors, walls, etc)
- 12. Healthcare Personnel Competency
 - a. Orientation and training
 - b. Continuing education programs
 - c. Peer review, supervisory review, performance evaluations, competency reviews, credentialing criteria
- 13. Anesthesia Care
 - a. Equipment safety
 - b. Anesthesia gases
 - c. Competency/Peer review
- 14. Surgical Counts
 - a. Policy and procedure reviews
- 15. Sharps Handling
 - a. Safe sharps containers in patient care areas for disposal
 - b. Exposure Control Program

- II. **The Patient Safety Officer:**
 - a. Chairs the Patient Safety Committee
 - b. Maintains documents and minutes of the Patient Safety Committee
 - c. Supervises the reporting of Sentinel Events to the State and maintains documentation
 - d. Assists in the investigation and analysis of any alleged sentinel event
 - e. Coordinates and conducts a risk assessment for the identification of potential patient safety hazards at least annually
 - f. Works with the Patient Safety Committee to determine resolutions to safety hazards identified in the risk assessment
 - g. Reports all actions of the Patient Safety Officer to the Patient Safety Committee

- III. **The Patient Safety Committee** is established to review, evaluate and recommend measures and actions designed to improve the safety of all patients receiving care at the Surgery Center. Committee members will also evaluate the actions and reports of the Patient Safety Officer regarding sentinel events and near-misses.
 - a. Multidisciplinary membership to include:
 - 1. Patient Safety Officer
 - 2. Administrator
 - 3. Director of Nursing
 - 4. Medical Director
 - 5. PACU Charge Nurse
 - 6. RN Pharmaceutical coordinator/Contracted Pharmacist
 - 7. Facility Safety Officer
 - 8. Ad Hoc members as appropriate (Materials Manager, Sterile Processing Technician, Surgical Technologist, Radiology Technologist, Orderly)Members serve indefinitely.
 - b. The committee generally meets monthly or in response to events or occurrences.
 - c. The committee reports activities and makes recommendations to the Patient Care Committee, the Clinical Review Committee and the Management Committee

- IV. The patient safety plan and policies and procedures regarding patient safety are reviewed and approved annually by the Management Committee. These policies are based on state and local regulations and AORN's Recommended Practices. Policies are reviewed by staff upon hire and on a continual basis throughout the year.
- V. Patient safety is routinely included in Quality Improvement activities.
- VI. Surgery Center staff will initially review the Patient Safety Plan following approval of this plan by the Management Committee. All staff members will subsequently conduct an annual review of the plan. Signature sheets to indicate staff review will be maintained in the Inservice binder.
- VII. Medical staff and Allied Health personnel will be notified of the plan through written postings throughout the Center. Copies of the plan will be readily available for review.
- VIII. Compliance with the Patient Safety Plan will be monitored by Patient Safety Committee Members and reported to the Center Administration.

The Patient Safety Plan was reviewed and recommended for approval by the Clinical Review Committee on 3/8/2011. It was approved by the Management Committee on 3/29/2011.



Patient Safety Plan

2017

This plan was created and revised by the Renown Health's Patient Safety Committee. Implementation of this plan is intended to optimize the healthcare quality and patient safety outcomes. In addition the plan is intended to encourage recognition, reporting, and acknowledgment of risks to patients, visitors, and employees as well as reduce medical/healthcare errors and /or preventable events.

Patient Safety Plan

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Commitment to Patient Safety

Renown Health is committed to a comprehensive approach to improving healthcare quality and patient safety by aligning with our Mission, Vision, and Values, creating an environment that supports a dynamic, proactive, and safe culture for patients, family members, visitors, and employees, through continuous learning and improving patient safety policies, systems, and processes.

Mission, Vision, and Values

In support of our mission, vision, and values, Renown Health's Patient Safety program promotes:

- Collaboration of healthcare, leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high quality healthcare.
- Honest, open communication to foster trusting and cooperative relationships among healthcare providers, staff members, and patients and their families, to ensure accountability for the patient safety priorities.
- Preservation of dignity and values for each patient, family member, employee, and other healthcare providers.
- Responsibility for safety related decision and action.
- A focus on continuous learning and improving, system design, and the management of choices and changes, bringing the best possible patient outcomes.
- Incorporation of evidence-based safety practice guidelines to deliver high quality healthcare.
- Education of staff, physicians, patients and their families to promote patient safety and continuous quality improvement.

Scope and Purpose

This Patient Safety Plan applies across the entire Renown Health organization.

All staff and physicians in Renown Health are required to fully support and participate in this plan, and devote their expertise to the patient safety and healthcare performance improvement process.

This plan is action oriented and solution focused. The purpose of this plan is to address patient safety related concerns, challenges and revise the program to better serve patients and their families.

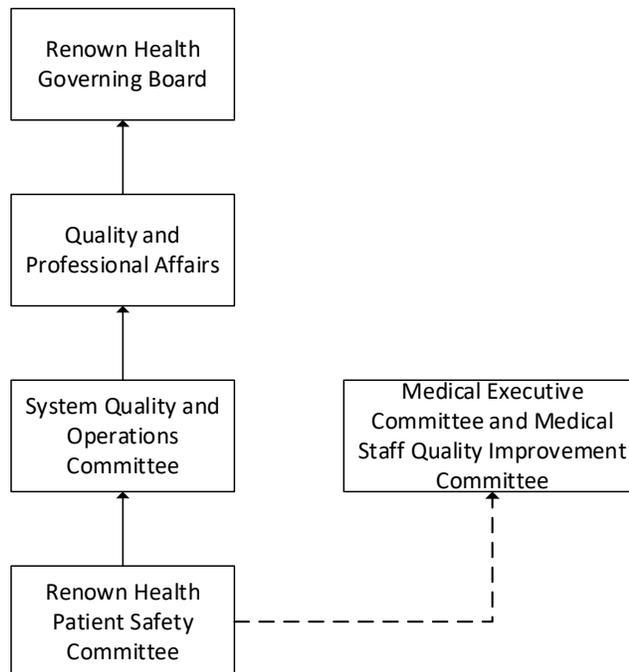
The plan focuses on the process rather than the individual, and recognizes both internal and external customers, as well as facilitates the need of analyzing and improving processes. The core principles of this plan include:

- Staff and physicians contributing their knowledge, vision, skill, and insight to improve the processes of patient safety
- Decisions made based on data and facts, with patient safety being considered
- Customer-focus including patients, families, and visitors
- System-based thinking
- Utilization of trained, expert staff and physicians.

Roles and Responsibilities

The Renown Health Patient Safety Committee ensures that the Patient Safety Plan is promoted and executed successfully as indicated in NRS439.875.

The Patient Safety Committee Organization



Roles and Responsibilities

- In accordance with [NRS 439.875](#), the Renown Health Patient Safety Committee is comprised of:
- The Renown Health Infection Control Officer;
- The Renown Health Patient Safety Officer;
- At least three providers of healthcare who treat patients, including at least one member of the medical, nursing and pharmaceutical staff of the medical organization; and
- One member of the executive or governing body of the medical organization;
- A representative from Executive Leadership.

Patient Safety Committee Responsibilities (based on [NRS 439.875](#) and [NRS 439.877](#))

- Monitor and document the effectiveness of the patient identification policy through event review when applicable.

- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the patient safety officer pursuant to [NRS 439.870](#).
- Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred.
- Review and evaluate the quality of measures carried out by the organization to improve the safety of patients.
- Review and evaluate the quality of measures carried out by the organization to prevent and control infections.
- Make recommendations to the executive or governing body of the organization to reduce the number and severity of sentinel events and infections.
- At least once each calendar quarter, report to the executive or governing body of the organization regarding:
 - (1) The number of sentinel events that occurred;
 - (2) The number and severity of infections that occurred; and
 - (3) Any recommendations to reduce the number and severity of sentinel events and infections.
- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

Patient Safety Officer Responsibilities (based on [NRS 439.870](#))

- Serve on the Renown Health Patient Safety Committee.
- Supervise the reporting of all sentinel events alleged to have occurred, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred.
- Report to the patient safety committee directly or through his/her designee any action taken in accordance with the responsibilities above.

Infection Control Officer Responsibilities (based on [NRS 439.873](#))

- Serve on the Renown Health Patient Safety Committee.
- Monitor the occurrences of infections to determine the number and severity of infections.
- Report to the patient safety committee concerning the number and severity of infections either directly or through his/her designee.
- Take such action as determines is necessary to prevent and control infections alleged to have occurred.
- Carry out the provisions of the infection control program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program.

Quality and Professional Affairs Committee of the Renown Health Board

- Provide vision and leadership to Patient Safety process, and develop and foster a safe learning and improving culture.
- Ensures the priorities of patient safety are aligned with the strategic priorities of the health system.

The Patient Safety Committee will meet monthly to accomplish the following:

- Report and discuss sentinel events and hospital acquired infections including:

- Number of sentinel events from previous calendar month
- Number of hospital acquired infections that occurred in the organization
- Corrective action plans for the sentinel events and infections.
- Patient safety policies and checklists
 - At least annually evaluate Patient Safety policies and checklists
 - Revise the patient safety policies and checklists as needed
 - Monitor and document the effectiveness of patient safety policies.

A meeting agenda and minutes noting follow-up tasks will be kept.

Components and Methods

Pursuant to [NRS 439.837](#), a medical facility shall, upon reporting a sentinel event pursuant to [NRS 439.835](#), conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event.”

Root Cause Analysis

Renown Health will use Root Cause Analysis (RCA) to determine the contributing factors and the underlying reasons for the deficiencies or failures. Transformational Health Care principles and methods are incorporated into Renown Health’s RCA process.

An RCA is a process for identifying the root causes of problems. It follows the principles of Just Culture by focusing on processes, instead of individuals.

Root Cause Analysis (RCA) Team Responsibilities

RCAs are conducted for all identified sentinel events and significant events/near misses involving complex process failure. Results of significant RCAs will be reported and monitored by the Renown Health Patient Safety Committee.

- Root Cause interviews, analysis, investigation, and corrective action plan implementations
- Participates in the RCA meetings and discussions
- Communicate honestly and openly about data and facts to the team members and their supervisors/leaders
- Incorporates the principles of Just Culture in the RCA process.

Causal Chain (5 Whys) technique will be used in Renown Health to explore the cause and effect relationship underlay a problem. One can find the root causes by asking “why” repeatedly.

Data Collection and Reporting

Data drives quality and patient safety efforts. Renown Health uses Midas and other databases for tracking sentinel events, healthcare infections, and other patient safety related data.

External data sources are those data sources which are collected outside the supervisory structure of the case. External data which will be utilized for Patient Safety plan include the data from:

Renown Health Patient Safety Plan

- AHRQ: Agency for Healthcare Research & Quality
- CDC: Centers for Disease Control and Prevention
- CMS: Centers for Medicare & Medicaid Services
- NQF: National Quality Forum
- NHSN: National Healthcare Safety Network
- TJC: The Joint Commission

Patient Safety Checklists and Patient Safety Policies

By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the organization;
- Other personnel who provide treatment or assistance to patients;
- Employees who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the organization; and
- Persons with whom the organization enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

The Renown Health Patient Safety Committee reviews and approves annually patient safety checklists based on policy.

Based on [NRS 439.865](#), the patient safety plan must also include an infection control program that carries out the infection control policy. The policy must consist of:

- The current guidelines appropriate for the scope of service developed by a nationally recognized infection control organization as approved by the State Board of Health which may include, the Association for Professionals in Infection Control and Epidemiology (APIC), the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO) and the Society for Healthcare Epidemiology of America (SHEA); and
- Facility-specific infection control developed under the supervision of a certified Infection Preventionist.

The Renown Health Infection Prevention Plan and Program is established and approved by the Renown Health Infection Control Committee. Regular reports and updates regarding the Infection Prevention Program are provided to the Patient Safety Committee.

Approval of Patient Safety Plan

The Renown Health Patient Safety Plan is reviewed and updated annually and is approved by the Quality and Professional Affairs Committee of the Renown Health Board.

According to [NRS 439.843](#), on or before March 1 of each year, a copy of the most current patient safety plan established to [NRS 439.865](#) must be submitted to the Division of Public and Behavioral Health.



PATIENT SAFETY PLAN

2018

Effective: February 2005 (combines Organization Safety and Patient Safety Plans)
Revised: October, 2005
Revised: December, 2006
Revised: December, 2007
Revised: January, 2009
Revised: January, 2010
Revised: January, 2011
Revised: January, 2012
Revised: February, 2014
Revised: November 2014
Revised: November 2015
Revised: December 2016
Revised: December 2017

INTRODUCTION

Carson Tahoe Regional Healthcare/ Regional Medical Center is a part of Carson Tahoe Health System, a Nevada not-for-profit hospital. We are committed to patient safety, quality patient care and quality patient outcomes consistent with our Mission and Core Values.

MISSION

To enhance the health and well being of the communities we serve.

CORE VALUES

Putting patients first

Treating everyone with dignity and respect.

PURPOSE

The Patient Safety Plan provides a planned, systematic, coordinated approach for continually improving the health and safety of patients who are treated at the medical facility, by reducing patient harm and maintaining a safety culture.

PLAN

- Establish Patient Safety Committee:
 - Mandatory 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
 - Additional non required members include: Quality Director, Chief Medical Officer, In-House Council, Environmental Safety Officer, Nursing Director.
 - Ad-Hoc invitees as appropriate
 - Committee required to meet at least once per month
- Inclusion of
 - Infection Control Program to prevent and control infections within the medical facility (this is a document separate from the Patient Safety Plan that meets the requirements for NRS 439.865)
 - Patient Safety checklists and patient safety policies as required by NRS. 439.877
 - 2018 Checklist Inventory *Attachment A*
 - Annual review and revision of checklists and policies
- Annual Report to Legislative Committee on Health Care
- Integration of all patient safety activities both ongoing and developing
- Ongoing orientation, education and training to emphasize specific job related aspects of patient safety to maintain and improve staff awareness

- Encourage internal reporting of medical / healthcare incidents and events, effectively respond to actual occurrences, manage occurrences and events with a non-punitive approach, and focus on processes and systems to minimize individual blame and retribution
- Periodic survey of the staff regarding willingness to report, actions taken and outcomes of occurrences and events
- Internal reporting of findings, actions taken and resolution; organizational learning and communication of occurrence and event information
- Consideration of patient safety priorities when designing and redesigning of relevant processes, functions and services

Involvement and education of patients, their families about their role in facilitating safe delivery of care, identifying potential risks and suggesting improvement to patient safety

SCOPE OF ACTIVITIES

The Patient Safety Committee integrates all components of safety into the organization-wide safety program in collaboration with Quality, Environmental Safety, Infection Control, Patient Care areas, Risk Management, Compliance and Ethics.

Patient Safety Committee activities include:

- Sentinel Events pursuant to NRS Chapter 439
 - Review alleged events reported to State of Nevada, RCA investigations and resulting action plans.
 - Recommendations, as appropriate, to the executive or governing body for reducing the number and severity of sentinel events and infections that occur
 - Provide emotional support for staff involved in incidents or events, through Human Resources, leadership, department supervisors and other resources as appropriate
 - Report at least quarterly to the executive or governing body
 - The number of sentinel events occurring in the previous quarter
 - The number/severity of infections occurring in the previous quarter
- Quality Measures: Review and evaluate
 - To improve the patient safety and outcomes
 - To reduce and/or prevent infections
- Monitor patient/ environment safety issues identified throughout the organization
- Promote internal and external knowledge and experience to prevent patient harm, adverse events and occurrences, to maintain and improve patient safety
- Dashboard Trending Report: Review aggregated or trended data including but not limited to: No harm events, Mild or moderate adverse outcomes, Near miss, Medication events, Falls, Adverse drug reactions, Transfusion reactions, Hazardous conditions, Present on admission / Hospital acquired conditions, Online incident reports, adding Restraint indicators for 2018
- Utilize a proactive approach to recognize and acknowledge medical/healthcare events and risks to patient safety, initiate actions and recommendations to reduce or prevent these events and risks
- Prioritize and recommend Patient Safety activities, as appropriate.
 - Utilizing trended data from Environmental safety, Security, Employee

health, Emergency management, Lab or radiation safety, Utilities management, Bio Med, Fire drills or inspections.

PATIENT SAFETY OFFICER

The Patient Safety Officer is designated by the medical facility and has administrative responsibilities as prescribed by NRS chapter 439 (specifically outlined in NRS 439.815 through NRS.439.875) and by other regulatory agencies and accrediting bodies. Duties and responsibilities include but are not limited to:

- Serving 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.

Attachment A

Carson Tahoe Regional Medical Center 2018- Checklist Inventory			
	Checklist title	Checklist Category	DEPT
2	Discharge Checklist for patient	Discharge	BHS
4	Discharge Checklist for Nursing	Discharge	BHS
5	Fire Drill Participation	Environment	Housewide - Security
6	Fire Report	Environment	Security
7	Fire Watch Form	Environment	Security
8	Life (Fire) Safety Inspection / Business Occupancy	Environment	Security
9	Life (Fire) Safety Inspection /Healthcare Occupancy	Environment	Security
Patient Room Housekeeping Checklist by area /by shift			
10	Form 100 Lead/Admin	Environment	Housekeeping
11	Form 101 Med Onc B / Rehab Telemetry	Environment	Housekeeping
12	Form 102 Med Onc A & Pharmacy	Environment	Housekeeping
13	Form 103 Tele & Therapy Med Onc B Therapy Gym	Environment	Housekeeping
14	Form 104 OB / Peds	Environment	Housekeeping
15	Form 105 Surg Ortho	Environment	Housekeeping
16	Form 106 ICU/CVU	Environment	Housekeeping
17	Form 107 ER /OBS / Fast track Days	Environment	Housekeeping
18	Form 108 OR days	Environment	Housekeeping
19	Form 109 Cath Lab /Outpatient Days	Environment	Housekeeping
20	Form 110 Areas to "police" Public Area	Environment	Housekeeping
21	Form 111 Waste Management Days	Environment	Housekeeping
22	Form 112 BHS Check Sheet	Environment	Housekeeping
23	Form 113 Senior Pathways & BHS Outpatient BHS "C" unit	Environment	Housekeeping
24	Form 114 Projects / Floor Care Floor Care / Police	Environment	Housekeeping
25	Form 200 Lead	Environment	Housekeeping
27	Form 202 Tele / OB Swing	Environment	Housekeeping
28	Form 203 Surg Ortho Swing Swing Surg/Ortho CVU and ICU	Environment	Housekeeping
29	Form 204 ICU / CVU Swing	Environment	Housekeeping
30	Form 205 ER / OBS Fast track Swing	Environment	Housekeeping
31	Form 206 OR Swing	Environment	Housekeeping
32	Form 207 X ray / Cath / Outpatient Swing Cath Lab/Xray Outpatient	Environment	Housekeeping

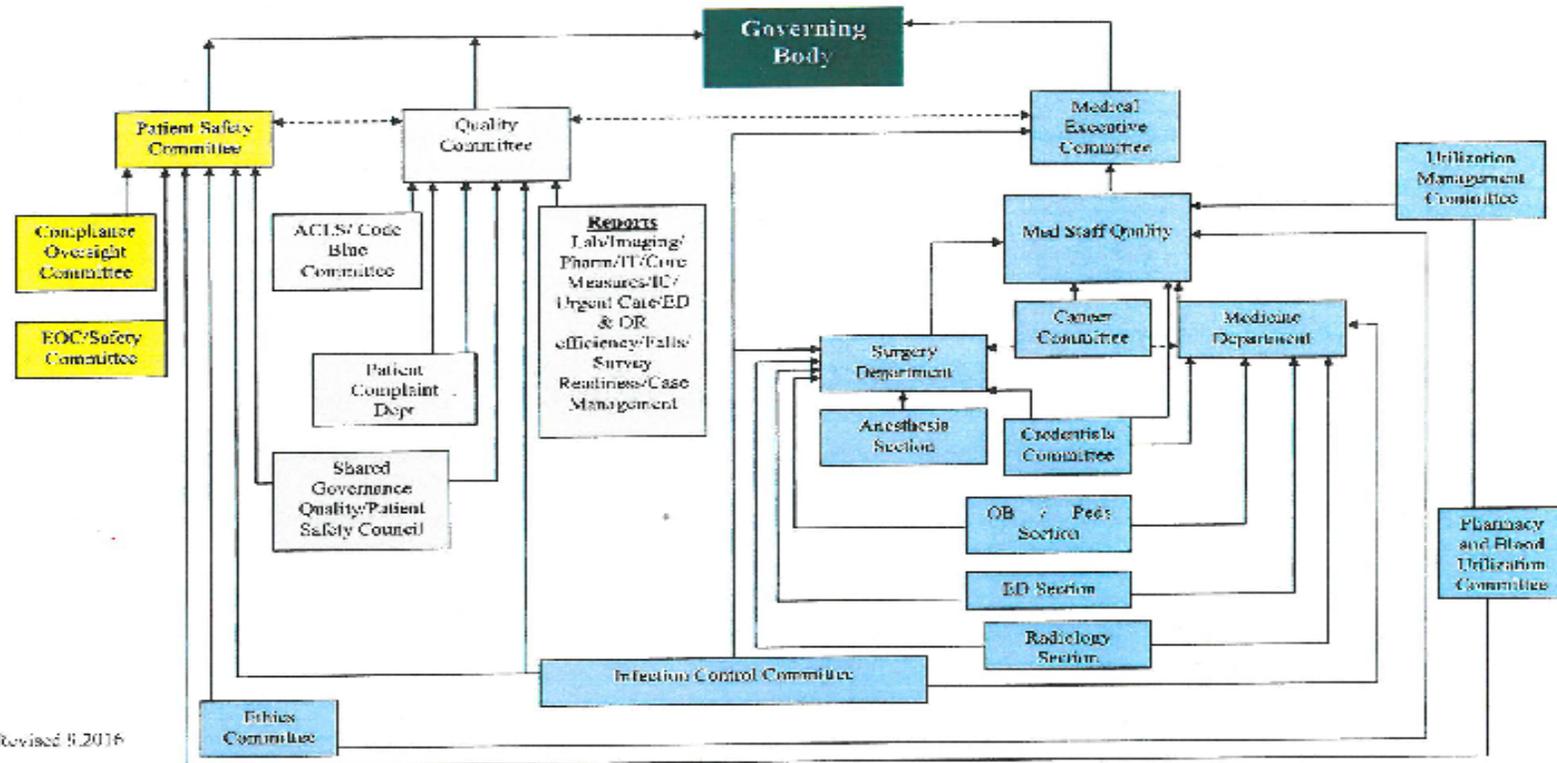
Carson Tahoe Regional Medical Center 2018- Checklist Inventory			
33	Form 208 Waste Management Swing	Environment	Housekeeping
34	Form 209 SMC First floor	Environment	Housekeeping
35	Form 210 Cancer / Merriner	Environment	Housekeeping
36	Form 211 Minden check list	Environment	Housekeeping
37	Form 212 Mica Surgery / Pain Clinic	Environment	Housekeeping
38	Form 213 Projects / Floor Care	Environment	Housekeeping
39	Form 214 Projects / Floor Care	Environment	Housekeeping
40	Form 215 Projects / Floor Care	Environment	Housekeeping
41	Form 216 Lab / Offices Swing	Environment	Housekeeping
42	Form 301 ER / OBS / Fast track Grave	Environment	Housekeeping
43	Form 302 OR Grave	Environment	Housekeeping
44	Form 303 Projects / floor Care Basement / Discharges/OR	Environment	Housekeeping
45	Quality Assurance Checklist	Environment	Housekeeping
46	Pediatric Unit Department Checklist	Environment	PEDS
CRASH CARTS			
47	Adult Crash Cart Check List	Other Safety	Housewide
48	New born Nursery Crash Cart Checklist	Other Safety	Housewide
49	OB hemorrhage Cart Checklist	Other Safety	Women's / Children
50	Pediatric Crash Cart Checklist	Other Safety	Women's / Children
51	OB Recovery Room Red Cart	Other Safety	Women's / Children
52	Obstetrics OR checklist	Other Safety	Women's / Children
53	3M Steam Flash Sterilization Log	Other Safety	Housewide
54	AED Checklist	Other Safety	Housewide
55	Breast Milk Refrigerator Temperature Log	Other Safety	Women's / Children
56	Refrigerator / Freezer Temperature Record	Other Safety	Housewide
59	List & Process Monitor Documentation System	Other Safety	GBI
60	Nevada State Immunization Program Temperature Log	Other Safety	Women's / Children
61	Nursery Blanket Warmer Temperature Log	Other Safety	Women's / Children
63	Obstetrics OR Checklist	Other Safety	Women's / Children

Carson Tahoe Regional Medical Center 2018- Checklist Inventory			
64	OR / RR Blanket Warmer Temperature Log Top Compartment	Other Safety	Housewide
65	Ticket to Ride	Other Safety	Housewide
66	Ventilator Calibration Checklist	Other Safety	Respiratory
67	Admission Checklist Nurse and Tech/Unit Clerk	Other Safety	BHS
68	BHS Unit Safety Rounds Worksheet	Other Safety	Housewide
69	Central Line Associated Blood Stream infection and CAUTI surveillance	Other Safety	Infection Control
69a	CAUTI Bundle Audit data collection	Other Safety	Infection Control
70	Emergency Equipment checklist	Other Safety	ICU
71	Urgent Heart Chart Daily checklist	Other Safety	ICU
72	Hand Hygiene Compliance monitoring	Other Safety	Infection Control
72a	Hand Hygiene Compliance monitoring		
73	Infection control Monitoring during construction	Other Safety	Infection Control
74	Patient Observation Checklist	Other Safety	Security
76	AMA Intervention checklist	Other Safety	BHS
76a	AMA bullet point		
79	Shift Checklist for Nursing staff	Other Safety	BHS
80	Chemotherapy Administration check list	Other Safety	Med Onc
81	Pre-Op/Circ./PACU - Chart Deficiency Check list	Treatment	Surgical areas
82	Hand Off Communication sheet Pre-op/OR/PACU	Treatment	Surgical areas
87	Magnetic Resonance Imaging History & Assessment	Treatment	Medical Imaging
88	Medical Imaging Invasive Procedure Checklist	Treatment	Medical Imaging
88a	Medical Imaging Invasive Procedure Checklist GBI		
89	Non Ionic and/or Ionic Contrast Consent Form	Treatment	Medical Imaging
91	Pre Cath / Vascular Lab Checklist	Treatment	Cath Lab
92	Pre-Op Education	Treatment	Mica Surgery

Carson Tahoe Regional Medical Center 2018- Checklist Inventory			
93	PsychoSocial Treatment Plan tracking form	Treatment	BHS
94	Sharp Contraband Tracking Form	Treatment	BHS
95	Surgical Checklist (part of Medical record)	Treatment	Surgical areas
96	Universal Protocol Checklist / Handoff communication	Treatment	Surgical areas not SSH
97	Universal Protocol Checklist for Injection Procedures	Treatment	Surgical areas not SSH
98	Foley Catheter Tracking	Treatment	Infection control
New forms added to checklist			
100	Pre –Op / Procedural check list (16599 1/18/11)	Other Safety	Surgical area not SSH
101	Carson Tahoe Emergency Department Triage Protocol	Other Safety	Emergency Dept
102	Carson Tahoe Emergency Department Stroke Protocol Physician Guidelines	Other Safety	Emergency Dept
103	HERT Team Leader Checklist	Other Safety	Emergency Mgmt
104	HERT Activation Checklist	Other Safety	Emergency Mgmt
105	HERT Ambulatory & Nonambulatory set up Checklist	Other Safety	Emergency Mgmt
106	Dirty Water Set-Up Checklist	Other Safety	Emergency Mgmt
107	HERT Triage / Morgue Set up Checklist	Other Safety	Emergency Mgmt
108	HERT Tent Set-Up Checklist	Other Safety	Emergency Mgmt
109	HERT Receiving checklist	Other Safety	Emergency Mgmt
110	HERT Dirty Water Set up Checklist	Other Safety	Emergency Mgmt
41a	217 Tele, Med OncA & Pharmacy Swing	Housekeeping	
44a	304 Projects / Floor Care	Housekeeping	
111	Use or Personal Protective Equipment (PPE) for isolation precautions	Other Safety	Infecton control
112	RMC Daily Visual air Pressure Vaneometer Monitoring for Isolations rooms	Other Safety	Infection control
113	Patient Room Safety Inspection	Other Safety	
56a	Refrigerator Temperature Record	Other Safety	
56b	Freezer Temperature Record	Other Safety	

	Carson Tahoe Regional Medical Center 2018- Checklist Inventory		
64a	Blanket Warmer Bottom Compartment	Other Safety	

Carson Tahoe Regional Health Quality Reporting Structure



Revised 9/2016

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Next Review: 01/2018
Owner: [REDACTED] Corporate Chief



Policy Area: A. Patient Rights and Organizational Ethics

References:

Applicability: Acadiana Management Group
AMG Physical Rehabilitation Hospital
Lafayette Physical Rehabilitation Hospital
North Alabama Specialty Hospital

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:

-  AMG Healthcare Failure Modes and Effects Analysis-FMEA- Intro.doc
-  ROOT CAUSE ANALYSIS AND ACTION PLAN FRAMEWORK TEMPLATE.docx

Approval Signatures

Approver	Date
[REDACTED]	01/2017
[REDACTED]	01/2017
[REDACTED]	12/2016



ROOT CAUSE ANALYSIS AND ACTION PLAN FRAMEWORK TEMPLATE

The Joint Commission Root Cause Analysis and Action Plan tool has 24 analysis questions. The following framework is intended to provide a template for answering the analysis questions and aid organizing the steps in a root cause analysis. All possibilities and questions should be fully considered in seeking “root cause(s)” and opportunities for risk reduction. Not all questions will apply in every case and there may be findings that emerge during the course of the analysis. Be sure however to enter a response in the “Root Cause Analysis Findings” field for each question #. For each finding continue to ask “Why?” and drill down further to uncover why parts of the process occurred or didn’t occur when they should have. Significant findings that are not identified as root causes themselves have “roots”.

As an aid to avoid “loose ends,” the two columns on the right are provided to be checked off for later reference:

- “Root cause” should be answered “Yes” or “No” for each finding. A root cause is typically a finding related to a process or system that has a potential for redesign to reduce risk. If a particular finding is relevant to the event is not a root cause, be sure that it is addressed later in the analysis with a “Why?” question such as “Why did it contribute to the likelihood of the event?” or “Why did it contribute to the severity of the event?” Each finding that is identified as a root cause should be considered for an action and addressed in the action plan.
- “Plan of action” should be answered “Yes” for any finding that can reasonably be considered for a risk reduction strategy. Each item checked in this column should be addressed later in the action plan.



When did the event occur?

Date:	Day of the week:	Time:
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Detailed Event Description Including Timeline:

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Diagnosis:

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Medications:

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Autopsy Results:

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Past Medical/Psychiatric History:

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#	Analysis Question	Prompts	Root Cause Analysis Findings	Root cause	Plan of Action
1	What was the intended process flow?	<p>List the relevant process steps as defined by the policy, procedure, protocol, or guidelines in effect at the time of the event. You may need to include multiple processes.</p> <p><i>Note:</i> The process steps <i>as they occurred in the event</i> will be entered in the next question. Examples of defined process steps may include, but are not limited to:</p> <ul style="list-style-type: none"> • Site verification protocol • Instrument, sponge, sharps count procedures • Patient identification protocol • Assessment (pain, suicide risk, physical, and psychological) procedures • Fall risk/fall prevention guidelines 			
2	Were there any steps in the process that did not occur as intended?	<p>Explain in detail any deviation from the intended processes listed in Analysis Item #1 above.</p>			
3	What human factors were relevant to the outcome?	<p>Discuss staff-related human performance factors that contributed to the event. Examples may include, but are not limited to:</p> <ul style="list-style-type: none"> • Boredom • Failure to follow established policies/procedures • Fatigue • Inability to focus on task • Inattentional blindness/ confirmation bias • Personal problems • Lack of complex critical thinking skills • Rushing to complete task • Substance abuse • Trust 			
4	How did the equipment performance affect the outcome?	<p>Consider all medical equipment and devices used in the course of patient care, including AED devices, crash carts, suction, oxygen,</p>			



#	Analysis Question	Prompts	Root Cause Analysis Findings	Root cause	Plan of Action
5	What controllable environmental factors directly affected this outcome?	<p>instruments, monitors, infusion equipment, etc. In your discussion, provide information on the following, as applicable:</p> <ul style="list-style-type: none"> • Descriptions of biomedical checks • Availability and condition of equipment • Descriptions of equipment with multiple or removable pieces • Location of equipment and its accessibility to staff and patients • Staff knowledge of or education on equipment, including applicable competencies • Correct calibration, setting, operation of alarms, displays, and controls 			
6	What uncontrollable external factors influenced this outcome?	<p>What environmental factors within the organization's control affected the outcome? Examples may include, but are not limited to:</p> <ul style="list-style-type: none"> • Overhead paging that cannot be heard • Safety or security risks • Risks involving activities of visitors • Lighting or space issues <p>The response to this question may be addressed more globally in Question #17. This response should be specific to this event.</p>			
7	Were there any other factors that directly influenced this outcome?	<p>Identify any factors the organization cannot change that contributed to a breakdown in the internal process, for example natural disasters.</p> <p>List any other factors not yet discussed.</p>			
8	What are the other areas in the organization where this could happen?	<p>List all other areas in which the potential exists for similar circumstances. For example:</p> <ul style="list-style-type: none"> • Inpatient surgery/outpatient surgery 			



#	Analysis Question	Prompts	Root Cause Analysis Findings	Root cause	Plan of Action
9	Was the staff properly qualified and currently competent for their responsibilities at the time of the event?	<ul style="list-style-type: none"> Inpatient psychiatric care/outpatient psychiatric care Identification of other areas within the organization that have the potential to impact patient safety in a similar manner. This information will help drive the scope of your action plan. 	<p>Include information on the following for all staff and providers involved in the event.</p> <p>Comment on the processes in place to ensure staff is competent and qualified. Examples may include but are not limited to:</p> <ul style="list-style-type: none"> Orientation/training Competency assessment (What competencies do the staff have and how do you evaluate them?) Provider and/or staff scope of practice concerns Whether the provider was credentialed and privileged for the care and services he or she rendered The credentialing and privileging policy and procedures Provider and/or staff performance issues 		
10	How did actual staffing compare with ideal levels?		<p>Include ideal staffing ratios and actual staffing ratios along with unit census at the time of the event. Note any unusual circumstance that occurred at this time. What process is used to determine the care area's staffing ratio, experience level and skill mix?</p>		
11	What is the plan for dealing with staffing contingencies?		<p>Include information on what the organization does during a staffing crisis, such as call-ins, bad weather or increased patient acuity. Describe the organization's use of alternative staffing. Examples may include, but are not limited to:</p>		



#	Analysis Question	Prompts	Root Cause Analysis Findings	Root cause	Plan of Action
12	Were such contingencies a factor in this event?	<ul style="list-style-type: none"> • Agency nurses • Cross training • Float pool • Mandatory overtime • PRN pool 			
13	Did staff performance during the event meet expectations?	<p>If alternative staff were used, describe their orientation to the area, verification of competency and environmental familiarity.</p> <p>Describe whether staff performed as expected within or outside of the processes. To what extent was leadership aware of any performance deviations at the time? What proactive surveillance processes are in place for leadership to identify deviations from expected processes? Include omissions in critical thinking and/ or performance variance(s) from defined policy, procedure, protocol and guidelines in effect at the time.</p>			
14	To what degree was all the necessary information available when needed? Accurate? Complete? Unambiguous?	<p>Discuss whether patient assessments were completed, shared and accessed by members of the treatment team, to include providers, according to the organizational processes. Identify the information systems used during patient care.</p> <p>Discuss to what extent the available patient information (e.g. radiology studies, lab results or medical record) was clear and sufficient to provide an adequate summary of the patient's condition, treatment and response to treatment. Describe staff utilization and adequacy of policy, procedure, protocol and guidelines specific to the patient care provided.</p>			
15	To what degree was the communication among participants adequate for this situation?	<p>Analysis of factors related to communication should include evaluation of verbal, written, electronic communication or the lack thereof. Consider the following in your response, as appropriate:</p>			



#	Analysis Question	Prompts	Root Cause Analysis Findings	Root cause	Plan of Action
16	Was this the appropriate physical environment for the processes being carried out for this situation?	<p>Consider processes that proactively manage the patient care environment. This response may correlate to the response in question 6 on a more global scale.</p> <p>What evaluation tool or method is in place to evaluate process needs and mitigate physical and patient care environmental risks? How are these process needs addressed organization-wide? Examples may include, but are not limited to:</p> <ul style="list-style-type: none"> • alarm audibility testing • evaluation of egress points • patient acuity level and setting of care managed across the continuum, • preparation of medication outside of pharmacy 			
17	What systems are in place to identify environmental risks?	<p>Identify environmental risk assessments.</p> <ul style="list-style-type: none"> • Does the current environment meet codes, specifications, regulations? • Does staff know how to report environmental risks? • Was there an environmental risk involved in the event that was not previously identified? 			



#	Analysis Question	Prompts	Root Cause Analysis Findings	Root cause	Plan of Action
18	What emergency and failure-mode responses have been planned and tested?	<p>Describe variances in expected process due to an actual emergency or failure mode response in connection to the event.</p> <p>Related to this event, what safety evaluations and drills have been conducted and at what frequency (e.g. mock code blue, rapid response, behavioral emergencies, patient abduction or patient elopement)?</p> <p>Emergency responses may include, but are not limited to:</p> <ul style="list-style-type: none"> • Fire • External disaster • Mass casualty • Medical emergency <p>Failure mode responses may include, but are not limited to:</p> <ul style="list-style-type: none"> • Computer down time • Diversion planning • Facility construction • Power loss • Utility issues 			
19	How does the organization's culture support risk reduction?	<p>How does the overall culture encourage change, suggestions and warnings from staff regarding risky situations or problematic areas?</p> <ul style="list-style-type: none"> • How does leadership demonstrate the organization's culture and safety values? • How does the organization measure culture and safety? • How does leadership establish methods to identify areas of risk or access employee suggestions for change? • How are changes implemented? 			



#	Analysis Question	Prompts	Root Cause Analysis Findings	Root cause	Plan of Action
20	What are the barriers to communication of potential risk factors?	Describe specific barriers to effective communication among caregivers that have been identified by the organization. For example, residual intimidation or reluctance to report co-worker activity. Identify the measures being taken to break down barriers (e.g. use of SBAR). If there are no barriers to communication discuss how this is known.			
21	How is the prevention of adverse outcomes communicated as a high priority?	Describe the organization's adverse outcome procedures and how leadership plays a role within those procedures.			
22	How can orientation and in-service training be revised to reduce the risk of such events in the future?	Describe how orientation and ongoing education needs of the staff are evaluated and discuss its relevance to event. (e.g. competencies, critical thinking skills, use of simulation labs, evidence based practice, etc.)			
23	Was available technology used as intended?	Examples may include, but are not limited to: <ul style="list-style-type: none"> • CT scanning equipment • Electronic charting • Medication delivery system • Tele-radiology services 			
24	How might technology be introduced or redesigned to reduce risk in the future?	Describe any future plans for implementation or redesign. Describe the ideal technology system that can help mitigate potential adverse events in the future.			



Action Plan	Organization Plan of Action Risk Reduction Strategies	Position/Title Responsible Party	Method: Policy, Education, Audit, Observation & Implementation
<p>For each of the findings identified in the analysis as needing an action, indicate the planned action expected, implementation date and associated measure of effectiveness. OR ...</p> <p>If after consideration of such a finding, a decision is made not to implement an associated risk reduction strategy, indicate the rationale for not taking action at this time.</p> <p>Check to be sure that the selected measure will provide data that will permit assessment of the effectiveness of the action.</p> <p>Consider whether pilot testing of a planned improvement should be conducted.</p> <p>Improvements to reduce risk should ultimately be implemented in all areas where applicable, not just where the event occurred. Identify where the improvements will be implemented.</p>	Action Item #1:		
	Action Item #2:		
	Action Item #3:		
	Action Item #4:		
	Action Item #5:		
	Action Item #6:		
	Action Item #7:		
	Action Item #8:		



Bibliography: Cite all books and journal articles that were considered in developing this root cause analysis and action plan.

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Healthcare Failure Modes and Effects Analysis (HFMEA)

JCAHO Standard LD.5.2 requires facilities to select at least one high-risk process for proactive risk assessment each year. This selection is to be based, in part, on information published periodically by the JCAHO that identifies the most frequently occurring types of sentinel events. The National Center for Patient Safety will also identify patient safety events and high risk processes that may be selected for this annual risk assessment.

HFMEA streamlines the hazard analysis steps found in the traditional Failure Modes and Effects Analysis (FMEA) process by combining the detectability and criticality steps of the traditional FMEA into an algorithm presented as a Decision Tree. It also replaces calculation of the risk priority number (RPN) with a hazard score that is read directly from the Hazard Matrix Table.

Healthcare FMEA Steps

STEP 1: Define the HFMEA Topic

Define the topic of the Healthcare FMEA along with a clear definition of the process to be studied. See Figure 1.

STEP 2: Assemble the Team

The team is to be multidisciplinary including Subject Matter Expert(s) and an advisor. See Figure 1.

STEP 3: Graphically Describe the Process

- A. Develop and verify the flow diagram (this is a process vs. chronological diagram).
- B. Consecutively number each process step identified in the process flow diagram.
- C. If the process is complex identify the area of the process to focus on (take manageable bites).
- D. Identify all sub processes under each block of this flow diagram. Consecutively letter these sub-steps (i.e. 1a, 1b...3e, etc.).
- E. Create a flow diagram composed of the sub processes. Consecutively letter these sub-steps

(Hint: It is very important that all process and sub-process steps be identified before proceeding.)

STEP 4: Conduct a Hazard Analysis

- A. List all possible/potential failure modes under the sub-processes identified in HFMEA Step 3. Consecutively number these failure modes (i.e. 1a (1), 1a(2)...3e(4), etc.). Transfer the failure modes to the HFMEA Worksheet, Line 2. See Figure 2.

(Hint: This is the step in the process where the expertise and experience of the team really pays off. Use various methods including brainstorming and cause and effect diagramming to identify potential failure modes.)

- B. Determine the Severity and Probability of the potential failure mode and record these on Lines 4 and 5 of HFMEA Worksheet. Look up the Hazard Score on the Hazard Score Matrix and record this number on Line 6 of the HFMEA Worksheet. See Figures 3, 4, and 5.
- C. Go to the HFMEA Decision Tree. Use the Decision Tree to determine if the failure mode warrants further action. Record the action to "Proceed" or to "Stop" on the HFMEA Worksheet, Line 7. If the action is to "Stop" proceed to the next sub-process identified in Step 4B. (Note: if the score is 8 or higher, document the rationale for any "Stop" decisions.). See Figure 6.
- D. List all of the failure mode causes for each failure mode where the decision is to "Proceed" and record them on the HFMEA Worksheet, Line 3.

(Hint: Each failure mode may have multiple failure mode causes. Failure modes include anything that could go wrong that would prevent the sub-process step from being carried out. For example: if logging onto a laptop computer is the process step, possible failure modes are not being able to log in and delayed login. Possible failure mode causes would include the computer not being available, no power, no log in ID for the operator, etc.)

STEP 5 Actions and Outcome Measures

- A. Determine if you want to "eliminate," "control," or "accept" the failure mode cause. Record this decision on Line 8 of the HFMEA Worksheet.
- B. Identify a Description of Action for each failure mode that will be eliminated or controlled.

(Hint: Place the control measure in the process at earliest feasible point. Multiple control measures can be placed in the process to control a single hazard. A control measure can be used more than one time in the process. Solicit input from the process owners if they are not represented on the team. Try to simulate any recommended process change to test them before facility-wide implementation.)

- C. Identify outcome measures that will be used to analyze and test the redesigned process.
- D. Identify a single, responsible individual by title to complete the recommended action.
- E. Indicate whether top management has concurred with the recommended action.

Definitions:

Effective Control Measure – A barrier that eliminates or substantially reduces the likelihood of a hazardous event occurring.

Healthcare Failure Mode & Effect Analysis (HFMEA) - (1) A prospective assessment that identifies and improves steps in a process thereby reasonably ensuring a safe and clinically desirable outcome. (2) A systematic approach to identify and prevent product and process problems before they occur.

Hazard Analysis - The process of collecting and evaluating information on hazards associated with the selected process. The purpose of the hazard analysis is to develop a list of hazards that are of such significance that they are reasonably likely to cause injury or illness if not effectively controlled.

Failure Mode - Different ways that a process or sub-process can fail to provide the anticipated result.

Probability – See the Probability Rating Scale, Figure 3.

Severity – See the Severity Rating Scale, Figure 4.

Figure 2. Healthcare FMEA Worksheet

Step 4							
1	Process Step						
2	Potential Failure Mode						
3	Potential Cause(s)						
4	Severity						
5	Probability						
6	Hazard Score						
7	Decision (Proceed or Stop) <i>(Note: If the score is 8 or higher and the decision is to "Stop," document the rationale for this decision)</i>						
8	Action (Eliminate, Control, or Accept)						
9	Description of Action						
10	Outcome Measure						
11	Person Responsible						
12	Management concurrence (yes or no)						
Step 5							

Figure 3. Severity Rating

<p>Catastrophic Event <i>(Traditional FMEA Rating of 10 - Failure could cause death or injury)</i></p>	<p>Major Event <i>(Traditional FMEA Rating of 7 – Failure causes a high degree of customer dissatisfaction.)</i></p>
<p>Patient Outcome: Death or major permanent loss of function (sensory, motor, physiologic, or intellectual), suicide, rape, hemolytic transfusion reaction, Surgery/procedure on the wrong patient or wrong body part, infant abduction or infant discharge to the wrong family Visitor Outcome: Death; or hospitalization of 3 or more. Staff Outcome: * A death or hospitalization of 3 or more staff Equipment or facility: **Damage equal to or more than \$250,000 Fire: Any fire that grows larger than an incipient</p>	<p>Patient Outcome: Permanent lessening of bodily functioning (sensory, motor, physiologic, or intellectual), disfigurement, surgical intervention required, increased length of stay for 3 or more patients, increased level of care for 3 or more patients Visitor Outcome: Hospitalization of 1 or 2 visitors Staff Outcome: Hospitalization of 1 or 2 staff or 3 or more staff experiencing lost time or restricted duty injuries or illnesses Equipment or facility: **Damage equal to or more than \$100,000 Fire: Not Applicable – See Moderate and Catastrophic</p>
<p>Moderate Event <i>(Traditional FMEA Rating of “4” – Failure can be overcome with modifications to the process or product, but there is minor performance loss.)</i></p>	<p>Minor Event <i>(Traditional FMEA Rating of “1” – Failure would not be noticeable to the customer and would not affect delivery of the service or product.)</i></p>
<p>Patient Outcome: Increased length of stay or increased level of care for 1 or 2 patients Visitor Outcome: Evaluation and treatment for 1 or 2 visitors (less than hospitalization) Staff Outcome: Medical expenses, lost time or restricted duty injuries or illness for 1 or 2 staff Equipment or facility: **Damage more than \$10,000 but less than \$100,000 Fire: Incipient stage[†] or smaller</p>	<p>Patients Outcome: No injury, nor increased length of stay nor increased level of care Visitor Outcome: Evaluated and no treatment required or refused treatment Staff Outcome: First aid treatment only with no lost time, nor restricted duty injuries nor illnesses Equipment or facility: **Damage less than \$10,000 or loss of any utility[‡] without adverse patient outcome (e.g. power, natural gas, electricity, water, communications, transport, heat/air conditioning). Fire: Not Applicable – See Moderate and Catastrophic</p>

Figure 4. Probability Rating

Frequent - Likely to occur immediately or within a short period (may happen several times in one year)
Occasional - Probably will occur (may happen several times in 1 to 2 years)
Uncommon - Possible to occur (may happen sometime in 2 to 5 years)
Remote - Unlikely to occur (may happen sometime in 5 to 30 years)

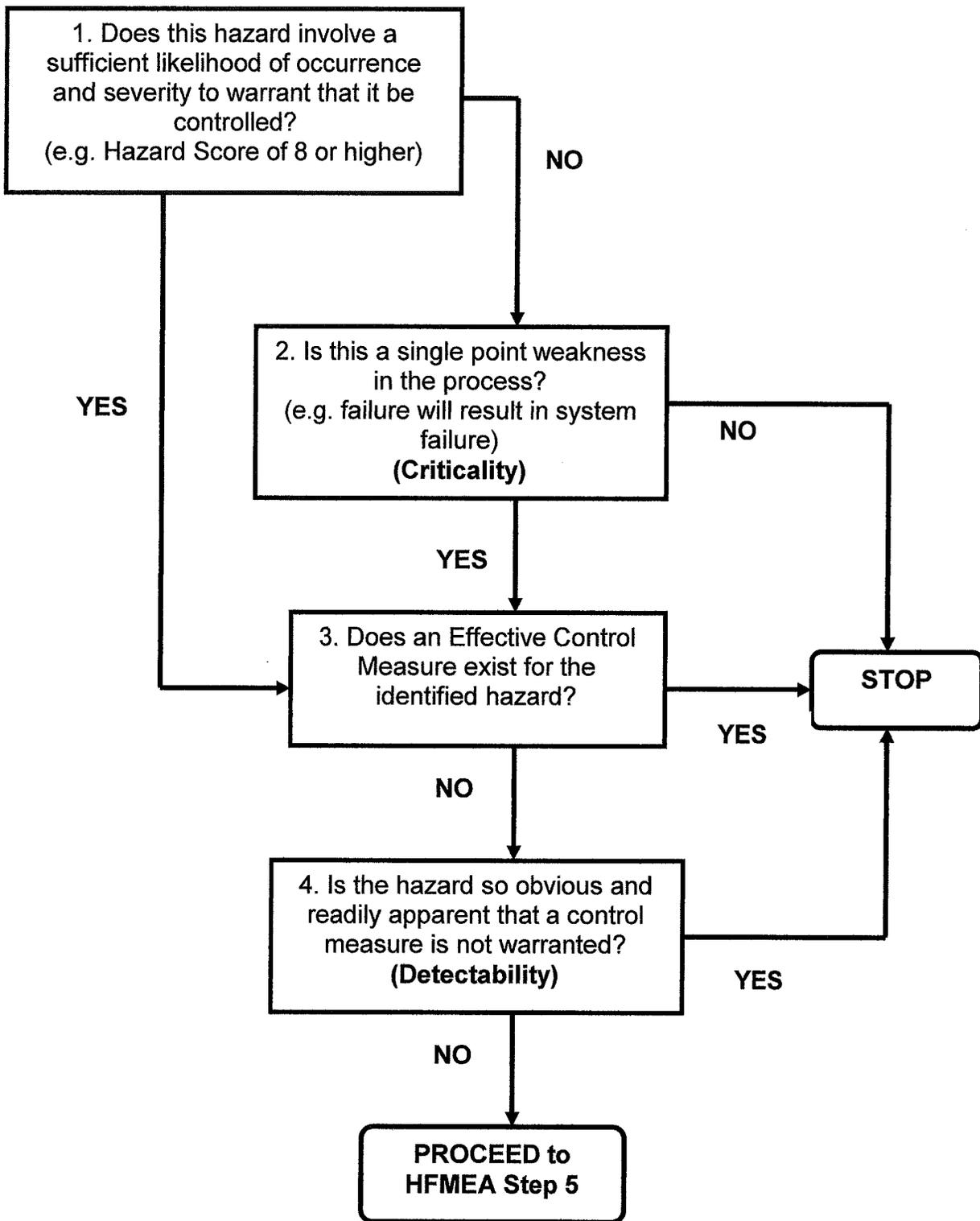
Figure 5. Hazard Scoring Matrix

	Severity of Effect				
		Catastrophic	Major	Moderate	Minor
Probability	Frequent	16	12	8	4
	Occasional	12	9	6	3
	Uncommon	8	6	4	2
	Remote	4	3	2	1

How to Use This Matrix:

- (1) Determine the Severity and Probability of the Hazard based upon the definitions included with this matrix.
- (2) Look up the Hazard Score on the Matrix.

Figure 6. Decision Tree



✍ You must document rationale for STOP decision.

**Dignity Health – St. Rose Dominican
Siena Campus**

PATIENT SAFETY/RISK MANAGEMENT PLAN

DATE: 01/01/2018

VERSION: 01



This plan was created and revised by the Dignity Health – St. Rose Dominican Patient Safety Officer with review and input from the Patient Safety Committee. Implementation of this plan is intended to optimize the healthcare quality and patient safety outcomes, encourage recognition, reporting, and acknowledgment of risks to patient, visitor, and employee safety, as well as reduce the medical/healthcare errors and /or preventable events.

**Patient Safety Committee/Program
St. Rose Dominican – Siena Campus**

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Commitment to Patient Safety

Dignity Health St. Rose Dominican Hospital – Siena Campus is committed to a comprehensive approach to improving healthcare quality and patient safety by aligning with our Mission, Vision, and Values, creating an environment that supports a dynamic, proactive, and safe culture for patients, family members, visitors, and employees, through continuous learning and improving patient safety policies, systems, and processes.

Mission, Vision, and Values

In support of our mission, vision, and values, Dignity Health – St. Rose Dominican, Siena Campus' Patient Safety/Risk Management program promotes:

- Honest, open collaboration and partnership of hospital leadership, medical staff, patients and their families, the community and other healthcare providers to deliver compassionate, high-quality, affordable healthcare.
- Promote justice and respect for those we serve.
- Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.
- Responsibility and accountability for every healthcare related decision and action.
- A focus on excellence, teamwork and innovation through continuous learning, improvement in system design, and the management of choices and changes, bringing the best possible outcomes or performances to the facility.
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare.
- Education of staff and physicians to assure participation of healthcare providers.

Scope and Purpose

The Patient Safety/Risk Management Program at St. Rose Dominican is an organization-wide/campus specific strategy that includes not only facility staff and medical staff, but is inclusive of patients, family and visitors. The Patient Safety/Risk Management Program at Siena Campus supports and encourages the active participation of each person in order to be an effective program. When processes, functions or services are designed or redesigned, information internal and external to the campus and/or organization regarding potential risks to patient safety will be considered and where appropriate, utilized to minimize the risk to patients affected by the new or redesigned process, function or services.

The purpose of this plan is to establish system-wide guidelines and processes supporting a comprehensive, effective, organization-wide Patient Safety/Risk Management Program Plan designed to promote and improve patient safety at Dignity Health – St. Rose Dominican, Siena Campus, by working to prevent medical/healthcare adverse events and reducing risk to patients and visitors.

Undesirable facility specific and system patterns or trends in performance and sentinel events will be intensively analyzed to determine where best to focus changes for improvement. Intensive analysis will be initiated when:

- Levels of performance, patterns or trends vary significantly and undesirably from those expected including significant near misses;
- Performance varies significantly and undesirable from that of other campuses/organizations;
- Performance varies significantly and undesirably from recognized standards; and/or
- A reportable event has occurred at that campus.

Minimally, data from the following areas will be gathered at each facility and presented at that facility for analysis with action plans developed reflective of the findings:

- Initial and on-going proactive risk assessments utilizing internal and external resources;
- Campus aggregate event reports reflective of all medical/healthcare events, with and without adverse outcomes, including but not limited to:
 - Hospital acquired infections
 - Medication events, to include delays in administration
 - Adverse drug events
 - Transfusion reactions
 - Patient falls
- Actual and near misses
- Hazardous conditions
- Restraint issues
- Medical record legibility issues
- Patient/family/staff opinions, needs, perceptions of risks to patients, and suggestions for improving patient safety;
- Identified data trends and analysis reports from sister facilities, Dignity Health Shared Learnings, etc.
- Others as defined by various campus committees, Leadership and/or Quality Council and Advisory Committee of the Board (QCAC).

Roles and Responsibilities

Per [NRS 439.875](#), a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plan is promoted and executed successfully.

The Patient Safety Committee Organization

Roles and Responsibilities

- In accordance with [NRS 439.875](#), a patient safety committee must be comprised of:
- The infection control officer of the medical facility;
- The patient safety officer of the medical facility, if he or she is not designated as the infection control officer;

- At least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility; and
- One member of the executive or governing body of the medical facility.

The roles and responsibilities are defined below.

Patient Safety Committee Responsibilities (based on [NRS 439.875](#) and [NRS 439.877](#))

The Patient Safety Committee convenes monthly in accordance with NRS 439.875. In collaboration with the Patient Safety Officer, the committee represents the Siena Campus and includes multidisciplinary team members which has oversight responsibility to ensure that the responsibilities and functions outlined in this program are carried forward throughout the organization. The following are responsibilities assigned:

- Serve as champions of the Patient Safety/Risk Management Program within the facility/organization.
- Establish and evaluate data to identify patient safety performance indicators.
- Evaluate other sources of patient safety data utilizing internal and external resources including but not limited to adopted patient safety checklists, risk assessments, sentinel event report/alert information and event reporting information from a variety of available resources including the event reporting system, APIC, CHPSO, etc.;
- Selection of a high-risk patient safety process for proactive risk assessment and improvement annually;
- Collaborates with each facility's Quality Council to identify, address and conduct follow-up on patient safety related trends, analysis results, changes in processes, and policies.
- Annual review of the Patient Safety Program to ensure its appropriateness of focus and effectiveness of efforts for each campus.
- Monitor and document the effectiveness of the patient identification policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the patient safety officer pursuant to [NRS 439.870](#).
- Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred.
- Review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- Review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the executive or governing body of the facility regarding:
 - (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);

- (2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and
 - (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

Root Cause Analysis (RCA) Team Responsibilities

- Root Cause interviews, analysis, investigation, and corrective action plan implementations.
- Participates in the RCA meetings and discussions.
- Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders.
- See Quality Department's Performance Improvement Plan

Patient Safety Officer Responsibilities (based on [NRS 439.870](#))

The 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 including:

- Serve on the patient safety committee.
- Supervise the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the patient safety committee regarding any action taken in accordance with the responsibilities above.
- Day to day responsibility for the Patient Safety/Risk Management Program at Siena Campus.
- Maintenance of related data collected, trended and analyzed at each campus.
- Routine reporting to leadership and QCAC on campus specific trended data and actions taken to improve the quality and safety of patient care.
- Working with QCAC to achieve the goals of the Patient Safety/Risk Management Program.

Infection Control Officer Responsibilities (based on [NRS 439.873](#))

- Serve on the patient safety committee.
- Monitor the occurrences of infections at the facility to determine the number and severity of infections.
- Report to the patient safety committee concerning the number and severity of infections at the facility.
- Take such action as determines is necessary to prevent and control infections alleged to have occurred at the facility.

- Carry out the provisions of the infection control program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program.

RCA team leader Responsibilities

- Organize and coordinate the RCA process.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA, and corrective action plan implementation process.
- Communicate the progress of the investigation, institutional barriers, and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.
- Provide training, education and direction to create RCA process that incorporates the Patient Safety and Quality Improvement elements.

RCA Facilitator Responsibilities

- Identify RCA participants and coordinate a time, date and location of RCA meeting.
- Inform RCA participants of the sentinel event process.
- Explain confidential nature of RCA.
- Explain Just Culture and its application.
- Review event using medical record and any other pertinent materials in preparation for the RCA.
- Provide RCA members access to relevant best practice/research documents/statutes and other literature to include hospital Policy and Procedure documents for reference.
- Conduct RCA in a manner consistent with Just Culture, using principles of human factors, systems theory, etc.

Executive or Governing Body Staff Responsibilities

Provide vision and leadership to Patient Safety and Quality Improvement process, and develop and foster a safe learning and improving culture.

- Provides oversight to the healthcare quality improvement processes and teams.
- Plan, discuss, and generate the organization patient safety goals and activities, in conjunction with the patient safety action plans.

Leadership

The Dignity Health St. Rose Dominican Board and campus Senior Leadership has overall responsibility for the implementation of an integrated, organization-wide Patient Safety/Risk Management Program. These responsibilities are campus specific and include the following:

- Foster an environment in which patients, their families and organization staff and leaders can identify and manage actual and potential risks to patient safety through personal example and the provision of resources to establish proactive mechanisms to reduce risk.

- Establish a culture in which communication flows freely regardless of authority gradient.
- Ensure that a define, on-going, proactive program for identifying risks to patient safety and reducing medical/healthcare adverse events is fully implemented and includes responses to actual and potential events;
- Ensure that patient safety issues are given a high priority and addressed when processes, functions or services are designed or redesigned;
- Provide for mechanisms to measure, analyze and manage variation in the performance of defined processes that affect patient safety;
- Allocate adequate resources, including personnel, time, information systems data associated with reducing risk and improving patient safety, and
- Active participation in the California Hospital Patient Safety Organization (CHPSO).

Physicians

Physicians are responsible, as participants in the Patient Safety/Risk Management Program for reporting events or near misses at each campus, and participating on focus teams to reduce identified patient safety risks. Whenever patient care outcomes differ significantly from the anticipated outcomes, the primary care provider and/or responsible licensed independent practitioner (LIP) or comparable designee shall clearly explain these outcomes to the patient, and when appropriate, the family. (See Disclosure Policy)

Patients/Families/Visitors

Patients, families and patient representatives via written communication are encouraged to be active participants in their care and as such are responsible for:

- Providing, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters relating to the patient's health;
- Reporting their patient and outcome of treatment of that pain
- Reporting perceived risks in their care and unexpected changes in the patient's condition to the responsible practitioner, and
- Asking questions when they do not understand what they have been told about the patient's care, infection control, safety precautions and programs or what they are expected to do etc.

Patients and families/patient representatives/visitors will be provided with educational materials explaining these expectations and their role in reducing risk exposure and improving patient safety at the time of admission and throughout the patient stay utilizing various delivery methods including pamphlets, television and verbal communication. Some patients may also be included in the development process to obtain their opinions, needs, perceptions of risks to patients and their suggestions for improving patient care.

Hospital Departments and Staff

Siena staff are key to promoting, identifying, and implementing activities to reduce risk and improve patient safety. Some of the activities include:

- Active participation in the activities to improve patient safety and the quality of healthcare delivered;

- Adherence to Infection prevention measures, the Joint Commission National Patient Safety Goals and other patient safety initiatives;
- Participation in education activities and process implementations;
- As appropriate, the provision of accurate, timely and complete verbal and written communication among caregivers, including test results relevant to the management of the patient's condition, and to all others involved in the utilization of data; and
- Participation in information needs assessment, staff surveys, and other processes that request information regarding the Patient Safety/Risk Management Program.
- Reporting all events and process variances (harm or no harm) even if they do not reach the patient (near miss).

The Patient Safety Committee

The Patient Safety Committee convenes monthly in accordance with NRS 439.875. In collaboration with the Patient Safety Officer, the committee represents the Siena Campus and includes multidisciplinary team members which have oversight responsibility to ensure that the responsibilities and functions outlined in this program are carried forward throughout the organization. The following responsibilities are assigned:

- Serve as champions of the Patient Safety/Risk Management Program within the facility/organization.
- Establish and evaluate data to identify patient safety performance indicators;
- Evaluate other sources of patient safety data utilizing internal and external resources including, but not limited to adopted patient safety checklists, risk assessments, sentinel event report/alert information and event reporting information from a variety of available resources including the event reporting system, APIC, CHPSO, etc.;
- Selection of a high-risk patient safety process for proactive risk assessment and improvement annually;
- Collaborates with each facility's Quality Council to identify, address and conduct follow up on patient safety related trends, analysis results, changes in processes, policies and other areas to make as a result of identified needs.
- Annual review of the Patient Safety Program to ensure its appropriateness of focus and effectiveness of efforts for each campus.
- Report and discuss sentinel events which include:
 - Number of sentinel events from previous calendar month (or quarter).
 - Number of severe infections that occurred in the facility.
- Corrective Action Plan for the sentinel events and infections
 - Evaluate the corrective action plan.
- Patient safety policies and checklists
 - At least annually evaluate Patient Safety policies and checklists
 - Revise the patient safety policies and checklists as needed.
 - Monitor and document the effectiveness of the patient safety policy.

A RCA meeting will meet as needed to accomplish the following:

- Define the healthcare issues or potential risks.
- Conduct Root Cause Analysis
 - Reviewing and analyzing the data.
 - Reviewing the RCA process and quality improvement related activities and timelines.
 - Brainstorming issues or the potential risks by using the fishbone diagrams.
 - Identify the contributing factors and conduct the Root Cause Analysis.
- Conduct Corrective Action Plan
 - Identifying the Plan-Do-Study-Act (PDSA) topics.
 - Discussing corrective action process and activities.
 - Discussing and presenting possible changes in procedure to improve areas indicated.
 - Identifying strengths and areas that need improvement.
 - Developing strategies, solutions, and steps to take next.
- Identify barriers and technical assistance needs for supporting the RCA efforts.

A meeting agenda and minutes noting follow-up tasks will be kept.

Objectives and Goals of the Patient Safety/Risk Management Plan

Goal	Plan	Due Date
Risk Assessments	1. Patient Safety/Risk Management to perform monthly risk assessments and report to PSC. 2. Infection Prevention to report to PSC findings of Risk Assessments.	Monthly PSC
FMEA	PSC to ensure one FMEA is conducted by Risk Management in CY 2018.	December 2018
Checklists	PSC will receive all new and renewed checklists used that impact patient safety whether directly or indirectly.	Monthly and ongoing
National Patient Safety Goals	PSC will support the posting of NPSGs throughout the hospital for staff reference.	Department leaders
Root Cause Analysis	RCAs will be conducted by Risk and Quality Management as soon as possible/practical after an event per Dignity Health policy	Ongoing
Manager orientation	Quality Risk Services will review/update Manager orientation.	March 31, 2018
Grievance Management	Grievances will be reviewed by the Grievance Committee to ensure compliance with CMS CoPs.	Quarterly and ongoing.
Staff and physician education	Patient Safety education will occur in various forms (e.g. Huddles, Department Meetings, Leadership Meetings, Posters) throughout the year.	Ongoing

Components and Methods

Proactive Risk Assessment Activities

The Patient Safety/Risk Management Department, in collaboration with the various facility committees including Infection Prevention, Quality Council and leadership will conduct proactive risk assessments to identify hazards/risks that may affect patient safety. Risk Assessment activities will include, but not be limited to the following:

- Patient Safety Risk Assessment evaluating known high risk processes/procedures that have associated risks,
- Review employee survey results to identify safety concerns,
- On-going risk assessments based on internal and external data, including sentinel event alerts,
- Focused risk assessments as determined by the Patient Safety Committee, Senior Leadership, external/internal events, etc.
- Selection of patient safety process improvements and risk reduction activities utilizing the priorities set criteria of Siena campus,
- Any information assessments conducted by St. Rose Dominican will include identification of barriers to effective communication among caregivers.
- Patient Satisfaction surveys will include a question determining how the patient/family thinks the individual facility can improve patient safety. Results from this question shall be analyzed and responded to in a manner that supports risk reduction.
- Infection Prevention Surveillance Program.
- Additional staff surveys may be conducted to assess for staff opinions, needs, perceptions of risks to patients and suggestions for improving patient safety, as well as the staff's willingness to report medical/healthcare events.

Event Reporting

Siena actively participates in the CHPSO and its Patient Safety Evaluation System for data collection, monitoring, collaboration and evaluation activities. As provided under the CHPSO (42 Code of Federal Regulations (CFR) Part 3 Section 3.20) the event report is considered a Patient Safety Work Product and as such is privileged and shall not be (1) subject to subpoena; (2) subject to discovery; (3) subject to disclosure and (4) admitted into evidence-provided such information is not subject to disclosure in certain criminal proceedings as described in regulation. (See Event Reporting and Management Policy).

- A. When an unplanned event/process variance occurs, the patient care provider will do the following:
 - a. Perform the necessary healthcare interventions to support the patient's clinical condition.
 - b. Perform the necessary interventions to contain the risks to others.
 - c. Notify the patient's attending physician.
 - d. Preserve any information related to the event including physical evidence. Preservation of the information includes the documentation of facts regarding the event or complication of event on the Event Report and in the patients' medical record.
 - e. Notify immediate supervisor of the event.
 - f. Submit electronically an Event Report form or handwritten Event Report form to Risk Management/Patient Safety Services.
- B. Identification of potential unsafe condition that may affect patient safety:

- a. Individual's identifying such a condition will immediately report such to their supervisor, and document in the Event Report.
- b. Take the necessary actions to ensure that any potential risks to patient care and safety are mitigated.

Event Monitoring/Risk Assessment Analysis, Action Planning and Intervention

- A. Patient safety related event reporting data within the scope of the Patient Safety Program and risk assessment results will be aggregated and presented routinely to various committees including but not limited to Medical Executive Committee (MEC), Medication Safety, Quality Council and Environment of Care for analysis and action. Based on analysis of this data and any actual or potential reviews, sentinel events and other internal and external data including TJC Sentinel Event Alerts, Dignity Health Shared Learnings, CHPSO trends, current literature, proactive action plan will be developed to include the following:
 - a. Assessment of the intended and actual implementation of processes to identify the steps in where there is, or may be, undesirable variation.
 - b. Identification of the possible effects of the undesirable variations on patients and how serious the effect or outcome on the patient might be;
 - c. For critical effects/outcomes, a root cause analysis will be conducted to determine why the variation leading to the effect may occur;
 - d. Redesign of the process and /or underlying systems to minimize the risk of that variation or to protect patients from the effects of the variation;
 - e. Test and implement the redesign process;
 - f. Identification and collaboration with Quality Management Systems on implementation of measures of the effectiveness of the redesigned process; and
 - g. Implementation of a strategy for maintaining the effectiveness of the process over time.
 - h. Events that do not require a Root Cause Analysis will have an incident review completed by Quality/Risk Services Department as soon as practicable of becoming aware of the event. The results will be forwarded to leadership for review.

Response to Reported Adverse/Sentinel Events

Reporting of events is an essential component of a Patient Safety/Risk Management program. Through its participation in the CHPSO; all related investigation of events will be securely conducted, collected and documented as Patient Safety Work Product (PSWP) to maintain confidentiality as defined in the Federal Regulation.

- A. Siena shall respond to all reported potential and actual adverse/sentinel events. (See Sentinel Event policy).
- B. Minimally, all adverse events will be analyzed utilizing a team of individuals including Risk Management/Patient Safety and Quality Departments, to conduct root cause analysis (RCA), incident review and/or a failure mode effects analysis (FMEA), implementation in action plan to reduce further risk to patients and establish measures of effectiveness.
 - a. The following events always elicit an intense analysis:
 - i. Confirmed transfusion reactions
 - ii. Significant adverse drug reactions
 - iii. Significant medication events and hazardous conditions

- iv. Manor discrepancies, or patterns of discrepancies, between preoperative and postoperative (including pathologic) diagnoses, including those identified during the pathologic review of specimens removed during surgical or invasive procedures; and
 - v. Significant adverse events associated with anesthesia use.
 - vi. Hospital acquired infections
 - vii. All events meeting the definition of Sentinel Events in the State of Nevada.
 - b. A root cause analysis is performed when a sentinel or State reportable event occurs.
 - c. An incident review is performed when a near miss or other event with significant areas for improvement are identified.
- C. Staff involved in an adverse/sentinel event shall be treated with respect and dignity.
 - a. A “JUST CULTURE” approach shall be taken in order to facilitate changes in systems and processes to prevent further risk to patient safety, as well as promote future reporting by other staff.
 - b. Involved staff should be involved in the RCA process.
 - c. The Department Manager will provide ongoing support to the staff member(s) as needed.
 - d. Whenever necessary, Crisis Intervention or Employee Assistance Programs (EAP) will be offered as support to the involved employee.

Education

- A. Staff Education
 - a. General orientation and other education and training programs as needed will emphasize specific job related aspects of patient safety and risk reduction strategies.
 - b. Specific Patient Safety/Risk Management Program training at orientation and annually thereafter will include:
 - i. An overview of the Patient Safety Program
 - ii. Overview of TJC National Patient Safety Goals
 - iii. Staff’s role and responsibilities in the Patient Safety/Risk Management Program
 - iv. Event reporting criteria and process
 - v. Methods to support and foster an interdisciplinary and collaborative approach to the delivery of patient care
 - vi. Examples of specific job related aspects of patient safety.
 - c. Staff participating at a higher level of the Patient Safety/Risk Management Program will receive appropriate training necessary to understand and complete their assigned responsibilities.
- B. Physician Education
 - a. An overview of the Patient Safety/Risk Management Program will be provided to physicians at time of initial appointment and annually thereafter that describes the program, emphasizes their role and responsibilities in the program and informs them of the event reporting mechanism.
 - b. Specific physicians may receive additional training to support their involvement at a higher level in the Patient Safety/Risk Management Program.

Pursuant to [NRS 439.837](#), a medical facility shall, upon reporting a sentinel event pursuant to [NRS 439.835](#), conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event.”

Siena Campus will use RCA process to determine the contributing factors and the underlying reasons for the deficiencies or failures. The Plan-Do-Study (check)-Act (PDSA or PDCA) is the model, developed by the Institute of Health Care Improvement, that we will use to test the changes.



Root Cause Analysis

A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals.

Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

Root cause analysis and action plan framework table, which was introduced by the Joint Commission. It contains 24 analysis questions. It guides the organization to the steps in a root cause analysis. Not all the questions apply to all the events or cases. This table can be used individually or with the fishbone diagram.

5 Whys technique will be used in Siena Campus to explore the cause and effect relationship underlay a problem. One can find the root causes by asking "why" no less than five times. This technique can be used individually or as a part of the fishbone diagram.

Fishbone Diagram

Once the problems are identified, a Fishbone Diagram will be used for analyzing the problems. You can use the fishbone diagram individually to analyze the root causes, or use it with the root cause analysis and action plan framework table.

A Fishbone Diagram, also called a Cause-and-Effect diagram, is a useful tool for a team to structurally brainstorm by discovering possible underlying factors or root causes from different major categories for the chosen problems. General categories used include: people, methods, materials, measurements, education, procedures, process, location, environment, etc. RCA team members will brainstorm and ask multiple times, “why did this happen?” for each cause until all ideas are exhausted. The highest priority root causes will be chosen for PDSA topics. Once all the categories are established on the fishbone diagram, 5 Whys technique also can be used to drill down the problem and find the root causes.

Model for Improvement

Please refer to the Dignity Health – St. Rose Dominican Performance Improvement Plan.

Data Collection and Reporting

Data should drive any quality and patient safety effort. Siena is using IVOS_for tracking the sentinel events, healthcare infection data, and Midas for internal data collection.

External data sources are those data sources which are collected outside the supervisory structure of the case. External data which will be utilized for Quality and Patient Safety plan include the data from:

- AHRQ: Agency for Healthcare Research & Quality
- CDC: Centers for Disease Control and Prevention
- CMS: Centers for Medicare & Medicaid Services
- NQF: National Quality Forum
- NHSN: National Healthcare Safety Network
- TJC: The Joint Commission

Ongoing Reporting and Review

Data points such as the following will be reviewed according to the schedule prescribed:

Monthly	Quarterly	Annually
1) Sentinel event monthly report 2) Severity of infection report 3) RCA assessment	1) Sentinel event quarterly report 2) Severity of infection report 3) Review and evaluate the measure of improvement of patient safety 4) Review and evaluate the measurement to prevent and control infections	1) Quality and Patient Safety Plan update 2) Checklists and Policies reviewing and revising

Assessment of the Quality and Patient Safety Plan

Please see the Patient Safety Assessment Tool (PSAT) from the VA National Center for Patient Safety for your reference.

Patient Safety Checklists and Patient Safety Policies

By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

The patient safety checklists must follow protocols to improve the health outcomes of patients at the medical facility and must include, without limitation:

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.
- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - Proper instructions concerning prescription medications;
 - Instructions concerning aftercare;
 - Any other instructions concerning his or her care upon discharge; and
 - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include the name and date of birth of the patient.
- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.

- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

Based on [NRS 439.865](#), the patient safety plan must also include an infection control program that carries out the infection control policy. The policy must consist of:

- The current guidelines appropriate for the facility's scope of service developed by a nationally recognized infection control organization as approved by the State Board of Health which may include, the Association for Professionals in Infection Control and Epidemiology (APIC), the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO) and the Society for Healthcare Epidemiology of America (SHEA); and
- Facility-specific infection control developed under the supervision of a certified Infection Preventionist.

http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf

<http://www.who.int/patientsafety/implementation/checklists/en/>

The following link provides you some patient safety policies for your reference

<https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>

Approval of Patient Safety Plan

According to [NRS 439.865](#), a medical facility shall submit its patient safety plan to the governing board of the facility for approval. After a facility's patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan.

The patient safety plan must be reviewed and **updated annually** in accordance with the requirements for approval set forth in this section.

According to [NRS 439.843](#), on or before March 1 of each year, a copy of the most current patient safety plan established to [NRS 439.865](#) must be submitted to the Division of Public and Behavioral Health.

Patient Safety Program Reporting and Review

All patient safety work product (PSWP) submitted through the CHPSO will be collected in the Patient Safety Evaluation System (PSES) for collection, management and analysis of information pursuant to the Patient Safety and Quality Improvement Act of 2005 (42 U.S.C. 299 et seq.).

- A. Patient safety/Risk Management related data and information reports will be provided routinely to various committees as previously identified including but not limited to medical staff, Quality Council and QCAC.

- B. A summary report of data, other internal and external information, as well as all actions taken by various committees and/or specific patient safety related teams will be submitted to the QCAC and the MEC.
- C. Annually, the Patient Safety/Risk Management Plan will be evaluated for effectiveness and the program updated to reflect the results of risk assessments related to patients, families and staff. The review shall include a summary of the occurrence of medical/healthcare events and actions taken to improve patient safety, both in response to actual occurrences and proactive efforts.
 - a. The review will be approved by QCAC.
 - b. Will be submitted to the Community Board for final review and approval.

References

- Root Cause Analysis Toolkit <http://www.health.state.mn.us/patientsafety/toolkit/>
- Quality and Service Improvement Tools http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html
- CQI 101 An Introduction to Continuous Quality Improvement: <https://www.coursehero.com/file/13827355/CQI-Overviewppt/>
- Quality Improvement <http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/>
- Root Cause Analysis <http://www.patientsafety.va.gov/professionals/onthejob/rca.asp>
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2 https://www.jointcommission.org/sentinel_event.aspx
- Hospital Policies <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>
- Checklists to Improve Patient Safety http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf
- Patient Safety Checklists <http://www.who.int/patientsafety/implementation/checklists/en/>
- Minutes of the Meeting of the Quality and Patient Safety Committee <http://www.cookcountyhhs.org/wp-content/uploads/2013/12/09-23-14-QPS-scan-Minutes.pdf>
- Title 40 – Public Health and Safety <https://www.leg.state.nv.us/NRS/NRS-439.html>

Reviewed/Approved:

Patient Safety Committee, February 2018

Quality Care Advisory Committee of the Board, March 2018

Community Board, March 2018

TENAYA SURGICAL CENTER, LLC

PATIENT SAFETY PLAN

Plan: To understand and prepare the patient for outpatient surgery and/or procedure in order to improve outcomes.

- Patients are adequately prepared pre-operatively
- Patients and caregivers are well educated for pre- and post-operatively for self-management after surgery
 - To include Medication Reconciliation
- Providers are fully informed of their patient's physical status as it pertains to their surgery/procedure
- The surgery/procedure is appropriately marked and performed (correct-site), clinically accurate, and pertinent to the diagnosis
- Tenaya Surgical Center, LLC (TSC) will follow the Nevada State statutes as it pertains to controlled substance prescribing
 - Patient teaching will encompass instructions on the safe use and disposal of controlled substances

Review:

Safe Environment of Care

TSC's policies will follow the guidelines set forth in the Association of periOperative Registered Nurses (AORN).

The facility itself will maintain an atmosphere of safety with no hazards in the hallways, no wet floor surfaces or other examples that may prove hazardous to the patient and/or staff.

Risk factors include, but are not limited to:

1. Patient age greater than 85 years
2. Peripheral vascular disease
3. Operating room (OR) time greater than one hour
4. Malignancy
5. Positive HIV status
6. Heart disease
7. General anesthesia
8. Obstructive sleep apnea
9. Hyperactive reactive airway disease
10. BMI >30, especially over 35
11. Any chronic disease affecting internal organs

Risk Assessment:

The pre-operative assessment process starts when the surgeon or the interventionist schedules the case. In general, the goal of the pre-op assessment is to identify and manage any risks associated with surgery

and anesthesia as early in the process as possible. However, the assessment process continues up to the point of surgery.

Anesthesia Society of America (ASA) Physical Status Classification System Guidelines used by anesthesia providers to evaluate a patient's risk for anesthesia and surgery, excerpted as follows:

ASA 1: A normal healthy patient

ASA 2: A patient with mild systemic disease

ASA 3: A patient with severe systemic disease

ASA 4: A patient with severe systemic disease that is a constant threat to life

ASA 5: A moribund patient who is not expected to survive without the operation

ASA 6: A patient that has been declared brain-dead, whose organs will be removed for donor purposes

Patients classified as ASA 5 or 6 will not have procedures done at TSC. It is left up to the discretion of the operating surgeon or interventionist and the anesthesiologist whether or not to perform a procedure on a patient with an ASA classification of 4.

Pre-operative Screening:

The initial screening process is the first step in identifying any concerns or disease processes that could potentially cause intra- or post-operative problems. AORN has issued a guidance statement for a nursing pre-operative evaluation in the ambulatory surgery setting. The initial step is careful pre-operative screening, which is initiated by the pre-operative telephone interview. It is the policy that all patients, except for cosmetic surgery patients, are called the day prior to their procedure by a registered nurse (RN). The screening includes the following:

- A baseline physical assessment
- Allergies and sensitivities
- Cultural, emotional, and socioeconomic assessment
- Pain assessment
- Medication history; to include prescription medications, over-the-counter medications, herbal medications and supplements, opioid and other controlled substances, cannabinoids, and illicit substances. Included is the frequency, dosage and time last dose taken
- Anesthetic history, including adverse reactions to any form of anesthesia
- Results of radiological examinations and other pre-operative testing
- Discharge planning
- Referrals
- Identification of physical alterations that require additional equipment or supplies

- Pre-operative teaching, including which medications are to be taken or withheld before surgery and NPO requirements
- Development of a care plan
- Documentation and communication of all information

Pre-operative Nursing Assessment:

After the pre-operative screening is completed, the pre-operative nursing assessment is an opportunity to verify information and obtain missed or forgotten information that may affect patient outcomes. The AORN guidance statement recommends that an RN conduct a pre-operative nursing assessment on the day of surgery. TSC follows these recommendations. Information obtained during the pre-admission screening is verified. During the assessment, the following data is obtained:

- Verification of the patient's identity using two identifiers
- Review of the pre-admission screening/assessment
- Baseline physical assessment
- Assessment of NPO status
- Hypo/hyperthermia assessment and management
- Pain scale assessment
- Identification of the presence of an advanced directive
- Identification of the planned procedure by the patient, significant other, or guardian and verified with the consent and surgical schedule
- Verification of the site, side, or level, as applicable
- Informed consent signed and witnessed. Patient verbalizes understanding of the procedure listed. If no understanding, the surgeon or interventionist notified so he/she can answer any questions the patient may have.
- Signs of abuse or neglect in vulnerable populations, to include pediatrics, geriatrics, and others at risk
- Assessment for prosthetic devices and implantable electronic devices
- Evaluation of the availability of safe transportation home and aftercare
- Obtaining contact information of the patient's significant other
- Assessment of the patient's understanding of pre-operative teaching and discharge planning
- Assessment of DVT risk and prophylaxis
- Fall assessment and prevention
- Assessment of communicable disease risk and procedure to follow if positive

Pre-operative Anesthesia Assessment:

The pre-operative anesthesia assessment is the part of the overall assessment process that identifies issues related to peri-operative anesthesia management of the patient. The anesthesiologist shall see the patient prior to the procedure to inform the patient of the plan of anesthesia and to answer any questions the patient may have in regards to anesthesia.

Post-anesthesia Care:

Patients should have a complete systems assessment during the first few minutes of PACU care. This assessment should include, but is not limited to:

- Vital signs
- Respiratory adequacy
- Post-operative cardiac status
- Peripheral circulation
- Post-operative neurological status
- Level of consciousness, including alertness, lucidity and orientation
- IV patency
- Allergies and sensitivities
- Pain management
- Motor abilities
- Return of sensory and motor control in areas affected by local or regional anesthetics
- Skin integrity
- Temperature regulation
- Positioning
- Surgical wound site
- Nausea and vomiting
- Fluid and electrolyte balance

The post-anesthesia nurse should provide ongoing assessments and re-evaluations concurrently with nursing interventions.

Post-operative Patient Outcomes

Nursing interventions are initiated to achieve a desired conclusion and/or to reduce the probability of patient outcomes that may be associated with a patient's post-operative experience.

Discharge Criteria

The patient's post-procedure status should be assessed before he or she is discharged from the PACU. The Aldrete score at discharge must be at least an eight. If possible, the patient will be discharged in the company of a responsible adult. Occasionally, a patient may not have someone to pick them up and will request to go home via public transportation. If undergoing Monitored Anesthesia Care, (MAC), then it is up to the

interventionist and anesthesiologist to allow this to happen. I allowed, the patient will spend a longer period of time in the PACU, anywhere from one to four hours, depending on the circumstances and the alertness of the patient. In this instance, the Aldrete score should be nine or over. Any patient undergoing general anesthesia is told to have a responsible adult with them for the first twenty-four hours after anesthesia. If this is not possible, surgery may be cancelled and rescheduled for a more opportune time. If the patient wishes to leave against medical advice, then the policy for this shall be followed.

Discharge criteria includes an evaluation of the patient for nausea, pain, surgical site condition and bleeding.

Patient Transfer

Whenever a patient is transferred from one level of care to another level of care, the peri-operative RN is to communicate all pertinent information to the next caregiver. This is to include, but is not limited to:

- Vital signs and airway patency
- Level of consciousness
- Allergies
- Condition of operative site/dressing
- Location and patency of tubes and/or drains if applicable
- Medications given and response
- Intake and output
- Tests ordered with results, if available
- Pain level
- Nausea and vomiting psychosocial status, and
- Discharge orders

The policies and procedures on emergency transfer will be followed and the patient to be transferred to a hospital who has a transfer agreement with TSC, i.e. Mountain View Hospital, Summerlin Hospital or Spring Valley Hospital.

Discharge Instructions and Discharge

The written post-operative care instructions shall be provided to each patient and shall be reviewed with them and their caregiver prior to discharge. Either the patient or the caregiver shall verbalize understanding of these instructions prior to release. The discharge information includes what to expect after the surgery or procedure, what not to expect after surgery or the procedure and information on how to contact their doctor, both during and after office hours. If the patient has been provided with a prescription for medication, the medication should be reviewed with the patient, including how to use the medication, the side effects, signs and symptoms to report and when to contact the health care provider for additional assistance.

The discharge instructions will be tailored to the patient and the type of procedure.

When discharging the patient, the nurse shall take the patient to his/her car by wheelchair and assure he/she is properly positioned in the vehicle. If the patient has had MAC anesthesia, then he/she may walk out with the assistance of medical care personnel to ensure he/she ambulates safely to the vehicle.

SUBJECT: RISK MANAGEMENT AND PATIENT SAFETY POLICY STATEMENT

To assure the continuing ability to provide quality health care, the Center has established a risk management and patient safety program to minimize the adverse events. The risk management and patient safety program includes several activities geared toward the protection of the patient and the Center's assets and reputation.

An effective risk management and patient safety program is the responsibility of all employees and medical staff members of the Center. Periodically, the Governing Board will affirm support of and review the results of the risk management and patient safety program.

It is the intent of the Center to reduce, eliminate, and prevent conditions and practices that may cause loss. The safety and well-being of the patients, personnel, and public shall have the highest priority.

1. Risk management and patient safety activities include:
 - a. The investigation and analysis of the frequency and causes of general categories and specific types of adverse and unanticipated events causing actual or potential injury to patients, employees, physicians, and visitors.
 - b. The development of appropriate measures to minimize the risk of injuries and adverse events to patients, employees, physicians, and visitors through cooperative efforts of all personnel. These measures will include risk management, patient safety, and risk prevention education and training of all non-physician personnel as follows:
 - i. Education and training of all non-physician personnel as part of their initial orientation; and
 - ii. At least one (1) hour of such education and training annually for all non-physician personnel of the facility.
 - c. The analysis of patient grievances that relate to patient care and the quality of medical services.
 - d. The development and implementation of a reporting system based upon the affirmative duty of all health care providers and all agents and employees of the health care facility to report injuries and adverse outcomes and unanticipated events.

SUBJECT: MANAGEMENT RESPONSIBILITIES

1. Management will appoint a patient safety officer to be responsible for risk management and patient safety activities.
2. State specific reporting requirements must be followed to comply with regulations for the reporting of certain adverse patient outcomes. The patient safety officer will be familiar with the State regulations regarding what must be reported regarding adverse patient outcomes or facility damage such as fire, flooding, or wind damage.
3. If the Surgery Center is accredited, the accrediting body may also require reporting at the time of the adverse outcome. During an accreditation survey, a surveyor will likely review whether the Center management conducted a systematic review of the unanticipated event, including an analysis of how it occurred with an action plan to prevent similar unanticipated events in the future.
4. To promote patient safety, Center management will review unanticipated events to determine if a process change is required to reduce the potential of further unanticipated events. Unanticipated events that involve patient injuries, "near misses", and unexpected outcomes will be reviewed by the patient safety officer.
5. There will be an ongoing evaluation of procedures, protocols, and systems to accurately identify patients, planned procedures, and the correct site of the planned procedure so as to minimize the performance of a surgical procedure on the wrong patient, a wrong surgical procedure, a wrong-site surgical procedure, or a surgical procedure otherwise unrelated to the patient's diagnosis or medical condition.
6. When risk management and patient safety services are provided by an outside consultant, the professional services agreement will be approved by the Governing Board which approves all outside service agreements. This approval must be documented in minutes of the Governing Board meeting or by the signature of the Governing Board Chair on the agreement or appointment letter.
7. Employees will receive education on the Risk Management/Patient Safety program and participate in activities.
 - a. The policies and procedures will be reviewed.
 - b. The purpose and completion of the Unanticipated Event Report form will be discussed.
 - c. Each employee will complete the risk management quiz and the answers will be reviewed and discussed so that everyone understands the duties and responsibilities. This quiz will be filed in the employees' educational records to document their participation in patient safety and risk management education.

- d. All new employees will receive training within the first 30 days of work.
 - e. Patient safety and risk management may be discussed at staff and committee meetings throughout the year.
 - f. Annually the employees will receive risk management/patient safety education. The key points covered in the educational program and attendance will be recorded in the employees' educational records to document their annual risk management/patient safety education.
8. The patient safety officer must contact management immediately if any of the following occur:
- a. Adverse Incidents
 - i. any unexpected occurrence involving a serious physical or psychological injury or illness, including loss of limb or function, not related to the natural course of the patient's illness or underlying condition;
 - ii. any process variation for which a recurrence carries a significant chance of a serious adverse outcome;
 - iii. events such as breaches in medical care; administrative procedures or other breaches resulting in a negative impact on a patient, even where death or loss of limb or function does not occur
 - b. Unanticipated Events, including
 - i. notification by a patient or attorney of the intent to sue;
 - ii. unanticipated and unplanned transfer to a higher level of care as a result of action or inaction that occurred at the surgery center.
 - c. Any of the following sentinel events:
 - i. death of a patient;
 - ii. brain or spinal damage to a patient;
 - iii. performance of a procedure on the wrong patient;
 - iv. performance of a wrong-site procedure;
 - v. performance of a wrong procedure;
 - vi. procedure unrelated to the patient's diagnosis or medical needs;
 - vii. procedure to remove foreign objects remaining from a previous or just completed procedure;
 - viii. repair of injuries or damage from a planned procedure where the damage is not a recognized specific risk as disclosed to the patient and documented through the informed consent process.

9. The patient safety officer, with assistance as needed from staff and the Medical Director, will review reports to identify the basic or causal factors that underlie the variation in performance. If the report involves an adverse event or a “near miss” of an adverse event, an analysis will be completed within 10 days of the time the patient safety officer is notified of the event. An action plan will be established and implemented to reduce the risk of similar incidents occurring. The action plan must address responsibility for implementation, oversight, testing when appropriate, time lines, and measurement of the effectiveness of the actions. The 10 day period for completion of the analysis may be extended if reports, such as laboratory results, autopsy findings, consultative findings or hospital discharge summaries are pending. However, as much information as possible should be gathered. If the analysis cannot be completed within 45 days, the patient safety officer must submit justification to the Medical Director and Administrative Director.
10. The patient safety risk management policies and procedures will be available for all employees for reference.
11. Blank Unanticipated Event Report forms will be available and the employees will be advised where they can locate the supply of forms.
12. When an unanticipated event occurs, an Unanticipated Event Report form will be completed by the employee who will present the form to the patient safety officer.
13. The patient safety officer will learn the circumstances and make all efforts to determine what happened, who was involved, what injury or potential problem occurred, the cause of the injury or potential problem, and the status of any injured persons.
14. A patient may request a different health care provider. If this should occur, the supervisor and the Medical Director will confer and review with the patient the opportunities to select another provider.
15. Periodically, the patient safety officer or designee will review the medical records for appropriateness and completion of the medical records. This review will include forms used, how they are completed, and signatures, as well as the clinical record policies. Particular attention will be paid to the consent process documentation and the documentation of the “time out” to verify correct patient, correct site, correct surgery.

SUBJECT: PATIENT SAFETY PROGRAM

POLICY:

The patient safety program integrates risk management, performance improvement, and a review of processes, functions, and services to improve safety by reducing the risk of system or process failures.

By establishing a system and providing training to encourage the reporting of unanticipated events, the organization can review sentinel events as well as a process variation which does not affect the outcome or result in an adverse event, but for which a recurrence carries significant chance of a serious adverse outcome or result in an adverse event, often referred to as a “near miss”.

Data analysis of unanticipated events will be used to identify and implement changes that will improve the quality of care, treatment, and services and reduce the risk of sentinel events occurring.

A patient safety officer will be appointed and patient safety committee will promote the health and safety of patients, review and evaluate the quality of patient safety measures used in the Center to assist with implementation of the patient safety plan. This patient safety committee can be the same members as the quality improvement/performance improvement committee and employee safety committee, reviewing all areas of performance, safe work environment, and safe patient care processes.

SUBJECT: RISK MANAGEMENT AND PATIENT SAFETY PROCESS

The corporate liability theory is held on the belief that the Center and its Governing Board owe a duty to the patients served. The duty is established by virtue of the Center's "custody" of the patient.

The delegation by the Governing Board to the Medical Staff for peer review and credentialing activities does not absolve the Governing Board from liability. The corporate issue is that of oversight.

A redefinition of the Center's legal duty to patients has given rise to Center corporate liability for malpractice. This liability is not derived from medical negligence by physicians, but rests on a separate, independent duty to protect patients from harm.

The principal control mechanism available to the Center is an effective internal risk management and patient safety program. To implement this program effectively, it is important that the goals of risk management and patient safety are understood.

By definition, risk management and patient safety is a pro-active process instituted in an effort to protect and preserve the financial assets and reputation of the health care provider and the Center.

1. There are four basic components of risk management and patient safety.
 - a. Identification
 - b. Analysis
 - c. Treatment
 - d. Evaluation
2. Risk or exposure identification requires a systematic means of detecting potential problems and a reliable method to predict events in the future.
3. General analysis objectives are to determine where to direct attention and resources. Specific objectives for analysis are
 - a. the probable frequency of the loss
 - b. the probable cause of the loss
 - c. the possible severity of the loss
 - d. the effect that any potential loss would have on the patient and the organization.

4. Treatment includes two techniques.
 - a. Control
 - b. Risk Financing involves methods used to pay for losses
5. Evaluation includes a constant review and evaluation of the entire system to ensure its effectiveness and its compliance with all applicable statutes and external requirements.

Title:	Patient Safety Program	Policy #:	051-37-026.2
Effective Date:	January 2004	Department: Category:	Quality Mgmt Performance Improvement
Revision Date(s)	Jan 2004; Mar 2012; Dec 2017	Changeability:	Fixed General

Patient Safety Program Addendum to the Performance Improvement Plan

Purpose

LifeCare Hospitals- Complex Care Hospital at Tenaya 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 Complex Care Hospital at Tenaya 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. 051-37-026.2 Patient Safety Program Page 3 of 9

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. 051-37-026.2 Patient Safety Program Page 4 of 9

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. 051-37-026.2 Patient Safety Program Page 5 of 9

Tahoe Pacific and Complex Care Hospital of Tenaya Patient Safety Program

Purpose

Tahoe Pacific Hospital and Complex Care Hospital of Tenaya have developed a Patient Safety Program in conjunction with the Performance Improvement Plan and Program, the Risk Management Plan and Program, and the Hospital Scope of Services, in order to provide guidelines for implementation of an integrated patient safety program throughout the hospital and to comply with the requirements of the state of Nevada. It is the intent of the leadership of the hospitals to foster a safe and safety-conscious environment that promotes well being, acknowledges and addresses risks, and encourages interdisciplinary safety and education focusing on process improvement.

Scope

Overall Patient Safety responsibilities include the following:

1. Improve the accuracy of patient identification. Through the use of 2 patient identifiers whenever performing procedures, administering medications or blood, taking blood samples or other specimens, or providing any other treatments or procedures.
2. Improve the effectiveness of communication among caregivers as contained in Handoff Communication Guidelines, Located under Best Practices in LifeCare Policies and Procedures
3. Improve the safety of using high-alert medications as contained in the LifeCare policy, Medication Safety: High Alert Medications
4. Ensure the identification, reporting, prevention and control of infections, including the role of proper hand hygiene as contained in the LifeCare policies, The Infection Control Plan and its addendums; Hand Hygiene, and other policies covering Blood and Body Fluid Exposure, Environmental Disinfection, Single Use of Drugs and Devices and Use of Isolation Precautions as contained in the Quality Management policy section.
5. Reduce patient falls and injuries from falls as contained in the LifeCare policy, Fall Prevention, through recommendations from the Falls Committee Performance Improvement Team and information about falls gathered from the Post Fall Assessment Form.
6. Improve the effectiveness of clinical alarms systems as contained in the LifeCare policy, Safety – Alarms- Clinical Equipment.
7. Identifying, preventing and correcting errors in the labeling, storing, prescription or administration of medications as contained in the LifeCare policies, Medication Storage, Dispensing – Labels, Dispensing Medications – General, and other policies contained in the Pharmacy section.
8. Ensuring the safe administration of prescription drugs, controlled substances, pharmaceutical services and other medications as contained in the LifeCare policy, Administration of Drugs, and other policies contained in the Pharmacy section.
9. The identification, investigation and reporting of Sentinel Events as contained in the LifeCare policy, Sentinel Events, and as prescribed by NRS 439.800 and following 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 051-37-026.2 Patient Safety Program Page 7 of 9

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. 051-37-026.2 Patient Safety Program Page 8 of 9

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. 051-37-026.2 Patient Safety Program Page 9 of 9

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.

Patient Safety Plan 2018

PURPOSE:

The purpose of the Patient Safety Program is to improve patient safety and reduce risk to patients, staff and visitors. Recognizing the effective medical/health care error reduction requires an integrated and coordinated approach; we have developed an organization-wide safety program. The program supports the creation of an environment in which patients, their families, and organization staff leaders can identify and manage actual and potential risks to patient safety.

OBJECTIVE:

It is our objective to foster an environment to improve patient safety, establish mechanism to support effective responses to actual occurrences and to be proactive in the reduction of medical/health care errors. Patient safety will be a priority in new design and all relevant organization processes, functions and services.

SCOPE:

The scope of the patient safety program will include compliance with standards identified by external regulatory agencies and accrediting bodies. Program activities will address occurrences ranging from "near misses" to sentinel events with serious adverse outcomes.

DEFINITIONS:

Actual Event-an event occurred that reached the patient or individual (e.g., visitor fall, student injury, etc.).

Near Miss-an event occurred but it did not reach the patient because of chance alone or because of active recovery efforts by caregivers.

Unsafe Condition- circumstances that could cause adverse events (e.g., look-alike medications, confusing equipment, failure to use proper signage when floor is wet).

Sentinel Event- is defined as a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in any of the following:

- Severe temporary harm which is defined as critical, potentially life-threatening harm lasting for a limited time with no permanent residual effect, but requires transfer to a higher level of care/monitoring for a prolonged period of time, transfer to a higher level of care for a life-threatening condition, or additional major surgery, procedure, or treatment to resolve the condition. (Hip fractures are always included)
- Permanent harm
- Death

For additional events also considered "sentinel" reference the HealthSouth Sentinel Event policy

PROCEDURES:

A. The responsibility for management of the organization-wide patient safety program is assigned to the Director of Quality/Risk Management.

1. The Safety Committee and Quality Council will provide interdisciplinary input related to patient, visitor and staff safety.
2. Reports of safety related activities and issues would be presented to Department Managers, Senior Staff, Medical Staff via the Medical Executive Committee, and the Governing Board. This communication is confidential and for quality assurance purposes only.

B. Staff will report information relating the medical/health care events as outlined in Risk Management Electronic Event Reporting Policy.

1. Staff will be oriented to the Risk Management Policies on hire and through ongoing in-service and other education and training programs.
2. Staff will be oriented to their roles in preventing adverse occurrences as related to their specific job responsibilities and as a part of the organization-wide efforts to improve patient safety.
3. Staff will be oriented to the importance of reporting "near misses," as well as adverse occurrences.
4. Team training to foster an interdisciplinary, collaborative approach to patient care delivery and to reinforce the need and way(s) to report medical/health care errors will be provided as appropriate.
5. The Director of Quality/Risk Management, Department Managers, and Senior Staff are responsible for interacting with staff in a manner that ensures staff do not fear disclosure, embarrassment, blame or punishment for reporting potential or actual events related to patient safety.
6. The Director of Quality/Risk Management, Department Manager and/or Senior Staff member may request the assistance of internal behavioral management staff or external resources if a staff member(s) needs support in coping with a sentinel event.

C. Hospital leadership will identify barriers to effective communication among caregivers relative to patient care, redesign the process to eliminate barriers and monitor for effectiveness. Specific attention will be directed to:

1. Process for ensuring accurate, timely, and complete verbal and written communication among care givers and all others involved in utilization of data, and
2. Test results relative to the management of the patient's condition.

D. All patients are entitled to information about all aspects of their health care, including information about clinically relevant unanticipated outcomes of care.

Patients and, when appropriate, their families are informed about the outcomes of care including unanticipated outcomes (i.e. sentinel events, State reportable events). Responsibility for disclosing unanticipated outcomes typically rests with the physician or designee who has overall responsibility for the patient's care. However, in some situations, other healthcare professionals may be deemed more appropriate to be responsible for disclosing the outcome. A hospital representative, preferably the

Quality/Risk Director, Chief Nursing Officer or the Chief Executive Officer should be present for the initial conversation and any follow-up discussions that may occur with the patient and/or patient's representative.

E. The Director of Quality/Risk Management or designee will respond immediately to notification of significant medical/health events to a patient/visitor or staff member.

1. The Nursing Supervisor or Department Manager will contact the Risk Manager and/or Administrator/Administrator-On-Call to report events.
2. Action(s) will be taken to protect the patient/visitor/staff members as indicated per hospital plans and policies.
3. Factual information will be obtained and preserved for subsequent analysis. Such information is confidential for quality assurance purposes.

F. The facility will review historical risk management, Environment of Care (EOC), Program Improvement (PI) and Human Resources (HR) data for high volume, high risk problem trends in medical and care processes, as well as unanticipated adverse occurrences affecting patients. These will be ranked as:

- A. Unsafe condition (Non-event)
- B1. Near Miss - No Harm/Didn't Reach Patient/Caught by Chance
- B2. Near Miss - No Harm/Didn't Reach Patient b/c of Active Recovery by Caregiver
- C. No Harm – Reached Patient No Monitoring Required
- D. No Harm – Reached Patient Monitoring Required
- E. Harm – Temporary, Intervention Needed
- F. Harm – Temporary, Hospitalization Needed
- G. Harm - Permanent
- H. Harm – Permanent, Intervention Required to Sustain Life
- I. Death

G. The facility will also perform intense analysis consistent with the Root Cause Analysis/Sentinel Event Policies, and reports as required by state, regulatory, and accreditation bodies. The Risk Management designee is responsible for ensuring compliance with reporting.

H. Emerging needs requiring reprioritizing performance improvement activities may be identified through data collection and assessment, unanticipated adverse occurrences affecting patients, changing regulatory requirements, significant patient and staff needs, changes in the environment of care, or changes in the community. Priority consideration in establishing performance improvement teams is given to:

1. Processes that affect a large percentage of patients.

2. Processes that place patients at risk, if not performed well, if performed when not indicated, or if not performed when indicated.

Processes that have been or are likely to be problem prone.

I. When designing/redesigning processes, Department Managers and staff will:

1. Incorporate information from within the organization and from other organizations about potential risks to patients, including the occurrence of sentinel events in order to minimize risks to patients affected by the new or redesigned process, function or service.
2. Conduct literature searches to obtain evidence based medical and/or care practices to be included in process redesign.
3. Include analysis and or pilot testing to determine whether the proposed design/redesign is an improvement.

J. Hospital leadership will consider the importance of patient safety in:

1. Development of hospital-wide patient care programs, policies and procedures that describe how patients' care needs are assessed and met.
2. Development and implementation of the hospital's plan for the provision of patient care.
3. Decision-making structures and processes.
4. Implementation of an effective and continuous program to measure assesses and improves performance.
5. Development of an interdisciplinary culture that emphasizes cooperation and communication. The leadership role of coaching will be used to promote communication among services, individual staff members and less formal structures such as quality action teams, performance-improvement teams or members of standing committees.
6. Development of a process to involve the patient, as appropriate to his/her condition, as a partner in helping to facilitate the safe delivery of care.
 - a. Patients/family members are oriented on admission of the importance of reporting perceived risks and concerns about the patient's care per Patient and Customer Complaint and Grievance Policy.
 - b. Department Managers and Senior Staff will review Press Ganey Patient Satisfaction Survey questions related to patient safety and develop a corrective action plan to patient/family complaints or suggestions for improving safety as appropriate.

7. The Governing Board will appoint the Director of Quality and Risk Management (DQR) as the Patient Safety Officer. The Patient Safety Officer/Director's role includes:

- Participating in hazard surveillance, event reporting, reviewing, and the development of patient safety policies and procedures.

- Analyzing and seeking resolution of patient safety issues and works with the appropriate staff to implement recommendations and to monitor patient safety improvement activities.
- Report on findings, recommendations, actions taken, and results of measurements through the hospital quality structure.

K. At least one (1) high-risk process is the subject of ongoing measurement and periodic analysis to determine the degree of variation from intended performance, a minimum of 1 proactive risk assessment every 18 months. The process selected will be based, in part, on the information identifying the most frequently occurring sentinel events and patient safety risk factors.

1. Assess the intended and actual implementation of this process to identify steps in the process where there is, or may be, undesirable variation (i.e. called potential "failure modes").
2. For each identified "failure mode, "identify the possible "effect(s)" and how serious the possible effect on the patient could be (i.e. "criticality "of the effect).
3. For the most critical effects, conduct a root cause analysis to determine the variation (failure mode) leading to that effect occur.
4. Redesign the process and/or underlying systems to minimize the risk of that failure mode to protect patients from the effect of that failure mode.
5. Test and implement the redesigned process.
6. Identify and implement measures of the effectiveness of the redesigned process.
7. Implement a strategy for maintaining the effectiveness of the redesigned process over time.

L. Hospital leadership will measure and assess the effectiveness of their contributions to improving patient safety. To accomplish these goals, leaders will.

1. Set measurable objectives for improving patient safety.
2. Actively request staff to periodically discuss their opinions, needs, perceptions of risks to patients and suggestions for improving patient safety. The actions taken as a result of this staff input will be reported to the MEC/GB bi- annually.
3. Review data on staff willingness to report medical/health events.
4. Review data from Patient Satisfaction Survey related to patient safety.
5. Use pre-established, objective process criteria to assess their effectiveness in improving patient safety.
6. Draw conclusions based on their findings and develop and implement improvement in their activities.
7. Evaluate their performance in supporting sustained improvement.

M. The DQR will report at a minimum quarterly to the Governing Board occurrences of medical/health events and actions to improve patient safety.

SAFETY MANAGEMENT PLAN 2018

PURPOSE: The Safety Management Plan of Las Vegas Recovery Center (LVRC) serves to provide a framework to promote a safe environment for clients, visitors, and staff. It identifies the established policies, programs, and processes used by LVRC to establish, support, train, and maintain an effective quality safety management program that is promoted and executed successfully.

SCOPE: This Safety Management Plan covers the activities of LVRC, and affiliated remote sites including:

- 3321 N Buffalo, Suites 100 and 150: Business Offices and Intensive Outpatient Program

Any differences in activities at the various sites are so noted in the plan.

RESPONSIBILITY: Oversight of the safety management program is accomplished through the Safety Committee. The Office of Primary Responsibility (OPR) is Corporate Compliance, however, executive oversight is maintained through the governing body by the review of the Safety Committee minutes, annual evaluation of this management plan, and through leadership to quality care and improvement processes throughout the organization. Supervisors are responsible for ensuring all subordinates are properly trained and informed of all safety related issues as they pertain to the specific duty section/location, job, and task.

OBJECTIVES:

1. Provide both a global and cross-functional approach to safety, by ensuring representation from appropriate departments on the Safety Committee.
2. Conduct ongoing surveillance to reduce risks to the lowest level possible to provide clients, visitors and staff with the safest possible environment.
3. Educate staff members, providers, and other personnel their roles in the Safety Management Plan.
4. Ensure staff members, providers, and other personnel follow protocols to secure safety and improve health outcomes of the client and their environment by incorporating the safety checklists and following all safety policies.

ELEMENTS OF PERFORMANCE:

Written Management Plan

LVRC has developed and implemented this Safety Management Plan in compliance with Joint Commission requirements to describe the processes involved with this function and to effectively manage the safety of all who use our facilities. The Sentinel event requirements however are specific to Nevada Revised Statutes (NRS) Chapter 49.

LVRC will follow Sentinel events protocol pursuant to the NRS Chapter 49 regulations as follows: (a) A person who is employed by a medical facility shall, within 24 hours after becoming aware of a sentinel event that occurred at the medical facility, notify the patient safety officer of the facility of the sentinel event; and (b) The patient safety officer shall, within 13 days after receiving notification pursuant to paragraph (a), report the date, the time and a brief description of the sentinel event to: (1) The Health Division; and (2) The representative designated pursuant to NRS 439.855, if that person is different from the patient safety officer. 2. If the patient safety officer of a medical facility personally discovers or becomes aware, in the absence of notification by another employee, of a sentinel event that occurred at the medical facility, the patient safety officer shall, within 14 days after discovering or becoming aware of the sentinel event, report the date, time and brief description of the sentinel event to: (a) The Health Division; and (b) The representative designated pursuant to NRS 439.855, if that person is different from the patient safety officer. 3. The State Board of Health shall prescribe the manner in which reports of sentinel events must be made pursuant to this section. A medical facility shall, upon reporting a sentinel event pursuant to NRS 439.835, conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event. A root cause analysis, cause and effect diagram, and PlanDoStudyAct (PDSA) are all models of improvements performed on Sentinel events as an ongoing effort to provide quality services and processes.

Plan Coordination

The Safety Management Plan is coordinated by the Safety Officer, who is appointed by the CEO. The Safety Officer's responsibilities include, but are not limited to:

- Serve on the Safety Committee, serving as the point of contact on safety, inspections, investigations, and reporting of all events, including Sentinel events.
- Ensuring the integration of monitoring and client safety functions and taking such actions as necessary to ensure the safety of clients, staff and visitors as result of an investigation of any event not within the normal standards of quality and safety, including Sentinel events alleged to have occurred at the facility.
- Serve as the Infection Control Officer, ensuring compliance with the Infection Control program including monitoring and reporting occurrences of infection.
- Maintaining appropriate safety reference material and assistance in safety policy and procedure development as requested.
- Coordination of the information flow to and from the Safety Committee.
- Coordination of the reports to the Safety Committee concerning problems, failures, and user errors in all areas of the Environment of Care.
- Regular participation in hazard surveillance by conducting documented facility safety surveys yearly to identify and correct environmental hazards and unsafe conditions.
- Providing summary information on a quarterly basis to the governing body or their designee.
- Monitor and document the effectiveness of the National Patient Safety Goals: NPSG.01.01.01 – Use at least two ways to identify individuals served, NPSG.03.06.01 – Record and pass along correct information about an individuals medicines, NPSG.07.01.01 – Use the hand cleaning guidelines from the World Health Organization, NPSG.15.01.01 Find out which individuals served are most likely to try to commit suicide.
- The Safety plan includes the most updated safety checklists and safety policies for use by all staff that provides services to the clients, including contracted practitioners, consultants, and other personnel. Checklist are related to specific types of treatment and processes, including discharge, aftercare, medication reconciliation, dietary standards, laundry, nursing, maintenance, housekeeping, etc.

Intervention Authority

The appointed Safety Officer or designee is authorized to intervene whenever conditions pose an immediate threat to life or health or pose a threat of damage to equipment or buildings. If this authority is exercised, it will be immediately reported to the CEO.

Risk Assessment

LVRC conducts a periodic risk assessment to evaluate the impact of new or existing conditions of the facilities, grounds, equipment, operations, and occupants on client, staff and public safety. The goal of performing risk assessment is to reduce the likelihood of incidents or other negative experiences that have the potential to result in injury, and accident, or other loss to clients, visitors, staff, or assets. Potential safety issues are reported and discussed in the Safety Committee meetings, along with all pertinent data and alternatives.

Procedures and Controls

Projects are planned and programmed so that they can compete for funding within the planning, programming, and budgeting process. A decision on management of the issue at hand is reached based on the Safety Committee's evaluation of the situation and the pertinent data. Documentation of this risk assessment process may be found in the Safety Committee minutes.

Results of the risk assessment process are used to create or revise safety policies, procedures, and practices, as well as develop safety orientation and education programs and safety performance monitors.

Safety Policies and Procedures

The Safety Committee develops safety policies and procedures to be implemented upon review and approval of the governing body. Safety policies and procedures include safety checklists and are reviewed and updated as often as necessary, but at least annually. New safety policies and procedures are coordinated with the Safety Officer prior to implementation. The safety committee is comprised of the infection control officer (also the safety officer), the Director of Nursing, the Medical Director, the Manager of Nursing Services, and the Administrator of the facility (member of the governing body). The policy includes: (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 and consider any additional patient safety checklists and patient safety policies that may be appropriate for adoption for use at the facility. (c) Revise a patient safety checklist and patient safety policy to ensure that the checklist or policy reflects the most current standards in patient safety protocols. (d) On or before July 1 of each year, submit a report to the Director of the Legislative Counsel Bureau for transmittal to the Legislative Committee on Health Care. The report must include information regarding the development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to item (b).

The most current safety plan and Sentinel Events Report is submitted to the Division of Public and Behavioral Health on or before March 1 of each year.

Product Safety Recalls

Product and equipment safety recalled by a vendor or otherwise cited for safety hazards are removed from or placed out of services and properly disposed of. Appropriate substitutes are obtained in a timely manner. All reports related to product and equipment safety recalls must be processed within 24 hours of receipt. End users must report actions taken with respect to the recall notice and product disposition to the appropriate department manager. Records must be maintained in the respective vendor file concerning actions taken and final disposition. Recalls will be reported to the Safety Committee.

Grounds and Equipment

The COO of the parent company of LVRC is responsible for management of LVRC and the grounds maintenance programs, including the grounds, parking lots, grass and shrubbery care, irrigation systems and pest control. Regular schedules are established for grass cutting, landscaping maintenance, adequate storm drain and pavement cleaning, and pest control.

Hazard Surveillance

The Safety Officer conducts and documents facility safety surveys of all areas twice a year to identify and correct environmental hazards and unsafe conditions. A schedule has been developed to ensure that all areas are surveyed in a timely manner.

Smoking

LVRC maintains a policy of no smoking within any client care buildings. All staff members are responsible for monitoring for compliance with this policy.

Supervisory notification will be made of any staff members found to be in violation of the no smoking policy. Clients or visitors violating the policy will be directed to appropriate outdoor smoking areas.

Pre-Construction Risk Assessment

LVRC uses a system of pre-construction risk assessment throughout all projects involving construction, renovation, or demolition. Infection control risk assessment will also be used as applicable for certain maintenance projects.

Key individuals involved in this team process (as applicable based on the scope of the project) include:

- Administration
- Infection Control
- Nursing Staff
- Medical Staff
- Architect
- Engineer
- Contractor

For each project, a risk assessment matrix is completed to ensure evaluation of its impact on client care, based on the type of project and the impacted client population. Particular attention is focused on the effect that the proposed activities will have on:

- Air quality
- Infection control
- Utilities
- Noise
- Vibration
- Emergency procedures

Controls are implemented as appropriate to the outcome of the assessment.

The Safety Officer is also responsible for the integration of the Environment of Care function with the organization-wide client safety program. Safety issues and the results of ensuing measurements are communicated to the appropriate components of the client safety program. The Safety Officer or designated representative is notified by maintenance or construction/project manager prior to beginning any work that may impact client safety.

Reporting Process

The Corporate Compliance Office manages the incident reporting program. The governing body reviews major incidents, administrator, director of nursing, and the director/manager of the department involved in any incident also reviews the report. Other reviewers (depending on nature of incident) may include Infection Control, the Safety Officer, the Safety Committee and Corporate Compliance. Reports from these departments are submitted, as appropriate, to the Safety Committee. Department managers do the initial investigation and the Corporate Compliance Office provides further follow-up and investigation as necessary. All incidents are tracked for adverse trends and findings reported to both the governing body and the Safety Committee.

EMPLOYEE HEALTH AND SAFETY: An incident report is completed for any staff occurrence involving medical or legal risk. Supervisors must suggest corrective action. Any incident involving exposure to blood borne pathogens will also be included in the incident reports.

Performance Monitoring

LVRC conducts appropriate monitoring of performance of this Safety Management Plan regarding actual or potential risk. Current performance monitors include:

- Staff members interviewed can appropriately identify their role in reporting safety issues.
- The number of incident reports will show a downward trend.
- The time to resolve issues, measured from their first appearance in the Safety Committee minutes to their resolution (in months), will exhibit a downward trend.

Results of this ongoing monitoring will be reported and reviewed at the Safety Committee meeting at least quarterly. This or other trend data will be considered by the committee annually for possible recommendation to leadership for a performance improvement activity in the Environment of Care.

Annual Evaluation

There will be an annual evaluation of this Safety Management Plan in terms of its objectives, scope, performance, and effectiveness, defined as follows:

Objectives: An assessment of whether or not the objectives identified in this management plan have been appropriately addressed in the preceding year. Any adjustments made to the objectives for the following year should also be included.

Scope: An assessment of whether or not the scope, as identified in this management plan, remains the same for the coming year, or needs to be adjusted according to changes in the organization.

Performance: A quantitative analysis of the performance monitoring data as identified in this management plan.

Effectiveness: A qualitative assessment of what was done well, and what needed improvement in the fulfillment of the Safety Management Plan during the preceding year. Any changes, not previously mentioned, that are needed for the coming year should also be addressed.

The annual evaluation will be compiled by the Safety Officer. The evaluation will be reviewed by the Safety Committee at its next meeting following the completion of the evaluation, and it will then be forwarded to the governing body.

Multidisciplinary Improvement Team

The Safety Committee is composed of representatives from medical, clinical, administrative, and support services, and chaired by the Corporate Compliance Manager. The Safety Committee meets quarterly.

Responsibilities of the Safety Committee include, but are not limited to:

- Evaluation of safety issues
- Recommendations for corrective measures
- Implementation and monitoring of recommendations
- Oversight of accident and injury investigations
- Hazard identification and elimination
- Oversight of safety education
- Review of performance monitoring

Orientation and Education

All staff members participate in an orientation and education program that includes:

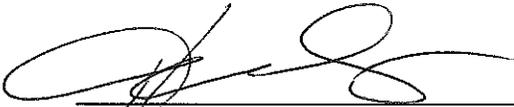
- General safety procedures
- Area-specific safety
- Specific job-related hazards
- Reporting procedures for incidents involving property damage, occupational illness, and injury to clients, staff, or visitors
- Actions to eliminate or minimize safety risks

The Safety Officer provides a broad overview of all safety related matters and general safety processes during newcomer's orientation. The orientation briefing and related material is provided and maintained by the Safety Officer or designee. During the newcomer's orientation, the employees are informed that their supervisor is the vital link in the safety training process at the department level. Refresher training is ongoing to include annual Safety and Incident Report training and safety related e-mails and fliers distributed by the Safety Officer throughout the year. Ongoing training by the Safety Officer ensures continuing education on safety issues.

Human Resources, and Safety Officer are responsible for orientation and education concerning area specific safety and job-related hazards.

SAFETY MANAGEMENT PLAN 2018

APPROVED:



Safety Officer

2-28-18
Date



Administrator (Governing Body)

2.28.18
Date

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.



INSTITUTE OF ORTHOPAEDIC SURGERY

LIFE SAFETY MANAGEMENT PLAN

I. Scope of Plan

The Institute of Orthopaedic Surgery administration and governing body are strongly committed to providing a safe and secure environment for patients, visitors, staff and property. The Life Safety Management Plan is the basis for managing the environment of care, including infection control, security, hazardous materials and wastes, emergency preparedness, and utility systems in a fire-safe environment and in accordance with applicable codes and regulations. This plan is reviewed annually.

II. Objectives

IOS strives to protect patients, visitors, staff, and property from infection and environmental hazards by meeting the following objectives:

- ✦ Prevent and control infections within the facility through the implementation of effective and nationally recognized infection control policies.
- ✦ Ensure proper operation of fire detection, alarm, and suppression systems through a program of regular inspection, testing, and maintenance.
- ✦ Provide portable fire extinguishers according to established criteria for type, placement, inspection, maintenance, and use.
- ✦ Ensure acquisitions such as curtains, furniture, waste baskets, and other equipment meet established fire safety criteria.
- ✦ Collect information on staff knowledge and skill during drills.
- ✦ Evaluate staff and equipment response during fire and facility emergencies.
- ✦ Ensure facility code compliance to identify and correct deficiencies.
- ✦ Provide fire safety orientation for new employees and quarterly thereafter.
- ✦ Provide for specific roles and responsibilities of personnel at the fire, at areas away from the fire and during evacuation.
- ✦ Establish a risk-assessment program that proactively evaluates the building, grounds, equipment, occupants, and internal physical systems and their potential impact on patient and public safety.
- ✦ Establish an emergency preparedness program designed to manage the consequences of natural disasters or other emergencies that may disrupt the facility's ability to provide care.

III. Standards of Performance

- ✦ All staff complete training in infection control, including aseptic technique and standard precautions, annually.
- ✦ Fire drills and education are conducted every quarter
- ✦ Staff will know locations of fire extinguishers and alarms
- ✦ Evacuation routes are posted in the facility
- ✦ Orientation and continuing education of the staff
- ✦ Management of hazardous materials and waste
- ✦ Bomb Threat drill and education twice a year
- ✦ Internal / External disaster at least twice a year

IV. Information Gathering and Reporting

The IOS Safety / Quality Improvement Committee is represented by administration, and clinical and business office staff. The committee will meet at least monthly.

Information regarding worker knowledge about life safety and the fire protection system is gathered during fire drills and safety rounds.

Performance improvement and trends are submitted to the Medical Executive Committee and Governing Body.

V. Organizational Roles and Responsibilities

The administrator and department supervisors have direct authority and responsibility for both the safe actions of employees and the safe performance of equipment within their department. Administration and the department supervisors shall:

- ✦ Ensure adherence to infection control policies and procedures not limited to, but including, the proper use of required personal protective equipment, aseptic technique, high level disinfection and sterilization.
- ✦ Take appropriate disciplinary action when safety rules are violated.
- ✦ Take prompt corrective action whenever unsafe working conditions are observed and report them to administration.
- ✦ Thoroughly investigate and report all accidents and take appropriate action(s) to prevent re-occurrence. All accidents shall be investigated, including those which do not result in injury or illness.
- ✦ Inform employees of the safety committee activities.
- ✦ Critique staff response during scheduled fire drills and emergency preparedness drills.
- ✦ Assess security and risk and make appropriate adjustments.

Each employee is responsible to practice safety on the job for themselves, patients, visitors, and other employees. Therefore each employee shall:

- ✦ Adhere to infection control policies and procedures not limited to, but including, the proper use of required personal protective equipment, aseptic technique, high level disinfection and sterilization.
- ✦ Report unsafe conditions to the department supervisor whenever a safety hazard or unsafe condition is identified.
- ✦ Promptly report all injuries and lost days due to work injuries or illness to the department supervisor.
- ✦ Use only equipment in safe operating condition. Tag and report defective equipment promptly.
- ✦ Respond to emergency situations in accordance with facility policies and procedures.

VI. INDICATORS AND THRESHOLDS

Continuing Safety Education and Training

- ✦ All new personnel are oriented to the Safety Management Program. Threshold 100%.
- ✦ All personnel participate in continuing safety education and training at least annually. Threshold 100%.

Hazardous Materials and Waste

- ✦ Proper storage of hazardous material. Threshold 100%
- ✦ Proper waste disposal equipment available. Threshold 100%
- ✦ Proper handling of hazardous material. Threshold 100%
- ✦ Fire drills conducted quarterly. Threshold 100%

Emergency Preparedness

- ✦ Drills are conducted semi-annually. Threshold 100%

Fire Safety

- ✦ Fire drills are conducted quarterly. Threshold 100%
- ✦ Portable fire extinguishers checked annually. Threshold 100%

Equipment Management

- ✦ Scheduled preventive maintenance is performed on patient equipment. Threshold: 100%.

- ✦ A summary of equipment problems / failures is immediately reported to the safety committee. Threshold 100%.

Security

- ✦ All theft and vandalism is immediately reviewed.

Performance Improvement

- ✦ A summary of actions taken by the performance improvement committee is reported quarterly. Threshold 100%

VII. DATA COLLECTION

Quality Indicator data, including patient care and other relevant data regarding furnished services, shall be incorporated. The data are used to monitor the effectiveness and safety of services and quality of care rendered. The data results will help identify opportunities to change and improve patient care. Data sources include:

- ✦ Incident Trending Report
- ✦ Infection Trending Report
- ✦ Patient / family / vendor complaints
- ✦ Patient Satisfaction Surveys
- ✦ Quality Assurance Committee findings

VIII. EVALUATION OF PLAN ACTIVITIES

IOS sets priorities for Quality Improvement activities that

- ✦ Focus on high risk, high volume and problem prone areas
- ✦ Consider incidence, prevalence and severity of problems in those areas
- ✦ Affect health outcomes, patient safety and quality of care

QI activities shall track adverse patient events, examine their causes, and ensure implemented improvements are sustained over time.

IOS shall implement preventive strategies throughout the facility, targeting adverse patient events and ensuring all staff members are familiar with the strategies.

IX. CORRECTIVE ACTION

The safety committee and other committees shall implement a corrective action and follow up for each indicator, as warranted.

X. ASSESS ACTIONS AND DOCUMENT IMPROVEMENT

The Safety / Quality Improvement Committee will oversee the effectiveness of corrective action and the progress toward problem solving resolution. The findings, conclusions, recommendations and follow-up will be reported to the medical executive committee and the governing board.

QUALITY IMPROVEMENT, RISK MANAGEMENT, AND PATIENT SAFETY PLAN

Specialty Surgery Center 2017

The mission of Specialty Surgery Center is focused on delivering the highest quality, cost effective healthcare that effectively responds to the needs and safety of our patients by minimizing the possibility for injury or harm to our patients. We are committed to the care, dignity and improvement of human life to the patient populations we serve.

In keeping with the mission of the Specialty Surgery Center, community, HCA initiatives, and regulatory standards for ambulatory surgical care, this plan allows for a planned, systematic, organization-wide approach to the quality improvement process, and assessing opportunities to reduce risk. This is accomplished through an effective risk and quality program, as well as a medication and radiation safety plan that are all targeted toward improving patient safety. The activities will be carried out in a collaborative and interdisciplinary manner. When identified, individual competency issues and process changes will be coordinated with management team and human resources. The overall strategies of the program include

- Improving patient safety and reducing risk to patients which includes, but not limited to medication and radiation safety, safe quality care and reducing risk of injury to patients and staff;
- Reducing medical/healthcare system errors and hazardous conditions by creating an environment in which patients, their families, surgery center staff, and medical staff are able to identify and manage actual or potential risks to patient safety;
- Assuring that quality improvement initiatives continue to focus on high priority areas of clinical care, monitoring of process and outcome indicators; redesigning processes and systems and providing education to foster improvement;
- Positioning the Specialty Surgery Center to achieve earning expectations and maintain effective cost-containment strategies while providing high quality of patient care, and
- Meeting the expectations of the HCA internal initiatives, as well as the external regulatory and accrediting bodies through the identification of opportunities to improve patient care, demonstration of appropriate action taken, and follow up on the effectiveness of action taken.

Strategies will be incorporated in each of the following areas to identify opportunities and set goals to achieve and sustain the desired results:

- Performance Improvement Processes
- Quality studies
- Risk Management Strategies
- Patient Safety Initiatives
- Infection Control Strategies
- Medication Safety Strategies
- Radiation Safety Initiatives

HCA Patient Safety Organization (PSO), LLC

HCA established a Patient Safety Organization, LLC in spring of 2014 in accordance with provisions of the Patient Safety and Quality Improvement Act (Public Law 109-41). The PSO is a component of its parent entity, HCA. The mission of the PSO is to conduct activities to improve patient safety and the quality of healthcare delivery. The vision is to assist participating providers in the elimination of preventable patient harm. The activities of the organization include:

- Improve patient safety and the quality of health care delivery
- Collect and analyze Patient Safety Work Product (PSWP)
- Develop and disseminate information regarding patient safety
- Utilize PSWP to encourage a culture of safety and provide assistance to effectively minimize patient risk
- Maintain procedures to preserve confidentiality and provide appropriate security of PSWP
- Utilize qualified medical personnel
- Operate a patient safety evaluation system (PSES) and provide feedback to participants of the PSO
- Utilizing the Serious Event Analysis (SEA) process to identify the root causes of adverse events

In early 2017 Specialty Surgery Center will begin to participate as a member of the HCA Patient Safety Organization (PSO), LLC. The Administrator will serve as the designated PSO Contact and oversees all activities of the PSO for the center. The Risk/Quality Manager shall serve as the Contact Designee, and the Administrator shall serve as the alternative. The Center will provide patient safety work products (PSWP) documents as requested by the PSO. The center will receive information from the PSES to evaluate opportunities for improving patient safety and quality care. All information submitted will remain confidential within the PSO.

Quality Improvement Plan

The Center maintains an ongoing quality improvement program that has a broad scope to address administrative, clinical, and cost effective performance. The program also addresses patient outcomes, patient care processes, as well as medication, radiation and patient safety. Elements of the program include, but are not limited to a:

- Written plan that addresses the scope of health care services provided by the Center and how the quality improvement plan for these services is assessed
- Interdisciplinary QI committee for the development, implementation, review and oversight of the program. The committee has administrative, clinical and physician participation
- Set of goals and objectives that are reviewed and updated at least annually
- Quality improvement activities such as audits and studies to identify problems with processes or patient care, evaluate them, and develop action plans when indicated. The studies will be done utilizing the ten (10) step process that is current practice in quality performance improvement
- Measurement of data against internal and external benchmarking sources
- Annual reviews of the effectiveness of the program
- Periodic reports to Governing Body that encompasses a summary of the quality improvement activities, findings and process changes if indicated

Risk Management and Patient Safety

Definitions of Potential Risk Issues:

Event: A discrete, auditable and clearly defined occurrence (NQF)

Occurrence: The action, fact, or instance of something that happens synonymous with an event; An event, situation, or process that contributes to, or has the potential to contribute to, a patient or visitor injury, or degrade our ability to provide optimal patient care. Reportable occurrences can generally be divided into the following types based on severity: Sentinel events, patient and visitor injuries, [adverse events], near misses (close calls, good catches), and safety concerns.(NPSF)

Incident: Synonymous with occurrence or event. An occurrence or event that interrupts normal procedure and can precipitate an untoward or unplanned outcome, or an unusual event that occurs at the facility, such as an

injury to a patient. Involved damage that is limited to parts of a unit, whether the failure disrupts the system or not. (NPSF). A patient safety event that reached the patient, whether or not the patient was harmed (NQF).

Adverse Event: Any deviation from usual medical care that causes an injury to the patient or poses a risk of harm. Events include errors, preventable adverse events, and hazards. An incident in which a patient is harmed (WHO). An injury or the risk thereof caused by medical management rather than the underlying disease. An untoward, undesirable, and usually unanticipated occurrence. An act of commission or omission arising during clinical care which causes physical or psychological injury to a patient regardless of severity, (NQF & NPSF). Any injury caused by medical care. An adverse event does not imply "error," "negligence," or poor quality care. It simply indicates that an undesirable clinical outcome resulted from some aspect of diagnosis or therapy, not an underlying disease process (AHRQ). Adverse events may be preventable or non-preventable (WHO).

Serious Preventable Adverse Events (SPAEE) / Sentinel event: A sentinel event is a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches the patient and results in any of the following (HCA policy definition):

- Death
- Permanent harm
- Severe temporary harm

In the ambulatory surgical setting, an event is also considered sentinel if it is one of the following:

- Discharge of an infant to the wrong family
- Abduction of any patient receiving care, treatment, and services
- Any elopement (that is, unauthorized departure) of a patient, leading to death, permanent harm, or severe temporary harm to the patient
- Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities (ABO, Rh, other blood groups)
- Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of any patient receiving care, treatment, and services while on site at the hospital
- Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of a staff member, licensed independent practitioner, visitor, or vendor while on site at the hospital
- Invasive procedure, including surgery, on the wrong patient, at the wrong site, or that is the wrong (unintended) procedure
- Unintended retention of a foreign object in a patient after an invasive procedure, including surgery
- Prolonged fluoroscopy with cumulative dose >1,500 rads to a single field
- Fire, flame, or unanticipated smoke, heat, or flashes occurring during an episode of patient care

Close Call / Near Misses / Good Catches: Events or situations that could have resulted in an adverse event (accident, injury, or illness), but did not, whether by chance or through timely intervention. Such events have also been referred to as "near miss" incidents. An example of a close call would be a surgery or other procedure almost performed on the wrong patient due to lapses in verification of patient identification, but caught prior to the procedure (Source: VA Patient Safety Program).

Reportable Event: Any event that is mandated to report by regulatory agencies or corporate within defined time frame. (HCA, CMS, FDA, SMDA, and/or local /state agencies).

Serious Event Analysis (SEA): A method of problem solving that tries to identify the root causes of faults or problems. The SEA process evaluates the underlying "why's" for the variance and solve problems by attempting to identify and correct the root causes of events, as opposed to simply addressing their symptoms. By focusing on the correction on root causes, problem recurrence can be prevented. An analysis is done *after* an event has occurred. All staff members involved, as well as, the Risk Manager, physicians involved shall participate in the SEA analysis. The SEA process is typically used as a reactive method of identifying event(s) causes, revealing problems and identifying opportunities to reduce the risk of future occurrences. The SEA action plan is reported at the quality meetings, MEC and GB meetings. In 2017 the ASD will be move toward an online program for analysis of serious events called Serious Event Analysis (SEA).

Risk Management

The Center maintains an ongoing risk management program that is designed to protect the life, safety and welfare of the patients and employees. Risk management addresses strategies from the organizational, operational, human resource and liability areas of the organization. Goals of the program include:

- Improving patient safety and reducing risk to patients
- Reducing medical/healthcare system errors and hazardous conditions by creating an environment in which patients, their families, surgery center staff, and medical staff are able to identify and manage actual or potential risks to patient safety
- Reviewing and tracking of all variance reports and litigations for trends
- Reviewing and tracking of all adverse outcomes, near misses (close calls) or sentinel events to identify gaps or opportunities for improvement
- Maintaining a strong credentialing and privileging process and current bylaws that meet community standards
- Keeping abreast of current standards for risk management and adapting practice and policies that are compliant with standards

It is evident through the goals, activities and processes that the quality improvement and risk management programs intertwine and cross all spectrums of the organization. Quality care, as well as patient and employee safety is at the center focus of both programs. The operational linkage between Risk management, Safety, Quality and Infection Control is accomplished through the following mechanisms:

- Issues or trends identified through chart reviews, peer reviews, safety, radiation and infection control rounds are discussed and referred to the appropriate department for evaluation and/or corrective action
- Data from variances, identified trends, adverse events or any events that impact the quality or safety of patient care will be reviewed and referred to appropriate risk and leadership personnel for investigation, analysis and corrective action
- The Risk Manager will review current issues and risk reduction strategies with appropriate personnel and develop a plan of action. This action plan will be reported to MEC/GB.
- The Quality Committee will serve as the oversight committee for Patient Safety and Risk management. Medication Safety and Radiation Safety fall within a subsection of the Quality Committee and will be addressed as indicated.

These plans engage active involvement of all members of the healthcare team, as well as patients, families and physicians, addressing an environment which:

- Encourages recognition and acknowledgment of opportunities to improve quality performance and to reduce risks to patient safety
- Initiates actions to improve processes or reduce these risks
- Encourages internal reporting of what has been found and the actions taken
- Focuses on processes and system
- Minimizes individual blame or retribution for involvement in a medical/health care error; and
- Challenges leaders of the organization to be responsible for fostering a “non punitive” culture of continuous improvement, reducing risk, and creating a safe environment for patients, employees and physicians.

Medication Safety

The Regional HCA Pharmacist oversees the medication practices and processes at the center. Their duties include, but not limited to:

- Conducting medication rounds and audits providing feedback on areas of opportunities
- Collaborating with the center on choice of pharmaceutical vendors and formularies
- Collaborating with the center on policy review and development
- Participating in review of any medication error or diversion
- Assuring controlled substance ordering and monitoring is in accordance to state and federal regulations

All relevant activities are reported through QI/MEC/GB committees

Radiation Safety

This facility utilizes radiation emitting equipment and therefore, by direction of the Governing Body/Board. Radiation Safety will be a subgroup of representatives will be included under the QI/Safety/Risk committee to report radiation safety activities. Key activities are established by the Radiation Right policies identified as CSG.MI.001 Governance and CSG.MI.003 Fluoroscopy:

- Designate an individual that is approved by MEC/GB to oversee the program
- Oversee ongoing measurement, periodic review, and improvement of key radiation safety practices and provide a quarterly report to the QI/Risk/Safety committee
- Periodic maintenance of equipment
- Maintaining exposure time logs
- Communicate relevant radiation safety activities, as necessary, to the staff.
- Serve as a resource for radiation safety as it relates to staff and patient safety/regulatory issues and for the regulatory component of accrediting agencies.
- Educate staff on radiation safety practices

Infection Control

The center conducts an annual infection control risk assessment to identify areas of opportunities to reduce the risk of infections. (See Infection Control Plan) All infection control activities are reported though QI/MEC/GB.

Peer Review

Ambulatory Surgery Centers are required by AAAHC, CMS, and other regulatory agencies to conduct quality improvement and peer review on Medical Staff and Dependent Healthcare Practitioners (DHP). Peer review activities include ongoing random review, specialty specific review and review of events / complications. Whenever possible, peer review is done by a physician of like specialty.

Whenever possible to avoid conflict of interest, peer review cases will be referred to physicians who are not affiliated with the practitioner being reviewed, and no physician will review a patient's care in which she/he has been professionally involved. Provisions are made to have cases evaluated by an outside expert when necessary.

Confidentiality

All quality improvement and peer review activities and data are considered confidential. Any requests for outside sources for any QI, Risk management, Peer Review or credentialing information or reports will be forwarded to the appropriate HCA administrative/corporate staff when indicated.

ORGANIZATION STRUCTURE AND PROCEDURE

Role of Leadership

Leaders play a key role in facilitating improvement and ensuring a safe environment. Specialty Surgery Center leadership includes the Governing Body, Medical Executive Committee; the facility based Medical Director, Administrator, Risk/Quality/Safety/Infection Control designees and Clinical Managers. Leaders foster quality improvement through planning, educating, setting priorities, providing support such as time and resources, and empowering staff as appropriate.

Governing Board/Medical Executive Committee

The Board has the ultimate authority and accountability for the quality and risk programs to ensure that the quality of patient care is provided in an efficient, timely and cost-effective manner. The Governing Body provides support for the improvement strategies and delegates to the Medical Executive Committee and leaderships at each facility, the authority to perform assessment and improvement activities through committees and teams. Quarterly, the Governing Body shall receive a report on the activities of the quality and risk management programs. These functions include, but not limited to:

Infection Control Coordinator:	Name Here RN
Patient Safety Committee Chair:	Name Here RN
Radiation Safety Officer	Name Here, M.D.

Key activities:

- Establish and oversee ongoing measurement, periodic review, and improvement of key processes
- Assist in identifying opportunities for improvement and participate in QI studies. In addition conduct re-audits to assure the changes have remained effective
- Participate in Ambulatory Surgery Division quality, risk and patient safety initiatives including Best Practices
- Communicate relevant activities, as necessary, to the staff
- Support a system that builds and reinforces a non-punitive culture for reporting and reducing errors
- Serve as a resource for patient safety/regulatory issues and for the regulatory component of accrediting agencies
- Provide periodic reports on quality improvement activities to Medical Executive Committee and Governing Board
- Educate staff on quality, risk and patient safety activities

Quality Studies

Quality studies will reflect the scope of services, priorities and findings from performance monitoring or other sources. Studies will address clinical, administrative, and/or cost of care issues and will be documented in the (10) step format which includes:

- State the purpose of the process improvement opportunity/purpose of the study
- Identify the goal of the study
- Description of data to be collected and established criteria
- Evidence of Data Collected
- Data analysis
- Comparison of actual data to goal
- Development of corrective action and execution timeline
- Re-measurement and monitoring to determine if actions have been achieved and improvements are sustained
- Development of additional corrective actions if needed
- Communication of results to appropriate personnel, MEC and Governing Board

Staff Education

The staff receives an orientation on quality improvement, risk management, infection control and patient/employee safety initiatives to be completed within 30 days of employment as part of new employee orientation. At least annually, a review of the process and accomplishments will be conducted through an appropriate mechanism. Clinical leaders will receive periodic training on any updates to initiatives, new statistical reporting or other information as indicated.

Ongoing Measurement

Ongoing measurement is overseen by the Quality/Risk Manager in collaboration with the Facility Administrator and Medical Director. These are outlined on the addendum to this plan.

Design of New Processes

When Specialty Surgery Center is considering a new process (for example, providing a new patient service, constructing a new facility, or redesigning an existing service), a multidisciplinary team will be convened to ensure that the process considers:

- The organization’s mission, vision and strategic plans

- Patient and community needs
- Information about performance and outcomes of the process (including information from reference data bases)
- Current evidence based practice and research
- Current regulatory standards

Periodic Assessment and Improvement

Based on ongoing review of measurement data, this plan provides for assessment of data against historical trends and available benchmarks whenever possible. All measures are reviewed quarterly by the Quality Committee, Medical Executive Committee and Governing Board.

Assessment is automatically triggered for any of the following:

- By any sentinel event
- By important undesirable single events, which include at a minimum:
 - Credentialing or bylaw violation
 - “Close call / Near miss” event
 - Significant injury or death
 - Any significant untoward event during moderate sedation or anesthesia
 - Any serious adverse drug or medication error event
 - Any significant hazardous condition
 - Any significant infection control breach or trend
- By important undesirable patterns or trends, which include at a minimum:
 - Staffing effectiveness or clinical issues
 - Any quality measure that varies substantially from an expected range
 - When the organization’s performance significantly varies below that of other ambulatory surgery settings or recognized standards

Select quality data is submitted to corporate and trended with internal benchmarks across the company. This information is shared at the facility, division and corporate level. This information is used to develop corporate wide quality and risk initiatives and for external benchmarking in the ambulatory surgery arena.

In addition to ongoing measurement, the Center may at any time proactively assess its culture of patient safety as well as specific processes of care that have been within the healthcare industry as having the potential to harm patients. Also the Center may periodically assess processes using tools provided from a variety of outside sources to identify potential risks to patients and opportunities for improvement.

ONGOING QUALITY AND RISK MANAGEMENT PERFORMANCE MEASUREMENTS

Customer Satisfaction Surveys

- Patient surveys done after discharge (written survey, call, email)
- Post op phone calls
- Employee Surveys as designated by corporate
- Physician surveys as designated by corporate
- Patient complaints (response and corrective action)
- Physician complaints (response and corrective action)

Patient Flow

- On time start of surgical cases
- Consistent delays in surgeries
- Turn around time
- Cases pulled correctly

- Equipment issues
- Cancelled cases (pre and intra-op)

Anesthesia Care

- Conscious sedation monitoring standards are standardized and consistent
- Anesthesia Care: complication rates for general/regional, assessment and plan of care developed prior to the start of anesthesia, physiological monitoring
- Annual malignant hyperthermia drill

Pre-op Care

- Completion of One Medical Passport prior to day of procedure
- Appropriate follow through on obtaining pre-op diagnostic studies per anesthesia guidelines and follow up on abnormal reports
- Pre op instructions
- DVT assessment –including use of SCD when indicated
- Falls Assessment
- Sleep Apnea assessment and Incentive Spirometer started on designated patient population (if applicable)

Intra-op Care and Processes

- Time Out/correct site process
- Retained foreign bodies
- Wrong sites
- Near misses / close calls
- Blood usages
- Complications

Complications

- Unexpected complications
- Post op DVT/PE
- Transfers to acute care (Direct Hospital Admits/ ER Transfers)
- Hospitalization or ED visit within 72 hours of discharge (Indirect Hospital Admits / ER visits)
- Variances of expected performance through clinical record review
- Mortality within 7 days of procedure or related to procedure.
- Falls
- Burns
- Loss of Vision

Resuscitation / Emergency Response

- Code blue drill(s) - Adult and Pediatric if there is a pediatric population
- Malignant Hyperthermia drill
- Emergent Blood drill
- Crash carts, Malignant Hyperthermia carts checked according to policy

Diagnostics Results

- Pre-op diagnostic studies clinically reviewed and documented.
- Pre- and post operative diagnosis agreement

Medication Usage

- Utilize “One Source” truth for allergy documentation
- Medication Reconciliation process

- Use of Medication Administration Record (MAR) for consistency in medication documentation
- Medication errors
- Adverse drug reactions
- Appropriate labeling of high alert and look alike/sound alike medications
- Independent double checks with administration of designated high risk medications
- Controlled substance audits
- External pharmacy audits
- Surveillance of security of medications and needles
- Verbal and telephone orders are read back and verified
- Appropriate medication ordering, preparation and administration of medications.
- Utilizing approved compounding pharmacies and continual monitoring for FDA alerts.

Infection Control

- Annual infection control risk assessment (ICRA)
- Proactive influenza vaccination program
- Compliance with hand washing standards- direct observation.
- Monitor compliance with cleaning protocols
- No use of razors except for urology cases
- Appropriate timing of pre-op prophylactic antibiotic administration
- Post-op infections (rate, type of organism, environmental causes) within 30 days of surgery
- Implant monitoring for 90 days
- OSHA training during orientation and annually
- Employee, physician, allied health and patient exposures
- Appropriate sterilization processes for instrumentation (quarterly audits – HCA BoosterPak)
- Appropriate endoscopy re-processing if applicable (quarterly audits – HCA BoosterPak)
- Monitoring IUSS rates
- 24/7 Monitoring of temperature and humidity of designated rooms

Provision of Care/ Medical Record Review

- Appropriate credentialing of medical staff
- Physician H&P on chart prior to start of surgery
- H&P reviewed on day of surgery and updated if indicated to include patient acceptable candidate for ASC setting
- Required elements of assessment documented
- Pain assessment on admission, during Phase I and prior to discharge
- Fall assessment during admission process and discharge
- Operative reports: timeliness, content, intra-operative progress note completion
- Appropriate monitoring during IV conscious sedation by non-anesthesia personnel (if applicable)
- Timely medical record completion
- Medication Reconciliation completed

Equipment

- Routine preventive maintenance
- Compliance with process of notification and removal of malfunctioning equipment.
- Initial and annual competencies

Safety

- Surveillance rounds and corrective follow up on deficiencies
- Process for notifying and following through on recalls
- Periodic checks for life safety and environmental equipment

- Fire drills
- Emergency preparedness drills
- Infant/child abduction drill
- Sharps prevention program
- Incapacitated healthcare provider drill
- Active Shooter drill

Radiation Safety

- Staff and physician training in radiation safety
- Physician and staff training in use of C-arms
- Compliance with radiation safety measures- direct observation
- Appropriate use of radiology equipment and shielding
- Dosimeter badge reports

Patient Safety

- Use of two patient identifiers- direct observation
- One source truth for allergies noted and communicated
- Time out verification for procedures
- Surgical Site marking
- Appropriate use of abbreviations
- Latex allergy precautions
- Falls prevention guidelines
- DVT assessment
- Close calls
- Hand off communication

EVALUATION OF THE 2016 QUALITY PROGRAM

1. Evaluation of 2016 Quality/Risk/Patient Safety Plan

- 100% Grievances entered into Risk Management workbook **and addressed** within time frame dictated by policy in 2016. (# grievances within time frame / #total grievances entered)
- 99% staff that received annual Risk Management In-service in 2016. (# staff with in-service/ total number staff at time of in-service)
- 100 % compliance with 2016 Risk Reduction Program (#components completed/#components required)
- 100 % of the HCA High Level Disinfection & Central Sterile Processing Boosterpak deliverables met
- 1 (#) Sentinel Events in 2016 and SEA completed.
- Comments: SEA was completed and reviewed by DQRM. Plan was accepted and process improvements were noted and implemented.

2. Goals – met / not met (if not met – Explain)

Division Goals

- To continue to reduce the number of sharp occurrences. (In 2014 the Division reported 20 occurrences and in 2015 the Division reported 17 sharp occurrences.)
- To continue to reduce the number of falls. (In 2014 there were 25 falls reported within the Division and in 2015 with the implementation of the falls toolkit, the falls reported rate decreased to 14 reported falls in 2015.)

- To complete the 2016 Risk Reduction Program Initiatives. **Completed.**
- To meet the 2016 ASD Clinical Objectives. – **Completed/Met**

Center specific Goals

- To reduce the number of falls within the facility – **Met.**
- To reduce sharp incidents within the facility – staff will review systems by 3rd quarter 2016 – **partial.**
- To continue to monitor for compliance with past agenda it4ems to ensure full compliance. – **Met.**

2017 QUALITY / RISK GOALS

2017 Clinical Agenda

- Medication Safety – all patients are weighed upon admission and documented in kg
- Medical Director Engagement – Conference attendance; Conduct Stanford Emergency Drills
- Infection Control – Certification for Sterile Processing and Endoscope processing
- Tissue Management – Perform tissue handling gap analysis; complete action items; staff education
- Unintended Retained Surgical Item Prevention – Review policies; update OR record for policy compliance; Use of standardized white boards for all surgical procedures.

2017 Division Goals

- To continue to reduce the number of sharp occurrences by implementing the sharps safety toolkit. In 2016 the Division reported an increase in sharp occurrences, in 2015 the Division reported 15 sharp occurrences.
- To decrease the Direct Hospital Admission rate per thousand by identifying commonalities/trends and increasing the use of One Medical Passport at the centers
- To sustain 100% compliance with IV Prophylactic Antibiotic Administration during 2017
- To complete the 2017 Clinical Safety Improvement (CSIP) Plan (Risk Reduction Program Initiatives).
- To meet the 2017 ASD Clinical Objectives

2017 Center Goals

- Perform monthly intraocular audits; in OR and in place
- Embelish usefulness with One Source documents; complete binder with most utilized procedures/instruments for immediate reference.
- Perform monthly facility rounding tool.
- Increase utilization of One Medical Passport by 20% by the end of the 2nd quarter of 2017.
- ICRA review annually.

Kindred Hospital Las Vegas Flamingo Campus

PATIENT SAFETY PLAN

DATE: 02/19/18



This plan was created and revised by the Kindred Hospital Las Vegas Flamingo Campus Patient Safety committee/team. Implementation of this plan is intended to optimize the healthcare quality and patient safety outcomes, encourage recognition, reporting, and acknowledgment of risks to patient, visitor, and employee safety, as well as reduce the medical/healthcare errors and /or preventable events.

Patient Safety Committee/Program
Kindred Hospital Las Vegas Flamingo Campus
2250 East Flamingo Road
Las Vegas, Nevada 89119

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Commitment to Patient Safety

Kindred Hospital Las Vegas Flamingo Campus is committed to a comprehensive approach to improving healthcare quality and patient safety by aligning with our Mission, Vision, and Values, creating an environment that supports a dynamic, proactive, and safe culture for patients, family members, visitors, and employees, through continuous learning and improving patient safety policies, systems, and processes.

Mission, Vision, and Values

In support of our mission, vision, and values, Kindred Hospital Las Vegas Flamingo Campus Patient Safety and Quality Improvement program promotes:

- Collaboration of healthcare, leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high quality healthcare.
- Communicate honestly and openly to foster trusting and cooperative relationships among healthcare providers, staff members, and patients and their families, to ensure accountability for the patient safety priorities.
- Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.
- Responsibility for every healthcare related decision and action.
- A focus on continuous learning and improving, system design, and the management of choices and changes, bringing the best possible outcomes or performances to the facility.
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare.
- Education of staff and physicians to assure participation of healthcare providers.

Scope and Purpose

The scope of this Quality and Patient Safety Plan is organizational-wide/hospital-wide/agency-wide which includes but is not limited to

- Patient safety
- Visitor safety
- Employee safety

All staff in Kindred Hospital Las Vegas Flamingo Campus are required to fully support and participate in this plan, and devote their expertise to the patient safety and healthcare quality improvement process.

This plan is action oriented and solution focused. The purpose of this plan is to address patient safety related concerns, challenges and revise the program to better serve the patients and their families. To this end, Kindred Hospital Las Vegas Flamingo Campus has developed this Patient Safety Plan.

The plan focuses on the process rather than the individual, and recognizes both internal and external customers, as well as facilitates the need of analyzing and improving processes. The

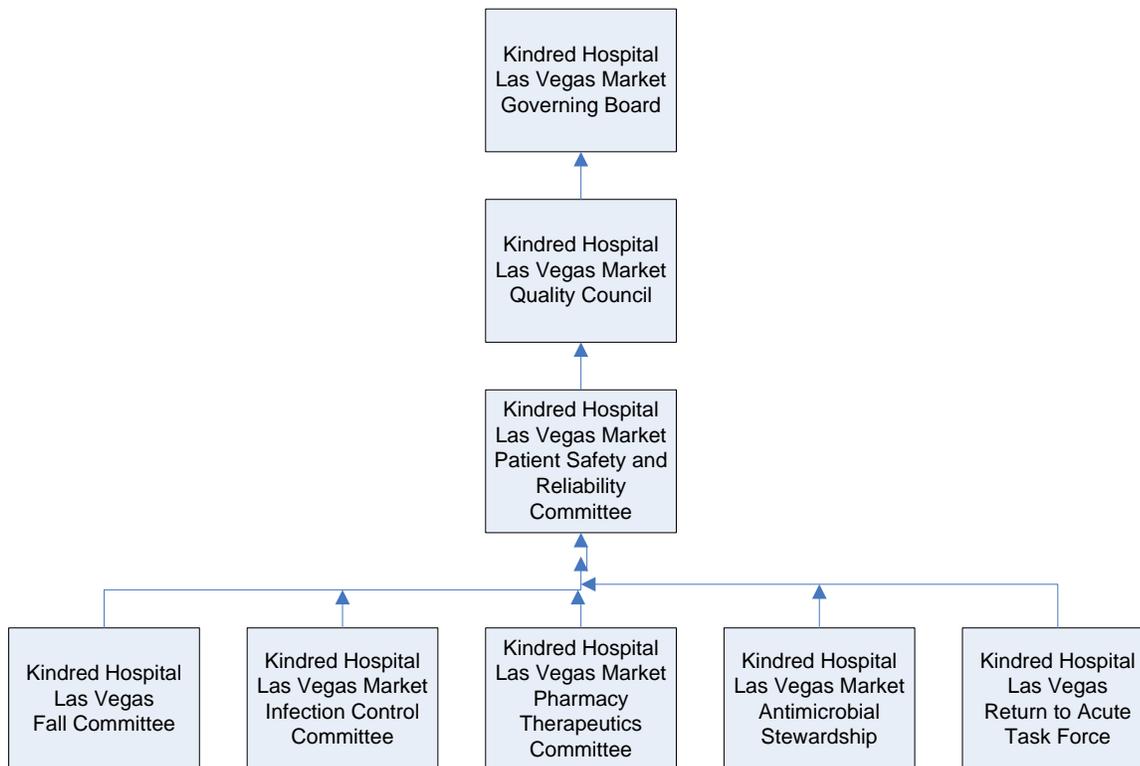
core principles of this plan include:

- All staff have the same goal and contribute their knowledge, vision, skill, and insight to improve the process of the Patient Safety Plan.
- Decisions will be based on data and facts, and staff will be encouraged to learn from the experiences.
- Customer based including patients, families, and visitors.
- Promote systems thinking.
- Employ well-trained and competent staff maintaining high healthcare quality.

Roles and Responsibilities

According to [NRS 439.875](#), a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plan is promoted and executed successfully.

The Patient Safety Committee Organization



Roles and Responsibilities

- In accordance with [NRS 439.875](#), a patient safety committee must be comprised of:
- The infection control officer of the medical facility;
- The patient safety officer of the medical facility, if he or she is not designated as the infection control officer;

- At least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility; and
- One member of the executive or governing body of the medical facility.

Based on [NAC 439.920](#), a medical facility that has fewer than 25 employees and contractors must establish a patient safety committee comprised of:

- The patient safety officer of the medical facility;
- At least two providers of healthcare who treat patients at the medical facility, including but without limitation, one member of the medical staff and one member of the nursing staff of the medical facility; and
- The Chief Executive Officer (CEO) or Chief Financial Officer (CFO) of the medical facility.

The roles and responsibilities are defined below (Please modify them as needed.)

Patient Safety Committee Responsibilities (based on [NRS 439.875](#) and [NRS 439.877](#))

- Monitor and document the effectiveness of the patient identification policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the patient safety officer pursuant to [NRS 439.870](#).
- Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred.
- Review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- Review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the executive or governing body of the facility regarding:
 - (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);
 - (2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and
 - (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

Root Cause Analysis (RCA) Team Responsibilities

- Root Cause interviews, analysis, investigation, and corrective action plan implementations.
- Participates in the RCA meetings and discussions.
- Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders.

Patient Safety Officer Responsibilities (based on [NRS 439.870](#))

- Serve on the patient safety committee.
- Supervise the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the patient safety committee regarding any action taken in accordance with the responsibilities above.

Infection Control Officer Responsibilities (based on [NRS 439.873](#))

- Serve on the patient safety committee.
- Monitor the occurrences of infections at the facility to determine the number and severity of infections.
- Report to the patient safety committee concerning the number and severity of infections at the facility.
- Take such action as determines is necessary to prevent and control infections alleged to have occurred at the facility.
- Carry out the provisions of the infection control program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program.

RCA Team Leader Responsibilities

- Organize and coordinate the RCA process.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA, and corrective action plan implementation process.
- Communicate the progress of the investigation, institutional barriers, and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.
- Provide training, education and direction to create RCA process that incorporate the Patient Safety and Quality Improvement elements.

RCA Facilitator Responsibilities

- Provide vision and leadership to the Root Cause Analysis process
- Work with the Director of Quality Management to assure process changes are implemented
- Guide the staff in the process of discovery and mitigation of future process failures

Executive or Governing Body Staff Responsibilities

- Provide vision and leadership to Patient Safety and Quality Improvement process, and develop and foster a safe learning and improving culture.
- Provides oversight to the healthcare quality improvement processes and teams.
- Plan, discuss, and generate the organization patient safety goals and activities, in conjunction with the patient safety action plans
- Provide fiduciary responsibilities

The Patient Safety Committee will meet monthly to accomplish the following:

- Report and discuss sentinel events which include:
 - Number of sentinel events from previous calendar month.
 - Number of severe infections that occurred in the facility.
- Corrective Action Plan for the sentinel events and infections
 - Evaluate the corrective action plan.
- Patient safety policies and checklists
 - At least annually evaluate Patient Safety policies and checklists
 - Revise the patient safety policies and checklists as needed.
 - Monitor and document the effectiveness of the patient safety policy.

A RCA meeting will meet as needed to accomplish the following:

- Define the healthcare issues or potential risks.
- Conduct Root Cause Analysis
 - Reviewing and analyzing the data.
 - Reviewing the RCA process and quality improvement related activities and timelines.
 - Brainstorming issues or the potential risks by using the fishbone diagrams.
 - Identify the contributing factors and conduct the Root Cause Analysis.
- Conduct Corrective Action Plan
 - Identifying the Plan-Do-Study-Act (PDSA) topics.
 - Discussing corrective action process and activities.
 - Discussing and presenting possible changes in procedure to improve areas indicated.
 - Identifying strengths and areas that need improvement.
 - Developing strategies, solutions, and steps to take next.
- Identify barriers and technical assistance needs for supporting the RCA efforts.

A meeting agenda and minutes noting follow-up tasks will be kept.

Objectives and Goals of the Quality and Patient Safety Plan

Objective	Goals	Plan	Planned Completion Date	Responsible Party
CLABSI Prevention	Reduce CLABSI by 10%	<ol style="list-style-type: none"> 1) Use Tegaderm Dressings 2) CHG Bathing Program 3) Staff education and competencies on hire and annually thereafter 4) Develop nurse-driven protocol for discontinuation of lines 5) RCA performed for each event 	12/31/18	ICP/CCO
CAUTI Prevention	Reduce CAUTI by 10%	<ol style="list-style-type: none"> 1) Staff education and competencies on hire and annually thereafter 2) Evaluate use of external female urine systems 3) RCA performed for each event 	12/31/18	ICP/CCO
NOWPU Prevention	Reduce NOWPU by 10%	<ol style="list-style-type: none"> 1) Use of Patient Safety Index to assure HAPU prevention 2) Braden Scale, Repositioning, Assessment and Wound Education to Patient Family Score 	12/31/18	Wound Care Coordinator/ Chief Clinical Officer

		3) RCA done for each event		
Antimicrobial Stewardship	Reduce Antibiotic usage to \leq 35% of total drug cost	<ol style="list-style-type: none"> 1) Enhance the Patient Safety Dashboard for Antimicrobial Therapy Use 2) Incorporate the Pharmacist/ICP/ Infectious Disease MD rounding 3) Staff, physician and Leadership Education 	12/31/18	Director Pharmacy/ICP/C CO/ID Medical Director
Fall Reduction	Reduce falls by 10%	<ol style="list-style-type: none"> 1) Fall risk assessment completed for each patient, each shift 2) Reimplement market Fall Reduction Performance Improvement Team 3) Staff education on hire and annually thereafter 4) Post-fall assessment completed for each event 	12/31/18	DQM/CCO

Components and Methods

Pursuant to [NRS 439.837](#), a medical facility shall, upon reporting a sentinel event pursuant to [NRS 439.835](#), conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event.”

Kindred Hospital Las Vegas Flamingo Campus will use RCA process to determine the contributing factors and the underlying reasons for the deficiencies or failures. The Plan-Do-Study (check)-Act (PDSA or PDCA) is the model, which was developed by the Institute of Health Care Improvement, which we will use to test the changes.



Root Cause Analysis

A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals.

Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

Root cause analysis and action plan framework table, which was introduced by the Joint Commission. It contains 24 analysis questions. It guides the organization to the steps in a root cause analysis. Not all the questions apply to all the events or cases. This table can be used individually or with the fishbone diagram.

5 Whys technique will be used in Kindred Hospital Las Vegas Flamingo Campus to explore the cause and effect relationship underlay a problem. One can find the root causes by asking “why” no less than five times. This technique can be used individually or as a part of the fishbone diagram.

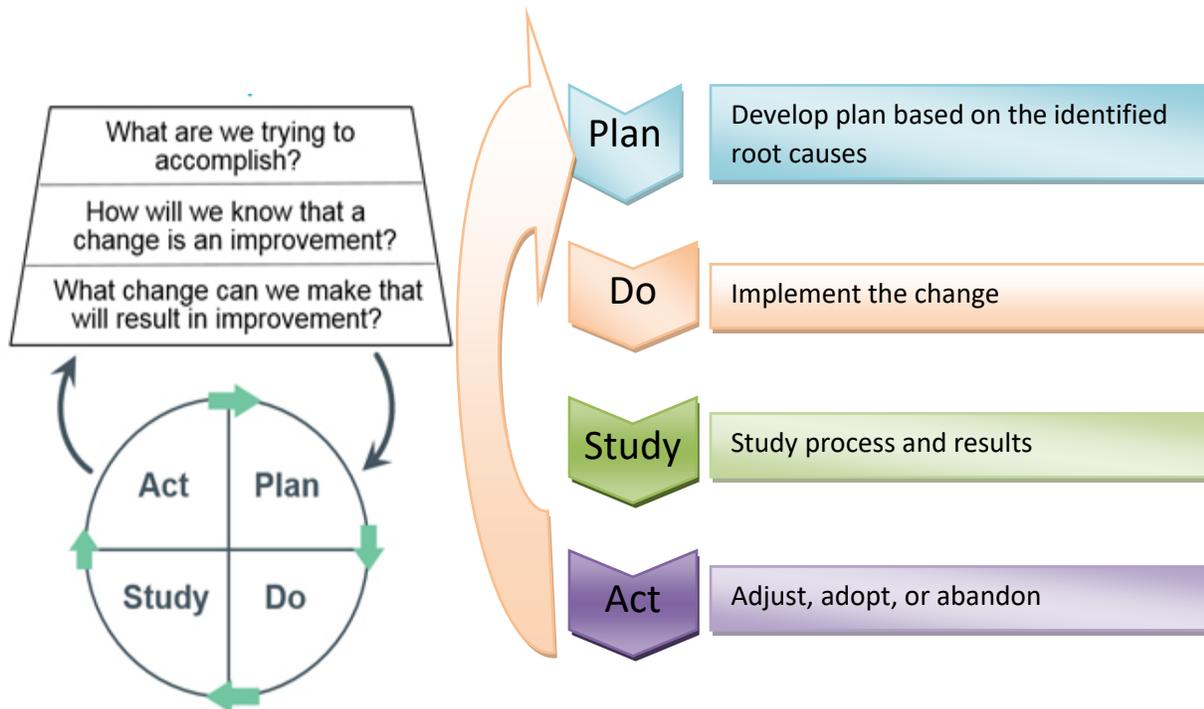
Fishbone Diagram

Once the problems are identified, a Fishbone Diagram (Appendix C) will be used for analyzing the problems. You can use the fishbone diagram individually to analyze the root causes, or use it with the root cause analysis and action plan framework table.

A Fishbone Diagram, also called a Cause-and-Effect diagram, is a useful tool for a team to structurally brainstorm by discovering possible underlying factors or root causes from different major categories for the chosen problems. General categories used include: people, methods, materials, measurements, education, procedures, process, location, environment, etc. RCA team members will brainstorm and ask multiple times, “why did this happen?” for each cause until all ideas are exhausted. The highest priority root causes will be chosen for PDSA topics. Once all the categories are established on the fishbone diagram, 5 Why’s technique also can be used to drill down the problem and find the root causes.

Model for Improvement

The Model for Improvement is a collaborative and ongoing effort model to improve the product and services quality and process. It provides multi-disciplinary quality team guidance from identifying the root causes; conducting the best tests to assess possible changes, and working in collaboration for implementation of the new approaches and solutions. It guides the test of a change to determine if the change is an improvement.



The cycle is defined as follows:

- Plan--collect data and establish appropriate goals. Identify the problem and the possible root causes, and answer the following questions.
 - What is the objective of the test?

- What are the steps for the test - who, what, when?
- How will you measure the impact of the test?
- What is your plan to collect the data needed?
- What do you predict will happen?

- Do--make changes designed to correct or improve the situation. Use the following questions for the guidance.
 - What were the results of the test?
 - Was the cycle carried out as designed or planned?
 - What did you observe that was unplanned or expected?

- Study -- Study the effect of the changes on the situation. Data should be collected on the new process and compared to the baseline or expected results. Results should be evaluated and by using the following questions as guidance.
 - Did the results match your prediction?
 - What did you learn?
 - What do you need to do next?

- Act--If the result is successful or desirable, standardize the changes and then work on the next prioritized problem or the further improvements. If the outcome is not yet successful, look for different ways to identify the causes or change the testing process.

PDSA worksheet will be used to map the potential change strategies and to establish a course of action. The PDSA worksheet and the PDSA progress report are attached in Appendix D-1.

Data Collection and Reporting

Data should drive any quality and patient safety effort. Kindred Hospital Las Vegas Sahara Campus is using the Kindred Event Reporting System for tracking the incident and sentinel events, NHSN for reporting healthcare infection data, WebIZ for reporting vaccinations, and Business Warehouse and Meditech for internal data collection.

External data sources are those data sources which are collected outside the supervisory structure of the case. External data which will be utilized for Quality and Patient Safety plan include the data from:

- AHRQ: Agency for Healthcare Research & Quality
- CDC: Centers for Disease Control and Prevention
- CMS: Centers for Medicare & Medicaid Services
- NQF: National Quality Forum
- NHSN: National Healthcare Safety Network
- TJC: The Joint Commission



Ongoing Reporting and Review

Data points such as the following will be reviewed according to the schedule prescribed:

Monthly	Quarterly	Annually
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<p>1) Sentinel event monthly report</p> <p>2) Severity of infection report</p> <p>3) RCA assessment</p>	<p>1) Sentinel event quarterly report</p> <p>2) Severity of infection report</p> <p>3) Review and evaluate the measure of improvement of patient safety</p> <p>4) Review and evaluate the measurement to prevent and control infections</p>	<p>1) Quality and Patient Safety Plan update</p> <p>2) Checklists and Policies reviewing and revising</p>
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Assessment of the Quality and Patient Safety Plan

Please see the Patient Safety Assessment Tool (PSAT) from the VA National Center for Patient Safety for your reference.

Patient Safety Checklists and Patient Safety Policies

By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

The patient safety checklists must follow protocols to improve the health outcomes of patients at the medical facility and must include, without limitation:

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.
- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - Proper instructions concerning prescription medications;
 - Instructions concerning aftercare;
 - Any other instructions concerning his or her care upon discharge; and
 - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include, the name and date of birth of the patient.
- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.
- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

Based on [NRS 439.865](#), the patient safety plan must also include an infection control program that carries out the infection control policy. The policy must consist of:

- The current guidelines appropriate for the facility's scope of service developed by a nationally recognized infection control organization as approved by the State Board of Health which may include, the Association for Professionals in Infection Control and Epidemiology (APIC), the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO) and the Society for Healthcare Epidemiology of America (SHEA); and
- Facility-specific infection control developed under the supervision of a certified Infection Preventionist.

The patient safety checklists are listed in Appendix E. (The following links provide some patient safety checklists for your reference— a checklist example is shown in **Appendix E.**)

http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf

<http://www.who.int/patientsafety/implementation/checklists/en/>

The patient safety policies are listed in Appendix F. (The following link provides you some patient safety policies for your reference—a policy example is shown in **Appendix F.**)

<https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>

Approval of Patient Safety Plan

According to [NRS 439.865](#), a medical facility shall submit its patient safety plan to the governing board of the facility for approval. After a facility's patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan.

The patient safety plan must be reviewed and **updated annually** in accordance with the requirements for approval set forth in this section.

According to [NRS 439.843](#), on or before March 1 of each year, a copy of the most current patient safety plan established to [NRS 439.865](#) must be submitted to the Division of Public and Behavioral Health.

Reference

- Root Cause Analysis Toolkit <http://www.health.state.mn.us/patientsafety/toolkit/>
- Quality and Service Improvement Tools http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html
- CQI 101 An Introduction to Continuous Quality Improvement: <https://www.coursehero.com/file/13827355/CQI-Overviewppt/>
- Quality Improvement <http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/>
- Root Cause Analysis <http://www.patientsafety.va.gov/professionals/onthejob/rca.asp>
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2 https://www.jointcommission.org/sentinel_event.aspx
- Hospital Policies <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>
- Checklists to Improve Patient Safety http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf
- Patient Safety Checklists <http://www.who.int/patientsafety/implementation/checklists/en/>
- Minutes of the Meeting of the Quality and Patient Safety Committee <http://www.cookcountyhhs.org/wp-content/uploads/2013/12/09-23-14-QPS-scan-Minutes.pdf>
- Title 40 – Public Health and Safety <https://www.leg.state.nv.us/NRS/NRS-439.html>

Appendix A: Terms and Definitions

Patient Safety: The Agency for Healthcare Research Quality (AHRQ) defines patient safety as “a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.”

http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

Sentinel event ([NRS 439.830](#))

1. Except as otherwise provided in subsection 2, “sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum.

2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:

(a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or

(b) July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published.

3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.

(Added to NRS by [2002 Special Session, 13](#); A [2005, 599](#); [2013, 217](#))

Institute for Healthcare Improvement (IHI) defines **medical harm** as “unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death.”

Facility-Associated Infection: ([NRS 439.802](#))

“Facility-acquired infection” means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections;
- Ventilator-associated pneumonia;
- Central line-related bloodstream infections;
- Urinary tract infections; and
- Other categories of infections as may be established by the State Board of Health by regulation pursuant to [NRS 439.890](#).

(Added to NRS by [2005, 599](#); A [2009, 553](#))

Medical facility ([NRS 439.805](#))

“Medical facility” means:

- A hospital, as that term is defined in [NRS 449.012](#) and [449.0151](#);
- An obstetric center, as that term is defined in [NRS 449.0151](#) and [449.0155](#);
- A surgical center for ambulatory patients, as that term is defined in [NRS 449.0151](#) and [449.019](#); and
- An independent center for emergency medical care, as that term is defined in [NRS 449.013](#) and [449.0151](#).

(Added to NRS by [2002 Special Session, 13](#))

Near miss: An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Mandatory reporting: Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985;254(6):796-800.)

Risk: Possibility of loss or injury. (Merriam-Webster's Online Dictionary, Risk, Available at <http://www.merriamwebster.com/dictionary/risk>. Last Accessed August 2009.)

Preventable event: Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Catheter Associated Urinary Tract Infection (CAUTI): A urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CUR_RENT_b.pdf.)

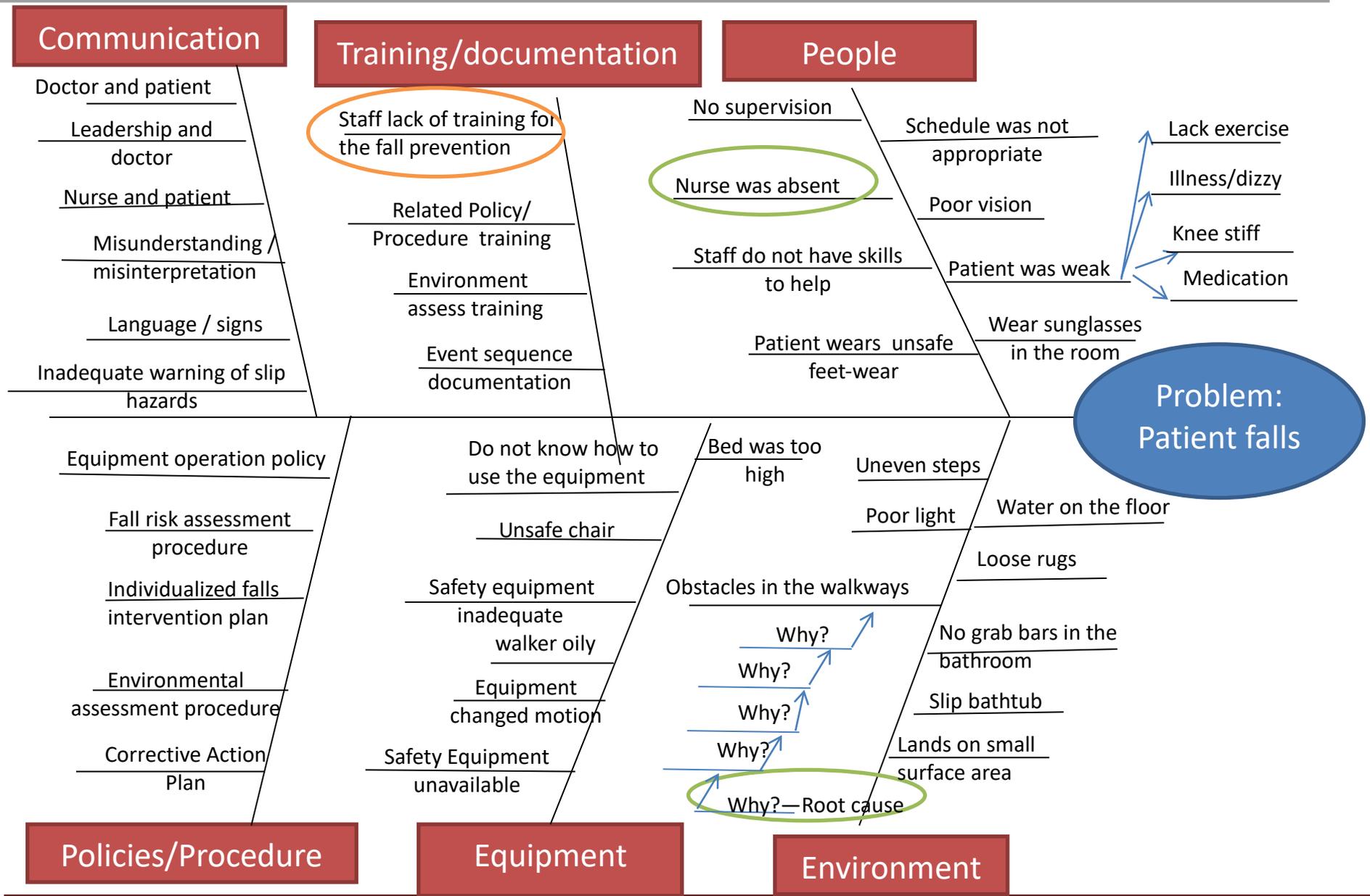
Central Line Associated Bloodstream Infections (CLABSI): Primary bloodstream infections that are associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection.

Appendix B: Patient Safety Goals

OBJECTIVE:	GOAL:	Q3 2014	Q4 2014	Q1 2015
ACTION PLAN:				
1. Create Systems that anticipate errors & either prevent or catch them before they cause harm.	a. Enhance retrospective chart review process.			Implement Trigger Tools. Develop automated surveillance reports in Cerner.
	b. Establish an automated surveillance process.		Complete an in-depth analysis of risk point utilizing the methods of FMEA.	
2. Establish Structures for reporting and a process for managing reports in the event reporting system.	a. Implement new electronic Voluntary Reporting System & participate in Patient Safety Organization.	Implemented e-MERS & PSO with UHC.	Create process for reviewing & closing reports in e-MERS.	
	b. Develop a structure to educate employees system-wide of the process for reporting hazards, errors and adverse events.		Increase number of events reported by 10%.	
	c. Establish a process for providing feedback regarding reported events.		Create process for communicating outcome of reported events.	
3. Develop a Culture of Safety where providers feel safe and supported when they report medical errors or near misses & voice concerns about patient safety.	a. Provide education on patient safety plan that emphasizes importance of blending a systems focus with appropriate individual accountability.		Educate Medical staff, Hospital Wide Oversight & the Quality Committees on the objectives and goals of the patient safety plan.	
	b. Establish a recognition program that rewards safe practices.		Include patient safety presentation in monthly New Employee Orientation.	
	c. Improve overall perceptions of safety as measured by the Culture of Safety Survey.		Develop 'Great Catch' awards program.	
				Re-evaluate culture of safety and develop action plan.
4. Establish Safety Priorities & Targets.	a. Develop Patient Safety Dashboard that includes national measures and benchmarks.		Present Patient Safety Dashboard monthly to Hospital Wide Oversight Committee.	
	b. Facilitate the development of action plans associated with measures not meeting benchmarks.	Complete 2014 Leapfrog Safety Survey.	Establish & implement a plan to improve performance of each leap.	
	c. Assess and improve processes related to hand-off, transition and communication	Develop method to track & report departmental progress and compliance of RCA action plans.		
5. Charter Safety Programs through teams, workgroups or projects.	a. Coordinate Improvement Efforts in order to ensure that capital, people, facilities & technologies are matched to strategic priorities for safe practices.		Establish Patient Safety Council.	
	b. Reduce and eliminate variation in care.		Establish workgroups focused on medication safety, reducing patient falls & hospital acquired pressure ulcers.	
			Revise or develop policies, procedures and protocols.	

Reference: Patient Safety Plan and Its Applicable Goals. 2014. Cook County Health and Hospitals System.

Appendix C: Fishbone Diagram



Appendix D-1: PDSA Worksheet

PDSA Worksheet

Topic:			
Person Completing Worksheet:		Date:	
Telephone/ Email:		Cycle:	
Patient Safety Committee Members			
CEOs/CFOs			
Patient Safety Officer			
Infection Control Officer			
Other Medical Staff			
Other team members			
Aim: (Describe the overall SMART goal that your team wishes to achieve.)			
Plan:			
1. List the tasks needed to set up this test of change.			
2. Predict what will happen when the test is carried out.			

3. List the steps to develop the test-who, what, and when.

Steps	By Whom	By When	Desired Outcome

Do: (Describe what actually happened when you ran your test, including any problems and unexpected findings.)

Study: (Describe what you learned and did you meet your measurement goal?)

Did you meet your measurement goal? Explain.	Summarize what was learned: success, failure, unintended consequences, etc.

Act: (Describe what you concluded from this cycle.)

Based on what was learned, please indicate what action will be considered.	Describe what modifications to the plan will be made for the next cycle based on what you learned.
<input type="checkbox"/> Adapt: modify changes and repeat PDSA Cycle	
<input type="checkbox"/> Adopt: expanding changes throughout organization	
<input type="checkbox"/> Abandon: change approach and repeat PDSA cycle	

Appendix D-2: PDSA Monthly / Quarterly Progress Report

Event:			
Person Complete Report:		Date:	
Patient Safety Officer		Contact Information:	
Monthly / Quarterly Report			
Items	Description		
1. What is your goal?			
2. Report on the PDSA cycle			
3. What system and practices are working well? Explain.			
4. What areas for improvement did the data identify?			
5. What barriers or system issues have been encountered implementing action activities?			
6. Action plans to address the barriers or system issues			
7. Lesson learned			
8. Support needed			
9. Additional discussion			
Notes:			

Appendix E: Checklist Example: Injuries from Falls and Immobility

Process Change	In Place	Not Done	Will Adopt	Notes (Responsible & By When?)
Conduct fall and injury risk assessment upon admission				
Reassess risk daily and with changes in patient condition				
Implement patient-specific intervention to prevent falls and injury				
Communicate risk across the team; use handoff forms, visual cues, huddles				
Round every 1 to 2 hours for high-risk patients; address needs (e.g., 3Ps: pain, potty, position-pressure). Combine with other tasks(vital signs)				
Individualize interventions. Use non-skid floor mats, hip protectors, individualized toileting schedule; adjust frequency of rounds				
Review medications (by pharmacist); avoid unnecessary hypnotics, sedatives				
Incorporate multidisciplinary input for falls				
Prevention from PT, OT, MD, RN and PharmD				
Include patients, families and caregivers in efforts to prevent falls. Educate regarding fall prevention measures; stay with patient				
Hold post-fall huddles immediately after event; analyze how and why; implement change to prevent other falls				

Reference: Checklists to Improve Patient Safety. June 2013. Health Research & Educational Trust.

Appendix F: Policy Example

[Reference: Hospital Policies. MERCY Hospital. <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>]

	HOSPITAL POLICY AND INFORMATION MANUAL	
<p>PERSONAL PROTECTIVE EQUIPMENT POLICY Page 1 of 2</p>	<p>Date Issued: 07/01 08/14 Date Last Revised: 08/17 Next Review Date: Approved By:</p>	<p>Policy Committee</p>

Key Words: personal protective equipment, PPE, safety equipment,

Policy Applies to:

- All staff employed by Mercy Hospital;
- Credentialed Specialists, Allied Health Professionals, patients, visitors and contractors will be supported in meeting policy requirements.

Related Standards:

- Infection and Prevention and Control Standards NZS 8134.3:2008
- Health and Safety in Employment Act 1992
- EQulP5 - 1.5.1 and 1.5.2 Infection Control
- EQulP5 - Standard 3.2 Criterion 3.2.1 Health and Safety

Rationale:

Mercy Hospital will provide suitable personal protective equipment (PPE) when the risk to health and safety cannot be eliminated or adequately controlled by other means.

Definitions:

Personal protective equipment (PPE) means all equipment which is intended to be worn or held by a person to protect them from risk to health and safety while at work.

Examples of PPE include: protective footwear, gloves, hard hats/helmets, clothing affording protection from the weather, visibility clothing, eye and face protection.

Objectives:

- To ensure appropriate PPE is identified to minimize hazards not able to be controlled by elimination or isolation;
- To ensure fit for purpose PPE is provided at Mercy Hospital for use by staff;
- To ensure adequate training in the use of PPE is provided;
- To monitor the use of PPE and evaluate effectiveness.

	HOSPITAL POLICY AND INFORMATION MANUAL	
<p>PERSONAL PROTECTIVE EQUIPMENT POLICY Page 2 of 2</p>	<p>Date Issued: Date Last Revised: Next Review Date: Approved By:</p>	<p>07/01 08/14 08/17 Policy Committee</p>

Implementation:

Risk Management

Department Managers, the Occupational Health/ Infection Prevention and Control Nurse (OH/IPC Nurse) and Health and Safety/ Infection Control Representatives (HSIC reps) will in consultation with staff:

Ensure PPE requirements are identified when carrying out risk assessments of activities;

- Regularly review the risk assessment of activities if substances or work processes change;
- Identify the most suitable type of PPE that is required;
- Ensure PPE is available to those who need it;
- Inform staff of the risks involved in their work and why PPE is required;
- Monitor compliance.

Process

Manager’s Responsibilities

Must ensure that:

- PPE requirements are considered when risks are assessed;
- Suitable PPE is provided and made accessible to employees;
- PPE is properly stored, maintained, cleaned repaired and replaced when necessary;
- Adequate information and training is provided to those who require PPE;
- PPE is properly used;
- Use of PPE is monitored and reviewed.

Employee’s Responsibilities All employees must ensure that:

- They use PPE whenever it is required;
- Attend and comply with training, instruction and information;
- Check the condition of their PPE;
- Store, clean and maintain their PPE;
- Report losses, defects or other problems with PPE to their manager.

Evaluation:

- Staff health and safety orientation
- Environmental audits
- Incident reports

Chapter 11 Safety

Safety

POLICY:

It is the policy of this Center in accordance with federal law, that all activities be conducted in the safest manner possible to protect our patients, our employees, the public, and to preserve our facility.

Safety is always to take precedence over expediency or shortcuts, and every attempt must be made by all employees to remove, correct, and/or report conditions that could cause accidents.

Exercise caution at all times in carrying out your duties. As you go about your work, you may observe unsafe conditions in the Center. If you cannot correct them yourself, report what you have seen to your supervisor and see that a warning sign, if necessary is posted.

You must also be on the lookout for fire hazards, which must be reported. In addition, be sure that your supervisor has explained your specific responsibilities in case of a fire, fire drill, or any other emergency condition.

It is the intent of all employees of this Center to provide services which directly and indirectly provide care needed by the patient and their significant others for whom we are responsible while within the Center until discharged or transferred from the premises.

We, therefore, urge employees to work cooperatively to achieve a functioning safety and health program to guard against injury and illness to themselves and to protect our patients from injury or the augmentation of existing illness.

OBJECTIVE:

To provide the safest facility possible to the patients, employees, and the public.

PROCEDURE: General Safety

Central Supply

1. Proper ventilation and adequate lighting must be maintained at all times.
2. Any accident or injury, no matter how slight, must be reported immediately and an incident report is to be filled out by the employee involved and signed and witnessed by the Director of Nursing or current nurse in charge.
3. Always use the proper step ladder for reaching high places. Do not use chairs, boxes, makeshifts on which to stand. Use hand rails.
4. All personnel are to be instructed in the proper methods of lifting and carrying. Improper lifting, reaching, climbing, or carrying are discouraged due to potential injuries.
5. Floors are to be kept clear and dry. Wipe up spills immediately.
6. Traffic areas must be kept clear of equipment and supplies.
7. Fire fighting equipment must be kept unobstructed.
8. Extreme caution must be exercised in the handling of all instruments. Pick up all instruments by their finger grips.
9. Report any unsafe condition that is observed.
10. Pick up or wipe any foreign matter found on the floor.

Chapter 11 Safety

Soiled Utility

1. All washer materials must be discarded according to established procedure.
2. Gloves must be used for all cleaning. When hand washing any items with a scrub brush, keep the item and the brush below the surface of the cleaning solution in the sink. This will prevent the spraying and spreading of organisms that are on the item into the air and onto yourself.
3. Do not wear jewelry.
4. Never lift anything that cannot be lifted comfortably and safely. Ask for help whenever necessary.
5. Do not pick up broken glass with your hands. Follow the procedure listed below:
 - A. Sweep up glass that has broken on the floor.
 - B. Use small forceps or tweezers to get glass out of the sink drain.
 - C. Wipe glass off counter top with damp cloth, towel, or cotton.
 - D. Broken glass – all glass can be discarded in the sharps container for needles, razors, and scalpels.
 - 1) Needles: Discard into sharps container in decontamination area.
 - 2) Scalpels: NEVER discard into waste basket. Sharps container also available in clean preparation area.
 - 3) Razors: Discard into sharps container in decontamination area.
 - E. Broken glass adapters in rubber tubing is a danger to the processing employee, the patients, and the equipment. We cannot be positive that all the glass splinters have been removed from the inside of the tubing. Tubing in this condition should be disposed of.
 - F. Handle all instrument trays carefully. Remove towels carefully, inspect thoroughly, watch for falling needles, knife blades, and broken glass.
6. Wear autoclave glove to open door of washer/sterilizer. Allow residual steam in chamber to escape.
7. Be extremely careful and alert to water on the floor – wipe up any water spots.

Clean Utility

1. DANGER HOT Remember that sterilizers and cart wash are very hot. Sterilizer jacket temperature reaches 270-275 F.
2. When opening door of autoclave, employee should step back away from the door to avoid being burned by escaping steam. Always cover hands when removing carts that have been steam sterilized.
3. Never lift more than one full instrument tray at a time.
4. Watch for SHARP or SEMI-SHARP instruments (scissors, shears, chisels, towel clips) while sorting them. Always grasp instruments by the finger grip end.
5. Employees should never push against walls when stocking them.
6. Carts are not to be overloaded. If you cannot easily propel a cart over carpeting, it is overloaded. Load carts so that you can see over, thru, or around the cart. If a cart should begin to tip over, DO NOT try to hold it – let it go. Supplies can be replaced – your back cannot.
7. NEEDLES, SCALPELS, RAZORS – discard into containers in the soiled utility. NEVER discard into wastebasket. Container also available in clean utility area.
8. GLASS – All glass can be discarded into any plastic lined wastebasket. Broken glass must be discarded in the sharps container for needles, razors, and scalpels.

Equipment Safety

1. All equipment used must be checked for electrical and mechanical safety prior to use.
2. Defective equipment must be removed from the area and repaired and recertified prior to use.
3. All equipment must be maintained in accordance with manufacture's recommendations and preventive maintenance schedules.
4. All electrical equipment that comes into patient contact will be inspected on a bi-annual basis.
5. Documentation of inspections and preventive maintenance must contain the date of inspections and/or service, the type of service performed, and the signature of person performing the inspection or service.

Chapter 11 Safety

6. All personnel must be trained in the handling, care, and use of center equipment and supplies.
7. Manufacturer's safety and inspection booklet must be on file and available in the center.
8. All personnel must be warned of any potential hazards in the use or handling of equipment. This includes electrical, mechanical, chemical, gas, or any other known hazard.
9. All drawers should be kept clean. Do not mix sharp instruments or needles with other instruments. Keep each type of instrument in separate places.
10. Never use contents of an unlabeled bottle. Unlabeled containers shall be discarded.

Electrical Equipment (Safety and Use)

1. DO NOT connect or disconnect any electrical operated equipment to an electrical outlet with wet or moist hands. Inspect all cords and plugs before inserting into electrical outlet.
2. All electrical equipment shall be equipped with an approved 3-prong ground plug.
3. All power cords shall be kept clear of the plumbing fixtures, water pipes, radiators, and other equipment in contact with the ground.
4. Plug adapters or cheater plugs shall never be used.
5. Any electrical wire with cut, broken, or frayed insulation shall be removed from service immediately. Tag equipment "Do Not Use – in Need of Repair"

BODY MECHANICS

1. Keep body in a straight line.
2. Carry body close to the body. This prevents shoulder tension. There are seven basic steps to be followed in any type of lifting procedure:
 - A. Use your thigh muscles
 - B. Keep spine straight
 - C. Divide weight between two hands
 - D. Firm, natural footing
 - E. Get as close to the object as possible
 - F. Squat or bend knees, then straighten
 - G. Bring weight up against your body
3. Here are some suggestions which may prove helpful in developing good body mechanics. Some of these are repetitious of the seven listed above:
 - A. Keep chest up and forward
 - B. Maintain normal spine curves
 - C. Stand with feet separated, toes pointed ahead, one foot forward for balance.
 - D. In all activity, keep weight balanced over base of support
 - E. Prepare muscles for action – stabilize position of pelvis by setting abdominal muscles.
 - F. Use large leg muscles and thigh muscles, rather than back muscles, when lifting.
 - G. Stand close to task, flex hips and knees for task requiring stooping or bending; have work at elbow height when possible.

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FILLING REPORTS OF ADVERSE EVENTS

- A. Reports are filed under Med Watch, the FDA Medical Products Reporting Program.
- B. Reports should be filed for serious adverse events and product problems, not only with medical devices but also with human drugs, biologics (except vaccines), special nutritional products, and other products regulated by the FDA. (See Med Watch Mandatory Reporting Form Code Manuals and federal regulations).
*Although all of the above products can be filed on the mandatory form, only medical devices are considered mandatory as of Fall, 1993.
- C. Med Watch is divided into two components, mandatory reporting and voluntary reporting. Each type of reporting has a separate form to be completed. As of December, 1993, Mandatory reporting is done on Form 3500A and Voluntary reporting is done on Form 3500 (the yellow form).
1. Mandatory Reporting – Form 3500A
- * Refer to Med Watch Instructions Booklet and Code Book
 - * Reportable deaths to BOTH the manufacturer and the FDA
 - * Report serious illness or serious injury to the manufacturer if known (if manufacturer is unknown, then report to FDA).
 - * Send a semiannual summary to the FDA for all reports submitted to manufacturers and/or the FDA (January 31 and July 31)
2. Voluntary Reporting – Form 3500
- * Refer to Voluntary Reporting Packet
 - * Report adverse events or product problems to manufacturer or to the FDA. If you report to the manufacturer, they are required by law to report to the FDA.
 - * Examples of other problems to report: Defective devices, inaccurate labeling, packaging, or product mix up, and contamination problems.
- D. Reports may be sent by mail (see address on forms) or by fax (see number on forms)
- E. General information
1. A semi annual report does not need to be filed if no reports were reported.
2. If a patient brings their own medical device to a facility (i.e. a wheelchair), and the device causes or contributes to a patient injury or death, the facility is responsible for reporting the event.
3. The outcome required intervention to prevent permanent impairment/damage is not intended to be used for adverse events that disappear after a medication was discontinued, the dosage was altered, or if the only intervention was to treat the patient with a routine prescription drug. The outcomes used only when you suspect that the use of a medical product may have resulted in a condition that required medical or surgical intervention to preclude permanent impairment or damage to a patient. For example, burns from radiation equipment, breakage from an orthopedic screw, Acetaminophen hepatotoxicity
4. Report even if you are unsure that the medical product caused the adverse event. If there is uncertainty if an adverse event meets the definition of serious and you feel it is something the FDA should know, report it.

It is the policy of this center to protect the employees and patients from violent situations.

OBJECTIVE:

Surgical Arts Center is committed to preventing workplace violence and to maintaining a safe work environment. Surgical Arts Center has adopted the following guidelines to deal with intimidation, harassment or other threats of or actual violence that may occur onsite or offsite during work-related activities.

PROCEDURE:

All employees, customers, vendors and business associates should be treated with courtesy and respect at all times. Employees are expected to refrain from fighting, "horseplay" or other conduct that may be dangerous to others. Conduct that threatens, intimidates or coerces another employee, customer, vendor or business associate will not be tolerated. Surgical Arts Center resources may not be used to threaten, stalk or harass anyone at or outside the workplace. Surgical Arts Center treats threats coming from an abusive personal relationship as it does other forms of violence.

Indirect or direct threats of violence, incidents of actual violence and suspicious individuals or activities should be reported as soon as possible to a supervisor, human resources (HR) or member of the Surgical Arts Center

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management team. When reporting a threat or incident of violence, the employee should be as specific and detailed as possible. Employees should not place themselves in peril, nor should they attempt to intercede during an incident. Employees should promptly inform the administrator of any protective or restraining order that they have obtained that lists the workplace as a protected area. Employees are encouraged to report safety concerns with regard to intimate partner violence. Surgical Arts Center will not retaliate against employees making good-faith reports. Surgical Arts Center is committed to supporting victims of intimate partner violence by providing referrals to community resources and providing time off for reasons related to intimate partner violence.

Investigations and Enforcement

Surgical Arts Center will promptly and thoroughly investigate all reports of threats of violence or incidents of actual violence and of suspicious individuals or activities. The identity of the individual making a report will be protected as much as possible. The Surgical Arts Center will not retaliate against employees making good-faith reports of violence, threats or suspicious individuals or activities. To maintain workplace safety and the integrity of its investigation, The Surgical Arts may suspend employees suspected of workplace violence or threats of violence, either with or without pay, pending investigation.

Anyone found to be responsible for threats of or actual violence or other conduct that is in violation of these guidelines will be subject to prompt disciplinary action up to and including termination of employment.

The Surgical Arts Center encourages employees to bring their disputes to the attention of their supervisors or the HR department before the situation escalates. The Surgical Arts will not discipline employees for raising such concerns.

To provide a safe workplace for the employees

1. Be physically fit for your work through good health habits, proper diet, sufficient rest, and cleanliness.
2. Prevent the spread of infection or contagious disease – when you are ill, call in, but remain home.
3. Personal hygiene should be paramount; wash your hands often.
4. Wear proper clothing and shoes for your particular job.
5. Know your job and all its responsibilities. Familiarize yourself with the safe work practices to follow.

Communicate your ideas on better and safer methods to the Director of Nursing.

6. Report any unsafe conditions, including defective or broken equipment to the Director of Nursing immediately.
7. Never engage in horseplay or play practical jokes.
8. Heed all warning signs – they caution you about a hazard or a condition detrimental to your safety.
9. Walk – do not run. Be cautious in congested areas and at blind corners.
10. Use handrails on stairways.
11. Use caution with swinging doors. If provided with a window panel, check clearance before opening. If no window panel is provided, open slowly using handle or push plate.
12. Always use a suitable ladder – never climb on chairs boxes to reach overhead items.
13. Be sure any foreign matter found on the floor is picked up and put into the proper receptacle.
14. Use or possession of intoxicating beverages, hypnotic, or hallucinogenic drugs while on duty is prohibited.
15. Know your part in the Center disaster plans.
16. Know your fire emergency plan and all the duties and responsibilities associated with the fire program, including evacuation procedures.
17. Be knowledgeable about the program adopted to control infectious disease.
18. Become acquainted with and participate in the center's safety program.
19. Report to the Director of Nursing all unusual and unscheduled events affecting the safety or well-being of patients, visitors, and other employees.
20. Report to the Director of Nursing any injury to yourself or a fellow employee.
21. Take a special interest in the new or inexperienced person; call attention to dangerous practices and help him/her to learn safe methods.
22. Notify all persons who may be endangered by a particular job you are doing.
23. Know the location of all fire extinguishers and how to use them.
24. Look for slipping or tripping hazards. Water, rubber bands, paper clips, pencils, etc., don't belong on the floor. Pick it up or have it cleaned up immediately.
25. Traffic areas must be kept clear of equipment and supplies. Do not leave chairs, stools, foot-rests, etc., in aisles or walk areas.
26. When descending stairways, use the handrail and watch your step.
27. Any equipment found defective must be removed from use and repaired.
28. Fire fighting equipment must remain unobstructed.
29. Always use "wet floor" signs when mopping floors.

Chapter 11
Safety

SPRING VALLEY HOSPITAL

Risk Management/ Patient Safety Plan

Nevada Acute Care Division

Revised 1/2018

I. Overview

SPRING VALLEY HOSPITAL endorses an integrated, system-wide patient safety program designed to improve patient safety and reduce risk to patients.

Patient safety is a cornerstone of quality care and is a leadership priority. **SPRING VALLEY HOSPITAL** operates as a Patient Safety Organization to further its commitment in promoting patient safety and assuring that **SPRING VALLEY HOSPITAL** remains at the forefront in the delivery of safe and effective clinical care. The Member Patient Safety Evaluation System (PSES) is utilized by **SPRING VALLEY HOSPITAL** to track safety information, generate Patient Safety Work Product (PSWP) analysis of safety and clinical performance, and promote best practices. This Acute Care Division Risk Management/Patient Safety Plan (“Plan”) provides the general framework to identify, manage, reduce, and eliminate patient safety risks.

The Plan identifies the mechanisms to continually assess and improve the patient safety systems at **SPRING VALLEY HOSPITAL**. It is our strategy to utilize statistical tools and defined project work to achieve breakthrough gains in patient safety. Performance improvement tools are used in developing and delivering consistent processes and services. The cultural aspect of the Plan is to promote a non-punitive approach to identifying and reporting adverse events. This is consistent with the “Just Culture” concept to promote patient safety practices by instituting a culture of safety and embracing concepts of teamwork and communication.

Most patient safety events are due to a failure of systems; therefore, a systems analysis approach is utilized in evaluations. The goal is to identify and track errors, deficiencies, and problematic trends in order to continuously improve the underlying systems and to intervene as necessary to improve system processes. Although a non-punitive culture is promoted, this approach is balanced by holding caregivers personally responsible for at-risk behaviors and failures to meet the standard of care. When warranted, discipline measures will be initiated as needed consistent with **SPRING VALLEY HOSPITAL** policies. **SPRING VALLEY HOSPITAL** employees, contractors, vendors, and members of each facility’s medical staff share responsibility to participate in detection, reporting, and remediation to prevent errors.

GENERAL STATEMENTS ON GOALS AND OBJECTIVES

To support, maintain and enhance the quality of patient care delivered by:

- Systematic and objective monitoring and evaluation of reports of injuries, accidents, patient safety issues, safety hazards, and/or clinical services findings.
- Identification and assessment of general areas of actual or potential risk in the clinical aspects of the delivery of patient care and safety.
- Implementation of appropriate corrective action, to the extent possible, to alleviate and resolve identified problems or concerns with patient safety issues.
- Evaluation and documentation of the effectiveness of actions implemented.

- Aggregation of data/information collected for integration in information management systems and use in managerial decisions and operations.

II. Mission and Vision

SPRING VALLEY HOSPITAL mission, vision and values drive the Plan and serve as the foundation in identifying strategic goals, objectives and priorities. Our mission is to improve patient safety and the quality of health care delivery through the provision of excellence in clinical care while fostering safe care to our communities, that our patients will recommend to their families and friends, physicians prefer for their patients, purchasers select for their clients, employees are proud of, and investors seek for long-term results. The vision is to be recognized as the provider of choice for healthcare services in the local community where we are trusted by our patients, families and physicians to create a safe, caring and compassionate experience.

In support of our mission, vision, and values, the Plan promotes:

- Collaboration of administrative leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high quality healthcare.
- Communicate honestly and openly to foster trusting and cooperative relationships among healthcare providers, staff members, and patients along with their families, to ensure accountability for the patient safety priorities.
- Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.
- Accountability for every healthcare related decision and action based on the level of risk-taking or egregious behavior identified.
- A focus on continuous learning and improving, system design, and the management of choices and changes, bringing the best possible outcomes or performances to the facility.
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare.
- Education of staff and physicians to assure coordination and integration of care across disciplines and specialties.

SPRING VALLEY HOSPITAL recognizes that providing safe patient care requires significant coordination and collaboration. The optimal approach to patient safety involves multiple departments and disciplines to establish and effectively implement the processes and mechanisms that comprise this plan.

III. ROLES AND RESPONSIBILITIES

A. Risk Management/Patient Safety Officer

SPRING VALLEY HOSPITAL has a designated risk director/manager responsible for patient safety risk identification and reduction for their respective facilities. The

designated Risk Director/Manager is also the Patient Safety Officer. Each facility is required to submit scheduled reports to the Board of Governors describing risk reduction efforts associated with facility specific, or industry identified risk exposures, including environmental risks and emergency management. Reports are thoroughly reviewed and analyzed by the risk staff to determine effectiveness and follow-through of identified corrective action plans.

The Patient Safety Officer responsibilities based upon [NRS 439.870](#) includes:

- Serving on the Patient Safety Committee (PSC)
- Supervising the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Taking action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the PSC regarding any action taken in accordance with the responsibilities above.

B. Infection Control Officer

The infection control officer designated for each facility, based on [NRS 439.873](#), responsibilities include:

- Serving on the Patient Safety Committee
- Monitoring the occurrences of infections at the facility to determine the number and severity of infections.
- Reporting to the PSC concerning the number and severity of infections at the facility each month.
- Taking such action as determined necessary to prevent and control infections alleged to have occurred at the facility.
- Carrying out the provisions of the Infection Control Program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program.

Based on [NRS 439.865](#), the patient safety plan must also include an infection control program that carries out the infection control policy. The policy must consist of:

- The current guidelines appropriate for the facility's scope of service developed by a nationally recognized infection control organization as approved by the State Board of Health which may include, the Association for Professionals in Infection Control and Epidemiology (APIC), the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO) and the Society for Healthcare Epidemiology of America (SHEA); and

- Facility-specific infection control developed under the supervision of a certified Infection Preventionist.

C. Patient Safety

SPRING VALLEY HOSPITAL has an established Patient Safety Councils (PSC) to support patient safety activities. The PSC should ensure that its Patient Safety Plan is promoted and executed successfully. **SPRING VALLEY HOSPITAL** has also assembled participants to serve in the Member Workforce and to utilize the Member PSES to generate PSWP and exchange analysis and recommendations with the Acute Care PSO Workforce. The main vehicles for these analytic activities occurring within the Member PSES and the member facility Patient Safety Council meetings. The Member PSES is made up of both electronic and physical spaces for the reporting, storing, and generation of PSWP, including secure SharePoint site, and other electronic databases (including but not limited to ClearSight (STARS) and Midas) to maintain and manage PSWP.

According to [NRS 439.875](#), a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plans are promoted and executed successfully.

I. Facility Patient Safety Committee

Each facility establishes a Patient Safety Committee (PSC) that meets on a regular basis and at least monthly.

Membership:

In accordance with [NRS 439.875](#), the committee core membership consists of the following Key Members: (CEO, CNO, Physician, Risk/ Patient Safety Officer, Infection Prevention Nurse, Pharmacy, and Quality). The COO, CMO and Regional CMO attend, as applicable. NRS requires that at least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing, and pharmaceutical staff of the medical facility. In addition, the infection control officer, patient safety officer, and one member of the executive or governing body of the medical facility.

Based on [NAC 439.920](#), a medical facility that has fewer than 25 employees and contractors must establish a patient safety committee comprised of: the Patient Safety Officer, at least two providers of healthcare who treat patients at the medical facility, including but without limitation, one member of the medical staff and one member of the nursing staff of the medical facility; and the Chief Executive Officer (CEO) or Chief Financial Officer (CF) of the medical facility.

Meetings:

The required members attend the meetings on a monthly basis. If a required member is absent, the facility makes a suitable replacement with someone that has authority to implement actions identified by the PSC.

Duties and Responsibilities:

SPRING VALLEY HOSPITAL PSC is charged with the assessment and improvement of high-risk processes related to patient safety. This is to be carried out using a four-step methodology.

- **Issue Identification:** The primary issue is the most important risk issue facing the facility and is determined by reviewing the facility's claims history, claims history unique to the facility, patient safety concerns, industry claims, and through discussions with the risk staff. Other issues may be related to process initiatives.
- **Best Practice:** Once identified, the primary issue is dissected to determine its component issues. For each component issue, a best practice is selected. Best practices represent the most appropriate method for performing the delineated process and should not be selected until the PSC is assured that it is truly the "Best Practice."
- **Implementation:** Implementation strategies are those methods used to put the best practices into place. Often this includes revising policies, education, newsletters, phone calls, meetings, formal training, etc. Responsible parties and dates for completion are identified to ensure success.
- **Monitoring and Accountability:** Monitoring is essential to ensure that the strategies identified have been effective. Improvement should be demonstrated statistically whenever possible.

Additional Patient Safety Committee Responsibilities, based upon [NRS 439.875](#) and [NRS 439.877](#), include:

- Monitor and document the effectiveness of the Patient Identification Policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the Patient Safety Officer pursuant to [NRS 439.870](#).
- Evaluate actions of the Patient Safety Officer in connection with all reports of sentinel events alleged to have occurred.
- The Quality member of the PSC will review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- The Quality member in conjunction with the Infection Control Officer will review and evaluate the quality of measures carried out by the facility to prevent and control infections.

- Make recommendations to the Board of Directors of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the Board of Directors of the facility regarding:
 - (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);
 - (2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and
 - (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

In addition to the work done on the primary issue, the PSC is charged with addressing issues identified through claims reporting, Safety Watch Newsletters, the Joint Commission (Sentinel Event Alerts) and others, HRUs and from the TERM evaluation or other surveys, such as the OBHRU Site Assessments. Feedback is provided on an ongoing basis as to the functioning of the Patient Safety Committee.

II. Patient Safety Advisories

When an untoward event occurs at a facility or in the industry, it is important that we respond in a positive manner. Systems that lead to failure at one facility can be assessed at other facilities to avoid the same or similar occurrence. To this end, the Acute Care PSO distributes Safety Watch newsletters. These alerts detail the circumstances that lead to the negative outcome and facilities are charged with assessment and improvement of their own processes.

SPRING VALLEY HOSPITAL is required to address the Safety Watch newsletters via their Patient Safety Council and this is evidenced in their monthly minutes. Responses to the Safety Watch are reviewed for the opportunity to generate a best practice to implement.

C. TERM Program

The facility has utilized its formalized risk management program identified as TERM: the Technical Elements of Risk Management. Each element focuses on a separate organizational function and details specific strategies for managing risk in these areas. These elements are summarized as follows:

Element I. Administration of the Risk Management Program: The tenets outlined in Element 1 lay the foundation for an effective risk management program. The Risk Manager/Director must be seen as a resource to administration, facility, and medical staff. Written plans, goals, and objectives provide a clear vision to meet the purpose of the risk program. Although the TERM program uses the title “Risk Manager,” this applies equally to Risk Directors.

Element II. Risk Identification: Risk identification is essential in order to avoid, mitigate, and eliminate risk-generating practices. This Element focuses on those steps taken to identify exposures faced by the facility.

Element III. Risk Education: Education is a cornerstone of the TERM program. Risk management education is intended to reduce and eliminate risk-generating practices and to promote best practices that enhance the provision of safe patient care.

Element IV. Patient Safety Initiative: Imperative to a comprehensive RM program is one that focuses on the improvement of patient and staff safety through the creation of an environment that maximizes safety and reduces liability claims exposure. The mechanism used to drive the culture of safety is the Patient Safety Committee (PSC) at each facility. The PSC operates using a four-step process. These steps include: identification of the problem, determining best practice, implementing the recommendations, and monitoring and accountability. Corrective actions are discussed, monitored, and validated by the PSC.

Element V. Patient Safety Priority: Root Cause Analysis (RCA): The cornerstones of an effective Patient Safety and Risk Management Program are (i) the performance of a thorough and credible RCA when a serious, sentinel, never event or a significant near miss event occurs; and (ii) implementation of systemic improvements to enhance patient safety and improve healthcare outcomes going forward.

Element VI. Environment of Care; Safety and Security Programs: The safety and security programs in the facility serve to protect and preserve both life and property. Areas of safety include licensing, accreditation and federal, state, and local safety practices and programs, including the EPA, TJC, etc.

Element VII. Claims and Litigation Management: The risk manager serves as the on-site representative of the insurance program in the management of general and professional claims and litigation.

Element VIII. Patient Safety Organization (PSO): Participants of the Member Workforce are expected to perform identified patient safety activities and to be trained in their responsibilities. They must also understand and acknowledge their obligations, including maintaining the confidentiality of PSWP, as required by the Patient Safety and Quality Improvement Act (PSQIA), and of Protected Health Information, as required by the

Health Insurance Portability and Accountability Act (HIPAA) and its regulations, and other federal and state laws.

Element IX. Measuring the Effectiveness of the Risk Management Program: In order to assure the effectiveness of the Risk Management Program, certain activities should be conducted to ensure that implementation of the TERM program has been successful. This includes, but is not limited to, data analysis and trending of events and potential claims, which are shared with the respective oversight committees.

D. MIDAS

The MIDAS system is the electronic event reporting system utilized by the facilities to report patient and visitor safety events. The risk management module allows for the collection, categorization, and analysis of incident data using electronic reporting functions (Remote Data Entry - RDE). The facility enters incidents into MIDAS through identification of the type of incident and characteristics of the event using risk parameters and outcomes. Additional information can be attributed to a department, physician, or individual, along with further details of the event. This allows the retrieval of information in a variety of ways for analysis and review.

E. ClearSight (STARS)

STARS is an integrated claims management program that allows for complete claims management, including extensive analysis of reportable fields associated with reported claims. STARS also provides for the electronic submission of potential claims by user facilities.

Delineation of issues featured in the probable claim module allows for the facility staff to identify causation factors associated with any reported event. The system also provides for the entry of details that will describe the event and liability concerns.

Trending of claim information is performed on a scheduled basis to operations leadership metrics to form strategies on facilitating risk reduction efforts. Previous examples of this function include the formation of an OB HRU and Perioperative concepts. Quarterly reports should be provided by the Facility's RM to the Governing Board of all claims activities.

F. Event Notification Site

The Risk Department developed the Event Notification Site or ENS, a web-based system that allows for contemporaneous reporting of serious adverse events and key near miss sentinel events to facility and corporate management. The ENS also provides an environment in which stakeholders can post questions and additional information to the

facility reporting the event. Updates to the event are reported in real-time to all identified facility and stakeholders via the ENS. The Risk Management staff reviews each ENS to determine if follow-up is needed; if follow-up is indicated, it is to be completed within 45 days.

G. Root Cause Analysis (RCA)

Pursuant to [NRS 439.837](#), a medical facility shall, upon reporting a sentinel event pursuant to [NRS 439.835](#), conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both of the sentinel event.

A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals. Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

It is recommended that the Joint Commission's root cause analysis and actions plan framework table are utilized. It contains analysis questions and guides the organization in the steps of a root cause analysis. Not all of the questions apply to all of the events or cases.

Utilization of the "5 Whys" technique should be used to explore the cause and effect relationship underlying a problem. One can find the root causes by asking "why" no less than five times.

RCA Responsibilities

- Organize and coordinate the RCA process. For Serious OB events, RCAs are to be done within 72Hrs. of the event.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA and corrective action plan implementation process.
- Communicate the progress of the investigation, institutional barriers and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.



H. Patient Safety Checklists

By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

The patient safety checklists must follow protocols to improve the health outcomes of patients at the medical facility and must include, without limitation:

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.

- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - Proper instructions concerning prescription medications;
 - Instructions concerning aftercare;
 - Any other instructions concerning his or her care upon discharge; and
 - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety checklists are listed in Appendix E. (The following links provide some patient safety checklists for your reference— a checklist example is shown in **Appendix B.**)

http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf

<http://www.who.int/patientsafety/implementation/checklists/en/>

I. Patient Safety Policies

The patient safety policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include, the name and date of birth of the patient.
- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.
- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

J. MEMBER PATIENT SAFETY EVALUATION SYSTEM (PSES)

The Patient Safety and Quality Improvement Act of 2005 (PSQIA) and its regulations govern the operations and activities of the UHS Acute Care PSO and its Members. This includes assembling a “workforce” of employees, volunteers, trainees, contractors, and other persons who carry out patient safety activities on behalf of the Members within the Member Patient Safety Evaluation System (“Member PSES”). Participants in the Member Workforce are expected to perform identified patient safety activities and to be well trained in their responsibilities. They must also understand and acknowledge their obligations, including maintaining the confidentiality of PSWP, as required by the PSQIA, and of Protected Health Information, as required by the Health Insurance Portability and Accountability Act (HIPAA) and its regulations, and other federal and state laws. The Member PSES serves as a means by which patient safety information is collected, maintained, reported, and analyzed for the UHS Acute Care PSO for the purposes of improving patient safety.

K. Training and Education

Training is essential to successful implementation of the Patient Safety and TERM program. All facility risk managers undergo extensive orientation and education related to Patient Safety, TERM program and other healthcare, risk-related topics. Newly hired risk managers receive both on-site and collaborative corporate-based education and training to afford them the requisite skills to manage their facility assignment. Each risk manager is provided a copy of the TERM source documents and other reference materials that guide the risk management function. In addition, formalized supplemental training is provided to all facility risk managers as needed, including quarterly risk management meetings. Risk leadership provides ongoing support and consultation to their assigned facility to facilitate the minimization of liability exposures and enhancement of safe patient care.

The leadership risk management staff provides consultative services to each facility and as members of designated projects. These activities include on-site assistance, research, and consulting from off-site. Examples of designated projects are as follows.

- Facility specific risk Issues
- Safety Watch newsletters
- MIDAS Focus advisories

IV. Risk Management Goals and Objectives 2018

- Surgical and Procedural Safety
 - Monitor compliance through tracer methodology and report monthly with oversight by leadership.

- Goal: Zero harm events: Prevent mistakes in surgeries and procedures
- OB HRU-Zero Preventable Harm
 - Goal: Reduction/ Elimination of Maternal Hemorrhage
 - Goal: Reduction/ Elimination of Serious Harm from Shoulder Dystocia
 - Goal: Reduction/ Elimination of Serious Harm by decreasing response time to changes in Fetal Monitoring Tracings
- Emergency Department
 - Goal: Reduction/ Elimination of Workplace Violence
- Medication Safety
 - Goal: Implement an effective Opioid – Pain Management strategy, as evidenced by compliance with Assembly Bill 474, NRS 233B.066, regarding prescribing of controlled substances and reporting of controlled substance overdoses.
- Perform monthly *Safety Watch* Gap Analysis and complete within 90 days.
- Spring Valley will increase incident reporting through Midas by 10%.
- Spring Valley will reduce falls by 5%.
- Spring Valley will reduce patient Complaints and Grievances by 5%.

V. Monitoring and Accountability

A. Evaluation of TERM Program

These evaluations consist of both a core risk and clinical risk review. The facility is required to submit a written corrective action plan for noted deficiencies determined during the TERM evaluation. All information is shared with senior staff and monitored through the facility PSC.

B. Patient Safety Council Coaching

As detailed above, each facility is required to post their monthly reports or minutes that details the work conducted by their Patient Safety Committee to the facility PSES site. These are then reviewed minutes and detailed feedback is provided to coach the committee on their form and function.

C. Dashboards

The Risk Management/Patient Safety Dashboard and the Environment of Care Dashboard include multiple indicators to demonstrate the facility's performance as to

these markers. These include: event reporting statistics, fall rate including harmful event rate, medication event rate including harmful medication events, timeliness of event review and closure, risk management education, events that meet the ECRI Top Patient Safety Concerns, and environment of care concerns.

VI. Evaluation/Review:

The risk staff reviews the effectiveness of the Patient Safety/Risk Management Plan to ensure activities are appropriately focused on improving patient safety, decreasing harmful errors, decreasing rate of compensable events, facility risk program consistency/functionality and support of clinical delivery in the field. Evaluation will include the following:

- The culture supports the identification and reporting of “Near Miss” events
- There is a framework that advances a “Just Culture”
- Accountability is promoted when acts of “at risk” or “reckless behavior” occur resulting in potential/actual adverse outcomes;
- Comparison of trended incident data to include analysis of performance to stated targets, submission of incident data in compliance to SOX stipulations and review of trended data submitted to the PSC for potential action;
- Review of annualized and prior year’s probable claim reports to determine needs for corporate-based projects designed to improve outcomes in an identified service line;
- Review of educational products distributed for the concluding operating year that were intended to improve outcomes associated with a particular clinical emphasis;
- Review information, analyses and reports from the Acute Care PSO for integration into the Patient Safety Evaluation System.

VII. Confidentiality

All patient safety/risk management work products are considered Patient Safety Work Products (PSWP) as defined by federal guidelines governing Patient Safety Organizations (PSO). All PSWP reported, stored, or generated in the Member PSES is confidential and privileged under Federal law. The Member PSES will only be accessed by authorized staff. Workforce participants will be trained on policies and procedures governing their patient safety activities and responsibilities.

VIII. Approval of Patient Safety Plan

According to [NRS 439.865](#), a medical facility shall submit its patient safety plan to the governing board of the facility for approval. After a facility's patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan. The patient safety plan must be reviewed and **updated annually** in accordance with the requirements for approval set forth in this section.

According to [NRS 439.843](#), on or before March 1 of each year, a copy of the most current patient safety plan established to [NRS 439.865](#) must be submitted to the Division of Public and Behavioral Health.

Appendix A: Terms and Definitions

Patient Safety: The Agency for Healthcare Research Quality (AHRQ) defines patient safety as “a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.”

http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

Sentinel event ([NRS 439.830](#))

1. Except as otherwise provided in subsection 2, “sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum.

2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:

(a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or

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3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.

(Added to NRS by [2002 Special Session, 13](#); A [2005, 599](#); [2013, 217](#))

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“Facility-acquired infection” means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections;
- Ventilator-associated pneumonia;

- Central line-related bloodstream infections;
- Urinary tract infections; and
- Other categories of infections as may be established by the State Board of Health by regulation pursuant to [NRS 439.890](#).

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“Medical facility” means:

- A hospital, as that term is defined in [NRS 449.012](#) and [449.0151](#);
- An obstetric center, as that term is defined in [NRS 449.0151](#) and [449.0155](#);
- A surgical center for ambulatory patients, as that term is defined in [NRS 449.0151](#) and [449.019](#); and
- An independent center for emergency medical care, as that term is defined in [NRS 449.013](#) and [449.0151](#).

(Added to NRS by [2002 Special Session, 13](#))

Near miss: An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Mandatory reporting: Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985;254(6):796-800.)

Risk: Possibility of loss or injury. (Merriam-Webster’s Online Dictionary, Risk, Available at <http://www.merriamwebster.com/dictionary/risk>. Last Accessed August 2009.)

Preventable event: Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Catheter Associated Urinary Tract Infection (CAUTI): A urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at

http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CUR_RENT_b.pdf.)

Central Line Associated Bloodstream Infections (CLABSI): Primary bloodstream infections that are associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection.

Appendix B: Checklist Example: Injuries from Falls and Immobility

Process Change	In Place	Not Done	Will Adopt	Notes (Responsible & By When?)
Conduct fall and injury risk assessment upon admission				
Reassess risk daily and with changes in patient condition				
Implement patient-specific intervention to prevent falls and injury				
Communicate risk across the team; use handoff forms, visual cues, huddles				
Round every 1 to 2 hours for high-risk patients; address needs (e.g., 3Ps: pain, potty, position-pressure). Combine with other tasks(vital signs)				
Individualize interventions. Use non-skid floor mats, hip protectors, individualized toileting schedule; adjust frequency of rounds				
Review medications (by pharmacist); avoid unnecessary hypnotics, sedatives				
Incorporate multidisciplinary input for falls				
Prevention from PT, OT, MD, RN and PharmD				
Include patients, families and caregivers in efforts to prevent falls. Educate regarding fall prevention measures; stay with patient				
Hold post-fall huddles immediately after event; analyze how and why; implement change to prevent other falls				

Reference: Checklists to Improve Patient Safety. June 2013. Health Research & Educational Trust.

Spring Valley Surgery Center LLC

2017 Sentinel event reporting

3835 S. Jones Blvd. Las Vegas NV 89103 License #: 3421

Safety committee:

The Administration has established a “Life Safety Enterprise Safety Program” designed to keep patients, Physicians, employees and the public safe while on the premises of the Facility. This program consists of elements which meet the requirements as defined by the The Administration has established a “Life Safety Enterprise Safety Program” designed to keep patients, Physicians, employees and the public safe while on the premises of the Facility. This program consists of elements which meet the requirements as defined by the Federal, State, Local and OSHA guidelines. The “Safety Plan” includes identification, evaluation and prevention of workplace hazards relating to the elements and specific criteria. The safety management of the Facility is composed of several elements regarding the safety features necessary for the protection and security of its patients and healthcare workers.

These elements are composed of two parts; one “Life Safety Enterprise Safety Plan” which is wide in scope, organizational and effectiveness, and the “Environmental Safety Management” which oversees the working environment elements of the Facility. These areas overlap each other but also provide individual elements which manage the overall security and safety of the Facility. A report from the Safety Committee is provided quarterly to the Medical Executive Committee (MEC) and onto the Governing Board. The Safety Committee meets and discusses how to improve and/or maintain patient and employee well-being and safety, items discussed range from falls to how to properly lift boxes, and the execution of a disaster drills, etcetera. If any incidents have occurred they will be discussed in detail, and prevention and safety will be implemented.

PATIENT SAFETY PLAN

1. Aseptic technique to be used during surgical intervention per facility policy
 - Multi-dose vial policy for the facility
 - Sterile technique for injections
 - Single dose vial policy for the facility

2. Infection Control per facility policy
 - Post surgical infection survey policy
 - Care of infectious patients

3. Pharmacist monthly reviews

4. Monthly safety inspections to assure a safe environment.

Please revise and expand this template to meet your facility's needs.

Facility Name: Seven Hills Surgery Center

QUALITY AND PATIENT SAFETY PLAN Template

DATE: 02/23/2018

VERSION: XX



This plan was created and revised by the (Seven Hills Surgery Center) Patient Safety committee/team. Implementation of this plan is intended to optimize the healthcare quality and patient safety outcomes, encourage recognition, reporting, and acknowledgment of risks to patient, visitor, and employee safety, as well as reduce the medical/healthcare errors and /or preventable events.

Patient Safety Committee/Program

Facility name: Seven Hills Surgery Center

876 Seven Hills Dr
Henderson, NV 89052
(702)914-2028

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Commitment to Patient Safety

(Seven Hills Surgery Center) is committed to a comprehensive approach to improving healthcare quality and patient safety by aligning with our Mission, Vision, and Values, creating an environment that supports a dynamic, proactive, and safe culture for patients, family members, visitors, and employees, through continuous learning and improving patient safety policies, systems, and processes.

Mission, Vision, and Values

In support of our mission, vision, and values, (Seven Hills Surgery Center) Patient Safety and Quality Improvement program promotes:

- Collaboration of healthcare, leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high quality healthcare.
- Communicate honestly and openly to foster trusting and cooperative relationships among healthcare providers, staff members, and patients and their families, to ensure accountability for the patient safety priorities.
- Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.
- Responsibility for every healthcare related decision and action.
- A focus on continuous learning and improving, system design, and the management of choices and changes, bringing the best possible outcomes or performances to the facility.
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare.
- Education of staff and physicians to assure participation of healthcare providers.

Scope and Purpose

The scope of this Quality and Patient Safety Plan is organizational-wide which includes but is not limited to

- Patient safety
- Visitor safety
- Employee safety

All staff in (Seven Hills Surgery Center) are required to fully support and participate in this plan, and devote their expertise to the patient safety and healthcare quality improvement process.

This plan is action oriented and solution focused. The purpose of this plan is to address patient safety related concerns, challenges and revise the program to better serve the patients and their families. To this end, (Seven Hills Surgery Center) has developed this Patient Safety Plan.

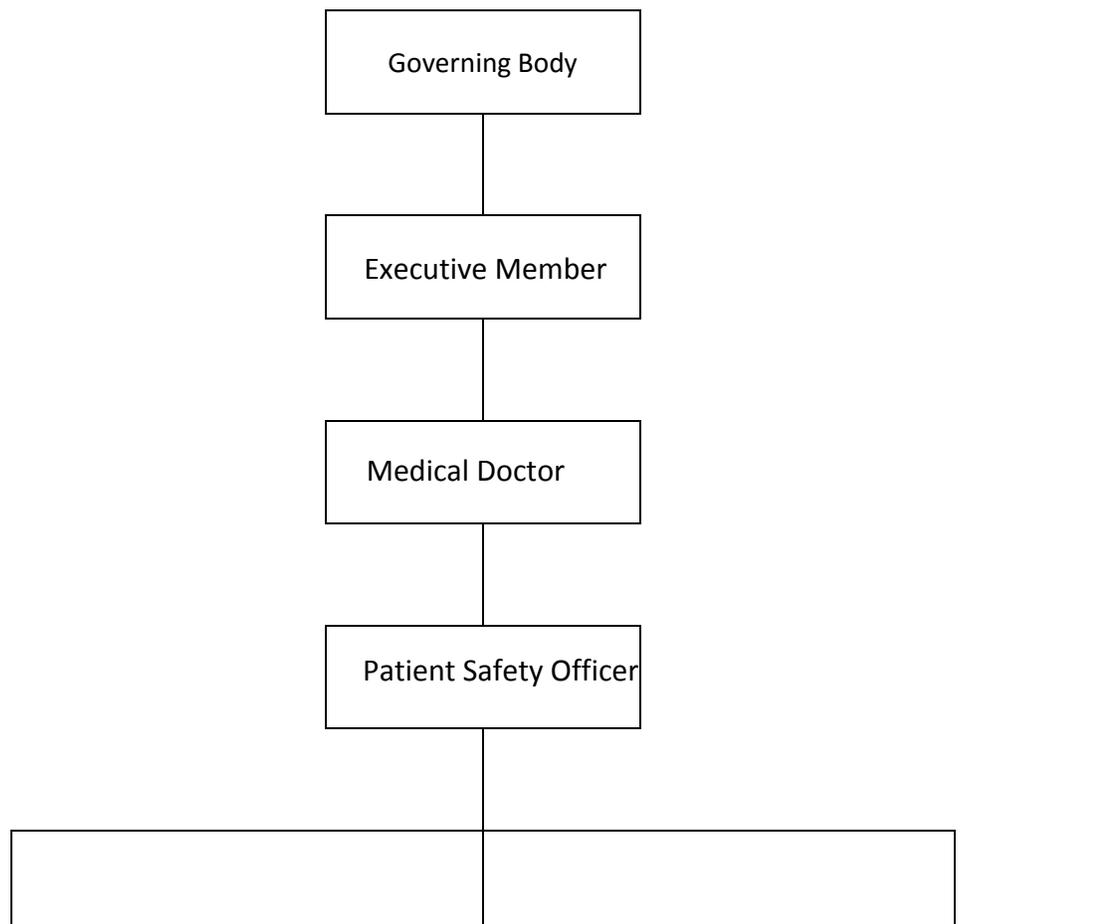
The plan focuses on the process rather than the individual, and recognizes both internal and external customers, as well as facilitates the need of analyzing and improving processes. The core principles of this plan include:

- All staff have the same goal and contribute their knowledge, vision, skill, and insight to improve the process of the Patient Safety Plan.
- Decisions will be based on data and facts, and staff will be encouraged to learn from the experiences.
- Customer based including patients, families, and visitors.
- Promote systems thinking.
- Employ well-trained and competent staff maintaining high healthcare quality.

Roles and Responsibilities

According to [NRS 439.875](#), a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plan is promoted and executed successfully.

The Patient Safety Committee Organization



Pharmacist

Infection Control Officer

Administrator

Roles and Responsibilities

- In accordance with [NRS 439.875](#), a patient safety committee must be comprised of:
- The infection control officer of the medical facility;
- The patient safety officer of the medical facility, if he or she is not designated as the infection control officer;
- At least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility; and
- One member of the executive or governing body of the medical facility.

Based on [NAC 439.920](#), a medical facility that has fewer than 25 employees and contractors must establish a patient safety committee comprised of:

- The patient safety officer of the medical facility;
- At least two providers of healthcare who treat patients at the medical facility, including but without limitation, one member of the medical staff and one member of the nursing staff of the medical facility; and
- The Chief Executive Officer (CEO) or Chief Financial Officer (CFO) of the medical facility.

The roles and responsibilities are defined below (Please modify them as needed.)

Patient Safety Committee Responsibilities (based on [NRS 439.875](#) and [NRS 439.877](#))

- Monitor and document the effectiveness of the patient identification policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the patient safety officer pursuant to [NRS 439.870](#).
- Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred.
- Review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- Review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least once each calendar (quarter depending on the number of employees and contractors in the facility), report to the executive or governing body of the facility regarding:
 - (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);

(2) The number and severity of infections that occurred at the facility during the preceding calendar quarter; and

(3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.

- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

Root Cause Analysis (RCA) Team Responsibilities (please revise as needed)

- Root Cause interviews, analysis, investigation, and corrective action plan implementations.
- Participates in the RCA meetings and discussions.
- Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders.

Patient Safety Officer Responsibilities (based on [NRS 439.870](#))

- Serve on the patient safety committee.
- Supervise the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the patient safety committee regarding any action taken in accordance with the responsibilities above.

Infection Control Officer Responsibilities (based on [NRS 439.873](#))

- Serve on the patient safety committee.
- Monitor the occurrences of infections at the facility to determine the number and severity of infections.
- Report to the patient safety committee concerning the number and severity of infections at the facility.
- Take such action as determines is necessary to prevent and control infections alleged to have occurred at the facility.
- Carry out the provisions of the infection control program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program.

RCA team leader Responsibilities (please revise as needed)

- Organize and coordinate the RCA process.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA, and corrective action plan implementation process.

- Communicate the progress of the investigation, institutional barriers, and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.
- Provide training, education and direction to create RCA process that incorporate the Patient Safety and Quality Improvement elements.

Executive or Governing Body Staff Responsibilities (please revise as needed)

- Provide vision and leadership to Patient Safety and Quality Improvement process, and develop and foster a safe learning and improving culture.
- Provides oversight to the healthcare quality improvement processes and teams.
- Plan, discuss, and generate the organization patient safety goals and activities, in conjunction with the patient safety action plans

The Patient Safety Committee will meet monthly to accomplish the following:

- Report and discuss sentinel events which include:
 - Number of sentinel events from previous calendar month (or quarter).
 - Number of severe infections that occurred in the facility.
- Corrective Action Plan for the sentinel events and infections
 - Evaluate the corrective action plan.
- Patient safety policies and checklists
 - At least annually evaluate Patient Safety policies and checklists
 - Revise the patient safety policies and checklists as needed.
 - Monitor and document the effectiveness of the patient safety policy.

A RCA meeting will meet as needed to accomplish the following:

- Define the healthcare issues or potential risks.
- Conduct Root Cause Analysis
 - Reviewing and analyzing the data.
 - Reviewing the RCA process and quality improvement related activities and timelines.
 - Identify the contributing factors and conduct the Root Cause Analysis.
- Conduct Corrective Action Plan
 - Identifying the Plan-Do-Study-Act (PDSA) topics.
 - Discussing corrective action process and activities.
 - Discussing and presenting possible changes in procedure to improve areas indicated.
 - Identifying strengths and areas that need improvement.
 - Developing strategies, solutions, and steps to take next.
- Identify barriers and technical assistance needs for supporting the RCA efforts.

A meeting agenda and minutes noting follow-up tasks will be kept.

Objectives and Goals of the Quality and Patient Safety Plan

Objective	Goals	Plan	Planned Completion Date	Responsible Party

Components and Methods

Pursuant to [NRS 439.837](#) and [NAC 439.917](#), within 45 days after reporting a sentinel event pursuant to [NRS 439.835](#), the medical facility shall conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event.”

(Seven Hills Surgery Center) will use RCA process to determine the contributing factors and the underlying reasons for the deficiencies or failures. The Plan-Do-Study (check)-Act (PDSA or PDCA) is the model, which was developed by the Institute of Health Care Improvement that we will use to test the changes.



Root Cause Analysis

A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals.

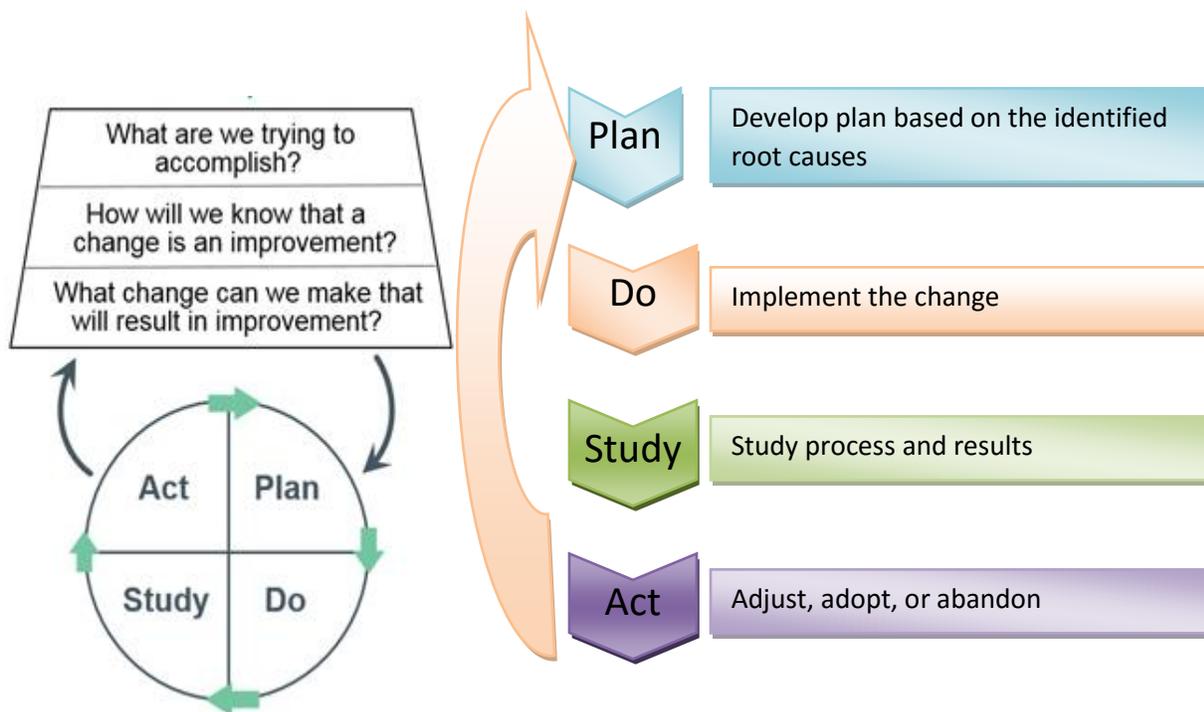
Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

Root cause analysis and action plan framework table, which was introduced by the Joint Commission. It contains 24 analysis questions. It guides the organization to the steps in a root cause analysis. Not all the questions apply to all the events or cases.

5 Whys technique will be used in (Seven Hills Surgery Center) to explore the cause and effect relationship underlay a problem. One can find the root causes by asking “why” no less than five times.

Model for Improvement

The Model for Improvement is a collaborative and ongoing effort model to improve the product and services quality and process. It provides multi-disciplinary quality team guidance from identifying the root causes; conducting the best tests to assess possible changes, and working in collaboration for implementation of the new approaches and solutions. It guides the test of a change to determine if the change is an improvement.



The cycle is defined as follows:

- Plan--Collect data and establish appropriate goals. Identify the problem and the possible root causes, and answer the following questions.
 - What is the objective of the test?

- What are the steps for the test - who, what, when?
 - How will you measure the impact of the test?
 - What is your plan to collect the data needed?
 - What do you predict will happen?
- Do--Make changes designed to correct or improve the situation. Use the following questions for the guidance.
 - What were the results of the test?
 - Was the cycle carried out as designed or planned?
 - What did you observe that was unplanned or expected?
 - Study -- Study the effect of the changes on the situation. Data should be collected on the new process and compared to the baseline or expected results. Results should be evaluated by using the following questions as guidance.
 - Did the results match your prediction?
 - What did you learn?
 - What do you need to do next?
 - Act--If the result is successful or desirable, standardize the changes and then work on the next prioritized problem or the further improvements. If the outcome is not yet successful, look for different ways to identify the causes or change the testing process.

PDSA worksheet will be used to map the potential change strategies and to establish a course of action. The PDSA worksheet and the PDSA progress report are attached in Appendix D-1.

Data Collection and Reporting

Data should drive any quality and patient safety effort. (Seven Hills Surgery Center) is using (internal processes) for tracking the sentinel events, healthcare infection data, and (Amkai) for internal data collection.

External data sources are those data sources which are collected outside the supervisory structure of the case. External data which will be utilized for Quality and Patient Safety plan include the data from:

- AHRQ: Agency for Healthcare Research & Quality
- CDC: Centers for Disease Control and Prevention
- CMS: Centers for Medicare & Medicaid Services
- NQF: National Quality Forum
- NHSN: National Healthcare Safety Network
- TJC: The Joint Commission
- Pinnacle III Facilities



Ongoing Reporting and Review

Data points such as the following will be reviewed according to the schedule prescribed:

Monthly	Quarterly	Annually
1) Sentinel event monthly report 2) Severity of infection report 3) RCA assessment	1) Sentinel event quarterly report 2) Severity of infection report 3) Review and evaluate the measure of improvement of patient safety 4) Review and evaluate the measurement to prevent and control infections	1) Quality and Patient Safety Plan update 2) Checklists and Policies reviewing and revising

Assessment of the Quality and Patient Safety Plan

Please see the Patient Safety Assessment Tool (PSAT) from the VA National Center for Patient Safety for your reference.

Patient Safety Checklists and Patient Safety Policies

By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

The patient safety checklists must follow protocols to improve the health outcomes of patients at the medical facility and must include, without limitation:

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.
- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - Proper instructions concerning prescription medications;
 - Instructions concerning aftercare;
 - Any other instructions concerning his or her care upon discharge; and
 - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include, the name and date of birth of the patient.

- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.
- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

Based on [NRS 439.865](#), the patient safety plan must also include an infection control program that carries out the infection control policy. The policy must consist of:

- The current guidelines appropriate for the facility's scope of service developed by a nationally recognized infection control organization as approved by the State Board of Health which may include, the Association for Professionals in Infection Control and Epidemiology (APIC), the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO) and the Society for Healthcare Epidemiology of America (SHEA); and
- Facility-specific infection control developed under the supervision of a Infection Preventionist.

The patient safety checklists are listed in Appendix E. The following links provide some patient safety checklists for your reference-a checklist example is shown in Appendix E.

<http://www.hpoe.org/Reports-HPOE/Cklist PatientSafety.pdf>
<http://www.who.int/patientsafety/implementation/checklists/en/>

The patient safety policies are listed in Appendix F. (The following link provides you some patient safety policies for your reference- a policy example is shown in Appendix F).

Approval of Patient Safety Plan

According to [NRS 439.865](#), a medical facility shall submit its patient safety plan to the governing board of the facility for approval. After a facility's patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan.

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Reference

- Root Cause Analysis Toolkit <http://www.health.state.mn.us/patientsafety/toolkit/>
- Quality and Service Improvement Tools
http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html
- CQI 101 An Introduction to Continuous Quality Improvement:
<https://www.coursehero.com/file/13827355/CQI-Overviewppt/>
- Quality Improvement <http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/>
- Root Cause Analysis <http://www.patientsafety.va.gov/professionals/onthejob/rca.asp>
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2
https://www.jointcommission.org/sentinel_event.aspx
- Hospital Policies <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>
- Checklists to Improve Patient Safety http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf
- Patient Safety Checklists <http://www.who.int/patientsafety/implementation/checklists/en/>
- Minutes of the Meeting of the Quality and Patient Safety Committee
<http://www.cookcountyhhs.org/wp-content/uploads/2013/12/09-23-14-QPS-scan-Minutes.pdf>
- Title 40 – Public Health and Safety <https://www.leg.state.nv.us/NRS/NRS-439.html>

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- Surgical site infections;
- Ventilator-associated pneumonia;
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- An independent center for emergency medical care, as that term is defined in [NRS 449.013](#) and [449.0151](#).

(Added to NRS by [2002 Special Session, 13](#))

Near miss: An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Mandatory reporting: Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985;254(6):796-800.)

Risk: Possibility of loss or injury. (Merriam-Webster’s Online Dictionary, Risk, Available at <http://www.merriamwebster.com/dictionary/risk>. Last Accessed August 2009.)

Preventable event: Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Catheter Associated Urinary Tract Infection (CAUTI): A urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CURRRENT_b.pdf.)

Appendix B: Patient Safety Goals

OBJECTIVE:	GOAL:	Q3 2014	Q4 2014	Q1 2015
ACTION PLAN:				
1. Create Systems that anticipate errors & either prevent or catch them before they cause harm.	a. Enhance retrospective chart review process.			Implement Trigger Tools. Develop automated surveillance reports in Cerner.
	b. Establish an automated surveillance process.		Complete an in-depth analysis of risk point utilizing the methods of FMEA.	
2. Establish Structures for reporting and a process for managing reports in the event reporting system.	a. Implement new electronic Voluntary Reporting System & participate in Patient Safety Organization.	Implemented e-MERS & PSO with UHC.	Create process for reviewing & closing reports in e-MERS.	
	b. Develop a structure to educate employees system-wide of the process for reporting hazards, errors and adverse events.		Increase number of events reported by 10%.	
	c. Establish a process for providing feedback regarding reported events.		Create process for communicating outcome of reported events.	
3. Develop a Culture of Safety where providers feel safe and supported when they report medical errors or near misses & voice concerns about patient safety.	a. Provide education on patient safety plan that emphasizes importance of blending a systems focus with appropriate individual accountability.		Educate Medical staff, Hospital Wide Oversight & the Quality Committees on the objectives and goals of the patient safety plan.	
	b. Establish a recognition program that rewards safe practices.		Include patient safety presentation in monthly New Employee Orientation.	
	c. Improve overall perceptions of safety as measured by the Culture of Safety Survey.		Develop 'Great Catch' awards program.	
				Re-evaluate culture of safety and develop action plan.
4. Establish Safety Priorities & Targets.	a. Develop Patient Safety Dashboard that includes national measures and benchmarks.		Present Patient Safety Dashboard monthly to Hospital Wide Oversight Committee.	
	b. Facilitate the development of action plans associated with measures not meeting benchmarks.	Complete 2014 Leapfrog Safety Survey.	Establish & implement a plan to improve performance of each leap.	
	c. Assess and improve processes related to hand-off, transition and communication	Develop method to track & report departmental progress and compliance of RCA action plans.		
5. Charter Safety Programs through teams, workgroups or projects.	a. Coordinate Improvement Efforts in order to ensure that capital, people, facilities & technologies are matched to strategic priorities for safe practices.		Establish Patient Safety Council.	
	b. Reduce and eliminate variation in care.		Establish workgroups focused on medication safety, reducing patient falls & hospital acquired pressure ulcers.	
			Revise or develop policies, procedures and protocols.	

Reference: Patient Safety Plan and Its Applicable Goals. 2014. Cook County Health and Hospitals System.

Patient Safety and Quality Improvement Plan

Appendix D-1: PDSA Worksheet

PDSA Worksheet

Topic:			
Person Completing Worksheet:		Date:	
Telephone/ Email:		Cycle:	
Patient Safety Committee Members			
CEOs/CFOs			
Patient Safety Officer			
Infection Control Officer			
Other Medical Staff			
Other team members			
Aim: (Describe the overall SMART goal that your team wishes to achieve.)			
Plan:			
1. List the tasks needed to set up this test of change.			
2. Predict what will happen when the test is carried out.			

3. List the steps to develop the test-who, what, and when.

Steps	By Whom	By When	Desired Outcome

Do: (Describe what actually happened when you ran your test, including any problems and unexpected findings.)

Study: (Describe what you learned and did you meet your measurement goal?)

Did you meet your measurement goal? Explain.	Summarize what was learned: success, failure, unintended consequences, etc.

Act: (Describe what you concluded from this cycle.)

Based on what was learned, please indicate what action will be considered.	Describe what modifications to the plan will be made for the next cycle based on what you learned.
<input type="checkbox"/> Adapt: modify changes and repeat PDSA Cycle	
<input type="checkbox"/> Adopt: expanding changes throughout organization	
<input type="checkbox"/> Abandon: change approach and repeat PDSA cycle	

Appendix D-2: PDSA Monthly / Quarterly Progress Report

Event:			
Person Complete Report:		Date:	
Patient Safety Officer		Contact Information:	
Monthly / Quarterly Report			
Items	Description		
1. What is your goal?			
2. Report on the PDSA cycle			
3. What system and practices are working well? Explain.			
4. What areas for improvement did the data identify?			
5. What barriers or system issues have been encountered implementing action activities?			
6. Action plans to address the barriers or system issues			
7. Lesson learned			
8. Support needed			
9. Additional discussion			
Notes:			

Appendix E: Checklist Example: Injuries from Falls and Immobility

Process Change	In Place	Not Done	Will Adopt	Notes (Responsible Physician)
Conduct fall and injury risk assessment upon admission				
Reassess risk daily and with changes in patient condition				
Implement patient-specific intervention to prevent falls and injury				
Communicate risk across the team use handoff forms visual cues huddles				
Round every 1 to 2 hours for high-risk patients address needs (e.g. P's: pain potty position-pressure) Combine with other tasks (vital signs)				
Individualize interventions Use non-slip floor mats hip protectors individualized toileting schedule adjust frequency of rounds				
Review medications (by pharmacist) avoid unnecessary hypnotics sedatives				
Incorporate multidisciplinary input for falls				
Prevention from PT OT MD RN and PharmD				
Include patients families and caregivers in efforts to prevent falls Educate regarding fall prevention measures stay with patient				
Hold post-fall huddles immediately after event analyze how and why implement change to prevent other falls				

Reference: Checklists to Improve Patient Safety. June 2013. Health Research & Educational Trust.

Appendix F: Policy Example

[Reference: Hospital Policies. MERCY Hospital. <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>]

	HOSPITAL POLICY AND INFORMATION MANUAL	
<p>PERSONAL PROTECTIVE EQUIPMENT POLICY Page 1 of 2</p>	<p>Date Issued: Date Last Revised: Next Review Date: Approved By:</p>	<p>07/01 08/14 08/17 Policy Committee</p>

Key Words: personal protective equipment, PPE, safety equipment,

Policy Applies to:

- All staff
- Credentialed Specialists, Allied Health Professionals, patients, visitors and contractors will be supported in meeting policy requirements.

Related Standards:

- Infection and Prevention and Control Standards NZS 8134.3:2008
- Health and Safety in Employment Act 1992
- EQulP5 - 1.5.1 and 1.5.2 Infection Control
- EQulP5 - Standard 3.2 Criterion 3.2.1 Health and Safety

Rationale:

Mercy Hospital will provide suitable personal protective equipment (PPE) when the risk to health and safety cannot be eliminated or adequately controlled by other means.

Definitions:

Personal protective equipment (PPE) means all equipment which is intended to be worn or held by a person to protect them from risk to health and safety while at work.

Examples of PPE include: protective footwear, gloves, hard hats/helmets, clothing affording protection from the weather, visibility clothing, eye and face protection.

Objectives:

- To ensure appropriate PPE is identified to minimize hazards not able to be controlled by elimination or isolation;
- To ensure fit for purpose PPE is provided at Mercy Hospital for use by staff;
- To ensure adequate training in the use of PPE is provided;
- To monitor the use of PPE and evaluate effectiveness.

	HOSPITAL POLICY AND INFORMATION MANUAL	
<p>PERSONAL PROTECTIVE EQUIPMENT POLICY Page 2 of 2</p>	<p>Date Issued: Date Last Revised: Next Review Date: Approved By:</p>	<p>07/01 08/14 08/17 Policy Committee</p>

Implementation:

Risk Management

Department Managers, the Occupational Health/ Infection Prevention and Control Nurse (OH/IPC Nurse) and Health and Safety/ Infection Control Representatives (HSIC reps) will in consultation with staff:

Ensure PPE requirements are identified when carrying out risk assessments of activities;

- Regularly review the risk assessment of activities if substances or work processes change;
- Identify the most suitable type of PPE that is required;
- Ensure PPE is available to those who need it;
- Inform staff of the risks involved in their work and why PPE is required;
- Monitor compliance.

Process

Manager’s Responsibilities

Must ensure that:

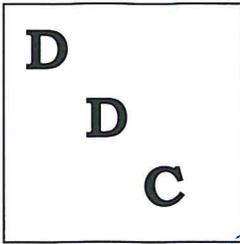
- PPE requirements are considered when risks are assessed;
- Suitable PPE is provided and made accessible to employees;
- PPE is properly stored, maintained, cleaned repaired and replaced when necessary;
- Adequate information and training is provided to those who require PPE;
- PPE is properly used;
- Use of PPE is monitored and reviewed.

Employee’s Responsibilities All employees must ensure that:

- They use PPE whenever it is required;
- Attend and comply with training, instruction and information;
- Check the condition of their PPE;
- Store, clean and maintain their PPE;
- Report losses, defects or other problems with PPE to their manager.

Evaluation:

- Staff health and safety orientation
- Environmental audits
- Incident reports



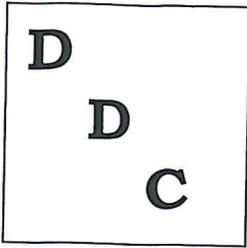
**P A T I E N T S A F E T Y
P O L I C Y & P R O C E D U R E**

Policy:

The policy set forth by the Digestive Disease Center (DDC) is to ensure patient safety, before, during, and after a patient's procedure.

Procedure:

- A. Each patient will have a history & physical examination documented in their chart within 7 days prior to their procedure.
- B. Each patient will complete the Medical History Questionnaire prior to his or her procedure.
- C. All patients will receive a copy of the Patient Rights and Responsibilities at the time of scheduling of procedure.
- D. All medical staff is CPR certified, and aware of the location and use of all emergency equipment. All DDC Physicians are ACLS certified.
- E. At least one ACLS certified Registered Nurse is staffed when patients are present in the facility, along with ACLS trained Anesthesiologist is present with sedated patients.
- F. Once a patient has been admitted to the facility, non-sedated patients are visualized frequently to ensure needs are meet. Sedated patients are monitored closely checking vital signs with observation to assure patients are free from complications related to the procedure and /or medical problems
- G. Each patient will meet the required discharge criteria set forth by DDC, and ANOR anesthesia standard, prior to being discharged. The physician will have the final decision, to discharge the patient, which will be documented, signed and become part of the patient's record.
- H. A written physician discharge order will be issued to each patient post procedure, providing them with post procedure instructions, precautions, and contact information in case of an emergency. A copy of this document will become part of the patient's record.
- I. The facility staff will make a follow up appointment for the patient as ordered by the physician.
- J. Each patient will be contacted within 24 hours after having their procedure to ensure that they are not experiencing any complications related to the procedure.
- K. A patient safety committee will be formed to include one physician from each site, the nurse manager from each site, the pharmacy consultant, and the medical director. The committee will meet quarterly to discuss patient safety.



Digestive Disease Center

**P A T I E N T S A F E T Y C O M P L I A N C E
P O L I C Y & P R O C E D U R E**

Policy:

The policy set forth by the Digestive Disease Center (DDC) is to ensure that staff, physicians, vendors, and contracted employees are compliant with patient safety including checklists, policies & procedures established by the DDC.

Procedure:

- A. All staff, physicians, vendors & contracted services are required to read and comply with the safety checklists, policies & procedures prior to working in the center.
- B. Policies & checklists will be provided to vendors & contracted services to provide to their employees.
- C. Staff educated upon hire & annually thereafter on the process for reporting violations to the Director of Nursing Services.
- D. Audits performed monthly utilizing the Infection Control Surveillance Tool to ensure compliancy & sanitation.
- E. The safety committee will meet monthly to discuss patient safety issues, review audits & monitor & document effectiveness of the patient identification policy.
- F. Safety Policies & Procedures, checklists will be reviewed at least annually & more often if needed.

Safety Committee Report

RN

Discussion:

Providers are required to complete OSHA/Infection Control training with Compliance Alliance.
 CSC staff completed annual OSHA training with Compliance Alliance.
 CSC staff completed annual malignant hyperthermia in service and mock drill.

Compliance Alliance completed an annual survey to evaluate compliance with OSHA and infection control standards. There were no deficiencies identified from the survey.

Conclusion:

Providers will complete annual OSHA training with Compliance Alliance.

Action items:

Use monthly Environmental Rounds to monitor for patient/employee safety issues.
 Provide monthly safety education to staff using the OSHA newsletters provided by Compliance Alliance.
 Present narcan policy in December staff meeting agenda.
 Include reporting of unusual discharge to Kellie Merrill in September staff meeting agenda.
 Schedule providers for OSHA webinar with Compliance Alliance.

Person responsible:

[Redacted]

Deadline:

Ongoing
 Ongoing
 complete
 complete
 January 31, 2017

Patient Satisfaction

RN

Discussion: Patient satisfaction surveys are reviewed monthly. Patient satisfaction was selected as a topic for CSC quality improvement (see attached QI study). Overall, patients are satisfied. The most common complaint is caregivers are not given discharge instructions.

Conclusions:

Recovery nurses will provide instructions to the patient's caregiver at discharge.

Action items:

Review submitted patient satisfaction surveys monthly.
 Tally patient satisfaction survey results using spreadsheet.
 Nurses will be informed to provide discharge instructions to caregivers in monthly staff meeting.

Person responsible:

[Redacted]

Deadline:

Ongoing
 Ongoing
 complete

Effective as of: 10-6-09
Reviewed & approved January 2018

Quality Improvement Plan

SUMMIT Surgery Center

Approved by the Medical Staff

By: _____ Dated: _____

Its President

Adopted by the Managing Body

By: _____ Dated: _____

Authorized Representative

SUMMIT Surgery Center

Quality Improvement Plan

Purpose:

This organization provides ongoing monitoring of important aspects of the care provided. Health care professionals participate in the development and application of the criteria used to evaluate the care they provide. The Quality Improvement (QI) program addresses clinical, administrative and cost-of-care issues, as well as actual patient outcomes. Data related to established criteria are collected in an ongoing manner. Collected data are periodically evaluated to identify unacceptable or unexpected trends or occurrences that influence patient outcomes. Information will be gathered, logged and identified on a quarterly basis by the Quality Improvement Committee. This will include the laboratory consultant who will review all logs kept (i.e. blood glucose). The radiology safety officer will monitor the radiation safety issues for the facility including radiation badge levels. The pharmacy consultant will review all pertinent pharmacy data including narcotic review monthly. In addition, the contract service providers may provide appropriate in-service education for the staff of the facility as requested by the facility.

QI Indicators to be monitored will include:

- 1) Patient Satisfaction, Employee Satisfaction, Physician Satisfaction
- 2) Patient Follow-up: a) post op phone calls b) post –op complications
- 3) Post Operative Occurrences
- 4) Medication Use , Pharmacist review, Adverse Reaction Log & Medication Error Log per occurrence reporting system
- 5) Cancellations on Day of Surgery
- 6) Medical Record Review
- 7) Safety
- 8) Infection Control
- 9) Credentials
- 10) Employee Files
- 11) Ancillary Services
- 12) Employee Blood Borne Pathogen Exposures
- 13.) Patient Complications – Transfers, Returns to Surgery,

Quality Improvement Issues:

In addition to the on-going monitoring of QI indicators, staff and department managers will be encouraged to develop and assess “Quality Improvement Issues” to ensure department concerns are addressed and corrected. QI activities are consistent with the characteristics of the organization’s overall QI program. QI activities will follow the five steps of “closing the QI loop”.

Routine monitoring will also include:

- Emergency Cart / Defibrillator checks
- Refrigerator and Fluid warmer temperature checks.

The Quality Improvement Plan, the Peer Review Plan and Processes and the Risk Management Plan are all integrally inter-related in the overall quality processes of the ASC. When one process is affected, all subsequent processes and plans can be affected and may require follow-up and/or evaluation of the quality of care provided and the risks to the facility.

Quality Improvement Annual Review:

The Quality Improvement Plan will be evaluated and/or updated by the organization on at least an annual basis. The evaluation will be completed by designated personnel, including, but not limited to the Administrator, the QI Nurse, etc. Results of the QI Plan annual review will be reported to the Governing Body.

Benchmarking:

The surgery center has a process in place to review key indicators in comparison to other similar organizations and surgery centers. The Benchmarking data collected is analyzed and reviewed to determine areas of patient care that may need to be addressed to reduce the gaps from benchmarking norms. Both internal and external benchmarks are evaluated and utilized in QI activities.

Risk Management:

The QI Plan includes a risk management plan, with policies and processes to maintain an environment designed to protect the life and welfare of our patients, visitors and employees.

Responsibility:

The Board of Directors has the ultimate responsibility to continually evaluate and if necessary, improve the quality of care. The Administrator has the responsibility to implement the Quality Improvement Plan. The Board of Directors and Medical Executive Committee (MEC) will review and approve the plan. The Quality Improvement Coordinator will be responsible to oversee the ongoing operations of the Quality Improvement Plan. The Quality Improvement Committee will meet at least quarterly to review the data and make recommendations to the MEC and the Board.

Committee Composition:

The professional and administrative staff of the Surgery Center understands, supports, and participates in programs of quality management and improvement, through organized mechanisms responsible to the governing body. Contracted services provided to the facility will participate in the quality improvement plan of the facility on an ad hoc basis. This will include radiology laboratory, environmental and pharmacy services. The committee will be comprised of key staff, management and a physician appointed by the Board:

Medical Director: Name Here

Administrator: Name Here

QI Coordinator/D.O.N.: Name Here

OR Supervisor: Name Here

PACU Supervisor: Name Here

Ad HOC members:

Pharmacy Consultant: Name Here

Laboratory Consultant: Name Here

Environmental Consultant: Engineer from Saint Mary's

Housekeeping Services: Xtra Clean

Medical Executive Committee: MEC chair Dr Name Here

Radiology Consultant: Radiologist from Saint Mary's

The managers may delegate to their staff in their respective department (i.e. pre-op/PACU, OR and Business Office) the responsibility to gather information to further the quality of care at the facility.

Scope of Care:

The facility provides services to all patients who require treatment and procedures on an ambulatory surgery basis.

Communication:

The QI committee will meet at least quarterly to review, monitor and evaluate all information gathered. All activities will be documented on the quarterly report. The committee will summarize all activity and submit a report to the MEC for review. The MEC will give direction and recommendation for the approved activity and then report results to the Governing Board. Finding of quality improvement activities are incorporated into the organization's educational activities. Information is communicated through the organization via feedback from the Administrator, QI Coordinator and/or managers to the staff members at the staff meetings so they can have the opportunity to participate in the plan.

Assessment will be a continued process to recognize priorities. Appropriate records of QI activities will be maintained.

Quality Improvement Goals and Objectives of the Quality Management / Quality Improvement Program focus on the following patient care services and priorities:

- Improving patient health outcomes through the identification and reduction of medical errors,
- Evaluating high risk, high volume, problem prone areas and the incidence, prevalence and severity in these areas
- Evaluating high risk, low volume, problem prone areas and the incidence, prevalence and the severity in these areas
- Trending and implementing strategies and processes that positively effect health outcomes for patients, staff and the medical staff,
- Evaluating, developing and implementing defined performance measures or indicators for patient safety and the quality of care provided including medical necessity and the appropriateness of care provided.

Performance Improvement Activities will consistently track all:

- Adverse patient events,
- Examine the causes,
- Implement improvements approved by leadership, and
- Re-check to ensure that improvements are sustained over time

Elements and Composition of the Quality Improvement Plan:

The Quality Improvement Plan is an integrated plan which addresses both administrative and clinical outcomes of the Surgery Center.

1. Identification of Problems and Concerns –
 - This is accomplished thru audits, complaints and occurrence reports, which are tracked and trended within the surgery center as well as after patient discharge.
2. Participation of physicians, allied health professionals, office staff personnel and administration –
 - A member from each department of the surgery center will participate in the Quality Improvement Committee. At least 2 physicians will be involved in evaluating all quality of care issues
3. Evaluation of frequency, severity, and the sources of suspected problems and concerns and evaluation of whether policies and procedures should be revised –
 - As all occurrences are tracked, trended and evaluated by both the QI committee and the governing body, recommendation regarding policy and procedure changes will be evaluated as well, and policy changes based on current standards of care.
4. Review of related processes and implementation of measures to address and resolve identified problems or concerns-
 - Recommendations and comparisons will be made by the QI committee to present to the Governing Body, addressing possible solution paths to implement in order to resolve identified problems or concerns within the facility.
5. Re-evaluation of problems or concerns to determine objectively whether the corrective measures achieved and sustained and the desired results –
 - All problems or concerns will be re-evaluated or re-studied to determine if corrective measures implemented or changed in policy and procedures have been effective or need to be changed in order to maintain desired change or results.
6. Reporting of findings to the governing body –
 - All findings of outcomes, problems or concerns will be reported to the Governing Body on a least quarterly basis. Additionally, all measures implemented or changed will have outcomes of such changes reported to the Governing Body in order to evaluate if changes or measures have been effective or ineffective and if further evaluation is needed in the long term or short term.

Quality Improvement Indicators

1. SATISFACTION SURVEYS

- a. Patient
- b. Employee
- c. Physician

Tool:

Patient/Family Satisfaction Questionnaire (CTQ)

CTQ has been contracted to send each patient a patient satisfaction survey via e-mail or mail. The facility is immediately notified of any negative surveys or of patients who request to be contacted. When returned, these surveys are inputted into an analysis report and provided to the Q.I. team who will review them accordingly and assimilate them into the Patient Evaluation Summary.

Evaluation Summary of each population

CTQ sends the facility a form summarizing the information received from the satisfaction surveys and reports. It enables the center to monitor the percentage of surveys returned and define follow-up actions that may be necessary in response to patient complaints, employee and physician concerns.

Percentage Monitored:

100% - all patients

Frequency:

Employee satisfaction survey is done once a year

Physician satisfaction survey is done a minimum of annually

Patient satisfaction survey is done on each patient and results are sent each month

Threshold:

Meet or exceed national benchmark of like facilities

Follow-Up:

Results of the indicator will be presented at the staff meetings, QI meetings and Board meetings. Cases of noncompliance with this indicator will be discussed at these meeting and also presented to the Q.I. Committee so improvements can be made.

Quarterly reports to Administration and D.O.N..

2. OPPORTUNITIES ENCOUNTERED ON PATIENT FOLLOW-UP

Tool:

Post-Operative Nursing Follow-up Call Form

All patients will be called by an R.N. within two working days after surgery and this form will be completed. If the patient is unable to be reached, a letter will be sent by the third working day. Anytime a patient is referred to their physician for a post-operative complication this completed form will be given to the D.O.N.

Post-op follow up (unable to reach card) will be mailed to each patient that was able to be reached for their follow up call.

Post-operative Complication Log

Per occurrence reports, a summary is filled out with the information received from the patient follow-up phone calls. It enables the center to monitor the complications and define actions that may be necessary to improve on patient care &/or post-op instructions.

Percentage Monitored:

Post-Op Nursing Follow-up Call attempt to contact 100% of patients within 24 hours, except for Friday patients as the amended Medicare regulation states. Those with post-op complications will be investigated through follow-up with patient and physician.

Frequency:

Reported Monthly

Threshold:

100% of the comments will be addressed to the staff for opportunity to improve or provide surveillance for change.

Follow-Up:

Results of the indicator will be presented at the monthly staff meeting. Cases of non-compliance with this indicator will be discussed at these meeting and also presented to the Q.I. Committee so that improvements can be made.

3. POST OPERATIVE OCCURRENCES

Tool:

A. Physician Review Form

This form will be completed by the assigned staff in procedures where there are complications prior to and/or during the surgery that may be related to anesthesia or surgical intervention patients who have an extended recovery period or are transferred to a hospital, are also reviewed.

B. Return to OR, Injury/Death to patient & Transfer Log

A log book will be maintained to monitor unanticipated returns, injury/deaths & transfers to a hospital. The person caring for the patient will enter the information on the occurrence report. The QI Committee will monitor and assimilate the information in the log book.

Percentage Monitored:

1. Physician Review Form – 100% of applicable cases.
2. Return, Injury/Death, & Transfer Log – 100%.

Frequency:

1. Physician Review Form – quarterly
2. Return, Injury/Death, & Transfer Log – quarterly

Threshold:

100% of post-op occurrences will be followed as appropriate.

Follow-up:

Results of the indicator will be presented at the quarterly MEC meeting. Cases of non-compliance with this indicator will be discussed at these meeting and also presented to the Q.I. Committee so improvements can be made. The Q.I. Committee will also be made aware of the number of unanticipated occurrences and respond accordingly.

4. MEDICATION USE

Tool:

- A. Pharmacy Review Documentation
This form will be complete by the Pharmacist on a monthly visit. Monitoring of the form will be done by the Q.I. team.
- B. Narcotic Log
A count will be done on all schedule II, III, IV, & V narcotics at the beginning and end of each day the center is open. Discrepancies will be resolved if possible. If the discrepancy can not be resolved, an incident report will be completed and submitted to the Q.I. team for further investigation.
- C. Occurrence Report
All incidents involving medication administration will be submitted to the Q.I. team for review.
- D. Medication Error Log
All medication incidents will be recorded according to type for monitoring, education and risk management purposes.
- E. Adverse Reaction Log
All adverse reactions will be recorded with subsequent follow-up. Pharmacy consultant will be notified with copy of form sent to consultant.

Percentage Monitored:

100% of all incidents involving the administration of medication will be reviewed and all schedule II, III, IV, V narcotics will be accounted for appropriately.

Frequency:

- A. Pharmacy Review- monthly
- B. Narcotic Log- Twice daily
- C. Occurrence Report – as needed.
- D. Medication Error Log – as needed
- E. Adverse Reaction Log – as needed

Threshold:

100% of all schedule II, III, IV & V narcotics will be documented appropriately and all incidents involving the administration of medication will be reviewed and processed accordingly.

Follow-up:

The Q.I. Committee will assimilate all data and report to the Q.I. meetings. The Q.I. Committee will also address and in-service the staff accordingly and report to MEC and Board of Directors as needed.

5. **CANCELLATION ON THE DAY OF SURGERY**

Tool:

A. Same Day Cancellation

This will be documented on an occurrence report and in HST by the staff member notified of the cancellation. Monitoring and assimilation of the documentation will be done by the Q.I. committee.

B. Cancellation Log

This form is filled out to summarize the reasons for cancellations. It enables the center to monitor the cancellations and define actions that may be necessary to avoid some of the same day cancellations.

Percentage Monitored

100% of cancellations on the day of surgery.

Frequency:

Monthly

Threshold:

100% of cancellation on the day of surgery will be followed for opportunities to avoid cancellations.

Follow-up:

The Q.I. committee will forward results of cancellations monitoring to the Q.I. Committee who will follow up accordingly.

6. **MEDICAL RECORD REVIEW**

- ❖ The results of peer review are used as part of the basis for granting continuation of clinical privileges.

Tool:

A. Daily Chart Review

This form will be completed on all patient charts. It will be utilized to verify the chart is put together in the correct order and that it is complete.

B. QI Chart Audit

This form will be completed on 10% of all completed procedures, representing every specialty. It will enable us to monitor many aspects of the completeness of the Medical Record, in addition to confirming the medical necessity of the procedure done. Results will be made available to the Q.I. Committee.

C. Incomplete Health Record Report

This form will be completed on all medical records that are delinquent past 30 days despite center attempts at completion. The report will be forwarded to the MEC and the Governing Body for further action.

Percentage Monitored:

1. QI Chart Review – 100% - all patients
2. Chart Audit – 10% of all procedures.
3. Incomplete Health Record Report – 100% of all delinquent charts.

Frequency:

1. QI Chart Review – monthly
2. Chart Audit – monthly
3. Incomplete Health Record Report – monthly

Threshold:

100% of medical records reviewed will be completed as required by law and Surgery Center Medical Staff Bylaws.

Follow-up:

Any matter that renders a chart incomplete will be appropriately addressed by the Q.I. Committee and forwarded to the MEC and Board of Directors.

7. SAFETY

Tool:

- A. Record of Safety Rounds
This form is completed by the Safety Committee to ensure accepted standards of safety are being utilized. Noncompliance will be addressed with personnel involved and according to the Center Safety Management Plan.
- B. Occurrence Report
This form is completed by any staff member whenever a potential safety concern is noted. It is forwarded to the Safety Committee/QI Committee who ensures resolution of the concern.
- C. Emergency Drill Records & Summary
These forms will be completed by the Safety Officer to evaluate compliance of center emergency preparedness and reports to QI Committee

Percentage Monitored:

100% of all safety concerns.

Frequency:

- A. Record of Safety Rounds - monthly
- B. Occurrence Report – on going
- C. Emergency Drill Records & Summary – quarterly

Threshold:

100% of all reported safety issues will be addressed and resolved

Follow-up:

The Safety/QI Committee reviews any deficiencies with the staff and implements changes as needed. If safety issues are due to staff noncompliance, those individuals involved will be counseled.

8. INFECTION CONTROL

Tool:

- A. Infection Report Form
This form will be completed on all cases of infection and will be referred to the Q.I. team for surgical case review.
- B. Infection Log
In order to track post-op infections through the physician's office, a letter will be mailed/faxed to physicians along with a list of their patients who had procedures. If the physician fails to respond, a second letter will be sent. After two unsuccessful attempts, the physician will be contacted via phone. All cases of infection will be investigated and reported to the staff and the Q.I. Committee.
- C. Infection Summary
This form will be used to summarize the number of post-op infections and percentage of reports returned.
- D. Sterilization Report
This form will be used to summarize the sterilization performance and report any positive biologicals.

Percentage Monitored:

- A. Infection Report Form- 100% of all cases that develop a post-op infection.
- B. Infection Log- 100% of the physicians who have completed procedures.
- C. Infection Summary- 100% of infections
- D. Sterilization Report- 100% of all positive biologicals will be reported

Frequency:

Monthly

Threshold:

100% of all reported infections will be investigated.

Follow-up:

Results of the indicator will be presented at the monthly staff meetings and at the Q.I. meeting. All cases of post-op infections will be discussed to determine appropriate systems corrections and preventive measures that may be deemed necessary and reported to MEC Committee, Board of Directors.

9. CREDENTIALS

Tool:

Credentialing Checklist

This form will be completed by the Medical Staff Credentialer to assure proper credentials are maintained by all physicians at the Surgery Center.

Credentialing Report

This form will be used to summarize the credentialing status of physician files to the Medical Director, MEC and ultimately the Board of Directors.

Percentage Monitored:

100% of all physicians and Allied Health Professionals

Frequency:

On-going

Threshold:

100% of the Surgery Center credentialed physicians and Allied Health Professionals will have the required current documents.

Follow-up:

Specific credentialing difficulties will be referred to the Medical Director, Administration, and if necessary the Q.I. Committee and the Board of Directors.

10. EMPLOYEE FILES

- ❖ All health care professionals have the necessary and appropriate training and skills to deliver the services provided by this organization.
- ❖ Health care professionals practice their professions in an ethical and legal manner.
- ❖ All personnel assisting in the provision of health care services are appropriately trained, qualified, and supervised and are available in sufficient numbers for the care provided.

Tool:

A. Employee File Checklist

This form will be maintained by the Manager for all employees in each employee file.

B. Employee Competency Record

This form is completed by the department manager to ensure strong knowledge and competency by all staff personnel.

C. Performance Review

This form will be completed by the department manager on an annual basis in order to document the employee's job performance.

Percentage Monitored:

100% of all employees

Frequency:

- A. Employee File Check List – initial hiring
- B. Employee Competency Record – on going
- C. Performance Review – annual

Threshold:

100% of employee files will have current proof of compliance as required by Surgery Center and State/Federal Regulations.

Follow-up:

Specific employee file difficulties will be referred to the Administrator if necessary.

11. ANCILLARY SERVICES

Tool:

- A. Glucose Monitoring Form
This form will be complete by the Laboratory consultant on a monthly basis. Monitoring of the form will be done by the Q.I. team.
- B. Pathology Review Checklist
This form will be utilized to record findings of pathology reports received and assure reporting to physician.
- C. Tissue Review Report
This form will be used to summarize tissue reporting.
- D. Annual Review of Lead Protection Devices
This form will be complete by the Radiology technician annually. Monitoring of the form will be done by the Q.I. team.

Percentage Monitored:

100% of all laboratory test & Radiology safety procedures.

Frequency:

- A. Glucose Monitoring results- monthly
- B. Pathology Review Checklist - quarterly
- C. Tissue Review Report- quarterly
- D. Review of Lead Protection Devices - Annual

Threshold:

100% of all glucose tests will be correctly performed and reported appropriately & Radiology safety procedures followed.

Follow-up:

The Q.I. team will assimilate all data and report to the Q.I. meetings. The Q.I. team will also address and in-service the staff accordingly.

12. Blood Borne Pathogens Exposure

Tool:

- A. Occurrence Reports
 - This form will be completed by the staff member involved with assistance from clinical Manager.
 - Employee will be sent for emergency treatment of exposure deemed significant. Concentra clinic will do follow up as needed on our employees.

- B. BBP exposure form
 - Employee Exposure
 - Patient consent

Percentage Monitored:

100% of all employee exposures

Frequency:

- A. Occurrence report ongoing
- B. BBP exposure report ongoing
- C. Annual report posted per OSHA guidelines

Threshold:

100% of employee exposures will be followed as appropriate

Follow-up:

The Q.I. team will assimilate all data and report to the Q.I. meetings. The Q.I. team will also address and in-service the staff accordingly.

Quality Improvement Reporting Schedule

The following matrix outlines the quarterly Quality Improvement Reports to the Q.I. Committee, Medical Executive Committee and Board of Directors. The reports are due in the month or quarter indicated based on data collated from the immediately preceding months. The Quality Improvement Committee will report to the MEC through the Administrator. Recommendations from the MEC and Board of Directors will be reported back to the QIC and or MEC through the Administrator.

Quarter	Report	Responsibility for Data
Every Month	QI Meeting Summary	D.O.N./ Administrator
	Infection control statistics	
	Pharmacy audits	
	Patient/Employee/Physician Satisfaction	
	Cancellation DOS	
	Sterilization Reports	
	Occurrence Reports/Patient Complications	
	Chart Review	
	Pathology/Laboratory	
	Extended Recovery Unit	
	Medication Errors & Adverse Drug Reactions	
	Physician Utilization Review	
	Quality Improvement Projects	
	Safety Reports	
	Peer Review/Credentialing	
Annual	Policies & Procedures	Administrator
	Infection Control Plan	
	Local Contracts	
	Quality Improvement/Risk Management Plan	
	Review Annual Marketing Plan	
	Annual Report to the Medical Staff	
	Annual Safety Program Summary	
	Employee Performance	
	Review/Approval Annual Budget	

Southern Hills Hospital and Medical Center

Patient Safety Plan

Updated: March 1, 2017

Quality of Care Committee: 3/9/2017

Medical Executive Committee: 3/16/2017

Board of Trustee: 3/22/2017

2017 PATIENT SAFETY PLAN

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I. **Introduction**

Purpose, Scope and Responsibility

- ✓ Purpose:
 - To define the essential components of the Patient Safety Program at Southern Hills Hospital, which is committed to ensuring a safe environment and reliable care processes.
 - To cultivate a culture of patient safety through the ongoing promotion of a safe practices and personal accountability.
- ✓ Scope: Patient safety is everyone's responsibility. The Southern Hills Hospital Patient Safety Program covers all activities and functions relating to patient safety at all sites and services within the organization.
- ✓ Responsibility: Leaders, employees, members of the medical staff, students and volunteers are to be familiar with and involved in the Patient Safety Program.

Participation in Patient Safety Organization

- ✓ Southern Hills Hospital is committed to an organizational environment aimed at improving patient safety and the quality of healthcare provided to the Hospital. To further this objective, the Hospital contracted with HCA Patient Safety Organization, LLC ("HCA PSO, LLC"), a federally certified Patient Safety Organization ("PSO"), to receive assistance in conducting a wide variety of patient safety activities intended to reduce medical errors in a legally protected environment. Generally speaking, patient safety work product ("PSWP") is not subject to subpoena or discovery in state or federal court, in administrative proceedings, or pursuant to the Freedom of Information Act ("FOIA"), and cannot be disclosed except as permitted under the Patient Safety and Quality Improvement Act ("PSQIA") and its associated regulations. *(See 42 CFR § 3.204, Privilege of patient safety work product; and 42 CFR § 3.206, Confidentiality of patient safety work product.)* The Hospital will be receiving and exchanging patient safety information with the PSO, including event or incident reports and investigations, analytic tools such as root cause analyses, patient safety communications, quality reviews, and other documents aimed at improving patient safety. Documents will be submitted in a standardized format to allow for comparison with like providers. As part of this effort, the Hospital will operate a Patient Safety Evaluation System ("PSES") designed to encourage internal reporting of adverse events, near misses, and unsafe conditions for purposes of reporting to HCA PSO, LLC. The PSES will be the vehicle for collecting, managing, and analyzing information for patient safety purposes. Designated Hospital personnel will collect patient safety information and report it to HCA PSO, LLC on an ongoing basis for analysis and feedback.

Definition of Terms

<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.
<u>Hazardous condition:</u>	Any set of circumstances (exclusive of the disease or condition in which the patient is being treated), which significantly increases the likelihood of serious adverse outcome.
<u>Healthcare FMEA:</u>	Healthcare Failure Mode and Effects Analysis: A proactive model for addressing potential risks within the organization.
<u>Human Error:</u>	An unintended act, or failure to act, that results in actual or potential patient injury, harm or adverse event in the process of care delivery.
<u>Near miss:</u>	Any process variation that did not affect the patient outcome, but for which a recurrence carries a significant chance of serious adverse outcome.
<u>Non-punitive:</u>	No punishment or disciplinary action imposed for specific error.
<u>Patient injury:</u>	Major permanent loss of function, sensory, motor, or intellectual impairment not present at admission, requiring continued treatment or lifestyle change. When "major permanent loss of function" cannot be immediately determined, patient injury is not established until either the patient is discharged with continued major loss of function, or two weeks have elapsed with

persistent major loss of function, whichever occurs first.

Patient safety event:

All adverse events or potential adverse events that are deemed preventable and Healthcare associated infections as defined by the CDC that are deemed to be preventable.

PSQIA

The Patient Safety and Quality Improvement Act (PSQIA) of 2005, Pub. L. 109-41, 42 U.S.C. 299b-21-b-26 (for which the final rule implementing the regulations became effective on January 19, 2009), was enacted in response to growing concern about patient safety in the United States and the Institute of Medicine's 1999 report, *To Err is Human: Building a Safer Health System*. The goal of the Act is to improve patient safety by encouraging voluntary and confidential reporting of events that adversely affect patients.

PSO

A Patient Safety Organization (PSO) means a private or public entity or component thereof that is listed as a PSO by the Secretary of Health and Human Services. A health insurance issuer or a component organization of a health insurance issuer may not be a PSO. The PSO enters into bona fide contracts, each of a reasonable period of time, each with a different provider for the purpose of receiving and reviewing patient safety work product.

PSES

A Patient Safety Evaluation System (PSES) means the collection, management, or analysis of information for reporting to or by a PSO.

PSWP

Patient Safety Work Product (PSWP) (1) Except as provided in (2) below, patient safety work product means any data, reports,

records, memoranda, analyses (such as root cause analyses), or written or oral statements (or copies of any of this material) (i) Which could improve patient safety, health care quality, or health care outcomes; and (A) Which are assembled or developed by a provider for reporting to a PSO and are reported to a PSO, which includes information that is documented as within a patient safety evaluation system for reporting to a PSO, and such documentation includes the date the information entered the patient safety evaluation system; or (B) Are developed by a PSO for the conduct of patient safety activities; or (ii) Which identify or constitute the deliberations or analysis of, or identify the fact of reporting pursuant to, a patient safety evaluation system. (2)(i) Patient safety work product does not include a patient's medical record, billing and discharge information, or any other original patient or provider information; nor does it include information that is collected, maintained, or developed separately, or exists separately, from a patient safety evaluation system. Such separate information or a copy thereof reported to a PSO shall not by reason of its reporting be considered patient safety work product. (ii) Patient safety work product assembled or developed by a provider for reporting to a PSO may be removed from a patient safety evaluation system and no longer considered patient safety work product if: (A) The information has not yet been reported to a PSO; and (B) The provider documents the act and date of removal of such information from the patient safety evaluation system. (iii) Nothing in this part shall be construed to limit information that is not patient safety work product from being: (A) Discovered or admitted in a criminal, civil or administrative proceeding; (B) Reported to a Federal, State, local or Tribal governmental agency for public health or health oversight purposes; or (C) Maintained as part of a provider's recordkeeping obligation under Federal, State, local or Tribal law.

Reliability: The extent of consistent performance over time.

Sentinel Event: A patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in death, permanent harm, and/or severe temporary harm (TJC, 2016). (A permanent loss of function related to the natural course of the patient's illness or underlying condition is not a Sentinel Event.) The State of Nevada defines a sentinel event as an event included in Appendix A of "Serious Reportable Events in Healthcare – 2011 Update: A Consensus Report," published by the National Quality Forum (Nevada Revised Statutes NRS §439.830 – effective October 1, 2013).

Sentinel Event Alert Gap Analysis: A model for prioritizing and addressing potential risks related to publish external sentinel or warning alerts.

Unusual Occurrence: Any event or condition not consistent with the normal or usual operation of the hospital or department and which has the potential for causing patient or visitor injury or property damage.

II. Policy

The Board of Trustees delegates responsibility for oversight of the patient safety program to the 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 Care Committee, Medical Executive Committee (MEC), and the Board of Trustees (BOT). The report includes at a minimum, occurrence or trending of patient safety indicators and actions taken in response to actual occurrences as well as proactive assessments of high-risk activities. The Environment of Care Committee oversees non-clinical safety related processes and system issues that affect patients, employees, and visitors in the environment of care.

Risk Management maintains the hospital-wide occurrence reporting system for patients, employees, and visitor occurrences and a referral system for hospital staff and physicians to report potential claims. Risk Management in conjunction with Hospital Quality and Patient Safety Leaders investigate actual and potential safety risk within the organization. They also evaluate occurrences to identify those that may require immediate follow up actions or meet the Sentinel Event, the Safe Medical Device Act, or regulatory agency reporting criteria, including CMS, FDA, OSHA, State of Nevada DHHS, or Joint Commission. Notification is made to Administration, Risk Management, appropriate regulatory and accrediting agencies, equipment manufacturers and other appropriate individuals as necessary.

The Organization ensures timely coordination and dissemination of reporting and data management of patient safety information at the appropriate medical staff/organizational committees for review and discussion.

III. Culture of Safety

Southern Hills Hospital is committed to creating a culture of safety by designing or redesigning systems and processes geared to prevent, detect, and minimize the hazards and likelihood of error. Southern Hills Hospital is focused on prevention, not blaming individuals. Patient safety events are viewed as an opportunity to learn. The Hospital believes in balancing the organization's accountability and the individual's accountability for assuring safe practices and a safe environment to care for patients.

IV. Structure, Roles and Responsibilities

The philosophy guiding the promotion of a culture of patient safety is accountability. To achieve a culture of patient safety the following accountabilities are expected at Southern Hills Hospital:

Role	Accountability	Specific Tasks
Board of Trustees, with Senior Leadership	Set goals, monitor performance & require accountability.	<ul style="list-style-type: none"> • Receive regular and thorough reports on patient safety risks, hazards and progress towards performance improvement objectives from the MEC and Patient Safety Committee. • Receive regular and thorough briefings regarding the results of culture measurement and performance improvement initiatives • Require multi-cause analysis of errors that lead to injury. • Set performance improvement goals for safety improvement. • Hold hospital leaders accountable for achieving the integrated patient safety agenda. • Receive systematic and regular assessment of resource and budget allocations to key systems (patient safety systems, human resources, quality systems, technology) related to the patient safety agenda.
Administrative (CEO, COO, CNO, VP's, Directors, & Physician Leaders)	Set the agenda for the rest of the team	<ul style="list-style-type: none"> • Ensure that an integrated patient safety program is implemented throughout the hospital. • Set performance improvement priorities and identify how the hospital adjusts priorities in response to unusual or urgent events. • Allocate adequate resources for measuring, assessing and improving the hospital's performance and improving patient safety. • Measure and assess the effectiveness of the performance improvement and safety improvement activities. • Monitor implementation for of corrective action of patient safety events. • Ensure remedial activities, identified through analysis of reported patient safety events, are implemented, effective, and do not cause unintended adverse consequences. • Develop a proactive approach to reducing errors. • Encourage an environment of openness & collaboration. • Support a dialogue about outcomes between patients and clinicians including systems to obtain direct feedback from patients regarding performance of the organization • Educate staff about safety. • Support staff and lead by example.

Role	Accountability	Specific Tasks
Patient Safety Officer	Lead patient safety initiatives with the medical staff and organizational staff	<ul style="list-style-type: none"> • Lead an integrated patient safety program. • Serve as the primary point of contact for questions about patient safety, and coordinate patient safety for education and deployment of system changes. • Execute performance improvement priorities and adjusts priorities in response to unusual or urgent events. • Assure effectiveness in measuring, assessing and improving the hospital's performance and improving patient safety. • Lead a proactive approach to reducing errors and make recommendation to reduce patient safety events. • Lead in an environment of openness & collaboration. • Assure dialogue about patient safety issues occurs effectively between patients and clinicians. • Report progress regularly, and educate about patient safety • Support staff and lead by example.
Quality Coordinators	Day to day coordination and facilitation of safety initiatives	<ul style="list-style-type: none"> • Implement operational aspects of the patient safety program throughout the hospital. • Implement proactive patient safety management that assures immediate, appropriate response to unusual or urgent events. • Participate in measuring, assessing and improving the hospital's performance and improving patient safety. • Be accountable for patient safety initiatives and strengthening a culture of safety in day to day practice. • Support an environment of openness & collaboration. • Support a dialogue about patient safety issues between patients and clinicians. • Report progress regularly, and educate about patient safety. • Support staff and lead by example.
Pharmacists	Ensure safe medication usage	<ul style="list-style-type: none"> • Ensure that authoritative, up-to-date drug information is available in reference form in patient care areas and prescribers' offices. • Periodically examine all drug products stored in patient care areas and procedures on drug storage/distribution to patient care areas. • Minimize the need for nurses to calculate, manipulate, or mix medications. • Establish a pharmacy led interdisciplinary team to spearhead medication safety activities. • Provide leadership to develop safe medication delivery systems.

Role	Accountability	Specific Tasks
Clinicians & Medical Staff	Monitor, report, & learn.	<ul style="list-style-type: none"> • Medical staff and other employee job descriptions and competency evaluations incorporate accountability for safety. • Medical staff & employees participate in education on the importance of safety, surveillance, and expectations for reporting safety concerns, beginning with orientation. • Medical staff & employees evaluations include an individual's contributions to safety for the organization. • Medical staff & employees are positively acknowledged for disclosing errors, near-misses, and safety concerns. • Employees and physicians work collaboratively assuring responsibilities of the team to the patients are met, and noticing errors before they cause harm. • Participate in the facility reporting system for PS events, both actual and potential event.
Patients/visitors	Involved partners in prevention.	<ul style="list-style-type: none"> • Inform doctors and nurses about medications they take, including prescriptions, over-the-counter drugs and dietary supplements. • Ask for written information about possible side effects. • Inform the doctors and nurses about allergies & adverse reactions. • Ask a relative or friend to be an advocate. • Learn about their medical condition by asking their doctor, nurse, and other reliable sources. • Upon hospital discharge, ask doctors for an explanation of the treatment plan to be used at home. • Provide feedback regarding performance of the organization • Report safety concerns through the Patient Safety hotline and other venues available.

V. Mechanisms for Coordination

Southern Hills Hospital Patient Safety Committee

The SHH 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 Care Committee 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 Care Committee, Infection Prevention, Pharmacy, other). Sentinel Event Alerts and other industry alerts are routed to the appropriate committee or teams to ensure evaluation of current care processes incorporate recommended changes.

The PSC reviews Sentinel Event Alerts, other industry alerts, compliance to The Joint Commission National Patient Safety Goals, State regulatory requirements, adverse events and potential adverse events that are deemed to be preventable, health care associated infections as defined by the CDC that are deemed to be preventable, and assures recommendations are integrated into processes. Additional resources such as national and local professional organizations/associations are monitored for changes in standards and potential risk events. Regular summary reports of progress are reported to the designated Quality Care Committee, Medical Executive Committee, and the Board of Trustees.

The 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 Southern Hills Hospital's philosophy that accountability for patient safety is imbedded in a collaborative relationship involving our Board of Trustees, administrative leadership, our medical staff, employees, patients and family.

Patient safety awareness information is posted in public areas throughout the hospital. This information contains basic strategies for patients to assist in assuring their safety. The admission and discharge patient information also contains information on the patient role in safety. Patient Guides are provided to in-patients upon admission, and includes strategies prevent untoward events such as falls, medication errors, and infections while in the hospital. Annually, Patient Safety Awareness Week activities are planned to educate and inform staff, patients and the community.

Patients or their families may contact the hospital to report patient safety concerns as well as to the State of Nevada Department of Health and Human Services or to the Joint Commission. The hospital's website and other patient materials include information on how to report issues internally as well as to the Joint Commission.

Patients are randomly selected to participate in completing the Patient Experience Survey after discharge, which include questions related to the patient safety experience. These results are reported to the hospital.

VII. Education

1. Staff Education

- General orientation, on-going in-service and other education and training programs will emphasize specific job-related aspects of patient safety
- Specific Patient Safety Program training at orientation and annually thereafter will include:
 - An overview of the Patient Safety Program
 - Staff's role and responsibilities in the Patient Safety Program
 - Event reporting, including the events requiring reporting and the process for reporting events.
 - Methods to support and foster an interdisciplinary and collaborative approach to the delivery of patient care;
 - Examples of specific job-related aspects of patient safety.

2. Physician Education - An overview of the Patient Safety Program is provided to physicians at time of initial appointment and periodically thereafter that describes the program, emphasizes their role and responsibilities in the program and informs them of the event reporting mechanism and Culture of Safety processes.

3. Organizational Learning: Patient safety is everyone's responsibility. Everyone has a responsibility to report. By reporting concerns, it enables the organization to learn and improve processes, procedures, and systems.

VIII. Safety Improvement Activities

Prioritization of Patient Safety Activities

Prioritization elements are defined in the annual performance improvement plan and apply to patient safety initiatives. The PSC annual goals are listed at the end of this plan and meet the prioritization elements.

Routine safety-related data collection analysis

- Unusual Occurrence reporting (see SPAE Guidance Policy)
- Medication Error Reporting
- Infection Surveillance
- Culture of Patient Safety Survey
- Environmental Safety Rounds and Assessment
- Patient Experience Survey
- Leadership Walk-around and Tracers
- National Patient Safety Goal Dashboard
- Annual Leapfrog (NQF Safe Practices) Survey
- Sentinel Event Alert Compliance
- Institute for Safe medication Practices(ISMP) and other industry Alerts
- Employee feedback survey

Identification, reporting, and management of patient safety events

1. To effectively improve processes and systems, health care providers should not be fearful of punishment or retribution for reporting mistakes.
2. An accessible multifaceted non-punitive, just culture reporting system exists .
3. Errors and accidents are tracked in an attempt to establish trends and patterns, to learn from them and prevent reoccurrence.
4. Healthcare providers participate in reporting and developing improved processes to effectively evaluate errors and near misses.
5. Reporting errors and near misses are a critical component of the Southern Hills Hospital Patient Safety Program.

The Meditech on-line incident reporting system is a tool for the documentation, investigation, and correction of patient safety issues as described in the organizational policy: The Patient Safety Director coordinates this process.

Organization or Medical Staff committees refer patient safety issues to the Patient Safety Officer for review at the PSC and corrective action.

NRS 439.877 – Monitoring and Compliance

Nevada statute NRS 439.877 requires medical facilities to adopt patient safety checklists and patient safety policies. These patient safety checklists are protocols used to improve the outcomes of patients at the hospital to include:

1. Patient Discharge Process-Healthy Living (Meditech)
2. Patient Identification Process (Policy)
3. Patient room/environment sanitation and cleaning (Sodexo 7-Step Cleaning Process)
4. Additional patient safety checklists which may be appropriate to ensure the safety of patients in the facility. These include, but are not limited to the following:

- a. Universal Protocol (Safe Procedural and Surgical Verification)
- b. Central Line Insertion Bundle (Meditech)

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 2 – Infection Prevention and Control Plan)

Proactive Risk Identification and Reduction:

1. Opportunities for improvement regarding patient safety issues and hazardous conditions are identified through trending of actual or potential occurrences involving patients or visitors and/or evidence-based literature (e.g. The Joint Commission Sentinel Event Alerts).
2. When an identified opportunity for improvement is identified, it is analyzed by the involved care providers according to level of severity, frequency of occurrence, potential for harm and liability.
3. At least every 18 months, one high-risk or error-prone process is selected for Failure Mode Effect Analysis (FMEA) process. The underlying systems are examined and modified or redesigned to minimize the risk of the identified failure mode.
4. Trending of adverse events, environmental safety issues, aggregate data collection, and review of intensive assessments are part of the identification and management of risks to safety and are used to prevent reoccurrences.
5. Serious unusual occurrences and sentinel events are reviewed with determination made for intensive assessment and root cause analysis according to the SPAE policy.
6. Near miss events are reviewed and root cause analysis conducted as deemed appropriate.
7. Regular communication about patient safety and risk management is conducted with designated Quality Care Committee, Medical Executive Committee, and the Board of Trustees.
Disclosure of an adverse event to a patient is in accordance with the SPAE policy.

IX. Reporting Patient Safety Results:

To the PSC:

The Patient Safety Committee reviews and recommends actions on the following reports:

- Audits and performance improvement activities on Patient Safety
- National Patient Safety Goals and Safe Practices compliance (including accordance with NRS 439.877)
- Culture of Patient Safety Survey

- Leapfrog Survey

To organization staff and medical staff:

Organizational staff receives patient safety results and information on:

- Culture of Safety Survey
- Patient experience survey results on patient safety components.
- National Patient Safety Goals and Safe Practices compliance (including accordance with NRS 439.877)
- Leapfrog Survey

To executive leadership and Board of Trustees:

The Board of Trustees and Executive Leadership receives periodic reports on:

- Culture of Safety Survey
- Leapfrog Survey
- Results of intensive analyses related to patient safety issues

X. Annual Review

The Patient Safety Program is reviewed annually and revised as necessary. It is submitted annually for review and approval by the Medical Executive Committee and the Board of Trustees.

XI. References/Authority

- The Joint Commission 2017 NPSG's
- HCA Patient Safety Organization PSO Operating Policy and Procedure
Federal Register- Department of Health and Human Services 42 CFR Part 3
Patient Safety and Quality Improvement

Appendix One

Strategic Priorities for 2017 - Goals

- Maintain at least 2 facility Master TeamSTEPPs trainers
- 100% of clinical directors/managers complete TeamSTEPPs training
- 100% of senior leaders complete TeamSTEPPs training
- 90% of clinical staff working in patient care areas complete TeamSTEPPs training
- Achieve 95% compliance with oxytocin process measures each quarter Q416-Q317
- Create facility-wide expansion and implementation plan for use of SBAR tool on all clinical high-risk areas
- 95% of leadership and staff complete viewership of “Hindsight” educational videography by end of Q317
- 95% of new hires from January 1-September 30, 2017 complete viewership of “The Dream” and “Hindsight” educational videography by end of Q317
- Complete and submit a minimum of 3 Serious Event Analyses (SEAs) to the PSO
- Submit a case study for a completed SEA to the PSO
- Submit 95% of all patient event and close call reports designated as PSWP within 60 days
- Participate in the Division-wide Patient Safety Table project
- Attend Patient Safety Director Development Program
- Obtain/maintain CPPS/CPHRM Certification
- Attend HCA PSO Seminar
- Attend National Patient Safety Foundation Patient Safety Congress

Appendix Two

Southern Hills Hospital and Medical Center

**Infection Prevention and Control
Plan**

2017

Approved by the Infection Prevention and Control Committee: 02/03/17
Approved by Medical Executive Committee: 02/16/17
Approved by Board of Trustees: 02/22/17

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SCOPE

This Infection Prevention and Control Plan applies to Southern Hills Hospital and Medical Center

POLICY

Southern Hills Hospital and Medical Center will develop and maintain a comprehensive and effective program of surveillance, prevention, and control of infection. The employees, medical staff, licensed independent practitioners, contract service workers, volunteers, students and visitors of Southern Hills Hospital and Medical Center will comply with the policies and procedures of this program, as well as all relevant federal laws and accrediting body standards.

The organization will employ a coordinated process to reduce the risks of endemic and epidemic nosocomial, or healthcare-associated, infections in patients and healthcare workers. Healthcare-associated infections (HAI) are defined by the Centers for Disease Control (CDC) as an infection that develops in a patient who is cared for in any setting where healthcare is delivered (e.g. acute care hospital, chronic care facility, ambulatory clinic, dialysis center, surgery center, home) and is related to receiving health care (i.e., was not incubating or present at the time healthcare was provided).

PURPOSE

- A. The purpose of the infection control program plan is to identify infections and reduce the risk of disease transmission through the introduction of preventive measures. The aim of our program is to deliver safe, cost-effective care to our patients, staff, visitors, and others in the healthcare environment (with emphasis on populations at high risk of infection). The program is designed to prevent and reduce hospital associated infections and provide information and support to all staff regarding the principles and practices of Infection Prevention & Control in order to support the development of a safe environment for all who enter the facility.
- B. Our goals include recommendation and implementation of risk reduction practices by integrating principles of infection prevention and control into all direct and indirect standards of practice.
- C. The program at Southern Hills Hospital and Medical Center is designed to provide processes for the infection prevention and control program among all departments and individuals within the organization. It supports the mission to serve, heal, and educate with a concern for the whole patient as well as an understanding of the economic environment and a commitment to quality.

- D. It includes an evaluation of surveillance, prevention and control activities for 2016 as well as future surveillance plans and goals; it is evaluated annually and as the need arises.

INFECTION PREVENTION & CONTROL PROGRAM DESCRIPTION

The Infection Prevention & Control Program is a multidisciplinary, systematic approach to quality patient care that emphasizes risk reduction of disease transmission in a health care environment by using sound epidemiological principles. It can further be defined as the establishment of a program or a plan of action to prevent disease transmission when possible, monitor its occurrence, and initiate measures to minimize the impact in those cases that cannot be prevented

Activities of the Infection Prevention & Control Program are appropriate to this hospital's geographic location, the volume of patients encountered; the patient populations served, the hospital's clinical focus, and number of employees (see risk analysis for more details).

The goals stated above are accomplished by setting controls or standards that have been proven effective in minimizing infections that cannot be prevented, preventing those that can be, and providing for early diagnosis and appropriate treatment of all infections. These controls include hospital policies and procedures and departmental protocols. Effectiveness is achieved by integrating principles of Infection Prevention & Control within each department.

In addition, as clinical practice guidelines and standards are reviewed/revised (such as CDC guidelines), measures are taken to identify practices followed in the name of Infection Prevention & Control and to evaluate them for implementation

PROGRAM OBJECTIVES

- A. To prevent/minimize disease transmission within the facility.
- B. To recommend methods for early identification and appropriate therapy when infections are inevitable
- C. To recommend practices oriented towards preventing introduction of infection into the facility and/or containing the spread of infection if it is introduced.
- D. To mitigate the unintended consequences of antimicrobial use (resistance, morbidity & mortality, cost)
- E. To analyze practices which have the potential to affect rates of health care associated infections
- F. To implement practices which decrease the risk of transmission of microorganisms within the organization
- G. To support Employee Health, Quality/Management, Public Safety, and Nursing Management efforts, using epidemiological and scientific methodologies.
- H. To facilitate compliance with reporting requirements of the facility to Public Health agencies.

PROGRAM AUTHORITY AND RESPONSIBILITY

- A. The Infection Prevention Coordinator through the Infection Prevention and Control Committee and will have the authority designated by the Medical Staff and Administration to institute any appropriate control measures or studies and to make decisions in an emergency regarding Infection Control. Such measures include but are not limited to the following:
 - Initiating culture and sensitivity testing.
 - Instituting appropriate isolation precautions.
 - Restricting visitors.
 - Closing units to admission.
 - Initiating potential outbreak investigations
- B. Statement of Accountability:

The Board of Trustees through the Hospital Administrative Team will be accountable for the assurance of a safe hospital environment, providing quality care and the necessary resources to prevent and control infections.

 - The Medical Staff through the Infection Prevention and Control Committee, comprised of indirect and direct patient care staff, and the Quality Council with input from the medical

committees, will be accountable for the guidance and direction of a comprehensive and effective infection control program.

- The Infection Prevention and Control Committee with the guidance of the chairman and the Infection Prevention Coordinator will be accountable for the review and analysis of health care-associated infections, the promotion of a preventative and corrective program designed to minimize infection hazards, and the supervision of infection control in all phases of the hospital's activities.
- The Infection Prevention Coordinator will be accountable for day-to-day infection control activities and for maintaining an effective infection control program in compliance with the county, state and federal laws and regulations.
- Each healthcare individual with the support, leadership and education provided by the Hospital Administrative Team will be accountable for the diligent adherence to appropriate practices that are designed to eliminate, control and reduce infections within the facility.

C. Members of the Infection Control Committee include:

- Representatives from: Medical Staff (to insure representation of the major services), Administration, Nursing, Surgical Services, Quality/Risk Management, Laboratory Services, Plant Operations, Nutritional Services, and Pharmacy
- The Chairperson of the Control Committee is the Infection Prevention and Control Coordinator

D. Duties and Responsibilities of the Infection Control Committee

- The Infection Control Program is designed and approved by the Infection Control Committee. This collaborative group will provide ongoing direction to the Infection Control Practitioner regarding all aspects of the Infection Control Program.

RESOURCES

A. Allocation of Resources for the Infection Control Program.

- Hospital leaders will review on an ongoing basis (but no less frequently than annually) the effectiveness of the hospital's infection prevention and control activities and report their findings to the integrated patient safety program.
- Systems to access information will be provided to support infection prevention and control activities.
- Laboratory support will be provided to support infection prevention and control activities.
- Equipment and supplies will be provided to support infection prevention and control activities.
- Infection control personnel will have appropriate access to medical or other relevant records and to staff members who can provide information on the adequacy of the institution's compliance with regard to regulations, standards and guidelines.

RISK ANALYSIS

A. The comprehensive risk analysis for our hospital will include an assessment of the geography, environment, services provided and population served; the available infection prevention and control data; and the care, treatment and services provided by this facility. The infection Prevention and Control program is ongoing and is reviewed and revised at least annually. Surveillance activities will be used to identify risks pertaining to patients, staff, volunteers, students, and licensed independent practitioners and as warranted, visitors.

1. Baseline (initial) risk assessment:

- A careful assessment of the risk for infections has been conducted for Southern Hills Hospital and Medical Center
- The risk assessment was conducted by: Infection Control Coordinator with input from the Infection Prevention and Control Committee
- The baseline risk assessment was based on: Southern Hills Hospital and Medical Center, located in the southwest valley of Las Vegas, Nevada.

- Licensed Beds, Setting, and Employees:
Southern Hills Hospital and Medical Center Medical Center is an acute care hospital consisting of 180 licensed beds located in an (urban) setting with approximately 917 employees.
 - The annual population includes approximately:
 - ◊ Number of admissions – 9138
 - ◊ Number of inpatients surgeries- 3057
 - ◊ Number of outpatients surgeries- 5193
 - ◊ Number of surgeries per year- 8250
 - ◊ Number of C-sections – 212
 - ◊ Number of endo cases – Inpatient-744 Outpatient - 1526
 - ◊ Number of ED visits - 40053
 - ◊ Number of Births – 1337
 - The services provided at this hospital include: Medical Surgical Services; Laboratory Services; Rehab Services, Maternal and Child Services (including Level 2 NICU), Behavioral Health Services, Emergency Care, Outpatient Surgery, Diagnostic Imaging, Cardiac Catherization and Surgical Services
 - In 2012 we opened a 14 bed Geri-Psych Unit
 - In 2016 we added 46 Ortho beds
 - In 2016 we opened a free standing Provider Based Emergency Department with 12 beds
 - In 2017 we will be adding an attached 80 bed Psychiatric Facility
 - Risk factors are identified and interventions are implemented to decrease the incidence of infections. Specific risk factors shall include the monitoring of:
 - ◊ Invasive devices
 - ◊ Compliance with surgical antibiotic prophylaxis
 - ◊ New and emerging infectious diseases as well as antimicrobial resistant pathogens
 - ◊ Compliance with infection control policies and procedures
2. Surveillance and Other Data
The hospital identifies risks for acquiring and transmitting infections based on the following: The analysis of surveillance activities and other infection control data.
3. Input from Staff
The hospital reviews and identifies its risks at least annually and whenever significant changes occur with input from, at a minimum, infection control personnel, medical staff, nursing, and leadership.”
4. Ranking Risk
The hospital prioritizes the identified risks for acquiring and transmitting infections. These prioritized risks are documented.
5. Periodic risk assessments:
At a minimum, a reassessment of risk will be conducted annually.

A reassessment will be conducted whenever risks are significantly changed.

PRIORITIES AND GOALS

- A. The hospital establishes priorities and sets goals for preventing the development of health care-associated infections within the hospital. In order to continue Southern Hills Hospital and Medical Center’s mission, the following infection control goals have been established:
- To identify and reduce the risks of acquiring and transmitting infections among patients, employees, physicians, other licensed independent practitioners, contract service workers, volunteers, students and visitors.

- To meet patient expectations of safe care and environment.
 - To meet employee expectations of a safe workplace environment.
 - To comply with all relevant federal law and accrediting body standards.
 - To reduce health care costs while delivering high quality care.
1. Strategies to meet the goals of Southern Hills Hospital and Medical Center's Infection Control and Prevention Program include the following:
- a. Hand-hygiene program
 - See Hospital Policy for Hand Hygiene. Initial training is given during General Orientation and periodically during the year as needed
 - This hospital has adopted the CDC Guidelines for Hand Hygiene in Healthcare Settings – 2002
 - Guideline For The Prevention And Control Of Norovirus Gastroenteritis Outbreaks In Healthcare Settings - 2011
 - b. Storage, cleaning, disinfection, sterilization and/or disposal of supplies and equipment
 - See Hospital Policy for Equipment, Patient, Cleaning; Cleaning Agents - Selection, Trophon Probe Cleaning.
 - The ICP participates on Product Evaluation Committee (SMAT) to ensure infection related products and equipment support safe and sound practices and principles and the ICP responds to notification of a recalled item(s) specific to infection related issues.
 - c. Appropriate reuse of single use equipment (when appropriate)
 - See Hospital Policy for Reprocessing of Single Use Devices
 - d. Personal protective equipment
 - See Hospital Policy for Bloodborne Pathogens Plan, BBP Departmental tasks and PPE. This plan and attachment addresses who is to use it, when they are to use it, and when they are trained
 - See Hospital Policy: Post Exposure to Blood/Body Fluid/OPIM
 - See Hospital Policies for Standard Precautions and Transmission-Based Precautions
 - This hospital has adopted the CDC Guidelines for [Guideline for Isolation Precautions in Hospitals](#) the Healthcare Infection Control Practices Advisory Committee. CDC and AM J Infect Control 2007;
 - e. Program to reduce the incidence of antimicrobial resistant infections
 - See Hospital Policy for MDROs
 - Detection of Vancomycin Resistant Staph
 - The Infection Prevention & Control Department and the appropriate Infectious Disease physician must be immediately contacted when a staph aureus/epidermidis isolate is recovered that is known or suspected to be intermediate or resistant to vancomycin.
 - Vancomycin resistant should be confirmed by the Microbiology Lab; this is done by repeating antimicrobial susceptibility testing using standard methods. It is advisable to re-streak the colony to ensure that the culture is pure.
 - The state health department and the CDC must be notified; the isolate will be sent through the state health department to the CDC (phone number 404-639-6413) for confirmation of vancomycin resistance.
 - Detection of Carbapenem-Resistant or Carbapenemase-Producing Enterobacteriaceae)
 - The Laboratory will promptly notify the nursing unit and the Infection Prevention & Control Dept. of all isolates that are non-susceptible to carbapenems or isolates that test positive for carbapenemase.

- Since CRE is not endemic, surveillance will continue. If CRE become endemic, or an outbreak occurs, then additional strategies will be considered as per the 2006 CDC MDRO guidelines.
 - Resources
 - Guidance for Control of Infections with Carbapenem-Resistant or Carbapenemase-Producing Enterobacteriaceae in Acute Care Facilities 2009.
 - Management of Multidrug-Resistant Organisms In Healthcare Settings, 2006
- g. Programs to prevent hospital acquired device-associated infections (namely central venous catheter-associated infections, urinary catheter associated infections and ventilator-associated infections).
- g. This facility has adopted the following CDC Prevention Guidelines:
 - Preventing Healthcare-Associated Pneumonia - 2003
 - Guidelines for the Prevention of Intravascular Catheter-Related Infections, 2011
 - Guideline for Prevention of Catheter-associated Urinary Tract Infections, 2009
- h. A program to prevent surgical site infections.
 - This hospital has adopted the CDC Guidelines for Prevention of Surgical Site Infections – 1999
- i. Additional guidelines
 - Guidance on Public Reporting of Healthcare-Associated Infections: Recommendations of the Healthcare Infection Control Practices Advisory Committee 2003
 - Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008
 - Guidelines for Preventing Health-Care--Associated Pneumonia, 2003
 - Guidelines for Environmental Infection Control in Health-Care Facilities 2003
 - Guideline for Prevention of Surgical Site Infection, 1999
- Employee Health (EH) Program:
The Employee Health program involves interventions for reducing the risk of infection transmission, including recommendations for immunizations and testing for immunity. In late 2014 we added a full time Employee Health Nurse
 - The program includes screening for health issues, childhood illness/immunization; tuberculosis screening; immunization for hepatitis B and influenza; evaluation of post-exposure assessment to blood/body fluid exposures and/or other communicable diseases.
 - When indicated, the program also includes monitoring of employee illnesses in order to identify potential relationships among employee illness, patient infectious processes and/or environmental health factors.
 - The infection control program will review and approve all policies and procedures developed in the employee health program that relate to the transmission of infections in the hospital. Infection Control/Employee Health Coordinator will develop, implement, and annually review and update the OSHA Bloodborne Pathogens Exposure Control Plan and Tuberculosis Control Plan.
 - The Hospital follows the following CDC guidelines
 - Influenza Vaccination of Healthcare Personnel (2006)
 - Immunization of Healthcare Workers (1997)
 - Infection Control in Healthcare Personnel (1998)
 - Tuberculosis (2005)
 - At the time of employment, all facility personnel will be evaluated by the employee health program for conditions relating to communicable diseases.

The evaluation includes the following:

- ◇ Medical history, including immunization status and assessment for conditions that may predispose personnel to acquiring or transmitting communicable diseases;
 - ◇ Tuberculosis testing (T-Spot);
 - ◇ Serologic screening for vaccine preventable diseases, if indicated;
 - ◇ Such medical examinations as are indicated by the above.
- Appropriate employees or other healthcare workers will have periodic medical evaluations to assess for new conditions related to infectious diseases that may have an impact on patient care, the employee, or other healthcare workers, which should include review of immunization and tuberculosis testing (T-Spot) status, if appropriate.
 - Southern Hills Hospital and Medical Center will maintain confidential medical records on all healthcare workers. Files are stored in locked file cabinets in the Employee Health Office
 - Employees will be offered appropriate immunizations for communicable diseases.
 - Immunizations will be based on regulatory requirements and Advisory Committee on Immunization Practices recommendations for healthcare workers.
 - The employee health program will develop policies and procedures for the evaluation of ill employees, including assessment of disease communicability, indications for work restrictions, and management of employees who have been exposed to infectious diseases, including postexposure prophylaxis and work restrictions.
 - This hospital has adopted the following Healthcare Worker Safety Guidelines
 - Management of Occupational Exposures to Hep B, Hep C, and HIV and Recommendations for Postexposure Prophylaxis 2001
 - Infection Control in Healthcare Personnel - 1998
2. Program Compliance
- To verify compliance with the program, Infection Control Coordinator shall conduct periodic infection control rounds with follow-up required by the department director.
 - The Department Director or designee will conduct direct observation of appearances and practices in their specific clinical areas.

2017 Goals Based on 2016 Risk Assessment

- Maintain central line related bloodstream infections NHSN SIR <1.000
- Continue to report department specific CLBSI to NHSN as required
- Decrease Ventilator Associated Pneumonia infections NHSN SIR <1.000
- Continue to monitor and maintain SSIs to NHSN SIR <1.000. Report COLO, HPRO, HYST, KRPO and LAM in NHSN.
- Maintain CAUTI's NHSN SIR <1.000. Continue reporting of ICU CAUTIS in NHSN.
- Continue HCA Corporate MRSA Campaign - SHHMC goal 95%.
- Monitor ESBLs
- Maintain MRSA HAIs less than 0.4 per 1000 patient days. NHSN reporting will continue in 2015
- Maintain VRE HAIs less than 0.1 cases per 1000 patient days
- Decrease C. Difficile HAIs NHSN SIR <1.000. Continue reporting to NHSN.
- Maintain HAI from Acinetobacter below 0.5 cases per 1000 patient days

SURVEILLANCE PLAN

- A. When developing infection prevention and control activities, the hospital uses evidence-based national guidelines or, in the absence of such guidelines, expert consensus CDC/HICPAC Guidelines
- Isolation Precautions (2007)
 - Multi-Drug Resistant Organisms (2006)
 - Influenza Vaccination of Healthcare Personnel (2006)
 - Tuberculosis (2005)
 - Healthcare Associated Pneumonia (2004)
 - Environmental Infection Control (2003)
 - Smallpox Vaccination (2003)
 - Intravascular Device-Related Infections (2002)
 - Hand Hygiene (2002)
 - Infection Control in Healthcare Personnel (1998)
 - Surgical Site Infection (1998)
 - Immunization of Healthcare Workers (1997)
- B. Activities
There is an active program for the prevention, control and investigation of infections and communicable diseases that includes a hospital-wide surveillance program. Surveillance data will be analyzed appropriately and used to monitor and improve infection control and healthcare outcomes.
- C. Surveillance and Monitoring:
Surveillance is performed as an adjunct to the Quality and Risk Prevention Programs. It includes (but is not limited to):
1. Monitoring high volume/high risk; low volume/high-risk and surgical procedures.
 2. Evaluating new programs as well as renovation or construction in conjunction with the hospital's Facilities Management Department and the Environment of Care (EOC) team.
 3. Compiling and analyzing surveillance data, presenting findings and making recommendations to the Infection Prevention and Control Committee and other departments appropriate.
 4. Using baseline surveillance data to determine if an outbreak is occurring.
 5. Investigating trends of infections, clusters, and unusual infections.
 6. Conducting or facilitating infection control rounds or focus reviews.
- D. Surveillance Methodology
1. Sources for infection identification include:
 - Microbiology records
 - Reports from TheraDoc
 - Reports from MEDITECH including patient census/diagnosis
 - Routine Chart reviews
 - Post-discharge surveillance following surgical procedures
 - Staff reports of suspect/known infections or infection control issues
 - Device-associated infections (i.e., Line day usage for urinary catheters, central line catheters and ventilator day use).
 - Employee Health reports reflecting epidemiological significant employee infections
 - Public Health reporting of State mandated reportable infections
 - Regular review of surveillance data
 2. Infection Definitions:
 - Recommended practices for surveillance: Association for Professionals in Infection Control and Epidemiology (APIC), Inc. American Journal of Infection Control 2007
 - National Healthcare Safety Network (NHSN) definitions
 3. Data Collection Methods
 - The infection Control Coordinator collects the infection prevention and control data
 4. Rate calculations:

Infection rates are calculated using formulas accepted by the Association for Professionals in Infection Control and Epidemiology (APIC) and the Centers for Disease and Control and Prevention (CDC).

- Infection rates will be compared to internal and external benchmarks.
- 5. The occurrence and follow-up of infections/communicable diseases among patients, staff and visitors will be documented by the Infection Control Coordinator and reported to the Infection prevention and Control Committee

E. Environmental Assessment/Surveillance:

1. Environmental Assessment/Surveillance is performed in conjunction with the Environment of Care (EOC) group and includes the following:
 - a. Verifying compliance with the IC program, the facility's ICP will conduct periodic infection control rounds with follow-up required by the surveyed department.
 - b. Ensuring clean equipment and supplies are stored separately from soiled ones.
 - c. Ensuring linens are kept covered during transport and storage.
 - d. Ensuring sterile supplies are stored in a manner as to prevent contamination or damage to the packaging.
 - e. Reviewing the sterilization parameters for all patient care items processed within the facility to assure standards are met.
 - f. Review the documentation of sterile processing in all areas including Sterile processing, Surgery and Gastroenterology Labs to ensure all sterilization done in the facility meets the same standards.
 - g. Evaluating the surgical department's review and report of the summary of all flash sterilization by instrument type to determine if adequate supplies are being maintained.
 - h. Assisting in the evaluation of sterilization failures, reporting findings to the Infection prevention and Control Committee, Medical Staff, Quality/Risk Management, Patient Safety Director, attending physician, and patient care manager of area involved.
 - i. Unused single-use device (SUD) will be reprocessed by an external company (Used single-use devices will not be reprocessed by the facility.)
 - j. Monitoring microbiology of treated water and dialysate according to State and Federal standards
 - k. Evaluating of patients or employees with infections or diseases from environmental organisms, e.g., Legionella, Aspergillus.
 - l. Routine sampling of the environment, air, surfaces, water, food, etc., is discouraged unless a related infection control issue is identified
 - m. Performing Pre Construction Infection Control Risk Assessments (PCRA) prior to renovation, construction, or planned interruption of the utility system within the patient care environment.
 - The PCRAs are to be approved by the appropriate committees, which may include, but are not limited to: EOC, Safety, and ICC.
 - Rounds of the construction/renovation site are conducted to evaluate compliance with PCRA requirements. The ICP will have the authority to stop any project that is in substantial non-compliance with the requirements.
 - Any time there is construction or renovation, the ICP will be consulted prior to final design.
 - n. Monitoring Atmospheric Guidelines
 - Evaluate the use of negative pressure environments in the care of patients with airborne diseases.
 - This hospital has adopted the following:
 - CDC Guidelines for Environmental Infection Control in Healthcare Facilities – 2003
6. Outbreak Plan

- a. Southern Hills Hospital & Medical Center will identify an outbreak as early as possible to protect patients, employees and visitors to the Hospital. Additional resources will be summoned to include the Infection Control Coordinator, the Infectious Prevention and Control Committee Physician representative Specialist, Laboratory and Microbiology experts, Hospital Administration and the Public Health Authorities. Normal surveillance may locate a disease that has been absent, or herald the onset of a new disease. One case may be sufficient for this identification.
 - b. The term outbreak describes the sudden rise in the incidence of a disease, especially a harmful one. An outbreak is characterized by a disease's bypassing of measures to control it. An outbreak may be defined as a localized increase in the expected incidence of a disease. .
7. All Components and Functions
All hospital components and functions are integrated into infection prevention and control activities.
 8. Communication Method
The hospital has a method for communicating responsibilities about preventing and controlling infection to licensed independent practitioners, staff, visitors, patients, and families
 9. External Reporting Methods
The hospital identifies methods for reporting infection surveillance and control information to external organizations.
 10. Influx of Infectious patients
The hospital has a separate plan which addresses the sudden influx of infectious patients

PLAN IMPLEMENTATION

- A. Epidemiologic data is used to plan, implement, evaluate and improve infection control strategies. Surveillance is a critical component of the program. Prevention and control efforts will include activities such as:
 - Identifying, managing, reporting, and following-up on persons with reportable and/or transmissible diseases.
 - Measuring, monitoring, evaluating and reporting program effectiveness.
 - Expanding activities as needed in response to unusual events or to control outbreaks of disease.
 - Addressing outbreaks and epidemics, and unusual activities in a timely manner.
 - Ensuring that all departments alert the Infection Control Coordinator whenever an unusual pathogen is isolated or suspected.
 - Focusing on medical and surgical services that have a high volume of procedures and/or have a population that may be at high risk for infection.
 - Complying with mandates listed under the umbrella of infection control by licensing and accrediting agencies

EVALUATION AND IMPROVEMENT

- A. Infection Classification and Analysis
 1. For the purposes of routine data collection, health care-associated infections are clinically active infections occurring in hospitalized patients in whom the infection was not present or incubating at the time of admission. When the incubation period is unknown, an infection is called health care-associated if it develops at any time after admission and meets established criteria
 2. Both infections with endogenous organisms carried by the patient and those with organisms originating in the animate or inanimate environment are included in the definition. When thus

defined, health care-associated infections include potentially preventable infections while admittedly including some infections that may be regarded as inevitable

3. In determining the presence or absence of a health care-associated infection for statistical measurements, strict criteria must be used for valid data analysis. Not all health care-associated infections are counted and presented for statistical analysis.
4. All positive cultures will be reviewed and classified as either:
 - Nosocomial Infection: All Nosocomial Infections (both device-associated and non-device-associated) are defined, in general as
 - ◇ An infection not present or incubating at the time of admission
 - ◇ An infection, with an unknown incubation period, that develops after admission
 - ◇ An infection present on admission that is directly related to or is the residual of a previous admission
 - ◇ An infection indicated as nosocomial in a patient chart, by a physician
 - Community-Acquired:
 - ◇ An infection present at the time of admission
 - Exception: An infection present on admission is nosocomial if it is directly related to or is the residual of a previous admission
 - Healthcare associated
 - Colonization: Organisms present but not causing an infection from a normally non sterile site.
 - Not Significant: Includes contamination (e.g., urine with a mixed culture, low colony counts in blood or sputum, etc.) and repeat cultures / cultures previously isolated.
- B. An assessment may be done for infections as determined by the facility as hospital acquired infection sentinel event process
 - In cooperation with the Quality/Risk Departments, the ICP will facilitate a root cause analysis of all nosocomial infections that result in serious injury or harm or the risk thereof.
 - Any suspected cases in which the hospital-acquired infection is the direct cause of death or major permanent loss of function will be referred to the Chairman of the Quality Committee for verification. If the Chairman deems this is a sentinel event, the case will be sent to the Quality Management Department for a root cause analysis to determine if the case meets the definition of "Hospital Acquired Infection Sentinel Event". The Infection Control Coordinator will participate in the analysis.
- C. Nevada Senate Bill 319/CMS Reporting
- D. **Nevada Revised Statute**
 - Nevada Revised Statutes 439.847 requires facilities to participate in the NHSN surveillance system, and facilities must provide the Health Division access to that information for the purpose of analyzing the data.
 - A hospital, which meets the criteria prescribed in subsection (1) of Section 4 of Senate Bill 319 of the 2009 legislative session shall collect and submit data related to methicillin-resistant staphylococcus aureus (MRSA). The hospital shall, at a minimum, report MRSA Metric 1 by each patient-care location in the medical facility where denominator data can be collected and on Metric 2 using a facility-wide measurement.
 - The Reporting Program CLABSI Requirements Hospitals must be enrolled in the National Healthcare Safety Network (NHSN) and use the CLABSI protocol to submit data elements needed to calculate the CLABSI measure.
 - Hospitals with a signed Notice of Participation indicating they participate in the Reporting Program do not need to sign a new Notice of Participation.
 - **All** hospitals participating in the Reporting Program are required to:
 - Submit quarterly data if a hospital has an ICU, in which there were central line days.

E. Program Evaluation

1. The Infection Prevention and Control Committee will annually evaluate (See Risk Assessment), revise as necessary, and approve a plan for surveillance, prevention, and control of infections. The following information will be used:
 - Data trend analyses generated by surveillance activities during the past year.
 - Effectiveness of prevention and control intervention strategies.
 - Services instituted during the past year as well as priorities or problems identified.
 - TB and Bloodborne pathogen exposure control programs.

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[Guide to the Elimination of MRSA Transmission in Hospital Settings, 2nd Edition \(2010\)](#)

[Guide to the Elimination of Multidrug-resistant Acinetobacter baumannii Transmission in Healthcare Settings \(2010\)](#)

[Guide to the Elimination of Orthopedic Surgical Site Infections \(2010\)](#)

[Guide to the Elimination of MRSA in the Long-Term Care Facility \(2009\)](#)

[Guide to the Elimination of MRSA Transmission in Hospital Settings - California Supplement \(2009\)](#)

[Guide for the Prevention of Mediastinitis Surgical Site Infections Following Cardiac Surgery \(2008\)](#)

Name Here, VP Quality/Risk Management, Sentinel Event Reporter 1/2017 – 6/2017

Name Here, VP Quality/Risk Management, Sentinel Event Reporter 6/2017 – 12/2017

Quality Care/Patient Safety Committee 2017

Chair, Name Here, MD Chief Medical Officer

Name Here, CEO

Name Here, COO

Name Here, CNO until October 2017

Name Here, Interim CNO 10/2017 – 12/2017

Name Here, CFO

Name Here, VP Quality/Risk Management 1/2017 – 6/2017

Name Here, VP Quality/Risk Management 6/2017 – 12/2017

Name Here, Director Critical Care

Name Here, Director Ortho/Neuro

Name Here, Director Med/Surg/Tele

Name Here, Director Behavioral Health

Name Here, Director Medical Staff Office

Name Here, Manager ED

Name Here, Manager ER at the Lakes,

Name Here, Director of Surgical Services

Name Here, Director Case Management

Name Here, Director Pharmacy

Name Here, Director Infection Prevention

Name Here, Manager Lab

Name Here, Ethics/Compliance, Director Lab

Name Here -Gonzalez, QM

Name Here -Smith, QM

Name Here, Manager PT/ST/OT

Name Here -Valmonte, Manager RT

Name Here, Director Advanced Clinical Applications

Policy Title: 2017 Patient Safety Plan

Audience: All Employees

References and Citations:

PURPOSE

The purpose of the Patient Safety Plan is to provide a systematic, coordinated and continuous approach to the maintenance and improvement of patient safety through the establishment of mechanisms that support effective responses to actual occurrences; ongoing proactive reduction in medical/health care errors; and integration of patient safety priorities into the new design and redesign of all relevant organization processes, functions and services. The goal of the Patient Safety Plan is to provide a safe environment for patients and their families. The approach to optimal patient safety involves multiple departments and disciplines in establishing the plans, processes and mechanisms that comprise the patient safety activities at the Hospital. The purpose includes creating an environment that encourages:

- Recognition and acknowledgment of risks to patient safety and medical/health errors;
- The initiation of actions to reduce these risks;
- The internal reporting of what has been found and the actions taken;
- A focus on processes and systems;
- Minimization of individual blame or retribution for involvement in a medical/healthcare error;
- Organizational learning about medical/healthcare errors;
- Support of the sharing of that knowledge to effect behavioral changes in itself and other health care organizations; and
- Disclosure of the outcomes of care, treatment and services.

The Patient Safety Plan developed by the interdisciplinary Patient Safety Committee and approved by the 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:

Original Effective Date: 9/30/2004

Revision Date: 4/9/2017

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- Best Practices and Took Kit Development;
 - Comparative Analysis of Adverse Event Reported in the Event Reporting System;
 - Unsafe Behavior Evaluations;
 - Raise safety awareness through the internal publication of anonymized Action Plans from root cause analysis;
 - Develop and publish Patient Safety Alerts; and
 - Monthly Comprehensive Risk Assessments.

Patient Safety Event Work Product:

Types of patient safety events, adverse outcomes, or medical/health care errors included in data analysis are:

- Event Reports- those events and outcomes reportable to the Director of Risk Management by an Event Report (Form RM 3301) during downtime or by entering the occurrence into the Event Reporting System include processes and outcomes of care that may result in no harm through serious injury or death. Examples include falls, medication variances, adverse drug reactions, intravenous therapy variances, procedure variances, procedure complications, patient complaints and AMA and elopement discharges. These may also include near miss events.
- Hemolytic transfusion reactions reported through the transfusion review channels.
- Hazardous Condition – any set of circumstances, exclusive of the disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious physical or psychological adverse patient outcome.
- Serious Safety Event & Sentinel Event: applies to events that have resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition. In addition, there are other event types that are considered sentinel due to the severity of the event even though the outcome was not death or permanent loss of function unrelated to the natural course of the patient's illness or underlying condition.
- Serious Safety Event & Sentinel event criteria and the procedures involved are detailed in the sentinel event and root cause analysis policies and procedures including definitions of near misses, which require a root cause analysis.
- Never Events and Hospital Acquired Conditions including:

Surgical events:

- Surgery performed on the wrong body part;
- Surgery performed on the wrong patient;
- Wrong surgical procedure performed on a patient;
- Unintended retention of a foreign object in a patient after surgery or other procedure;
- Intraoperative or immediately postoperative death in an American Society of Anesthesiologists Class I patient; or
- Artificial insemination with the wrong sperm or donor egg

Product or device events:

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- Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the health care facility;
 - Patient death or serious disability associated with the use or function of a device in patient care, in which the device is used for functions other than as intended; or
 - Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a health care facility e.g., luer connectors are implicated in or contribute to many of these errors because they enable functionality of dissimilar tubes to be connected.

Patient protection events:

- Infant discharged to the wrong person;
- Patient death or serious disability associated with patient elopement (disappearance); or
- Patient suicide or attempted suicide resulting in serious disability, while being cared for in a health care facility

Care management events:

- Patient death or serious disability associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration);
- Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA-incompatible blood or blood products;
- Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a health care facility;
- Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a health care facility;
- Death or serious disability (kernicterus) associated with failure to identify and treat hyperbilirubinemia in neonates;
- Stage 3 or 4 pressure ulcers acquired after admission to a health care facility; or
- Patient death or serious disability due to spinal manipulative therapy

Environmental events:

- Patient death or serious disability associated with an electric shock or electrical cardio-version while being cared for in a health care facility;
- Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances;
- Patient death or serious disability associated with a burn incurred from any source while being cared for in a health care facility;
- Patient death or serious disability associated with a fall while being cared for in a health care facility; or
- Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a health care facility.

Criminal events:

Original Effective Date: 9/30/2004

Revision Date: 4/9/2017

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- Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider
 - Abduction of a patient of any age;
 - Sexual assault on a patient within or on the grounds of the health care facility;
 - Death or significant injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of the health care facility; or
 - Environment of care significant incidents involving employee, visitor, utility or property damage

Sources of external knowledge and experience include the Sentinel Event Alerts. Published by The Joint Commission, safety alerts published by the Food and Drug Administration, Patient Safety Alerts, adverse outcome and lessons learned from RCA's, information from insurance carriers and other private and public healthcare safety organizations.

The scope of the organization-wide Safety Program encompasses all people including the patient population, visitors, volunteers and staff (including medical staff). The program addresses maintenance and improvement in patient safety issues in every department throughout the facility, as well as employee safety, physical plant and facilities, equipment and supply-related safety issues, among other safety issues. To promote efficiency, there is an Environment of Care Committee, chaired by the Environmental Safety Officer, that addresses employee events and safety, workers compensation, needle sticks and products, visitor Events, hazard surveillance, and the safety management plans. To promote integration, communication and analysis of inter-related issues, there is cross membership between the committees, and both committees report to the Quality Improvement Council for oversight and further integration of related issues. Physician peer review of medical errors is also conducted at the Quality Improvement Council level (or at their direction).

The Serious Safety Event Rate (SSER) calculation will then be reviewed on a monthly basis. The SSER should be considered Patient Safety Work Product and will be reported to the following council/committees, Patient Safety, 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' Director of Risk Management will serve as the Patient Safety Officer in most instances.

Procedures

Committee responsibilities:

1. The interdisciplinary Patient Safety Committee is responsible for the oversight and management of the Patient Safety Program. This includes making recommendations to organization leaders regarding the adequacy of resources allocated to support patient safety activities. The committee will oversee data and analysis in order to prioritize patient safety activities, including, but not limited to patient safety work product, Medication Variances, Infection Surveillance, Safety Surveillance, Staff Perceptions of and suggestions for improving patient safety, Staff willingness to report errors (Employee Surveys), Patient/Family perceptions of, and suggestions for improving patient safety, and results of risk assessment surveys by department.
2. The Patient Safety Committee is responsible to review and approve the organization-wide and departmental patient safety-related policies, procedures and CHS PSO information. This should include the content of any proactive risk self-assessments prior to data collection, as well as patient/family education regarding their role in helping to facilitate the safe delivery of care.

All departments within the organization (patient care and non-patient care departments) are responsible to report patient safety occurrences, and potential occurrences to the Director of Risk Management, who will aggregate occurrence information and present a report to the Patient Safety Committee on a 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.

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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.
 7. The Patient Safety Committee consists of the following personnel: Patty Holden, CEO; David Howell, Plant Operations; Kathy Jo Knight, Administrative Laboratory Director; Janeen Johansen, Inpatient Director; Dan Crossley, Pharmacy Director; Roger Silva, Radiology Director; Susan Stowell, Quality Director; Jan Call, ED Director; Steve Siegrist, HR Director; Mary Lyman, Director Risk Management; Julie Roberts, Surgical Services Director; Johnny Neve, Materials Management; Norma Zierle, HIM director and Nancy Seck, CNO.

The proactive risk assessment will include:

- ◆ Assessment of the intended and actual implementation of the process to identify the steps in the process where there is, or may be, undesirable variation (failure mode). For each identified failure mode, identify the possible effects of the undesirable variation on patients, and how serious the possible effect on the patient could be (criticality);
- For the most critical effects, conduct a root cause analysis to determine why the variation (failure mode) leading to that effect may occur;
- Redesign the process and/or underlying systems to minimize the risk of that failure mode or to protect patients from the effects of that failure mode;
- Test and implement the redesigned process;
- Identify and implement measures of the effectiveness of the redesigned process; and
- Implement a strategy for maintaining the effectiveness of the redesigned process over time.

Organization-wide activities:

1. Education regarding employee responsibilities for patient safety is included in initial and annual orientation programs, both by the Director of Risk Management and department manager. This includes reporting requirements and mechanisms. As appropriate, training which incorporates methods of team training to foster an interdisciplinary, collaborative approach to patient care delivery is provided. The Patient Safety Committee and other committees may recommend education as a patient safety improvement activity at any time throughout the year. Training on failure mode analysis, effects and criticality analysis should be done for those involved with this risk reduction tool.
2. Patient safety is included as a regular agenda item for at least the clinical and support service departments of the organization. The intent is to foster a culture of "patient safety as job number one", "Safety First". Patient safety is a high priority function in the design and redesign of processes, functions and systems that impact or involve patient care.

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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 Director of Risk Manager per the Patient Safety Evaluation System.

Individuals in any department identifying a potential patient safety issue should notify their supervisor and document the findings on an Event Report. This Patient Safety Work Product includes patient safety near misses. The Event Report should be submitted to the Director of Risk Manager 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 Director of Risk Manager per organizational policy
- Serious Safety Event & Sentinel Event - staff should perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then follow the organizational Sentinel Event Policy and Procedure. A root cause analysis should be

performed for any sentinel event and near miss as defined in the sentinel event policy and procedure.

- Near Miss – staff should report the near miss event to their immediate supervisor, describe the facts of the near miss on an event report and submit the report to the Director of Risk Manager. A proactive risk assessment may be performed to prevent recurrence if it is determined that a recurrence poses a significant safety risk to future patients. This may be determined by the Director of Risk Manager and/or the Patient Safety Committee if there is any disagreement as to risk potential.

An effective Patient Safety Program cannot exist without optimal reporting of medical/health care errors and occurrences. Therefore, it is the intent of this organization to adopt a non-punitive approach in its management of errors and occurrences. All personnel are required to report suspected and identified medical/health care errors, and should do so without the fear of reprisal in relation to their employment. This organization supports the concept that errors occur due to a breakdown in systems and processes, and will focus on improving systems and processes, rather than disciplining those responsible for errors and occurrences. A focus will be placed on remedial actions to assist rather than punish staff members.

Staff Support:

Staff members involved in a sentinel event occurrence will receive support from the Director of Risk Manager regarding the staff member's professional and emotional reconciliation of the sentinel event. The staff member's involvement in the root cause analysis and action plan processes is encouraged, to allow the staff member an active role in process resolution. Additionally, any staff member involved in a sentinel event or other medical/health care error may request and receive supportive personal counseling from the hospital's social worker, psychologist or psychiatrist on staff and/or their department supervisor.

Disclosure:

Patients, and when appropriate, their families are informed regarding the unanticipated outcomes of care, or when the outcomes differ significantly from the anticipated outcomes. The Patient Safety Committee will monitor for compliance with this standard through the information management function of record reviews, and through reports from the Patient Safety Officer of evidence found upon individual record review for other risk management purposes. (See also policy regarding disclosure of unanticipated outcomes.)

Communication:

1. Medical/health care errors and occurrences, including sentinel events, will be reported to the CHS PSO, LLC and externally, per hospital policy through the channels established by this plan. External reporting will be performed in accordance with state, federal and regulatory body rules, laws and requirements (i.e., regarding medical devices in accordance with the Safe Medical Devices Act.).

2. An annual report will be compiled by the Patient Safety Committee and forwarded to the Quality Improvement Council, the Medical Executive Committee and on to the governing board. This report shall include at least aggregate data regarding patient safety, an analysis thereof (conclusions), recommendations and actions taken to improve patient safety, both in response to actual occurrences and proactively. These reports shall be protected to the extent allowable under the disclosure laws applicable to peer review, the Quality Improvement Council, and risk management.
3. The governing board, upon evaluation of received reports (at a minimum, annually), should assess the allocation of resources, the assignment of personnel and their time, the provision of information services and data management processes, and staff training in terms of adequacy of their allocation of human, information, physical and financial resources to support patient safety improvement priorities.

Patient and Family Education:

The organization urges patients and families to get involved in their care. Educational efforts to increase consumer awareness and involvement are supported by the Centers for Medicare and Medicaid Services and TJC as a critical process to improve patient safety. The organization encourages patients and families to:

- ◆ Speak up if they have questions or concerns, and if they don't understand, ask again. Encouraging patients that it is their right to know
- ◆ Pay attention to the care received. Making sure you are getting the right treatments and medications by the right health care professionals. Don't assume anything.
- ◆ Educate yourself about diagnosis, the medical tests you are undergoing and your treatment plan.
- ◆ Ask a trusted family member or friend to be your advocate.
- ◆ Know what medications you take and why you take them. Medication errors are the most common health care mistakes.
- ◆ And to participate in all decisions about your treatment. You are the center of the health care team.

SUBJECT: PATIENT SAFETY PLAN

POLICY NUMBER: 7.2

Introduction:

Safety at Elite Endoscopy encompasses:

- i. The environment of care; and
- ii. The process of care.

The environment of care is addressed in the Environmental Standards, and Safety and Infection Control Plan, while this document addresses the process of care.

Purpose:

As part of a continuous focus on the safe delivery of healthcare services, the Patient Safety Program was established as an interdisciplinary collaborative effort.

The purpose of the Patient Safety Program is to identify and effectively resolve events that result in, or have the potential to result in adverse patient care outcomes. The program is also designed to examine existing patient care processes and identify and effect improvements that reduce the risk of adverse outcomes. In achieving such, Elite Endoscopy has cultured an environment that encourages:

- i. The recognition and acknowledgement of medical/health care errors and their risks to patient safety;
- ii. The initiation of actions to reduce these risks;
- iii. The internal reporting of what has been found and the actions taken;
- iv. A focus on processes and systems;
- v. A non-punitive culture with minimization of individual blame or retribution for involvement in a medical/health care error; and
- vi. Organizational learning about medical/health care errors.

Scope of Program Activities:

The scope of the Patient Safety Program is designed to support and reflect Elite Endoscopy's commitment to fostering a culture of safety, service and continuous improvement to assure the highest-quality patient care. The Patient Safety Program is broad in its scope and includes patients, visitors, and staff. The program addresses maintenance and improvement of safety issues in the facility.

Objectives:

The objectives of the Patient Safety Program are as follows:

- i. Establish and convene an appropriate group to develop and monitor Patient Safety Program initiatives;
- ii. Develop an awareness of the Patient Safety Plan;
- iii. Develop knowledge and skills related to the analysis of patient safety events;
- iv. Prioritize and effect patient safety improvements;
- v. Determine if corrective actions and improvements are effective; and
- vi. Report to the Governing Body at least quarterly.

Responsibilities:

All personnel will participate in the patient safety program. All personnel are responsible for reporting patient occurrences and potential occurrences.

Patient Safety will be under the direction of the Quality Assurance Patient Safety Committee and will assist with the identification, coordination and implementation of patient safety initiatives.

Non-Punitive Reporting Culture

An effective Patient Safety Program cannot exist without optimal reporting of medical/health care errors and occurrences. Therefore, Elite Endoscopy strives for a non-punitive approach in its management of errors and occurrences. Personnel are required to report suspected and identified medical/health care errors, and should do so without the

fear of reprisal in relationship to their employment. Elite Endoscopy supports the concept that errors occur due to a breakdown in systems and processes, and focuses on improving systems and processes, rather than disciplining those responsible for errors and occurrences. A focus is placed on remedial actions to assist, rather than punish, staff members. Any identified instances of incompetence, negligence, and malfeasance that are discovered and ascertained during the evaluation of errors and occurrences are forwarded to Medical Director.

Methodology:

Identification of Medical/ Health Care Errors:

The identification of medical/health care errors includes, but is not limited, to the following mechanisms:

- Incident reporting (which includes adverse drug reactions and emergency patient transfer), and
- Sentinel Event Reporting

Options for reporting patient events are continuously being explored and will be included as they are approved.

Response to medical/health care errors

Upon identification of a medical/health care error, the staff immediately:

- i. Performs emergency healthcare interventions (if necessary) to treat the patient's clinical condition. As appropriate to the occurrence, necessary healthcare interventions are performed to contain the risk to others.
- ii. Contacts the patient's providing physician and/or other physicians, as appropriate, to report the error and carry out any physician orders as necessary.
- iii. Reports the medical/health care error to the Director of Nursing and preserves any information related to the error (including physical information). Preservation of information includes documenting facts regarding the error on an occurrence report and in the medical record as appropriate.

iv. Submits the report of occurrence to the Quality Assurance Committee for review under Risk Management.

v. Patients and, when appropriate, their families are informed about the outcomes of care, this includes unanticipated adverse outcomes- a result that differs significantly, and adversely, from what was anticipated from a treatment or procedure.

Classification of Medical/Health Care Errors

Elite Endoscopy defines medical/health care error as an unintended event during the process of care. Nevada Digestive classifies unintended events during the process of care by "clinical significance" which correlates with injury severity and ranges from none to catastrophic. This classification process assists the organization in determining the types of analysis that may be applied to the event. For example, a Root Cause Analysis is always completed for those errors classified as Sentinel Events.

1. Events of No Clinical Significance –there is no evidence of injury to the patient.

2. Events of Minor Clinical Significance – these events result in only first aid care (no additional procedures, tests, medications, or increased length of stay or increased level of care).

3. Events of Moderate Clinical Significance - these events result in additional procedures, tests, or medications, or transfer to a hospital.

4. Events of Major Clinical Significance - these events result in, surgical intervention, and transfer to a hospital.

5. Events of Catastrophic Clinical Significance (Sentinel Event) - An event involving death or serious physical or psychological injury, or the risk thereof, including any process variation for which a recurrence would carry a significant chance of serious adverse outcome. Serious injury specifically includes loss of limb or function. Sentinel event criteria includes:

i. An event that has resulted in an unanticipated death or major, permanent loss of function, not related to the natural course of the patient's illness or underlying condition.

ii. An infant abduction or discharge to the incorrect family.

iii. The rape of a patient.

iv. A hemolytic transfusion reaction.

v. Surgery on the wrong patient or body part; and the suicide of a patient (where the patient received “around the clock” care.

The type of analysis will be determined after evaluation of the event by the Quality Assurance Committee.

Prioritization of Safety Improvement Activities:

In a continuing effort to prevent errors and improve patient safety, Elite Endoscopy's Patient Safety Program utilizes internal and external informational resources, to identify potential improvements in patient safety. Patient complaints, occurrence reporting, State and Federal recommendations, and current literature, including the National Quality Forum (NQF) compilation of Best Patient Safety Practices, will be collected and utilized in the program.

Patient Education and Patient Responsibilities:

Staff educates patients and their families about their respective roles in helping to facilitate the safe delivery of care. Patients are given information of their rights and responsibilities upon admission

Staff Education:

Staff receives education and training during their initial orientation process and on a continuing basis. The education includes, but is not limited to; the need and process of reporting medical/health care errors, and the identification and disclosure of potential risks of healthcare errors

Patient Safety Assessment:

The Patient Safety Program includes at a minimum, an annual assessment of patients, their families, and staff (including medical staff) opinions, needs and perceptions of risks to patients, and request suggestions for improving patient safety.

Governing Body

The Governing Body is responsible and accountable for the approval of the Patient Safety Plan and the oversight of the Patient Safety Program. The Governing Body supports the appropriation of the resources necessary to address identified patient safety issues. Elite

Endoscopy's progress with Patient Safety initiatives is evaluated and actions are planned based on the conclusions and recommendations forwarded to it by the Quality Assurance Committee.

Quality Assurance Committee/Patient Safety Committee

The Quality Assurance Committee/Patient Safety Committee is charged with developing and monitoring the Patient Safety Program. The Quality Assurance Committee is knowledgeable of ongoing safety activities, and promotes new initiatives when necessary. Under the Patient Safety Program, the Quality Assurance Committee/Patient Safety Committee is responsible for:

- Enhancing Elite Endoscopy's commitment to patient safety
- Facilitating and coordinating patient safety activities.

POLICIES AND PROCEDURES

SECTION: N-140

DATE: 07/03

REVIEWED: 12/2017

TITLE: SAFETY RULES AND REGULATIONS (GENERAL)

POLICY: IT IS THE POLICY OF ALTA ROSE SURGERY CENTER TO PROVIDE A SAFE, HEALTHFUL, AND SANITARY WORKING ENVIRONMENT FOR PATIENTS, STAFF, AND VISITORS. STANDARDS SHALL BE SET AND MAINTAINED ACCORDING TO LOCAL, STATE AND FEDERAL RULES, LAWS, AND REGULATIONS. IT IS ONE OF THE OBJECTIVES OF THE CENTER TO COMPLY WITH ALL RULES, MANDATES, LAWS, AND REGULATIONS PERTAINING TO THE SAFETY AND HEALTH OF ITS EMPLOYEES.

PROCEDURE: EACH DEPARTMENT MANAGER IS RESPONSIBLE FOR DEVELOPING SPECIFIC WRITTEN SAFETY RULES AND REGULATIONS. THESE RULES AND REGULATIONS MUST BE A PART OF THE INTRODUCTION AND ORIENTATION OF EACH NEW EMPLOYEE BROUGHT INTO THE DEPARTMENT. SAFETY SYSTEMS WILL BE DEVELOPED AND MAINTAINED THROUGH POLICIES AND PROCEDURES TO MINIMIZE HAZARDS TO PATIENTS, STAFF, AND VISITORS. GUIDELINES FOR ALL EMPLOYEES INCLUDE THE FOLLOWING:

- 1) KNOW THE SAFETY RULES AND REGULATIONS FOR BOTH DEPARTMENT AND THOSE APPLICABLE TO THE OPERATION OF THE CENTER.
- 2) KNOW THE LOCATION AND OPERATION OF THE CENTER'S TELEPHONES, FIRE EXTINGUISHERS, EXITS, AND YOUR INDIVIDUAL RESPONSIBILITIES IN CASE OF FIRE, BOMB THREAT, OR DISASTER.
- 3) REPORT IMMEDIATELY TO YOUR SUPERVISOR HAZARDS OR VIOLATIONS OF SAFETY STANDARDS, SUCH AS IN THE FOLLOWING EXAMPLES:
 - A) DEFECTIVE EQUIPMENT;
 - B) CARELESS USE OF EQUIPMENT;
 - C) OBSTRUCTION TO EXIT DOORS, CORRIDORS, ENTRY WAYS OR ENTRY DOORS TO PATIENT ROOMS, OFFICES, OR DEPARTMENTS;
 - D) SMOKING IN UNAUTHORIZED AREAS;
 - E) WET OR SLIPPERY FLOORS;
 - F) COMBUSTIBLE MATERIALS NEAR HEAT OR OPEN FLAMES.
- 4) OBSERVE SAFETY STANDARDS IN THE USE OF WHEELCHAIRS, STRETCHERS, BEDS, OR OTHER EQUIPMENT RELATED TO PATIENT CARE.
- 5) OBSERVE THE BASIC RULES FOR LIFTING PATIENTS. PROPER BODY MECHANICS SHOULD BE USED WHEN LIFTING OR MOVING PATIENTS. REQUEST ASSISTANCE AS NECESSARY.
- 6) USE CARE WHEN APPROACHING SWINGING DOORS, CONGESTED AREAS, OR TURNING CORNERS. "NEVER RUN".
- 7) REPORT UNAUTHORIZED INDIVIDUALS NEAR OR IN THE FACILITY
- 8) DO NOT OPERATE EQUIPMENT UNLESS YOU HAVE BEEN PROPERLY INSTRUCTED.
- 9) UNPROFESSIONAL CONDUCT WILL NOT BE ALLOWED
- 10) FOLLOW SAFETY PRECAUTIONS IN DISPOSING OF ALL TYPES OF NEEDLES OR OTHER SHARP ITEMS IN THE APPROPRIATE SHARPS PUNCTURE RESISTANT CONTAINERS.
- 11) INJURY RELATED ACCIDENTS ARE TO BE REPORTED IMMEDIATELY TO YOUR SUPERVISOR.
- 12) OPERATE TOOLS AND EQUIPMENT ONLY AFTER INSTRUCTIONS AND PROPER DEMONSTRATION OF PROFICIENCY.

- 13) USE PROTECTIVE CLOTHING/EQUIPMENT WHERE INDICATED, I.E., GOWNS, MASKS, GLOVES, EYE SHIELDS, ETC.
- 14) CLEAN SPILLS IMMEDIATELY.
- 15) DISPOSE OF SHARP OBJECTS, CONTAMINATED TRASH, OR HAZARDOUS MATERIALS IN THE PROPER CONTAINERS.
- 16) FOLLOW PROTOCOL FOR HANDWASHING.
- 17) NEVER OPERATE OR USE ELECTRICAL EQUIPMENT THAT IS NOT PROPERLY GROUNDED, HAS FRAYED CORDS, OR IS MALFUNCTIONING IN ANY WAY.
- 18) MALFUNCTIONING OR BROKEN EQUIPMENT SHOULD BE IMMEDIATELY REMOVED FROM USE, APPROPRIATELY LABELED, REPORTED TO THE SUPERVISOR, AND SUBMITTED FOR REPAIR.



CARSON VALLEY MEDICAL CENTER	Section/number	Revision Date:
Department: Quality	QA 2.004	Revision Date:
Assurance and Risk Management		6/22/09 7/17/09 3/4/11 7/12/11 12/9/11 5/21/12, 2/27/15, 2/26/16, 02/28/17
	New Date:	Reviewed Date: 8/27/10
Title: Patient Safety Program	8/13/08	Pages 1 of 11 pages

PURPOSE:

The purpose of the organizational Patient Safety Program at Carson Valley Medical Center is to improve patient safety and reduce risk to patients through an environment that encourages:

- A Patient Centered approach to care
- Integration of safety priorities into all relevant organization processes, functions and services
- Recognition and acknowledgment of risks to patient safety and medical/health care errors
- The initiation of actions to reduce these risks
- The internal reporting of what has been found and the actions taken
- A focus on processes and systems, and the reduction of process and system failures.
- Minimization of individual blame or retribution for involvement in a medical/health care error
- Organizational learning about medical/health care errors
- Support of the sharing of that knowledge to effect behavioral changes in itself and other healthcare organizations

The Patient Safety Program provides a systematic, coordinated and continuous approach to the maintenance and improvement of patient safety; ongoing proactive reduction in medical/health care errors; and integration of patient safety priorities into the new design and redesign of all relevant organization processes, functions and services.

As we work toward Patient Centered Care, and therefore the maintenance and improvement of patient safety, it is a coordinated and collaborative effort. The approach to optimal patient safety involves all departments and disciplines in establishing the plans, processes and mechanisms that comprise the patient safety activities at Carson Valley Medical Center. The Patient Safety Program

is developed by an interdisciplinary Patient Safety Committee and approved by the Governing Body and administration, outlines the components of the organizational Patient Safety Program.

PATIENT SAFETY PROGRAM:

Scope of Activities:

The scope of the Patient Safety Program includes an ongoing assessment, using internal and external knowledge and experience, to prevent error occurrence, maintain and improve patient safety. Patient safety occurrence information from aggregated data reports and individual incident occurrence reports will be reviewed by the Patient Safety Committee to prioritize organizational patient safety activity efforts. Types of patient safety or medical/health care errors included in data analysis are:

- No Harm Errors - those unintended acts, either of omission or commission, or acts that do not achieve their intend outcome - that do not result in a physical or psychological negative outcome, or the potential for a negative outcome, for the patient.
- Mild-Moderate Adverse Outcome Errors - those unintended acts, either of omission or commission, or acts that do not achieve their intend outcome, that result in an identified mild to moderate physical or psychological adverse outcome for the patient.
- Any Medication Error resulting in an adverse event
- Any Adverse Drug Reaction
- Any Transfusion Reaction
- Hazardous Condition - any set of circumstances, exclusive of the disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious physical or psychological adverse patient outcome.

Sentinel Event –NRS 439.830

“An unexpected occurrence involving facility acquired infection, death or serious physical or psychological injury or the risk thereof, including without limitation, any process variation from which a recurrence would carry a significant chance of a serious adverse outcome. The term includes loss of limb or function.”

- ◆ The event has resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient’s illness or underlying condition.
- ◆ The event is one (1) of the following (even if the outcome was not death or major permanent loss of function):

Reporting Requirements NRS 439.835 Appendix A:

1. Surgical or Invasive Procedure Events

- A. Surgery or other invasive procedure performed on the wrong site
- B. Surgery or other invasive procedure performed on the wrong patient

- C. Wrong surgical or other invasive procedure performed on a patient
 - D. Unintended retention of a foreign object in a patient after surgery or other invasive procedure
 - E. Intraoperative or immediately postoperative/post procedure death in an ASA Class 1 patient
2. Product or Device Events
- A. Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting
 - B. Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended
 - C. Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting
3. Patient Protection Events
- A. Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person
 - B. Patient death or serious injury associated with patient elopement (disappearance)
 - C. Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting
4. Care Management Events
- A. Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)
 - B. Patient death or serious injury associated with unsafe administration of blood products
 - C. Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting
 - D. Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy
 - E. Patient death or serious injury associated with a fall while being cared for in a healthcare setting
 - F. Any Stage 3, Stage 4, or unstageable pressure ulcers acquired after admission/presentation to a healthcare setting
 - G. Artificial insemination with the wrong donor sperm or wrong egg
 - H. Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen
 - I. Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results
5. Environmental Events
- A. Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting
 - B. Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances
 - C. Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting
 - D. Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting

6. Radiologic Events

- A. Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area

7. Potential Criminal Events

- A. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider
 - B. Abduction of a patient/resident of any age
 - C. Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting
 - D. Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting
- Near Miss - any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome.

The scope of the Patient Safety Program encompasses the patient population, visitors, volunteers and staff (including medical staff). The program addresses maintenance and improvement in patient safety issues in every department throughout the facility. There will be an emphasis on important hospital and patient care functions of:

- Ethics, Rights and Responsibilities
- Provision of Care, Treatment and Services
- Medication Management
- Surveillance, Prevention and Control of Infection
- Improving Organization Performance
- Leadership
- Management of the Environment of Care
- Management of Human Resources
- Management of Information

Methodology:

The Patient Safety Committee is responsible for the oversight of the Patient Safety Program. The Director of Operations will have administrative responsibility for the program.

NRS 439.875 A Patient Safety Committee established pursuant to subsection 1 must be composed of:

- (1) The Infection Control Officer of the medical facility.

- (2) The patient safety officer of the medical facility.
- (3) At least three providers of health care who treat patients at the medical facility, including, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility.
- (4) One member of the executive or governing body of the medical facility.

The Patient Safety Committee shall meet at least once each month.

The Patient Safety Committee shall:

- (a) Receive reports from the patient safety officer pursuant to **NRS 439.870**.
- (b) Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred at the medical facility.
- (c) Review and evaluate the quality of measures carried out by the medical facility to improve the safety of patients who receive treatment at the medical facility.
- (d) Review and evaluate the quality of measures carried out by the medical facility to prevent and control infections at the medical facility.
- (e) Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur at the medical facility.
- (f) At least once each calendar quarter, report to the executive or governing body of the medical facility regarding:
 - 1) The number of sentinel events that occurred at the medical facility during the preceding calendar quarter; and
 - 2) The number and severity of infections that occurred at the medical facility during the preceding calendar quarter
 - 3) Any recommendations to reduce the number and severity of sentinel events that occur at the medical facility.
- (g) Adopt patient safety checklists and patient safety policies as required by NRS 439.877, review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

The Patient Safety Officer duties include:

- (a) Serve on and facilitate the patient safety committee.
- (b) Supervise the reporting of all sentinel events alleged to have occurred at the medical facility, including, without limitation, performing the duties required pursuant to **NRS 439.835**.
- (c) Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the medical facility.

(d) Report to the patient safety committee regarding any action taken in accordance with paragraph (c).

(e) Serve on the Occurrence Report 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 Patient Safety Officer and complete an occurrence report. The Patient Safety Officer in conjunction with Risk will aggregate occurrence information and present a report to the Occurrence Report Committee on at least a monthly basis. The report will contain aggregated information related to type of occurrence, severity of occurrence, number/type of occurrences per department, occurrence impact on the patient, remedial actions taken, and patient outcome. The Patient Safety Officer will report this information to the Patient Safety Committee, which will analyze the report information and determine further patient safety activities as appropriate.

- Through review of internal data reports and reports from external sources (including, but not limited to Core Measure performance data, occurrence reporting information from state and federal sources and current literature), and through the Risk Performance Improvement report, the Patient Safety Committee will review Patient Safety occurrences. The Quality Manager, Patient Safety Officer, or Department Leader will:
 - Redesign the process and/or underlying systems to minimize the risk of that undesirable variation or to protect patients from the effects of that undesirable variation
 - Test and implement the redesigned process
 - Identify and implement measures of the effectiveness of the redesigned process
 - Implement a strategy for maintaining the effectiveness of the redesigned process over time
 - Document the process improvement on the CQI form and send to the QA department

The following include description of mechanisms to ensure that all components of the healthcare organization are integrated into and participate in the organization wide program.

Upon identification of a process or system failure and/or medical/health care error, the patient care provider will immediately:

Perform necessary healthcare interventions to protect and support the patient's clinical condition.

- As appropriate to the occurrence, perform necessary healthcare interventions to contain the risk to others - example: immediate removal of contaminated IV fluids from floor stock should it be discovered a contaminated lot of fluid solutions was delivered and stocked.

- Contact the patient's family/caregivers to report the incident. Contact the attending physician and other physicians, as appropriate, to report the error, carrying out any physician orders as necessary. Document that this has been done in the medical record.
- Preserve any information related to the error (including physical information). Examples of preservation of physical information are: Removal and preservation of blood unit for a suspected transfusion reaction; preservation of IV tubing, fluids bags and/or pumps for a patient with a severe drug reaction from IV medication; preservation of medication label for medications administered to the incorrect patient. Preservation of information includes documenting the facts regarding the error on an occurrence report, and in the medical record as appropriate to organizational policy and procedure.
- Report the process/system failure or medical/health care error to the staff member's immediate supervisor.
- Submit the occurrence report to the Risk Management Department per organizational policy.

Any individual in any department identifying a process/system failure and/or potential patient safety issue will immediately notify his or her supervisor and document the findings on an occurrence report. The occurrence report will be submitted to the Risk Management Department per organizational policy.

Staff response to process/system failures and/or medical/health care errors is dependent upon the type of error identified:

- No Harm Failures or Errors - (including "no harm" medication errors) - staff will document appropriately in the medical record according to organizational policy, document the circumstances regarding the no harm error on an occurrence report form, submit the form to the Risk Management Department and notify their immediate supervisor.
- Mild-Moderate Adverse Outcome Failures or Errors (including medication errors) - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then preserve any physical evidence as appropriate, notify his/her immediate supervisor, document facts appropriately in the medical record and on an occurrence report - submitting the report to the Risk Management Department per organizational policy.
- Medication Errors - the staff member identifying a medication error (no harm and mild-moderate harm) will complete an occurrence report.
- Adverse Drug Reaction - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then preserve any physical evidence as appropriate, notify his/her immediate supervisor, document facts appropriately in the medical record and on an occurrence report,

submitting the report to the Risk Management Department per organizational policy. Staff will also notify the Pharmacy Department.

- Transfusion Reaction - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then follow the Suspected Transfusion Reaction Nursing Worksheet Policy and Procedure BB-35.
- Hazardous Condition/Patient Safety Issue - as appropriate, and if possible, staff will contain the hazardous condition or patient safety issue. Staff identifying a hazardous condition or potential patient safety issue will immediately notify his or her supervisor and document the findings on an occurrence report. The occurrence report will be submitted to the Risk Management Department and Patient Safety Officer per organizational policy.
- Sentinel Event - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. The staff will also notify the patient's family/caregiver to notify them of the incident and will document all notifications and interventions in the medical record. Staff will then follow the organizational Sentinel Event Policy and Procedure. The Patient Safety Officer will organize a Root Cause Analysis (RCA) as soon as possible after the event.
- Near Miss - staff will report the near miss event to his/her immediate supervisor, describe the facts of the near miss on an occurrence report and submit the report to the Risk Management Department.

Established organizational policy (such as the Sentinel Event Policy) and/or the Patient Safety Committee and the Environment of Care Committee will determine the organizational response to process/system failures and/or medical/health care errors and occurrences. All sentinel events and other occurrences as deemed appropriate will have a root cause analysis conducted. The determination of the Patient Safety Committee and the Quality Committee members, based on internal and external data analysis and prioritizing of patient safety criticality, will determine:

- Further remedial action activities necessary for identified occurrences
- Proactive occurrence reduction activities
- Necessity and benefit of root cause analysis performance for identified occurrences or proactive reduction activities
- An effective Patient Safety Program cannot exist without optimal reporting of process/system failures and medical/health care errors and occurrences. Therefore, it is the intent of this institution to adopt a non-punitive approach in its management of failures, errors and occurrences. ***See reporting of occurrences and sentinel events policy #2.025***
- All personnel are required to report suspected and identified medical/health care errors, and should do so without the fear of reprisal in relationship to their employment. This organization supports the concept that errors occur due to a

breakdown in systems and processes, and will focus on improving systems and processes, rather than disciplining those responsible for errors and occurrences. A focus will be placed on remedial actions to assist rather than punish staff members using the Just Culture method, with the Patient Safety Committee and the Environment of Care Committee and the individual staff member's department supervisor determining the appropriate course of action to prevent error recurrence.

- Sentinel Events – Quality Assurance and Risk Management encourages the staff member's involvement in the root cause analysis and action plan processes, to allow the staff member an active role in process resolution. Additionally, any staff member involved in a sentinel event or other medical/health care error may request and receive supportive personal counseling from the Human Resources Department and/or his or her department supervisor (Refer to the Critical Incident Stress policy).
- The Patient Safety Program includes implementation of the recommendations set forth by the Joint Commission, or identified alternative recommendations defined by this institution, to achieve compliance with the Joint Commission established National Patient Safety Goals. The selected recommendations will be monitored on a routine basis to evaluate the organization's effectiveness in the implementation of the recommendations in achieving compliance with the identified National Patient Safety Goals.
- Patients, and when appropriate, their families are informed about the outcomes of care, including unanticipated outcomes, or when the outcomes differ significantly from the anticipated outcomes. ***See Managing the Disclosure of Unanticipated Outcomes policy # 2.049.***
- Observation will be used ensure compliance with patient safety checklists and will offer opportunities for corrective feedback. This approach is a learning opportunity not intended for disciplinary purposes. ***See Active Surveillance of Patient Safety Checklist Use policy # 2.030.***
- Staff will receive education and training during their initial orientation process and on an ongoing basis regarding job-related aspects of patient safety, including the need and method to report medical/health care errors. And, because the optimal provision of healthcare is provided in an interdisciplinary manner, staff will be educated and trained on the provision of an interdisciplinary approach to patient care.
- Medical/health care errors and occurrences, including sentinel events, will be reported internally and externally, per hospital policy and through the channels established by this plan. External reporting will be performed in accordance with all state, federal and regulatory body rules, laws and requirements.

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

Subject: **VIII - Patient Safety Plan**

I. PURPOSE:

The purpose of the Patient Safety Plan is to outline the process for implementing a patient safety program at Western Nevada Surgical Center (WNSC) that supports the proactive reduction of medical / health care errors as well as an effective response to actual occurrences.

II. POLICY:

It is the policy of Western Nevada Surgical Center to promote the reduction of risks to patients through an integrated and coordinated organization-wide approach. The Governing Body is committed to providing the resources, delegating responsibility, and acting on reports to provide a systematic program designed to effectively reduce errors and other factors that lead to unanticipated adverse patient outcomes.

Administration shall provide an environment in which patients, their families, facility staff, managers and physicians are encouraged to identify, report and manage both actual and potential risks to patient safety. The program shall be non-punitive in nature, focusing on processes, procedures and systems rather than individuals.

III. SCOPE:

The objectives include:

- A. To recognize risks to patient safety and sources of medical/health care errors and to initiate actions to proactively reduce these risks;
- B. To encourage learning about errors and share this knowledge to improve patient safety ;
- C. To encourage internal reporting of errors and issues;
- D. To focus on the improvement of processes and systems associated with medical/health care errors; and
- E. To minimize individual blame or retribution for involvement in a medical / health care error.
- F. To review and implement the Patient Safety goals
 - Improve the accuracy of patient identification
 - Improve the effectiveness of communication among caregivers
 - Improve the safety of using high-alert medications
 - Eliminate wrong-site, wrong-patient and wrong-procedure surgery
 - Improve the effectiveness of clinical alarm systems

IV. AUTHORITY & RESPONSIBILITY:

- A. Governing Body – The Governing Body of WNSC has the ultimate responsibility for patient safety. To fulfill the commitment to patient safety, the board delegates

Subject: VIII - Patient Safety Plan

the responsibility for identifying, analyzing and managing patient safety activities to administration, management, supervisors, medical staff and employees. The Governing Body recognizes that proactive management of patient safety is a continuous, ongoing process; therefore they will provide the necessary resources to carry out this philosophy. Through the development of strategic initiatives, the Governing Body provides direction for the organization's improvement activities. Reports from the Utilization Review/Quality Improvement Committee provide the Board with a means of evaluating the organization's effectiveness in reducing risks to patient safety.

- B. Administration and Managers – Administration and managers are responsible for supporting the Patient Safety Plan and the risk reduction efforts of the organization. These efforts are given a high priority, especially when processes are designed or redesigned. To support these activities the organization will provide:
- Adequate resources;
 - Staff to participate in risk reduction activities;
 - Adequate time for staff to participate;
 - Adequate information systems and data management systems; and
 - Staff education regarding risk reduction strategies.
- C. Medical Staff -The Medical Staff is involved in patient safety activities by participation in the Utilization/Quality Improvement Committee..

V. MEDICAL/HEALTH CARE ERROR AND NEAR MISS REPORTING

- A. Definitions:
- Error – an unintended act, either of omission or commission, or an act that does not achieve its intended outcome.
 - Near Miss - used to describe any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome.
- B. In response to a medical/health care error, appropriate steps will be taken in the care of the patient to minimize negative outcomes. Any appropriate steps that would decrease the possibility of the error occurring again, or that would protect others from the risk, will be implemented immediately.
- C. The physician or his/her designee will clearly explain the outcome of any treatments or procedures to the patient and/or family members as soon after the incident as is possible and appropriate whenever those outcomes differ significantly from the anticipated outcomes.
- D. When a medical/health care error occurs that has caused harm to a patient, staff members will immediately notify the Administrator. The Administrator is then responsible for notifying the appropriate organizational leaders .

Subject: **VIII - Patient Safety Plan**

- E. When a medical/health care error or near miss occurs, a staff member involved in the occurrence will complete an Incident Report and Follow-Up.
- F. The Nurse of the department where the error or near miss occurred will begin the preliminary analysis. All information obtained during the analysis will be reported to the Administrator.
- G. Care will be taken at the time that an error or near miss occurs to preserve any information or evidence that may be helpful in the analysis of the error.
- H. Depending on the nature and severity of the medical/health care error, the appropriate external authorities (such as the Food and Drug Administration (FDA), National Institute Occupational Safety Administration (NIOSA), United States Pharmacopeia (USP), Nevada Department of Health) will be notified of the error. The Administrator will discuss the details of each case with appropriate staff to determine what authorities need to be notified.
- I. Data related to medical/health care errors will be aggregated , analyzed across the organization to identify patterns and trends and appropriate action implemented.

VI. NEW AND REVISED PROCESSES

Patient safety is given high priority at Western Nevada Surgical Center. Patient safety considerations must be an integral part of the development of new policies, procedures, systems and services. When existing policies, procedures, systems and services are revised and re-evaluated, patient safety considerations will be addressed.



PATIENT SAFETY PLAN

2018

Effective: February 2005 (combines Organization Safety and Patient Safety Plans)
Revised: October, 2005
Revised: December, 2006
Revised: December, 2007
Revised: January, 2009
Revised: January, 2010
Revised: January, 2011
Revised: January, 2012
Revised: February, 2014
Revised: November 2014
Revised: November 2015
Revised: December 2016
Revised: December 2017

INTRODUCTION

Carson Tahoe Regional Healthcare/ Regional Medical Center is a part of Carson Tahoe Health System, a Nevada not-for-profit hospital. We are committed to patient safety, quality patient care and quality patient outcomes consistent with our Mission and Core Values.

MISSION

To enhance the health and well being of the communities we serve.

CORE VALUES

Putting patients first

Treating everyone with dignity and respect.

PURPOSE

The Patient Safety Plan provides a planned, systematic, coordinated approach for continually improving the health and safety of patients who are treated at the medical facility, by reducing patient harm and maintaining a safety culture.

PLAN

- Establish Patient Safety Committee:
 - Mandatory 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
 - Additional non required members include: Quality Director, Chief Medical Officer, In-House Council, Environmental Safety Officer, Nursing Director.
 - Ad-Hoc invitees as appropriate
 - Committee required to meet at least once per month
- Inclusion of
 - Infection Control Program to prevent and control infections within the medical facility (this is a document separate from the Patient Safety Plan that meets the requirements for NRS 439.865)
 - Patient Safety checklists and patient safety policies as required by NRS. 439.877
 - 2018 Checklist Inventory *Attachment A*
 - Annual review and revision of checklists and policies
- Annual Report to Legislative Committee on Health Care
- Integration of all patient safety activities both ongoing and developing
- Ongoing orientation, education and training to emphasize specific job related aspects of patient safety to maintain and improve staff awareness

- Encourage internal reporting of medical / healthcare incidents and events, effectively respond to actual occurrences, manage occurrences and events with a non-punitive approach, and focus on processes and systems to minimize individual blame and retribution
- Periodic survey of the staff regarding willingness to report, actions taken and outcomes of occurrences and events
- Internal reporting of findings, actions taken and resolution; organizational learning and communication of occurrence and event information
- Consideration of patient safety priorities when designing and redesigning of relevant processes, functions and services

Involvement and education of patients, their families about their role in facilitating safe delivery of care, identifying potential risks and suggesting improvement to patient safety

SCOPE OF ACTIVITIES

The Patient Safety Committee integrates all components of safety into the organization-wide safety program in collaboration with Quality, Environmental Safety, Infection Control, Patient Care areas, Risk Management, Compliance and Ethics.

Patient Safety Committee activities include:

- Sentinel Events pursuant to NRS Chapter 439
 - Review alleged events reported to State of Nevada, RCA investigations and resulting action plans.
 - Recommendations, as appropriate, to the executive or governing body for reducing the number and severity of sentinel events and infections that occur
 - Provide emotional support for staff involved in incidents or events, through Human Resources, leadership, department supervisors and other resources as appropriate
 - Report at least quarterly to the executive or governing body
 - The number of sentinel events occurring in the previous quarter
 - The number/severity of infections occurring in the previous quarter
- Quality Measures: Review and evaluate
 - To improve the patient safety and outcomes
 - To reduce and/or prevent infections
- Monitor patient/ environment safety issues identified throughout the organization
- Promote internal and external knowledge and experience to prevent patient harm, adverse events and occurrences, to maintain and improve patient safety
- Dashboard Trending Report: Review aggregated or trended data including but not limited to: No harm events, Mild or moderate adverse outcomes, Near miss, Medication events, Falls, Adverse drug reactions, Transfusion reactions, Hazardous conditions, Present on admission / Hospital acquired conditions, Online incident reports, adding Restraint indicators for 2018
- Utilize a proactive approach to recognize and acknowledge medical/healthcare events and risks to patient safety, initiate actions and recommendations to reduce or prevent these events and risks
- Prioritize and recommend Patient Safety activities, as appropriate.
 - Utilizing trended data from Environmental safety, Security, Employee

health, Emergency management, Lab or radiation safety, Utilities management, Bio Med, Fire drills or inspections.

PATIENT SAFETY OFFICER

The Patient Safety Officer is designated by the medical facility and has administrative responsibilities as prescribed by NRS chapter 439 (specifically outlined in NRS 439.815 through NRS.439.875) and by other regulatory agencies and accrediting bodies. Duties and responsibilities include but are not limited to:

- Serving 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.

Attachment A

Carson Tahoe Regional Medical Center 2018- Checklist Inventory			
	Checklist title	Checklist Category	DEPT
2	Discharge Checklist for patient	Discharge	BHS
4	Discharge Checklist for Nursing	Discharge	BHS
5	Fire Drill Participation	Environment	Housewide - Security
6	Fire Report	Environment	Security
7	Fire Watch Form	Environment	Security
8	Life (Fire) Safety Inspection / Business Occupancy	Environment	Security
9	Life (Fire) Safety Inspection /Healthcare Occupancy	Environment	Security
Patient Room Housekeeping Checklist by area /by shift			
10	Form 100 Lead/Admin	Environment	Housekeeping
11	Form 101 Med Onc B / Rehab Telemetry	Environment	Housekeeping
12	Form 102 Med Onc A & Pharmacy	Environment	Housekeeping
13	Form 103 Tele & Therapy Med Onc B Therapy Gym	Environment	Housekeeping
14	Form 104 OB / Peds	Environment	Housekeeping
15	Form 105 Surg Ortho	Environment	Housekeeping
16	Form 106 ICU/CVU	Environment	Housekeeping
17	Form 107 ER /OBS / Fast track Days	Environment	Housekeeping
18	Form 108 OR days	Environment	Housekeeping
19	Form 109 Cath Lab /Outpatient Days	Environment	Housekeeping
20	Form 110 Areas to "police" Public Area	Environment	Housekeeping
21	Form 111 Waste Management Days	Environment	Housekeeping
22	Form 112 BHS Check Sheet	Environment	Housekeeping
23	Form 113 Senior Pathways & BHS Outpatient BHS "C" unit	Environment	Housekeeping
24	Form 114 Projects / Floor Care Floor Care / Police	Environment	Housekeeping
25	Form 200 Lead	Environment	Housekeeping
27	Form 202 Tele / OB Swing	Environment	Housekeeping
28	Form 203 Surg Ortho Swing Swing Surg/Ortho CVU and ICU	Environment	Housekeeping
29	Form 204 ICU / CVU Swing	Environment	Housekeeping
30	Form 205 ER / OBS Fast track Swing	Environment	Housekeeping
31	Form 206 OR Swing	Environment	Housekeeping
32	Form 207 X ray / Cath / Outpatient Swing Cath Lab/Xray Outpatient	Environment	Housekeeping

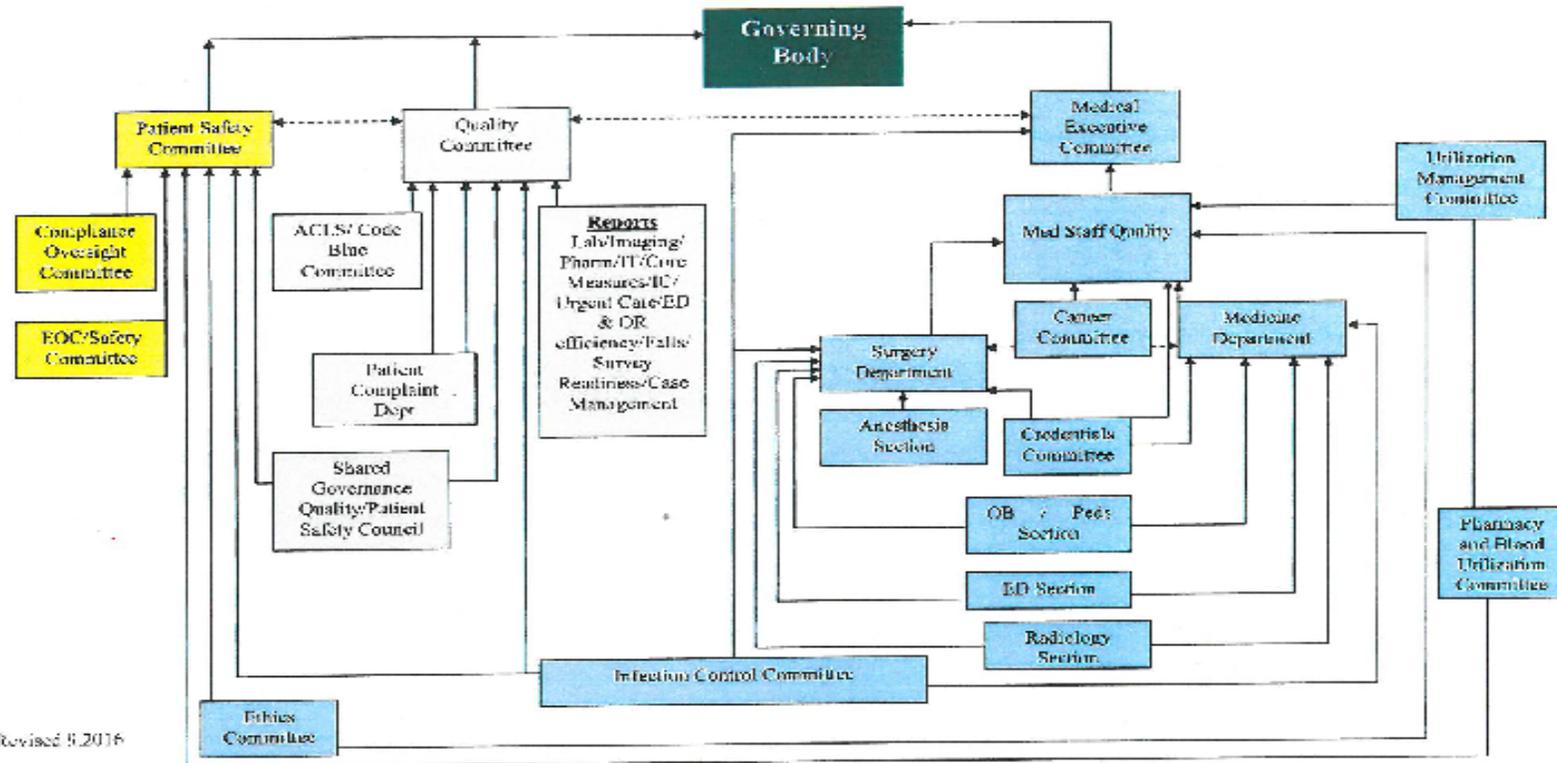
Carson Tahoe Regional Medical Center 2018- Checklist Inventory			
33	Form 208 Waste Management Swing	Environment	Housekeeping
34	Form 209 SMC First floor	Environment	Housekeeping
35	Form 210 Cancer / Merriner	Environment	Housekeeping
36	Form 211 Minden check list	Environment	Housekeeping
37	Form 212 Mica Surgery / Pain Clinic	Environment	Housekeeping
38	Form 213 Projects / Floor Care	Environment	Housekeeping
39	Form 214 Projects / Floor Care	Environment	Housekeeping
40	Form 215 Projects / Floor Care	Environment	Housekeeping
41	Form 216 Lab / Offices Swing	Environment	Housekeeping
42	Form 301 ER / OBS / Fast track Grave	Environment	Housekeeping
43	Form 302 OR Grave	Environment	Housekeeping
44	Form 303 Projects / floor Care Basement / Discharges/OR	Environment	Housekeeping
45	Quality Assurance Checklist	Environment	Housekeeping
46	Pediatric Unit Department Checklist	Environment	PEDS
CRASH CARTS			
47	Adult Crash Cart Check List	Other Safety	Housewide
48	New born Nursery Crash Cart Checklist	Other Safety	Housewide
49	OB hemorrhage Cart Checklist	Other Safety	Women's / Children
50	Pediatric Crash Cart Checklist	Other Safety	Women's / Children
51	OB Recovery Room Red Cart	Other Safety	Women's / Children
52	Obstetrics OR checklist	Other Safety	Women's / Children
53	3M Steam Flash Sterilization Log	Other Safety	Housewide
54	AED Checklist	Other Safety	Housewide
55	Breast Milk Refrigerator Temperature Log	Other Safety	Women's / Children
56	Refrigerator / Freezer Temperature Record	Other Safety	Housewide
59	List & Process Monitor Documentation System	Other Safety	GBI
60	Nevada State Immunization Program Temperature Log	Other Safety	Women's / Children
61	Nursery Blanket Warmer Temperature Log	Other Safety	Women's / Children
63	Obstetrics OR Checklist	Other Safety	Women's / Children

Carson Tahoe Regional Medical Center 2018- Checklist Inventory			
64	OR / RR Blanket Warmer Temperature Log Top Compartment	Other Safety	Housewide
65	Ticket to Ride	Other Safety	Housewide
66	Ventilator Calibration Checklist	Other Safety	Respiratory
67	Admission Checklist Nurse and Tech/Unit Clerk	Other Safety	BHS
68	BHS Unit Safety Rounds Worksheet	Other Safety	Housewide
69	Central Line Associated Blood Stream infection and CAUTI surveillance	Other Safety	Infection Control
69a	CAUTI Bundle Audit data collection	Other Safety	Infection Control
70	Emergency Equipment checklist	Other Safety	ICU
71	Urgent Heart Chart Daily checklist	Other Safety	ICU
72	Hand Hygiene Compliance monitoring	Other Safety	Infection Control
72a	Hand Hygiene Compliance monitoring		
73	Infection control Monitoring during construction	Other Safety	Infection Control
74	Patient Observation Checklist	Other Safety	Security
76	AMA Intervention checklist	Other Safety	BHS
76a	AMA bullet point		
79	Shift Checklist for Nursing staff	Other Safety	BHS
80	Chemotherapy Administration check list	Other Safety	Med Onc
81	Pre-Op/Circ./PACU - Chart Deficiency Check list	Treatment	Surgical areas
82	Hand Off Communication sheet Pre-op/OR/PACU	Treatment	Surgical areas
87	Magnetic Resonance Imaging History & Assessment	Treatment	Medical Imaging
88	Medical Imaging Invasive Procedure Checklist	Treatment	Medical Imaging
88a	Medical Imaging Invasive Procedure Checklist GBI		
89	Non Ionic and/or Ionic Contrast Consent Form	Treatment	Medical Imaging
91	Pre Cath / Vascular Lab Checklist	Treatment	Cath Lab
92	Pre-Op Education	Treatment	Mica Surgery

Carson Tahoe Regional Medical Center 2018- Checklist Inventory			
93	PsychoSocial Treatment Plan tracking form	Treatment	BHS
94	Sharp Contraband Tracking Form	Treatment	BHS
95	Surgical Checklist (part of Medical record)	Treatment	Surgical areas
96	Universal Protocol Checklist / Handoff communication	Treatment	Surgical areas not SSH
97	Universal Protocol Checklist for Injection Procedures	Treatment	Surgical areas not SSH
98	Foley Catheter Tracking	Treatment	Infection control
New forms added to checklist			
100	Pre –Op / Procedural check list (16599 1/18/11)	Other Safety	Surgical area not SSH
101	Carson Tahoe Emergency Department Triage Protocol	Other Safety	Emergency Dept
102	Carson Tahoe Emergency Department Stroke Protocol Physician Guidelines	Other Safety	Emergency Dept
103	HERT Team Leader Checklist	Other Safety	Emergency Mgmt
104	HERT Activation Checklist	Other Safety	Emergency Mgmt
105	HERT Ambulatory & Nonambulatory set up Checklist	Other Safety	Emergency Mgmt
106	Dirty Water Set-Up Checklist	Other Safety	Emergency Mgmt
107	HERT Triage / Morgue Set up Checklist	Other Safety	Emergency Mgmt
108	HERT Tent Set-Up Checklist	Other Safety	Emergency Mgmt
109	HERT Receiving checklist	Other Safety	Emergency Mgmt
110	HERT Dirty Water Set up Checklist	Other Safety	Emergency Mgmt
41a	217 Tele, Med OncA & Pharmacy Swing	Housekeeping	
44a	304 Projects / Floor Care	Housekeeping	
111	Use or Personal Protective Equipment (PPE) for isolation precautions	Other Safety	Infecton control
112	RMC Daily Visual air Pressure Vaneometer Monitoring for Isolations rooms	Other Safety	Infection control
113	Patient Room Safety Inspection	Other Safety	
56a	Refrigerator Temperature Record	Other Safety	
56b	Freezer Temperature Record	Other Safety	

	Carson Tahoe Regional Medical Center 2018- Checklist Inventory		
64a	Blanket Warmer Bottom Compartment	Other Safety	

Carson Tahoe Regional Health Quality Reporting Structure



Revised 9/2016

**Draft Policy**

Policy#: 180	Title: Patient Safety Plan	Category: Plans
Policy Status: Draft	Effective Date: N/A	Last Reviewed Date: N/A

PROCEDURE INSTRUCTIONS**PURPOSE:**

The purpose of the Patient Safety Program is to improve patient safety and reduce risk to patients, staff and visitors. Recognizing the effective medical/health care error reduction requires an integrated and coordinated approach; we have developed an organization-wide safety program. The program supports the creation of an environment in which patients, their families, and organization staff leaders can identify and manage actual and potential risks to patient safety.

OBJECTIVE:

It is our objective to foster an environment to improve patient safety, establish mechanism to support effective responses to actual occurrences and to be proactive in the reduction of medical/health care errors. Patient safety will be a priority in new design and all relevant organization processes, functions and services.

SCOPE:

The scope of the patient safety program will include compliance with standards identified by external regulatory agencies and accrediting bodies. Program activities will address occurrences ranging from "near misses" to sentinel events with serious adverse outcomes.

DEFINITIONS:

Actual Event-an event occurred that reached the patient or individual (e.g., visitor fall, student injury, etc.).

Near Miss-an event occurred but it did not reach the patient because of chance alone or because of active recovery efforts by caregivers.

Unsafe Condition- circumstances that could cause adverse events (e.g., look-alike medications, confusing equipment, failure to use proper signage when floor is wet).

Sentinel Event- is defined as a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in any of the following:

- Severe temporary harm which is defined as critical, potentially life-threatening harm lasting for a limited time with no permanent residual effect, but requires transfer to a higher level of care/monitoring for a prolonged period of time, transfer to a higher level of care for a life-threatening condition, or additional major surgery, procedure, or treatment to resolve the condition. (Hip fractures are always included)
- Permanent harm
- Death

For additional events also considered "sentinel" reference the HealthSouth Sentinel Event policy

PROCEDURES:

A. The responsibility for management of the organization-wide patient safety program is assigned to the Director of Quality/Risk Management.

1. The Safety Committee and Quality Council will provide interdisciplinary input related to patient, visitor and staff safety.
2. Reports of safety related activities and issues would be presented to Department Managers, Senior Staff, Medical Staff via the Medical Executive Committee, and the Governing Board. This communication is confidential and for quality assurance purposes only.

B. Staff will report information relating the medical/health care events as outlined in Risk Management Electronic Event Reporting Policy.

1. Staff will be oriented to the Risk Management Policies on hire and through ongoing in-service and other education and training programs.
2. Staff will be oriented to their roles in preventing adverse occurrences as related to their specific job responsibilities and as a part of the organization-wide efforts to improve patient safety.
3. Staff will be oriented to the importance of reporting "near misses," as well as adverse occurrences.
4. Team training to foster an interdisciplinary, collaborative approach to patient care delivery and to reinforce the need and way(s) to report medical/health care errors will be provided as appropriate.
5. The Director of Quality/Risk Management, Department Managers, and Senior Staff are responsible for interacting with staff in a manner that ensures staff do not fear disclosure, embarrassment, blame or punishment for reporting potential or actual events related to patient safety.
6. The Director of Quality/Risk Management, Department Manager and/or Senior Staff member may request the assistance of internal behavioral management staff or external resources if a staff member(s) needs support in coping with a sentinel event.

C. Hospital leadership will identify barriers to effective communication among caregivers relative to patient care, redesign the process to eliminate barriers and monitor for effectiveness. Specific attention will be directed to:

1. Process for ensuring accurate, timely, and complete verbal and written communication among care givers and all others involved in utilization of data, and
2. Test results relative to the management of the patient's condition.

D. All patients are entitled to information about all aspects of their health care, including information about clinically relevant unanticipated outcomes of care.

Patients and, when appropriate, their families are informed about the outcomes of care including unanticipated outcomes (i.e. sentinel events, State reportable events). Responsibility for disclosing unanticipated outcomes typically rests with the physician or designee who has overall responsibility for the patient's care. However, in some situations, other healthcare professionals may be deemed more appropriate to be responsible for disclosing the outcome. A hospital representative, preferably the Quality/Risk Director, Chief Nursing Officer or the Chief Executive Officer should be present for the initial conversation and any follow-up discussions that may occur with the patient and/or patient's representative.

E. The Director of Quality/Risk Management or designee will respond immediately to notification of significant medical/health events to a patient/visitor or staff member.

1. The Nursing Supervisor or Department Manager will contact the Risk Manager and/or Administrator/Administrator-On-Call to report events.
2. Action(s) will be taken to protect the patient/visitor/staff members as indicated per hospital plans and policies.

3. Factual information will be obtained and preserved for subsequent analysis. Such information is confidential for quality assurance purposes.

F. The facility will review historical risk management, Environment of Care (EOC), Program Improvement (PI) and Human Resources (HR) data for high volume, high risk problem trends in medical and care processes, as well as unanticipated adverse occurrences affecting patients. These will be ranked as:

- A. Unsafe condition (Non-event)
- B1. Near Miss - No Harm/Didn't Reach Patient/Caught by Chance
- B2. Near Miss - No Harm/Didn't Reach Patient b/c of Active Recovery by Caregiver
- C. No Harm - Reached Patient No Monitoring Required
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- E. Harm - Temporary, Intervention Needed
- F. Harm - Temporary, Hospitalization Needed
- G. Harm - Permanent
- H. Harm - Permanent, Intervention Required to Sustain Life
- I. Death

G. The facility will also perform intense analysis consistent with the Root Cause Analysis/Sentinel Event Policies, and reports as required by state, regulatory, and accreditation bodies. The Risk Management designee is responsible for ensuring compliance with reporting.

H. Emerging needs requiring reprioritizing performance improvement activities may be identified through data collection and assessment, unanticipated adverse occurrences affecting patients, changing regulatory requirements, significant patient and staff needs, changes in the environment of care, or changes in the community. Priority consideration in establishing performance improvement teams is given to:

1. Processes that affect a large percentage of patients.
2. Processes that place patients at risk, if not performed well, if performed when not indicated, or if not performed when indicated.

Processes that have been or are likely to be problem prone.

I. When designing/redesigning processes, Department Managers and staff will:

1. Incorporate information from within the organization and from other organizations about potential risks to patients, including the occurrence of sentinel events in order to minimize risks to patients affected by the new or redesigned process, function or service.
2. Conduct literature searches to obtain evidence based medical and/or care practices to be included in process redesign.
3. Include analysis and or pilot testing to determine whether the proposed design/redesign is an improvement.

J. Hospital leadership will consider the importance of patient safety in:

1. Development of hospital-wide patient care programs, policies and procedures that describe how patients' care needs are assessed and met.
2. Development and implementation of the hospital's plan for the provision of patient care.
3. Decision-making structures and processes.
4. Implementation of an effective and continuous program to measure assesses and improves performance.
5. Development of an interdisciplinary culture that emphasizes cooperation and communication. The leadership role of coaching will be used to promote communication among services, individual staff members and less formal structures such as quality action teams, performance-improvement teams or members of standing committees.
6. Development of a process to involve the patient, as appropriate to his/her condition, as a partner in helping to facilitate the safe delivery of care.
 - a. Patients/family members are oriented on admission of the importance of reporting perceived risks and concerns about the patient's care per Patient and Customer Complaint and Grievance Policy.

b. Department Managers and Senior Staff will review Press Ganey Patient Satisfaction Survey questions related to patient safety and develop a corrective action plan to patient/family complaints or suggestions for improving safety as appropriate.

7. The Governing Board will appoint the Director of Quality and Risk Management (DQR) as the Patient Safety Officer. The Patient Safety Officer/Director's role includes:

- Participating in hazard surveillance, event reporting, reviewing, and the development of patient safety policies and procedures.
- Analyzing and seeking resolution of patient safety issues and works with the appropriate staff to implement recommendations and to monitor patient safety improvement activities.
- Report on findings, recommendations, actions taken, and results of measurements through the hospital quality structure.

K. At least one (1) high-risk process is the subject of ongoing measurement and periodic analysis to determine the degree of variation from intended performance, a minimum of 1 proactive risk assessment every 18 months. The process selected will be based, in part, on the information identifying the most frequently occurring sentinel events and patient safety risk factors.

1. Assess the intended and actual implementation of this process to identify steps in the process where there is, or may be, undesirable variation (i.e. called potential "failure modes").
2. For each identified "failure mode," identify the possible "effect(s)" and how serious the possible effect on the patient could be (i.e. "criticality" of the effect).
3. For the most critical effects, conduct a root cause analysis to determine the variation (failure mode) leading to that effect occur.
4. Redesign the process and/or underlying systems to minimize the risk of that failure mode to protect patients from the effect of that failure mode.
5. Test and implement the redesigned process.
6. Identify and implement measures of the effectiveness of the redesigned process.
7. Implement a strategy for maintaining the effectiveness of the redesigned process over time.

L. Hospital leadership will measure and assess the effectiveness of their contributions to improving patient safety. To accomplish these goals, leaders will.

1. Set measurable objectives for improving patient safety.
2. Actively request staff to periodically discuss their opinions, needs, perceptions of risks to patients and suggestions for improving patient safety. The actions taken as a result of this staff input will be reported to the MEC/GB bi- annually.
3. Review data on staff willingness to report medical/health events.
4. Review data from Patient Satisfaction Survey related to patient safety.
5. Use pre-established, objective process criteria to assess their effectiveness in improving patient safety.
6. Draw conclusions based on their findings and develop and implement improvement in their activities.
7. Evaluate their performance in supporting sustained improvement.

M. The DQR will report at a minimum quarterly to the Governing Board occurrences of medical/health events and actions to improve patient safety.

PROCEDURE

PROCEDURE INSTRUCTIONS

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7. Evaluate their performance in supporting sustained improvement.

M. The DQR will report at a minimum quarterly to the Governing Board occurrences of medical/health events and actions to improve patient safety.

N. The DQR will report any sentinel event within the allotted timeframe to the Nevada Division of Public and Behavioral Health via "RedCap" along with reporting to corporate risk management.

**Dignity Health – St. Rose Dominican
San Martin Campus
PATIENT SAFETY/RISK MANAGEMENT PLAN**

DATE: 01/01/2018
VERSION: 01



This plan was created and revised by the Dignity Health – St. Rose Dominican Patient Safety Officer with review and input from the Patient Safety Committee. Implementation of this plan is intended to optimize the healthcare quality and patient safety outcomes, encourage recognition, reporting, and acknowledgment of risks to patient, visitor, and employee safety, as well as reduce the medical/healthcare errors and /or preventable events.

Patient Safety Committee/Program
St. Rose Dominican – San Martin Campus
8280 West Warm Springs Road
Las Vegas, NV 89113
702.616.5552

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Commitment to Patient Safety

Dignity Health St. Rose Dominican Hospital – San Martin Campus is committed to a comprehensive approach to improving healthcare quality and patient safety by aligning with our Mission, Vision, and Values, creating an environment that supports a dynamic, proactive, and safe 2018 for patients, family members, visitors, and employees, through continuous learning and improving patient safety policies, systems, and processes.

Mission, Vision, and Values

In support of our mission, vision, and values, Dignity Health – St. Rose Dominican, San Martin Campus' Patient Safety/Risk Management program promotes:

- Honest, open collaboration and partnership of hospital leadership, medical staff, patients and their families, the community and other healthcare providers to deliver compassionate, high-quality, affordable healthcare.
- Promote justice and respect for those we serve.
- Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.
- Responsibility and accountability for every healthcare related decision and action.
- A focus on excellence, teamwork and innovation through continuous learning, improvement in system design, and the management of choices and changes, bringing the best possible outcomes or performances to the facility.
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare.
- Education of staff and physicians to assure participation of healthcare providers.

Scope and Purpose

The Patient Safety/Risk Management Program at St. Rose Dominican is an organization-wide/campus specific strategy that includes not only facility staff and medical staff, but is inclusive of patients, family and visitors. The Patient Safety/Risk Management Program at San Martin Campus supports and encourages the active participation of each person in order to be an effective program. When processes, functions or services are designed or redesigned, information internal and external to the campus and/or organization regarding potential risks to patient safety will be considered and where appropriate, utilized to minimize the risk to patients affected by the new or redesigned process, function or services.

The purpose of this plan is to establish system-wide guidelines and processes supporting a comprehensive, effective, organization-wide Patient Safety/Risk Management Program Plan designed to promote and improve patient safety at Dignity Health – St. Rose Dominican, San Martin Campus, by working to prevent medical/healthcare adverse events and reducing risk to patients and visitors.

Undesirable facility specific and system patterns or trends in performance and sentinel events will be intensively analyzed to determine where best to focus changes for improvement. Intensive analysis will be initiated when:

- Levels of performance, patterns or trends vary significantly and undesirably from those expected including significant near misses;
- Performance varies significantly and undesirable from that of other campuses/organizations;
- Performance varies significantly and undesirably from recognized standards; and/or
- A reportable event has occurred at that campus.

Minimally, data from the following areas will be gathered at each facility and presented at that facility for analysis with action plans developed reflective of the findings:

- Initial and on-going proactive risk assessments utilizing internal and external resources;
- Campus aggregate event reports reflective of all medical/healthcare events, with and without adverse outcomes, including but not limited to:
 - Hospital acquired infections
 - Medication events, to include delays in administration
 - Adverse drug events
 - Transfusion reactions
 - Patient falls
- Actual and near misses
- Hazardous conditions
- Restraint issues
- Medical record legibility issues
- Patient/family/staff opinions, needs, perceptions of risks to patients, and suggestions for improving patient safety;
- Identified data trends and analysis reports from sister facilities, Dignity Health Shared Learnings, etc.
- Others as defined by various campus committees, Leadership and/or Quality Council and Advisory Committee of the Board (QCAC).

Roles and Responsibilities

Per [NRS 439.875](#), a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plan is promoted and executed successfully.

The Patient Safety Committee Organization

Roles and Responsibilities

- In accordance with [NRS 439.875](#), a patient safety committee must be comprised of:
- The infection control officer of the medical facility;

- The patient safety officer of the medical facility, if he or she is not designated as the infection control officer;
- At least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility; and
- One member of the executive or governing body of the medical facility.

The roles and responsibilities are defined below.

Patient Safety Committee Responsibilities (based on [NRS 439.875](#) and [NRS 439.877](#))

The Patient Safety Committee convenes monthly in accordance with NRS 439.875. In collaboration with the Patient Safety Officer, the committee represents the San Martin Campus and includes multidisciplinary team members which has oversight responsibility to ensure that the responsibilities and functions outlined in this program are carried forward throughout the organization. The following are responsibilities assigned:

- Serve as champions of the Patient Safety/Risk Management Program within the facility/organization.
- Establish and evaluate data to identify patient safety performance indicators.
- Evaluate other sources of patient safety data utilizing internal and external resources including but not limited to adopted patient safety checklists, risk assessments, sentinel event report/alert information and event reporting information from a variety of available resources including the event reporting system, APIC, CHPSO, etc.;
- Selection of a high-risk patient safety process for proactive risk assessment and improvement annually;
- Collaborates with each facility's Quality Council to identify, address and conduct follow-up on patient safety related trends, analysis results, changes in processes, and policies.
- Annual review of the Patient Safety Program to ensure its appropriateness of focus and effectiveness of efforts for each campus.
- Monitor and document the effectiveness of the patient identification policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the patient safety officer pursuant to [NRS 439.870](#).
- Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred.
- Review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- Review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur.

- At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the executive or governing body of the facility regarding:
 - (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);
 - (2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and
 - (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

Root Cause Analysis (RCA) Team Responsibilities

- Root Cause interviews, analysis, investigation, and corrective action plan implementations.
- Participates in the RCA meetings and discussions.
- Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders.
- See Quality Department's Performance Improvement Plan

Patient Safety Officer Responsibilities (based on [NRS 439.870](#))

The 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 including:

- Serve on the patient safety committee.
- Supervise the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the patient safety committee regarding any action taken in accordance with the responsibilities above.
- Day to day responsibility for the Patient Safety/Risk Management Program at San Martin Campus.
- Maintenance of related data collected, trended and analyzed at each campus.
- Routine reporting to leadership and QCAC on campus specific trended data and actions taken to improve the quality and safety of patient care.
- Working with QCAC to achieve the goals of the Patient Safety/Risk Management Program.

Infection Control Officer Responsibilities (based on [NRS 439.873](#))

- Serve on the patient safety committee.
- Monitor the occurrences of infections at the facility to determine the number and severity of infections.

- Report to the patient safety committee concerning the number and severity of infections at the facility.
- Take such action as determines is necessary to prevent and control infections alleged to have occurred at the facility.
- Carry out the provisions of the infection control program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program.

RCA team leader Responsibilities

- Organize and coordinate the RCA process.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA, and corrective action plan implementation process.
- Communicate the progress of the investigation, institutional barriers, and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.
- Provide training, education and direction to create RCA process that incorporates the Patient Safety and Quality Improvement elements.

RCA Facilitator Responsibilities

- Identify RCA participants and coordinate a time, date and location of RCA meeting.
- Inform RCA participants of the sentinel event process.
- Explain confidential nature of RCA.
- Explain Just Culture and its application.
- Review event using medical record and any other pertinent materials in preparation for the RCA.
- Provide RCA members access to relevant best practice/research documents/statutes and other literature to include hospital Policy and Procedure documents for reference.
- Conduct RCA in a manner consistent with Just Culture, using principles of human factors, systems theory, etc.

Executive or Governing Body Staff Responsibilities

Provide vision and leadership to Patient Safety and Quality Improvement process, and develop and foster a safe learning and improving culture.

- Provides oversight to the healthcare quality improvement processes and teams.
- Plan, discuss, and generate the organization patient safety goals and activities, in conjunction with the patient safety action plans.

Leadership

The Dignity Health St. Rose Dominican Board and campus Senior Leadership has overall responsibility for the implementation of an integrated, organization-wide Patient Safety/Risk Management Program. These responsibilities are campus specific and include the following:

- Foster an environment in which patients, their families and organization staff and leaders can identify and manage actual and potential risks to patient safety through personal example and the provision of resources to establish proactive mechanisms to reduce risk.
- Establish a culture in which communication flows freely regardless of authority gradient.
- Ensure that a define, on-going, proactive program for identifying risks to patient safety and reducing medical/healthcare adverse events is fully implemented and includes responses to actual and potential events;
- Ensure that patient safety issues are given a high priority and addressed when processes, functions or services are designed or redesigned;
- Provide for mechanisms to measure, analyze and manage variation in the performance of defined processes that affect patient safety;
- Allocate adequate resources, including personnel, time, information systems data associated with reducing risk and improving patient safety, and
- Active participation in the California Hospital Patient Safety Organization (CHPSO).

Physicians

Physicians are responsible, as participants in the Patient Safety/Risk Management Program for reporting events or near misses at each campus, and participating on focus teams to reduce identified patient safety risks. Whenever patient care outcomes differ significantly from the anticipated outcomes, the primary care provider and/or responsible licensed independent practitioner (LIP) or comparable designee shall clearly explain these outcomes to the patient, and when appropriate, the family. (See Disclosure Policy)

Patients/Families/Visitors

Patients, families and patient representatives via written communication are encouraged to be active participants in their care and as such are responsible for:

- Providing, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters relating to the patient's health;
- Reporting their patient and outcome of treatment of that pain
- Reporting perceived risks in their care and unexpected changes in the patient's condition to the responsible practitioner, and
- Asking questions when they do not understand what they have been told about the patient's care, infection control, safety precautions and programs or what they are expected to do etc.

Patients and families/patient representatives/visitors will be provided with educational materials explaining these expectations and their role in reducing risk exposure and improving patient safety at the time of admission and throughout the patient stay utilizing various delivery methods including pamphlets, television

and verbal communication. Some patients may also be included in the development process to obtain their opinions, needs, perceptions of risks to patients and their suggestions for improving patient care.

Hospital Departments and Staff

San Martin staff are key to promoting, identifying, and implementing activities to reduce risk and improve patient safety. Some of the activities include:

- Active participation in the activities to improve patient safety and the quality of healthcare delivered;
- Adherence to Infection prevention measures, the Joint Commission National Patient Safety Goals and other patient safety initiatives;
- Participation in education activities and process implementations;
- As appropriate, the provision of accurate, timely and complete verbal and written communication among caregivers, including test results relevant to the management of the patient's condition, and to all others involved in the utilization of data; and
- Participation in information needs assessment, staff surveys, and other processes that request information regarding the Patient Safety/Risk Management Program.
- Reporting all events and process variances (harm or no harm) even if they do not reach the patient (near miss).

The Patient Safety Committee

The Patient Safety Committee convenes monthly in accordance with NRS 439.875. In collaboration with the Patient Safety Officer, the committee represents the San Martin Campus and includes multidisciplinary team members which have oversight responsibility to ensure that the responsibilities and functions outlined in this program are carried forward throughout the organization. The following responsibilities are assigned:

- Serve as champions of the Patient Safety/Risk Management Program within the facility/organization.
- Establish and evaluate data to identify patient safety performance indicators;
- Evaluate other sources of patient safety data utilizing internal and external resources including, but not limited to adopted patient safety checklists, risk assessments, sentinel event report/alert information and event reporting information from a variety of available resources including the event reporting system, APIC, CHPSO, etc.;
- Selection of a high-risk patient safety process for proactive risk assessment and improvement annually;
- Collaborates with each facility's Quality Council to identify, address and conduct follow up on patient safety related trends, analysis results, changes in processes, policies and other areas to make as a result of identified needs.
- Annual review of the Patient Safety Program to ensure its appropriateness of focus and effectiveness of efforts for each campus.
- Report and discuss sentinel events which include:
 - Number of sentinel events from previous calendar month (or quarter).

- Number of severe infections that occurred in the facility.
- Corrective Action Plan for the sentinel events and infections
 - Evaluate the corrective action plan.
- Patient safety policies and checklists
 - At least annually evaluate Patient Safety policies and checklists
 - Revise the patient safety policies and checklists as needed.
 - Monitor and document the effectiveness of the patient safety policy.

A RCA meeting will meet as needed to accomplish the following:

- Define the healthcare issues or potential risks.
- Conduct Root Cause Analysis
 - Reviewing and analyzing the data.
 - Reviewing the RCA process and quality improvement related activities and timelines.
 - Brainstorming issues or the potential risks by using the fishbone diagrams.
 - Identify the contributing factors and conduct the Root Cause Analysis.
- Conduct Corrective Action Plan
 - Identifying the Plan-Do-Study-Act (PDSA) topics.
 - Discussing corrective action process and activities.
 - Discussing and presenting possible changes in procedure to improve areas indicated.
 - Identifying strengths and areas that need improvement.
 - Developing strategies, solutions, and steps to take next.
- Identify barriers and technical assistance needs for supporting the RCA efforts.

A meeting agenda and minutes noting follow-up tasks will be kept.

Objectives and Goals of the Patient Safety/Risk Management Plan

Goal	Plan	Due Date
Risk Assessments	1. Patient Safety/Risk Management to perform monthly risk assessments and report to PSC. 2. Infection Prevention to report to PSC findings of Risk Assessments.	Monthly PSC
FMEA	PSC to ensure one FMEA is conducted by Risk Management in CY 2018.	December 2018
Checklists	PSC will receive all new and renewed checklists used that impact patient safety whether directly or indirectly.	Monthly and ongoing
National Patient Safety Goals	PSC will support the posting of NPSGs throughout the hospital for staff reference.	Department leaders
Root Cause Analysis	RCAs will be conducted by Risk and Quality Management as soon as possible/practical after an event per Dignity Health policy	Ongoing
Manager orientation	Quality Risk Services will review/update Manager orientation.	March 31, 2018
Grievance Management	Grievances will be reviewed by the Grievance Committee to ensure compliance with CMS CoPs.	Quarterly and ongoing.

Goal	Plan	Due Date
Staff and physician education	Patient Safety education will occur in various forms (e.g. Huddles, Department Meetings, Leadership Meetings, Posters) throughout the year.	Ongoing

Components and Methods

Proactive Risk Assessment Activities

The Patient Safety/Risk Management Department, in collaboration with the various facility committees including Infection Prevention, Quality Council and leadership will conduct proactive risk assessments to identify hazards/risks that may affect patient safety. Risk Assessment activities will include, but not be limited to the following:

- Patient Safety Risk Assessment evaluating known high risk processes/procedures that have associated risks,
- Review employee survey results to identify safety concerns,
- On-going risk assessments based on internal and external data, including sentinel event alerts,
- Focused risk assessments as determined by the Patient Safety Committee, Senior Leadership, external/internal events, etc.
- Selection of patient safety process improvements and risk reduction activities utilizing the priorities set criteria of San Martin campus,
- Any information assessments conducted by St. Rose Dominican will include identification of barriers to effective communication among caregivers.
- Patient Satisfaction surveys will include a question determining how the patient/family thinks the individual facility can improve patient safety. Results from this question shall be analyzed and responded to in a manner that supports risk reduction.
- Infection Prevention Surveillance Program.
- Additional staff surveys may be conducted to assess for staff opinions, needs, perceptions of risks to patients and suggestions for improving patient safety, as well as the staff’s willingness to report medical/healthcare events.

Event Reporting

San Martin actively participates in the CHPSO and its Patient Safety Evaluation System for data collection, monitoring, collaboration and evaluation activities. As provided under the CHPSO (42 Code of Federal Regulations (CFR) Part 3 Section 3.20) the event report is considered a Patient Safety Work Product and as such is privileged and shall not be (1) subject to subpoena; (2) subject to discovery; (3) subject to disclosure and (4) admitted into evidence-provided such information is not subject to disclosure in certain criminal proceedings as described in regulation. (See Event Reporting and Management Policy).

- A. When an unplanned event/process variance occurs, the patient care provider will do the following:
 - a. Perform the necessary healthcare interventions to support the patient’s clinical condition.
 - b. Perform the necessary interventions to contain the risks to others.
 - c. Notify the patient’s attending physician.
 - d. Preserve any information related to the event including physical evidence. Preservation of the information includes the documentation of facts regarding the event or complication of event on the Event Report and in the patients’ medical record.

- e. Notify immediate supervisor of the event.
 - f. Submit electronically an Event Report form or handwritten Event Report form to Risk Management/Patient Safety Services.
- B. Identification of potential unsafe condition that may affect patient safety:
- a. Individual's identifying such a condition will immediately report such to their supervisor, and document in the Event Report.
 - b. Take the necessary actions to ensure that any potential risks to patient care and safety are mitigated.

Event Monitoring/Risk Assessment Analysis, Action Planning and Intervention

- A. Patient safety related event reporting data within the scope of the Patient Safety Program and risk assessment results will be aggregated and presented routinely to various committees including but not limited to Medical Executive Committee (MEC), Medication Safety, Quality Council and Environment of Care for analysis and action. Based on analysis of this data and any actual or potential reviews, sentinel events and other internal and external data including TJC Sentinel Event Alerts, Dignity Health Shared Learnings, CHPSO trends, current literature, proactive action plan will be developed to include the following:
- a. Assessment of the intended and actual implementation of processes to identify the steps in where there is, or may be, undesirable variation.
 - b. Identification of the possible effects of the undesirable variations on patients and how serious the effect or outcome on the patient might be;
 - c. For critical effects/outcomes, a root cause analysis will be conducted to determine why the variation leading to the effect may occur;
 - d. Redesign of the process and /or underlying systems to minimize the risk of that variation or to protect patients from the effects of the variation;
 - e. Test and implement the redesign process;
 - f. Identification and collaboration with Quality Management Systems on implementation of measures of the effectiveness of the redesigned process; and
 - g. Implementation of a strategy for maintaining the effectiveness of the process over time.
 - h. Events that do not require a Root Cause Analysis will have an incident review completed by Quality/Risk Services Department as soon as practicable of becoming aware of the event. The results will be forwarded to leadership for review.

Response to Reported Adverse/Sentinel Events

Reporting of events is an essential component of a Patient Safety/Risk Management program. Through its participation in the CHPSO; all related investigation of events will be securely conducted, collected and documented as Patient Safety Work Product (PSWP) to maintain confidentiality as defined in the Federal Regulation.

- A. San Martin shall respond to all reported potential and actual adverse/sentinel events. (See Sentinel Event policy).
- B. Minimally, all adverse events will be analyzed utilizing a team of individuals including Risk Management/Patient Safety and Quality Departments, to conduct root cause analysis (RCA), incident review and/or a failure mode effects analysis (FMEA), implementation in action plan to reduce further risk to patients and establish measures of effectiveness.
 - a. The following events always elicit an intense analysis:
 - i. Confirmed transfusion reactions

- ii. Significant adverse drug reactions
 - iii. Significant medication events and hazardous conditions
 - iv. Manor discrepancies, or patterns of discrepancies, between preoperative and postoperative (including pathologic) diagnoses, including those identified during the pathologic review of specimens removed during surgical or invasive procedures; and
 - v. Significant adverse events associated with anesthesia use.
 - vi. Hospital acquired infections
 - vii. All events meeting the definition of Sentinel Events in the State of Nevada.
 - b. A root cause analysis is performed when a sentinel or State reportable event occurs.
 - c. An incident review is performed when a near miss or other event with significant areas for improvement are identified.
- C. Staff involved in an adverse/sentinel event shall be treated with respect and dignity.
- a. A “JUST CULTURE” approach shall be taken in order to facilitate changes in systems and processes to prevent further risk to patient safety, as well as promote future reporting by other staff.
 - b. Involved staff should be involved in the RCA process.
 - c. The Department Manager will provide ongoing support to the staff member(s) as needed.
 - d. Whenever necessary, Crisis Intervention or Employee Assistance Programs (EAP) will be offered as support to the involved employee.

Education

A. Staff Education

- a. General orientation and other education and training programs as needed will emphasize specific job related aspects of patient safety and risk reduction strategies.
- b. Specific Patient Safety/Risk Management Program training at orientation and annually thereafter will include:
 - i. An overview of the Patient Safety Program
 - ii. Overview of TJC National Patient Safety Goals
 - iii. Staff’s role and responsibilities in the Patient Safety/Risk Management Program
 - iv. Event reporting criteria and process
 - v. Methods to support and foster an interdisciplinary and collaborative approach to the delivery of patient care
 - vi. Examples of specific job related aspects of patient safety.
- c. Staff participating at a higher level of the Patient Safety/Risk Management Program will receive appropriate training necessary to understand and complete their assigned responsibilities.

B. Physician Education

- a. An overview of the Patient Safety/Risk Management Program will be provided to physicians at time of initial appointment and annually thereafter that describes the program, emphasizes their role and responsibilities in the program and informs them of the event reporting mechanism.
- b. Specific physicians may receive additional training to support their involvement at a higher level in the Patient Safety/Risk Management Program.

Pursuant to [NRS 439.837](#), a medical facility shall, upon reporting a sentinel event pursuant to [NRS 439.835](#), conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event.”

San Martin Campus will use RCA process to determine the contributing factors and the underlying reasons for the deficiencies or failures. The Plan-Do-Study (check)-Act (PDSA or PDCA) is the model, developed by the Institute of Health Care Improvement, that we will use to test the changes.



Root Cause Analysis

A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals.

Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

Root cause analysis and action plan framework table, which was introduced by the Joint Commission. It contains 24 analysis questions. It guides the organization to the steps in a root cause analysis. Not all the questions apply to all the events or cases. This table can be used individually or with the fishbone diagram.

5 Whys technique will be used in San Martin Campus to explore the cause and effect relationship underlay a problem. One can find the root causes by asking “why” no less than five times. This technique can be used individually or as a part of the fishbone diagram.

Fishbone Diagram

Once the problems are identified, a Fishbone Diagram will be used for analyzing the problems. You can use the fishbone diagram individually to analyze the root causes, or use it with the root cause analysis and action plan framework table.

A Fishbone Diagram, also called a Cause-and-Effect diagram, is a useful tool for a team to structurally brainstorm by discovering possible underlying factors or root causes from different major categories for the chosen problems. General categories used include: people, methods, materials, measurements, education, procedures, process, location, environment, etc. RCA team members will brainstorm and ask multiple times, “why did this happen?” for each cause until all ideas are exhausted. The highest priority root causes will be chosen for PDSA topics. Once all the categories are established on the fishbone diagram, 5 Whys technique also can be used to drill down the problem and find the root causes.

Model for Improvement

Please refer to the Dignity Health – St. Rose Dominican Performance Improvement Plan.

Data Collection and Reporting

Data should drive any quality and patient safety effort. San Martin is using IVOS for tracking the sentinel events, healthcare infection data, and Midas for internal data collection.

External data sources are those data sources which are collected outside the supervisory structure of the case. External data which will be utilized for Quality and Patient Safety plan include the data from:

- AHRQ: Agency for Healthcare Research & Quality
- CDC: Centers for Disease Control and Prevention
- CMS: Centers for Medicare & Medicaid Services
- NQF: National Quality Forum
- NHSN: National Healthcare Safety Network
- TJC: The Joint Commission

Ongoing Reporting and Review

Data points such as the following will be reviewed according to the schedule prescribed:

Monthly	Quarterly	Annually
1) Sentinel event monthly report 2) Severity of infection report 3) RCA assessment	1) Sentinel event quarterly report 2) Severity of infection report 3) Review and evaluate the measure of improvement of patient safety 4) Review and evaluate the measurement to prevent and control infections	1) Quality and Patient Safety Plan update 2) Checklists and Policies reviewing and revising

Assessment of the Quality and Patient Safety Plan

Please see the Patient Safety Assessment Tool (PSAT) from the VA National Center for Patient Safety for your reference.

Patient Safety Checklists and Patient Safety Policies

By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

The patient safety checklists must follow protocols to improve the health outcomes of patients at the medical facility and must include, without limitation:

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.
- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - Proper instructions concerning prescription medications;
 - Instructions concerning aftercare;
 - Any other instructions concerning his or her care upon discharge; and
 - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include the name and date of birth of the patient.
- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.

- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

Based on [NRS 439.865](#), the patient safety plan must also include an infection control program that carries out the infection control policy. The policy must consist of:

- The current guidelines appropriate for the facility's scope of service developed by a nationally recognized infection control organization as approved by the State Board of Health which may include, the Association for Professionals in Infection Control and Epidemiology (APIC), the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO) and the Society for Healthcare Epidemiology of America (SHEA); and
- Facility-specific infection control developed under the supervision of a certified Infection Preventionist.

http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf

<http://www.who.int/patientsafety/implementation/checklists/en/>

The following link provides you some patient safety policies for your reference

<https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>

Approval of Patient Safety Plan

According to [NRS 439.865](#), a medical facility shall submit its patient safety plan to the governing board of the facility for approval. After a facility's patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan.

The patient safety plan must be reviewed and **updated annually** in accordance with the requirements for approval set forth in this section.

According to [NRS 439.843](#), on or before March 1 of each year, a copy of the most current patient safety plan established to [NRS 439.865](#) must be submitted to the Division of Public and Behavioral Health.

Patient Safety Program Reporting and Review

All patient safety work product (PSWP) submitted through the CHPSO will be collected in the Patient Safety Evaluation System (PSES) for collection, management and analysis of information pursuant to the Patient Safety and Quality Improvement Act of 2005 (42 U.S.C. 299 et seq.).

- A. Patient safety/Risk Management related data and information reports will be provided routinely to various committees as previously identified including but not limited to medical staff, Quality Council and QCAC.

- B. A summary report of data, other internal and external information, as well as all actions taken by various committees and/or specific patient safety related teams will be submitted to the QCAC and the MEC.
- C. Annually, the Patient Safety/Risk Management Plan will be evaluated for effectiveness and the program updated to reflect the results of risk assessments related to patients, families and staff. The review shall include a summary of the occurrence of medical/healthcare events and actions taken to improve patient safety, both in response to actual occurrences and proactive efforts.
 - a. The review will be approved by QCAC.
 - b. Will be submitted to the Community Board for final review and approval.

References

- Root Cause Analysis Toolkit <http://www.health.state.mn.us/patientsafety/toolkit/>
- Quality and Service Improvement Tools http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html
- CQI 101 An Introduction to Continuous Quality Improvement: <https://www.coursehero.com/file/13827355/CQI-Overviewppt/>
- Quality Improvement <http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/>
- Root Cause Analysis <http://www.patientsafety.va.gov/professionals/onthejob/rca.asp>
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2 https://www.jointcommission.org/sentinel_event.aspx
- Hospital Policies <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>
- Checklists to Improve Patient Safety http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf
- Patient Safety Checklists <http://www.who.int/patientsafety/implementation/checklists/en/>
- Minutes of the Meeting of the Quality and Patient Safety Committee <http://www.cookcountyhhs.org/wp-content/uploads/2013/12/09-23-14-QPS-scan-Minutes.pdf>
- Title 40 – Public Health and Safety <https://www.leg.state.nv.us/NRS/NRS-439.html>

Reviewed/Approved:

Patient Safety Committee, February 2018

Quality Care Advisory Committee of the Board, March 2018

Community Board, March 2018

Spring Mountain Sahara
ORGANIZATIONAL PLAN FOR PATIENT SAFETY

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.

Facility Name: Durango Outpatient Surgery Center	Policy And Procedure Guideline Name: Safety Management Program (Environment Of Care)	Policy Number: SAFE 104
	Subject Category: SAFETY	Effective Date: 10/01/2016
		Revised Date: 12/2017
		Page 1 Of 4

Policy: The facility shall provide guidelines and implement proactive practices, which provide a safe environment of care in relation to property, equipment, patients, personnel and the public. The facility and each OR must be designed and maintained so that all types of surgery can be performed in a manner that protects the lives and assures the physical safety of all individuals. ORs include not only traditional ORs, but also procedure rooms, including those where surgical procedures that do not require a sterile environment are performed.

Purpose: The reduction of physical hazards and the implementation of safe practices enhance environmental safety.

Procedure Guidelines:

Responsibility:

1. Facility leadership takes action to minimize identified safety risks in the physical environment. Employees are responsible for:
 - A. Intervention when, safety conditions pose a threat to life or health, or threaten damage to equipment or buildings.
 - B. The continuing maintenance of the facility property, eliminating hazards upon discovery.
 - C. Reporting equipment or maintenance problems and incidents of property damage to the Administrator/ Clinical Director upon discovery.
 - D. Reporting injuries and illness to the Administrator/Clinical Director.
 - E. Obtaining the information necessary to perform tasks in a manner that prevents injury to themselves, patients and others.

2. The Administrator/Clinical Director, and Safety Officer, as agents of the Quality Assurance Committee are responsible for:
 - A. Environment of Care development, implementation and monitoring.
 - B. Report of Safety Surveillance and activities to the Quality Assurance Committee/PI committee.
 - C. Every 12 months the organization evaluates the Environment of Care Plan for objectives, scope, performance and effectiveness.

Maintenance And Supervision:

1. Comply with the NFPA 101®, Life Safety Code® (LSC) for maintaining and supervising the facility grounds, buildings and equipment.
2. Maintain equipment and utilities following a preventative maintenance schedule.
3. Maintain sufficient light in the parking and entrance areas to reduce the potential for falls and security concerns.
4. Maintain signs and emergency systems to meet the needs of the visual and hearing impaired.
5. Maintain smoke free environment.
6. Provide facility cleaning, maintenance, and inspection, following a schedule for daily, weekly, monthly, semi-annual and annual activities.
7. Construction and Renovation (Interim Life Safety Plan):
 - A. Meet the existing ambulatory health care occupancy health code requirements for construction or renovation.
 - B. Train staff in alternative safety processes including the use of new specialized equipment and space.
 - C. Train staff to compensate for changes in Life Safety Plan.
 - D. Provide increased facility safety monitoring with construction and renovation included reference to the NFPA 101®, Life Safety Code® (LSC).
 - E. Inspect and monitor components of Life Safety Plan weekly or more frequently if indicated.

Risk Assessment:

1. Provide risk assessment and hazard surveillance to evaluate the impact of the center building, grounds, equipment, occupants, and internal physical systems on patient, employee and public safety.
 - A. Assign a Safety Officer to maintain risk and hazard surveillance.

- B. Record Hazard surveillance.
 - C. Report environmental hazard and safety surveillance to the Quality Assurance Committee. Provide follow-up to staff concerning safety issue recommendations.
2. Report and document patient, personnel or visitor injury, and occupational illness. Document incidents on a Variance Report, Occurrence Report, or Incident Report.
- A. Investigate and evaluate each report for opportunities to improve performance.
 - B. Include injuries and occupational illness in the report to the Quality Assurance Committee.

Product Safety Recalls:

1. Address a product safety recall upon notification.
- A. Inventory and remove recalled product from possible use.
 - B. Notify affected medical staff and evaluate a substitute product.
 - C. Inventory patients who may have received a recalled medical device from implant logs or records.
 - D. Consult with the Medical Director and/or Quality Assurance Committee to evaluate the situation and determine an appropriate method for patient notification if an implanted medical device has been recalled. The medical director, as an agent of the QA/PI committee reports the incident to the Medical Executive Committee.

Safety Education:

1. Provide Safety Education and Training at orientation and at least annually thereafter. Address general safety processes; area specific safety and job related hazards.
2. Provide Safety Guidelines in the General Orientation including:
- A. Review of Safety Policies and Guidelines.
 - B. Body Mechanics.
 - C. Hazardous Materials Communication.
 - D. SDS/ Hazardous Waste.
 - E. Safety Risk / Responsibilities.
 - F. Equipment Safety/Operations Manuals.
 - G. Emergency Preparedness.
 - H. Utility Systems and Electrical Safety.

- I. Infection Control/Exposure OSHA.
 - J. Reporting of Sentinel Events.
 - K. Variance, accidents/injuries, Security and Safety concerns.
 - L. Fire and Life Safety.
 - M. Safety Concerns.
 - N. Security.
 - O. OSHA.
3. Include specific safety standards related to safe practices and the safe use, inspection, cleaning and maintenance of specialized equipment in the Department /Job Specific orientation.
 4. Provide updates when new equipment is introduced.
 5. Review General Safety Guidelines annually.

Reference:

Center for Medicare and Medicaid Services (April, 2015). Standard Operations Manual Appendix L – Guidance for Surveyors: Ambulatory Surgery.

The Joint Commission. (2017) Accreditation Standards and Requirements for Ambulatory Surgery Centers

EYE SURGERY CENTER OF NORTHERN NEVADA:

QUALITY AND PATIENT SAFETY PLAN

This plan was created and reviewed by ESCNN Patient Safety committee. Implementation of this plan is intended to optimize the healthcare quality and patient safety outcomes, encourage recognition, reporting, and acknowledgment of risks to patient, visitor, and employee safety, as well as reduce the medical/healthcare errors and/or preventable events.

Commitment to Patient Safety

ESCNN is committed to a comprehensive approach to improving healthcare quality and patient safety by aligning with our Mission, Vision, and Values, creating an environment that supports a dynamic, proactive, and safe culture for patients, family members, visitors, and employees, through continuous learning and improving patient safety policies, systems, and processes.

Mission, Vision, and Values

In support of our mission, vision, and values, ESCNN Patient Safety and Quality Improvement program promotes:

- Collaboration of healthcare, leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high quality healthcare.
- Communicate honestly and openly to foster trusting and cooperative relationships among healthcare providers, staff members, and patients and their families, to ensure accountability for the patient safety priorities.
- Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.
- Responsibility for every healthcare related decision and action.
- A focus on continuous learning and improving, system design, and the management of choices and changes, bringing the best possible outcomes or performances to the facility.
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare.
- Education of staff and physicians to assure participation of healthcare providers.

Scope and Purpose

The scope of this Quality and Patient Safety Plan is organizational-wide which includes but is not limited to

- Patient safety
- Visitor safety
- Employee safety

All staff in ESCNN are required to fully support and participate in this plan, and devote their expertise to the patient safety and healthcare quality improvement process.

This plan is action oriented and solution focused. The purpose of this plan is to address patient safety related concerns, challenges and revise the program to better serve the patients and their families. To this end, ESCNN has developed this Patient Safety plan.

The plan focuses on the process rather than the individual, and recognizes both internal and

external customers, as well as facilitates the need of analyzing and improving processes.

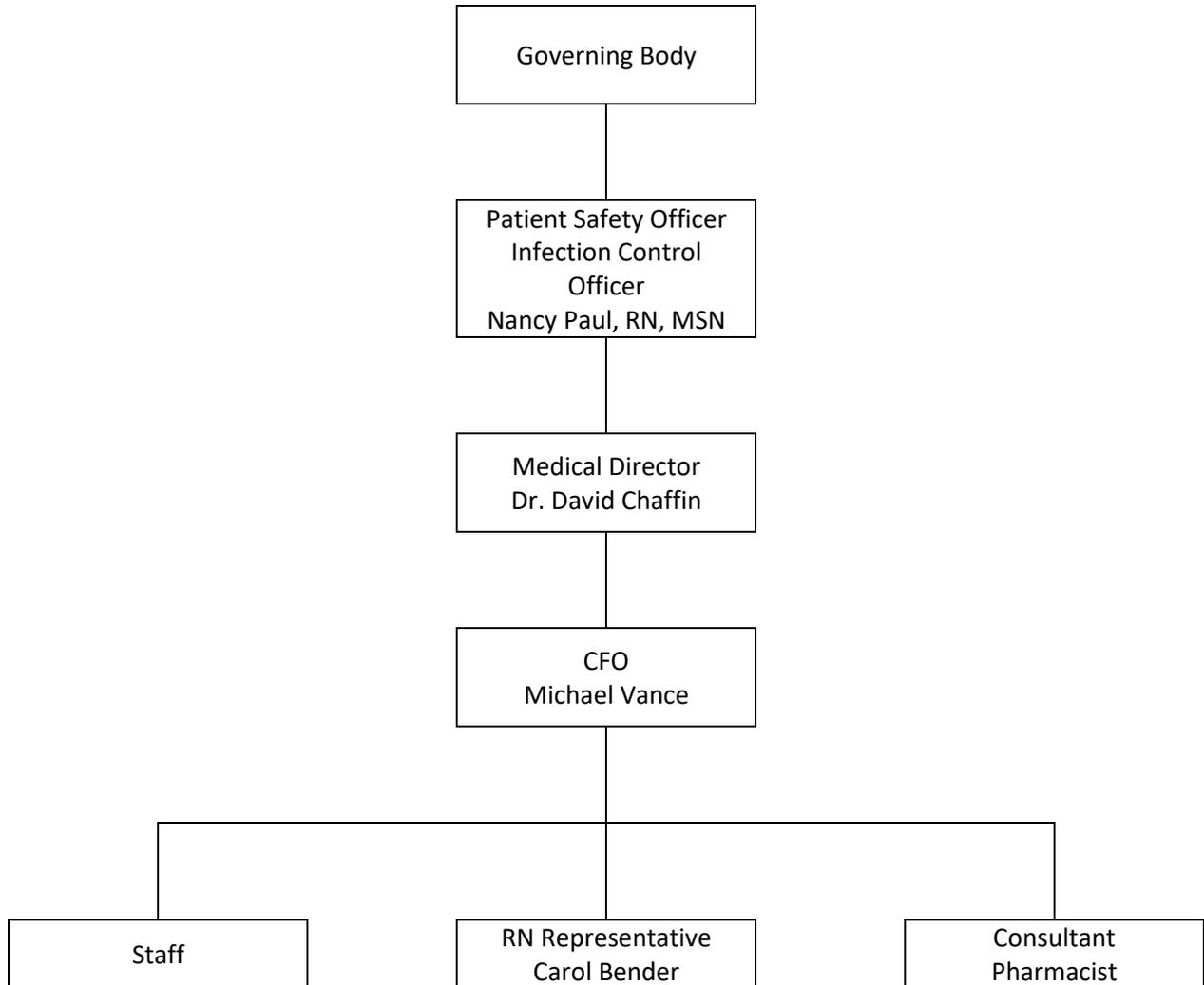
The core principles of this plan include:

- All staff have the same goal and contribute their knowledge, vision, skill, and insight to improve the process of the Patient Safety Plan.
- Decisions will be based on data and facts, and staff will be encouraged to learn from the experiences.
- Customer based including patients, families, and visitors.
- Promote systems thinking.
- Employ well-trained and competent staff maintaining high healthcare quality.

Roles and Responsibilities

According to [NRS 439.875](#), a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plan is promoted and executed successfully.

The Patient Safety Committee Organization



Roles and Responsibilities

- In accordance with [NRS 439.875](#), a patient safety committee must be comprised of:
- The infection control officer of the medical facility;
- The patient safety officer of the medical facility, if he or she is not designated as the infection control officer;
- At least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility; and
- One member of the executive or governing body of the medical facility.

Based on [NAC 439.920](#), a medical facility that has fewer than 25 employees and contractors must establish a patient safety committee comprised of:

- The patient safety officer of the medical facility;
- At least two providers of healthcare who treat patients at the medical facility, including but without limitation, one member of the medical staff and one member of the nursing staff of the medical facility; and
- The Chief Executive Officer (CEO) or Chief Financial Officer (CFO) of the medical facility.

The roles and responsibilities are defined below:

Patient Safety Committee Responsibilities (based on [NRS 439.875](#) and [NRS 439.877](#))

- Monitor and document the effectiveness of the patient identification policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the patient safety officer pursuant to [NRS 439.870](#).
- Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred.
- Review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- Review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the executive or governing body of the facility regarding:
 - (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);
 - (2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and
 - (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.

- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

Root Cause Analysis (RCA) :

- Conduct RCA as needed utilizing members of the Patient Safety Committee.
- Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders.
- Make policy changes as needed based on RCA results.

Patient Safety Officer Responsibilities (based on [NRS 439.870](#))

- Serve on the patient safety committee.
- Supervise the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the patient safety committee regarding any action taken in accordance with the responsibilities above.

Infection Control Officer Responsibilities (based on [NRS 439.873](#))

- Serve on the patient safety committee.
- Monitor the occurrences of infections at the facility to determine the number and severity of infections.
- Report to the patient safety committee concerning the number and severity of infections at the facility.
- Take such action as determines is necessary to prevent and control infections alleged to have occurred at the facility.
- Carry out the provisions of the infection control program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program.

Executive or Governing Body Staff Responsibilities

- Provide vision and leadership to Patient Safety and Quality Improvement process, and develop and foster a safe learning and improving culture.
- Provides oversight to the healthcare quality improvement processes and teams.
- Plan, discuss, and generate the organization patient safety goals and activities, in conjunction with the patient safety action plans

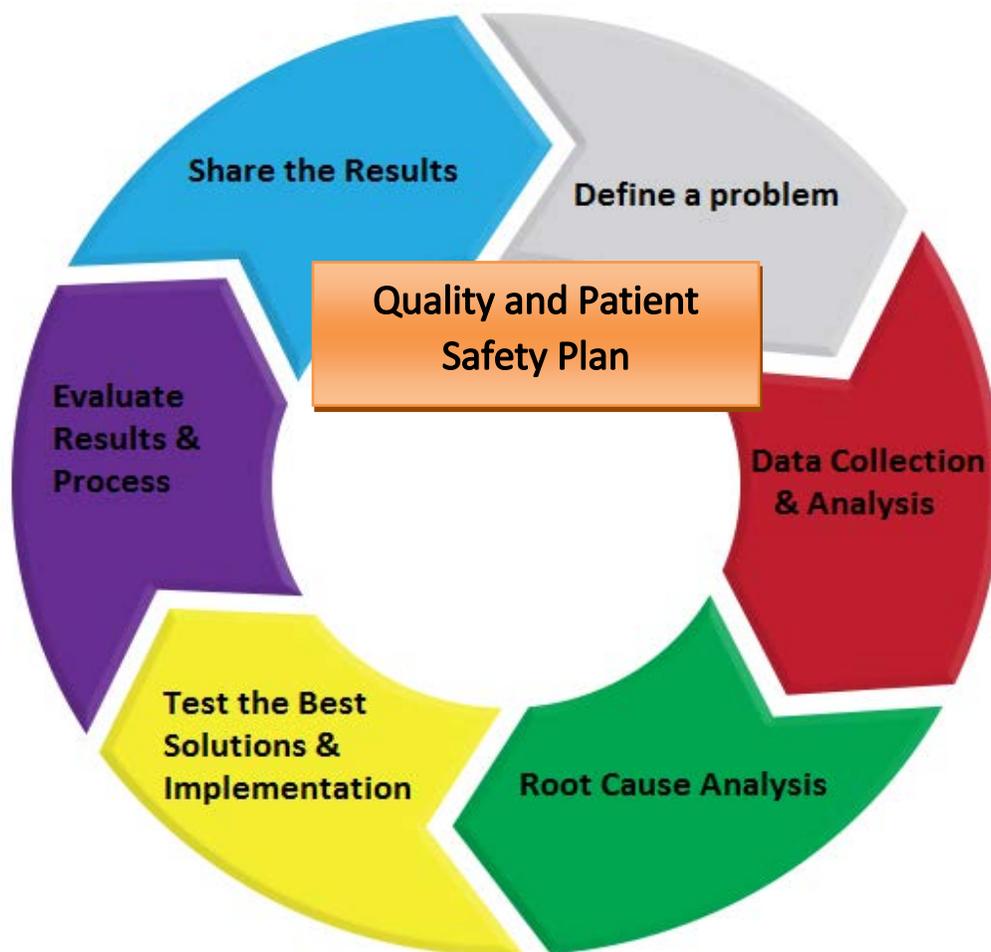
The Patient Safety Committee will meet monthly (or quarterly) to accomplish the following:

- Report and discuss sentinel events which include:
 - Number of sentinel events from previous calendar month (or quarter).
 - Number of severe infections that occurred in the facility.
- Corrective Action Plan for the sentinel events and infections
 - Evaluate the corrective action plan.
- Patient safety policies and checklists
 - At least annually evaluate Patient Safety policies and checklists
 - Revise the patient safety policies and checklists as needed.
 - Monitor and document the effectiveness of the patient safety policy.

Components and Methods

Pursuant to [NRS 439.837](#), a medical facility shall, upon reporting a sentinel event pursuant to [NRS 439.835](#), conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event.”

ESCNN will use RCA process to determine the contributing factors and the underlying reasons for the deficiencies or failures. The Plan-Do-Study (check)-Act (PDSA or PDCA) is the model, which was developed by the Institute of Health Care Improvement, that we will use to test the changes.



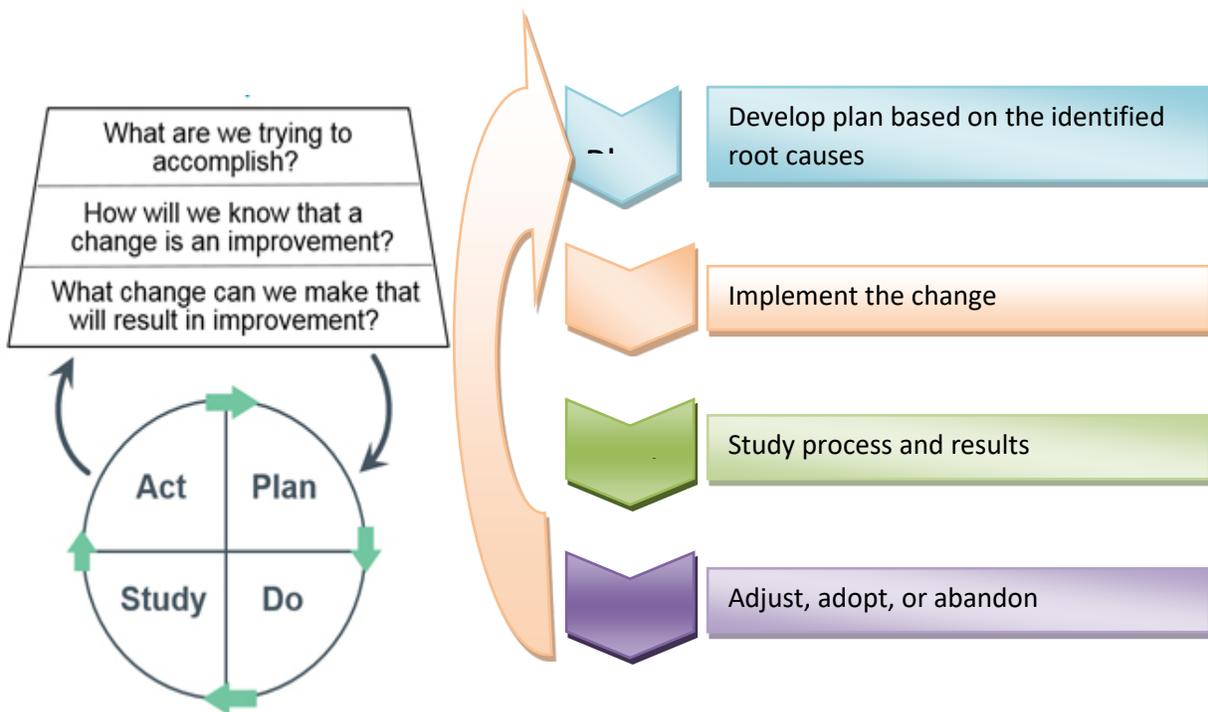
Root Cause Analysis

A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals.

Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

Model for Improvement

The Model for Improvement is a collaborative and ongoing effort model to improve the product and services quality and process. It provides multi-disciplinary quality team guidance from identifying the root causes; conducting the best tests to assess possible changes, and working in collaboration for implementation of the new approaches and solutions. It guides the test of a change to determine if the change is an improvement.



The cycle is defined as follows:

- Plan--collect data and establish appropriate goals. Identify the problem and the possible root causes, and answer the following questions.
 - What is the objective of the test?
 - What are the steps for the test - who, what, when?
 - How will you measure the impact of the test?
 - What is your plan to collect the data needed?
 - What do you predict will happen?

- Do--make changes designed to correct or improve the situation. Use the following questions for the guidance.
 - What were the results of the test?
 - Was the cycle carried out as designed or planned?
 - What did you observe that was unplanned or expected?

- Study -- Study the effect of the changes on the situation. Data should be collected on the new process and compared to the baseline or expected results. Results should be evaluated and by using the following questions as guidance.
 - Did the results match your prediction?
 - What did you learn?
 - What do you need to do next?

- Act--If the result is successful or desirable, standardize the changes and then work on the next prioritized problem or the further improvements. If the outcome is not yet successful, look for different ways to identify the causes or change the testing process.

Data Collection and Reporting

Data should drive any quality and patient safety effort. ESCNN is tracking sentinel events and healthcare infection data.

External data sources are those data sources which are collected outside the supervisory structure of the case. External data which will be utilized for Quality and Patient Safety plan include the data from:

- AHRQ: Agency for Healthcare Research & Quality
- CDC: Centers for Disease Control and Prevention
- CMS: Centers for Medicare & Medicaid Services
- NQF: National Quality Forum
- NHSN: National Healthcare Safety Network

Patient Safety Checklists and Patient Safety Policies

By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility.

The patient safety checklists must follow protocols to improve the health outcomes of patients at the medical facility and must include, without limitation:

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - Proper instructions concerning prescription medications;
 - Instructions concerning aftercare;
 - Any other instructions concerning his or her care upon discharge.

The patient safety policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include, the name and date of birth of the patient.
- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.
- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

Based on [NRS 439.865](#), the patient safety plan must also include an infection control program that carries out the infection control policy. The policy must consist of:

- The current guidelines appropriate for the facility's scope of service developed by a nationally recognized infection control organization as approved by the State Board of Health which may include, the Association for Professionals in Infection Control and Epidemiology (APIC), the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO) and the Society for Healthcare Epidemiology of America (SHEA).

Approval of Patient Safety Plan

According to [NRS 439.865](#), a medical facility shall submit its patient safety plan to the governing board of the facility for approval. After a facility's patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan.

The patient safety plan must be reviewed and **updated annually** in accordance with the requirements for approval set forth in this section.

According to [NRS 439.843](#), on or before March 1 of each year, a copy of the most current patient safety plan established to [NRS 439.865](#) must be submitted to the Division of Public and Behavioral Health.

**NEVADA ENDOSCOPY MANAGEMENT INC
GASTROENTEROLOGY CONSULTANTS LTD
RENO ENDOSCOPY CENTER LLC
SOUTH MEADOWS ENDOSCOPY CENTER LLC
CARSON ENDOSCOPY CENTER LLC**

POLICY AND PROCEDURE MANUAL

Policy: Patient Safety Plan
Owner: Center
Date last updated: Revised 4/2016

Purpose: Gastroenterology Consultants, Ltd (GIC) and affiliated Endoscopy Centers are committed to ensuring the ongoing safety of our patients. To ensure the ongoing safety and care of our patients we follow specific guidelines and policies which, at a minimum, include:

I Infection Control (IC): Refer also to the Infection Control (IC) Policy

Guidelines followed include:

- a. American Society for Gastrointestinal Endoscopy (ASGE) Multisociety Guideline on Reprocessing Flexible Gastrointestinal Endoscopes 2011
- b. Society of Gastroenterology Nurses and Associates, Inc. (SGNA) Standards of Infection Prevention in Reprocessing Flexible Gastrointestinal Endoscopes 2015
- c. Society of Gastroenterology Nurses and Associates, Inc. (SGNA) Standard of Infection Prevention in the Gastroenterology Setting 2015
- d. Society of Gastroenterology Nurses and Associates, Inc. (SGNA) Guideline for Use of High Level Disinfectants and Sterilants for Reprocessing Flexible Gastrointestinal Endoscopes 2013
- e. American Society for Gastrointestinal Endoscopy (ASGE) Infection Control during GI Endoscopy 2008
- f. Center for Disease Control (CDC) Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings 2007
- g. CDC Guide to Infection Prevention for Outpatient Settings 2014
- h. Association for Professionals in Infection Control and Epidemiology (APIC) Guide to the Elimination of Clostridium difficile in Healthcare Settings 2013
- i. CDC Safe Injection Practices

The IC Policy includes at a minimum processes or guidelines for:

- a. Patient selection and placement within the facility
- b. Infection Control Monitoring and Surveillance, Reporting
- c. Standard and Transmission Precautions, Hand Hygiene, Personal Protective Equipment, Respiratory Hygiene / Cough Etiquette and General Infection Control Practices in Healthcare Facilities as developed by the CDC and APIC
- d. Environmental and Terminal Cleaning
- e. Infection Control Officer

Approved Board of Managers REC/SEC/ CEC 10/11/11; Revised 8/9/12, Approved Board of Managers REC/SEC 1-31-16; CEC 1-25-16; Approved Medical Directors 4/2016

The proceedings and records of a patient safety committee are subject to the same privilege and protection from discovery as the proceedings and records described in NRS 49.117 - 49.123 and NRS 49.265.

- f. Equipment Processing: Cleaning, Disinfection, High Level Disinfection and Sterilization

II □ Patient Selection and Screening: Refer also to the Criteria for Scheduling Patients at ASC Policy.

1. To ensure patients are appropriate for the planned procedure in the planned setting patients undergo:
 - a. Pre-procedure scheduling evaluation with referral for office visit or consultation as appropriate
 - b. Pre-procedure assessment which includes at a minimum:
 - i. Review of past medical & surgical history
 - ii. Medication reconciliation, review
 - iii. Allergy and reaction, review of
 - iv. Physical assessment; assessment for communicable diseases
 - v. Vital signs

III □ Patient Identification: Refer to Patient Identification Policy. Patient identity is verified with at minimum two (2) identifiers at check-in and at multiple points throughout care.

IV □ Safe Surgery Checklist: Refer to Safe Surgery Checklist Policy. Patient and procedure are verified immediately prior to procedures.

V □ Discharge Teaching: Patients are provided with written discharge instructions which are reviewed with patient and driver, as applicable, prior to discharge. Medications are reconciled prior to discharge if any new medications are ordered. Information specific to diagnosis, as best as known, is given to the patient. Patients are educated about signs and symptoms to report and given a twenty-four (24) hour telephone number to call in event of questions or concerns.

VI □ Post Procedure Callbacks: Patients are contacted one (1) to two (2) business days post-procedure for follow up of any concerns and questions regarding discharge instructions.

VII □ Pathology follow up: Patients are notified of pathology results and given information and follow up orders as applicable within two (2) weeks.

VIII □ Pharmaceutical Services: Refer to Pharmaceutical Services Policy. Safe injection practices are strictly followed. Pharmaceutical services are overseen by a contracting pharmacist on a monthly basis.

I □ Quality Assurance and Benchmarking: Refer to the Quality Management Plan. More than one hundred (100) quality assurance checkpoints are monitored on per patient, per case, per day, per week or per month basis as applicable. Benchmarking of multiple facility and nursing care factors are completed on an ongoing basis. In addition, multiple procedure-related factors are tracked and trended in aggregate and specific to individual

Approved Board of Managers REC/SEC/ CEC 10/11/11; Revised 8/9/12, Approved Board of Managers REC/SEC 1-31-16; CEC 1-25-16; Approved Medical Directors 4/2016

The proceedings and records of a patient safety committee are subject to the same privilege and protection from discovery as the proceedings and records described in NRS 49.117 - 49.123 and NRS 49.265.

physicians on an ongoing basis. Incidents, procedure complications/events, adverse and sentinel events are investigated tracked and trended by facility, staff and physician. All data is reported to the Quality Management Committee.

- **Staff Training:** Extensive staff training is done at time of hire. Annual staff retraining is mandatory; ongoing training is provided as applicable. Staff are evaluated for customer service and performance on an ongoing basis.
- I□ **Checklists:** All items above are monitored via specific checklists, logs and or chart documentation.

Refer to:

- Infection Control Policy
- Criteria for Scheduling Patients at ASC Policy
- Identification of Patient Policy
- Pharmaceutical Services Policy
- Quality Management Plan
- Safe Surgery Checklist Policy
- Incident Reports Policy
- Complications: Procedure Event, Adverse and Sentinel Events Policy
- Staff Training Competencies and Logs
- NRS 439.865; 439.877

Approved Board of Managers REC/SEC/ CEC 10/11/11; Revised 8/9/12, Approved Board of Managers REC/SEC 1-31-16; CEC 1-25-16; Approved Medical Directors 4/2016

The proceedings and records of a patient safety committee are subject to the same privilege and protection from discovery as the proceedings and records described in NRS 49.117 - 49.123 and NRS 49.265.

RENO ORTHOPAEDIC SURGERY CENTER, LLC

POLICY MANUAL*APPROVED BY: BOARD OF DIRECTORS*

SECTION: SAFETY – SAFETY PROGRAM

EFFECTIVE DATE: 10-12-07

REVISED: 2-28-12; 10-21-16

TITLE: Safety Program**SCOPE:** All ROSC Staff**PURPOSE:**

To adopt, implement and monitor a comprehensive environmental control program relative to safety and sanitation that involves staff, equipment operation and maintenance in order to provide a functionally and environmentally safe atmosphere for patients, personnel and visitors.

POLICY:

A Safety Committee will be established to implement the safety and environmental control program of the facility.

1. The safety committee will include: Administrator, Safety Officer, MD, Infection Control Officer, Pharmacy Consultant, and Clinical Manager.
2. Management will appoint a Safety Officer.
3. The Safety Committee will meet monthly as part of the Medical Advisory Committee.
4. Meeting minutes will be taken and maintained.
5. Committee findings and recommendations are reported and submitted in writing to the Quality Management Improvement and the Governing Board.
6. The Safety Officer will prepare the agenda and preside at the meetings. The Safety Officer is responsible for carrying out directives of the Committee and submitting reports to other committees.
7. The Committee members' responsibilities include reporting unsafe conditions, reporting all accidents or near accidents, investigating all serious accidents, contributing ideas and suggestions for improvement, making inspections, participating in In-service education and orientation, familiarizing themselves with standards for safety and sanitation, and assisting in policy and procedure development.

RENO ORTHOPAEDIC SURGERY CENTER, LLC

POLICY MANUAL

APPROVED BY: BOARD OF DIRECTORS

SECTION: SAFETY – SAFETY PROGRAM

EFFECTIVE DATE: 10-12-07

REVISED: 2-28-12

RESPONSIBILITIES OF SAFETY COMMITTEE:

1. To implement and review policies and procedures concerning functional safety and environmental control.
2. To function as a liaison with the Infection Control Officer.
3. To participate in the In-service Education and Orientation program.
4. To conduct Hazard surveillance.
5. To be knowledgeable regarding community safety agencies, especially those concerned with fire and other disasters.
6. To evaluate the effectiveness of the Safety Program and revise and update the program annually and as necessary.

RENO ORTHOPAEDIC SURGERY CENTER, LLC

POLICY MANUAL

APPROVED BY: BOARD OF DIRECTORS

SECTION: SAFETY – ANESTHETIC WASTE GASES

EFFECTIVE DATE: 10-12-07

REVISED:

TITLE: Anesthetic Waste Gases

SCOPE: ROSC Management

PURPOSE:

To provide a safe environment for staff at the Reno Orthopaedic Surgery Center

POLICY:

There is a scavenger system attached to all anesthesia machines used at the center. Monitoring of waste gases is done quarterly by an outside service to assure that escaping gases are within a safe range.

PROCEDURE:

1. There will be a scavenger system connected to a separate vacuum from each anesthesia machine. The anesthesia practitioner makes sure that the hose is attached and inspected for leaks on a daily basis.
2. Quarterly inspections with written reports are obtained by an outside company qualified to test anesthesia waste gases. Management coordinates the inspection.
3. If any leaks are found on inspection, or the safe range is exceeded, the problem is immediately remedied before further use of the machine.

RENO ORTHOPAEDIC SURGERY CENTER, LLC

POLICY MANUAL

APPROVED BY: BOARD OF DIRECTORS

SECTION: SAFETY – CHECKLIST

EFFECTIVE DATE: 9-20-11

REVISED: 2-28-12; 2-20-15

TITLE: Checklist

SCOPE: ROSC Staff
Physicians
Contracted Vendors

PURPOSE:

Provide for protocols to improve the health outcomes of patients.

POLICY:

ROSC Safety Committee adopts the following criteria as a safety checklist for patient surgery.

According the WHO Guidelines for Safe Surgery 2009 the Reno Orthopaedic Surgery Center meets the following highly recommended objectives listed below.

Objective 1: The team will operate on the correct patient at the correct site
Universal Protocol

- Verification: Correct patient, site and procedure identified on the
 - Pre-op, Anesthesia and Intra op document.
- Marking: Preoperatively the patient participates along with the surgeon that marks the site.
- Time Out: Intra-operatively by the team and documented on the intraoperative record.

Objective 2: The team will use methods known to prevent harm from administration of anesthetics, while protecting the patient from pain

- Pulse oximetry & capnography are supplied and performed by an anesthesiologist or directed by a physician.
- Circulation is monitored and documented in surgery and post op by anesthesia and nursing.
- Temperature is monitored and recorded pre-op, intra-op and post op.
- Consciousness is monitored and recorded pre-op, intra-op and post op.

Objective 3: The team will recognize and effectively prepare for life-threatening loss of airway or respiratory function

- Airway is assessed and documented by anesthesia on the anesthesia record.

SECTION: SAFETY – CHECKLIST

EFFECTIVE DATE: 9-20-11

REVISED: 2-28-12; 2-20-15

- A difficult intubation cart is equipped and ready for use by anesthesia.
- Only credentialed anesthesiologist provide anesthesia at ROSC.

Objective 4: The team will recognize and effectively prepare for risk of high blood loss

- Large volume blood loss is not anticipated in a majority of the cases performed at ROSC
- The anesthesiologists communicate with the surgeon and evaluate each case appropriately.
- The Medical Director evaluates all questionable cases prior to surgery.
- IV's are established prior to each surgical case.
- Blood loss is recorded on the anesthesia record.
- Blood is not administered at ROSC.

Objective 5: The team will avoid inducing an allergic or adverse drug reaction for which the patient is known to be at significant risk

- Credentialed anesthesiologists administer pharmacologic agents.
- Nursing administers medication under a physician order.
- Both physician and clinical staff are responsible for identifying the patient and the medication administered.
- A Patient Medication Reconciliation Record (signed by the patient), is obtained prior to surgery.
- Allergies and sensitivities are recorded on the front of the chart.
- Allergies and sensitivities are checked and recorded on the pre-op, intraop, PACU and anesthesia records.
- Aseptic medication technique is performed upon hire and annually.
- Medication drawn up and labeled is administered by the same person drawing and labeling the medication.
- National patient safety goals for the medication are followed by ROSC.

Objective 6: The team will consistently use methods known to minimize the risk for surgical site infection

- Prophylactic antibiotics are administered to all surgical cases prior to surgery by the anesthesiologist.
- Sterilization process involves the use of indicators used on every tray and peel pack. A Biological is run each load.
- A surgical scrub for OR is done for 2-5 minutes.
- Sterile surgical attire is provided for each surgical case.

Objective 7: The team will prevent inadvertent retention of instruments and sponges in surgical wounds

- Sponge and sharps counts are performed before and after each procedure and documented on the intra-op record.

RENO ORTHOPAEDIC SURGERY CENTER, LLC

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SECTION: SAFETY – CHECKLIST

EFFECTIVE DATE: 9-20-11

REVISED: 2-28-12; 2-20-15

Objective 8: The team will secure and accurately identify all surgical specimens

- All specimens have a patient label attached to the container.
- Pathology Specimen Request is complete and accompanies the patient specimen.

Objective 9: The team will effectively communicate and exchange critical information for the safe conduct of the operation.

- The team prepares for instruments, implants, intra-operative imaging, and pathology in advance of each case.
- Anesthesia issues are addressed by each anesthesiologist and surgeon prior to each case. When patient safety is in question, the case is cancelled.

Objective 10: Hospitals and public health systems will establish routine surveillance of surgical capacity, volume and results.

- ROSC Facility will report the following Outcomes to the Nevada State Bureau of Health & Welfare Annually
 - Number of operating rooms –
 - Number of procedure rooms –
 - Number of surgical procedures performed
 - Number of board certified Orthopaedic surgeons –
 - Number of Anesthesiologist
 - Day of surgery mortality rate
 - Post operative in hospital mortality rate
 - Surgical Site Infection Rate
 - Surgical Complications

2) All treatment provided is ordered by the physician.

3) Any prescription given to the patient is filled at the patients' pharmacy of choice. Medication is taken as directed by the surgeon and pharmacist and documented on the discharge instruction sheet.

4) All after care and all other discharge instruction are given as ordered by the physician and documented on the discharge instruction sheet.

5) An environmental, staff and patient safety checklist is completed monthly the safety officer. (attached)

6) Orientation checklist – (attached).

RENO ORTHOPAEDIC SURGERY CENTER, LLC

POLICY MANUAL

APPROVED BY: BOARD OF DIRECTORS

SECTION: SAFETY – COMPRESSED GAS HANDLING

EFFECTIVE DATE: 10-12-07

REVISED:

TITLE: Compressed Gas Handling

SCOPE: ROSC Staff

PURPOSE:

To provide guidelines for safe handling of compressed gas.

POLICY:

IDENTIFICATION:

1. All gases are properly labeled with contents and whether they are flammable.
2. Never rely on the color of the tank for identification of the contents.

STORAGE & HANDLING:

1. Tanks of compressed gases are stored upright and chained to a support system to minimize falling over.
2. A safety cap is used during transport of H-cylinders.
3. Always use proper DISS or pin index safety system for the gas being used.
4. The gas storage area is kept cool and out of direct rays of the sun and away from heat pipes. It is well ventilated to prevent "pocketing " of fumes, and is fireproof with some means for cooling in the event of fire.
5. Regulators, fittings or gauges will never be lubricated or come in contact with oil or grease.
6. Never use leaking or defective tubing or equipment that is in need of repair.
7. When opening cylinder valve, always open with the face pointed away from any person.
8. Care should be taken to handle tanks safely. Seek assistance if tank is too heavy to handle alone. Never handle tank with greasy hands.

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POLICY MANUAL

APPROVED BY: BOARD OF DIRECTORS

SECTION: SAFETY – COMPRESSED GAS HANDLING

EFFECTIVE DATE: 10-12-07

REVISED:

DISPOSAL:

1. All anesthesia gas scavenging systems are vented to the outside.
2. Empty cylinders and tanks are returned to the distributor.

RENO ORTHOPAEDIC SURGERY CENTER, LLC

POLICY MANUAL

APPROVED BY: BOARD OF DIRECTORS

SECTION: SAFETY – ELECTRICAL SAFETY

EFFECTIVE DATE: 10-12-07

REVISED:

TITLE: Electrical Safety

SCOPE: All ROSC Staff

PURPOSE:

To provide guidelines for general electrical safety

POLICY:

1. All staff will observe for signs of electrical hazards. Equipment with frayed cords, exposed wire, or broken plugs will be taken out of use immediately. A sign that states "DO NOT USE" will be placed on equipment, and Management notified. Management will have the equipment repaired by the biomedical engineer.
2. Extension cords will be used only on an emergency basis.
3. All electrical devices being used in the operating room must have three-pin plugs and connect into three-hole receptacles.
4. Cheater plugs will never be used.
5. Keep fluids away from all electrical equipment.
6. Remove power plugs by grasping the plug; never pull on the cord.

RENO ORTHOPAEDIC SURGERY CENTER, LLC

POLICY MANUAL

APPROVED BY: BOARD OF DIRECTORS

SECTION: SAFETY – ELECTRICAL SAFETY CHECKS

EFFECTIVE DATE: 10-12-07

REVISED:

TITLE: Electrical Safety Checks

SCOPE: Biomedical Engineering Contractor
Management

PURPOSE:

To assure that patients and employees are protected from electrical shock.

POLICY:

All electrical appliances or equipment destined for patient care is to have an electrical safety check performed before use in the facility with annual safety checks performed thereafter.

PROCEDURE:

1. Management or designee contacts the Biomedical Engineer to perform electrical safety inspections before new electrical equipment is used.
2. The Biomedical Engineering Contractor inspects the equipment and places a label stating when the inspection took place and that the item is safe for use.
3. The Biomedical Engineering Contractor has a contract with ROSC to inspect new equipment and to perform annual inspections on all electrical equipment.
4. During routine inspections, if equipment is found to be defective or hazardous, Management is informed and a decision is made as to whether the item will be replaced or repaired.

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POLICY MANUAL

APPROVED BY: BOARD OF DIRECTORS

SECTION: SAFETY – GENERAL SAFETY IN THE WORKPLACE

EFFECTIVE DATE: 10-12-07

REVISED:

TITLE: General Safety In The Workplace

SCOPE: All ROSC Staff

PURPOSE:

To identify general safety rules for all employees of ROSC.

POLICY:

All employees of the Center will be familiar with the following safety rules of the workplace. Employees will be responsible to observe and correct any hazards in the workplace.

1. Keep traffic areas clear of obstructions.
2. Pick up any foreign matter on floors and put in proper receptacles.
3. Wipe up spills immediately.
4. Use caution when opening doors. If no viewing window is present, open door slowly.
5. Be physically and mentally prepared for work.
6. Prevent spread of infectious disease by staying out of the workplace when ill.
7. Never engage in horseplay or practical jokes.
8. Walk, never run in the facility.
9. Heed all warning signs that caution a hazardous condition. (i.e., wet floor signs.)
10. Know location of fire alarm pulls, extinguishers, and exits.
11. Be familiar with Emergency Codes.

RENO ORTHOPAEDIC SURGERY CENTER, LLC

POLICY MANUAL*APPROVED BY: BOARD OF DIRECTORS*

SECTION: SAFETY – INSTALLATION OF ALCOHOL BASED HAND RUBS

EFFECTIVE DATE: 8-30-10

REVISED:

TITLE: Installation of Alcohol Based Hand Rubs**SCOPE:** Management**PURPOSE:**

To maintain a safe environment

POLICY:

ROSC will follow CFC 416.44 (b) Standard: Safety from Fire.

(5) Notwithstanding any provisions of the 2000 edition of the Life Safety Code to the contrary, an ASC may place alcohol-based hand rub dispensers in its facility if—

(i) Use of alcohol-based hand rub dispensers does not conflict with any State or local codes that prohibit or otherwise restrict the placement of alcohol-based hand rub dispensers in health care facilities;

(ii) The dispensers are installed in a manner that minimizes leaks and spills that could lead to falls;

iii) The dispensers are installed in a manner that adequately protects against access by vulnerable populations; and

(iv) The dispensers are installed in accordance with the following provisions:

(A) Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 ft (1.8m);

(B) The maximum individual dispenser fluid capacity shall be: (1) 0.3 gallons (1.2 liters) for dispensers in rooms, corridors, and areas open to corridors. (2) 0.5 gallons (2.0 liters) for dispensers in suites of rooms;

(C) The dispensers shall have a minimum horizontal spacing of 4 ft (1.2m) from each other;

(D) Not more than an aggregate 10 gallons (37.8 liters) of ABHR solution shall be in use in a single smoke compartment outside of a storage cabinet;

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POLICY MANUAL

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SECTION: SAFETY – INSTALLATION OF ALCOHOL BASED HAND RUBS

EFFECTIVE DATE: 8-30-10

REVISED:

(E) Storage of quantities greater than 5 gallons (18.9 liters) in a single smoke compartment shall meet the requirements of NFPA 30, Flammable and Combustible Liquids Code;

(F) The dispensers shall not be installed over or directly adjacent to an ignition source; and

(G) In locations with carpeted floor coverings, dispensers installed directly over carpeted surfaces shall be permitted only in sprinklered smoke compartments.

RENO ORTHOPAEDIC SURGERY CENTER, LLC

POLICY MANUAL

APPROVED BY: BOARD OF DIRECTORS

SECTION: SAFETY – LATEX ALLERGY

EFFECTIVE DATE: 10-12-07

REVISED: 8-30-10

TITLE: Latex Allergy

SCOPE: All ROSC Staff

PURPOSE:

To provide for a latex safe environment for patients with known latex allergies. To help prevent or minimize the risk of an allergic anaphylactic reaction secondary to exposure and sensitization to latex.

POLICY:

When possible, schedule procedure as first case of the day, otherwise plan for a latex safe environment.

PROCEDURE:

- 1) Notify all health care providers of potential or known latex-allergic patient before scheduled procedure.
- 2) Exchange latex-free products for all latex-containing items.
- 3) Notify surgeon and anesthesia care provider if no alternative latex free product is available.
- 4) Remove latex items from OR unless no non latex alternative exists.
 - a. Remove boxes of latex gloves and replace with non-latex gloves (e.g., sterile, nonsterile).
 - b. Double check all supplies and equipment for latex and remove any latex-containing items.
- 5) Educate patient about latex-safe plan.

RENO ORTHOPAEDIC SURGERY CENTER, LLC

POLICY MANUAL*APPROVED BY: BOARD OF DIRECTORS*

SECTION: SAFETY – MEDICAL DEVICE PROBLEM & RECALL

EFFECTIVE DATE: 10-12-07

REVISED:

TITLE: Medical Device Problem & Recall**SCOPE:** All ROSC Staff**PURPOSE:**

To establish a uniform policy to ensure that product problem and recall information is documented, disseminated and reported according to Federal guidelines.

POLICY:

The following steps will be performed by Management for all reported product alerts and product problems:

1. When a product alert is received, Management determines if the product is stocked in the surgery center.
2. If the product is in ROSC, appropriate action takes place according to instruction of the recall. This may include revision of usage instructions, removal of the product, or modification of the product.
3. Staff and physicians are notified by Management as to the proper action to follow.
4. If the product has been used on a patient, the manufacturer and the patient are notified.
5. If a product is used on a patient and malfunctions during use, the manufacturer must be notified and if any injury or potential injury has occurred, an incident report is filled out.
6. If a medical device has in all probability caused death, serious injury or illness of a patient, the FDA and the Nevada Department of Public Health and Environment must be notified. Management or Administrator files the appropriate reports.
7. The report to the FDA must be made within ten days after the facility becomes aware of the problem. The report includes the facility name and address, the device's name, serial number and model number; the manufacturer's name and address and a brief description of the event reported to the manufacturer.

RENO ORTHOPAEDIC SURGERY CENTER, LLC

POLICY MANUAL

APPROVED BY: BOARD OF DIRECTORS

SECTION: SAFETY – MEDICAL DEVICE PROBLEM & RECALL

EFFECTIVE DATE: 10-12-07

REVISED:

8. The “Occurrence Report – Equipment Malfunction or Misuse” form must be completed and submitted to the Nevada Department of Public Health and Environment (within one (1) business day of the occurrence. (See copy of form following this policy.)

9. A copy of the recall or problem and a copy of the reports to the FDA and applicable State reports is kept on file in the facility.

TITLE: Patient Safety Plan

SCOPE: All ROSC Staff

PURPOSE:

To provide ongoing safety and care for patients.

POLICY:

1. Guidelines followed:
 - a. CDC Guideline for Hand Hygiene
 - b. ANSI/AAMI Comprehensive guide to steam sterilization and sterility assurance in health care facilities. Supported by CDC Guideline for Sterilization and Disinfection in Health Care Facilities.
 - c. CDC Environmental Infection Control in Healthcare Facilities
 - d. AORN Peri-Operative Standards and Recommended Practices
 - e. APIC Text of Infection Control and Epidemiology Guideline for Isolation Precautions
2. Additional Infection Control Policies – See Infection Control in Policy Manual for details
 - a. Aseptic Technique
 - b. Communicable Disease Reporting
 - c. Environmental Controls
 - d. Facility Sanitation
 - e. Housekeeping Logs
 - f. Infection and Complication Tracking
 - g. Laundry Guidelines
 - h. Operating Room Sanitation
 - i. Pest Control
 - j. Sterilizer Monitoring
 - k. Traffic Patterns
 - l. Wound Classification
 - m. Universal Precautions
3. Patient Selection and Screening
 - a. Patients are pre-screened by the Surgeons and Medical Director for appropriateness for surgery.

RENO ORTHOPAEDIC SURGERY CENTER, LLC

POLICY MANUAL

APPROVED BY: BOARD OF DIRECTORS

SECTION: SAFETY – PATIENT SAFETY PLAN

EFFECTIVE DATE: 12-20-11

REVISED:

- b. Patients with known infections and communicable disease are not a candidate for surgery at the facility.
 - c. In the event that an infection or communicable disease is discovered at the facility the patient is isolated and appropriate discharge is determined by the physician. Reports are made to the appropriate agencies.
4. Patient Identification
 - a. Identity is verified with two identifiers upon admission and prior to any procedure or treatment.
5. Timeout: Timeout is performed prior to procedure or surgery.
6. Discharge Teaching
 - a. Written discharge instructions are reviewed with the patient and significant other prior to discharge.
 - b. Patient medication is reconciled prior to discharge and a copy of their Medication Reconciliation Sheet is given to the patient.
 - c. Patients are educated to report general as well as specific signs and symptoms related to the procedure.
 - d. Patients are given a telephone number where they can reach a surgeon 24 hours a day.
7. Post Procedure Call
 - a. Two attempts to call the patient post procedure is made one business day following the procedure.
8. Pathology results
 - a. Pathology results are sent directly to the surgeon's office.
 - b. A designated ROSC nurse follows up on all pathology results and verifies that the surgeon received and reviewed the results
9. Pharmacy
 - a. ROSC has a consulting Pharmacist who reviews, updates and educates staff on policy and procedure related to Medications. (See Medication section of Policy and Procedure)
 - b. The consulting Pharmacist performs a monthly audit of the Controlled Substances, DEA 222 forms, anesthesia narcotic reconciliation, patient charts.
 - c. The Pharmacist produces a monthly report, recommendations and corrective actions are made to Management, Medical Director and the Medical Advisory Committee as deemed necessary.
10. Quality Management and Improvement

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POLICY MANUAL

APPROVED BY: BOARD OF DIRECTORS

SECTION: SAFETY – PATIENT SAFETY PLAN

EFFECTIVE DATE: 12-20-11

REVISED:

- a. Clinical data is collected on however not limited to the following: transfers to an acute facility, infections, patient falls, other patient complications, medication incidents and medical device issues.
 - b. Quality Improvement Studies are performed to analyze issues for improvement.
 - c. Data is reported to the Medical Advisory Committee and Board of Directors.
11. Staff Training
- a. Staff training is provided on hire, annually and as needed.
12. Checklist and Logs
- a. Checklists and logs cover but are not limited to the following: safety, staff skills, cart checks, temperatures and expirations.
13. Policies, Quality Management and Fire and Disaster Manual detail staff and patient safety.

RENO ORTHOPAEDIC SURGERY CENTER, LLC

POLICY MANUAL

APPROVED BY: BOARD OF DIRECTORS

SECTION: SAFETY – RADIATION SAFETY

EFFECTIVE DATE: 10-12-07

REVISED: 8-30-10; 10-21-16

TITLE: Radiation Safety

SCOPE: Physicians
Clinical Staff
Radiology Technicians

PURPOSE:

To provide guidelines that will limit exposure to radiation to personnel and patients in ROSC.

POLICY:

1. All personnel in the operating room will wear a lead shield while x-rays are being taken. Personnel wearing lead aprons should always face the x-ray unit.
2. Leaded shields will be used, when possible, to protect the patient's reproductive organs and thyroid during x-rays. The circulating nurse will document the type of protection used on the patient.
3. All reasonable means of reconciling an incorrect count should be implemented before using an x-ray to locate an unaccounted item.
4. Lead aprons will be laid flat or hung by the shoulders when not in use, to minimize cracking of shield.
5. The C-arm equipment will be inspected and calibrated annually by a state physicist, to ensure the equipment is working properly and meets safety regulations. Aprons and shields will be x-rayed bi-annually for any breaks in integrity. Any damaged aprons and shields will be disposed of.
6. All staff members working in the presence of fluoroscopy will wear dosimetry badges. Dosimetry Badges will be maintained and monitored.
7. All staff who are assigned a dosimetry badge will be requested to report all other badge reports on an ongoing basis in order to help keep track of cumulative exposure.

SECTION: SAFETY – RADIATION SAFETY

EFFECTIVE DATE: 10-12-07

REVISED: 8-30-10; 10-21-16

8. The staff member assigned to operate the fluoroscopy equipment must carefully observe all radiation safety precautions and remind other medical personnel if radiation safety rules/practices are violated. Violations of radiation safety rules/practices must be documented and reported to Management.
9. Personnel are limited to receiving no more than the maximum permissible radiation dose limit per State or Federal guidelines.
10. Reproductive organ shielding shall be provided to all patients unless this area is essential to the clinical image.
11. All fertile female patients will be evaluated for the potential of pregnancy.
12. Thyroid shields will be worn by staff if they are in proximity to the patient.
13. The facility has an established BioMed agreement for the maintenance of all radiation equipment.
14. Any questions regarding radiological safety must be directed to Management who will contact the contracted X-ray technician or the state physicist.
15. Signs will be posted on OR or procedure room door when x-ray is in use.
16. A yearly radiation safety competency will be completed by all staff.

RENO ORTHOPAEDIC SURGERY CENTER, LLC

POLICY MANUAL

APPROVED BY: BOARD OF DIRECTORS

SECTION: SAFETY – REFRIGERATOR MONITORING

EFFECTIVE DATE: 10-12-07

REVISED:

TITLE: Refrigerator Monitoring

SCOPE: ROSC Staff

PURPOSE:

To insure medications and food that require refrigeration are kept at proper temperature.

POLICY:

The temperature in the refrigerator used for storage of patient food or medication must be kept between 36 degrees and 46 degrees Fahrenheit.

PROCEDURE:

1. Medications and food is stored in separate refrigerators.
2. Refrigerators containing patient food or medications have a thermometer.
3. Staff checks the refrigerator temperature daily.
4. The temperature is recorded daily on the flow sheet. Flow sheet is filed with Management and kept for two years.
5. If there is a variance from the recommended temperature, the nurse notifies maintenance to have the refrigerator checked.

RENO ORTHOPAEDIC SURGERY CENTER, LLC

POLICY MANUAL

APPROVED BY: BOARD OF DIRECTORS

SECTION: SAFETY – REPORTING OF DEFECTIVE EQUIPMENT/INSTRUMENTS

EFFECTIVE DATE: 10-12-07

REVISED:

TITLE: Reporting of Defective Equipment/Instruments

SCOPE: All ROSC Staff

PURPOSE:

To define the protocol to be used when an instrument or piece of equipment is not working properly. To assure that equipment and instruments that are defective are removed from the system until they are repaired.

POLICY:

Any item that is found to be defective is tagged and sent to Management.

PROCEDURE:

1. When an instrument or any piece of equipment in the Operating Room or Recovery Room is found to be defective, the employee discovering the problem tags the item and removes it from service. Management is notified so action can be taken to have the device repaired or replaced.
2. The employee labels the item and describes the exact problem that was observed, to improve rapid repairs.
3. Management further investigates and has the item sent for repair as needed. Management communicates with the staff that the item has been sent out of the department for repair and if a loaner can be expected.
4. Upon return of the item, the device is checked by a staff member who is familiar with the performance or, if necessary, it is evaluated by the Biomedical Engineering Contractor prior to being returned to service.

TITLE: Safe Use of Sterilizer

SCOPE: OR Staff/Sterile Processing

PURPOSE:

To assure safe use of sterilizers and prevent injuries from occurring when sterilizers are used.

POLICY:

Any staff member who will be using autoclaves will be educated and trained in the safe and proper operation of the sterilizer.

PROCEDURE:

1. Employees participate in an inservice on the use of the sterilizer. They demonstrate that they can safely operate the autoclaves, and are familiar with the manual operation of the autoclaves.
2. The chamber door is opened slowly and never opened until the pressure gauge reads zero. Never look directly at the autoclave when opening the door. Excess steam may have accumulated and be released when the door is opened.
3. When removing items from the autoclave, mitts, towels or forceps are used. Never reach in the autoclave with bare hands or arms.

TITLE: Safety Precautions When Using Oxygen

SCOPE: All ROSC Staff

PURPOSE:

To assure safe handling of oxygen in the facility.

DISCUSSION:

Oxygen is a non-flammable, non-explosive gas, however it readily supports combustion. Any material that will burn in air will ignite more readily in an oxygen-enriched atmosphere. The higher concentration of oxygen, the greater is the intensity of burning. When oxygen is administered, the following precautions must be taken to prevent explosions and fire.

POLICY:

1. The facility is a "no smoking" facility. "No Smoking" signs are posted and visitors are reminded of this policy.
2. Any defect in the oxygen administration system such as a leak or a malfunctioning flow meter must be reported to Management who contacts the appropriate service for repair or replacement of the part.
3. Oxygen equipment must have an oxygen pressure interlock system and fail safe mechanism.
4. All electrical cords and equipment must be grounded.
5. Materials such as oil, grease, alcohol and other highly flammable substances must be kept away from oxygen and oxygen equipment.
6. Be sure there is no oil on hands when handling any oxygen administration equipment.

TITLE: Safety When Moving Patients or Objects

SCOPE: All ROSC Staff

PURPOSE:

To provide guidelines for moving patients and objects to avoid injury to staff.

POLICY:

PROCEDURE:

1. Lifting:
 - a. Look over the object to be lifted, making sure it is not too heavy or clumsy to handle alone.
 - b. Stand close to the object with feet apart for balance. Make sure footing is secure.
 - c. Bend knees. Keep back as straight as possible.
 - d. Get a good grip and keep the weight close to your body.
 - e. Lift gradually. Straighten knees and stand. Use leg muscles. Avoid quick, jerky motions.
 - f. When the weight is too heavy or the object is too bulky to lift safely, get help.

2. Pushing and pulling objects:
 - a. Get a good grip on the object; hands inside handles.
 - b. Keep back as straight as possible.
 - c. Brace your feet for maximum leg power.
 - d. Bend your knees to get the best use of your body weight.

3. Carrying:
 - a. Keep the load close to your body.
 - b. Make sure your vision is clear and the load does not obstruct your view.
 - c. Do not change grip while carrying the load.
 - d. Always face the spot on which the load will rest.

4. Transferring:

RENO ORTHOPAEDIC SURGERY CENTER, LLC

POLICY MANUAL

APPROVED BY: BOARD OF DIRECTORS

SECTION: SAFETY – SAFETY WHEN MOVING PATIENTS OR OBJECTS

EFFECTIVE DATE: 10-12-07

REVISED: 8-30-10

- a. Lock bed, recliner or wheelchair
- b. Explain transfer steps
- c. Encourage independent movement from the individual
- d. Keep individual close to the body
- e. Follow steps for lifting
- f. Transfer to locked bed, recliner or wheelchair
- g. Secure individual

RENO ORTHOPAEDIC SURGERY CENTER, LLC

POLICY MANUAL

APPROVED BY: BOARD OF DIRECTORS

SECTION: SAFETY – USE OF SIDE RAILS

EFFECTIVE DATE: 10-12-07

REVISED: 8-30-10

TITLE: Use of Side Rails

SCOPE: All Staff

PURPOSE:

To assure the safety of patients who have had sedation or anesthetic drugs.

POLICY:

PROCEDURE:

1. The side rails of stretchers are put in an upright position if the patient has been given a preoperative sedative.
2. All patients transported on a stretcher must have the side rails in an upright position.
3. When the procedure is complete and the anesthetized patient is moved to the stretcher, the side rails are put in an upright position and remain up until the patient is transferred to a recliner or discharged.

RENO ORTHOPAEDIC SURGERY CENTER, LLC

POLICY MANUAL*APPROVED BY: BOARD OF DIRECTORS*

SECTION: SAFETY – SENTINEL EVENTS

EFFECTIVE DATE: 10-12-07

REVISED: 8-30-10; 2-27-15

TITLE: Sentinel Event**SCOPE:** All ROSC Staff**PURPOSE:**

To identify and report to appropriate health regulatory agencies events resulting in unexpected outcomes. A thorough investigation for root cause analysis, implementation of improvement to reduce risk, and monitoring of the effectiveness of process improvement will occur following any reportable event.

DEFINITION:

Per NRS 439.830 defines a sentinel event as: an unexpected occurrence involving facility-acquired infection, death or serious physical or psychological injury or the risk thereof, including, without limitation, any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. The term includes loss of limb or function.

POLICY:

Any event identified below is reported to the Department of health and Human Services Nevada Division of Public and Behavioral Health. All occurrences are reported by the next business day.

A written report using the format provided by the State, is completed and returned within 5 days of the occurrence. Prevention is encouraged through safe practices by the healthcare team.

REPORTABLE OCCURRENCES:

As of October 1, 2013 reportable events to the state Sentinel Registry include:

Surgical or Invasive Procedure Events

- A.** Surgery or other invasive procedure performed on the wrong site
- B.** Surgery or other invasive procedure performed on the wrong patient
- C.** Wrong surgical or other invasive procedure performed on a patient
- D.** Unintended retention of a foreign object in a patient after surgery or other invasive procedure
- E.** Intraoperative or immediately postoperative/post procedure death in an American Society of Anesthesiologists Class 1 patient.

Product or Device Events

- A.** Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting
- B.** Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended.
- C.** Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting.

Patient Protection Events

- A.** Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person
- B.** Patient death or serious injury associated with patient elopement (disappearance)
- C.** Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a health care setting.

Care Management Events

- A.** Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)
- B.** Patient death or serious injury associated with unsafe administration of blood products
- C.** Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting
- D.** Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy
- E.** Patient death or serious injury associated with a fall while being cared for in a healthcare setting
- F.** Any Stage 3, Stage 4, and un-stage-able pressure ulcers acquired after admission/presentation to a healthcare setting
- G.** Artificial insemination with the wrong donor sperm or wrong egg
- H.** Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen
- I.** Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results.

Environmental Events

- A.** Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting
- B.** Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances
- C.** Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting
- D.** Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting.

Radiologic Events

Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area.

Potential Criminal Events

- A.** Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider
- B.** Abduction of a patient/resident of any age
- C.** Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting
- D.** Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting.



QUALITY AND PATIENT SAFETY PLAN

Lake's Crossing Center

500 Galletti Way
Sparks, NV 89431
775-688-1900

Name Here

Commitment to patient safety

Lake's Crossing Center provides statewide residential and outpatient services to individuals who have been evaluated as requiring mental health services in order to proceed with their adjudication. Such services require a fully coordinated effort with responsibilities for treatment, evaluation and consultation. Lake's Crossing Center must meet a wide range of needs for a diverse population and we are committed to a comprehensive approach for continuous improvement of patient safety.

Mission, Vision and Values

The purpose of this policy is to establish a plan for patient safety designed to promote patient safety throughout all departments in Lake's Crossing Center. Thus, the plan will focus on system-wide integrated performance improvement activities aimed at assuring an integrated approach to patient safety. In support of our commitment to patient safety, Lake's Crossing Patient Safety and Quality Improvement program includes oversight regarding:

- Providing the necessary services to clients in the least restrictive manner appropriate to the client, utilizing collaboration of leadership, medical staff and other staff providers to deliver integrated and high quality care within the program.
- Consultation and collaboration with other Division agencies on the treatment and management of clients.
- Providing treatment oriented toward development of socially appropriate and community-oriented skills stabilizing potentially dangerous behavior.
- Ensuring appropriate placement and follow-up of clients adjudicated not guilty by reason of insanity or un-restorable to competency.
- Continuing education of staff and medical personnel to assure quality of care and monitoring of standards.

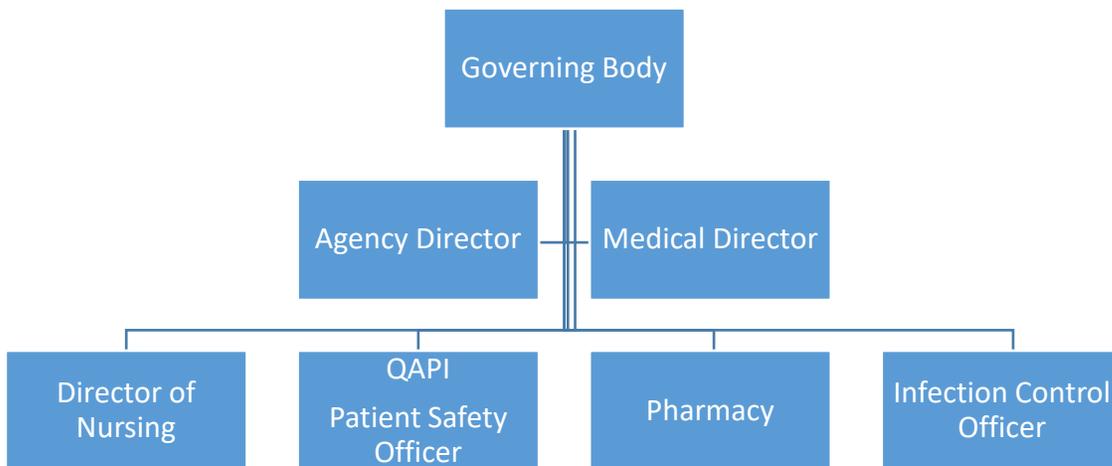
Scope and Purpose

The scope of the Patient Safety Plan is agency wide and includes all aspects of patient safety, visitor safety, vendor safety and employee safety. All staff in Lake's Crossing are required to fully support and participate in this plan and devote their expertise to the patient safety and quality improvement process.

This plan is action oriented and solution focused. The purpose of this plan is to address patient safety related concerns, challenges and revise the program to better serve the clients and facilitate our accountability to the courts. The plan further focuses on the processes involved and facilitates the need of analyzing and improving processes. The core principles of this plan include:

- All staff have the same goal and contribute their knowledge, vision, skill, and insight to improve the process of the Patient Safety Plan.
- Decisions regarding implementations of the Patient Safety Plan will be based on data and facts and will be reported to and tracked by the QAPI department.

As per NRS 439.875, a medical facility shall establish a Patient Safety Committee. This Patient Safety Committee should ensure that the Quality and Patient Safety Plan is promoted and executed successfully. The Patient Safety Committee organizational chart for Lake's Crossing is as follows:



Roles and Responsibilities of the Patient Safety Committee:

- Meet at least once a month
- Receive reports from the Patient Safety officer as per NRS 439.870
- Evaluate the actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred at Lake's Crossing.
- Review and evaluate the quality of measures carried out by the facility to improve the safety of clients who receive care at Lake's Crossing.
- Review and evaluate the quality of measures carried out by the facility to prevent and control infections at Lake's Crossing.
- Make recommendations to the governing body to reduce the possible number and severity of sentinel events and infections that could occur at Lake's Crossing.
- Report to the governing body at least once each quarter regarding the number of sentinel events occurring at Lake's Crossing during the preceding calendar quarter; the number and severity of infections that occurred at Lake's Crossing during the preceding calendar quarter; any identified recommendations to reduce the number and severity of any sentinel events and infections that occur at Lake's Crossing.

- Adopt and put into use, patient safety checklists and patient safety policies, as required in NRS 439.877, review the checklists and policies annually and revise as determined by the patient safety committee.
- On or before March 1 of each year, submit a report to the Director of the Legislative Counsel Bureau that will be transmitted to the Legislative Committee on Health Care. This report is to include information regarding the development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review.

Roles and Responsibilities of the Patient Safety Officer:

- Serve on the Patient Safety Committee
- Conduct root cause analysis through utilization of interviews, analysis, investigation and corrective action plan implementations.
- Perform the duties as required in NRS 439.835 regarding the reporting of sentinel events.
- Take such action as is determined to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at Lake's Crossing.
- Report to the Patient Safety Committee regarding any action taken in accordance with the above responsibilities.

Roles and Responsibilities of the Infection Control Officer:

- Serve on the Patient Safety Committee
- Monitor the occurrences of infections at Lake's Crossing to determine the number and severity of infections.
- Report to the Patient Safety Committee concerning the number and severity of infections at Lake's Crossing
- Take such action as is determined to prevent and control infections as identified at Lake's Crossing.
- Carry out the provisions of the infection control program pursuant to NRS 439.865 and ensure compliance with the program.

Roles and Responsibilities of the Governing Body

- Provide vision, leadership and oversight to the Patient Safety and Quality Improvement process and develop and foster a safe learning and improving culture at Lake's Crossing.
- Plan, discuss, and work with the committee and its members in accomplishing the patient safety goals and activities.

Objectives, Goals and Assessment of the Quality and Patient Safety Plan

Pursuant to NRS 439.837, Lakes Crossing will utilize the proper procedures to report any sentinel events and conduct an investigation concerning the causes or contributing factors and implement a plan to remedy the causes or contributing factors of the sentinel event through the use of Root Cause Analysis. Also considered for analysis will be near misses, repeated problems such as medication errors and events which have or could have resulted in patient harm. The objective will be to determine where gaps lie and how to determine them; not to place a blame in any particular department or individual.

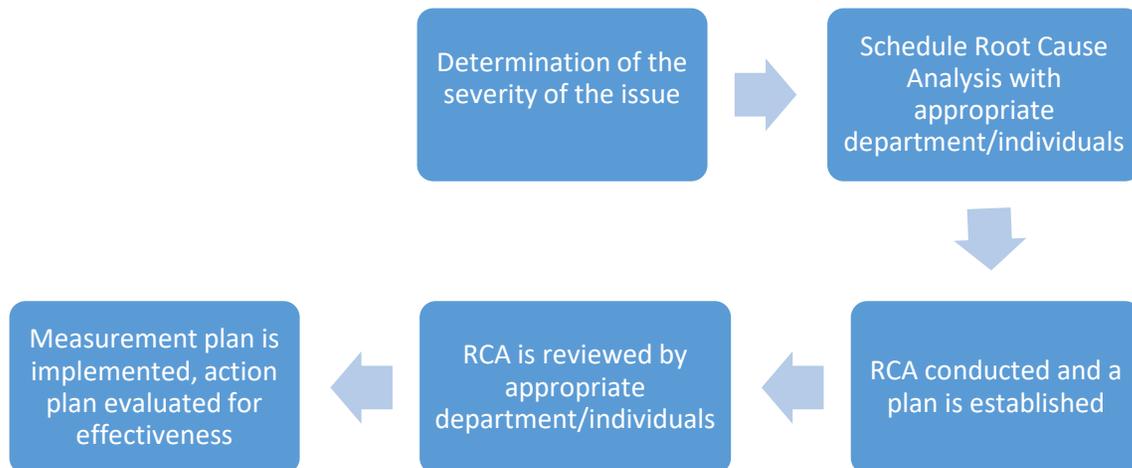
The event will be analyzed based on the factors of *catastrophic, major, moderate and minor*. The probability will be measured on the frequency – is it a frequent occurrence, occasional occurrence, uncommon occurrence or remote occurrence.

TABLE 1: Safety Assessment Matix

Severity 	Catastrophic	Major	Moderate	Minimal	Comments
Frequent	3	3	2	1	
Occasional	3	2	1	1	
Uncommon	3	2	1	1	
Remote	3	2	1	1	

The above matrix will be used as a determining factor for if a Root Cause Analysis would be necessary for the incident with “3” being the highest rating.

Upon identification of an incident necessitating a Root Cause Analysis a meeting will be held with determination steps as follows:



According to NRS 439.865, the patient safety plan must include certain required checklists relating specifically to our facility. The specific checklists which are **required** to be included are listed below as well as others pertinent to Lake’s Crossing Center.

Patient Safety Checklists and Patient Safety Policies:

Check Lists Include:	Usage	Existing	Developed	Reviewed	Revised
Documentation of physician orders	Nursing	No	In process		
Discharged client room cleaning inspection	Janitorial	yes	Yes	Yes	
Discharge instructions	Nursing, Social Services	Yes	Yes	Yes	
Pharmacy error tracking	Pharmacy	yes	Yes	Yes	
Fall Prevention	Nursing	yes	Yes	Yes	
Sanitation QA checklist	Janitorial	yes	Yes	Yes	
Food service meal incident communication log	Nutritional Services	Yes	Yes	Yes	
Eyewash station	Janitorial	Yes	Yes	Yes	
Chemical sanitizing dish machine log	Nutritional Services	Yes	Yes	Yes	
Refrigerator & freezer logs	Nutritional Services	Yes	Yes	Yes	
Patient Safety Policies Include:	Usage	Existing	Developed	Reviewed	Revised
Two personal patient identifiers	All Staff	yes	Yes	Yes	Yes
Nationally recognized standard precautions protocol	All staff	Yes	Yes	Yes	
Nationally recognized hand washing procedures	All staff	Yes	Yes	Yes	Yes
Infection control policies	Nursing	yes	Yes	Yes	Yes

Summary of Review	Total # Developed	Total # Reviewed	Total # Revised
Patient Safety Checklists	9	9	
Patient Safety Policies	4	4	3

Ongoing Reporting and Review:

Monthly	Quarterly	Annually
1) Sentinel Event monthly report	1) Sentinel Event quarterly report	1) Report submitted to LCB
2) Severity of infection report	2) Severity of infection quarterly report	2) Quality and Patient Safety plan update
3) Meeting of the Patient Safety Committee	3) Review and evaluate the measure of improvement of patient safety	3) Checklists and policies reviewed and revised as necessary
4) Monitoring of contract personnel	4) Review and evaluate the measurement to prevent and control infections	

SUBJECT: PATIENT SAFETY IN THE PROCEDURE ROOM	REFERENCE #7002
DEPARTMENT: AMBULATORY CARE SERVICES	PAGE: 1 OF: 3
	EFFECTIVE: 02/15/2010
APPROVED BY:	REVISED: 01/19/11

PURPOSE:

To identify and eliminate potential safety hazards, thereby reducing risk to patients, personnel and visitors.

POLICY:

Patient safety refers to a systematic facility-wide program to minimize preventable physical injuries, accidents and undue psychological stress during the visit. The HSC nursing practice for safety standards is as follows:

1. Patient Identification:

The RN always identifies the patient by checking the wristband with the patient's chart and the operating schedule. In addition, the RN verifies patient identification through verbal communication with the patient and/or caregiver.

2. Patient Observation:

Side rails are always to be in the UP position when a patient is on a gurney. Special care is ensured by provision of an adequate number of personnel when positioning patients. When positioning patients, it is essential to provide supportive devices to protect nerves and blood vessels. Limbs are never to be hyperextended.

3. Dedication to Meticulous Aseptic Technique:

Facility team members must know and apply the principles of aseptic technique at all times to avoid life- threatening postoperative infection.

4. Use of Operating Equipment:

All equipment and appliances must be set up and used according to the recommendations and instructions of the manufacturer. All new electrical equipment must be inspected prior to use and every six (6) months thereafter by the biomedical engineer. Electrical equipment must be properly grounded to prevent electric shock and burns.

5. Prevention of Burns:

All electrical equipment must be inspected by the bio medical contractor prior to use.

SUBJECT: PATIENT SAFETY IN THE PROCEDURE ROOM	REFERENCE #7002
DEPARTMENT: AMBULATORY CARE SERVICES	PAGE: 2
	OF: 3
APPROVED BY:	EFFECTIVE: 02/15/2010
	REVISED: 01/19/11

6. Administration of Drugs:

All drugs used by the anesthesiologist are logged in the anesthesia record.

7. Preparation of Specimens:

- Tissue removed from a patient is sent to the Pathology Laboratory and labeled with the site of the specimen as ordered by physician.
- It is the responsibility of the physician to communicate to the RN the origin of each specimen.
- It is the responsibility of the RN to label and record each specimen accurately.
- All specimens for frozen section are placed in a dry container and forwarded to the Pathology Laboratory.

8. Fire Safety:

Response of the facility's staff to a fire is outlined in the Fire/Emergency Management Plan. Facility personnel participate in the quarterly fire drills as appropriate and review fire precautions in the annual recertification program.

9. Emergency Management Responses:

Response of the facility team in a disaster situation is outlined in the Fire/Emergency Management Manual. Facility personnel participate in disaster drills and review emergency management precautions in their annual recertification program.

10. Equipment Maintenance:

All operating room equipment is inspected for operational integrity by facility personnel prior to each use. Equipment is to be removed from service immediately, if needed repair or a malfunction is evident.

11. Disposal of Waste:

All infectious (bio hazardous) wastes, including glass, are single red-bagged, placed in the special collection container marked "Bio hazardous Waste" and disposed of by contracted medical waste company.

SUBJECT: PATIENT SAFETY IN THE PROCEDURE ROOM	REFERENCE #7002
DEPARTMENT: AMBULATORY CARE SERVICES	PAGE: 3 OF: 3
	EFFECTIVE: 02/15/2010
APPROVED BY:	REVISED: 01/19/11

12. Disposal of Needles and Syringes:

Used needles and syringes are disposed of by placement in a rigid sharps disposal container which is present in each operating room. When container is 3/4 full it is capped and disposed of in the bio hazardous waste collection container.

13. Use of Adapters:

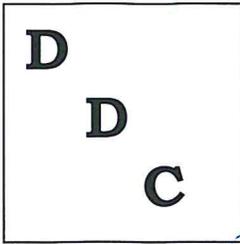
Adaptor use within the facility is prohibited.

14. Anesthesia Safety:

Refer to Anesthesia Policy and Procedures' for other anesthetic safety standards.

15. Visitor Safety:

Visitor safety in the facility is based on the safety practices and standards developed by the facility Safety Committee. All visitors entering the facility shall be instructed by the appropriate supervisor as to proper attire and safety hazards. Visitors who are injured in the facility are referred to the Administrator for evaluation and treatment. Visitor injuries are summarized on an unusual occurrence form by the supervisor and forwarded to administration. The facility Safety Committee reviews visitor injury reports, identifies hazardous conditions and recommends preventive measures.



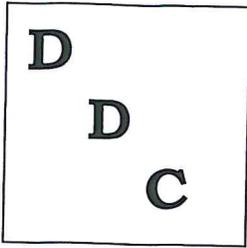
**P A T I E N T S A F E T Y
P O L I C Y & P R O C E D U R E**

Policy:

The policy set forth by the Digestive Disease Center (DDC) is to ensure patient safety, before, during, and after a patient's procedure.

Procedure:

- A. Each patient will have a history & physical examination documented in their chart within 7 days prior to their procedure.
- B. Each patient will complete the Medical History Questionnaire prior to his or her procedure.
- C. All patients will receive a copy of the Patient Rights and Responsibilities at the time of scheduling of procedure.
- D. All medical staff is CPR certified, and aware of the location and use of all emergency equipment. All DDC Physicians are ACLS certified.
- E. At least one ACLS certified Registered Nurse is staffed when patients are present in the facility, along with ACLS trained Anesthesiologist is present with sedated patients.
- F. Once a patient has been admitted to the facility, non-sedated patients are visualized frequently to ensure needs are met. Sedated patients are monitored closely checking vital signs with observation to assure patients are free from complications related to the procedure and /or medical problems
- G. Each patient will meet the required discharge criteria set forth by DDC, and ANOR anesthesia standard, prior to being discharged. The physician will have the final decision, to discharge the patient, which will be documented, signed and become part of the patient's record.
- H. A written physician discharge order will be issued to each patient post procedure, providing them with post procedure instructions, precautions, and contact information in case of an emergency. A copy of this document will become part of the patient's record.
- I. The facility staff will make a follow up appointment for the patient as ordered by the physician.
- J. Each patient will be contacted within 24 hours after having their procedure to ensure that they are not experiencing any complications related to the procedure.
- K. A patient safety committee will be formed to include one physician from each site, the nurse manager from each site, the pharmacy consultant, and the medical director. The committee will meet quarterly to discuss patient safety.



Digestive Disease Center

**P A T I E N T S A F E T Y C O M P L I A N C E
P O L I C Y & P R O C E D U R E**

Policy:

The policy set forth by the Digestive Disease Center (DDC) is to ensure that staff, physicians, vendors, and contracted employees are compliant with patient safety including checklists, policies & procedures established by the DDC.

Procedure:

- A. All staff, physicians, vendors & contracted services are required to read and comply with the safety checklists, policies & procedures prior to working in the center.
- B. Policies & checklists will be provided to vendors & contracted services to provide to their employees.
- C. Staff educated upon hire & annually thereafter on the process for reporting violations to the Director of Nursing Services.
- D. Audits performed monthly utilizing the Infection Control Surveillance Tool to ensure compliancy & sanitation.
- E. The safety committee will meet monthly to discuss patient safety issues, review audits & monitor & document effectiveness of the patient identification policy.
- F. Safety Policies & Procedures, checklists will be reviewed at least annually & more often if needed.

Centennial Hills Hospital MEDICAL CENTER

A Member of The Valley Health System™

Risk Management/ Patient Safety Plan

Nevada Acute Care Division

I. Overview

Centennial Hills Hospital endorses an integrated, system-wide patient safety program designed to improve patient safety and reduce risk to patients.

Patient safety is a cornerstone of quality care and is a leadership priority. **Centennial Hills Hospital** operates as a Patient Safety Organization to further its commitment in promoting patient safety and assuring that **Centennial Hills Hospital** remains at the forefront in the delivery of safe and effective clinical care. The Member Patient Safety Evaluation System (PSES) is utilized by **Centennial Hills Hospital** to track safety information, generate Patient Safety Work Product (PSWP) analysis of safety and clinical performance, and promote best practices. This Acute Care Division Risk Management/Patient Safety Plan ("Plan") provides the general framework to identify, manage, reduce, and eliminate patient safety risks.

The Plan identifies the mechanisms to continually assess and improve the patient safety systems at **Centennial Hills Hospital**. It is our strategy to utilize statistical tools and defined project work to achieve breakthrough gains in patient safety. Performance improvement tools are used in developing and delivering consistent processes and services. The cultural aspect of the Plan is to promote a non-punitive approach to identifying and reporting adverse events. This is consistent with the "Just Culture" concept to promote patient safety practices by instituting a culture of safety and embracing concepts of teamwork and communication.

Most patient safety events are due to a failure of systems; therefore, a systems analysis approach is utilized in evaluations. The goal is to identify and track errors, deficiencies, and problematic trends in order to continuously improve the underlying systems and to intervene as necessary to improve system processes. Although a non-punitive culture is promoted, this approach is balanced by holding caregivers personally responsible for at-risk behaviors and failures to meet the standard of care. When warranted, discipline measures will be initiated as needed consistent with **Centennial Hills Hospital** policies. **Centennial Hills Hospital** employees, contractors, vendors, and members of each facility's medical staff share responsibility to participate in detection, reporting, and remediation to prevent errors.

GENERAL STATEMENTS ON GOALS AND OBJECTIVES

To support, maintain and enhance the quality of patient care delivered by:

- Systematic and objective monitoring and evaluation of reports of injuries, accidents, patient safety issues, safety hazards, and/or clinical services findings.
- Identification and assessment of general areas of actual or potential risk in the clinical aspects of the delivery of patient care and safety.

- Implementation of appropriate corrective action, to the extent possible, to alleviate and resolve identified problems or concerns with patient safety issues.
- Evaluation and documentation of the effectiveness of actions implemented.
- Aggregation of data/information collected for integration in information management systems and use in managerial decisions and operations.

II. Mission and Vision

Centennial Hills Hospital's mission, vision and values drive the Plan and serve as the foundation in identifying strategic goals, objectives and priorities. Our mission is to improve patient safety and the quality of health care delivery through the provision of excellence in clinical care while fostering safe care to our communities, that our patients will recommend to their families and friends, physicians prefer for their patients, purchasers select for their clients, employees are proud of, and investors seek for long-term results. The vision is to be recognized as the provider of choice for healthcare services in the local community where we are trusted by our patients, families and physicians to create a safe, caring and compassionate experience.

In support of our mission, vision, and values, the Plan promotes:

- Collaboration of administrative leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high quality healthcare.
- Communicate honestly and openly to foster trusting and cooperative relationships among healthcare providers, staff members, and patients along with their families, to ensure accountability for the patient safety priorities.
- Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.
- Accountability for every healthcare related decision and action based on the level of risk-taking or egregious behavior identified.
- A focus on continuous learning and improving, system design, and the management of choices and changes, bringing the best possible outcomes or performances to the facility.
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare.
- Education of staff and physicians to assure coordination and integration of care across disciplines and specialties.

Centennial Hills Hospital recognizes that providing safe patient care requires significant coordination and collaboration. The optimal approach to patient safety involves multiple departments and disciplines to establish and effectively implement the processes and mechanisms that comprise this plan.

III. ROLES AND RESPONSIBILITIES

A. Risk Management/Patient Safety Officer

Centennial Hills Hospital has a designated risk director/manager responsible for patient safety risk identification and reduction for their respective facilities. The designated Risk Director/Manager is also the Patient Safety Officer. Each facility is required to submit scheduled reports to the Board of Governors describing risk reduction efforts associated with facility specific, or industry identified risk exposures, including environmental risks and emergency management. Reports are thoroughly reviewed and analyzed by the risk staff to determine effectiveness and follow-through of identified corrective action plans.

The Patient Safety Officer responsibilities based upon NRS 439.870 includes:

- Serving on the Patient Safety Committee (PSC)
- Supervising the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to NRS 439.835.
- Taking action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the PSC regarding any action taken in accordance with the responsibilities above.

B. Infection Control Officer

The infection control officer designated for each facility, based on NRS 439.873, responsibilities include:

- Serving on the Patient Safety Committee
- Monitoring the occurrences of infections at the facility to determine the number and severity of infections.
- Reporting to the PSC concerning the number and severity of infections at the facility each month.
- Taking such action as determined necessary to prevent and control infections alleged to have occurred at the facility.
- Carrying out the provisions of the Infection Control Program adopted pursuant to NRS 439.865 and ensure compliance with the program.

Based on NRS 439.865, the patient safety plan must also include an infection control program that carries out the infection control policy. The policy must consist of:

- The current guidelines appropriate for the facility's scope of service developed by a nationally recognized infection control organization as approved by the State Board of Health which may include, the Association for Professionals in Infection Control and Epidemiology (APIC), the Centers for Disease Control and Prevention (CDC), the World

- Health Organization (WHO) and the Society for Healthcare Epidemiology of America (SHEA); and
- Facility-specific infection control developed under the supervision of a certified Infection Preventionist.

C. Patient Safety

Centennial Hills Hospital has an established Patient Safety Councils (PSC) to support patient safety activities. The PSC should ensure that its Patient Safety Plan is promoted and executed successfully. **Centennial Hills Hospital** has also assembled participants to serve in the Member Workforce and to utilize the Member PSES to generate PSWP and exchange analysis and recommendations with the Acute Care PSO Workforce. The main vehicles for these analytic activities occurring within the Member PSES and the member facility Patient Safety Council meetings. The Member PSES is made up of both electronic and physical spaces for the reporting, storing, and generation of PSWP, including secure SharePoint site, and other electronic databases (including but not limited to ClearSight (STARS) and Midas) to maintain and manage PSWP.

According to NRS 439.875, a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plans are promoted and executed successfully.

I. Facility Patient Safety Committee

Each facility establishes a Patient Safety Committee (PSC) that meets on a regular basis and at least monthly.

Membership:

In accordance with NRS 439.875, the committee core membership consists of the following Key Members: (CEO, CNO, Physician, Risk/ Patient Safety Officer, Infection Prevention Nurse, Pharmacy, and Quality). The COO, CMO and Regional CMO attend, as applicable. NRS requires that at least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing, and pharmaceutical staff of the medical facility. In addition, the infection control officer, patient safety officer, and one member of the executive or governing body of the medical facility.

Based on NAC 439.920, a medical facility that has fewer than 25 employees and contractors must establish a patient safety committee comprised of: the Patient Safety Officer, at least two providers of healthcare who treat patients at the medical facility, including but without limitation, one member of the medical staff and one member of the nursing staff of the medical facility; and the Chief Executive Officer (CEO) or Chief Financial Officer (CF)) of the medical facility.

Meetings:

The required members attend the meetings on a monthly basis. If a required member is absent, the facility makes a suitable replacement with someone that has authority to implement actions identified by the PSC.

Duties and Responsibilities:

Centennial Hills Hospital's PSC is charged with the assessment and improvement of high-risk processes related to patient safety. This is to be carried out using a four-step methodology.

- **Issue Identification:** The primary issue is the most important risk issue facing the facility and is determined by reviewing the facility's claims history, claims history unique to the facility, patient safety concerns, industry claims, and through discussions with the risk staff. Other issues may be related to process initiatives.
- **Best Practice:** Once identified, the primary issue is dissected to determine its component issues. For each component issue, a best practice is selected. Best practices represent the most appropriate method for performing the delineated process and should not be selected until the PSC is assured that it is truly the "Best Practice."
- **Implementation:** Implementation strategies are those methods used to put the best practices into place. Often this includes revising policies, education, newsletters, phone calls, meetings, formal training, etc. Responsible parties and dates for completion are identified to ensure success.
- **Monitoring and Accountability:** Monitoring is essential to ensure that the strategies identified have been effective. Improvement should be demonstrated statistically whenever possible.

Additional Patient Safety Committee Responsibilities, based upon NRS 439.875 and NRS 439.877, include:

- Monitor and document the effectiveness of the Patient Identification Policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to NRS 439.877(4)(b).
- Receive reports from the Patient Safety Officer pursuant to NRS 439.870.
- Evaluate actions of the Patient Safety Officer in connection with all reports of sentinel events alleged to have occurred.
- The Quality member of the PSC will review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.

- The Quality member in conjunction with the Infection Control Officer will review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- Make recommendations to the Board of Directors of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the Board of Directors of the facility regarding:
 - (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);
 - (2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and
 - (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
 - Adopt patient safety checklists and patient safety policies as required by NRS 439.877, review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

In addition to the work done on the primary issue, the PSC is charged with addressing issues identified through claims reporting, Safety Watch Newsletters, the Joint Commission (Sentinel Event Alerts) and others, HRUs and from the TERM evaluation or other surveys, such as the OBHRU Site Assessments. Feedback is provided on an ongoing basis as to the functioning of the Patient Safety Committee.

II. Patient Safety Advisories

When an untoward event occurs at a facility or in the industry, it is important that we respond in a positive manner. Systems that lead to failure at one facility can be assessed at other facilities to avoid the same or similar occurrence. To this end, the Acute Care PSO distributes Safety Watch newsletters. These alerts detail the circumstances that lead to the negative outcome and facilities are charged with assessment and improvement of their own processes.

Centennial Hills Hospital is required to address the Safety Watch newsletters via their Patient Safety Council and this is evidenced in their monthly minutes. Responses to the Safety Watch are reviewed for the opportunity to generate a best practice to implement.

C. TERM Program

The facility has utilized its formalized risk management program identified as TERM: the Technical Elements of Risk Management. Each element focuses on a separate organizational function and details specific strategies for managing risk in these areas. These elements are summarized as follows:

Element I. Administration of the Risk Management Program: The tenets outlined in Element 1 lay the foundation for an effective risk management program. The Risk Manager/Director must be seen as a resource to administration, facility, and medical staff. Written plans, goals, and objectives provide a clear vision to meet the purpose of the risk program. Although the TERM program uses the title "Risk Manager," this applies equally to Risk Directors.

Element II. Risk Identification: Risk identification is essential in order to avoid, mitigate, and eliminate risk-generating practices. This Element focuses on those steps taken to identify exposures faced by the facility.

Element III. Risk Education: Education is a cornerstone of the TERM program. Risk management education is intended to reduce and eliminate risk-generating practices and to promote best practices that enhance the provision of safe patient care.

Element IV. Patient Safety Initiative: Imperative to a comprehensive RM program is one that focuses on the improvement of patient and staff safety through the creation of an environment that maximizes safety and reduces liability claims exposure. The mechanism used to drive the culture of safety is the Patient Safety Committee (PSC) at each facility. The PSC operates using a four-step process. These steps include: identification of the problem, determining best practice, implementing the recommendations, and monitoring and accountability. Corrective actions are discussed, monitored, and validated by the PSC.

Element V. Patient Safety Priority: Root Cause Analysis (RCA): The cornerstones of an effective Patient Safety and Risk Management Program are (i) the performance of a thorough and credible RCA when a serious, sentinel, never event or a significant near miss event occurs; and (ii) implementation of systemic improvements to enhance patient safety and improve healthcare outcomes going forward.

Element VI. Environment of Care; Safety and Security Programs: The safety and security programs in the facility serve to protect and preserve both life and property. Areas of safety include licensing, accreditation and federal, state, and local safety practices and programs, including the EPA, TJC, etc.

Element VII. Claims and Litigation Management: The risk manager serves as the on-site representative of the insurance program in the management of general and professional claims and litigation.

Element VIII. Patient Safety Organization (PSO): Participants of the Member Workforce are expected to perform identified patient safety activities and to be trained in their responsibilities. They must also understand and acknowledge their obligations, including maintaining the confidentiality of PSWP, as required by the Patient Safety and Quality Improvement Act (PSQIA), and of Protected Health Information, as required by the Health Insurance Portability and Accountability Act (HIPAA) and its regulations, and other federal and state laws.

Element IX. Measuring the Effectiveness of the Risk Management Program: In order to assure the effectiveness of the Risk Management Program, certain activities should be conducted to ensure that implementation of the TERM program has been successful. This includes, but is not limited to, data analysis and trending of events and potential claims, which are shared with the respective oversight committees.

D. MIDAS

The MIDAS system is the electronic event reporting system utilized by the facilities to report patient and visitor safety events. The risk management module allows for the collection, categorization, and analysis of incident data using electronic reporting functions (Remote Data Entry - RDE). The facility enters incidents into MIDAS through identification of the type of incident and characteristics of the event using risk parameters and outcomes. Additional information can be attributed to a department, physician, or individual, along with further details of the event. This allows the retrieval of information in a variety of ways for analysis and review.

E. ClearSight (STARS)

STARS is an integrated claims management program that allows for complete claims management, including extensive analysis of reportable fields associated with reported claims. STARS also provides for the electronic submission of potential claims by user facilities.

Delineation of issues featured in the probable claim module allows for the facility staff to identify causation factors associated with any reported event. The system also provides for the entry of details that will describe the event and liability concerns.

Trending of claim information is performed on a scheduled basis to operations leadership metrics to form strategies on facilitating risk reduction efforts. Previous examples of this function include the formation of an OB HRU and Perioperative concepts. Quarterly reports should be provided by the Facility's RM to the Governing Board of all claims activities.

F. Event Notification Site

The Risk Department developed the Event Notification Site or ENS, a web-based system that allows for contemporaneous reporting of serious adverse events and key near miss sentinel events to facility and corporate management. The ENS also provides an environment in which stakeholders can post questions and additional information to the facility reporting the event. Updates to the event are reported in real-time to all identified facility and stakeholders via the ENS. The Risk Management staff reviews each ENS to determine if follow-up is needed; if follow-up is indicated, it is to be completed within 45 days.

G. Root Cause Analysis (RCA)

Pursuant to NRS 439.837, a medical facility shall, upon reporting a sentinel event pursuant to NRS 439.835, conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both of the sentinel event.

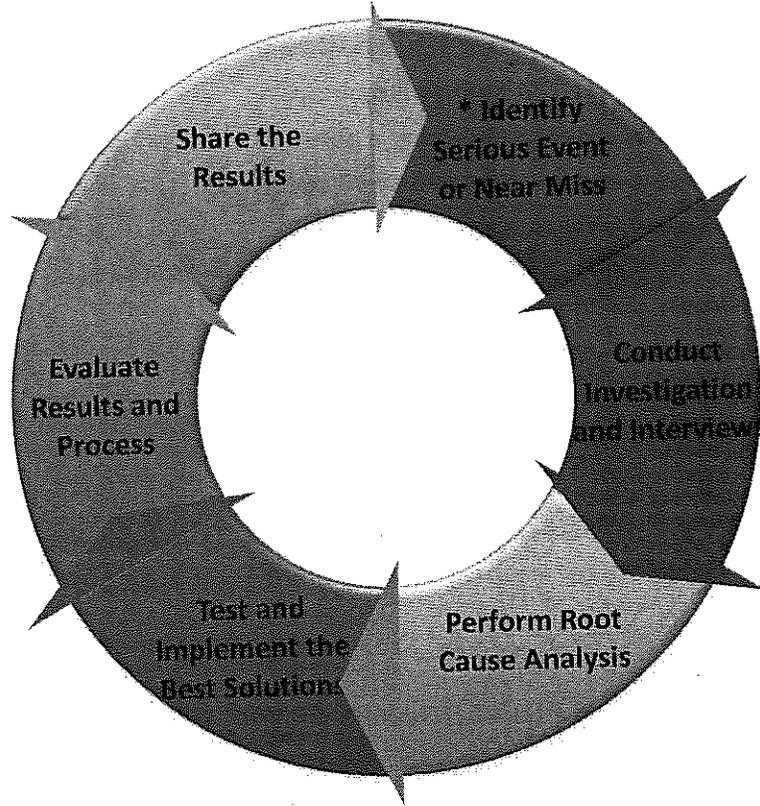
A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals. Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

It is recommended that the Joint Commission's root cause analysis and actions plan framework table are utilized. It contains analysis questions and guides the organization in the steps of a root cause analysis. Not all of the questions apply to all of the events or cases.

Utilization of the "5 Whys" technique should be used to explore the cause and effect relationship underlying a problem. One can find the root causes by asking "why" no less than five times.

RCA Responsibilities

- Organize and coordinate the RCA process. For Serious OB events, RCAs are to be done within 72Hrs. of the event.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA and corrective action plan implementation process.
- Communicate the progress of the investigation, institutional barriers and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.



H. Patient Safety Checklists

By NRS 439.865, the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

The patient safety checklists must follow protocols to improve the health outcomes of patients at the medical facility and must include, without limitation:

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.

- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - Proper instructions concerning prescription medications;
 - Instructions concerning aftercare;
 - Any other instructions concerning his or her care upon discharge; and
 - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety checklists are listed in Appendix E. (The following links provide some patient safety checklists for your reference— a checklist example is shown in **Appendix B.**)

http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf

<http://www.who.int/patientsafety/implementation/checklists/en/>

I. Patient Safety Policies

The patient safety policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include, the name and date of birth of the patient.
- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.
- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

J. MEMBER PATIENT SAFETY EVALUATION SYSTEM (PSES)

The Patient Safety and Quality Improvement Act of 2005 (PSQIA) and its regulations govern the operations and activities of the UHS Acute Care PSO and its Members. This includes assembling a "workforce" of employees, volunteers, trainees, contractors, and other persons who carry out patient safety activities on behalf of the Members within the Member Patient Safety Evaluation System ("Member PSES"). Participants in the Member Workforce are expected to perform identified patient safety activities and to be well trained in their responsibilities. They must also understand and acknowledge their obligations, including maintaining the confidentiality of PSWP, as required by the PSQIA, and of Protected Health Information, as required by the Health Insurance Portability and Accountability Act (HIPAA) and its regulations, and other federal and state laws. The Member PSES serves as a means by which patient safety information is collected, maintained, reported, and analyzed for the UHS Acute Care PSO for the purposes of improving patient safety.

K. Training and Education

Training is essential to successful implementation of the Patient Safety and TERM program. All facility risk managers undergo extensive orientation and education related to Patient Safety, TERM program and other healthcare, risk-related topics. Newly hired risk managers receive both on-site and collaborative corporate-based education and training to afford them the requisite skills to manage their facility assignment. Each risk manager is provided a copy of the TERM source documents and other reference materials that guide the risk management function. In addition, formalized supplemental training is provided to all facility risk managers as needed, including quarterly risk management meetings. Risk leadership provides ongoing support and consultation to their assigned facility to facilitate the minimization of liability exposures and enhancement of safe patient care.

The leadership risk management staff provides consultative services to each facility and as members of designated projects. These activities include on-site assistance, research, and consulting from off-site. Examples of designated projects are as follows.

- Facility specific risk Issues
- Safety Watch newsletters
- MIDAS Focus advisories

IV. Risk Management Goals and Objectives 2018

- Surgical and Procedural Safety
 - Monitor compliance through tracer methodology and report monthly with oversight by leadership.

- Goal: Zero harm events: Prevent mistakes in surgeries and procedures
- OB HRU-Zero Preventable Harm
 - Goal: Reduction/ Elimination of Maternal Hemorrhage
 - Goal: Reduction/ Elimination of Serious Harm from Shoulder Dystocia
 - Goal: Reduction/ Elimination of Serious Harm by decreasing response time to changes in Fetal Monitoring Tracings
- Emergency Department
 - Goal: Reduction/ Elimination of Workplace Violence
- Medication Safety
 - Goal: Implement an effective Opioid – Pain Management strategy, as evidenced by compliance with Assembly Bill 474, NRS 233B.066, regarding prescribing of controlled substances and reporting of controlled substance overdoses.
- Perform monthly *Safety Watch* Gap Analysis and complete within 90 days.
- Increase MIDAS manager completion within 10 days compliance from percentage of 75% to 90%.
- Decrease fall rate from 2.63 to ≤ 2.24 .
- Decrease harm level E-I events from 0.423 to ≤ 0.357 .
- Increase Medication Reconciliation compliance from 40% to 85%
- Complete formal risk assessments of the following areas:
 - Emergency Department
 - Culture of Safety
 - Fall Prevention

V. Monitoring and Accountability

A. Evaluation of TERM Program

These evaluations consist of both a core risk and clinical risk review. The facility is required to submit a written corrective action plan for noted deficiencies determined during the TERM evaluation. All information is shared with senior staff and monitored through the facility PSC.

B. Patient Safety Council Coaching

As detailed above, each facility is required to post their monthly reports or minutes that details the work conducted by their Patient Safety Committee to the facility PSES site. These are then reviewed minutes and detailed feedback is provided to coach the committee on their form and function.

C. Dashboards

The Risk Management/Patient Safety Dashboard and the Environment of Care Dashboard include multiple indicators to demonstrate the facility's performance as to

these markers. These include: event reporting statistics, fall rate including harmful event rate, medication event rate including harmful medication events, timeliness of event review and closure, risk management education, events that meet the ECRI Top Patient Safety Concerns, and environment of care concerns.

VI. Evaluation/Review:

The risk staff reviews the effectiveness of the Patient Safety/Risk Management Plan to ensure activities are appropriately focused on improving patient safety, decreasing harmful errors, decreasing rate of compensable events, facility risk program consistency/functionality and support of clinical delivery in the field. Evaluation will include the following:

- The culture supports the identification and reporting of “Near Miss” events
- There is a framework that advances a “Just Culture”
- Accountability is promoted when acts of “at risk” or “reckless behavior” occur resulting in potential/actual adverse outcomes;
- Comparison of trended incident data to include analysis of performance to stated targets, submission of incident data in compliance to SOX stipulations and review of trended data submitted to the PSC for potential action;
- Review of annualized and prior year’s probable claim reports to determine needs for corporate-based projects designed to improve outcomes in an identified service line;
- Review of educational products distributed for the concluding operating year that were intended to improve outcomes associated with a particular clinical emphasis;
- Review information, analyses and reports from the Acute Care PSO for integration into the Patient Safety Evaluation System.

VII. Confidentiality

All patient safety/risk management work products are considered Patient Safety Work Products (PSWP) as defined by federal guidelines governing Patient Safety Organizations (PSO). All PSWP reported, stored, or generated in the Member PSES is confidential and privileged under Federal law. The Member PSES will only be accessed by authorized staff. Workforce participants will be trained on policies and procedures governing their patient safety activities and responsibilities.

VIII. Approval of Patient Safety Plan

According to NRS 439.865, a medical facility shall submit its patient safety plan to the governing board of the facility for approval. After a facility's patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan. The patient safety plan must be reviewed and **updated annually** in accordance with the requirements for approval set forth in this section.

According to NRS 439.843, on or before March 1 of each year, a copy of the most current patient safety plan established to NRS 439.865 must be submitted to the Division of Public and Behavioral Health.

Appendix A: Terms and Definitions

Patient Safety: The Agency for Healthcare Research Quality (AHRQ) defines patient safety as “a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.”

http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

Sentinel event (NRS 439.830)

1. Except as otherwise provided in subsection 2, “sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum.

2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:

(a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or

(b) July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published.

3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.

(Added to NRS by 2002 Special Session, 13; A 2005, 599; 2013, 217)

Institute for Healthcare Improvement (IHI) defines **medical harm** as “unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death.”

Facility-Associated Infection: (NRS 439.802)

“Facility-acquired infection” means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections;
- Ventilator-associated pneumonia;

- Central line-related bloodstream infections;
 - Urinary tract infections; and
 - Other categories of infections as may be established by the State Board of Health by regulation pursuant to NRS 439.890.
- (Added to NRS by 2005, 599; A 2009, 553)

Medical facility (NRS 439.805)

“Medical facility” means:

- A hospital, as that term is defined in NRS 449.012 and 449.0151;
- An obstetric center, as that term is defined in NRS 449.0151 and 449.0155;
- A surgical center for ambulatory patients, as that term is defined in NRS 449.0151 and 449.019; and
- An independent center for emergency medical care, as that term is defined in NRS 449.013 and 449.0151.

(Added to NRS by 2002 Special Session, 13)

Near miss: An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Mandatory reporting: Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985;254(6):796-800.)

Risk: Possibility of loss or injury. (Merriam-Webster’s Online Dictionary, Risk, Available at <http://www.merriamwebster.com/dictionary/risk>. Last Accessed August 2009.)

Preventable event: Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Catheter Associated Urinary Tract Infection (CAUTI): A urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at

[http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN Manual PatientSafetyProtocol CUR RE NT b.pdf.](http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CUR_RENT_b.pdf))

Central Line Associated Bloodstream Infections (CLABSI): Primary bloodstream infections that are associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection.

Appendix B: Checklist Example: Injuries from Falls and Immobility

Process Change	In Place	Not Done	Will Adopt	Notes (Responsible & By When?)
Conduct fall and injury risk assessment upon admission				
Reassess risk daily and with changes in patient condition				
Implement patient-specific intervention to prevent falls and injury				
Communicate risk across the team; use handoff forms, visual cues, huddles				
Round every 1 to 2 hours for high-risk patients; address needs (e.g., 3Ps: pain, potty, position-pressure). Combine with other tasks(vital signs)				
Individualize interventions. Use non-skid floor mats, hip protectors, individualized toileting schedule; adjust frequency of rounds				
Review medications (by pharmacist); avoid unnecessary hypnotics, sedatives				
Incorporate multidisciplinary input for falls				
Prevention from PT, OT, MD, RN and PharmD				
Include patients, families and caregivers in efforts to prevent falls. Educate regarding fall prevention measures; stay with patient				
Hold post-fall huddles immediately after event; analyze how and why; implement change to prevent other falls				

Reference: Checklists to Improve Patient Safety. June 2013. Health Research & Educational Trust.

Box Canyon Surgery Center

Policy Name:	PATIENT SAFETY
Section:	Safety
Policy #:	IV.4.2
Purpose	Staff Education

Approved Date	Reviewed Date	Revised Date
2-3-09	2-23-10, 2-23-11, 2-6-12, 2-4-13, 2-24-14,2-6-15,3-28-16	

- Keep stretcher in low position with side rails raised when patient is unattended.
- Assist patient when getting on or off stretcher.
- Never leave post-sedated patient unattended in restroom.
- Always lock stationary stretchers and wheelchairs to prevent falls.
- Offer assistance to patient dressing or undressing to prevent falls.
- Any spillage of water or liquid substance will be cleaned up immediately to avoid falls.
- Patients should not walk around without shoes.
- Patients may not drive themselves home after being sedated.
- Be aware of patients, family and your working environment and watch for safety hazards.



CARSON TAHOE
— HEALTH —
Continuing Care Hospital

PATIENT SAFETY PLAN

Carson Tahoe Continuing Care Hospital

2018

Effective: February 2005 (combines Organization Safety and Patient Safety Plans)
Revised: October, 2005
Revised: December, 2006
Revised: December, 2007
Revised: January, 2009
Revised: January, 2010
Revised: January, 2011
Revised: January, 2012
Revised: February, 2014
Revised: November 2014
Revised: January 2016
Revised: January 2017
Revised: January 2018

INTRODUCTION

The Carson Tahoe Continuing Care Hospital is a part of Carson Tahoe Health System, a Nevada not-for-profit hospital. We are committed to patient safety, quality patient care and quality patient outcomes consistent with our Mission and Core Values.

MISSION

To enhance the health and well being of the communities we serve.

CORE VALUES

Putting patients first and treating everyone with dignity and respect.

PURPOSE

The Patient Safety Plan provides a planned, systematic, coordinated approach for continually improving the health and safety of patients who are treated at the medical facility, by reducing patient harm and maintaining a safety culture.

PLAN

- Continue Patient Safety Committee:
 - Mandatory Membership includes:
 - Patient Safety Officer
 - Infection Control Officer
 - At least 3 providers of health care team who treat patient at the medical facility, including one medical, nursing and pharmaceutical staff
 - In 2016 added Lead Pharmacist, CNA, Nurse Manager, Respiratory Therapist, Physician, & Physical Therapist
 - One member of the executive or governing body
- Committee required to meet on a monthly basis (NRS 439.875).
- Inclusion of
 - Infection Control Program to prevent and control infections within the medical facility (this is a document separate from the Patient Safety Plan that meets the requirements for NRS 439.865)
 - Patient Safety checklists and patient safety policies as required by NRS. 439.877
 - 2018 Checklist Inventory *Attachment A*
 - Annual review and revision of checklists and policies
- Annual Report to Legislative Committee on Health Care
- Integration of all patient safety activities both ongoing and developing
- Ongoing orientation, education and training to emphasize specific job related aspects of patient safety to maintain and improve staff awareness
- Encourage internal reporting of medical / healthcare incidents and events, effectively respond to actual occurrences, manage occurrences and events with a non-punitive approach, and focus on processes and systems to minimize individual blame and retribution
- Periodic survey of the staff regarding willingness to report, actions taken and outcomes of occurrences and events
- Internal reporting of findings, actions taken and resolution; organizational learning and communication of occurrence and event information

- Consideration of patient safety priorities when designing and redesigning of relevant processes, functions and services
- Involvement and education of patients, their families about their role in facilitating safe delivery of care, identifying potential risks and suggesting improvement to patient safety

SCOPE OF ACTIVITIES

The Carson Tahoe Continuing Care Hospital (CTCCH) Patient Safety Committee integrates all components of safety into the organizationwide safety program in collaboration with the Carson Tahoe Health System Quality, Environmental Safety, Infection Control, Patient Care areas, Risk Management, Compliance and Ethics.

Patient Safety Committee activities include:

- Sentinel Events pursuant to NRS Chapter 439
 - Review alleged events reported to State of Nevada, RCA investigations and resulting action plans.
 - Recommendations to the executive or governing body for reducing the number and severity of sentinel events and infections that occur
 - Provide emotional support for staff involved in incidents or events, through Human Resources, leadership, department supervisors and other resources as appropriate
 - Report at least quarterly to the executive or governing body
 - The number of sentinel events occurring in the previous quarter
 - The number/severity of infections occurring in the previous quarter
- Review and evaluate Quality Measures
 - To improve the patient safety and outcomes
 - To reduce and/or prevent infections
- Monitor patient/ environment safety issues identified throughout the organization
- Promote internal and external knowledge and experience to prevent patient harm, adverse events and occurrences, to maintain and improve patient safety
- Review aggregated or trended data including: No harm events, Mild or moderate adverse outcomes, Near miss, Medication events, Adverse drug reactions, Transfusion reactions, Hazardous conditions, Present on admission / Hospital acquired conditions, Online incident reports,
- Utilize a proactive approach to recognize and acknowledge medical/healthcare events and risks to patient safety, initiate actions and recommendations to reduce or prevent these events and risks
- Prioritize and recommend Patient Safety activities, as appropriate.
 - Utilizing trended data from Environmental safety, Security, Employee health, Emergency management, Lab or radiation safety, Utilities management, Bio Med, Fire drills or inspections.

PATIENT SAFETY OFFICER

The Patient Safety Officer is designated by the medical facility and has administrative responsibilities as prescribed by NRS chapter 439 (specifically outlined in NRS 439.815 through NRS.439.875) and by other regulatory agencies and accrediting bodies. Duties and responsibilities include but are not limited to:

- Serving as Chair of the Patient Safety Committee
- Supervising sentinel event reporting to the State
- Conducting mandatory investigations; developing and implementing action plans

- Ensuring notification as appropriate within the medical facility

STRUCTURE

The CTCCH Patient Safety Reporting Structure Model visually diagrams the reporting structure.

CTCCH Patient Safety Reporting Structure



STRUCTURE

The Hospital Board of Directors has the ultimate responsibility for Patient Safety.

The CTCCH Director of Nursing oversees the Hospital Safety Program and, as appropriate, reports Patient Safety and Quality activities and issues or concerns directly to Administration and the Hospital Board of Directors.

The CTCCH Director of Nursing is the hospital Patient Safety Officer. The Patient Safety Officer has the administrative responsibilities as prescribed by Nevada State law NRS chapter 439 (specifically outlined in NRS 439.815 through NRS 439.875, other regulatory agencies and accrediting bodies.) The Patient Safety Officer chairs the Patient Safety Committee which reports at least quarterly to the Hospital Board of Directors, and reports to the Medical Staff via Quality Management Committee and Medical Executive Committee as needed.

Attachment A

Carson Tahoe Continuing Care Hospital 2018 Checklist Inventory		
Checklist title	Checklist Category	DEPT

Carson Tahoe Continuing Care Hospital 2018 Checklist Inventory		
Discharge Checklist	Discharge	Electronic Health Record
Fire Drill Participation	Environment	Housewide
Fire Report	Environment	CTH Facility Staff/Spruce Engineering
Fire Watch Form	Environment	CTH Facility Staff/Spruce Engineering
Life (Fire) Safety Inspection / Business Occupancy	Environment	CTH Facility Staff/Spruce Engineering
Life (Fire) Safety Inspection /Healthcare Occupancy	Environment	CTH Facility Staff/Spruce Engineering
Patient Room Housekeeping Checklist by area /by shift		
Environmental Rounds Performed by Charge RN each shift	Environment	Nursing
Quality Assurance Checklist	Environment	Housekeeping
Unit Department Checklist	Environment	Nursing
CRASH CARTS		
Adult Crash Cart Check List	Other Safety	Nursing
AED Checklist	Other Safety	Nursing
Refrigerator / Freezer Temperature Record	Other Safety	Nursing/Pharmacy/Dietary
Blanket Warmer Temp Logs	Other Safety	Nursing
Transfer Checklist for Transportation	Other Safety	Housewide
Ventilator Calibration Checklist	Other Safety	Respiratory
Central Line Associated Blood Stream infection and CAUTI surveillance	Other Safety	Infection Control & Nursing
Emergency Equipment checklist	Other Safety	Nursing Administration/Emergency Preparedness
Hand Hygiene	Other Safety	Infection Control
Infection control Monitoring during construction	Other Safety	Infection Control
Central Line Insertion	Other Safety	Nursing
Charge Nurse checklist	Other Safety	Nursing
Hand Off Communication sheet Pre-Op/OR/PACU	Treatment	Receiving CTH facilities
Magnetic Resonance Imaging History & Assessment	Treatment	Medical Imaging
Medical Imaging Invasive Procedure Checklist	Treatment	Medical Imaging
Non Ionic and/or Ionic Contrast Consent Form	Treatment	Medical Imaging
Foley Catheter Tracking	Treatment	Infection Control & Nursing

**2018 Patient Safety Plan
Carson Tahoe Continuing Care Hospital Organizational Patient Safety Plan
Reviewed and Approved by:**

Name Here, Patient Safety Officer Continuing Care **Date**

Name Here, Chief Operating Officer CTHS **Date**

Name Here, Director of Quality and Outcomes Management **Date**

Name Here, MD, Chief Medical Officer Continuing Care **Date**

Chair, Carson Tahoe Continuing Care Board of Directors **Date**

Chair, CTHS Quality Patient Safety Committee **Date**

Chair, CTHS Board of Directors **Date**

2018 Patient Safety Plan

"The key to reliable, safe care does not lie in exhorting individuals to be more careful and try harder. It lies in learning about causes of error and designing systems to prevent human error whenever possible" (IHI, 2008, p. 19).

Mission Statement

Seven Hills Hospital

"It is the Mission of Seven Hills Hospital to improve the quality of life for our patients, their families and communities by providing consistently excellent and compassionate behavioral health and substance abuse treatment services."

Patient Safety

Through a robust Patient Safety Program, the Patient Safety Committee fulfills its commitment to aiming for the elimination of medical errors through the use of best practice and setting the standards of excellence of quality mental health care.

Guiding Principles

The Patient Safety Plan is a conceptualized model of care founded on the belief that a just culture holds the key to a patient safety focused organization. Seven Hills Hospital supports a just culture and focusses on analyzing structural, process, and outcome measures and using an evidence-based approach to support interventions.

Data and safety monitoring is a system for auditing and analyzing outcome data from continuous research. The Patient Safety Committee provides guidance for clinical staff while confirming compliance to organizational goals of providing a safe and therapeutic environment that enhances recovery. Patterson (2011) reported on an innovative quality improvement success describing an interview with an Infection Prevention Coordinator, who credited their success in overcoming communication barriers by stating that "if workers own the solutions and share them with their colleagues, the solutions are adopted a lot better than if someone from Infection Control comes in and tells them they have to do things a certain way" (p.22). Similarly, the Patient Safety Plan operates on the premise that front-line staff are untapped resources with the ability to influence peers towards best practice.

Goals & Objectives for Patient Safety

Prioritize opportunities for improvement that have the greatest potential impact on safety, patient care, treatment, and services provided.

Goal # 1: Reduce the likelihood of falls by 5% in 2018.

- o Objectives:

1. Increase accessibility to wheelchairs with anti-tippers and rollers for the Geriatric Unit. This will provide patients with a safer alternative for mobility.
2. Eliminate the use of unsafe and inefficient assistive devices (e.g. rollator walkers) on the Generations Unit.

3. Assessment of Geriatric Unit staffing matrix identify opportunities to provide additional support for current staff.
4. Review and implementation of refined process for initiating Special Precautions upon Intake/Admission.
5. Collaborative initiative with nursing leadership to utilize the Preventing Falls Targeted Solutions Tool, endorsed by The Joint Commission, to achieve significant improvement in all falls and falls with injuries.

Goal # 2: Reduce Medication variances by 5% in 2018

- o Objectives:
 1. Identify and assess medication variances on a monthly basis to maximize patient safety and identify causes of and trends in preventable events that may cause or lead to inappropriate medication use.
 2. Develop an effective relationship with Pharmacy and Nursing to enhance major methods of detecting medication errors.
 3. Promote major methods for detecting medication errors and associated adverse drug-related events such as chart audits, computerized monitoring, direct observation, voluntary reporting, patient monitoring and incident reporting.
 4. A newly appointed Assistant Director of Nursing has been providing direct oversight in appropriate follow-ups and continuing education to operators and witnesses.

Goal # 3: Promote the Culture of Safety

- o Objectives:
 1. Promote compliance with the National Patient Safety Goals.
 2. Improve the dissemination of safety related efforts across the organization readily.
 3. Enhance the Patient Safety Committee transitioning to a more active committee with monthly meetings.

Responsibility

All staff employed or contracted through Seven Hills Hospital are responsible for knowledge of policies and procedures. This plan supports the staff compliance towards established policies and procedures. Staff supervisors work alongside front-line staff to identify deviations from policy, procedures, or standards and promptly resolve errors. In addition, opportunities for enhancing or policies or procedures are identified and routed through the Patient Safety Committee or the Patient Safety Officer.

In a culture of safety, each staff member is a provider of service—the consumer is both the patient and organization. Staff provide services with safety in mind. The organization is provided with an environment rich in safe practices and ultimately benefits all patients and staff receiving best practices.

Sullivan et al. (2011) suggests patient safety to begin with prevention of adverse events. Preventable adverse events are often the result of missing systems, checks and balances, or failure to comply with existing systems designed to catch and prevent these adverse events as demonstrated in Figure 1. Staff work together to promote safety awareness across the organization and influence policy and procedures through supporting resiliency and risk reduction efforts.

Hazards

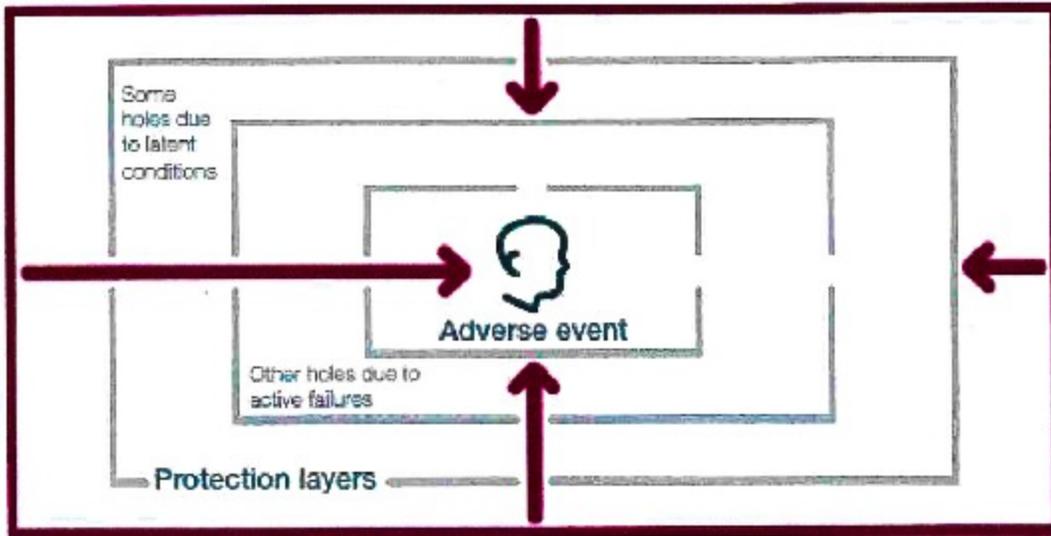


Figure 1. Active failures and latent conditions cause adverse events. Based on the "swiss cheese" model by J. Reason.

Patient Safety Committee

The Patient Safety Committee consists of a Physician, a member of the Executive Staff, the Director of Performance Improvement and Risk Management/Patient Safety Officer, Infection Control Officer, Pharmacist, and front-line staff. Data is received, analyzed, processed 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

Stonecreek Surgery Center

QUALITY AND PATIENT SAFETY PLAN



VERSION: 2

This plan was created and revised by the Stonecreek Surgery Center Patient Safety committee/team. Implementation of this plan is intended to optimize the healthcare quality and patient safety outcomes, encourage recognition, reporting, and acknowledgment of risks to patient, visitor, and employee safety, as well as reduce the medical/healthcare errors and /or preventable events.

Patient Safety Committee/Program
Stonecreek Surgery Center
5915 S. Rainbow Blvd. Ste 108
(702) 227-7959

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Commitment to Patient Safety

[Stonecreek Surgery Center](#) is committed to a comprehensive approach to improving healthcare quality and patient safety by aligning with our Mission, Vision, and Values, creating an environment that supports a dynamic, proactive, and safe culture for patients, family members, visitors, and employees, through continuous learning and improving patient safety policies, systems, and processes.

Mission, Vision, and Values

In support of our mission, vision, and values, [Stonecreek Surgery Center](#) Patient Safety and Quality Improvement program promotes:

- Collaboration of healthcare, leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high quality healthcare.

- Communicate honestly and openly to foster trusting and cooperative relationships among healthcare providers, staff members, and patients and their families, to ensure accountability for the patient safety priorities.
- Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.
- Responsibility for every healthcare related decision and action.
- A focus on continuous learning and improving, system design, and the management of choices and changes, bringing the best possible outcomes or performances to the facility.
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare.
- Education of staff and physicians to assure participation of healthcare providers.

Scope and Purpose

The scope of this Quality and Patient Safety Plan is organizational-wide/hospital-wide/agency-wide which includes but is not limited to

- Patient safety
- Visitor safety
- Employee safety

All staff in [Stonecreek Surgery Center](#) are required to fully support and participate in this plan, and devote their expertise to the patient safety and healthcare quality improvement process.

This plan is action oriented and solution focused. The purpose of this plan is to address patient safety related concerns, challenges and revise the program to better serve the patients and their families. To this end, [Stonecreek Surgery Center](#) has developed this Patient Safety plan.

The plan focuses on the process rather than the individual, and recognizes both internal and external customers, as well as facilitates the need of analyzing and improving processes. The core principles of this plan include:

- All staff have the same goal and contribute their knowledge, vision, skill, and insight to improve the process of the Patient Safety Plan.
- Decisions will be based on data and facts, and staff will be encouraged to learn from the experiences.
- Customer based including patients, families, and visitors.
- Promote systems thinking.
- Employ well-trained and competent staff maintaining high healthcare quality.

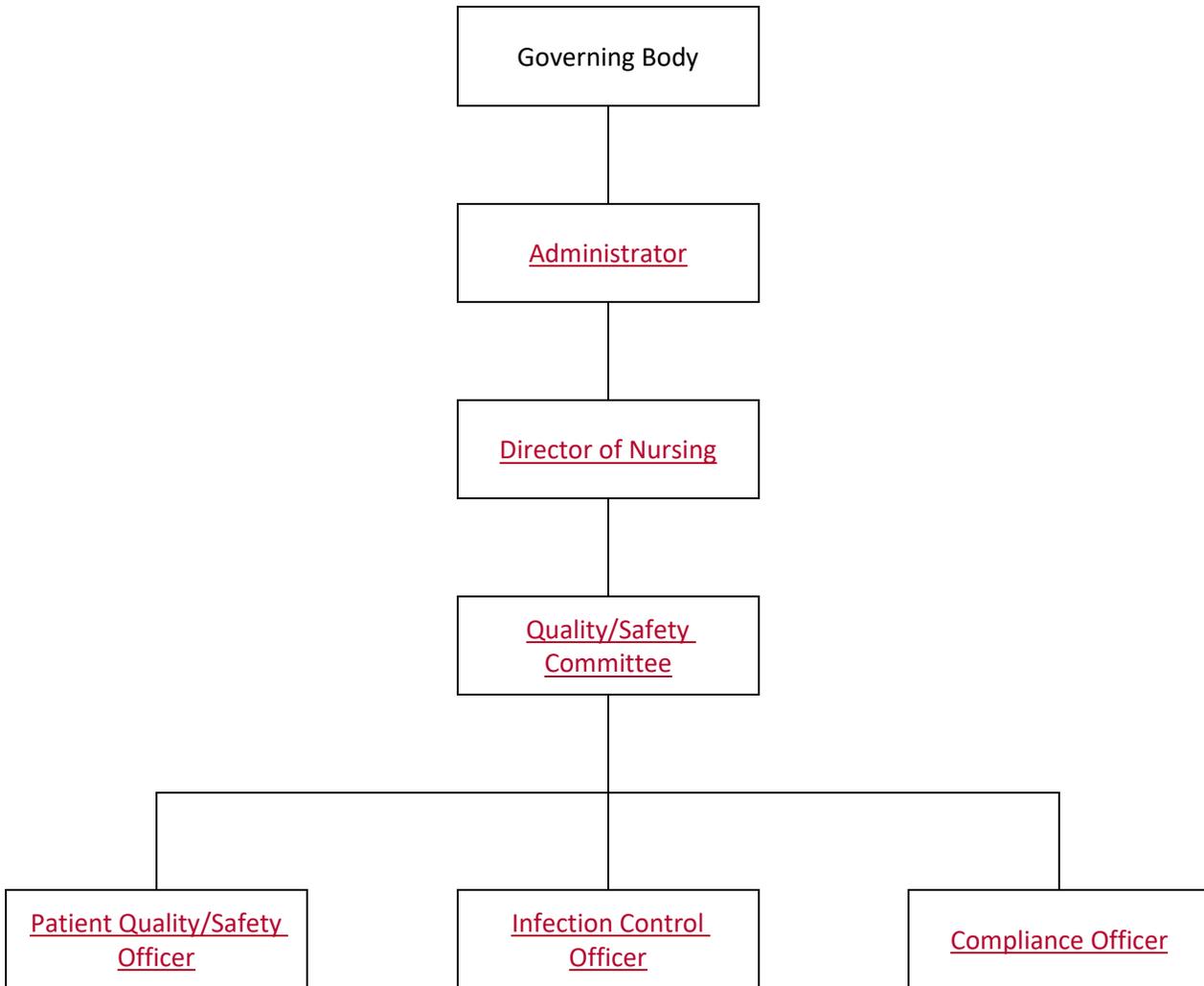
Roles and Responsibilities

According to [NRS 439.875](#), a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plan is promoted and

Patient Safety and Quality Improvement Plan

executed successfully.

The Patient Safety Committee Organization



Roles and Responsibilities

- In accordance with [NRS 439.875](#), a patient safety committee must be comprised of:
- The infection control officer of the medical facility;
- The patient safety officer of the medical facility, if he or she is not designated as the infection control officer;
- At least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility; and
- One member of the executive or governing body of the medical facility.

The roles and responsibilities are defined below (Please modify them as needed.)

Patient Safety Committee Responsibilities (based on [NRS 439.875](#) and [NRS 439.877](#))

- Monitor and document the effectiveness of the patient identification policy.
- **On or before July 1** of each year, submit a report to the Board of Managers for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the patient safety officer pursuant to [NRS 439.870](#).
- Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred.
- Review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- Review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the executive or governing body of the facility regarding:
 - (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);
 - (2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and
 - (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

Root Cause Analysis (RCA) Team Responsibilities

- Root Cause interviews, analysis, investigation, and corrective action plan implementations.
- Participates in the RCA meetings and discussions.
- Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders.

Patient Safety Officer Responsibilities (based on [NRS 439.870](#))

- Serve on the patient safety committee.
- Supervise the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the patient safety committee regarding any action taken in accordance with the responsibilities above.

(Additional responsibilities here if needed)

Infection Control Officer Responsibilities (based on [NRS 439.873](#))

Patient Safety and Quality Improvement Plan

- Serve on the patient safety committee.
- Monitor the occurrences of infections at the facility to determine the number and severity of infections.
- Report to the patient safety committee concerning the number and severity of infections at the facility.
- Take such action as determines is necessary to prevent and control infections alleged to have occurred at the facility.
- Carry out the provisions of the infection control program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program.

(Additional responsibilities here if needed)

RCA team leader Responsibilities

- Organize and coordinate the RCA process.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA, and corrective action plan implementation process.
- Communicate the progress of the investigation, institutional barriers, and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.
- Provide training, education and direction to create RCA process that incorporate the Patient Safety and Quality Improvement elements.

Executive or Governing Body Staff Responsibilities

- Provide vision and leadership to Patient Safety and Quality Improvement process, and develop and foster a safe learning and improving culture.
 - Provides oversight to the healthcare quality improvement processes and teams.
- Plan, discuss, and generate the organization patient safety goals and activities, in conjunction with the patient safety action plans

The Patient Safety Committee will meet monthly to accomplish the following:

- Report and discuss sentinel events which include:
 - Number of sentinel events from previous calendar Quarter.
 - Number of severe- infections that occurred in the facility.
- Corrective Action Plan for the sentinel events and infections
 - Evaluate the corrective action plan.
- Patient safety policies and checklists
 - At least annually evaluate Patient Safety policies and checklists
 - Revise the patient safety policies and checklists as needed.
 - Monitor and document the effectiveness of the patient safety policy.

A RCA meeting will meet as needed to accomplish the following:

Patient Safety and Quality Improvement Plan

- Define the healthcare issues or potential risks.
- Conduct Root Cause Analysis
 - Reviewing and analyzing the data.
 - Reviewing the RCA process and quality improvement related activities and timelines.
 - Identify the contributing factors and conduct the Root Cause Analysis.
- Conduct Corrective Action Plan
 - Identifying the Plan-Do-Study-Act (PDSA) topics.
 - Discussing corrective action process and activities.
 - Discussing and presenting possible changes in procedure to improve areas indicated.
 - Identifying strengths and areas that need improvement.
 - Developing strategies, solutions, and steps to take next.
- Identify barriers and technical assistance needs for supporting the RCA efforts.

A meeting agenda and minutes noting follow-up tasks will be kept.

Objectives and Goals of the Quality and Patient Safety Plan

Objective	Goals	Plan	Planned Completion Date	Responsible Party
Timely reporting of all variances	All staff will be able to independently complete variance reports	Educate all staff to the variance reporting system and forms	3/1/2018	Patient Safety Officer
Garner greater physician participation	Have physicians report all variances reported outside of the facility	Educate physicians to the patient safety plan. Encourage reporting of all variances regardless of cause.	3/15 /2018	Patient Safety Officer
Increase accountability of the Quality/Safety Committee	Increase the number of quality and safety projects at the facility	Create sub-Committees within the group to specialize in projects related to their areas.	3/15/2018	Patient Safety Officer

Components and Methods

Pursuant to [NRS 439.837](#), a medical facility shall, upon reporting a sentinel event pursuant to [NRS 439.835](#), conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event.”

{[Stonecreek Surgery Center](#) will use RCA process to determine the contributing factors and the underlying reasons for the deficiencies or failures. The Plan-Do-Study (check)-Act (PDSA or PDCA) is the model, which was developed by the Institute of Health Care Improvement, that we will use to test the changes.



Root Cause Analysis

A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals.

Before analyzing the root causes, defining problems based on facts and data is essential for successfully

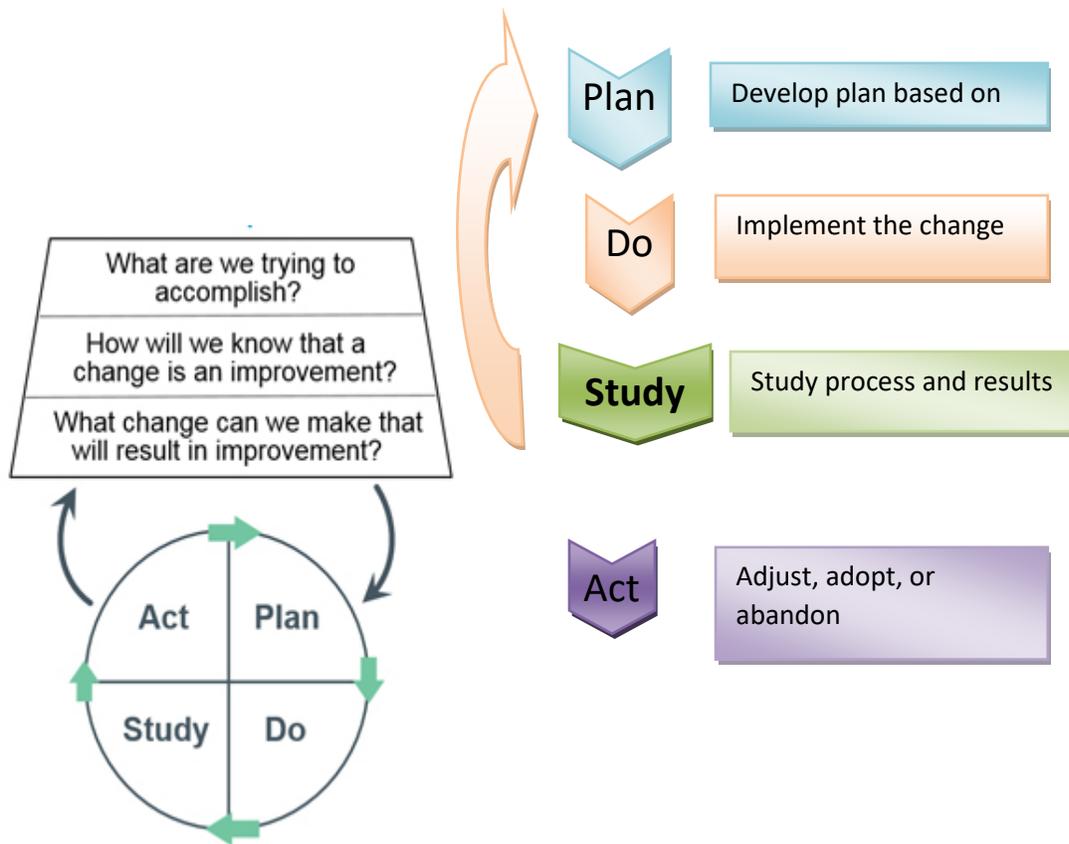
conducting root cause analysis.

Root cause analysis and action plan framework table, which was introduced by the Joint Commission. It contains 24 analysis questions. It guides the organization to the steps in a root cause analysis. Not all the questions apply to all the events or cases.

5 Whys technique will be used in (facility name) to explore the cause and effect relationship underlay a problem. One can find the root causes by asking “why” no less than five times.

Model for Improvement

The Model for Improvement is a collaborative and ongoing effort model to improve the product and services quality and process. It provides multi-disciplinary quality team guidance from identifying the root causes; conducting the best tests to assess possible changes, and working in collaboration for implementation of the new approaches and solutions. It guides the test of a change to determine if the change is an improvement.



The cycle is defined as follows:

- Plan--collect data and establish appropriate goals. Identify the problem and the possible root causes, and answer the following questions.
 - What is the objective of the test?
 - What are the steps for the test - who, what, when?
 - How will you measure the impact of the test?
 - What is your plan to collect the data needed?
 - What do you predict will happen?
- Do--make changes designed to correct or improve the situation. Use the following questions for the guidance.
 - What were the results of the test?
 - Was the cycle carried out as designed or planned?
 - What did you observe that was unplanned or expected?
- Study -- Study the effect of the changes on the situation. Data should be collected on the new process and compared to the baseline or expected results. Results should be evaluated and by using the following questions as guidance.
 - Did the results match your prediction?
 - What did you learn?
 - What do you need to do next?
- Act--If the result is successful or desirable, standardize the changes and then work on the next prioritized problem or the further improvements. If the outcome is not yet successful, look for different ways to identify the causes or change the testing process.

PDSA worksheet will be used to map the potential change strategies and to establish a course of action. The PDSA worksheet and the PDSA progress report are attached in Appendix D-1.

Data Collection and Reporting

Data should drive any quality and patient safety effort. [Stonecreek Surgery Center](#) is using a [paper system](#) for tracking the sentinel events, healthcare infection data, [and](#) for internal data collection.

External data sources are those data sources which are collected outside the supervisory structure of the case. External data which will be utilized for Quality and Patient Safety plan include the data from:

- AHRQ: Agency for Healthcare Research & Quality
- CDC: Centers for Disease Control and Prevention
- CMS: Centers for Medicare & Medicaid Services
- NQF: National Quality Forum
- NHSN: National Healthcare Safety Network
- TJC: The Joint Commission



Ongoing Reporting and Review

Data points such as the following will be reviewed according to the schedule prescribed:

Monthly	Quarterly	Annually
1) Sentinel event monthly report 2) Severity of infection report 3) RCA assessment	1) Sentinel event quarterly report 2) Severity of infection report 3) Review and evaluate the measure of improvement of patient safety 4) Review and evaluate the measurement to prevent and control infections	1) Quality and Patient Safety Plan update 2) Checklists and Policies reviewing and revising

Patient Safety Checklists and Patient Safety Policies

By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

The patient safety checklists must follow protocols to improve the health outcomes of patients at the medical facility and must include, without limitation:

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.
- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - Proper instructions concerning prescription medications;
 - Instructions concerning aftercare;
 - Any other instructions concerning his or her care upon discharge; and
 - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction

with a provider of healthcare. The personal identifiers may include, the name and date of birth of the patient.

- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.
- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

Based on [NRS 439.865](#), the patient safety plan must also include an infection control program that carries out the infection control policy. The policy must consist of:

- The current guidelines appropriate for the facility's scope of service developed by a nationally recognized infection control organization as approved by the State Board of Health which may include, the Association for Professionals in Infection Control and Epidemiology (APIC), the Centers for Disease Control and Prevention (CDC), the World Health Organization- (WHO) and the Society for Healthcare Epidemiology of America (SHEA); and

The patient safety checklists are listed in Appendix E. (The following links provide some patient safety checklists for your reference— a checklist example is shown in **Appendix E**.)

http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf

<http://www.who.int/patientsafety/implementation/checklists/en/>

The patient safety policies are listed in Appendix F. (The following link provides you some patient safety policies for your reference—a policy example is shown in **Appendix F**.)

Approval of Patient Safety Plan

According to [NRS 439.865](#), a medical facility shall submit its patient safety plan to the governing board of the facility for approval. After a facility's patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan.

The patient safety plan must be reviewed and **updated annually** in accordance with the requirements for approval set forth in this section.

According to [NRS 439.843](#), on or before March 1 of each year, a copy of the most current patient safety plan established to [NRS 439.865](#) must be submitted to the Division of Public and Behavioral Health.

Reference

- Root Cause Analysis Toolkit <http://www.health.state.mn.us/patientsafety/toolkit/>
- Quality and Service Improvement Tools http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html
- CQI 101 An Introduction to Continuous Quality Improvement: <https://www.coursehero.com/file/13827355/CQI-Overviewppt/>
- Quality Improvement <http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/>
- Root Cause Analysis <http://www.patientsafety.va.gov/professionals/onthejob/rca.asp>
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2 https://www.jointcommission.org/sentinel_event.aspx
- Checklists to Improve Patient Safety http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf
- Patient Safety Checklists <http://www.who.int/patientsafety/implementation/checklists/en/>
- —Title 40 – Public Health and Safety <https://www.leg.state.nv.us/NRS/NRS-439.h>

Appendix A: Terms and Definitions

Patient Safety: The Agency for Healthcare Research Quality (AHRQ) defines patient safety as “a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.” http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

Sentinel event (NRS 439.830)

1. Except as otherwise provided in subsection 2, “sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum.

2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:

(a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or

(b) July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published.

3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.

(Added to NRS by [2002 Special Session, 13](#); A [2005, 599](#); [2013, 217](#))

Institute for Healthcare Improvement (IHI) defines **medical harm** as “unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical

treatment) that requires additional monitoring, treatment or hospitalization, or results in death.”

Facility-Associated Infection: ([NRS 439.802](#))

“Facility-acquired infection” means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections;
- Other categories of infections as may be established by the State Board of Health by regulation pursuant to [NRS 439.890](#).

(Added to NRS by [2005, 599](#); A [2009, 553](#))

Medical facility ([NRS 439.805](#))

“Medical facility” means:

- A hospital, as that term is defined in [NRS 449.012](#) and [449.0151](#);
- An obstetric center, as that term is defined in [NRS 449.0151](#) and [449.0155](#);
- A surgical center for ambulatory patients, as that term is defined in [NRS 449.0151](#) and [449.019](#); and
- An independent center for emergency medical care, as that term is defined in [NRS 449.013](#) and [449.0151](#).

(Added to NRS by [2002 Special Session, 13](#))

Near miss: An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Mandatory reporting: Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985;254(6):796-800.)

Risk: Possibility of loss or injury. (Merriam-Webster’s Online Dictionary, Risk, Available at <http://www.merriamwebster.com/dictionary/risk>. Last Accessed August 2009.)

Preventable event: Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Appendix D-1: PDSA Worksheet

PDSA Worksheet

Topic:			
Person Completing Worksheet:		Date:	
Telephone/ Email:		Cycle:	
Patient Safety Committee Members			
CEOs/CFOs			
Patient Safety Officer			
Infection Control Officer			
Other Medical Staff			
Other team members			
Aim: (Describe the overall SMART goal that your team wishes to achieve.)			
Plan:			
1. List the tasks needed to set up this test of change.			
2. Predict what will happen when the test is carried out.			

3. List the steps to develop the test-who, what, and when.

Steps	By Whom	By When	Desired Outcome

Do: (Describe what actually happened when you ran your test, including any problems and unexpected findings.)

Study: (Describe what you learned and did you meet your measurement goal?)

Did you meet your measurement goal? Explain.	Summarize what was learned: success, failure, unintended consequences, etc.

Act: (Describe what you concluded from this cycle.)

Based on what was learned, please indicate what action will be considered.	Describe what modifications to the plan will be made for the next cycle based on what you learned.
<input type="checkbox"/> Adapt: modify changes and repeat PDSA Cycle	
<input type="checkbox"/> Adopt: expanding changes throughout organization	
<input type="checkbox"/> Abandon: change approach and repeat PDSA cycle	

Appendix D-2: PDSA Monthly / Quarterly Progress Report

Event:			
Person Complete Report:		Date:	
Patient Safety Officer		Contact Information:	
Monthly / Quarterly Report			
Items	Description		
1. What is your goal?			
2. Report on the PDSA cycle			
3. What system and practices are working well? Explain.			
4. What areas for improvement did the data identify?			
5. What barriers or system issues have been encountered implementing action activities?			
6. Action plans to address the barriers or system issues			
7. Lesson learned			
8. Support needed			
9. Additional discussion			
Notes:			

AMBULATORY SURGICAL CENTER OF SOUTHERN NEVADA

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I. PURPOSE:

Attention to maintaining and improving patient safety and well being is inherent in Ambulatory Surgical Center of Southern Nevada's (ASC of Southern Nevada) commitment to the relief of suffering and improvement in the quality of life to those in the community it serves. In committing ourselves to safeguarding individuals, ASC of Southern Nevada must fully understand the processes and systems that are utilized by the organization to deliver patient care. From this deeper understanding, ASC of Southern Nevada will be able to analyze, evaluate, develop and implement changes that will continuously improve the way we deliver care to patients.

The results of these efforts will:

- Demonstrate ASC of Southern Nevada's commitment to the community it serves.
- Unite ASC of Southern Nevada and individuals who work and practice at ASC to respond appropriately to adverse events, proactively identify risk reduction strategies and participate in process and system redesigns to reduce risk of patient harm.
- Allow ASC to implement processes technology or systems that will reduce the risk of errors reaching patients and causing harm.
- Promote greater medical staff and employee involvement in improving clinical care which will result in improved employee and medical staff satisfaction.
- Translate into a more efficient and cost-effective model of care at ASC.

Ambulatory Surgical Center of Southern Nevada's leadership and employees must actively embrace and support the patient safety plan in order to achieve the results outlined above.

II. SCOPE:

The Ambulatory Surgical Center of Southern Nevada Patient Safety Plan is an all-inclusive, integrated method to planning, designing, measuring, assessing and improving patient safety quality care and outcomes. Assessing day to day operations, employee input and customer needs are integrated into the development of the program. This program will incorporate all patient related activities and use interdisciplinary teams whenever possible.

Important aspects of patient care and service that involves the monitoring of activities and making improvements include:

- Complications of anesthesia
- Post procedure bleeding
- Post procedure infection
- Medication errors/Look alike sound alike medications

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- Allergic reaction
- Medical Equipment related adverse event
- Technical difficulty with procedure
- Proper indication
- Proper consent
- Current H & P
- Risk Stratification
- Anticoagulation Problems
- Patient Satisfaction
- Pathology Specimen errors
- Time outs
- Patient Education/discharge instructions
- Day of Procedure Cancellations
- Identity Theft/Lack of ID
- Reprocessing errors
- Non-compliant patients with pre-procedure instructions
- Communication with referring providers
- Sentinel Events
- Medical Records Documentation
- Scheduling errors
- Infection Control Survey Rounds
- Help patients to be involved in their care.
- Medication reconciliation
- Improve staff communication
- Hand hygiene
- Prevent patient from falls
- Responsible adult to accompany patient home
- Patient Identification
- Single use of injection devices
- Fire Prevention and Safety in the Procedure Rooms

The Ambulatory Surgical Center of Southern Nevada recognizes that risk management and patient safety are priorities that include establishing, maintaining and improving the safety of patients and the facility.

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III. STRUCTURE:

Governing Body

The Governing Body of the Ambulatory Surgical Center of Southern Nevada (ASC of Southern Nevada) is comprised of members including: ASC principal owners, Administrator and Medical Director. The Governing Body assumes full legal responsibility for determining, implementing and monitoring policies so as to provide quality health care in a safe environment and to protect the health and safety of patients and employees. When services are provided through a contract with an outside resource, the Ambulatory Surgical Center of Southern Nevada (ASC of Southern Nevada) will, to the best of its ability, assure that these services are provided in a safe and effective manner. The Governing Body will carry out the following duties and responsibilities either directly or by delegation to committee(s).

The Governing Body oversees this responsibility by:

- Ensuring each patient admitted to the facility is under the care of a physician.
- Ensuring each patient admitted to the facility has had a pre-surgical exam within seven days prior to the date of the procedure.
- Ensuring that a physician is on the premises and is immediately available at all times while patients are in procedure rooms or in the recovery area.
- Maintaining an adequate number of qualified and competent staff to meet the needs of the patients.
- Oversight and accountability for developing a program of quality improvement and risk management appropriate to the specific needs of ASC of Southern Nevada that follow all federal, state and third party regulatory requirements.
- Ensuring that the facility policies and procedures are administered in such a manner that provides health care in a safe environment.

Medical Director

The Medical Director who also serves as the Patient Safety Officer represents the ASC and the medical staff in decision-making processes through direct participation and/or formal referral recommendations. The Medical Director is responsible for determinations as to needed resources when providing services relating to patient care.

The duties of the Medical Director include:

- Oversee and actively participate in the Quality Assurance/Risk Management activities.
- Oversee and actively participate in the Patient Safety Committee
- Participate in the development and have final approval on all service specific policies and procedures associated with patient care.
- Responsible for providing continuing educational in-services for the facility and medical staff in regards to patient care when necessary.
- Active role in evaluating and identifying staffing needs.

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Risk Management/Patient Safety Officer

The Patient Safety Officer will have primary oversight of the facility-wide patient safety program. The Patient Safety Officer will direct others within the facility towards process improvements that will support the reduction of medical/health care errors and other factors that contribute to unexpected adverse patient outcomes.

The duties of the Patient Safety Officer include:

- Notify the liability insurance carrier when adverse or reportable events occur.
- Coordinates the activities of the Patient Safety Committee.
- Investigate patient safety issues, along with the patient safety committee, within the facility.
- Recommend and facilitate change within the organization to improve patient safety based on identified risks.
- Serve as a resource on issues of patient safety.
- Support and encourage error reporting throughout the facility through a non-punitive error reporting system.
- Take such action as he/she determines necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the Governing Body on the occurrence of known medical and health care errors and identified near misses and dangerous conditions within the facility.

Patient Safety Committee

Patient Safety Committee is a part of the Quality Assessment Performance Improvement Committee and is comprised of the Medical Director, Administrator/ Patient Safety Officer,, Director of Nursing and the charge. The Patient Safety Committee/Quality Assessment Performance Improvement Committee is responsible to the Governing Body and Administration for the overall operation of the Risk Management and Patient Safety Plan. The Patient Safety Committee meets on a quarterly basis or as needed. Patient Safety Goals will be developed on a yearly basis.

The duties of the Patient Safety Committee include:

- Reviewing and evaluating the quality of patient safety measures.
- Review all adverse outcomes.
- Review incidents
- Making recommendations to eliminate future serious events or incidents.
- Reporting to the Governing Body on a quarterly basis to include the occurrence of medical/health care errors and actions taken to improve patient safety.

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- Make recommendations to the Governing Body to reduce the number and severity of sentinel events that occur at the facility.
- Assess the quality indicators that affect patient safety and patient health outcomes.
- Coordinate the collection of data from the quality indicators where needed, perform QI studies and improve our patient care processes.

IV. Definitions

Incident - any occurrence that is not consistent with the routine care or operation of the organization. Incidents may involve patients, visitors, employees and medical staff members (i.e. patient fall, employee injury, etc.).

Adverse Incident/Sentinel event – Is defined as an unexpected occurrence during a healthcare visit involving, death or serious physical or psychological injury or the risk thereof, including, loss of limb or function, not related to the natural course of the patient's illness or underlying condition (AAAHC/Nevada Revised Statutes).

Root Cause Analysis – Is a process for identifying the basic or causal factors that underlies variation in performance, including the occurrence or possible occurrence of a sentinel event. A root cause analysis focuses primarily on systems and processes, not on individual performance. It progresses from special causes in clinical processes to common causes in organizational processes and systems and identifies potential improvements in processes or systems that would tend to decrease the likelihood of such events in the future or determines, after analysis, that no such improvement opportunities exist. [Joint Commission on Accreditation of Healthcare Organizations]

Action Plan – The product of the root cause analysis is an action plan that identifies the strategies that the organization intends to implement in order to reduce the risk of similar events occurring in the future. The plan should address responsibility for implementation, oversight, pilot testing as appropriate, time lines, and strategies for measuring the effectiveness of the actions. [Joint Commission on Accreditation of Healthcare Organizations]

Near Miss – any process variation that did not affect an outcome but for which a recurrence carries a significant chance of a serious adverse outcome. [Joint Commission on Accreditation of Healthcare Organizations] It is an event or situation that could have resulted in an accident, injury or illness, but did not, either by chance or by timely intervention. Near misses are opportunities. Examples of near miss that would require the use of an incident form include but are not limited to:

- Equipment Reprocessing errors not used on patients.

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V. Reporting Mechanisms

To effectively reduce adverse patient outcomes, there must be an environment that supports employees by identifying and learning from errors and system failures. Ambulatory Surgical Center of Southern Nevada (ASC) encourages all employees to report any errors or work methods that may lead to potential adverse patient outcomes. The ASC supports a non-punitive, open communication culture.

A. Non-Punitive Reporting

The facility recognizes that if we are to create a safe environment for our patients and visitors, we must create an environment that is safe for caregivers to report and learn from events and near misses. The facility requires that employees report errors and encourages them to do so.

1. The goal is to identify and track errors in order to continuously improve our systems and to provide the necessary education to prevent reoccurrence.
2. All events, especially those of a clinical nature need to be reported immediately. It is expected that complete disclosure shall occur. Reporting will be in confidence and shall not suffer harassment or retaliation.
3. An employee who knowingly fails to report a clinical error will be subject to disciplinary action.

B. Adverse Event/Incident/Complication/Infection Tracking System

1. All information regarding Complications and Adverse events is collected and documented in the Incident Tracking Report and the Adverse Reactions and Complications Report.
2. The data reviewed that is not consistent with the normal operations of the facility or the anticipated disease/treatment process of the patient is communicated to the Medical Director and or Administrator.
3. The facility's processes will be reviewed to determine methods to prevent reoccurrence, improve quality care and ensure patient and visitor safety.

C. Sentinel Events

When a sentinel event occurs, appropriate individuals are notified and immediate attention investigation is undertaken. The sentinel event policy describes the reporting structure and responsibilities of the designated individuals. A root cause analysis and action plan may be implemented if necessary.

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D. Patient Complaint/Grievance

Complaints can be reported to the Director of Nursing, Administrator or Medical Director. Employees should report all complaints immediately to their supervisor. Patients should notify the Director of Nursing. All complaints will be investigated and a response or corrective action will be made.

VI. Communicating With Patients About Safety

1. Patients Rights and Responsibilities, Advance Directive, Complaint and Grievance Process and Physician Ownership Disclosure shall be explained to the patient at the time the procedure is scheduled via the written copy provided to them.
2. Patients are also provided instructions prior to their procedure.
3. Patient education is provided on safe use of medication regarding their procedure.
4. The day of procedure, the nurse reviews the procedure with the patient and what is involved in the pre and post op care.
5. The nurse verifies the allergies with the patient and medications' confirming that the patient has withheld the anticoagulants, anti-inflammatory and aspirin as ordered by the physician.
6. Verify procedure with patient.
7. Encourage patient to ask questions.
8. If there is a language barrier provide interpretation.
9. Use side rails once patient is in gurney to prevent falls.
10. Make sure the patient uses the call light to ambulate off gurney.
11. Involve patients in Time Outs in procedure room before start of case.
12. Review post-op instructions with patient or family member and verify that the patient understands his/her instructions.
13. Confirm that the patient has an adult to drive them home and does not operate vehicle post procedure if sedation was administered.
14. Confirm that follow-up appointment is communicated with patient if needed.
15. Provide educational pamphlets on diagnosed conditions for patient education.

VII. Staff Education

1. Initial and annual training is provided to all employees on safety in the work environment.
2. Risk Management, Infection Control, Hand Hygiene, Blood Borne Pathogens, Personal Protective Equipment and Safe Injection Practices Training is provided to staff.
3. Educating and following the Time Out Policy to assure that we have the right patient and

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and the right procedure.

4. Importance of verifying color of arm band for the correct patient, correct procedure.
5. Staff meetings are held to communicate quality improvement and patient safety issues.
6. Ongoing education to staff is provided regarding patient safety issues.
7. Staff education on all disinfectants used throughout the facility.
8. Patient safety checkpoints are added to the pre, intra and post documentation.

VIII. Safety Improvement Activities/Methodologies

Medication/Pharmacy Surveillance – All matters pertaining to the use of drugs in the Center will be monitored on a monthly basis by a contracted pharmacist. See service Contracts for facility.

High Alert Medications – All employees or providers that handle patient medication will follow the procedure for the safe storage and handling of high alert medications. See High Alert Medication Policy.

Infection Surveillance – Infection surveillance will be completed by the Director of Nursing, or his/her designee, on a monthly basis or as needed and the findings reviewed with the Patient

Safety Committee and staff. Identifying processes that can cause potential risk to patient and visitor safety will be addressed. Recommendations will be communicated to staff members on any new measures to be implemented to ensure patient and visitor safety.

Facility Safety Surveillance – Facility safety surveillance will be done on a monthly basis by a designated employee or as needed to ensure there are no hazardous conditions that would be a safety concern for patients, visitors or employees.

Follow-up Phone Calls to Patients – All patients are called post procedure to document any Complications they may be having or questions they may have.

Patient Satisfaction Survey – Patient Satisfaction surveys are completed on a random number of patients on a monthly basis. The results are communicated to the employees Physicians and the Administrator which function collaboratively to achieve positive patient outcomes when possible.

Monthly Physician Infection Control Reports – Physicians communicate to the Director of

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Nursing any patient that may have developed an infection that was not identified on the Follow-up phone call made by the nurse.

High-Level Disinfectant Solution Checks – Before each endoscope is placed in the automated endoscope reprocessor, the minimum effective concentration is checked to ensure that the active ingredient in the solution still passes the manufacturer’s guidelines for reuse before the endoscope is placed in the machine. This is done for each endoscope with all data documented into log books.

Cleaning and Disinfection of Patient Care Equipment – All reusable equipment is classified and processed according to the CDC’s guidelines. Employees clean all reusable equipment to ensure the health and safety of our patients.

Safe Injection Practices – All patient care providers follow safe injection practices to prevent patient to patient transmission of bloodborne pathogens. See Safe Injection Practices policy.

Time Outs – Performed with the anesthesia provider, physician and GI Tech before the start of each procedure to verify right patient, right procedure and allergies.

Hospital Transfers – Any patient transferred to the hospital post procedure will have a peer review process performed to recommend areas of improvement if necessary and quality of care.

Cecal Intubation Rates – All physicians are monitored and reported on a monthly basis. Rates are benchmarked against best practices for colonoscopy completion rate. Effective colonoscopists should be able to intubate the cecum in more than 90% of all cases and in more than 95% when the indication is screening and healthy adult.

Withdrawal Time – All physicians are monitored and reported on a monthly basis. Rates are benchmarked against best practice which is more than or equal to 6 minutes.

Physician Peer Review – All physicians are monitored quarterly. Ten charts are reviewed per physician and anesthesia provider. Results are communicated to the Medical Director.

IX. Annual Review of Patient Safety Plan

The Patient Safety Committee is responsible for the annual review of the Patient Safety Plan. Included in this review the committee will set goals for the new year and focus on

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the patient quality indicators that affect patient safety and patient health outcomes. Quality Indicators will be selected throughout the year and QI studies will be implemented to evaluate our current processes. This effort is undertaken so that processes, functions and services can be designed or redesigned to improve patient services or prevent any health risks to patients.

**NEVADA ENDOSCOPY MANAGEMENT INC
GASTROENTEROLOGY CONSULTANTS LTD
RENO ENDOSCOPY CENTER LLC
SOUTH MEADOWS ENDOSCOPY CENTER LLC
CARSON ENDOSCOPY CENTER LLC**

POLICY AND PROCEDURE MANUAL

Policy: Patient Safety Plan
Owner: Center
Date last updated: Revised 4/2016

Purpose: Gastroenterology Consultants, Ltd (GIC) and affiliated Endoscopy Centers are committed to ensuring the ongoing safety of our patients. To ensure the ongoing safety and care of our patients we follow specific guidelines and policies which, at a minimum, include:

I Infection Control (IC): Refer also to the Infection Control (IC) Policy

Guidelines followed include:

- a. American Society for Gastrointestinal Endoscopy (ASGE) Multisociety Guideline on Reprocessing Flexible Gastrointestinal Endoscopes 2011
- b. Society of Gastroenterology Nurses and Associates, Inc. (SGNA) Standards of Infection Prevention in Reprocessing Flexible Gastrointestinal Endoscopes 2015
- c. Society of Gastroenterology Nurses and Associates, Inc. (SGNA) Standard of Infection Prevention in the Gastroenterology Setting 2015
- d. Society of Gastroenterology Nurses and Associates, Inc. (SGNA) Guideline for Use of High Level Disinfectants and Sterilants for Reprocessing Flexible Gastrointestinal Endoscopes 2013
- e. American Society for Gastrointestinal Endoscopy (ASGE) Infection Control during GI Endoscopy 2008
- f. Center for Disease Control (CDC) Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings 2007
- g. CDC Guide to Infection Prevention for Outpatient Settings 2014
- h. Association for Professionals in Infection Control and Epidemiology (APIC) Guide to the Elimination of Clostridium difficile in Healthcare Settings 2013
- i. CDC Safe Injection Practices

The IC Policy includes at a minimum processes or guidelines for:

- a. Patient selection and placement within the facility
- b. Infection Control Monitoring and Surveillance, Reporting
- c. Standard and Transmission Precautions, Hand Hygiene, Personal Protective Equipment, Respiratory Hygiene / Cough Etiquette and General Infection Control Practices in Healthcare Facilities as developed by the CDC and APIC
- d. Environmental and Terminal Cleaning
- e. Infection Control Officer

Approved Board of Managers REC/SEC/ CEC 10/11/11; Revised 8/9/12, Approved Board of Managers REC/SEC 1-31-16; CEC 1-25-16; Approved Medical Directors 4/2016

The proceedings and records of a patient safety committee are subject to the same privilege and protection from discovery as the proceedings and records described in NRS 49.117 - 49.123 and NRS 49.265.

- f. Equipment Processing: Cleaning, Disinfection, High Level Disinfection and Sterilization

II □ Patient Selection and Screening: Refer also to the Criteria for Scheduling Patients at ASC Policy.

1. To ensure patients are appropriate for the planned procedure in the planned setting patients undergo:
 - a. Pre-procedure scheduling evaluation with referral for office visit or consultation as appropriate
 - b. Pre-procedure assessment which includes at a minimum:
 - i. Review of past medical & surgical history
 - ii. Medication reconciliation, review
 - iii. Allergy and reaction, review of
 - iv. Physical assessment; assessment for communicable diseases
 - v. Vital signs

III □ Patient Identification: Refer to Patient Identification Policy. Patient identity is verified with at minimum two (2) identifiers at check-in and at multiple points throughout care.

IV □ Safe Surgery Checklist: Refer to Safe Surgery Checklist Policy. Patient and procedure are verified immediately prior to procedures.

V □ Discharge Teaching: Patients are provided with written discharge instructions which are reviewed with patient and driver, as applicable, prior to discharge. Medications are reconciled prior to discharge if any new medications are ordered. Information specific to diagnosis, as best as known, is given to the patient. Patients are educated about signs and symptoms to report and given a twenty-four (24) hour telephone number to call in event of questions or concerns.

VI □ Post Procedure Callbacks: Patients are contacted one (1) to two (2) business days post-procedure for follow up of any concerns and questions regarding discharge instructions.

VII □ Pathology follow up: Patients are notified of pathology results and given information and follow up orders as applicable within two (2) weeks.

VIII □ Pharmaceutical Services: Refer to Pharmaceutical Services Policy. Safe injection practices are strictly followed. Pharmaceutical services are overseen by a contracting pharmacist on a monthly basis.

I □ Quality Assurance and Benchmarking: Refer to the Quality Management Plan. More than one hundred (100) quality assurance checkpoints are monitored on per patient, per case, per day, per week or per month basis as applicable. Benchmarking of multiple facility and nursing care factors are completed on an ongoing basis. In addition, multiple procedure-related factors are tracked and trended in aggregate and specific to individual

Approved Board of Managers REC/SEC/ CEC 10/11/11; Revised 8/9/12, Approved Board of Managers REC/SEC 1-31-16; CEC 1-25-16; Approved Medical Directors 4/2016

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physicians on an ongoing basis. Incidents, procedure complications/events, adverse and sentinel events are investigated tracked and trended by facility, staff and physician. All data is reported to the Quality Management Committee.

- **Staff Training:** Extensive staff training is done at time of hire. Annual staff retraining is mandatory; ongoing training is provided as applicable. Staff are evaluated for customer service and performance on an ongoing basis.
- I□ **Checklists:** All items above are monitored via specific checklists, logs and or chart documentation.

Refer to:

- Infection Control Policy
- Criteria for Scheduling Patients at ASC Policy
- Identification of Patient Policy
- Pharmaceutical Services Policy
- Quality Management Plan
- Safe Surgery Checklist Policy
- Incident Reports Policy
- Complications: Procedure Event, Adverse and Sentinel Events Policy
- Staff Training Competencies and Logs
- NRS 439.865; 439.877

Approved Board of Managers REC/SEC/ CEC 10/11/11; Revised 8/9/12, Approved Board of Managers REC/SEC 1-31-16; CEC 1-25-16; Approved Medical Directors 4/2016

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Section 3 Safety Management	Smoke Ranch Surgery Center
Policy Name: PATIENT SAFETY GOALS	
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Approved: JAN 27 2010	Revised:

The Governing Body of this facility is committed to providing the patients at Smoke Ranch Surgery Center the safest environment within the control of the organization. This facility will incorporate these patient safety goals as a part of the overall Safety Program.

- **Goal 1: Improve the accuracy of patient identification.**
 - Use at least two patient identifiers when providing care, treatment or services, such as medication administration.
 - Eliminate transfusion errors related to patient misidentification.
- **Goal 2: N/A**
- **Goal 3: Improve the safety of using medications.**
 - Label all medications, medication containers and all other solutions on and off the sterile field in perioperative and other procedural settings. Note: Medication containers include syringes, medicine cups and basins.
 - Remove all labeled containers on the sterile field and discard their contents at the conclusion of the procedure.
- **Goal 4, 5, 6: N/A**
- **Goal 7: Reduce the risk of health care-associated infections.**
 - Comply with CDC or WHO hand hygiene guidelines.
 - Implement evidence-based practices for preventing surgical site infections.
- **Goal 8: Accurately and completely reconcile medication across the continuum of care.** (Note: all requirements for Goal 8 are not in effect at this time)
 - Obtain an accurate list of the patient's current medications (including OTC and herbal) and known allergies, prior to surgery.
- **Goal 9, 10, 11: N/A**
- **Goal 12, 13: N/A**
- **Goal 14, 15, 16: N/A**

Section 3 Safety Management	Smoke Ranch Surgery Center	
Policy Name: PATIENT SAFETY GOALS		Page 1 of 3
Approved: JAN 27 2010	Revised: FEB 01 2011	

The Governing Body of this facility is committed to providing the patients at Smoke Ranch Surgery Center the safest environment within the control of the organization. This facility will incorporate these patient safety goals as a part of the overall Safety Program.

- Goal 1: **Improve the accuracy of patient identification.**
 - Use at least two patient identifiers when providing care, treatment or services, such as medication administration. Patient identifiers can be the individual's name, date of birth, assigned identification number, telephone number or other person specific identifier.
 - Eliminate transfusion errors related to patient misidentification.
- Goal 2: **N/A**
- Goal 3: **Improve the safety of using medications.**
 - Label all medications, medication containers and all other solutions on and off the sterile field in perioperative and other procedural settings. Note: Medication containers include syringes, medicine cups and basins.
 - Remove all labeled containers on the sterile field and discard their contents at the conclusion of the procedure.
 - See also policies in the Anesthesia/Pharmacy manual and the Nursing manual.
- Goal 4, 5, 6: **N/A**
- Goal 7: **Reduce the risk of health care-associated infections.**
 - Comply with CDC or WHO hand hygiene guidelines.
 - Set goals for improving hand hygiene compliance.
 - Implement evidence-based practices for preventing surgical site infections.
 - Conduct Infection Control risk assessments.
- Goal 8: **Medication Reconciliation.** (Note: all requirements for Goal 8 are not in effect at this time. This goal will be updated when it is in effect.)
- Goal 9, 10, 11: **N/A**
- Goal 12, 13: **N/A**
- Goal 14, 15, 16: **N/A**

Section 3 Safety Management	Smoke Ranch Surgery Center
Policy Name: PATIENT SAFETY GOALS	Page 2 of 3

- **Universal Protocol for Preventing Wrong Site, Wrong Procedure and Wrong Person Surgery**

- Create and use a preoperative verification process, such as a checklist, to confirm that appropriate documents (e.g., medical records, imaging studies) are available.
- Implement a process to mark the surgical site, and involve the patient in the marking process.
- Conduct a TIME OUT immediately before starting the procedure.

The National Quality Forum's (NQF) new report, *Safe Practices for Better Healthcare*, lists best practices that experts agree would significantly improve patient safety. Some of the practices that will be incorporated in Smoke Ranch Surgery Center's safety plan include, but are not limited to:

- Create a culture of safety by establishing policies on issues such as prioritizing and analyzing patient safety events and training staff in teamwork-based problem solving skills.
- Specify a protocol to ensure that you have adequate nursing care based on your patient mix and nurse experience.
- Record and read back verbal orders to the prescriber immediately.
- Use only abbreviations and doses that the organization has standardized.
- Prepare patient care summaries from original source documents, not from memory.
- Transmit care information, such as order changes or diagnostic information, on time and in an understandable format to all providers who may need the information to care for a patient.
- Ask patients or legal surrogates to repeat what providers explained to them about informed consent.
- Prominently display patient's preferences for life-sustaining treatment in their charts.
- Standardize protocols for preventing wrong-site or wrong-patient procedures by using a pre-surgical checklist and establishing a process to mark the operative site.
- Evaluate preoperative patients for the risk of surgical site infection and implement appropriate preventive measures such as antibiotic prophylaxis.
- Use a hygienic hand rub or wash your hands with disinfectant soap before and after contact with patients or objects immediately around them.
- Keep the medication preparation area clean, orderly, well lit and free of clutter, distraction and noise.
- Use standard methods for labeling, packaging and storing medications.
- Identify all "high-alert" drugs, such as chemotherapy agents, anticoagulants, insulin or narcotics.

Section 3 Safety Management	Smoke Ranch Surgery Center
Policy Name: PATIENT SAFETY IN THE OPERATING ROOM	Page 1 of 4
Approved: JAN 27 2010	Revised:

POLICY:

Patient safety refers to a systematic facility-wide program to minimize preventable physical injuries, accidents and undue psychological stress during the visit. The nursing practice for safety standards is as follows:

- Patient Identification
 - The Operating Room RN always identifies the patient by checking the wristband with the patient's chart and the operating schedule. In addition, the RN verifies the patient identification through verbal communication with the patient and/or caregiver.
- Patient Observation
 - Patients on stretchers or operating tables are never left unattended. Side rails and/or safety straps are utilized.
 - Special care is ensured by provision of an adequate number of personnel when moving patients to and from the operating table or when positioning patients on the operating table. When positioning patients, it is essential to provide supportive devices to protect nerves and blood vessels. Limbs are never to be hyperextended.
- Dedication to Meticulous Aseptic Technique
 - Facility team members must know and apply the principles of aseptic and sterile technique at all times to avoid life-threatening postoperative infection.
- Execution of Accurate Counts
 - The responsibility of accounting for all sponges, instruments, needles and sharps before the surgery begins and at the time of closure rests with the circulating and scrub persons per established policy. The Operating Room RN must document on the operative record the outcome of all final counts. Patients are not to leave the operating room until final counts are correct. If necessary x-ray will be used to determine that the missing item is not located in a patient cavity.

using two patient identifiers, i.e. Name and DOB

- Use of Operating Equipment
 - All equipment and appliances must be set up and used according to the recommendations and instructions of the manufacturer. The biomedical engineer must inspect all new electrical equipment prior to use and every six (6) months thereafter. Electrical equipment must be properly grounded to prevent electric shock and burns.

- Prevention of Burns
 - The scrub person shall immerse all hot instruments in a basin of cool sterile water prior to handing them to the surgeon.
 - Proper placement of the electrosurgical ground pad is essential to prevent electrical burns. Cautery devices, when not in use, are to be secured in a holster. Coagulation/cutting settings on the electrosurgical units are set at the lowest setting and gradually increased.
 - Flammable solutions (i.e., alcohol) are not to be utilized when electrosurgery is in progress.
 - All electrical equipment must be inspected prior to use.

- Administration of Drugs
 - All drugs used by the surgeon are documented in the operative record. The Operating Room RN and the scrub person identify all drugs transferred to the sterile field.
 - The scrub person repeats the name and dosage of the drug when transferring it to the surgeon.
 - If more than one drug is present on the sterile field, each drug must be correctly identified.

- Preparation of Specimens
 - All tissue removed from a patient, unless exempt, is sent to the pathology laboratory and labeled with the site of the specimen.

- *It is the responsibility of the scrub person to communicate to the Operating Room RN the origin of each specimen. It is the responsibility of the Operating Room RN to label and record each specimen accurately.*
- All specimens for frozen section are placed in a dry container and forwarded to the pathology laboratory. **NOTE:** Frozen section specimens are delivered to the pathology laboratory by a special courier. The courier signs the specimen log denoting delivery of the frozen section specimen.
- Fire Safety
 - Response of the facility team to a fire is outlined in the Safety Manual. Facility personnel participate in the quarterly drills as appropriate and review fire precautions annually.
- Emergency Management Responses
 - Response of the facility team in a disaster situation is outlined in the Comprehensive Emergency Management Plan. Facility personnel participate in regularly scheduled disaster drills and inservice education.
- Radiation Safety
 - X-ray badges are issued quarterly to all scrub persons and Operating Room RNs and are to be worn at all times in the operating suite. Badges are forwarded to the radiation detection company. Dosimetry reports are reviewed by the Clinical Director for current and cumulative dose per employee. These reports are filed in the facility.
 - Radiation barrier gloves are available for use whenever there is a potential for radiation exposure to hands.
- Equipment Maintenance
 - All operating room equipment is inspected for operational integrity by facility personnel prior to each use and on a monthly basis. Equipment is to be removed from service immediately if needed repair or a malfunction is evident. A repair tag is attached indicating the name of the department and the source of the malfunction.

- Disposal of Waste
 - All infectious (biohazardous) wastes, including glass, are single red-bagged, placed in a special collection container marked "Biohazardous Waste" and disposed of appropriately.
- Disposal of Needles and Syringes
 - Used needles and syringes are placed in rigid sharps disposal container, which are located throughout the facility. When container is 3/4 full, it is disposed of with the biohazardous waste and replaced with a new sharps disposal container.
- Use of Extension Cords
 - Under normal conditions, extension cords shall not be used. Temporary use of extension cords may be permitted under specified conditions and with the proper approval.
 - Power failure: Extension cords may be used to connect items to limited charged power outlets.
 - Extension cords will be 16 AWG or heavier.
- Use of Adapters
 - Adaptor use within the facility is prohibited.
- Anesthesia Safety
 - Only nonflammable anesthetic agents are utilized in the operating rooms.
 - Refer to Anesthesia Policy and Procedure Manual for other anesthetic safety standards.

CORONADO SURGERY CENTER

QUALITY AND PATIENT SAFETY



This plan was created and revised by the Coronado Surgery Center Patient Safety committee/team. Implementation of this plan is intended to optimize the healthcare quality and patient safety outcomes, encourage recognition, reporting, and acknowledgment of risks to patient, visitor, and employee safety, as well as reduce the medical/healthcare errors and /or preventable events.

**Patient Safety Committee/Program
Coronado Surgery Center**

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Commitment to Patient Safety

Coronado Surgery Center is committed to a comprehensive approach to improving healthcare quality and patient safety by aligning with our Mission, Vision, and Values, creating an environment that supports a dynamic, proactive, and safe culture for patients, family members, visitors, and employees, through continuous learning and improving patient safety policies, systems, and processes.

Mission, Vision, and Values

In support of our mission, vision, and values, Coronado Surgery Center Patient Safety and Quality Improvement program promotes:

- Collaboration of healthcare, leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high quality healthcare.
- Communicate honestly and openly to foster trusting and cooperative relationships among healthcare providers, staff members, and patients and their families, to ensure accountability for the patient safety priorities.
- Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.
- Responsibility for every healthcare related decision and action.
- A focus on continuous learning and improving, system design, and the management of choices and changes, bringing the best possible outcomes or performances to the facility.
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare.
- Education of staff and physicians to assure participation of healthcare providers.

Scope and Purpose

The scope of this Quality and Patient Safety Plan is organizational-wide/hospital-wide/agency-wide which includes but is not limited to

- Patient safety
- Visitor safety
- Employee safety

All staff in Coronado Surgery Center are required to fully support and participate in this plan, and devote their expertise to the patient safety and healthcare quality improvement process.

This plan is action oriented and solution focused. The purpose of this plan is to address patient safety related concerns, challenges and revise the program to better serve the patients and their families. To this end, Coronado Surgery Center has developed this Patient Safety plan.

The plan focuses on the process rather than the individual, and recognizes both internal and

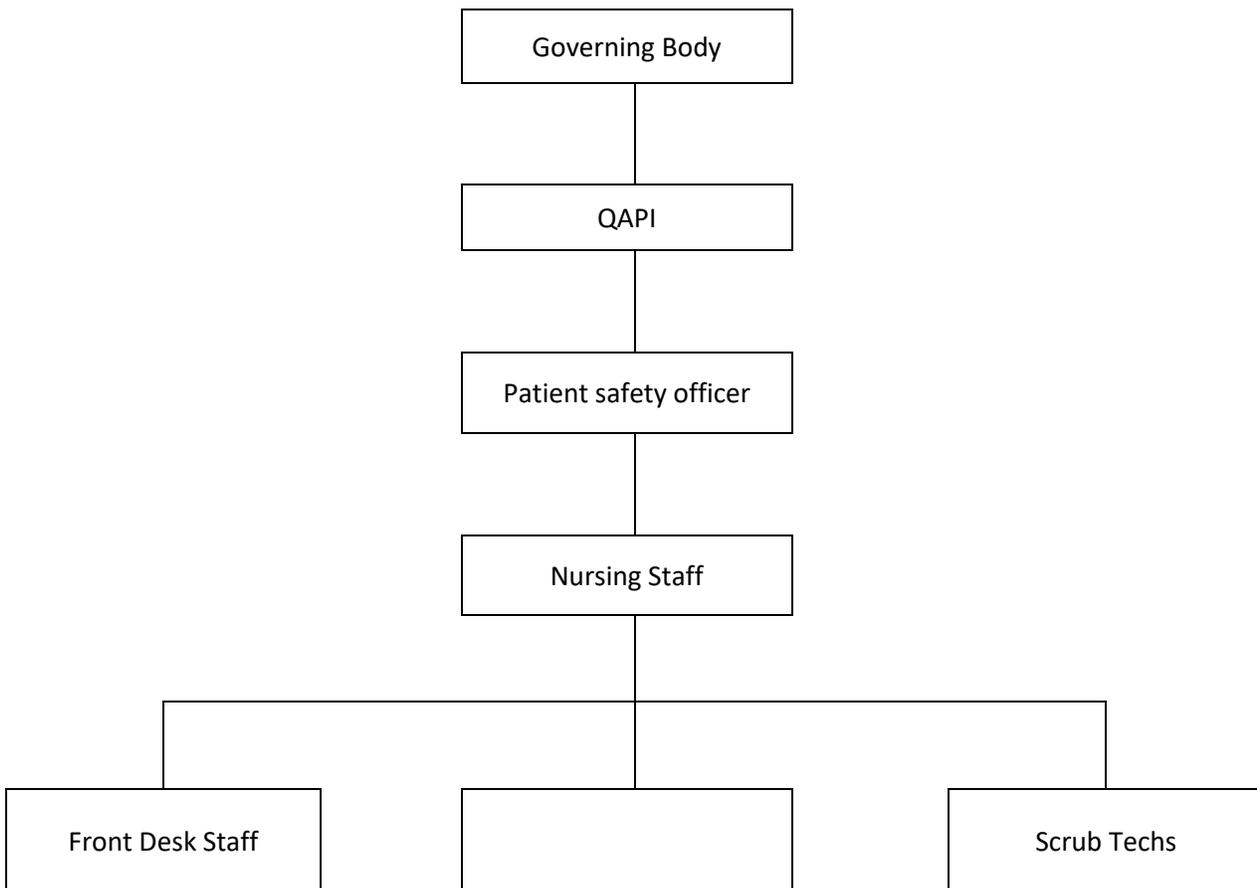
external customers, as well as facilitates the need of analyzing and improving processes. The core principles of this plan include:

- All staff have the same goal and contribute their knowledge, vision, skill, and insight to improve the process of the Patient Safety Plan.
- Decisions will be based on data and facts, and staff will be encouraged to learn from the experiences.
- Customer based including patients, families, and visitors.
- Promote systems thinking.
- Employ well-trained and competent staff maintaining high healthcare quality.

Roles and Responsibilities

According to [NRS 439.875](#), a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plan is promoted and executed successfully.

The Patient Safety Committee Organization



Roles and Responsibilities

- In accordance with [NRS 439.875](#), a patient safety committee must be comprised of:
- The infection control officer of the medical facility;
- The patient safety officer of the medical facility, if he or she is not designated as the infection control officer;
- At least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility; and
- One member of the executive or governing body of the medical facility.

Based on [NAC 439.920](#), a medical facility that has fewer than 25 employees and contractors must establish a patient safety committee comprised of:

- The patient safety officer of the medical facility;
- At least two providers of healthcare who treat patients at the medical facility, including but without limitation, one member of the medical staff and one member of the nursing staff of the medical facility; and
- The Chief Executive Officer (CEO) or Chief Financial Officer (CFO) of the medical facility.

The roles and responsibilities are defined below (Please modify them as needed.)

Patient Safety Committee Responsibilities (based on [NRS 439.875](#) and [NRS 439.877](#))

- Monitor and document the effectiveness of the patient identification policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the patient safety officer pursuant to [NRS 439.870](#).
- Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred.
- Review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- Review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the executive or governing body of the facility regarding:
 - (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);
 - (2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and
 - (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.

- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

Root Cause Analysis (RCA) Team Responsibilities

- Root Cause interviews, analysis, investigation, and corrective action plan implementations.
- Participates in the RCA meetings and discussions.
- Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders.

Patient Safety Officer Responsibilities (based on [NRS 439.870](#))

- Serve on the patient safety committee.
- Supervise the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the patient safety committee regarding any action taken in accordance with the responsibilities above.

(Additional responsibilities here if needed)

Infection Control Officer Responsibilities (based on [NRS 439.873](#))

- Serve on the patient safety committee.
- Monitor the occurrences of infections at the facility to determine the number and severity of infections.
- Report to the patient safety committee concerning the number and severity of infections at the facility.
- Take such action as determines is necessary to prevent and control infections alleged to have occurred at the facility.
- Carry out the provisions of the infection control program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program.

(Additional responsibilities here if needed)

RCA team leader Responsibilities

- Organize and coordinate the RCA process.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA, and corrective action plan implementation process.
- Communicate the progress of the investigation, institutional barriers, and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.

- Provide training, education and direction to create RCA process that incorporate the Patient Safety and Quality Improvement elements.

RCA Facilitator Responsibilities

- Collect Data
- Reconstruct event
- Record review
- Interview Staff
- Identify how/why event occurred
- Expose actions that led to event to prevent future harm
- Use swiss cheese model

Executive or Governing Body Staff Responsibilities

Provide vision and leadership to Patient Safety and Quality Improvement process, and develop and foster a safe learning and improving culture.

- Provides oversight to the healthcare quality improvement processes and teams.
- Plan, discuss, and generate the organization patient safety goals and activities, in conjunction with the patient safety action plans

The Patient Safety Committee will meet quarterly to accomplish the following:

- Report and discuss sentinel events which include:
 - Number of sentinel events from previous or quarter.
 - Number of severe infections that occurred in the facility.
- Corrective Action Plan for the sentinel events and infections
 - Evaluate the corrective action plan.
- Patient safety policies and checklists
 - At least annually evaluate Patient Safety policies and checklists
 - Revise the patient safety policies and checklists as needed.
 - Monitor and document the effectiveness of the patient safety policy.

A RCA meeting will meet as needed to accomplish the following:

- Define the healthcare issues or potential risks.
- Conduct Root Cause Analysis
 - Reviewing and analyzing the data.
 - Reviewing the RCA process and quality improvement related activities and timelines.
 - Brainstorming issues or the potential risks by using the fishbone diagrams.
 - Identify the contributing factors and conduct the Root Cause Analysis.
- Conduct Corrective Action Plan
 - Identifying the Plan-Do-Study-Act (PDSA) topics.
 - Discussing corrective action process and activities.
 - Discussing and presenting possible changes in procedure to improve areas indicated.
 - Identifying strengths and areas that need improvement.

- Developing strategies, solutions, and steps to take next.
- Identify barriers and technical assistance needs for supporting the RCA efforts.

A meeting agenda and minutes noting follow-up tasks will be kept.

Objectives and Goals of the Quality and Patient Safety Plan

Quality Guiding Principles

1. Focus on Quality and Patient Safety – it is everyone's responsibility
2. Improve all that is undertaken
3. Provide service excellence to our customers
4. Align Mission, Vision, and Strategy
5. Ensure continuous improvement that is process-focused, data-driven, and measures results
6. Foster creativity and innovation in an environment that values and encourages employee participation
7. Practice teamwork and collaboration, recognizing the unique and valuable contribution each member makes to the team
8. Ensure the program is a continuing one, not just a one-time effort
9. Ensure the program identifies in a systematic manner what data will be collected to measure various aspects of quality of care, the frequency of data collection, and how the data will be collected and analyzed.
10. Ensure the data collected is used to assess quality and stimulate performance improvement.

Components and Methods

Pursuant to [NRS 439.837](#), a medical facility shall, upon reporting a sentinel event pursuant to [NRS 439.835](#), conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event.”

Coronado Surgery Center will use RCA process to determine the contributing factors and the underlying reasons for the deficiencies or failures. The Plan-Do-Study (check)-Act (PDSA or PDCA) is the model, which was developed by the Institute of Health Care Improvement, that we will use to test the changes.



Root Cause Analysis

A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals.

Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

Root cause analysis and action plan framework table, which was introduced by the Joint Commission. It contains 24 analysis questions. It guides the organization to the steps in a root cause analysis. Not all the questions apply to all the events or cases. This table can be used individually or with the fishbone diagram.

5 Whys technique will be used at Coronado Surgery Center to explore the cause and effect relationship underlay a problem. One can find the root causes by asking “why” no less than five times. This technique can be used individually or as a part of the fishbone diagram.

Fishbone Diagram

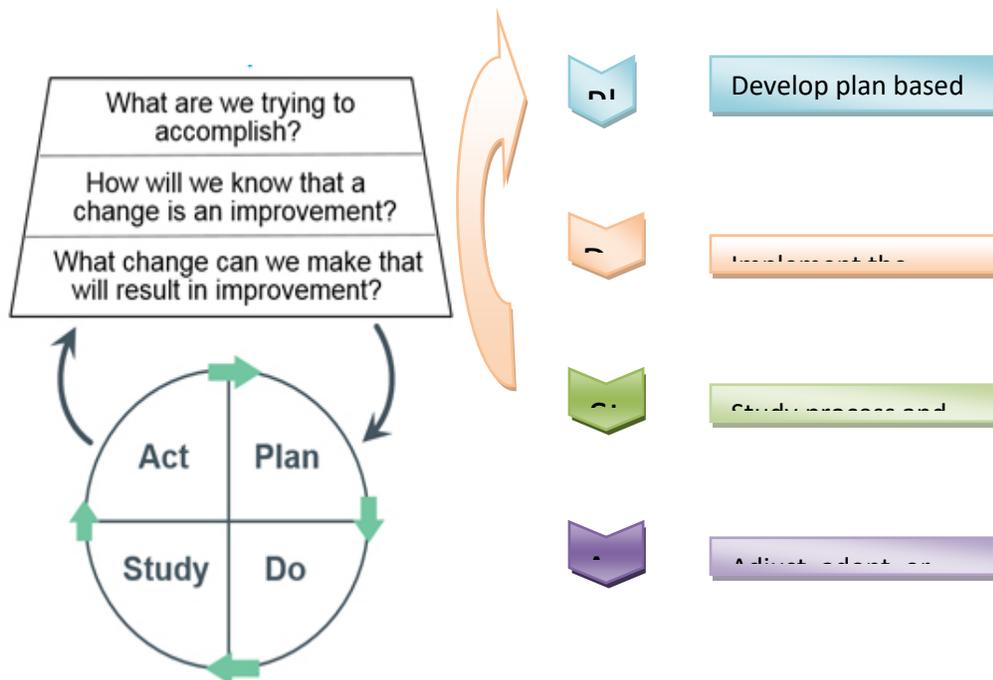
Patient Safety and Quality Improvement Plan

Once the problems are identified, a Fishbone Diagram (Appendix C) will be used for analyzing the problems. You can use the fishbone diagram individually to analyze the root causes, or use it with the root cause analysis and action plan framework table.

A Fishbone Diagram, also called a Cause-and-Effect diagram, is a useful tool for a team to structurally brainstorm by discovering possible underlying factors or root causes from different major categories for the chosen problems. General categories used include: people, methods, materials, measurements, education, procedures, process, location, environment, etc. RCA team members will brainstorm and ask multiple times, “why did this happen?” for each cause until all ideas are exhausted. The highest priority root causes will be chosen for PDSA topics. Once all the categories are established on the fishbone diagram, 5 Why’s technique also can be used to drill down the problem and find the root causes.

Model for Improvement

The Model for Improvement is a collaborative and ongoing effort model to improve the product and services quality and process. It provides multi-disciplinary quality team guidance from identifying the root causes; conducting the best tests to assess possible changes, and working in collaboration for implementation of the new approaches and solutions. It guides the test of a change to determine if the change is an improvement.



The cycle is defined as follows:

- Plan--collect data and establish appropriate goals. Identify the problem and the possible root causes, and answer the following questions.
 - What is the objective of the test?

- What are the steps for the test - who, what, when?
 - How will you measure the impact of the test?
 - What is your plan to collect the data needed?
 - What do you predict will happen?
- Do--make changes designed to correct or improve the situation. Use the following questions for the guidance.
 - What were the results of the test?
 - Was the cycle carried out as designed or planned?
 - What did you observe that was unplanned or expected?
 - Study -- Study the effect of the changes on the situation. Data should be collected on the new process and compared to the baseline or expected results. Results should be evaluated and by using the following questions as guidance.
 - Did the results match your prediction?
 - What did you learn?
 - What do you need to do next?
 - Act--If the result is successful or desirable, standardize the changes and then work on the next prioritized problem or the further improvements. If the outcome is not yet successful, look for different ways to identify the causes or change the testing process.

PDSA worksheet will be used to map the potential change strategies and to establish a course of action. The PDSA worksheet and the PDSA progress report are attached in Appendix D-1.

Data Collection and Reporting

Data should drive any quality and patient safety effort. Coronado Surgery Center is using Redcap for tracking the sentinel events, healthcare infection data, and variance reports for internal data collection.

External data sources are those data sources which are collected outside the supervisory structure of the case. External data which will be utilized for Quality and Patient Safety plan include the data from:

- AHRQ: Agency for Healthcare Research & Quality
- CDC: Centers for Disease Control and Prevention
- CMS: Centers for Medicare & Medicaid Services
- NQF: National Quality Forum
- NHSN: National Healthcare Safety Network
- TJC: The Joint Commission

Ongoing Reporting and Review

Patient Safety and Quality Improvement Plan

Data points such as the following will be reviewed per the schedule prescribed:

Monthly	Quarterly	Annually
1) Sentinel event monthly report 2) Severity of infection report 3) RCA assessment	1) Sentinel event quarterly report 2) Severity of infection report 3) Review and evaluate the measure of improvement of patient safety 4) Review and evaluate the measurement to prevent and control infections	1) Quality and Patient Safety Plan update 2) Checklists and Policies reviewing and revising

Assessment of the Quality and Patient Safety Plan

Please see the Patient Safety Assessment Tool (PSAT) from the VA National Center for Patient Safety for your reference.

Patient Safety Checklists and Patient Safety Policies

By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

The patient safety checklists must follow protocols to improve the health outcomes of patients at the medical facility and must include, without limitation:

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.
- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - Proper instructions concerning prescription medications;
 - Instructions concerning aftercare;
 - Any other instructions concerning his or her care upon discharge; and
 - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include, the name and date of birth of the patient.
- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.
- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

Based on [NRS 439.865](#), the patient safety plan must also include an infection control program that carries out the infection control policy. The policy must consist of:

- The current guidelines appropriate for the facility's scope of service developed by a nationally recognized infection control organization as approved by the State Board of Health which may include, the Association for Professionals in Infection Control and Epidemiology (APIC), the Centers

for Disease Control and Prevention (CDC), the World Health Organization (WHO) and the Society for Healthcare Epidemiology of America (SHEA); and

- Facility-specific infection control developed under the supervision of a certified Infection Preventionist.

The patient safety checklists are listed in Appendix E. checklists for your reference—

http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf

<http://www.who.int/patientsafety/implementation/checklists/en/>

The patient safety policies are listed in Appendix F. (The following link provides you some patient safety policies for your reference—a policy example is shown in **Appendix F.**)

<https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>

Approval of Patient Safety Plan

According to [NRS 439.865](#), a medical facility shall submit its patient safety plan to the governing board of the facility for approval. After a facility's patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan.

The patient safety plan must be reviewed and **updated annually** in accordance with the requirements for approval set forth in this section.

According to [NRS 439.843](#), on or before March 1 of each year, a copy of the most current patient safety plan established to [NRS 439.865](#) must be submitted to the Division of Public and Behavioral Health.

Reference

- Root Cause Analysis Toolkit <http://www.health.state.mn.us/patientsafety/toolkit/>
- Quality and Service Improvement Tools
http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html
- CQI 101 An Introduction to Continuous Quality Improvement:
<https://www.coursehero.com/file/13827355/CQI-Overviewppt/>
- Quality Improvement <http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/>
- Root Cause Analysis <http://www.patientsafety.va.gov/professionals/onthejob/rca.asp>
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2
https://www.jointcommission.org/sentinel_event.aspx
- Hospital Policies <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>
- Checklists to Improve Patient Safety http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf
- Patient Safety Checklists <http://www.who.int/patientsafety/implementation/checklists/en/>

- Minutes of the Meeting of the Quality and Patient Safety Committee
<http://www.cookcountyhhs.org/wp-content/uploads/2013/12/09-23-14-QPS-scan-Minutes.pdf>
- Title 40 – Public Health and Safety <https://www.leg.state.nv.us/NRS/NRS-439.html>

Appendix A: Terms and Definitions

Patient Safety: The Agency for Healthcare Research Quality (AHRQ) defines patient safety as “a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.”
http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

Sentinel event ([NRS 439.830](#))

1. Except as otherwise provided in subsection 2, “sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum.

2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:

(a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or

(b) July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published.

3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.

(Added to NRS by [2002 Special Session, 13](#); A [2005, 599](#); [2013, 217](#))

Institute for Healthcare Improvement (IHI) defines **medical harm** as “unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death.”

Facility-Associated Infection: ([NRS 439.802](#))

“Facility-acquired infection” means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections;
- Ventilator-associated pneumonia;
- Central line-related bloodstream infections;
- Urinary tract infections; and
- Other categories of infections as may be established by the State Board of Health by regulation pursuant to [NRS 439.890](#).

(Added to NRS by [2005, 599](#); A [2009, 553](#))

Medical facility ([NRS 439.805](#))

“Medical facility” means:

- A hospital, as that term is defined in [NRS 449.012](#) and [449.0151](#);
- An obstetric center, as that term is defined in [NRS 449.0151](#) and [449.0155](#);
- A surgical center for ambulatory patients, as that term is defined in [NRS 449.0151](#) and [449.019](#); and
- An independent center for emergency medical care, as that term is defined in [NRS 449.013](#) and [449.0151](#).

(Added to NRS by [2002 Special Session, 13](#))

Near miss: An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Mandatory reporting: Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985;254(6):796-800.)

Risk: Possibility of loss or injury. (Merriam-Webster’s Online Dictionary, Risk, Available at <http://www.merriamwebster.com/dictionary/risk>. Last Accessed August 2009.)

Preventable event: Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Catheter Associated Urinary Tract Infection (CAUTI): A urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CUR_RENT_b.pdf.)

Central Line Associated Bloodstream Infections (CLABSI): Primary bloodstream infections that are associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection.

Appendix B: Patient Safety Goals

OBJECTIVE:	GOAL:	Q3 2014	Q4 2014
ACTION PLAN:			
1. Create Systems that anticipate errors & either prevent or catch them before they cause harm.	a. Enhance retrospective chart review process. b. Establish an automated surveillance process. c. Conduct a proactive risk assessment in a high risk area.		Complete an in-depth analysis of risk point utilizing the methods of FMEA.
	2. Establish Structures for reporting and a process for managing reports in the event reporting system.	a. Implement new electronic Voluntary Reporting System & participate in Patient Safety Organization. b. Develop a structure to educate employees system-wide of the process for reporting hazards, errors and adverse events. c. Establish a process for providing feedback regarding reported events.	Implemented e-MERS & PSO with UHC.
3. Develop a Culture of Safety where providers feel safe and supported when they report medical errors or near misses & voice concerns about patient safety.		a. Provide education on patient safety plan that emphasizes importance of blending a systems focus with appropriate individual accountability. b. Establish a recognition program that rewards safe practices. c. Improve overall perceptions of safety as measured by the Culture of Safety Survey.	
	4. Establish Safety Priorities & Targets.	a. Develop Patient Safety Dashboard that includes national measures and benchmarks. b. Facilitate the development of action plans associated with measures not meeting benchmarks. c. Assess and improve processes related to hand-off, transition and communication	Complete 2014 Leapfrog Safety Survey. Develop method to track & report departmental progress and compliance of RCA action plans.
5. Charter Safety Programs through teams, workgroups or projects.		a. Coordinate Improvement Efforts in order to ensure that capital, people, facilities & technologies are matched to strategic priorities for safe practices. b. Reduce and eliminate variation in care.	

Appendix D-1: PDSA Worksheet

PDSA Worksheet

Topic:			
Person Completing Worksheet:		Date:	

Telephone/ Email:		Cycle:	
Patient Safety Committee Members			
CEOs/CFOs			
Patient Safety Officer			
Infection Control Officer			
Other Medical Staff			
Other team members			
Aim: (Describe the overall SMART goal that your team wishes to achieve.)			
Plan:			
1. List the tasks needed to set up this test of change.			
2. Predict what will happen when the test is carried out.			
3. List the steps to develop the test-who, what, and when.			
Steps	By Whom	By When	Desired Outcome

Do: (Describe what actually happened when you ran your test, including any problems and unexpected findings.)			
Study: (Describe what you learned and did you meet your measurement goal?)			
Did you meet your measurement goal? Explain.		Summarize what was learned: success, failure, unintended consequences, etc.	
Act: (Describe what you concluded from this cycle.)			
Based on what was learned, please indicate what action will be considered.		Describe what modifications to the plan will be made for the next cycle based on what you learned.	
<input type="checkbox"/> Adapt: modify changes and repeat PDSA Cycle			
<input type="checkbox"/> Adopt: expanding changes throughout organization			
<input type="checkbox"/> Abandon: change approach and repeat PDSA cycle			

Appendix D-2: PDSA Quarterly Progress Report

Event:

Person Complete Report:		Date:	
Patient Safety Officer		Contact Information:	
Monthly / Quarterly Report			
Items	Description		
1. What is your goal?			
2. Report on the PDSA cycle			
3. What system and practices are working well? Explain.			
4. What areas for improvement did the data identify?			
5. What barriers or system issues have been encountered implementing action activities?			
6. Action plans to address the barriers or system issues			
7. Lesson learned			
8. Support needed			
9. Additional discussion			
Notes:			

Appendix E: Injuries from Falls and Immobility

Process Change	In Place	Not Done	Will Adopt	Notes (Responsible & By When?)
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Conduct fall and injury risk assessment upon admission				
Implement patient-specific intervention to prevent falls and injury				
Communicate risk across the team; use handoff forms, visual cues, huddles				
Review medications avoid unnecessary hypnotics, sedatives				
Incorporate multidisciplinary input for falls				
Prevention from PT, when applicable MD, RN				
Include patients, families and caregivers in efforts to prevent falls. Educate regarding fall prevention measures; stay with patient				
Hold post-fall huddles immediately after event; analyze how and why; implement change to prevent other falls				

Reference: Checklists to Improve Patient Safety. June 2013. Health Research & Educational Trust.

Appendix F: Policy Example

- Credentialed Specialists, Allied Health Professionals, patients, visitors and contractors will be supported in meeting policy requirements.

Related Standards:

- Infection and Prevention and Control Standards NZS 8134.3:2008
- Health and Safety in Employment Act 1992

Rationale:

Coronado Surgery Center will provide suitable personal protective equipment (PPE) when the risk to health and safety cannot be eliminated or adequately controlled by other means.

Definitions:

Patient Safety and Quality Improvement Plan

Personal protective equipment (PPE) means all equipment which is intended to be worn or held by a person to protect them from risk to health and safety while at work.

Examples of PPE include: protective footwear, gloves, hard hats/helmets, clothing affording protection from the weather, visibility clothing, eye and face protection.

Objectives:

- To ensure appropriate PPE is identified to minimize hazards not able to be controlled by elimination or isolation;
- To ensure fit for purpose PPE is provided at Mercy Hospital for use by staff;
- To ensure adequate training in the use of PPE is provided;
- To monitor the use of PPE and evaluate effectiveness.

Implementation:

Risk Management

Department Managers, Infection Prevention and Control Nurse and Safety Officer will in consultation with staff:

Ensure PPE requirements are identified when carrying out risk assessments of activities;

- Regularly review the risk assessment of activities if substances or work processes change;
- Identify the most suitable type of PPE that is required;
- Ensure PPE is available to those who need it;
- Inform staff of the risks involved in their work and why PPE is required;
- Monitor compliance.

Process

Manager's Responsibilities

Must ensure that:

- PPE requirements are considered when risks are assessed;
- Suitable PPE is provided and made accessible to employees;
- PPE is properly stored, maintained, cleaned repaired and replaced when necessary;
- Adequate information and training is provided to those who require PPE;
- PPE is properly used;
- Use of PPE is monitored and reviewed.

Employee's Responsibilities All employees must ensure that:

<p>Coronado Surgery Center</p>	<p>POLICY AND INFORMATION MANUAL</p>		
<p>PERSONAL PROTECTIVE EQUIPMENT POLICY Page 2 of 2</p>	<p>Date Issued: Date Last Revised: Next Review Date: Approved By:</p>	<p>1/1/2017 1/1/2018 Policy Committee</p>	

- They use PPE whenever it is required;
- Attend and comply with training, instruction and information;
- Check the condition of their PPE;
- Store, clean and maintain their PPE;
- Report losses, defects or other problems with PPE to their manager.

Evaluation:

- Staff health and safety orientation
- Environmental audits
- Incident reports

Spring Valley Surgery Center LLC

2016 Sentinel event reporting

3835 S. Jones Blvd. Las Vegas NV 89103 License #: 3421

2705 W. Horizon Ridge Pkwy Henderson NV 89052 License #: 5491

7175 N. Durango Drive Las Vegas NV 89149 License #: 7592

1900 N. Nellis Blvd Las Vegas NV 89115 License #: 7891

1050 E. Sahara Ave Las Vegas NV 89104 License # 8688

Safety committee:

The Administration has established a “Life Safety Enterprise Safety Program” designed to keep patients, Physicians, employees and the public safe while on the premises of the Facility. This program consists of elements which meet the requirements as defined by the The Administration has established a “Life Safety Enterprise Safety Program” designed to keep patients, Physicians, employees and the public safe while on the premises of the Facility. This program consists of elements which meet the requirements as defined by the Federal, State, Local and OSHA guidelines. The “Safety Plan” includes identification, evaluation and prevention of workplace hazards relating to the elements and specific criteria. The safety management of the Facility is composed of several elements regarding the safety features necessary for the protection and security of its patients and healthcare workers.

These elements are composed of two parts; one “Life Safety Enterprise Safety Plan” which is wide in scope, organizational and effectiveness, and the “Environmental Safety Management” which oversees the working environment elements of the Facility. These areas overlap each other but also provide individual elements which manage the overall security and safety of the Facility. A report from the Safety Committee is provided quarterly to the Medical Executive Committee (MEC) and onto the Governing Board. The Safety Committee meets and discusses how to improve and/or maintain patient and employee well-being and safety, items discussed range from falls to how to properly lift boxes, and the execution of a disaster drills, etcetera. If any incidents have occurred they will be discussed in detail, and prevention and safety will be implemented.

Facility Name: Parkway Surgery Centers	Policy And Procedure Guideline Name: Safety Management Program (Environment Of Care)	Policy Number: SAFE 104
	Subject Category: SAFETY	Effective Date: 12/01/2016
		Revised Date: 12/14/2017
		Page 1 Of 4 (Update Field)

Policy: The facilities shall provide guidelines and implement proactive practices, which provide a safe environment of care in relation to property, equipment, patients, personnel and the public.

Purpose: The reduction of physical hazards and the implementation of safe practices enhance environmental safety.

Procedure Guidelines:

Responsibility:

1. Employees are responsible for:
 - A. Intervention when, safety conditions pose a threat to life or health, or threaten damage to equipment or buildings.
 - B. The continuing maintenance of the facility property, eliminating hazards upon discovery.
 - C. Reporting equipment or maintenance problems and incidents of property damage to the Safety Officer or Administrator/ Clinical Director upon discovery.
 - D. Reporting injuries and illness to the Administrator/Clinical Director.
 - E. Obtaining the information necessary to perform tasks in a manner that prevents injury to themselves, patients and others.

2. The Administrator/Clinical Director and designated Safety Officer, as agents of the Quality Assurance Committee are responsible for:
 - A. Environment of Care development, implementation and monitoring.

- B. Report of Safety Surveillance and activities to the Quality Assurance Committee.
- C. Annual review of the Environment of Care policies and guidelines for objectives, scope, performance and effectiveness.

Maintenance and Supervision:

1. Comply with the NFPA 101®, Life Safety Code® (LSC) for maintaining and supervising the facility grounds, buildings and equipment.
2. Maintain equipment and utilities following a preventative maintenance schedule.
3. Maintain sufficient light in the parking and entrance areas to reduce the potential for falls and security concerns.
4. Maintain signs and emergency systems to meet the needs of the visual and hearing impaired.
5. Maintain smoke free environment.
6. Provide facility cleaning, maintenance, and inspection, following a schedule for daily, weekly, monthly, semi-annual and annual activities.
7. Construction and Renovation (Interim Life Safety Plan):
 - A. Meet the existing ambulatory health care occupancy health code requirements for construction or renovation.
 - B. Train staff in alternative safety processes including the use of new specialized equipment and space.
 - C. Train staff to compensate for changes in Life Safety Plan.
 - D. Provide increased facility safety monitoring with construction and renovation included reference to the NFPA 101®, Life Safety Code® (LSC).
 - E. Inspect and monitor components of Life Safety Plan weekly or more frequently if indicated.

Risk Assessment:

1. Provide risk assessment and hazard surveillance to evaluate the impact of the center building, grounds, equipment, occupants, and internal physical systems on patient, employee and public safety.
 - A. Assign a Safety Officer to maintain risk and hazard surveillance.
 - B. Record Hazard surveillance.
 - C. Report environmental hazard and safety surveillance to the Quality Assurance Committee. Provide follow-up to staff concerning safety issue recommendations.
2. Report and document patient, personnel or visitor injury, and occupational illness. Document

incidents on a Variance Report, Occurrence Report, or Incident Report.

- A. Investigate and evaluate each report for opportunities to improve performance.
- B. Include injuries and occupational illness in the report to the Quality Assurance Committee.

Product Safety Recalls:

1. Address a product safety recall upon notification.
 - A. Inventory and remove recalled product from possible use.
 - B. Notify affected medical staff and evaluate a substitute product.
 - C. Inventory patients who may have received a recalled medical device from implant logs or records.
 - D. Consult with the Medical Director and/or Quality Assurance Committee to evaluate the situation and determine an appropriate method for patient notification if an implanted medical device has been recalled. The medical director, as an agent of the Quality Assurance Committee reports the incident to the Medical Executive Committee.

Safety Education:

1. Provide Safety Education and Training at orientation and at least annually thereafter. Address general safety processes; area specific safety and job related hazards.
2. Provide Safety Guidelines in the General Orientation including:
 - A. Review of Safety Policies and Guidelines.
 - B. Body Mechanics.
 - C. Hazardous Materials Communication.
 - D. SDS/ Hazardous Waste.
 - E. Safety Risk / Responsibilities.
 - F. Equipment Safety/Operations Manuals.
 - G. Emergency Preparedness.
 - H. Utility Systems and Electrical Safety.
 - I. Infection Control/Exposure OSHA.
 - J. Reporting of Sentinel Events.

- K. Variance, accidents/injuries, Security and Safety concerns.
 - L. Fire and Life Safety.
 - M. Safety Concerns.
 - N. Security.
 - O. OSHA.
3. Include specific safety standards related to safe practices and the safe use, inspection, cleaning and maintenance of specialized equipment in the Department /Job Specific orientation.
 4. Provide updates when new equipment is introduced.
 5. Review General Safety Guidelines annually.

Reference:

Center for Medicare and Medicaid Services (July, 2011). Standard Operations Manual Appendix L – Guidance for Surveyors: Ambulatory Surgery.

The Joint Commission. (2011) Accreditation Standards and Requirements for Ambulatory Surgery Centers

The Accreditation Association for Ambulatory Care. (2011). Accreditation Handbook.

Patient Safety Plan

**Premium Surgical Services Center
Las Vegas, Nevada**

Originating Department: Environment of Care/Patient Safety Committee

TITLE: Patient Safety Plan	POLICY #: EOC - 1
AFFECTED DEPARTMENTS: All	APPROVED: EOC/Pt. Safety Comm.
EFFECTED DATE: 10/01/10	REVISED DATE: 12/01/2017

PURPOSE:

The purpose of the Patient Safety Plan at Premium Surgical Services Center (PSSC) is to improve patient safety and reduce risk to patients through an environment that encourages:

- Recognition and acknowledgment of risks to patient safety and medical/health errors;
- The initiation of actions to reduce these risks;
- The internal reporting of what has been found and the actions taken;
- A focus on processes and systems;
- Minimization of individual blame or retribution for involvement in a medical/health care error
- Organizational learning about medical/health care errors;
- Support of the sharing of that knowledge to effect behavioral changes

The Patient Safety Plan provides a systematic, coordinated and continuous approach to the maintenance and improvement of patient safety. This is accomplished through the establishment of mechanisms that support effective responses to actual occurrences; ongoing proactive reduction in medical/health care errors; and integration of patient safety priorities into the new design and redesign of all relevant organization processes, functions and services.

As patient care, and therefore the maintenance and improvement of patient safety, is a coordinated and collaborative effort, the approach to optimal patient safety involves multiple departments and disciplines in establishing the plans, processes and mechanisms that comprise the patient safety activities at PSSC. The Patient Safety Plan developed by the interdisciplinary EOC/Patient Safety Committee (Dr. Name Here, Name Here, RN, Dr. Name Here, ST, Name Here)outlines the components of the Patient Safety Program.

PATIENT SAFETY PROGRAM:

I. SCOPE OF ACTIVITIES:

A. The scope of the Patient Safety Program includes an ongoing assessment, using internal and external knowledge and experience, to prevent error occurrence and maintains and improves patient safety. Patient safety occurrence information from aggregated data reports and individual incident occurrence reports will be reviewed by the Environment of Care/Patient Safety Committee (includes Dr. Name Here, Name Here, RN, Dr. Name Here, ST, Name Here) to prioritize organizational patient safety activity efforts. Types of patient safety or medical/health care errors included in data analysis are:

1. No Harm Errors - those unintended acts, either of omission or commission, or acts that do not achieve their intended outcome - that do not result in a physical or psychological negative outcome, or the potential for a negative outcome, for the patient
2. Mild-Moderate Adverse Outcome Errors - those unintended acts, either of omission or commission, or acts that do not achieve their intended outcome, that result in an identified mild to moderate physical or psychological adverse outcome for the patient
3. Any Medication Error
4. Any Adverse Drug Reaction
5. Any Transfusion Reaction
6. Hazardous Condition - any set of circumstances, exclusive of the disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious physical or psychological adverse patient outcome chance of a serious adverse outcome.
7. Sentinel Event

B. The scope of the Patient Safety Program encompasses the patient population, visitors, volunteers and staff (including Medical Staff). The program addresses maintenance and improvement in patient safety issues in every department throughout the facility. There will be an emphasis on important hospital and patient care functions of:

1. Patient Rights
2. Assessment of Patients
3. Care of Patients
4. Patient/Family Education
5. Continuum of Care
6. Leadership
7. Improving Organization Performance
8. Management of Information
9. Management of Human Resources
10. Management of the Environment of Care
11. Surveillance, Prevention, and Control of Infection

II. METHODOLOGY:

A. The Interdisciplinary EOC/Patient Safety Committee (Dr. Name Here, Name Here, RN, Dr. Name Here, ST, Name Here) is responsible for the oversight of the Patient Safety Program. The EOC/Patient Safety Committee Chairperson (Dr. Name Here) will have administrative responsibility for the program, or the EOC/Patient Safety Committee (Dr. Name Here, Name Here, RN, Dr. Name Here, ST, Name Here) may assign this responsibility to another member of the committee (Name Here, RN).

B. All departments within the organization (patient care and non-patient care departments) are responsible to report patient safety occurrences and potential occurrences to the Administrator (Dr. Name Here), who will aggregate occurrence information and present a report to the EOC/Patient Safety Committee (Dr. Name Here, Name Here, RN, Dr. Name Here, ST, Name Here) on a quarterly basis. The EOC/Patient Safety Committee will analyze the report information and determine further patient safety activities as appropriate.

C. Through review of internal data reports and reports from external sources (including, but not limited to JCAHO sentinel event report information, ORYX and Core Measure performance data, occurrence reporting information from state and federal sources and current literature), and through the Performance Improvement priority criteria grid, the EOC/Patient Safety Committee (Dr. Name Here, Name Here, RN, Dr. Name Here, ST, Name Here) will select at least one high-risk safety process for proactive risk assessment annually. The proactive risk assessment will include:

1. Assessment of the intended and actual implementation of the process to identify the steps in the process where there is, or may be, undesirable variation. Identify the possible effects of the undesirable variation on patients, and how serious the possible effect on the patient could be.
2. For the most critical effects, conduct a root cause analysis to determine why the undesirable variation leading to that effect may occur
3. Redesign the process and/or underlying systems to minimize the risk of that undesirable variation or to protect patients from the effects of that undesirable variation
4. Test and implement the redesigned process
5. Identify and implement measures of the effectiveness of the redesigned process
6. Implement a strategy for maintaining the effectiveness of the redesigned process over time
7. Ensure that all components of the health care organization are integrated into and participate in the organization-wide program.

D. Upon identification of a medical/health care error, the patient care provider will immediately:

1. Perform necessary healthcare interventions to protect and support the patient's clinical condition
2. As appropriate to the occurrence, perform necessary healthcare interventions to contain the risk to others - example: immediate removal of contaminated IV fluids from floor stock should it be discovered a contaminated lot of fluid solutions was delivered and stocked
3. Contact the patient's physician and other physicians, as appropriate, to report the error, carrying out any physician orders as necessary.
4. Preserve any information related to the error (including physical information). Examples of preservation of physical information are: preservation of IV tubing, fluids bags and/or pumps for a patient with a severe drug reaction from IV medication; preservation of medication label for medications administered to the incorrect patient. Preservation of information includes documenting the facts regarding the error on an occurrence report, and in the medical record
5. Report the medical/health care error to the staff member's manager and Administrator.
6. Submit the occurrence report to the Administrator (Dr. Stile) per organizational policy.

E. Any individual in any department identifying a potential patient safety issue will immediately notify his or her manager and document the findings on an occurrence report. The occurrence report will be submitted to the Administrator

F. Staff response to medical/health care errors is dependent upon the type of error identified:

1. No harm errors - (including "no harm" medication errors) - staff will document in the medical record the circumstances regarding the no harm error on an occurrence report form, submit the form to the Administrator and notify their immediate supervisor
2. Mild-Moderate Adverse Outcome Errors (including medication errors) - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then preserve any physical evidence as appropriate, notify his/her immediate supervisor, document facts in the medical record and on an occurrence report - submitting the report to the Administrator.
3. Medication Errors - the staff member identifying a medication error (no harm and mild-moderate harm) will document facts on an occurrence report - submitting the report to the Administrator.
4. Adverse Drug Reaction - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then preserve any physical evidence as appropriate;

- notify his/her manager (Name Here, RN or Name Here) and Administrator (Dr. Name Here), document facts in the medical record and on an occurrence report - submitting the report to the Administrator.
5. Transfusion Reaction – We do not handle blood products at our facility.
 6. Hazardous Condition/Patient Safety Issue - as appropriate, and if possible, staff will contain the hazardous condition or patient safety issue. Staff identifying a hazardous condition or potential patient safety issue will immediately notify his or her supervisor, take appropriate action and document the findings on an occurrence report. The occurrence report will be submitted to the Administrator (Dr. Name Here).
 7. Sentinel Event - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, and his/her manager (Name Here, RN or Name Here) and Administrator (Dr. Name Here) carrying out any necessary physician orders. Staff will then follow the organizational Sentinel Event Policy and Procedure document facts appropriately in the medical record and on an occurrence report - submitting the report to the Quality Management Division.
 8. Near Miss - staff will report the near miss event to his/her manager (Name Here RN or Name Here), describe the facts of the near miss on an occurrence report and submit the report to the Administrator (Dr. Name Here) .
 9. At the direction of the Administrator (Dr. Name Here) of the Medical Staff all sentinel events and near miss occurrences will have a root cause analysis conducted.

G. It is the intent of this organization to adopt a non-punitive approach in its management of errors and occurrences. All personnel are required to report suspected and identified medical/health care errors, and should do so without the fear of reprisal in relationship to their employment.

H. The organization will focus on improving systems and processes and on remedial actions to assist rather than punish staff members. The Environment of Care/Patient Safety will review the course of action to prevent error recurrence.

I. Sentinel Events - staff members involved in a sentinel event occurrence will receive support from the Administrator (Dr. Name Here) of the Medical Staff regarding the staff member's professional and emotional reconciliation of the sentinel event. The Environment of Care/Patient Safety and Care Oversight Committees (Dr. Name Here, Name Here, RN, Dr. Name Here, ST, Name Here) encourage the staff member's involvement in the root cause analysis and action plan processes, to allow the staff member an active role in process resolution. Additionally, any staff member involved in a sentinel event or other medical/health care error may request and receive supportive personal counseling from the department supervisor

J. On at least an annual basis, staff will be queried regarding their willingness to report medical/health care errors.

K. The Patient Safety Program includes an annual survey of patients, their families, volunteers and staff (including medical staff) opinions, needs and perceptions of risks to patients and requests suggestions for improving patient safety.

L. Patients, and when appropriate, their families are informed about the outcomes of care, including unanticipated outcomes, or when the outcomes differ significantly from the anticipated outcomes. The Environment of Care/Patient Safety Committee (Dr. Name Here, Name Here, RN, Dr. Name Here, ST, Name Here) will receive a report verifying compliance with informing the patient about outcomes of care.

M. Staff will educate patients and their families about their role in helping to facilitate the safe delivery of care.

N. Staff will receive education and training during their initial orientation process and on an ongoing basis regarding job-related aspects of patient safety, including the need and method to report medical/health care errors. Staff will be educated and trained on the provision of an interdisciplinary approach to patient care

O. Medical/health care errors and occurrences, including sentinel events, will be reported internally and externally, per hospital policy and through the channels established by this plan. External reporting will be performed in accordance with all state, federal and regulatory body rules, laws and requirements.

P. Quarterly reports from the Environment of Care/Patient Safety Committee (Dr. Name Here, Name Here, RN, Dr. Name Here, ST, Name Here) will be submitted to the Quality Council, Care Oversight Committee of the Medical Staff and Board QI Committee (Dr. Name Here, Name Here, RN, Dr. Name Here, ST, Name Here), which exists as the oversight committee for the Environment of Care/Patient Safety Committee (Dr. Name Here, Name Here, RN, Dr. Name Here, ST, Name Here).

INNOVATIVE PROCEDURAL AND SURGICAL CENTER (IPSC)

Subject: Patient Safety Plan

Effective Date 01/2012

Revised: 03/2012

Reviewed/Accepted: 03/2012, 7/2013, 03/2014, 03/2015, 01/2016, 1/2017

I. Introduction:

The Patient Safety Program supports and promotes the mission, vision and values of Innovative Procedural and Surgical Center through organization prioritization of patient, visitor, and employee safety.

The Patient Safety Program is implemented through the Patient Safety Committee and is supported by leadership's promotion of a safety culture that:

- Encourages recognition, reporting, and acknowledgment of risks to patient/visitor and employee safety and medical/healthcare errors
- Initiates/monitors actions to reduce risks/errors
- Internally reports findings and actions taken
- Promotes a blame-free culture facilitating the reporting and follow-up on safety concerns, errors and adverse events
- Educates staff and physicians to assure participation in the program

II. Purpose:

The Patient Safety Program is designed to enhance patient care delivery and prevent adverse outcomes of care by utilizing a systematic, coordinated and continuous approach to the improvement of patient safety. This approach focuses on actual and potential occurrences; ongoing proactive risk management; and integration of patient-safety priorities in the development and revision of processes, functions and services.

III. Mission, Vision and Values:

In support of the mission, vision and values of this organization the Patient Safety Program promotes:

- Collaboration among staff members, physicians and other providers to deliver comprehensive, integrated and quality health care
- A focus on comprehensive, integrated quality service
- Open and honest communication to foster trust relationships among staff members, physicians, other providers and patients

IV. Objectives:

The objectives of the Patient Safety Program are to:

- Encourage organizational learning about adverse or potentially adverse events
- Incorporate recognition of patient safety as an integral job responsibility
- Provide patient safety education

INNOVATIVE PROCEDURAL AND SURGICAL CENTER (IPSC)

Subject: Patient Safety Plan

Effective Date 01/2012

Revised: 03/2012

Reviewed/Accepted: 03/2012, 7/2013, 03/2014, 03/2015, 01/2016, 1/2017

- Involve patients in decisions about their health care and promote open communication
- Collect and analyze data, evaluate care processes for opportunities to reduce risk and initiate proactive measures
- Report internally the finding and actions taken to reduce risk
- Support sharing of knowledge to effect change

V. Responsibilities/Duties:

The Patient Safety Committee provides a multidisciplinary collaboration for the collection and analysis of risk to patient safety and the dissemination of information on identified risk for the purpose of improving patient care. It shall review reports on occurrences including near misses to sentinel events. It shall identify those individuals or groups best situated to perform a root cause analysis and develop and implement an action plan for identified issues. It shall review, analyze and disseminate the information it receives, as appropriate, to the QI Committee and the Governing Board of Managers. It shall provide recommendations concerning identified risks, approve plans for corrective action and evaluate the implementation of corrective actions taken.

The Patient Safety Committee of Innovative Procedural and Surgical Center is comprised of the Patient Safety Officer, two providers of health care who treat patients at the facility, including one member of the medical staff and one member of the nursing staff, and the Chief Executive Officer of the facility.

The Patient Safety Committee shall meet at least once every calendar quarter.

The Governing Board of Managers shall designate an officer or employee of Innovative Procedural and Surgical Center to serve as the Patient Safety Officer of the facility.

The Patient Safety Officer of the facility will:

- Serve on the Patient Safety Committee
- Supervise the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties pursuant to NRS 439.835.

Duties pursuant to NRS 439.835 are

- a) A person who is employed by IPSC shall, within twenty-four (24) hours after becoming aware of a sentinel event that occurred at IPSC, notify the Patient Safety Officer of the event
- b) The Patient Safety Officer will, within thirteen (13) days after receiving notification, report the date, the time and a brief description of the sentinel event to the Nevada State Health Division and facility representative if that person is different from the Patient Safety Officer.

INNOVATIVE PROCEDURAL AND SURGICAL CENTER (IPSC)

Subject: Patient Safety Plan

Effective Date 01/2012

Revised: 03/2012

Reviewed/Accepted: 03/2012, 7/2013, 03/2014, 03/2015, 01/2016, 1/2017

- c) If the Patient Safety Officer of IPSC personally discovers or becomes aware, in the absence of notification by another employee, of a sentinel event that occurred at IPSC, the Patient Safety Officer will, within fourteen (14) days after discovering or becoming aware of the sentinel event report the date, time and brief description of the event to those listed in b) above.
- Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at IPSC
 - Report to the IPSC Patient Safety Committee regarding any action taken in accordance to the above paragraph
 - Upon discovery notify the CEO immediately

The Patient Safety Committee shall:

- Receive reports from the Patient Safety Officer
- Evaluate actions of the Patient Safety Officer in connection with all reports of sentinel events alleged to have occurred at the medical facility
- Review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment at the facility
- Make recommendations to the Governing Board of Managers to reduce the number and severity of sentinel events and infections that occur at the facility
- At least once each calendar quarter, report to the Governing Board of Managers of the facility regarding:
 - a) The number of sentinel events that occurred at the facility during the preceding calendar quarter
 - b) The number and severity of infections that occurred at the facility during the preceding calendar quarter
 - c) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the facility
- Adopt patient safety checklists and patient safety policies
 - a) The patient safety checklists adopted pursuant to this section must follow protocols to improve the health outcomes of patients at the facility and must include without limitation:
 - *Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of health care
 - *Checklists for ensuring that employees of the facility and contractors with the facility who are not providers of health care follow protocols to ensure that the room and environment of the patient is sanitary
 - *A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received proper

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instructions concerning prescription medications, instructions concerning aftercare, and any other instructions concerning his or her care upon discharge

*Any other checklists which may be appropriate to ensure the safety of patients at the facility

*A policy for appropriately identifying a patient before providing treatment.

Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of health care. The personal identifiers may include, without limitation, the name and date of birth of the patient

*A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of health care at the facility including, without limitation, protocols relating to hand hygiene

*A policy to ensure compliance with the patient safety checklists and patient safety policies adopted, which may include, without limitation, active surveillance. Active surveillance may include, without limitation, a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials

- Focus on fall prevention activities: Staff is trained on fall-related topics including extrinsic and intrinsic risk factors, occurrence of syncope during IV starts, anti-fall precautions, importance of proper equipment use and maintenance, fall reporting procedures.
 - A fall is any unintentional change in position where the patient ends up on the floor or other lower level. This includes witnessed and un-witnessed falls and includes whether there is an injury or not. Serious injuries can occur including fractures, lacerations and can lead to emergency room visits or hospital admissions.
 - There are many factors that can increase the risk of patient falls which include, but are not limited to: use of medications affecting the central nervous and/or cardiovascular system, i.e. benzodiazepines, sedatives, hypnotics, antihypertensives; chronic degenerative illnesses i.e. arthritis, cataracts, dementia and diabetes; visual impairment; unsteady gait.
 - Ensure a safe environment for patients:
 - Floors will be flat, dry, nonslip and free of area/throw rugs or other loose coverings
 - All spaces will be clear of obstacles and evenly illuminated
 - Assistive devices are present in bathrooms to accommodate disabled patients
 - Functioning emergency call systems are present in all patient care areas, bathrooms and changing rooms
 - Procedure tables are equipped with proper safeguards, such as side rails, grip handles and step risers

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- Wheelchairs have appropriate seat cushioning and anti-rollback devices, and are locked when in a stationary position
- Nonskid footstools are available to assist patients climb on and off procedure tables
- Side rails and wheel locks are engaged whenever patients are on procedure tables or gurneys
- Patients are instructed to dangle their legs over the side of the table before moving to an upright position
- Whenever patients are left unattended, procedure tables and gurneys are left in the lowest position
- Patients receiving sedative agents are always under close supervision
- Monitor and document the effectiveness of the patient identification policy adopted
- At least annually, review the patient safety checklists and patient safety policies adopted, and consider any additional patient safety checklists and patient safety policies that may be appropriate for adoption for use at this facility
- Revise a patient safety checklist and patient safety policy as necessary to ensure that the checklist or policy, as applicable, reflects the most current standards in patient safety protocols
- On or before July 1st of each year, submit a report to the Director of the Legislative Counsel Bureau for transmittal to the Legislative Committee on Health Care. The report must include information regarding the development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted.
- The proceedings and records of a patient safety committee are subject to the same privilege and protection from discovery as the proceedings and records described in NRS 49.265.

VI. Scope:

The types of occurrences to be addressed include, but are not limited to, sentinel events, near misses, and actual events related to:

- Patient Safety
- Adverse drug events (medication errors and adverse drug reactions)
- Health acquired infections
- Patient Falls
- Other patient incidents/unexpected clinical/medical events
- Unsafe conditions
- Visitor safety/Visitor incidents
- Employee Safety

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- Blood/body fluid exposures
- Occupational diseases
- Communicable disease exposures
- Musculoskeletal injuries
- Immunization programs
- Other employee incidents
- Environmental safety
- Product recalls
- Drug recalls
- Product/equipment malfunction
- Construction-Infection Control Risk Assessment
- Water Quality
- Air Quality
- Disaster Planning
- Security Incidents
- Workplace Violence

Data from external sources, including but not limited to:

- Centers for Disease Control (CDC)
- Accreditation Association for Ambulatory Health Care (AAAHC)
- Occupational Safety and Health Administration (OSHA)
- Nevada State Health Division
- Published literature

VII. Definitions:

Sentinel Event is defined as an unexpected occurrence involving death or serious physical or psychological injury or the risk thereof including any process variation for which a recurrence would carry a significant chance of serious adverse outcome. Serious injury specifically includes loss of limb or function.

Occurrence is an event that is not consistent with routine patient care of procedure in which either did not or could have resulted in injury, loss to a patient or visitor or which may give rise to a claim against the facility, an employee of the facility, or a member of the facility medical staff.

Near Misses are any process variation which did not affect the outcome due to a screening by chance but for a recurrence carries a significant chance of a serious adverse outcome. Some may call it a potential for error.

Error is an unintended act, either omission or commission, or an act that does not achieve its outcome such as medication errors and adverse drug events or reactions.

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Hazardous Condition is any set of circumstances, exclusive of the disease or condition the patient is being treated for, which significantly increases the likelihood of a serious physical or psychological adverse patient outcome.

Facility Acquired Infections are a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was treated at the facility, including surgical site infections.

VIII. Structure:

The authority for the Patient Safety Plan rests with the CEO, Governing Board of Managers, Quality Improvement/Quality Assurance Committees, and Patient Safety Officer, and has delegated the authority to implement and maintain activities described in this plan to the IPSC Patient Safety Committee.

IX. Quality Review Information

To the extent possible, and in a manner consistent with the protection of confidentiality of quality assurance and patient safety data, pertinent information will be shared between the Quality Improvement Program and the Patient Safety Program.

In an attempt to protect quality review information from discovery, all quality review documents must be labeled as a Quality Review document. Documents should be in a formal format, handled by a limited number of individuals and secured in the Director of Nursing's office accessible only to designated individuals. Nevada Revised Statutes protecting Quality documents in NRS 49.265.

X. Education:

Quarterly/Annual Staff and Physician/Provider education as applicable includes, but is not limited to the following topics:

- Fire Drills (Quarterly)
- Emergency and Disaster Drills
- Workplace violence
- Customer service
- Creating, implementing, achieving and maintaining a culture of safety
- Risk management and error prevention
- Teamwork

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XI. Safety Improvement Activities:

Specify Measures for an annual focus (Examples listed below)

- Patient Satisfaction Surveys
- Medical Records review; legible documentation, clear, complete, signed
- Complaint and resolution-to improve care and satisfaction (trends)
- Confidentiality; ensure patient and employee information is secure
- Appointments/scheduling process; accessibility to physician
- Informed consent policy and procedure
- Medication management and reconciliation
- Telephone response time to callers
- Occurrence review

Give consideration to measures that facilitate safe practices (Examples listed below)

- Involve patients in their health care; consider literacy issues and cultural values, partner with patients in developing and planning their care
- Use a team approach to safety; hold focused safety meetings
- Endorse open, effective communication; identify shared values and attitudes among all members. Interview and/or survey staff for attitudes, perceptions and communication barriers
- Encourage error reporting to include near miss events. Institute a non-punitive reporting that is confidential and timely.
- Ensure employee and patient information or event reports shared with staff for educational purposes do not identify individuals
- Facilitate communication skills learning (teamwork)
- Examine physical premises to identify and correct potential hazardous conditions
- Orient physicians and new employees to risk management and patient safety concepts
- Conduct patient safety rounds
- Provide education and training on high risk processes

XII. Methodology:

Structure:

- Proactive risk prevention strategies
- Identification of high risk areas
- General incidences (Patient injuries)
- Potential or actual adverse events (medication errors)

Method: Establish a process for

- Identification, selection, prioritization
- Data collection and analyses

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- Development of actions
- Implementation
- Reporting
- Follow-up

Process Improvement: Establish teams/individual staff members to implement processes and to monitor for effectiveness. Utilize applicable tools to facilitate improvement for example

- PDCA: Plan, Do, Check, Act with focus on process improvement
- FMEA: Failure Mode Effect Analysis a systematic process for identifying potential process failures before they occur with the intent to eliminate or minimize risk
- RCA: Root Cause Analysis is a retrospective approach to error analysis that identifies what and how the event occurred and why it happened. The focus in on the process and systems not individuals

XIII. Program Evaluation:

The Patient Safety Committee will submit an Annual Report to the Quality Improvement Committee and include:

- Definition of the scope of occurrences including sentinel events, near misses and serious occurrences
- Detail of activities that demonstrate the Patient Safety Program has a proactive component by identifying the high-risk process selected
- Results of the high-risk or error-prone processes selected for ongoing measurement and analysis
- A description of how the function of process design that incorporates patient safety has been carried out using specific examples of process design or redesign that include patient safety principles
- The results of how input is solicited and participation from patients and families in improving patient safety is obtained
- The results of the program that assesses and improves staff willingness to report errors
- A description of the examples of ongoing education and training programs that are maintaining and improving staff competence

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Adapted from Medical Mutual Template Safety Plan and Nevada State Health Division Regulations

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SAFETY PLAN

Components of Plan:

I. NRS 439.875

1. **Patient Safety committee (PSC)** – VVSC has established a patient safety committee. VVSC's Patient Safety Committee is the Medical Executive Committee and will fulfill the functions as required by NRS439.875.
2. Composed of:
 - (a) (1) The infection control officer (ICO) of VVSC. The ICO will fulfill the designation and duties as required by NSR439.873.
The ICO and the PSO are employed by VVSC.
 - (2) The PSO (PSO) The PSO will fulfill the designation and duties as required by NSR439.870.
 - (3) At least three providers of health care who treat patients at VVSC facility, including, without limitation, at least one member of the medical, nursing and contract Consultant Pharmacist VVSC.
 - (4) One member of the governing body of VVSC.
 - (b) Frequency of meetings: The PSC shall meet at least once each month via the monthly Pharmaceutical and Therapeutic Meeting.
3. VVSC has more than 25 employees and the PSC meets monthly.
4. The PSC shall:
 - (a) Receive reports from the PSO pursuant to NRS 439.870.
 - (b) Evaluate actions of the PSO in connection with all reports of sentinel events alleged to have occurred at VVSC.
 - (c) Review and evaluate the quality of measures carried out by VVSC to improve the safety of patients who receive treatment at the medical facility.
 - (d) Review and evaluate the quality of measures carried out by VVSC to prevent and control infections at VVSC.
 - (e) Make recommendations to the Governing Board (GB) of VVSC to reduce the number and severity of sentinel events and infections that occur.
 - (f) At least once each calendar quarter, report to the GB of the VVSC regarding:
 - (1) The number of sentinel events that occurred during the preceding calendar quarter;
 - (2) The number and severity of infections that occurred during the preceding calendar quarter;
 - (3) Any recommendations to reduce the number and severity of sentinel events and infections that occurs at VVSC.
 - (g) Adopt patient safety checklists and patient safety policies etc., as required by [NRS 439.877](#), review the checklist and policies annually and revise the checklist and policies as the PSC determines necessary. See NRS439.877 at end of Safety Plan.
5. The proceedings and records of the PSC are subject to the same privilege and protection from discovery as the proceedings and records described in NRS 49.265.

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II. NRS 439.835 Mandatory Reporting of sentinel events.

1. Except as otherwise provided in subsection 2:
 - (a) Any person employed by VVSC will, within 24 hours after becoming aware of a sentinel event that occurred at VVSC, notify the PSO of VVSC of the sentinel event; and
 - (b) The PSO shall, within 13 days after receiving notification pursuant to paragraph (a), report the date, the time and a brief description of the sentinel event to:
 - (1) The Division; and
 - (2) The representative designated pursuant to [NRS 439.855](#), who is the attending MD.
2. If the PSO of VVSC personally discovers or becomes aware, in the absence of notification by another employee, of a sentinel event that occurred at VVSC, the PSO shall, within 14 days after discovering or becoming aware of the sentinel event, report the date, time and brief description of the sentinel event to:
 - (a) The Division; and
 - (b) The representative designated pursuant to [NRS 439.855](#), if that person is different from the PSO.
3. The State Board of Health shall prescribe the manner in which reports of sentinel events must be made pursuant to this section.

III. NRS 439.837 Mandatory investigation of sentinel event by VVSC.

VVSC shall, upon reporting a sentinel event pursuant to [NRS 439.835](#), conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event.

IV. NRS 439.855 Notification of patients involved in sentinel events.

1. VVSC designates the attending physician to notify the his/her patient who have been involved in sentinel events at VVSC.
2. The attending physician to notify the his/her patient shall, not later than 7 days after discovering or becoming aware of a sentinel event that occurred at VVSC, provide notice of that fact to each patient who was involved in that sentinel event.
3. The provision of notice to a patient pursuant to subsection 2 must not, in any action or proceeding, be considered an acknowledgment or admission of liability.
4. A representative designated pursuant to subsection 1 may or may not be the same person who serves as VVSC's PSO.

V. NRS 439.856 Provision of certain information relating to facility-acquired infections to patients. These certain information is provided in VVSC Patient's Information Packet, (VVSC PIP) that the patient receives when scheduling procedure at VVSC.

1. VVSC shall:
 - (a) Provide to each patient of VVSC, upon admission of the patient, the general and its-specific information relating to its acquired infections required by subsection 2.

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- (b) Post in publicly accessible areas of VVSC information on reporting its acquired infections, including, without limitation, the contact information for making reports to the Division. Such information may be added to other required notices concerning the making of reports to the Division.
2. The following information is contained in VVSC PIP and is provided to each patient pursuant to paragraph (a) of subsection 1 must include, without limitation: This
 - (a) The measures used by VVSC for preventing infections, including VVSC acquired infections;
 - (b) Information on determining whether a patient had an infection upon admission to VVSC, risk factors for acquiring infections and determining whether an infection has been acquired;
 - (c) Information on preventing VVSC acquired infections;
 - (d) Instructions for reporting VVSC acquired infections, including, without limitation, the contact information for making reports to the Division; Posted instructions are listed on the Patients' Bill of Rights for reporting facility-acquired infections, including, without limitation, the contact information for making reports to the Southern Nevada Health District at 775-684-1068 Department of Health and Human Services, Health Division, Bureau of Health Care Quality and Compliance (BHQC) at 702-486-6515, Fax 775-684-1073.
 - (e) Any other information that VVSC deems necessary.

VI. NRS 439.857 Procedure for informing patient, legal guardian or other person that patient at VVSC has infection, immunity from liability for providing certain information.

1. Except as otherwise provided in subsection 2, when VVSC confirms that a patient at its facility has an infection, the attending physician shall, as soon as practicable but not later than 5 days after the diagnosis is confirmed, inform the patient or the legal guardian or other person authorized by the patient to receive such information that the patient has an infection.
2. The attending physician may delay providing information about an infection if the patient does not have a legal guardian, has not authorized any other person to receive such information and:
 - (a) is not capable of understanding the information;
 - (b) is not conscious; or
 - (c) in the judgment of the provider of health care, is (c) likely to harm himself or herself if informed about the infection.
3. If the attending physician delays providing information about an infection pursuant to subsection 2, such information must be provided as soon as practicable after:
 - (a) The patient is capable of understanding the information;
 - (b) The patient regains consciousness;
 - (c) In the judgment of the attending physician, the patient is not likely to harm himself or herself if informed about the infection; or

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- (d) A legal guardian or other person authorized to receive such information is available.
- 4. VVSC shall ensure that the providers of health care of the VVSC follows its protocols in accordance with this section that provide the manner in which a provider of health care or his or her designee must:
 - (a) Inform a patient or the legal guardian or other (a) person authorized by a patient to receive such information that the patient has an infection with 5 days of determination; and
 - (b) If known or determined while a patient remains at VVSC, inform the patient or the legal guardian or other person authorized by the patient to receive such information whether the infection was acquired at the VVSC and of the apparent source of the infection.
 - (c) A person or governmental entity who, with reasonable care, informs a patient or the legal guardian or other person authorized by the patient to receive such information that an infection was not acquired at the medical facility and of the apparent source of the infection pursuant to subsection 4 is immune from any criminal or civil liability for providing that information.

VII. NRS.865 Patient safety plan: Development; inclusion of infection control program to prevent and control infections; approval; notice' compliance' annual review and update.

1. VVSC has an internal patient safety plan to improve the health and safety of patients who are treated at VVSC.
2. The patient safety plan must include, without limitation:
 - (a) The patient safety checklists and patient safety policies most recently adopted pursuant to [NRS 439.877](#).
 - (b) An infection control program to prevent and control infections within VVSC. To carry out the program, VVSC shall adopt an infection control policy. The policy must consist of:
 - (1) The current guidelines appropriate for VVSC's scope of service developed by a nationally recognized infection control organization as approved by the State Board of Health which may include, without limitation, the Association for Professionals in Infection Control and Epidemiology, Inc., the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the World Health Organization and the Society for Healthcare Epidemiology of America; and
 - (2) VVSC-specific infection control developed under the supervision of a trained infection preventionist.
3. The program to prevent and control infections within VVSC must provide for the designation of a person, who is the Infection Control Officer, is responsible for infection control at all times.
4. VVSC shall submit its patient safety plan to the GB of VVSC for approval in accordance with the requirements of this section.

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5. After VVSC's patient safety plan is approved, VVSC shall notify all providers of health care who provide treatment to patients at VVSC of the existence of the plan and of the requires of the plan. VVSC shall require compliance with its patient safety plan.
6. The patient safety plan must be reviewed and updated annually in accordance with the requirements for approval set forth in this session.

VIII. NRS 439.877 Patient safety checklists and patient safety policies: Adoption by patient safety committee; required provisions; duties of patient safety committee. Some of the required checklists below are contained in VVSC's Surgical/Procedural Safety Check list form, VVSC's S/P Safety Check List.

1. The PSC established pursuant to [NRS 439.875](#) by VVSC adopts patient safety checklists and patient safety policies for use by:
 - (a) Providers of health care who provide treatment to patients at VVSC;
 - (b) Other personnel of VVSC who provide treatment or assistance to patients;
 - (c) Employees of VVSC who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the VVSC, including, without limitation, a janitor of VVSC. VVSC contracts with an independent cleaning services and uses the checklist entitled Surgery Center Nightly Checklist as its safety and infection checklist: and
 - (d) Persons with whom VVSC enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients at VVSC.
2. The patient safety checklists adopted pursuant to subsection 1 must follow protocols to improve the health outcomes of patients at VVSC and must include, without limitation:
 - (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. This is #4 and #5 in VVSC's S/P Safety Check List.
 - (b) Checklists for ensuring that employees of VVSC, (this is #1, #12, and #19 VVSC's S/P Safety Check List) and contractors with VVSC who are not providers of health care follow protocols to ensure that the room and environment of the patient is sanitary.
 - (b) A checklist to be used when discharging a patient from VVSC is included in VVSC's PACU Record or Post Procedure Record, includes, without limitation, verifying that the patient received:
 - (1) Proper instructions concerning prescription medications
 - (2) Instructions concerning aftercare; and
 - (3) Any other instructions concerning his or her care upon discharge.
 - (c) Any other checklists which may be appropriate to ensure the safety of patients at VVSC.
3. The patient safety policies adopted pursuant to subsection 1 must include, without limitation:
 - (a) A policy, located in VVSC's Policy and Procedure (P&P) Manual, Section: Appendix

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Nursing Services, Subject Patient Identifiers, 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 include, without limitation, the name and date of birth of the patient.

- (b) A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of health care at VVSC including, without limitation, protocols relating to hand hygiene.
 - (c) A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, without limitation, active surveillance. Active surveillance may include, without limitation, a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.
4. The patient safety committee shall:
- (a) Monitor and document the effectiveness of the patient identification policy adopted pursuant to paragraph (a) of subsection 3.
 - (b) At least annually, review the patient safety checklists and patient safety policies adopted pursuant to this section and consider any additional patient safety checklists and patient safety policies that may be appropriate for adoption for use at VVSC.
 - (c) Revise a patient safety checklist and patient safety policy adopted pursuant to this section as necessary to ensure that the checklist or policy, as applicable, reflects the most current standards in patient safety protocols.
 - (d) On or before July 1 of each year, submit a report to the Director of the Legislative Counsel Bureau for transmittal to the Legislative Committee on Health Care. The report must include information regarding the development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to paragraph (b).

References

1. [NRS 49.265](#) (Added to NRS by [1977, 785; A 1977, 1314; 1981, 1967; 1987, 1188; 1989, 1506; 2005, 2518 Special Session, 13; A 2009, 553](#))
2. [NRS 439.835](#) (Added to NRS by 2002 Special Session, 13; A 2009, 553)
3. [NRS 439.835](#) (Added to NRS by [2002 Special Session, 13](#) A [2009, 553](#))
4. [NRS 439.855](#) (Added to NRS by [2002 Special Session, 14](#))
5. [NRS 439.856](#) (Added to NRS by [2011, 1580](#), effective January 1, 2012)
6. [NRS 439.857](#) (Added to NRS by [2011, 1581](#))
7. [NRS 439.865](#) (Added to NRS by [2002 Special Session, 15: A 2011, 679, 1583](#))

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8. [NRS 439.875](#). (Added to NRS by [2002 Special Session, 15](#); A [2011, 679](#), [1584](#), effective January 1, 2012)
9. [NRS 439.877](#) (Added to NRS by [2011, 677](#))

Reference: AAAHC Standards, Quality Management and Improvement, *Patient Safety Plan*, Section 5.3.1

Kindred Hospital Las Vegas DeLima Campus

PATIENT SAFETY PLAN

DATE: 02/19/18



This plan was created and revised by the Kindred Hospital Las Vegas DeLima Campus Patient Safety committee/team. Implementation of this plan is intended to optimize the healthcare quality and patient safety outcomes, encourage recognition, reporting, and acknowledgment of risks to patient, visitor, and employee safety, as well as reduce the medical/healthcare errors and /or preventable events.

Patient Safety Committee/Program
Kindred Hospital Las Vegas DeLima Campus
102 East Lake Mead Parkway
Henderson, Nevada 89105

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Commitment to Patient Safety

Kindred Hospital Las Vegas DeLima Campus is committed to a comprehensive approach to improving healthcare quality and patient safety by aligning with our Mission, Vision, and Values, creating an environment that supports a dynamic, proactive, and safe culture for patients, family members, visitors, and employees, through continuous learning and improving patient safety policies, systems, and processes.

Mission, Vision, and Values

In support of our mission, vision, and values, Kindred Hospital Las Vegas DeLima Campus Patient Safety and Quality Improvement program promotes:

- Collaboration of healthcare, leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high quality healthcare.
- Communicate honestly and openly to foster trusting and cooperative relationships among healthcare providers, staff members, and patients and their families, to ensure accountability for the patient safety priorities.
- Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.
- Responsibility for every healthcare related decision and action.
- A focus on continuous learning and improving, system design, and the management of choices and changes, bringing the best possible outcomes or performances to the facility.
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare.
- Education of staff and physicians to assure participation of healthcare providers.

Scope and Purpose

The scope of this Quality and Patient Safety Plan is organizational-wide/hospital-wide/agency-wide which includes but is not limited to

- Patient safety
- Visitor safety
- Employee safety

All staff in Kindred Hospital Las Vegas DeLima Campus are required to fully support and participate in this plan, and devote their expertise to the patient safety and healthcare quality improvement process.

This plan is action oriented and solution focused. The purpose of this plan is to address patient safety related concerns, challenges and revise the program to better serve the patients and their families. To this end, Kindred Hospital Las Vegas DeLima Campus has developed this Patient Safety Plan.

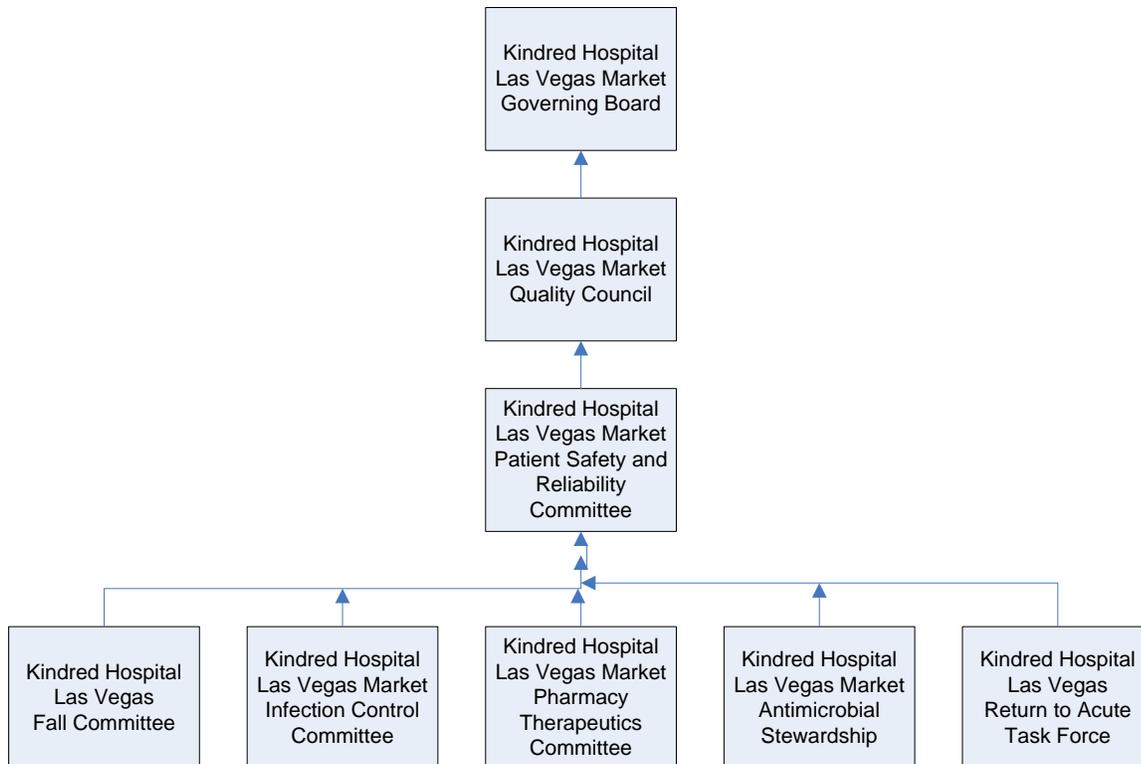
The plan focuses on the process rather than the individual, and recognizes both internal and external customers, as well as facilitates the need of analyzing and improving processes. The core principles of this plan include:

- All staff have the same goal and contribute their knowledge, vision, skill, and insight to improve the process of the Patient Safety Plan.
- Decisions will be based on data and facts, and staff will be encouraged to learn from the experiences.
- Customer based including patients, families, and visitors.
- Promote systems thinking.
- Employ well-trained and competent staff maintaining high healthcare quality.

Roles and Responsibilities

According to [NRS 439.875](#), a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plan is promoted and executed successfully.

The Patient Safety Committee Organization



Roles and Responsibilities

- In accordance with [NRS 439.875](#), a patient safety committee must be comprised of:
- The infection control officer of the medical facility;
- The patient safety officer of the medical facility, if he or she is not designated as the infection control officer;
- At least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility; and
- One member of the executive or governing body of the medical facility.

Based on [NAC 439.920](#), a medical facility that has fewer than 25 employees and contractors must establish a patient safety committee comprised of:

- The patient safety officer of the medical facility;
- At least two providers of healthcare who treat patients at the medical facility, including but without limitation, one member of the medical staff and one member of the nursing staff of the medical facility; and
- The Chief Executive Officer (CEO) or Chief Financial Officer (CFO) of the medical facility.

The roles and responsibilities are defined below (Please modify them as needed.)

Patient Safety Committee Responsibilities (based on [NRS 439.875](#) and [NRS 439.877](#))

- Monitor and document the effectiveness of the patient identification policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the patient safety officer pursuant to [NRS 439.870](#).
- Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred.
- Review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- Review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the executive or governing body of the facility regarding:
 - (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);
 - (2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and
 - (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.

- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

Root Cause Analysis (RCA) Team Responsibilities

- Root Cause interviews, analysis, investigation, and corrective action plan implementations.
- Participates in the RCA meetings and discussions.
- Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders.

Patient Safety Officer Responsibilities (based on [NRS 439.870](#))

- Serve on the patient safety committee.
- Supervise the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the patient safety committee regarding any action taken in accordance with the responsibilities above.

Infection Control Officer Responsibilities (based on [NRS 439.873](#))

- Serve on the patient safety committee.
- Monitor the occurrences of infections at the facility to determine the number and severity of infections.
- Report to the patient safety committee concerning the number and severity of infections at the facility.
- Take such action as determines is necessary to prevent and control infections alleged to have occurred at the facility.
- Carry out the provisions of the infection control program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program.

RCA Team Leader Responsibilities

- Organize and coordinate the RCA process.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA, and corrective action plan implementation process.
- Communicate the progress of the investigation, institutional barriers, and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.

- Provide training, education and direction to create RCA process that incorporate the Patient Safety and Quality Improvement elements.

RCA Facilitator Responsibilities

- Provide vision and leadership to the Root Cause Analysis process
- Work with the Director of Quality Management to assure process changes are implemented
- Guide the staff in the process of discovery and mitigation of future process failures

Executive or Governing Body Staff Responsibilities

- Provide vision and leadership to Patient Safety and Quality Improvement process, and develop and foster a safe learning and improving culture.
- Provides oversight to the healthcare quality improvement processes and teams.
- Plan, discuss, and generate the organization patient safety goals and activities, in conjunction with the patient safety action plans
- Provide fiduciary responsibilities

The Patient Safety Committee will meet monthly to accomplish the following:

- Report and discuss sentinel events which include:
 - Number of sentinel events from previous calendar month.
 - Number of severe infections that occurred in the facility.
- Corrective Action Plan for the sentinel events and infections
 - Evaluate the corrective action plan.
- Patient safety policies and checklists
 - At least annually evaluate Patient Safety policies and checklists
 - Revise the patient safety policies and checklists as needed.
 - Monitor and document the effectiveness of the patient safety policy.

A RCA meeting will meet as needed to accomplish the following:

- Define the healthcare issues or potential risks.
- Conduct Root Cause Analysis
 - Reviewing and analyzing the data.
 - Reviewing the RCA process and quality improvement related activities and timelines.
 - Brainstorming issues or the potential risks by using the fishbone diagrams.
 - Identify the contributing factors and conduct the Root Cause Analysis.
- Conduct Corrective Action Plan
 - Identifying the Plan-Do-Study-Act (PDSA) topics.
 - Discussing corrective action process and activities.
 - Discussing and presenting possible changes in procedure to improve areas indicated.
 - Identifying strengths and areas that need improvement.
 - Developing strategies, solutions, and steps to take next.

- Identify barriers and technical assistance needs for supporting the RCA efforts.

A meeting agenda and minutes noting follow-up tasks will be kept.

Objectives and Goals of the Quality and Patient Safety Plan

Objective	Goals	Plan	Planned Completion Date	Responsible Party
CLABSI Prevention	Reduce CLABSI by 10%	<ol style="list-style-type: none"> 1) Use Tegaderm Dressings 2) CHG Bathing Program 3) Staff education and competencies on hire and annually thereafter 4) Develop nurse-driven protocol for discontinuation of lines 5) RCA performed for each event 	12/31/18	ICP/CCO
CAUTI Prevention	Reduce CAUTI by 10%	<ol style="list-style-type: none"> 1) Staff education and competencies on hire and annually thereafter 2) Evaluate use of external female urine systems 3) RCA performed for each event 	12/31/18	ICP/CCO
NOWPU Prevention	Reduce NOWPU by 10%	<ol style="list-style-type: none"> 1) Use of Patient Safety Index to assure HAPU prevention 2) Braden Scale, Repositioning, Assessment and Wound Education to Patient Family Score 	12/31/18	Wound Care Coordinator/ Chief Clinical Officer

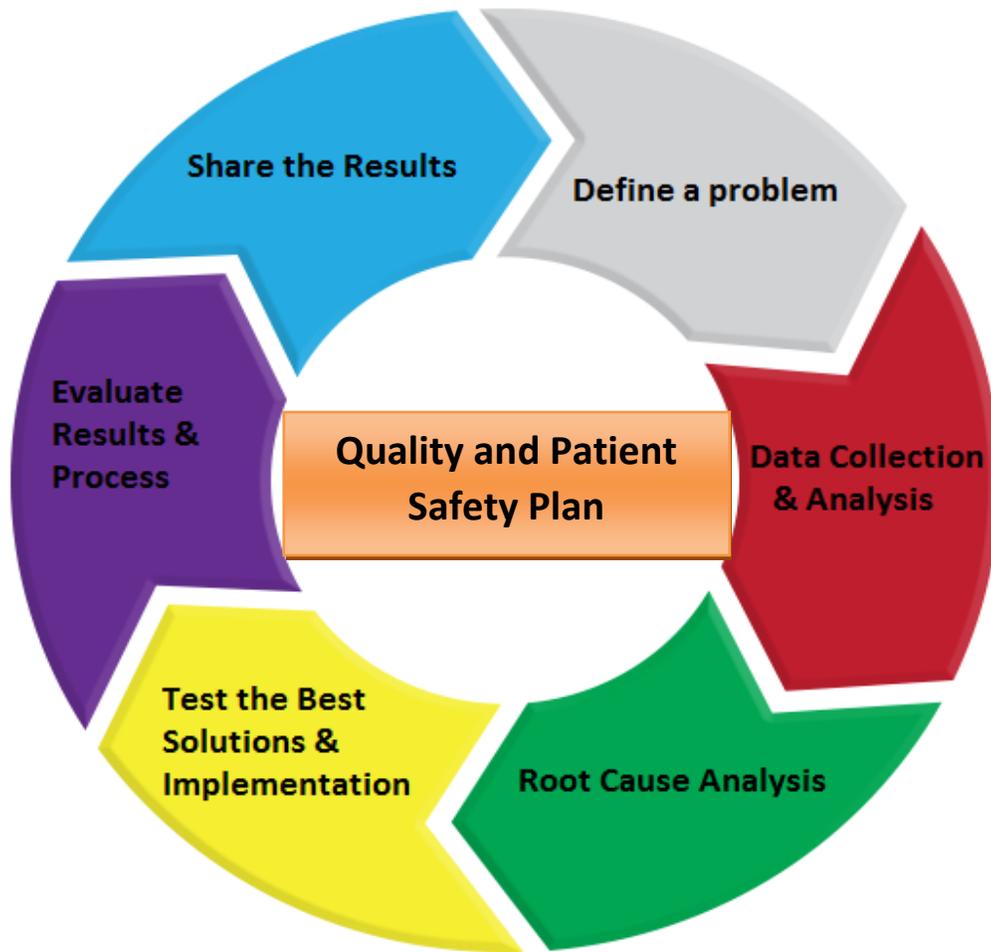
		3) RCA done for each event		
Antimicrobial Stewardship	Reduce Antibiotic usage to ≤ 35% of total drug cost	<ol style="list-style-type: none"> 1) Enhance the Patient Safety Dashboard for Antimicrobial Therapy Use 2) Incorporate the Pharmacist/ICP/ Infectious Disease MD rounding 3) Staff, physician and Leadership Education 	12/31/18	Director Pharmacy/ICP /CCO/ID Medical Director
Fall Reduction	Reduce falls by 10%	<ol style="list-style-type: none"> 1) Fall risk assessment completed for each patient, each shift 2) Re-implement market Fall Reduction Performance Improvement Team 3) Staff education on hire and annually thereafter 4) Post-fall assessment completed for each event 	12/31/18	DQM/CCO

Components and Methods

Pursuant to [NRS 439.837](#), a medical facility shall, upon reporting a sentinel event pursuant to [NRS 439.835](#), conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event.”

Kindred Hospital Las Vegas DeLima Campus will use RCA process to determine the contributing factors and the underlying reasons for the deficiencies or failures. The Plan-Do-Study (check)-Act (PDSA or PDCA) is the model, which was developed by the Institute of Health Care

Improvement, which we will use to test the changes.



Root Cause Analysis

A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals.

Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

Root cause analysis and action plan framework table, which was introduced by the Joint Commission. It contains 24 analysis questions. It guides the organization to the steps in a root cause analysis. Not all the questions apply to all the events or cases. This table can be used individually or with the fishbone diagram.

5 Whys technique will be used in Kindred Hospital Las Vegas DeLima Campus to explore the cause and effect relationship underlay a problem. One can find the root causes by asking “why” no less than five times. This technique can be used individually or as a part of the fishbone diagram.

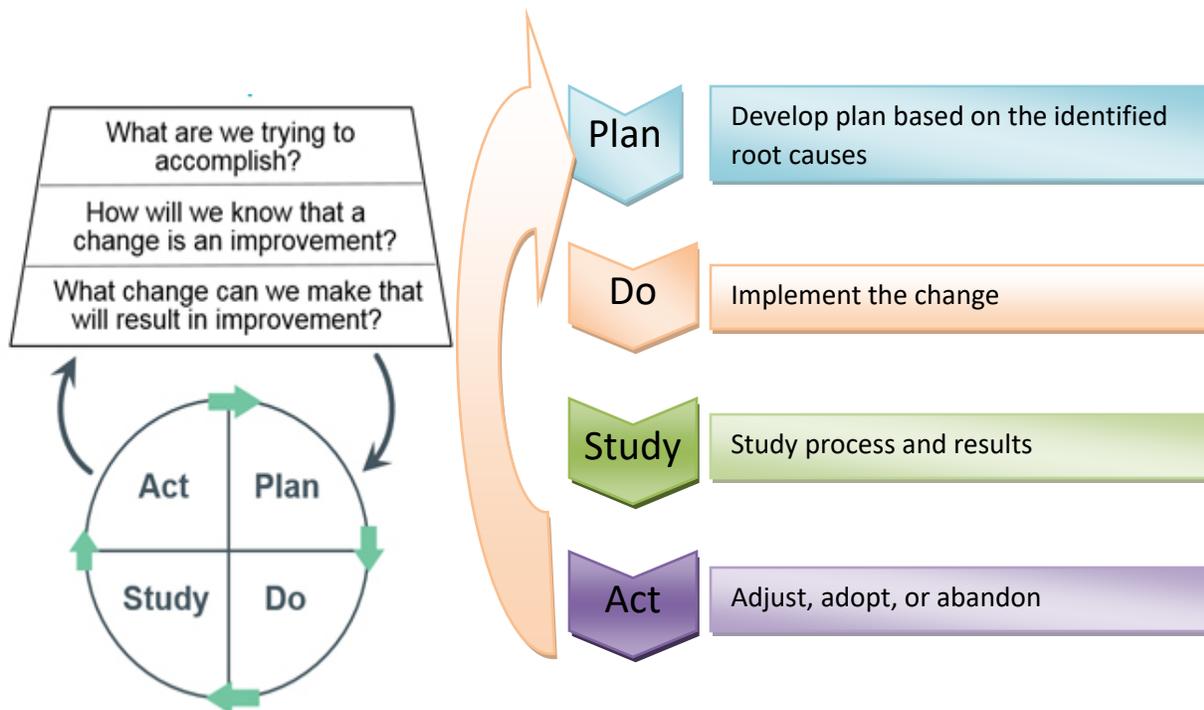
Fishbone Diagram

Once the problems are identified, a Fishbone Diagram (Appendix C) will be used for analyzing the problems. You can use the fishbone diagram individually to analyze the root causes, or use it with the root cause analysis and action plan framework table.

A Fishbone Diagram, also called a Cause-and-Effect diagram, is a useful tool for a team to structurally brainstorm by discovering possible underlying factors or root causes from different major categories for the chosen problems. General categories used include: people, methods, materials, measurements, education, procedures, process, location, environment, etc. RCA team members will brainstorm and ask multiple times, “why did this happen?” for each cause until all ideas are exhausted. The highest priority root causes will be chosen for PDSA topics. Once all the categories are established on the fishbone diagram, 5 Why’s technique also can be used to drill down the problem and find the root causes.

Model for Improvement

The Model for Improvement is a collaborative and ongoing effort model to improve the product and services quality and process. It provides multi-disciplinary quality team guidance from identifying the root causes; conducting the best tests to assess possible changes, and working in collaboration for implementation of the new approaches and solutions. It guides the test of a change to determine if the change is an improvement.



The cycle is defined as follows:

- Plan--collect data and establish appropriate goals. Identify the problem and the possible root causes, and answer the following questions.
 - What is the objective of the test?
 - What are the steps for the test - who, what, when?
 - How will you measure the impact of the test?
 - What is your plan to collect the data needed?
 - What do you predict will happen?

- Do--make changes designed to correct or improve the situation. Use the following questions for the guidance.
 - What were the results of the test?
 - Was the cycle carried out as designed or planned?
 - What did you observe that was unplanned or expected?

- Study -- Study the effect of the changes on the situation. Data should be collected on the new process and compared to the baseline or expected results. Results should be evaluated and by using the following questions as guidance.
 - Did the results match your prediction?
 - What did you learn?
 - What do you need to do next?

- Act--If the result is successful or desirable, standardize the changes and then work on the next prioritized problem or the further improvements. If the outcome is not yet successful, look for different ways to identify the causes or change the testing process.

PDSA worksheet will be used to map the potential change strategies and to establish a course of action. The PDSA worksheet and the PDSA progress report are attached in Appendix D-1.

Data Collection and Reporting

Data should drive any quality and patient safety effort. Kindred Hospital Las Vegas Sahara Campus is using the Kindred Event Reporting System for tracking the incident and sentinel events, NHSN for reporting healthcare infection data, WebIZ for reporting vaccinations, and Business Warehouse and Meditech for internal data collection.

External data sources are those data sources which are collected outside the supervisory structure of the case. External data which will be utilized for Quality and Patient Safety plan include the data from:

- AHRQ: Agency for Healthcare Research & Quality
- CDC: Centers for Disease Control and Prevention
- CMS: Centers for Medicare & Medicaid Services
- NQF: National Quality Forum
- NHSN: National Healthcare Safety Network

- TJC: The Joint Commission



Ongoing Reporting and Review

Data points such as the following will be reviewed according to the schedule prescribed:

Monthly	Quarterly	Annually
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<p>1) Sentinel event monthly report</p> <p>2) Severity of infection report</p> <p>3) RCA assessment</p>	<p>1) Sentinel event quarterly report</p> <p>2) Severity of infection report</p> <p>3) Review and evaluate the measure of improvement of patient safety</p> <p>4) Review and evaluate the measurement to prevent and control infections</p>	<p>1) Quality and Patient Safety Plan update</p> <p>2) Checklists and Policies reviewing and revising</p>
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Assessment of the Quality and Patient Safety Plan

Please see the Patient Safety Assessment Tool (PSAT) from the VA National Center for Patient Safety for your reference.

Patient Safety Checklists and Patient Safety Policies

By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

The patient safety checklists must follow protocols to improve the health outcomes of patients at the medical facility and must include, without limitation:

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.
- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - Proper instructions concerning prescription medications;
 - Instructions concerning aftercare;
 - Any other instructions concerning his or her care upon discharge; and
 - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include, the name and date of birth of the patient.
- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.
- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

Based on [NRS 439.865](#), the patient safety plan must also include an infection control program that carries out the infection control policy. The policy must consist of:

- The current guidelines appropriate for the facility's scope of service developed by a nationally recognized infection control organization as approved by the State Board of Health which may include, the Association for Professionals in Infection Control and Epidemiology (APIC), the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO) and the Society for Healthcare Epidemiology of America (SHEA); and
- Facility-specific infection control developed under the supervision of a certified Infection Preventionist.

The patient safety checklists are listed in Appendix E. (The following links provide some patient safety checklists for your reference— a checklist example is shown in **Appendix E.**)

http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf

<http://www.who.int/patientsafety/implementation/checklists/en/>

The patient safety policies are listed in Appendix F. (The following link provides you some patient safety policies for your reference—a policy example is shown in **Appendix F.**)

<https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>

Approval of Patient Safety Plan

According to [NRS 439.865](#), a medical facility shall submit its patient safety plan to the governing board of the facility for approval. After a facility's patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan.

The patient safety plan must be reviewed and **updated annually** in accordance with the requirements for approval set forth in this section.

According to [NRS 439.843](#), on or before March 1 of each year, a copy of the most current patient safety plan established to [NRS 439.865](#) must be submitted to the Division of Public and Behavioral Health.

Reference

- Root Cause Analysis Toolkit <http://www.health.state.mn.us/patientsafety/toolkit/>
- Quality and Service Improvement Tools
http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html
- CQI 101 An Introduction to Continuous Quality Improvement:
<https://www.coursehero.com/file/13827355/CQI-Overviewppt/>
- Quality Improvement <http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/>
- Root Cause Analysis <http://www.patientsafety.va.gov/professionals/onthejob/rca.asp>
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2
https://www.jointcommission.org/sentinel_event.aspx
- Hospital Policies <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>
- Checklists to Improve Patient Safety http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf
- Patient Safety Checklists <http://www.who.int/patientsafety/implementation/checklists/en/>

- Minutes of the Meeting of the Quality and Patient Safety Committee
<http://www.cookcountyhhs.org/wp-content/uploads/2013/12/09-23-14-QPS-scan-Minutes.pdf>
- Title 40 – Public Health and Safety <https://www.leg.state.nv.us/NRS/NRS-439.html>

Appendix A: Terms and Definitions

Patient Safety: The Agency for Healthcare Research Quality (AHRQ) defines patient safety as “a discipline in the healthcare sector that applies safety science methods toward the goal of achieving

a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.”

http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

Sentinel event ([NRS 439.830](#))

1. Except as otherwise provided in subsection 2, “sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum.

2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:

(a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or

(b) July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published.

3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.

(Added to NRS by [2002 Special Session, 13](#); A [2005, 599](#); [2013, 217](#))

Institute for Healthcare Improvement (IHI) defines **medical harm** as “unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death.”

Facility-Associated Infection: ([NRS 439.802](#))

“Facility-acquired infection” means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections;
- Ventilator-associated pneumonia;
- Central line-related bloodstream infections;
- Urinary tract infections; and
- Other categories of infections as may be established by the State Board of Health by regulation pursuant to [NRS 439.890](#).

(Added to NRS by [2005, 599](#); A [2009, 553](#))

Medical facility ([NRS 439.805](#))

“Medical facility” means:

- A hospital, as that term is defined in [NRS 449.012](#) and [449.0151](#);
- An obstetric center, as that term is defined in [NRS 449.0151](#) and [449.0155](#);
- A surgical center for ambulatory patients, as that term is defined in [NRS 449.0151](#) and [449.019](#); and

- An independent center for emergency medical care, as that term is defined in [NRS 449.013](#) and [449.0151](#).

(Added to NRS by [2002 Special Session, 13](#))

Near miss: An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Mandatory reporting: Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985;254(6):796-800.)

Risk: Possibility of loss or injury. (Merriam-Webster's Online Dictionary, Risk, Available at <http://www.merriamwebster.com/dictionary/risk>. Last Accessed August 2009.)

Preventable event: Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Catheter Associated Urinary Tract Infection (CAUTI): A urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CUR_RENT_b.pdf.)

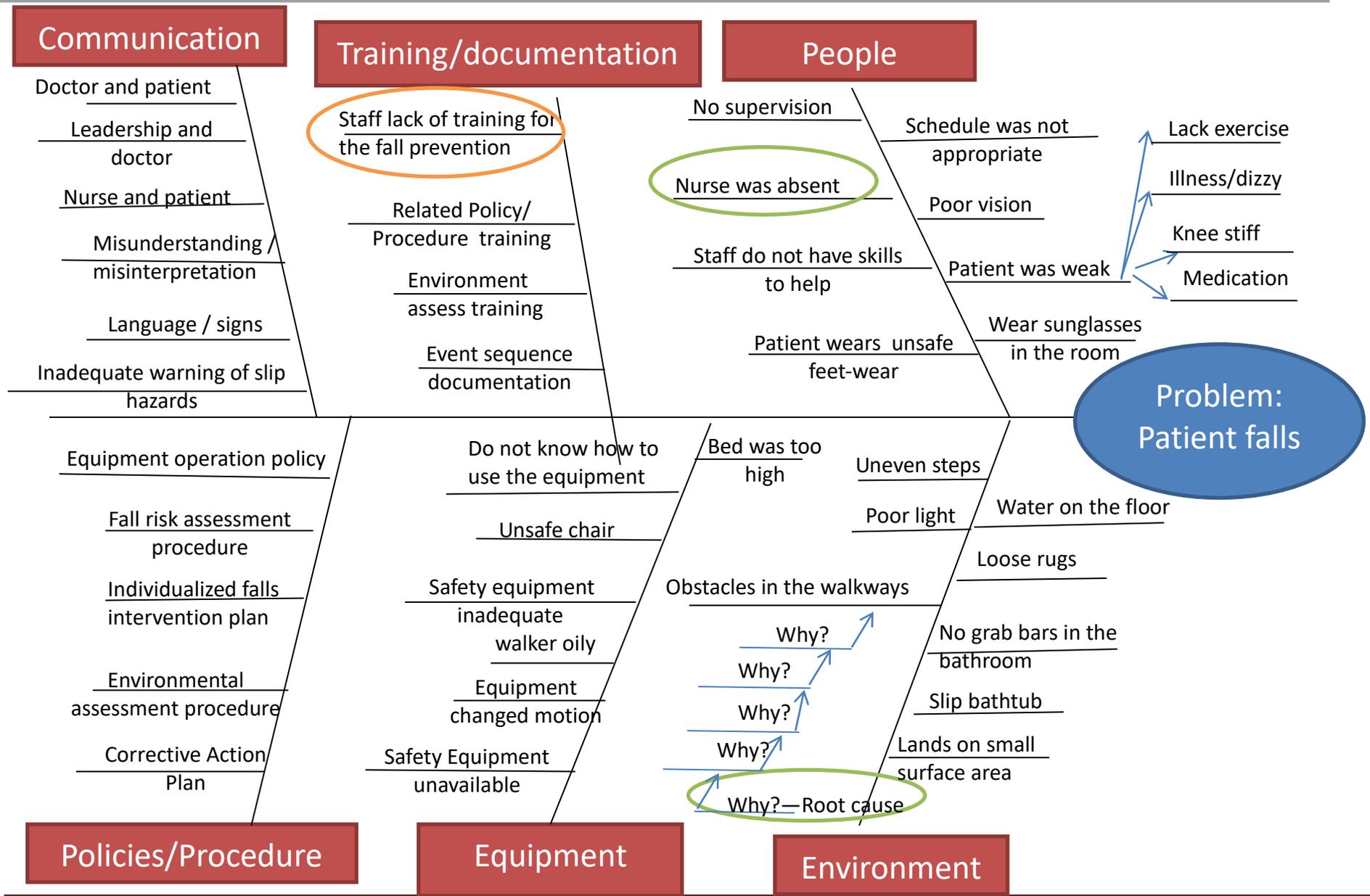
Central Line Associated Bloodstream Infections (CLABSI): Primary bloodstream infections that are associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection.

Appendix B: Patient Safety Goals

OBJECTIVE:	GOAL:	Q3 2014	Q4 2014	Q1 2015
ACTION PLAN:				
1. Create Systems that anticipate errors & either prevent or catch them before they cause harm.	a. Enhance retrospective chart review process.			Implement Trigger Tools. Develop automated surveillance reports in Cerner.
	b. Establish an automated surveillance process.		Complete an in-depth analysis of risk point utilizing the methods of FMEA.	
2. Establish Structures for reporting and a process for managing reports in the event reporting system.	a. Implement new electronic Voluntary Reporting System & participate in Patient Safety Organization.	Implemented e-MERS & PSO with UHC.	Create process for reviewing & closing reports in e-MERS.	
	b. Develop a structure to educate employees system-wide of the process for reporting hazards, errors and adverse events.		Increase number of events reported by 10%.	
	c. Establish a process for providing feedback regarding reported events.		Create process for communicating outcome of reported events.	
3. Develop a Culture of Safety where providers feel safe and supported when they report medical errors or near misses & voice concerns about patient safety.	a. Provide education on patient safety plan that emphasizes importance of blending a systems focus with appropriate individual accountability.		Educate Medical staff, Hospital Wide Oversight & the Quality Committees on the objectives and goals of the patient safety plan.	
	b. Establish a recognition program that rewards safe practices.		Include patient safety presentation in monthly New Employee Orientation.	
	c. Improve overall perceptions of safety as measured by the Culture of Safety Survey.		Develop 'Great Catch' awards program.	
				Re-evaluate culture of safety and develop action plan.
4. Establish Safety Priorities & Targets.	a. Develop Patient Safety Dashboard that includes national measures and benchmarks.		Present Patient Safety Dashboard monthly to Hospital Wide Oversight Committee.	
	b. Facilitate the development of action plans associated with measures not meeting benchmarks.	Complete 2014 Leapfrog Safety Survey.	Establish & implement a plan to improve performance of each leap.	
	c. Assess and improve processes related to hand-off, transition and communication	Develop method to track & report departmental progress and compliance of RCA action plans.		
5. Charter Safety Programs through teams, workgroups or projects.	a. Coordinate Improvement Efforts in order to ensure that capital, people, facilities & technologies are matched to strategic priorities for safe practices.		Establish Patient Safety Council.	
	b. Reduce and eliminate variation in care.		Establish workgroups focused on medication safety, reducing patient falls & hospital acquired pressure ulcers.	
			Revise or develop policies, procedures and protocols.	

Reference: Patient Safety Plan and Its Applicable Goals. 2014. Cook County Health and Hospitals System.

Appendix C: Fishbone Diagram



Appendix D-1: PDSA Worksheet

PDSA Worksheet

Topic:			
Person Completing Worksheet:		Date:	
Telephone/ Email:		Cycle:	
Patient Safety Committee Members			
CEOs/CFOs			
Patient Safety Officer			
Infection Control Officer			
Other Medical Staff			
Other team members			
Aim: (Describe the overall SMART goal that your team wishes to achieve.)			
Plan:			
1. List the tasks needed to set up this test of change.			
2. Predict what will happen when the test is carried out.			

3. List the steps to develop the test-who, what, and when.

Steps	By Whom	By When	Desired Outcome

Do: (Describe what actually happened when you ran your test, including any problems and unexpected findings.)

Study: (Describe what you learned and did you meet your measurement goal?)

Did you meet your measurement goal? Explain.	Summarize what was learned: success, failure, unintended consequences, etc.

Act: (Describe what you concluded from this cycle.)

Based on what was learned, please indicate what action will be considered.	Describe what modifications to the plan will be made for the next cycle based on what you learned.
<input type="checkbox"/> Adapt: modify changes and repeat PDSA Cycle	
<input type="checkbox"/> Adopt: expanding changes throughout organization	
<input type="checkbox"/> Abandon: change approach and repeat PDSA cycle	

Appendix D-2: PDSA Monthly / Quarterly Progress Report

Event:			
Person Complete Report:		Date:	
Patient Safety Officer		Contact Information:	
Monthly / Quarterly Report			
Items	Description		
1. What is your goal?			
2. Report on the PDSA cycle			
3. What system and practices are working well? Explain.			
4. What areas for improvement did the data identify?			
5. What barriers or system issues have been encountered implementing action activities?			
6. Action plans to address the barriers or system issues			
7. Lesson learned			
8. Support needed			
9. Additional discussion			
Notes:			

Appendix E: Checklist Example: Injuries from Falls and Immobility

Process Change	In Place	Not Done	Will Adopt	Notes (Responsible & By When?)
Conduct fall and injury risk assessment upon admission				
Reassess risk daily and with changes in patient condition				
Implement patient-specific intervention to prevent falls and injury				
Communicate risk across the team; use handoff forms, visual cues, huddles				
Round every 1 to 2 hours for high-risk patients; address needs (e.g., 3Ps: pain, potty, position-pressure). Combine with other tasks(vital signs)				
Individualize interventions. Use non-skid floor mats, hip protectors, individualized toileting schedule; adjust frequency of rounds				
Review medications (by pharmacist); avoid unnecessary hypnotics, sedatives				
Incorporate multidisciplinary input for falls				
Prevention from PT, OT, MD, RN and PharmD				
Include patients, families and caregivers in efforts to prevent falls. Educate regarding fall prevention measures; stay with patient				
Hold post-fall huddles immediately after event; analyze how and why; implement change to prevent other falls				

Reference: Checklists to Improve Patient Safety. June 2013. Health Research & Educational Trust.

Appendix F: Policy Example

[Reference: Hospital Policies. MERCY Hospital. <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>]

	HOSPITAL POLICY AND INFORMATION MANUAL	
<p>PERSONAL PROTECTIVE EQUIPMENT POLICY Page 1 of 2</p>	<p>Date Issued: Date Last Revised: Next Review Date: Approved By:</p>	<p>07/01 08/14 08/17 Policy Committee</p>

Key Words: personal protective equipment, PPE, safety equipment,

Policy Applies to:

- All staff employed by Mercy Hospital;
- Credentialed Specialists, Allied Health Professionals, patients, visitors and contractors will be supported in meeting policy requirements.

Related Standards:

- Infection and Prevention and Control Standards NZS 8134.3:2008
- Health and Safety in Employment Act 1992
- EQulP5 - 1.5.1 and 1.5.2 Infection Control
- EQulP5 - Standard 3.2 Criterion 3.2.1 Health and Safety

Rationale:

Mercy Hospital will provide suitable personal protective equipment (PPE) when the risk to health and safety cannot be eliminated or adequately controlled by other means.

Definitions:

Personal protective equipment (PPE) means all equipment which is intended to be worn or held by a person to protect them from risk to health and safety while at work.

Examples of PPE include: protective footwear, gloves, hard hats/helmets, clothing affording protection from the weather, visibility clothing, eye and face protection.

Objectives:

- To ensure appropriate PPE is identified to minimize hazards not able to be controlled by elimination or isolation;
- To ensure fit for purpose PPE is provided at Mercy Hospital for use by staff;
- To ensure adequate training in the use of PPE is provided;
- To monitor the use of PPE and evaluate effectiveness.

	HOSPITAL POLICY AND INFORMATION MANUAL	
<p>PERSONAL PROTECTIVE EQUIPMENT POLICY Page 2 of 2</p>	<p>Date Issued: Date Last Revised: Next Review Date: Approved By:</p>	<p>07/01 08/14 08/17 Policy Committee</p>

Implementation:

Risk Management

Department Managers, the Occupational Health/ Infection Prevention and Control Nurse (OH/IPC Nurse) and Health and Safety/ Infection Control Representatives (HSIC reps) will in consultation with staff:

Ensure PPE requirements are identified when carrying out risk assessments of activities;

- Regularly review the risk assessment of activities if substances or work processes change;
- Identify the most suitable type of PPE that is required;
- Ensure PPE is available to those who need it;
- Inform staff of the risks involved in their work and why PPE is required;
- Monitor compliance.

Process

Manager’s Responsibilities

Must ensure that:

- PPE requirements are considered when risks are assessed;
- Suitable PPE is provided and made accessible to employees;
- PPE is properly stored, maintained, cleaned repaired and replaced when necessary;
- Adequate information and training is provided to those who require PPE;
- PPE is properly used;
- Use of PPE is monitored and reviewed.

Employee’s Responsibilities All employees must ensure that:

- They use PPE whenever it is required;
- Attend and comply with training, instruction and information;
- Check the condition of their PPE;
- Store, clean and maintain their PPE;
- Report losses, defects or other problems with PPE to their manager.

Evaluation:

- Staff health and safety orientation
- Environmental audits
- Incident reports

Physicians' Surgery Center of Nevada

QUALITY AND PATIENT SAFETY PLAN Template

DATE:12/13/2017
VERSION: 1



This plan was created and revised by the Physicians' Surgery Center of Nevada Patient Safety committee. Implementation of this plan is intended to optimize the healthcare quality and patient safety outcomes, encourage recognition, reporting, and acknowledgment of risks to patient, visitor, and employee safety, as well as reduce the medical/healthcare errors and /or preventable events.

Patient Safety Committee
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775-885-7726

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Commitment to Patient Safety

Physicians' Surgery Center of Nevada is committed to a comprehensive approach to improving healthcare quality and patient safety by aligning with our Mission, Vision, and Values, creating an environment that supports a dynamic, proactive, and safe culture for patients, family members, visitors, and employees, through continuous learning and improving patient safety policies, systems, and processes.

Mission, Vision, and Values

In support of our mission, vision, and values, Physicians' Surgery Center of Nevada Patient Safety and Quality Improvement program promotes:

- Collaboration of healthcare, leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high quality healthcare.
- Communicate honestly and openly to foster trusting and cooperative relationships among healthcare providers, staff members, and patients and their families, to ensure accountability for the patient safety priorities.
- Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.
- Responsibility for every healthcare related decision and action.
- A focus on continuous learning and improving, system design, and the management of choices and changes, bringing the best possible outcomes or performances to the facility.
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare.
- Education of staff and physicians to assure participation of healthcare providers.

Scope and Purpose

The scope of this Quality and Patient Safety Plan is organizational-wide/hospital-wide/agency-wide which includes but is not limited to

- Patient safety
- Visitor safety
- Employee safety

All staff in Physicians' Surgery Center of Nevada are required to fully support and participate in this plan, and devote their expertise to the patient safety and healthcare quality improvement process.

This plan is action oriented and solution focused. The purpose of this plan is to address patient safety related concerns, challenges and revise the program to better serve the patients and their families. To this end, Physicians' Surgery Center of Nevada has developed this Patient Safety plan.

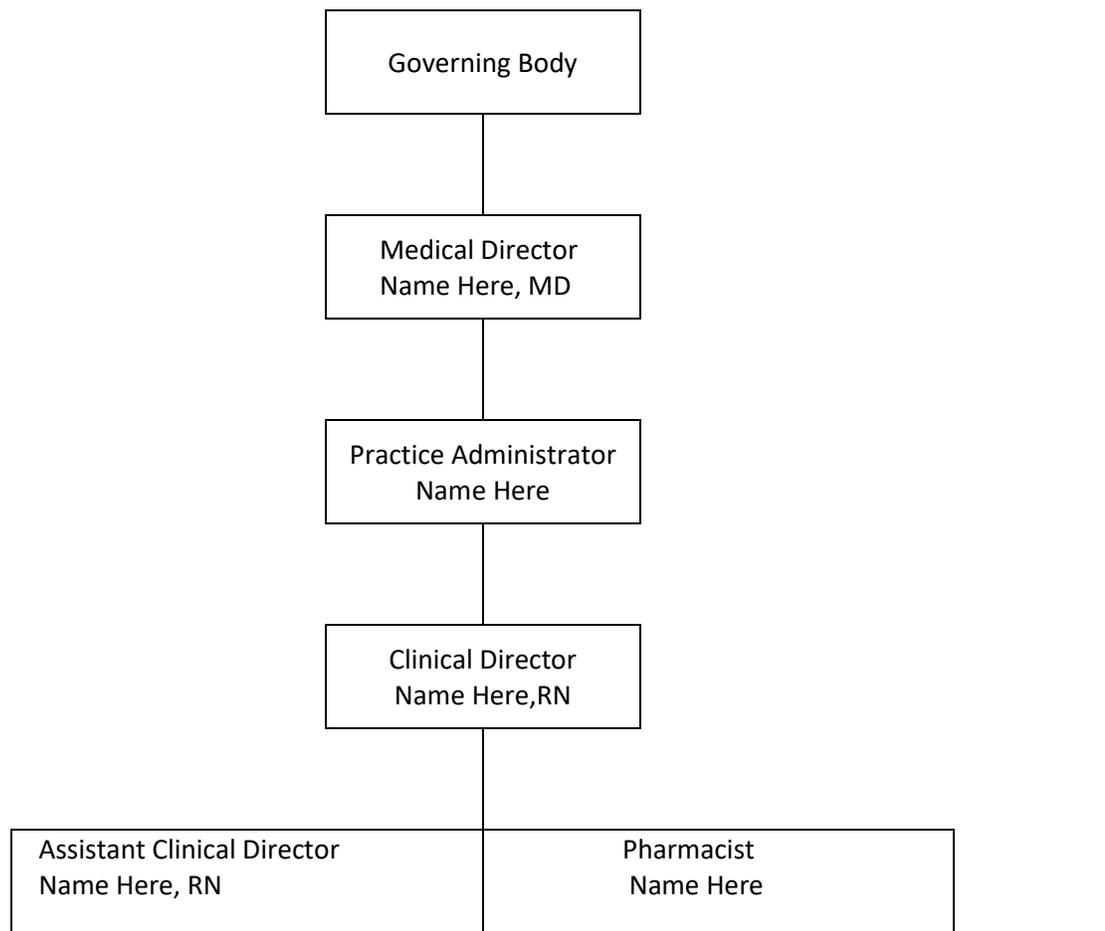
The plan focuses on the process rather than the individual, and recognizes both internal and external customers, as well as facilitates the need of analyzing and improving processes. The core principles of this plan include:

- All staff have the same goal and contribute their knowledge, vision, skill, and insight to improve the process of the Patient Safety Plan.
- Decisions will be based on data and facts, and staff will be encouraged to learn from the experiences.
- Customer based including patients, families, and visitors.
- Promote systems thinking.
- Employ well-trained and competent staff maintaining high healthcare quality.

Roles and Responsibilities

According to [NRS 439.875](#), a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plan is promoted and executed successfully.

The Patient Safety Committee Organization



Roles and Responsibilities

- In accordance with [NRS 439.875](#), a patient safety committee must be comprised of:
- The infection control officer of the medical facility;
- The patient safety officer of the medical facility, if he or she is not designated as the infection control officer;
- At least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility; and
- One member of the executive or governing body of the medical facility.

Based on [NAC 439.920](#), a medical facility that has fewer than 25 employees and contractors must establish a patient safety committee comprised of:

- The patient safety officer of the medical facility;
- At least two providers of healthcare who treat patients at the medical facility, including but without limitation, one member of the medical staff and one member of the nursing staff of the medical facility; and
- The Chief Executive Officer (CEO) or Chief Financial Officer (CFO) of the medical facility.

The roles and responsibilities are defined below (Please modify them as needed.)

Patient Safety Committee Responsibilities (based on [NRS 439.875](#) and [NRS 439.877](#))

- Monitor and document the effectiveness of the patient identification policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the patient safety officer pursuant to [NRS 439.870](#).
- Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred.
- Review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- Review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the executive or governing body of the facility regarding:
 - (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);
 - (2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and

(3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.

- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

Root Cause Analysis (RCA) Team Responsibilities

- Root Cause interviews, analysis, investigation, and corrective action plan implementations.
- Participates in the RCA meetings and discussions.
- Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders.

Patient Safety Officer Responsibilities (based on [NRS 439.870](#))

- Serve on the patient safety committee.
- Supervise the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the patient safety committee regarding any action taken in accordance with the responsibilities above.

Infection Control Officer Responsibilities (based on [NRS 439.873](#))

- Serve on the patient safety committee.
- Monitor the occurrences of infections at the facility to determine the number and severity of infections.
- Report to the patient safety committee concerning the number and severity of infections at the facility.
- Take such action as determines is necessary to prevent and control infections alleged to have occurred at the facility.
- Carry out the provisions of the infection control program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program.

RCA team leader/facilitator Responsibilities

- Organize and coordinate the RCA process.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA, and corrective action plan implementation process.
- Communicate the progress of the investigation, institutional barriers, and finalized action plan to executive leadership.

- Monitor goals and progress towards completion of the Corrective Action Plans.
- Provide training, education and direction to create RCA process that incorporate the Patient Safety and Quality Improvement elements.

Executive or Governing Body Staff Responsibilities

- Provide vision and leadership to Patient Safety and Quality Improvement process, and develop and foster a safe learning and improving culture.
- Provides oversight to the healthcare quality improvement processes and teams.
- Plan, discuss, and generate the organization patient safety goals and activities, in conjunction with the patient safety action plans

The Patient Safety Committee will meet quarterly to accomplish the following:

- Report and discuss sentinel events which include:
 - Number of sentinel events from previous quarter.
 - Number of severe infections that occurred in the facility.
- Corrective Action Plan for the sentinel events and infections
 - Evaluate the corrective action plan.
- Patient safety policies and checklists
 - At least annually evaluate Patient Safety policies and checklists
 - Revise the patient safety policies and checklists as needed.
 - Monitor and document the effectiveness of the patient safety policy.

A RCA meeting will meet as needed to accomplish the following:

- Define the healthcare issues or potential risks.
- Conduct Root Cause Analysis
 - Reviewing and analyzing the data.
 - Reviewing the RCA process and quality improvement related activities and timelines.
 - Brainstorming issues or the potential risks by using the fishbone diagrams.
 - Identify the contributing factors and conduct the Root Cause Analysis.
- Conduct Corrective Action Plan
 - Identifying the Plan-Do-Study-Act (PDSA) topics.
 - Discussing corrective action process and activities.
 - Discussing and presenting possible changes in procedure to improve areas indicated.
 - Identifying strengths and areas that need improvement.
 - Developing strategies, solutions, and steps to take next.
- Identify barriers and technical assistance needs for supporting the RCA efforts.

A meeting agenda and minutes noting follow-up tasks will be kept.

Objectives and Goals of the Quality and Patient Safety Plan

Objective	Goals	Plan	Planned Completion Date	Responsible Party

Components and Methods

Pursuant to [NRS 439.837](#), a medical facility shall, upon reporting a sentinel event pursuant to [NRS 439.835](#), conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event.”

Physicians' Surgery Center of Nevada will use RCA process to determine the contributing factors and the underlying reasons for the deficiencies or failures. The Plan-Do-Study (check)-Act (PDSA or PDCA) is the model, which was developed by the Institute of Health Care Improvement, that we will use to test the changes.



Root Cause Analysis

A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals.

Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

Root cause analysis and action plan framework table, which was introduced by the Joint Commission. It contains 24 analysis questions. It guides the organization to the steps in a root cause analysis. Not all the questions apply to all the events or cases. This table can be used individually or with the fishbone diagram.

5 Whys technique will be used in Physicians' Surgery Center of Nevada to explore the cause and effect relationship underlay a problem. One can find the root causes by asking "why" no less than five times. This technique can be used individually or as a part of the fishbone diagram.

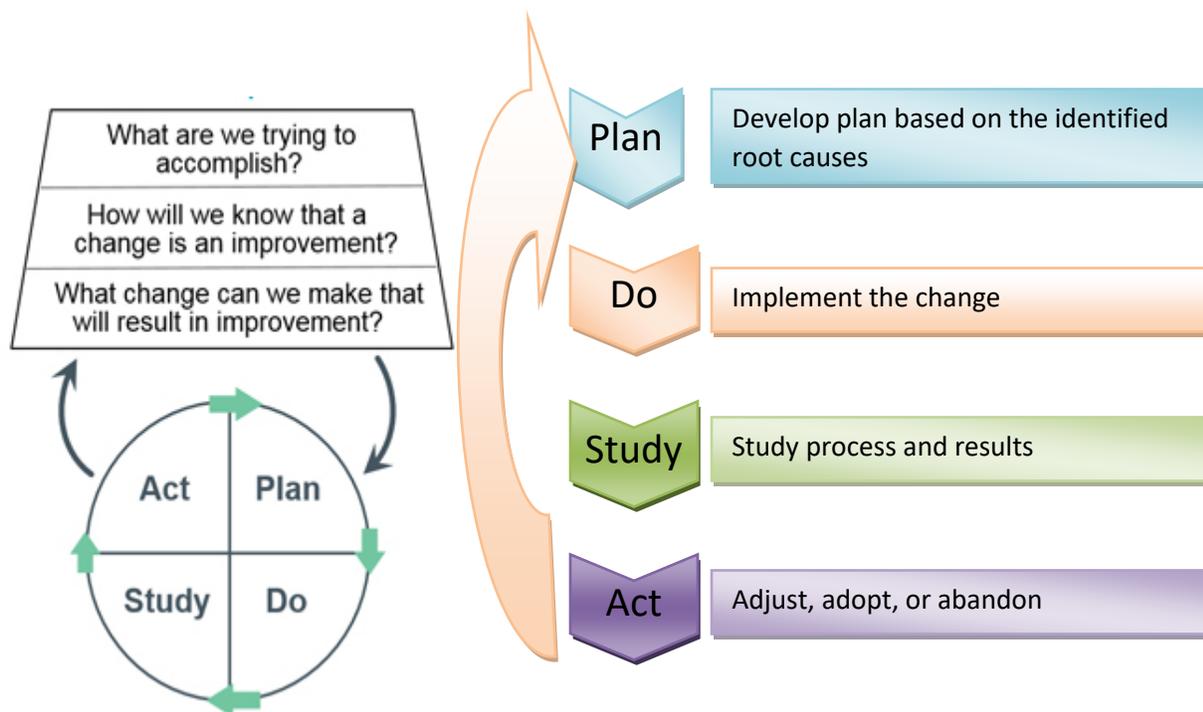
Fishbone Diagram

Once the problems are identified, a Fishbone Diagram (Appendix C) will be used for analyzing the problems. You can use the fishbone diagram individually to analyze the root causes, or use it with the root cause analysis and action plan framework table.

A Fishbone Diagram, also called a Cause-and-Effect diagram, is a useful tool for a team to structurally brainstorm by discovering possible underlying factors or root causes from different major categories for the chosen problems. General categories used include: people, methods, materials, measurements, education, procedures, process, location, environment, etc. RCA team members will brainstorm and ask multiple times, "why did this happen?" for each cause until all ideas are exhausted. The highest priority root causes will be chosen for PDSA topics. Once all the categories are established on the fishbone diagram, 5 Why's technique also can be used to drill down the problem and find the root causes.

Model for Improvement

The Model for Improvement is a collaborative and ongoing effort model to improve the product and services quality and process. It provides multi-disciplinary quality team guidance from identifying the root causes; conducting the best tests to assess possible changes, and working in collaboration for implementation of the new approaches and solutions. It guides the test of a change to determine if the change is an improvement.



The cycle is defined as follows:

- Plan--collect data and establish appropriate goals. Identify the problem and the possible root causes, and answer the following questions.

- What is the objective of the test?
 - What are the steps for the test - who, what, when?
 - How will you measure the impact of the test?
 - What is your plan to collect the data needed?
 - What do you predict will happen?
- Do--make changes designed to correct or improve the situation. Use the following questions for the guidance.
 - What were the results of the test?
 - Was the cycle carried out as designed or planned?
 - What did you observe that was unplanned or expected?
 - Study -- Study the effect of the changes on the situation. Data should be collected on the new process and compared to the baseline or expected results. Results should be evaluated and by using the following questions as guidance.
 - Did the results match your prediction?
 - What did you learn?
 - What do you need to do next?
 - Act--If the result is successful or desirable, standardize the changes and then work on the next prioritized problem or the further improvements. If the outcome is not yet successful, look for different ways to identify the causes or change the testing process.

PDSA worksheet will be used to map the potential change strategies and to establish a course of action. The PDSA worksheet and the PDSA progress report are attached in Appendix D-1.

Data Collection and Reporting

Data should drive any quality and patient safety effort. Physicians' Surgery Center of Nevada is using Redcap for tracking the sentinel events, healthcare infection data, and for internal data collection.

External data sources are those data sources which are collected outside the supervisory structure of the case. External data which will be utilized for Quality and Patient Safety plan include the data from:

- AHRQ: Agency for Healthcare Research & Quality
- CDC: Centers for Disease Control and Prevention
- CMS: Centers for Medicare & Medicaid Services
- NQF: National Quality Forum
- NHSN: National Healthcare Safety Network
- TJC: The Joint Commission



Ongoing Reporting and Review

Data points such as the following will be reviewed according to the schedule prescribed:

Monthly	Quarterly	Annually
1) Sentinel event monthly report 2) Severity of infection report 3) RCA assessment	1) Sentinel event quarterly report 2) Severity of infection report 3) Review and evaluate the measure of improvement of patient safety 4) Review and evaluate the measurement to prevent and control infections	1) Quality and Patient Safety Plan update 2) Checklists and Policies reviewing and revising

Assessment of the Quality and Patient Safety Plan

Please see the Patient Safety Assessment Tool (PSAT) from the VA National Center for Patient Safety for your reference.

Patient Safety Checklists and Patient Safety Policies

By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

The patient safety checklists must follow protocols to improve the health outcomes of patients at the medical facility and must include, without limitation:

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.
- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - Proper instructions concerning prescription medications;
 - Instructions concerning aftercare;
 - Any other instructions concerning his or her care upon discharge; and
 - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include, the name and date of birth of the patient.

- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.
- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

Based on [NRS 439.865](#), the patient safety plan must also include an infection control program that carries out the infection control policy. The policy must consist of:

- The current guidelines appropriate for the facility's scope of service developed by a nationally recognized infection control organization as approved by the State Board of Health which may include, the Association for Professionals in Infection Control and Epidemiology (APIC), the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO) and the Society for Healthcare Epidemiology of America (SHEA); and
- Facility-specific infection control developed under the supervision of a certified Infection Preventionist.

The patient safety checklists are listed in Appendix E. (The following links provide some patient safety checklists for your reference— a checklist example is shown in **Appendix E.**)

http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf

<http://www.who.int/patientsafety/implementation/checklists/en/>

The patient safety policies are listed in Appendix F. (The following link provides you some patient safety policies for your reference—a policy example is shown in **Appendix F.**)

<https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>

Approval of Patient Safety Plan

According to [NRS 439.865](#), a medical facility shall submit its patient safety plan to the governing board of the facility for approval. After a facility's patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan.

The patient safety plan must be reviewed and **updated annually** in accordance with the requirements for approval set forth in this section.

According to [NRS 439.843](#), on or before March 1 of each year, a copy of the most current patient safety plan established to [NRS 439.865](#) must be submitted to the Division of Public and Behavioral Health.

Reference

- Root Cause Analysis Toolkit <http://www.health.state.mn.us/patientsafety/toolkit/>
- Quality and Service Improvement Tools
http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html
- CQI 101 An Introduction to Continuous Quality Improvement:
<https://www.coursehero.com/file/13827355/CQI-Overviewppt/>
- Quality Improvement <http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/>
- Root Cause Analysis <http://www.patientsafety.va.gov/professionals/onthejob/rca.asp>
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2
https://www.jointcommission.org/sentinel_event.aspx
- Hospital Policies <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>
- Checklists to Improve Patient Safety http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf
- Patient Safety Checklists <http://www.who.int/patientsafety/implementation/checklists/en/>
- Minutes of the Meeting of the Quality and Patient Safety Committee
<http://www.cookcountyhhs.org/wp-content/uploads/2013/12/09-23-14-QPS-scan-Minutes.pdf>
- Title 40 – Public Health and Safety <https://www.leg.state.nv.us/NRS/NRS-439.html>

Appendix A: Terms and Definitions

Patient Safety: The Agency for Healthcare Research Quality (AHRQ) defines patient safety as “a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.”
http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

Sentinel event ([NRS 439.830](#))

1. Except as otherwise provided in subsection 2, “sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum.

2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:

(a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or

(b) July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published.

3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.

(Added to NRS by [2002 Special Session, 13](#); A [2005, 599](#); [2013, 217](#))

Institute for Healthcare Improvement (IHI) defines **medical harm** as “unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death.”

Facility-Associated Infection: ([NRS 439.802](#))

“Facility-acquired infection” means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections;
- Ventilator-associated pneumonia;
- Central line-related bloodstream infections;
- Urinary tract infections; and
- Other categories of infections as may be established by the State Board of Health by regulation pursuant to [NRS 439.890](#).

(Added to NRS by [2005, 599](#); A [2009, 553](#))

Medical facility ([NRS 439.805](#))

“Medical facility” means:

- A hospital, as that term is defined in [NRS 449.012](#) and [449.0151](#);
- An obstetric center, as that term is defined in [NRS 449.0151](#) and [449.0155](#);
- A surgical center for ambulatory patients, as that term is defined in [NRS 449.0151](#) and [449.019](#); and
- An independent center for emergency medical care, as that term is defined in [NRS 449.013](#) and [449.0151](#).

(Added to NRS by [2002 Special Session, 13](#))

Near miss: An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Mandatory reporting: Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985;254(6):796-800.)

Risk: Possibility of loss or injury. (Merriam-Webster's Online Dictionary, Risk, Available at <http://www.merriamwebster.com/dictionary/risk>. Last Accessed August 2009.)

Preventable event: Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Catheter Associated Urinary Tract Infection (CAUTI): A urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CURRENT_b.pdf.)

Central Line Associated Bloodstream Infections (CLABSI): Primary bloodstream infections that are associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection.

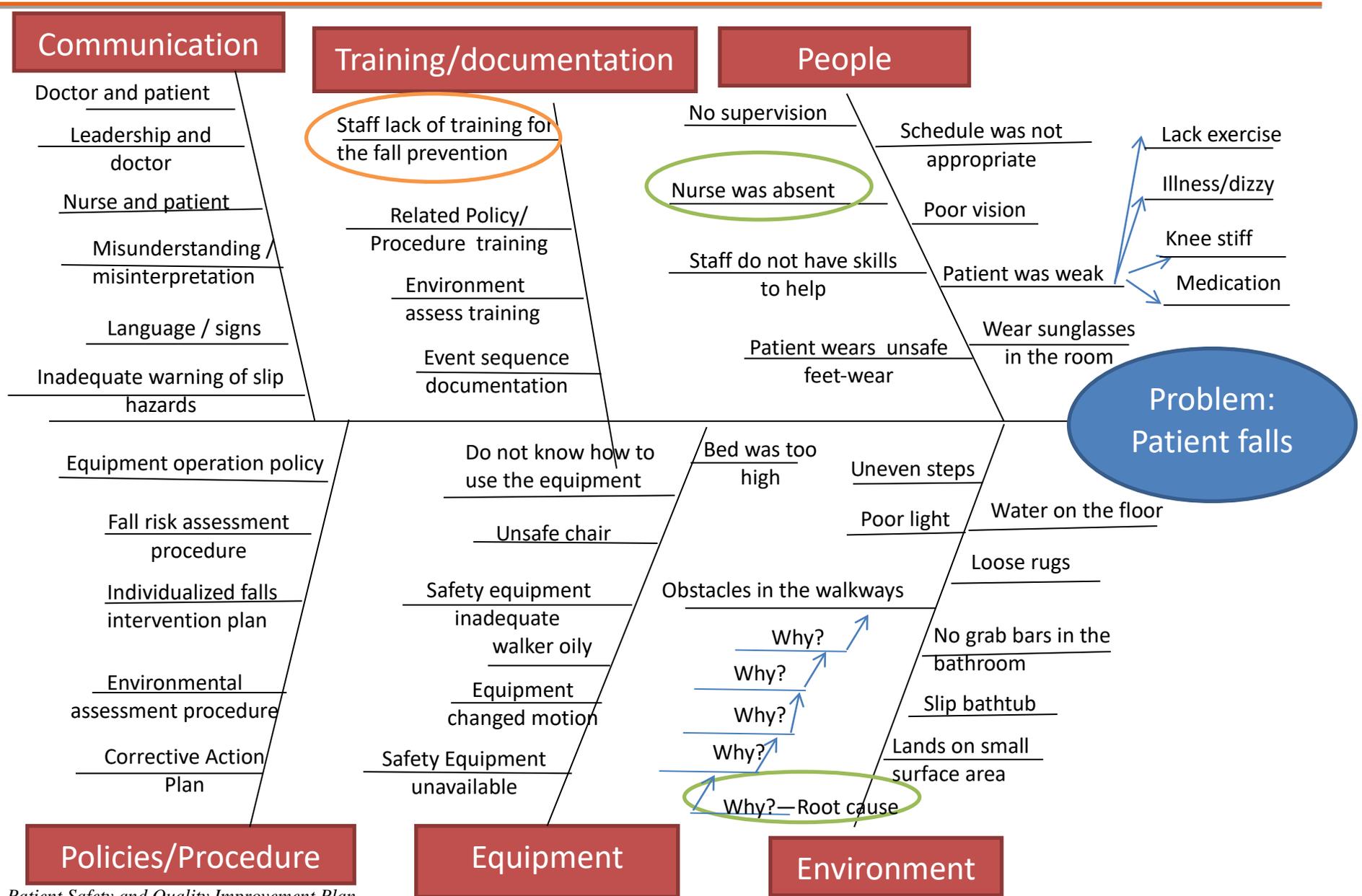
Appendix B: Patient Safety Goals

OBJECTIVE:	GOAL:	Q3 2014	Q4 2014	Q1 2015
ACTION PLAN:				
1. Create Systems that anticipate errors & either prevent or catch them before they cause harm.	a. Enhance retrospective chart review process.			Implement Trigger Tools. Develop automated surveillance reports in Cerner.
	b. Establish an automated surveillance process.		Complete an in-depth analysis of risk point utilizing the methods of FMEA.	
2. Establish Structures for reporting and a process for managing reports in the event reporting system.	a. Implement new electronic Voluntary Reporting System & participate in Patient Safety Organization.	Implemented e-MERS & PSO with UHC.	Create process for reviewing & closing reports in e-MERS.	Increase number of events reported by 10%. Create process for communicating outcome of reported events.
	b. Develop a structure to educate employees system-wide of the process for reporting hazards, errors and adverse events.			
	c. Establish a process for providing feedback regarding reported events.			
3. Develop a Culture of Safety where providers feel safe and supported when they report medical errors or near misses & voice concerns about patient safety.	a. Provide education on patient safety plan that emphasizes importance of blending a systems focus with appropriate individual accountability.		Educate Medical staff, Hospital Wide Oversight & the Quality Committees on the objectives and goals of the patient safety plan.	Re-evaluate culture of safety and develop action plan.
	b. Establish a recognition program that rewards safe practices.		Include patient safety presentation in monthly New Employee Orientation.	
	c. Improve overall perceptions of safety as measured by the Culture of Safety Survey.		Develop 'Great Catch' awards program.	
4. Establish Safety Priorities & Targets.	a. Develop Patient Safety Dashboard that includes national measures and benchmarks.		Present Patient Safety Dashboard monthly to Hospital Wide Oversight Committee.	Establish & implement a plan to improve performance of each leap.
	b. Facilitate the development of action plans associated with measures not meeting benchmarks.	Complete 2014 Leapfrog Safety Survey.		
	c. Assess and improve processes related to hand-off, transition and communication	Develop method to track & report departmental progress and compliance of RCA action plans.		
5. Charter Safety Programs through teams, workgroups or projects.	a. Coordinate Improvement Efforts in order to ensure that capital, people, facilities & technologies are matched to strategic priorities for safe practices.		Establish Patient Safety Council.	Establish workgroups focused on medication safety, reducing patient falls & hospital acquired pressure ulcers. Revise or develop policies, procedures and protocols.
	b. Reduce and eliminate variation in care.			

Reference: Patient Safety Plan and Its Applicable Goals. 2014. Cook County Health and Hospitals System.

Patient Safety and Quality Improvement Plan

Appendix C: Fishbone Diagram



Appendix D-1: PDSA Worksheet

PDSA Worksheet

Topic:			
Person Completing Worksheet:		Date:	
Telephone/ Email:		Cycle:	
Patient Safety Committee Members			
CEOs/CFOs			
Patient Safety Officer			
Infection Control Officer			
Other Medical Staff			
Other team members			
Aim: (Describe the overall SMART goal that your team wishes to achieve.)			
Plan:			
1. List the tasks needed to set up this test of change.			
2. Predict what will happen when the test is carried out.			

3. List the steps to develop the test-who, what, and when.			
Steps	By Whom	By When	Desired Outcome
Do: (Describe what actually happened when you ran your test, including any problems and unexpected findings.)			
Study: (Describe what you learned and did you meet your measurement goal?)			
Did you meet your measurement goal? Explain.		Summarize what was learned: success, failure, unintended consequences, etc.	
Act: (Describe what you concluded from this cycle.)			
Based on what was learned, please indicate what action will be considered.		Describe what modifications to the plan will be made for the next cycle based on what you learned.	
<input type="checkbox"/> Adapt: modify changes and repeat PDSA Cycle			
<input type="checkbox"/> Adopt: expanding changes throughout organization			
<input type="checkbox"/> Abandon: change approach and repeat PDSA cycle			

Appendix D-2: PDSA Quarterly Progress Report

Event:			
Person Complete Report:		Date:	
Patient Safety Officer		Contact Information:	
Monthly / Quarterly Report			
Items	Description		
1. What is your goal?			
2. Report on the PDSA cycle			
3. What system and practices are working well? Explain.			
4. What areas for improvement did the data identify?			
5. What barriers or system issues have been encountered implementing action activities?			
6. Action plans to address the barriers or system issues			
7. Lesson learned			
8. Support needed			
9. Additional discussion			
Notes:			

Appendix E: Checklist Example: Injuries from Falls and Immobility

Process Change	In Place	Not Done	Will Adopt	Notes (Responsible & By When?)
Conduct fall and injury risk assessment upon admission				
Reassess risk daily and with changes in patient condition				
Implement patient-specific intervention to prevent falls and injury				
Communicate risk across the team; use handoff forms, visual cues, huddles				
Round every 1 to 2 hours for high-risk patients; address needs (e.g., 3Ps: pain, potty, position-pressure). Combine with other tasks(vital signs)				
Individualize interventions. Use non-skid floor mats, hip protectors, individualized toileting schedule; adjust frequency of rounds				
Review medications (by pharmacist); avoid unnecessary hypnotics, sedatives				
Incorporate multidisciplinary input for falls				
Prevention from PT, OT, MD, RN and PharmD				
Include patients, families and caregivers in efforts to prevent falls. Educate regarding fall prevention measures; stay with patient				
Hold post-fall huddles immediately after event; analyze how and why; implement change to prevent other falls				

Reference: Checklists to Improve Patient Safety. June 2013. Health Research & Educational Trust.

Appendix F: Policy Example

[Reference: Hospital Policies. MERCY Hospital. <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>]

	HOSPITAL POLICY AND INFORMATION MANUAL	
<p>PERSONAL PROTECTIVE EQUIPMENT POLICY Page 1 of 2</p>	<p>Date Issued: Date Last Revised: Next Review Date: Approved By:</p>	<p>07/01 08/14 08/17 Policy Committee</p>

Key Words: personal protective equipment, PPE, safety equipment,

Policy Applies to:

- All staff employed by Mercy Hospital;
- Credentialed Specialists, Allied Health Professionals, patients, visitors and contractors will be supported in meeting policy requirements.

Related Standards:

- Infection and Prevention and Control Standards NZS 8134.3:2008
- Health and Safety in Employment Act 1992
- EQulP5 - 1.5.1 and 1.5.2 Infection Control
- EQulP5 - Standard 3.2 Criterion 3.2.1 Health and Safety

Rationale:

Mercy Hospital will provide suitable personal protective equipment (PPE) when the risk to health and safety cannot be eliminated or adequately controlled by other means.

Definitions:

Personal protective equipment (PPE) means all equipment which is intended to be worn or held by a person to protect them from risk to health and safety while at work.

Examples of PPE include: protective footwear, gloves, hard hats/helmets, clothing affording protection from the weather, visibility clothing, eye and face protection.

Objectives:

- To ensure appropriate PPE is identified to minimize hazards not able to be controlled by elimination or isolation;
- To ensure fit for purpose PPE is provided at Mercy Hospital for use by staff;
- To ensure adequate training in the use of PPE is provided;
- To monitor the use of PPE and evaluate effectiveness.

	HOSPITAL POLICY AND INFORMATION MANUAL	
PERSONAL PROTECTIVE EQUIPMENT POLICY Page 2 of 2	Date Issued: Date Last Revised: Next Review Date: Approved By:	07/01 08/14 08/17 Policy Committee

Implementation:

Risk Management

Department Managers, the Occupational Health/ Infection Prevention and Control Nurse (OH/IPC Nurse) and Health and Safety/ Infection Control Representatives (HSIC reps) will in consultation with staff:

Ensure PPE requirements are identified when carrying out risk assessments of activities;

- Regularly review the risk assessment of activities if substances or work processes change;
- Identify the most suitable type of PPE that is required;
- Ensure PPE is available to those who need it;
- Inform staff of the risks involved in their work and why PPE is required;
- Monitor compliance.

Process

Manager's Responsibilities

Must ensure that:

- PPE requirements are considered when risks are assessed;
- Suitable PPE is provided and made accessible to employees;
- PPE is properly stored, maintained, cleaned repaired and replaced when necessary;
- Adequate information and training is provided to those who require PPE;
- PPE is properly used;
- Use of PPE is monitored and reviewed.

Employee's Responsibilities All employees must ensure that:

- They use PPE whenever it is required;
- Attend and comply with training, instruction and information;
- Check the condition of their PPE;
- Store, clean and maintain their PPE;
- Report losses, defects or other problems with PPE to their manager.

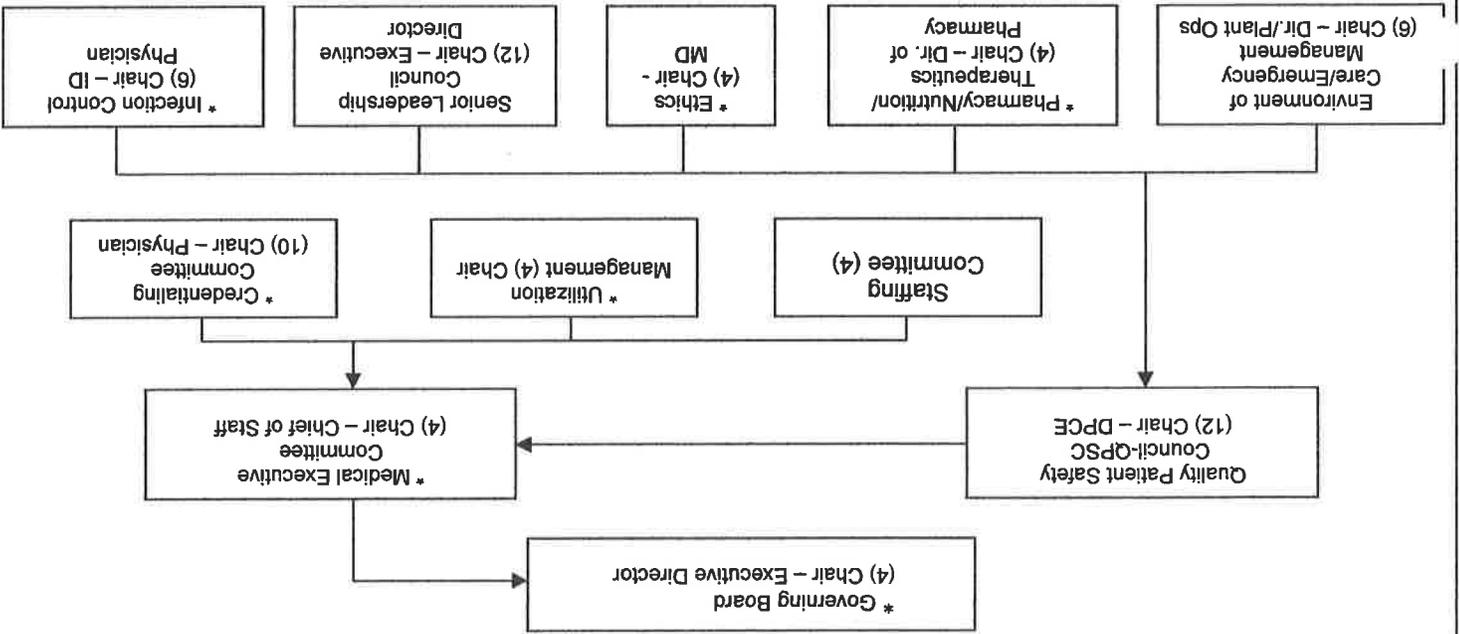
Evaluation:

- Staff health and safety orientation
- Environmental audits
- Incident reports

2018

Horizon Specialty Hospitals
Quality Assurance and
Improvement Plan
Las Vegas and Henderson

**HORIZON SPECIALTY HOSPITAL
COMMITTEE ORGANIZATIONAL
CHART**



*MD on Committee

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PLAN

PURPOSE

The Governing Body, Administration, Medical Staff, and staff of Horizon Specialty Hospitals will demonstrate a consistent endeavor to deliver optimal care to all patients through the establishment of a hospital-wide continuous Quality Assessment and Performance Improvement (QAPI) plan. The organization's leaders will plan and implement a hospital-wide continuous Quality Assessment and Performance Improvement Plan in accordance with our mission, vision, and values as well as applicable laws and regulations. QAPI is incorporated into each aspect of our patient care delivery process. Quality is multidisciplinary and the processes for monitoring, analyzing, and improving quality involve various methodologies. Multiple tools and techniques are used to gather data, analyze information, evaluate solutions, and demonstrate improvement. Organizational functions and processes that most significantly impact patient care and outcomes will be evaluated in accordance with clinically valid criteria, indicators, and standards. Data can be obtained through a variety of sources (Appendix A). Performance measures may include efficacy, appropriateness, availability, timeliness, effectiveness, continuity, safety efficiency, respect, and caring. Continuously monitoring, analyzing, and improving performance of clinical and other processes are the focus of the QAPI Plan.

OBJECTIVES

The objective of the plan is to provide an optimal, uniform level of care through reduction and/or elimination of unnecessary and correctable risks, hazards, and expense within the hospital by:

- Establishing a planned and systematic approach to monitor, analyze, and improve performance to optimize patient outcomes
- Coordinating the integration of all quality improvement activities throughout the organization
- Implementing a system for evaluation of information collected through ongoing monitoring/evaluation and utilization of comparative data sources to identify trends, risks, or opportunities for improvement
- Objectively assessing the cause and scope of identified risks and variations
- Implementing appropriate processes for improvement and sustaining improved performance
- Documenting improved patient care and improved patient outcomes through quality improvement initiatives
- Assuring communication and reporting of quality improvement activities between hospital staff and administration, Medical staff, and the Governing Body

AUTHORITY AND ACCOUNTABILITY

The normal operation and administrative structure of the hospital and its Medical Staff are not altered by this plan.

A. Governing Body

The Governing Body of Horizon Specialty Hospital has the responsibility for the QAPI Plan. The Governing Body has delegated these functions to be carried out by the medical and hospital staff.

B. Medical Staff

The Medical Executive Committee (MEC) has the authority and responsibility to take necessary corrective action based on findings and recommendations of the quality improvement activities. This action could be in the form of, but is not limited to the following:

- a. New or revised policies and procedures
- b. Changes in privileges and assignments
- c. Educational and training programs
- d. Recommendations for equipment or facility changes
- e. Counseling of hospital or Medical staff
- f. Recommending a Performance Improvement Team

C. Quality Patient Safety Council (QPSC) Committee

The QPSC shall have the responsibility for coordinating and integrating the hospitals QAPI Plan and shall be accountable to the MEC of the Medical Staff, Administration, and the Governing Body. The council will monitor all quality improvement activities of the Medical Staff and hospital departments/programs.

D. Administration and Hospital Staff

The Executive Director (ED) has the responsibility for assuring that necessary action is taken in the administrative area based on findings of quality improvement activities.

The department and program directors shall be responsible for the implementation of quality improvement activities within their department/program. The quality department and program directors shall be accountable to the ED for taking necessary corrective action based on findings of the quality improvement activities as related to their area of responsibility.

CONFLICT OF INTEREST

In quality improvement activities which include Medical Staff ongoing Professional Practice Review (OPPE) and Focused Professional Practice Review (FPPPE), no physician shall have primary review responsibility for any case in which he/she is involved. This does not preclude the physician from participating in the case presentation process which facilitates education.

CONFIDENTIALITY

When monitoring, analyzing, and reporting quality improvement data, all reasonable steps shall be taken to ensure the confidentiality rights of patients, physicians, and staff that are affected by the data reviewed. All information related to quality improvement activities performed by the Medical Staff or hospital staff in accordance with this plan is confidential. Some information may be disseminated on a "need to know" basis as required by agencies, such as federal review agencies, regulatory bodies, the National Practitioners Data Bank, or others approved by the MEC, Hospital Administration, and/or the Governing Body. QPSC meeting minutes and reports generated are considered confidential. Official actions pertinent to individual clinical performance are personal and confidential.

QUALITY PATIENT SAFETY COUNCIL (QPSC) COMMITTEE

A. Membership/Organization

The membership of the QPSC Committee will be composed to all hospital departments, both internal and contracted. Meetings will be held on a monthly basis. More frequent meetings may be called at the discretion of the Committee Chairperson.

B. Responsibilities

The QPSC shall coordinate all quality improvement activities, having the responsibility for the following functions:

1. Setting priorities for hospital-wide quality improvement activities designed to provide quality outcomes and improved efficiency. Prioritizations of quality improvement activities is based on the following:

- a. Impact on patient care
- b. Urgency
- c. Information on unanticipated adverse occurrences affecting patients
- d. Potential for resistance to change, manageability and measurability
- e. Special attention will be given to those activities that are determined to involve high volume, high risk, and/or problem-prone aspects of care
- f. Quality improvement priorities will be established annually and specified in Appendix B of this plan

2. Chartering Performance Improvement Teams (PIT) as recommended and reviewing team activities. Proposed action from PIT's will be reviewed by the QPSC Committee for approval.

3. Ensuring that directors, staff, and teams have appropriate education, time, and resources for quality improvement activities.
4. Reviewing all performance improvement reports and data from hospital departments and committees as well as contracted services.
5. Assisting in the development of goals and selecting criteria to be used for ongoing monitoring and quality improvements activities.
6. Assisting in determining methods for review and assessment of identified concerns.
7. Requesting reports of performance improvement activities.
8. Recommending corrective action for identified concerns as appropriate.
9. Determining if further review should be done prospectively, concurrently, or retrospectively.
10. Monitoring corrective action through resolution.
11. Selecting and reviewing performance of comparative indicators and core measures.
12. Reviewing the results Sentinel Event or Near Miss investigations, including any analysis of the adequacy of staffing. Making recommendations based on event and investigation conducted.
13. Forwarding findings to the MEC and Governing Body as appropriate.
14. Performing an annual review of each clinical department's performance improvement indicators.
15. Performing an annual evaluation of the Hospital-wide QAPI Plan.

C. QPSC Committee Chairperson

- The Chairperson is the vital link to ensure communication between the QPSC Committee, the ED, MEC, Governing Board, IP Committee, Environment of Care/Emergency Management and the medical and hospital staff. The chairperson is responsible for the administration of the QAPI and Safety Plan. His/her responsibilities include, but are not limited to:
1. Chairmanship of multidisciplinary QPSC Committee.
 2. Presents final PSC activities and reports to the MEC and Governing Board.

- A. Ongoing monitoring and assessment of important aspects of care, processes, and functions, as well as review of occurrences identified through the medical record screening process and incident reporting. Monitoring will be carried out utilizing objective criteria and indicators that reflect current knowledge and clinical experience. Performance measurement data will be collected on the following as appropriate:
- Performance improvement priorities identified by hospital administration
 - Invasive procedure monitoring
 - Adverse events related to the use of procedural sedation
 - Blood and blood component use, including reported and confirmed transfusion reactions.

REVIEW PROCESS/SCOPE OF ACTIVITIES

Quality assessment and performance improvement shall be complete through:

1. Assuring that all quality improvement activities are documented with a focus on effective communication of conclusions, recommendations, actions, and follow-up evaluation.
2. Keeping the QPSC Committee informed of the results of all ongoing quality improvement activities and initiatives.
3. Assisting departments and services in developing a monitoring and assessment system to evaluate patient outcomes and important processes of the department or service in a continuous manner
4. Facilitation and training of Performance Improvement Teams as needed.
5. Informing ancillary and contracted services of quality improvement activities in process or completed that may be relevant to their respective areas.
6. Storing and retaining all departmental, committee, and team reports presented to the QPSC Committee.
7. Evaluation of the QAPI Plan annually.
8. Requesting follow-up information on concerns from hospital administration and Medical staff members.

D. Director of Patient/Customer Experience (DPCE)

- The Director of Patient/Customer Experience (DPCE) responsibilities include, but are not limited to:
3. Screening of sensitive information that should be referred to the appropriate authority other than the QPSC Committee because of the urgent or privileged nature of the information.
 4. Reviewing medical staff and departmental quality improvement activities with the Senior Leadership Council, MEC, and Governing Board to determine patterns/trends, integration of information and compliance with CMS and The Joint Commission standards.
 5. Providing input to the Credentials Committee as needed.
 6. Participation in identification of multidisciplinary or departmental issues or concerns.

A. **Blood Usage Measurement**- Blood usage measurement shall be conducted on an ongoing basis. Blood usage data is reviewed and analyzed quarterly by the MEC. Clinically valid criteria and indicators will be used in the screening process and in the more intensive evaluation of any identified or suspected concerns in blood usage. Blood usage measurement will include the following:

MEDICAL STAFF AND/OR QUALITY IMPROVEMENT FUNCTIONS

Reports of the Medical Staff department quality improvement activities are reviewed by the MEC, Governing Board, the Executive Director (ED), and the Chief Nursing Officer (CNO). As part of the annual evaluation of the hospital's QAPI Plan, the effectiveness of the quality assessment and improvement activities by the Medical Staff department shall be evaluated.

- B. Periodic analysis of the data collected through ongoing monitoring and assessment including information collected by appointed Medical Staff committees, task forces, and PTT's to identify trends or opportunities for improvement.
- C. Taking action when concerns regarding patient care and clinical performance or opportunities for improvement have been identified.
- D. Evaluation of the effectiveness of action taken.
- E. Documentation of the results of monitoring and assessment activities, including conclusions, recommendations, actions taken, and follow-up and evaluation of the effectiveness of actions taken in the minutes of the departmental or committee meetings.

- The results of resuscitation
- Restraint utilization and safety
- Medication Management, including significant medication errors and adverse drug reactions
- Patient perception of the safety and quality of care, treatment, and services
- Staff perception of hospital safety culture (surveys to be completed no less than every two years)
- Fall reduction and Safety activities
- Effectiveness of response to a change or deterioration of a patient's condition
- Review of Rapid Response Team response
- Organ Procurement conversion rate
- Infection Prevention activities
- Mortality and Morbidity reviews including use of autopsy criteria
- Utilization Management
- Timeliness of reporting critical test results and compliance with all National Patient Safety Goals (NPSG)

- Monitoring the use of whole blood and blood components
 - Evaluation of all reported and confirmed transfusion reactions
 - Development/approval of policies and procedures relating to the distribution, handling, and administration of blood and blood components
 - Measuring, assessing, and improving the ordering, distribution, handling, dispensing, administration, and monitoring of the effects of blood and blood components
 - Review of the adequacy of transfusion services
- B. Credentials Committee-** The Credentials Committee shall meet monthly, but no less than quarterly. This committee shall ensure that each medical staff member is qualified for membership, and shall strive to maintain the optimal level of professional performance of the medical staff through the appointment/reappointment process, the specific delineation of privileges, the approval of physician assistant/nurse practitioner, and physician employees, and the periodic review of each staff member.
- C. Medical Executive Committee (MEC)-** The Medical Staff Executive Committee is delegated the primary authority over activities related to functions of quality assessment and performance improvement of the professional services provided by individuals with clinical privileges. The MEC shall meet quarterly to receive and act upon reports and recommendations from medical staff committees, clinical departments, assigned activity groups, and the QPSC Committee.
- D. Quality Patient Safety Council Committee (QPSC) -** The QPSC shall meet monthly. There shall be representation from the Medical Staff, hospital Administration and all hospital departments, services and programs as well as contracted services. The committee shall adopt, implement, and monitor a comprehensive hospital-wide Quality, Risk, and Safety Program. The committee is responsible for the oversight of the Patient Safety Program and to evaluate effectiveness and recommend changes in equipment, policies & procedures, and processes as appropriate for the safe, effective delivery of care. The committee shall oversee the Patient Complaint and Grievance process and all adverse occurrences.
- In addition, the QPSC shall review and evaluate The Joint Commission Sentinel Event Alerts and National Patient Safety Goals as they are published, make recommendations regarding further action and determine which areas within the hospital shall be involved with review/evaluation of each alert/goal and implementation of risk reduction strategies to ensure compliance.
- E. Infection Prevention Committee-** The Infection Prevention committee shall meet bi-monthly to review and evaluate the hospital-wide infection control activities. The committee shall have representation from the Medical Staff, Hospital Administration, the person directly responsible for management of infection surveillance, prevention

- Based on clinical experience, it is known or suspected that the drug causes adverse reactions or interacts with another drug(s) in a manner that represents significant health risk
 - Following reasons:
 - G. **Pharmacy, Nutrition, and Therapeutics Committee (PNT)**- The PNT Committee shall meet quarterly and oversee the measurement, assessment, and improvement of the selection, ordering and transcribing, preparing and dispensing, administering, and monitoring of medications. Drugs may be selected for evaluation for one or more of the following reasons:
 - F. **Environment of Care/Emergency Management Committee**- The committee shall meet at least quarterly. Committee representation shall include Hospital Administration, the person directly responsible for all aspects of plant operations and emergency management, clinical leader, Human Resource Director, and Central Supply Manager. The committee shall adopt, implement, and monitor requirements related to safety, security, hazardous materials, emergency management, life safety, medical equipment, and utility systems of the hospital, which shall be designed to produce safe characteristics and practices, and to eliminate or reduce, to the extent possible, hazards to patients, hospital staff, and visitors.
 - G. **Pharmacy, Nutrition, and Therapeutics Committee (PNT)**- The PNT Committee shall meet quarterly and oversee the measurement, assessment, and improvement of the selection, ordering and transcribing, preparing and dispensing, administering, and monitoring of medications. Drugs may be selected for evaluation for one or more of the following reasons:
 - F. **Environment of Care/Emergency Management Committee**- The committee shall meet at least quarterly. Committee representation shall include Hospital Administration, the person directly responsible for all aspects of plant operations and emergency management, clinical leader, Human Resource Director, and Central Supply Manager. The committee shall adopt, implement, and monitor requirements related to safety, security, hazardous materials, emergency management, life safety, medical equipment, and utility systems of the hospital, which shall be designed to produce safe characteristics and practices, and to eliminate or reduce, to the extent possible, hazards to patients, hospital staff, and visitors.
 - Current literature and/or new recommendations from the Centers for Disease Control, OSHA, APIC and other agencies as indicated.
 - Procedures and practices of new services instituted and any problems identified
 - Prevalence and incidence studies
 - above the usual baseline infection rates
 - Unusual epidemics, clusters of infections, unusual pathogens, and occurrences of antimicrobial susceptibility/resistance trend studies
 - Annual program evaluation of risk assessments and outcomes using the results of antimicrobial susceptibility/resistance trend studies
 - hospital.
 - proposals for special infection control studies conducted throughout the hospital.
 - Special collection of surveillance data directed by the committee such as employee infection surveillance and environmental sampling. This includes other proposals for special infection control studies conducted throughout the hospital.
 - Annual program evaluation of risk assessments and outcomes using the results of antimicrobial susceptibility/resistance trend studies
 - Unusual epidemics, clusters of infections, unusual pathogens, and occurrences above the usual baseline infection rates
 - Prevalence and incidence studies
 - Procedures and practices of new services instituted and any problems identified
 - Current literature and/or new recommendations from the Centers for Disease Control, OSHA, APIC and other agencies as indicated.
- The surveillance activities and system are selected by reviewing:
targeted surveillance, problem-oriented surveillance, or a combination of these systems. the detection of nosocomial infection will be selected from total house surveillance, approve the type and scope of surveillance activities. The type of surveillance system for hospital from the community. The committee will evaluate, revise as indicated, and prevent, identify, and control infections acquired in the hospital or brought into the function will include the use of pre-established criteria and will be performed to and control program, and, as appropriate, other department and services. The review

The quality and appropriateness of patient care will be monitored and evaluated in all important aspects of care, key processes, and important functions of clinical departments and support services. This review may include the following dimensions of performance:

HOSPITAL AND/OR CONTRACTED SERVICES

Results of quality improvement activities are considered when evaluating each physician at the time of reappointment. As part of the annual evaluation of the hospital's QAPI Plan, the effectiveness of quality assessment and performance improvement activities by medical staff committees shall be evaluated.

Documentation of the results of monitoring and evaluation activities shall be included in the minutes of the committee meetings. The minutes will reflect all conclusions, recommendations, follow-up, and actions taken. All concerns and review activities are presented to the MEC and Governing Board.

H. **Utilization Management (UM) Committee**- The UM Committee shall meet quarterly to address over-utilization, under-utilization, and inefficient scheduling of resources for federal (QIO) and non-federal patients. This shall be accomplished through screening of admissions, evaluation of ancillary services as to inappropriate utilization, evaluation of "avoidable days", and evaluation of the results of discharge planning.

Department-specific information is forwarded to the appropriate medical staff department for review and follow-up.

- The drug is used in the treatment of patients who may be at high risk for adverse drug reactions because of age, disability, or unique, metabolic characteristics
- The drug has unusual toxicity or potential for causing serious complications from their pharmacologic effects if not prescribed correctly
- The drug has been designated, through the hospital's Antibiotic Stewardship Program or other continuous quality improvement activities for monitoring and evaluation
- The drug is one of the most frequently prescribed drugs; and/or The drug has greater cost than other drugs of comparable pharmacologic effect
- Monitor medication errors and adverse drug reaction and take appropriate follow-up actions
- Develop and approve policies and procedures related to the selection and procurement, storage, ordering and transcribing, preparing and dispensing, administering and monitoring of medications
- Develop and maintain a drug formulary or drug list

Performance Improvement Teams and/or Task Forces are comprised of individuals from cross-functional groups. Teams are chartered to improve systems and operational processes involved

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT TEAMS & TASK FORCES

and/or contracted services shall be evaluated. the hospital's QAPI Plan, the effectiveness of the quality improvement activities by clinical the office of the Director of Patient/Customer Experience. As part of the annual evaluation of evaluation activities of the medical staff. All evaluation activities will be coordinated through Where possible, clinical and/or support services evaluation activities will be integrated with the effectiveness of actions taken shall be documented and submitted to the QPSC Committee. Results of the quality improvement activities including evaluation, actions taken, and the QPSC on a quarterly basis. Laboratory, Diagnostic Imaging, Dialysis, and Rehabilitation quality data will be reported to the issues/concerns impacting system processes and functions which affect patient care and safety; Each department/service is also responsible for identifying and participating in the analysis

- **Nursing Services- Chief Nursing Officer**
- **Respiratory Care Services- Director of Ancillary Services**
- **Dietary Services- Registered Dietician via PNT Committee**
- **Wound Care Services- Wound Care Services Registered Nurse**
- **ABG Laboratory Services- Director of Ancillary Services**
- **Pharmacy Services- Director of Pharmacy via the PNT Committee**
- **Patient & Family Services- Chief Nursing Officer**

responsible individual listed: Each department/service is responsible for establishing specific quality improvement indicators or projects which are reflective of the hospital-wide plan and prioritizes aspects of care to be studied. The indicator results will be presented to the QPSC at least quarterly by the

documentation of quality improvement activities) will be used. The same process as outlined for the medical staff and clinical departments (ongoing monitoring, periodic evaluation, the use of objective criteria, establishing thresholds, taking action for identified concerns, evaluation of the effectiveness of actions taken, and

- **Efficacy**
- **Appropriateness**
- **Availability**
- **Timeliness**
- **Effectiveness**
- **Continuity**
- **Safety**
- **Efficiency**
- **Respect and caring**

**RISK MANAGMENT PLAN MATRIX
2017**

Identified Loss/Risk Exposure <small>Is this a risk/loss exposure for the facility? Who does it most immediately impact? State as a problem. At what point is there a risk? What is the reason for monitoring?</small>	Severity Assessment <small>1-Insignificant 2-Minor 3-Moderate 4-Major 5-Catastrophic</small>	Likelihood Assessment <small>1-Rare 2-Unlikely 3-Moderate 4-Likely 5-Almost Certain</small>	Loss Exposure Analysis Score <small>Loss/Risk Exposure Range: 1 to 10 Low to High</small>	Preparedness Assessment <small>1-Well-prepared 2-Adequately Prepared 3-Moderately Prepared 4-Poorly Prepared 5-Unprepared</small>	Action Steps to reduce/eliminate the loss/risk exposure	Person (s) Responsible	Targeted Completion Date	Actual Completion Date	Annual Plan Review Date(s)	Person Responsible to Monitor	
A Contractual Liability-Decrease in Service Capacity/Providers											
A1	Facility Fails at Cost Containment w/ affiliation agreements & capacity.	3	3	8	2	a.) Strategic plan development	CEO	01/01/2017	01/01/2017	Quarterly	CEO
A2	Facility fails to check clinicians' licenses to make sure that none have been revoked, suspended or expired.	4	2	10	2	a.) Monthly internal audits of personnel files. b.) Company licensure's checked for expiration dates.	Human Resources	Ongoing	Quarterly 2016	Monthly amd Annually	Human Resources
A3	Decrease in Census	4	3	8	2	a.) Admission/Discharge data b.) The ADC will be monitored and addressed.	CEO	Ongoing	Daily	Q1 - 2017 Annual Strategic Plan, Budget and Quarterly Operational Reports to the GB	CEO
A4	Facility background checks on employees	4	1	7	1	a.) Policies- internal audits b.) Employee orientation	Human Resources	Ongoing	N/A	At hire and every 5 years thereafter	Human Resources
A5	Facility fails to check staff needing certifications (CPR/First Aid, etc.) and all other Staff Required training	3	3	4	3	a.) Audit process to check expiration. b.) Provider needs to make required trainings accessible	Human Resources	Ongoing	Ongoing	Q1 - 2017 Annual Review and Revisions to the Staff Development Plan	Human Resources
A6	Facility fails to seek new contracts	4	2	10	2	a.) Attending community meetings/board meetings. b.) Marketing c.) Submitting proposals	CEO	Ongoing	Ongoing	Q1 - 2017 Annual Strategic Plan, Budget and Quarterly Operational Reports to the GB	CEO

**RISK MANAGEMENT PLAN MATRIX
2017**

Identified Loss/Risk Exposure Is this a risk/loss exposure for the facility? Who does it most immediately impact? State as a problem. At what point is there a risk? What is the reason for monitoring?	Severity Assessment 1-Insignificant 2-Minor 3-Moderate 4-Major 5-Catastrophic	Likelihood Assessment 1-Rare 2-Unlikely 3-Moderate 4-Likely 5-Almost Certain	Loss Exposure Analysis Score Loss/Risk Exposure Range: 1 to 10 Low to High	Preparedness Assessment 1-Well-prepared 2-Adequately Prepared 3-Moderately Prepared 4-Poorly Prepared 5-Unprepared	Action Steps to reduce/eliminate the loss/risk exposure	Person (s) Responsible	Targeted Completion Date	Actual Completion Date	Annual Plan Review Date(s)	Person Responsible to Monitor	
B Degregation in Care/Harm to Patients											
B1	Confidentiality breaches (HIPAA w/ contract agencies notes, cl. info) Develop HIPAA process/training, printer, inter-office, hallways, phones)	4	2	10	2	a.) Inform staff of HIPAA Process. b.) Review Confidentiality Policy w/ staff and contractual agencies.	Clinical Director, Human Resources, CEO	Ongoing	Ongoing per plan	Q1 - 2017 Annual Review and Revisions to the Staff Development Plan	Clinical Director Human Resources CEO
B2	Professional boundaries	4	2	7	2	a.) Review and Update the Code of Ethics Policy (as needed) and review with staff. b.) Discussions and monitoring of boundaries with peers. c.) Grievance Policy is in place. d.) Staff Satisfaction Surveys e.) EIPs and Additional Staff Trainings	Clinical Director, Human Resources, CEO	Ongoing	Ongoing	Q1 - 2017 Annual Policy and Procedure Review	Human Resources
C Loss of Funding/Financial Loss											
C1	Changes in funding streams/ contracts	4	3	10	3	a) Develop a reduction in force plan. b) Seek alternative funding opportunities. c) Ensure infrastructure stays intact so organization continues to meet existing objectives.	CEO	Ongoing	Ongoing	Q1- 2017 Annual Strategic Plan, Budget and Quarterly Operational Reports to the GB	CEO
D Facility Liability											
D1	Effective Corporate Compliance	3	2	6	2	a.) Staff training. Report corporate compliance issues to Governing Board b.)	Human Resources	Ongoing	Ongoing	Q1 - 2017 Annual Staff Development Plan Review and Quaterly Reporting to GB	Human Resources
D2	Insurance coverage adequate	4	1	10	2	a.) Review annually for policy changes and coverage amounts.	CEO	Annually	Q2 2016	Q4 Annually via AAC	CEO

**RISK MANAGEMENT PLAN MATRIX
2017**

Identified Loss/Risk Exposure <small>Is this a risk/loss exposure for the facility? Who does it most immediately impact? State as a problem. At what point is there a risk? What is the reason for monitoring?</small>	Severity Assessment <small>1-Insignificant 2-Minor 3-Moderate 4-Major 5-Catastrophic</small>	Likelihood Assessment <small>1-Rare 2-Unlikely 3-Moderate 4-Likely 5-Almost Certain</small>	Loss Exposure Analysis Score <small>Loss/Risk Exposure Range: 1 to 10 Low to High</small>	Preparedness Assessment <small>1-Well-prepared 2-Adequately Prepared 3-Moderately Prepared 4-Poorly Prepared 5-Unprepared</small>	Action Steps to reduce/eliminate the loss/risk exposure	Person (s) Responsible	Targeted Completion Date	Actual Completion Date	Annual Plan Review Date(s)	Person Responsible to Monitor
D3 Property loss due to fire, natural disasters, or accidents	4	2	7	1	a.) Property contents insurance, general liability insurance b.) AAC keeps backed up data on off site server c.) Server is backed up daily	IT Department, CEO	Ongoing	Ongoing	Q1- 2017 Technical Services Plan Review	Human Resources
E Employee Liability										
E1 Personal safety	2	2	5	1	a.) Safety in the Workplace Staff Development. b.) CPR and First Aid Training. c.) Safety drills held. d.) Notification to staff and patients via telephone e.) Review and revise Health and Safety policies. f.) Recertify fire extinguishers.	Human Resources, CEO	Ongoing	Ongoing	Q1 - 2017 Annual Policy and Procedure Review Annual Staff Development Plan Review	Human Resources
E2 Retention/Turnover Issues: a.) Burnout/Stress b.) Communication Issues (Complaints and Problems Not Resolved)	2	2	5	1	a.) Burnout/Stress: Supervision. b.) Communication Issues: Address through Strategic Planning/Organizational meetings. b1.) Staff Meetings. b2.) Communication Policy Revision and Staff Awareness. b3.) Staff Review Policy and Procedures annually. b4.) Educate staff on the use of EMR	Human Resources, CEO, Clinical Director	Ongoing	Ongoing	Q1 - 2017 Annual Staff Development Plan Review Annual Employee Satisfaction Surveys (Q2-2016)	Human Resources, Clinical Director, CEO

**RISK MANAGEMENT PLAN MATRIX
2017**

Identified Loss/Risk Exposure <small>Is this a risk/loss exposure for the facility? Who does it most immediately impact? State as a problem. At what point is there a risk? What is the reason for monitoring?</small>	Severity Assessment <small>1-Insignificant 2-Minor 3-Moderate 4-Major 5-Catastrophic</small>	Likelihood Assessment <small>1-Rare 2-Unlikely 3-Moderate 4-Likely 5-Almost Certain</small>	Loss Exposure Analysis Score <small>Loss/Risk Exposure Range: 1 to 10 Low to High</small>	Preparedness Assessment <small>1-Well-prepared 2-Adequately Prepared 3-Moderately Prepared 4-Poorly Prepared 5-Unprepared</small>	Action Steps to reduce/eliminate the loss/risk exposure	Person (s) Responsible	Targeted Completion Date	Actual Completion Date	Annual Plan Review Date(s)	Person Responsible to Monitor	
F Professional Liability											
F1	False innuendoes and accusations	3	2	10	1	a.) Code of Ethics Policy.	Clinical Director Director of Human Resources	Ongoing	Ongoing	Q2- 2016 Annual Policy and Procedure Review	Clinical Director Director of Human Resources
G Property Loss or Damage											
G1	Claims of breach of confidentiality	4	2	10	2	a.) Staff trained on confidentiality issues related to HIPAA and State law. b.) Policies in place. c.) Liability insurance coverage purchased.	CEO Director of Human Resources	Ongoing	Ongoing	Q1 - 2017 Annual Review and Revisions to the Staff Development Plan	CEO Director of Human Resources
G2	Claims of discrimination in hiring/employment practices	4	3	10	1	a.) Ongoing training regarding employment practices. b.) CEO consults with Director of Administrative Services on employment practices.	CEO Director of Human Resources	Ongoing	Ongoing	Q1 - 2017 Annual Review of HR Policies	CEO Director of Human Resources
G3	Theft by employee	3	2	5	2	Safeguards in place regarding: a.) Who can write checks & who can sign checks. b.) Procedures for handling of cash receipts for copays. c.) Handling of petty cash. d.) Strengthen Equipment Inventory Process	CEO	Ongoing	Ongoing	Q1 - 2017 Annual Review of Policies and Procedures	CEO
G4	Claims of employee hurt on the job	3	2	5	2	a.) Workman's Compensation insurance purchased to cover claims. b.) Policies in place regarding incident reporting and safety in the workplace.	CEO Director of Human Resources	Annually	Q2 2016	Q1 - 2017 Annual Review of Policies and Procedures	CEO Director of Human Resources
G5	Claims of abuse of co-workers or patients by employees	3	2	10	2	a.) Safety in the workplace training provided. b.) Training regarding avoidance of potential situations that could result in claims of abuse. c.) Professional Liability insurance	CEO Director of Human Resources	Ongoing	Q2 2016	Q1 - 2017 Annual Review of Policies and Procedures	CEO Director of Human Resources
H Business Interruption											

**RISK MANAGMENT PLAN MATRIX
2017**

Identified Loss/Risk Exposure <small>Is this a risk/loss exposure for the facility? Who does it most immediately impact? State as a problem. At what point is there a risk? What is the reason for monitoring?</small>	Severity Assessment <small>1-Insignificant 2-Minor 3-Moderate 4-Major 5-Catastrophic</small>	Likelihood Assessment <small>1-Rare 2-Unlikely 3-Moderate 4-Likely 5-Almost Certain</small>	Loss Exposure Analysis Score <small>Loss/Risk Exposure Range: 1 to 10 Low to High</small>	Preparedness Assessment <small>1-Well-prepared 2-Adequately Prepared 3-Moderately Prepared 4-Poorly Prepared 5-Unprepared</small>	Action Steps to reduce/eliminate the loss/risk exposure	Person (s) Responsible	Targeted Completion Date	Actual Completion Date	Annual Plan Review Date(s)	Person Responsible to Monitor	
H1	Keep organization electronically viable	4	3	8	4	a.) Update computer system as needed. b.) Update and maintain electronic medical records	CEO and Director of Nursing	Ongoing	Onoging	As needed	CEO
H2	Develop Strategic Plan approved by Governing Board	4	3	8	3	a.) Develop Written Strategic Plan, inform staff, and approve by Governing Board.	CEO	01/08/2016	Q1 - 2017	Quarterly	CEO
I Loss of Loss Accreditation/Licensure											
I1	Maintain up to date policies and procedures	4	2	10	1	a.) Review and update plans annually	CEO and Director of Human Resources	Ongoing	Onoging	Q1 - 2017 Policy and Procedures and Plans Review	Director of Human Resources
I2	Maintain up to date standards and applicable state law requirements	4	3	10	3	a.) Order JCAHO standards manual when notified of changes in standards b.) Print up to date state law requirements when notified of changes in state laws	CEO and Director of Human Resources	Ongoing	Onoging	As needed	Director of Human Resources

Approved by CEO on _____

Approved by the Governing Board on _____

Reviewed Annually	
CEO	_____
	Date
Governing Board	_____
	Date

<h1>MICOE</h1>	MINIMALLY INVASIVE CENTER OF EXCELLENCE		
	ORIGINAL DATE: January 2013	REVISED DATE: 8/14/17	PAGE NUMBER: 1 of 2
	SUBJECT: SAFETY PROGRAM		NURSE MANAGER: MEDICAL DIRECTOR: Dr. Name Here
POLICY NUMBER: 7.60			

POLICY:

The surgery center maintains a safety program to address the centers environment of care, safety of patients, staff, and others. The safety program is directly linked to the Quality Assurance Performance Improvement Program. The Governing Body has approved the Safety Program.

PROCEDURE:

- A. The safety program processes for the management of identified hazards, potential threats, near misses, and other safety concerns like
 - 1. Adverse Incidents
 - 2. Incidents/Injuries
 - 3. Medication Errors
 - 4. Recalls
 - 5. Fall Prevention
 - 6. Fire Safety/Prevention (see chapter 8 policies for specifics)
- B. Referenced items have their own individualized policies in the policy and procedure manual.
- C. The safety program is supervised by the Quality Assurance Performance Improvement Committee. The DON is designated as the Safety Officer.
- D. The Safety Officer and Administrator will provide education. Staff in-servicing and/or drills are conducted at the center. In-services/drills provide education and training on safety issues to all staff, such as:
 - 1. Disaster and Emergency Drills and/or Fire Prevention/Safety
 - 2. Universal Precautions
 - 3. Sharps Prevention

The center also provides code drills such as:

- 1. Malignant Hyperthermia
- 2. CPR

- E. At time of employment personnel is oriented, provided training and competency (s).
- F. Unique patient identifiers are consistently used throughout care.
- G. Center has policies for anesthesia support, and post-procedural care.
- H. Center has a written emergency and disaster preparedness plan and documentation of requesting to participate on a community level.
- I. Environmental hazards associated with safety are identified and safe practices are established.
- J. Measures are implemented to prevent skin and tissue from injury from chemicals, cleaning solutions, and other hazardous exposure.
- K. Patients are educated about prescribed medical devices and associated protocols and guidelines.
- L. Methods for ensuring food and drink for patient use is stored, served, and disposed of properly
- M. A process to assess and reduce risks associated with physical hazards.
- N. Products including medications and solutions that carry an expiration date are monitored. The center has policies for disposal of expired medications and supplies in accordance with local, state, and federal guidelines.
- O. The center will designate the DON or surgeon if applicable to provide appropriate education to intended operators of newly acquired devices or products to be used in the care of patients. At MINIMALLY INVASIVE CENTER OF EXCELLENCE the Director of Nursing is designated the Safety Program Officer.

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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
- Near Miss - any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome.
- Hospital Acquired Conditions (HACs):
 - a. Falls and trauma (fracture, dislocation, intracranial injury, crushing injury, burn, other injuries)
- The scope of the Patient Safety Plan encompasses the patient population, visitors, volunteers and staff (including medical staff). The plan addresses maintenance and improvement in patient safety issues in every department throughout the facility. There will be an emphasis on important hospital and patient care functions of:
 - Environment of Care
 - Emergency Management
 - Human Resources
 - Infection Prevention and Control
 - Information Management
 - Leadership
 - Life Safety
 - Medication Management

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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 as appropriate to organizational policy and procedure.

- Report the process/system failure or medical/health care error to the staff member's immediate supervisor.
- Submit the occurrence report to the Performance Improvement Department per organizational policy.
- Any individual in any department identifying a process/system failure and/or potential patient safety issue will immediately notify his/her supervisor and document the findings on an incident report. The report will be submitted to the Director PI/Risk Management per organizational policy.
- Staff response to process/system failures and/or medical/health care errors is dependent upon the type of error identified:
 - No Harm Failures or Errors (including "no harm" medication errors) - staff will document appropriately in the medical record according to organizational policy, document the circumstances regarding the no harm error on an occurrence report form, submit the form to the Performance Improvement Department and notify their immediate supervisor.
 - Mild-Moderate Adverse Outcome Failures or Errors (including medication errors/variances) - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then preserve any physical evidence as appropriate, notify his/her immediate supervisor, document facts appropriately in the medical record and on an occurrence report - submitting the report to the PI/Risk Management Department per organizational policy.
 - Medication Variances/errors - the staff member identifying a medication variance/error (no harm and mild-moderate harm) will notify the Pharmacy Department of the event.
 - Adverse Drug Reaction (ADR) - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders.

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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.

- Hazardous Condition/Patient Safety Issue - as appropriate, and if possible, staff will contain the hazardous condition or patient safety issue. Staff identifying a hazardous condition or potential patient safety issue will immediately notify his/her supervisor and document the findings on an incident report. The report will be submitted to the PI/Risk Management Department per organizational policy.
- Sentinel Event - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then follow the organizational Sentinel Event Policy and Procedure.
- Near Miss - staff will report the near miss event to his/her immediate supervisor, describe the facts of the near miss on an incident report and submit the report to the PI/Risk Department.
- Hospital Acquired Conditions - staff will follow all established protocols, guidelines and policies and procedures. Staff shall complete incident reports for any breaks in technique or policy not followed.

Established organizational policy (such as the Sentinel Event Policy) and/or the Safety/Environment of Care Committee will determine the organizational response to process/system failures and/or medical/health care errors and occurrences. All sentinel events and near miss occurrences will have a root cause analysis conducted. The determination of the Safety/Environment of Care Committee members, based on internal and external data analysis and prioritizing of patient safety criticality, will determine:

- Further remedial action activities necessary for identified occurrences
- Proactive occurrence reduction activities
- Necessity and benefit of root cause analysis performance for identified occurrences or proactive reduction activities

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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 required to report suspected and identified medical/health care errors, and should do so without the fear of reprisal in relationship to their employment. This organization supports the concept that errors occur due to a breakdown in systems and processes, and will focus on improving systems and processes, rather than disciplining those responsible for errors and occurrences. A focus will be placed on remedial actions to assist rather than punish staff members, with the Safety/Environment of Care Committee and the individual staff member's department supervisor determining the appropriate course of action to prevent error recurrence.
- Sentinel Events - staff members involved in a sentinel event occurrence will receive support from the Safety/Environment of Care Committee regarding the staff member's professional and emotional reconciliation of the sentinel event. The Safety/Environment of Care Committee encourages the staff member's involvement in the root cause analysis and action plan processes, to allow the staff member an active role in process resolution. Additionally, any staff member involved in a sentinel event or other medical/health care error may request and receive supportive personal counseling from the Social Service Department, Human Resources Department and/or his/her department supervisor.

As part of this organization's culture of safety and quality, any staff member who has concerns about the safety or quality of care provided by the organization may report these concerns to their accrediting organization. The organization supports the staff member's right to report these concerns and will take no disciplinary or retaliatory action against the staff member for reporting the safety or quality of care concern to their accrediting organization.

- On at least an annual basis, staff will be queried regarding their willingness to report medical/health care errors.
- The Patient Safety Plan includes implementation of the recommendations set forth by the accrediting organization, or identified alternative recommendations defined by this institution, to achieve compliance with established safety standards. The selected recommendations will be monitored on a routine basis to evaluate the organization's effectiveness in the implementation of the recommendations in achieving compliance with the identified safety standards.

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- 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)

Section 6 Patient Safety	Sun Valley Surgery Center
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POLICY:

Sun Valley Surgery Center will institute and administer a comprehensive and continuous Patient Safety Program for all patients to improve patient safety and reduce risk to patients through an environment that encourages:

- Recognition of risks to patient safety and medical/health care errors
- Actions to reduce these risks
- Internal reporting of incidents and potential incidents and actions taken
- Focus on processes and systems rather than individual blame

PURPOSE:

The Patient Safety Program provides a systematic, coordinated and continuous approach to maintenance and improvement of patient safety by using established mechanisms to support responses to actual occurrences, have an ongoing proactive plan to reduce medical/health errors, and integrate patient safety as a high priority in all relevant organizational processes and services.

RESPONSIBILITY:

As with patient care, it is a coordinated and collaborative effort of the entire organization to maintain and improve patient safety.

The Governing Body approves the data-driven Patient Safety Program and ensures the program reflects the complexity of the facility's organization and services, including those services furnished under contract or arrangement and focuses on the prevention and reduction of medical/health errors and adverse effects.

The Clinical Director is responsible for the management of the Patient Safety Program by:

- Coordinating all patient safety activities
- Facilitating assessment and appropriate responses to reportable events
- Monitoring Root Cause Analysis and resulting action plans

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- Serving as a liaison among the departments to assure facility wide integration of the Patient Safety Program.

Each individual employee within the organization acts as a patient advocate for safety and is responsible to report patient safety occurrences and potential occurrences to the QAPI Coordinator and the Clinical Director, who will aggregate the occurrence information and report to the Governing Body.

PROGRAM:

The scope of the Patient Safety Program includes an ongoing assessment to prevent error occurrence, maintain and improve patient safety.

Patient Safety occurrence information from aggregated data reports and individual incident occurrence reports will be reviewed to prioritize organizational patient safety efforts.

Types Of Patient Safety Or Medical/Health Care Errors:

- No Harm Errors – those unintended acts, either of omission or commission, or acts that do not achieve their intended outcome, that do not result in a physical or psychological negative outcome, or the potential for a negative outcome, for the patient.
- Mild-Moderate Adverse Outcome Errors – those unintended acts, either of omission or commission, or acts that do not achieve their intended outcome, that result in an identified mild to moderate physical or psychological adverse outcome for the patient.
- Any Medication Error
- Any Adverse Drug Reaction
- Any Transfusion Reaction
- Hazardous Condition – any set of circumstances, exclusive of the disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious physical or psychological adverse patient outcome.
- Sentinel Event – an unexpected occurrence involving death or serious physical or psychological injury or the risk thereof, including any process variation for which a recurrence would carry a significant chance of serious adverse outcome. Serious injury specifically includes loss of limb or function. Sentinel event criteria includes:

- The event has resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition.
- The event is one of the following (even if the outcome was not death or major permanent loss of function):
 - Suicide of a patient.
 - The sexual assault of a patient during treatment or while the patient was on the premises of the facility.
 - A hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities.
 - Medication error resulting in a patient's unanticipated death or major permanent loss of bodily function in circumstances unrelated to the natural course of the illness or underlying condition of the patient.
 - A surgical procedure on the wrong patient or on the wrong body part of a patient.
 - A foreign object accidentally left in a patient during a procedure.
 - A patient death or serious disability associated with the use or function of a device designed for patient care that is used or functions other than as intended.
 - Near Miss – any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome.

What To Do When A Patient Safety Error Occurs

Upon identification of a medical/health care error, the patient care provider will immediately:

- Perform necessary healthcare interventions to protect and support the patient's clinical condition.
- As appropriate to the occurrence, perform necessary healthcare interventions to contain the risk to others – example: immediate removal of contaminated IV fluids from supply should it be discovered a contaminated lot of fluid solutions was delivered and stocked.
- Contact the patient's attending physician and other physicians, as appropriate, to report the error, carrying out any physician orders as necessary.

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- Preserve any information related to the error (including physical information). Examples of preservation of physical information are: Removal and preservation of blood unit for a suspected transfusion reaction; preservation of IV tubing, piggyback fluid for a patient with a severe drug reaction from IV medication; preservation of medication label for medications administered to the incorrect patient. Preservation of information includes documenting the facts regarding the error on an occurrence report, and in the medical record as appropriate to organizational policy and procedure.
- Report the medical/health care error to the staff member's immediate supervisor.
- Submit the incident occurrence report to the QAPI Committee per organizational policy.

Internal Reporting Of The Error/Event

Staff response to medical/health care errors is dependent upon the type of error identified:

- **No Harm Errors** – (including “no harm medication errors), staff will document appropriately in the medical record according to organizational policy, document the circumstances regarding the no harm error on an incident occurrence report form, submit the form to the QAPI Committee and notify their immediate supervisor.
- **Mild-Moderate Adverse Outcome Errors** (including medication errors), staff will perform any necessary clinical interventions to support and protect the patient and notify the physician responsible for the patient, carrying out any necessary physician orders. Staff will then preserve any physical evidence as appropriate, notify their immediate supervisor, document facts in the medical record and on an incident occurrence report, submitting the report to the QAPI Committee per policy.
- **Adverse Drug Reaction** – staff will perform any necessary clinical interventions to support and protect the patient and notify the physician responsible for the patient, carrying out any necessary physician orders. Staff will then preserve any physical evidence as appropriate, notify their immediate supervisor, document facts appropriately in the medical record and on an incident occurrence report, submitting the report to QAPI Committee per organizational policy.
- **Transfusion Reaction** – staff will perform any necessary clinical interventions to support and protect the patient and notify the physician responsible for the patient, carrying out any necessary orders. Staff will then follow the organization policy and procedure for this event.

Section 6 Patient Safety	Sun Valley Surgery Center
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- **Hazardous Condition/Patient Safety Issue** - as appropriate, and if possible, staff will contain the hazardous condition or patient safety issue. Staff identifying a hazardous condition or potential patient safety issue will immediately notify their supervisor and document the findings on an incident occurrence report which is then submitted to QAPI Committee
- **Sentinel Event** – staff will perform any necessary clinical interventions to support and protect the patient and notify the physician responsible for the patient, carrying out any necessary physician orders. Staff will then follow the organizational Sentinel Event Policy and Procedure, which includes a root cause analysis and action plan.
- **Near Miss** – staff will report the near miss event to their immediate supervisor, describe the facts of the near miss on an occurrence report and submit the report to QAPI Committee.
- It is the intent of this facility to adopt a non-punitive approach in its management of errors and occurrences. All personnel are required to report suspected and identified medical/health care errors, and should do so without the fear of reprisal in relationship to, their employment. This organization supports the concept that errors occur due to a breakdown in systems and processes, and will focus on improving systems and processes, rather than disciplining those responsible for errors and occurrences. A focus will be placed on remedial actions to assist rather than punish staff members, with the individual staff member's supervisor determining the appropriate course of action to prevent error recurrence.

Root Cause Analysis

- All sentinel events and near miss occurrences will have a root cause analysis conducted to examine the cause and effect of the event through an impartial process
- A Root Cause Analysis is an interdisciplinary review process for identifying the basic or contributing causal factors that underlie a variation in performance associated with an adverse event or reportable patient safety event. It focuses primarily on systems and processes, includes an analysis of underlying cause and effect, progresses from special causes in clinical processes to common causes in organizational processes, and identifies potential improvements in processes or systems.
- The QAPI Committee is responsible for conducting the root cause analysis. It will be completed within 45 days of becoming aware of one of the reportable events. They will encourage the staff members' involvement in the root cause analysis and action plan processes, to allow the staff member an active role in process resolution.

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A written Root Cause Analysis and "Action Plan" will be created which includes specific measures to correctly identify problems or areas of concern, identify strategies for implementing system improvements; and also includes outcome measures to indicate the effectiveness of system improvements in reducing, controlling or eliminating identified problem areas. The action plan must specifically address responsibility for implementation and oversight, time frames for implementation, and the strategy for measuring the effectiveness of the actions.

- The Joint Commission recommended "A Framework for a Root Cause Analysis and Action Plan In Response to a Sentinel Event" format may be used. See attached.
- Results of the entire Root Cause Analysis will be presented to the Governing Body for evaluation.

Communication of Action Plans and Root Cause Analysis

- Action Plans related to a Root Cause Analysis will be shared with the entire staff upon Completion by the QAPI Committee. Possible recommendations to update or change policy and procedures may be presented to the staff, management and Governing Body to improve patient safety.
- Staff will educate patients and their families about their role in helping to facilitate the safe delivery of care. There will be a random record review verifying compliance with this educational process.
- Root Cause Analysis and Action Plans will be made available to the state health department representatives during onsite reviews.

Reporting Obligations

- Medical/Health care errors and occurrences, including sentinel events, will be reported internally and externally, through the channels established by this plan. External reporting will be performed in accordance with all state, federal and regulatory body rules, laws and requirements.

Patient Safety Program Staff Education/Training

- Staff will receive education and training during their initial orientation process and on an ongoing basis regarding job-related aspects of patient safety, including the need and method to report medical/health care errors. And, because the optimal provision of healthcare is provided in an interdisciplinary manner, staff will be educated and trained on the provision of an interdisciplinary approach to patient care.

- Medical errors results from multiple factors. Flawed systems or processes can combine with active failures by caregivers in the clinical setting to produce accidents and errors. Some contributing factors are:
 - Inadequate communication among team members
 - Incomplete review of patient health records and diagnostic studies
 - Traditional hierarchical and autocratic cultures
 - Patient – related decisions made only by physicians
 - Unclear instructions
 - Confusing packaging of medications and supplies
 - Time pressures and constraints, Multi-tasking
 - Failure to include the patient and family members in assessment and decision-making

- Staff will be trained about error reduction, which requires the commitment of all members of the health care team. Besides correcting the identified factors above, the following individual and facility changes will be focused on:
 - Reduce reliance on memory by using checklists and protocols.
 - Standardize processes as much as possible for procedures and other activities.
 - Focus on the safety aspects of products during the selection and evaluation process.
 - Promote safety related clinical competency.
 - Educate employees about the potential for errors and how to avoid them.
 - Creating a “Culture of Safety” whereby there is a change of environment from blaming individuals for errors to one in which errors are treated as opportunities to improve systems. This is accomplished by:
 - establishing a sense of trust among team members;
 - dissemination and verifying receipt of information to all levels of staff and management;
 - developing and supporting a proactive approach rather than a reactive approach;
 - making a sincere commitment to affirming safety as the first priority.

- Quarterly Patient Safety Program meetings will be incorporated into the QAPI Program and conducted to review any incident occurrence reports and review any new patient safety recommendations or alerts.

ROOT CAUSE ANALYSIS AND ACTION PLAN

Level of Analysis		Questions	Findings	Root Cause?	Ask Why?	Take Action?
What happened?	Sentinel Event	What are the details of the event? (Brief Description)				
		When did the event occur? (Date, day of week, time)				
		What area/service was impacted?				
Why did it happen?	The process or activity in which the event occurred.	What were the steps in the process, as designed? (A flow diagram may be helpful here)				
		What steps were involved in (contributed to) the event?				
	Human factors	What human factors were relevant to the outcome?				
What were the proximate factors?	Equipment factors	How did the equipment performance affect the outcome?				
	Controllable environmental factors	What factors directly affected the outcome?				
(typically "special cause" variation)	Uncontrollable external factors	Are they truly beyond the organization's control?				
	Other	Are there any other factors that have directly influences this outcome?				
		What other areas of services are impacted?				

ROOT CAUSE ANALYSIS AND ACTION PLAN

The following template is provided as an aid in organizing the steps in a root cause analysis. Not all possibilities and questions will apply in every case and there may be others that will emerge in the course of the analysis. However, all possibilities and questions should be fully considered in your quest for "root cause" and risk reduction.

As an aid to avoiding "loose ends" the three columns on the right are provided to be checked off for later reference.

- **"Root Cause?"** - should be answered "yes" or "no" for each finding. A root cause is typically a finding related to a process or system that has a potential for redesign to reduce risk. If a particular finding that is relevant to the event is not a root cause, be sure that is addressed later in the analysis with a "why?" question. Each finding that is identified as a root cause should be considered for an action and addressed in the action plan.
- **"Ask Why?"** - should be checked off whenever it is reasonable to ask why the particular finding occurred (or didn't occur when it should have (in other words, to drill down further). Each item checked in this column should be addressed in the analysis with a "Why?" question. If it is expected that any significant finding that are not identified as root causes themselves have "roots."
- **"Take Action?"** - should be checked for any finding that can reasonably be considered for a risk reduction strategy. Each item checked in this column should be addressed later in the action plan. It will be helpful to write down the number of the associated Action item on page 3 in the "Take Action?" column for each of the findings that requires action.

ROOT CAUSE ANALYSIS AND ACTION PLAN

Level of Analysis	Questions	Findings	Root Cause?	Ask Why?	Take Action?
<p>Human Resources Issues.</p> <p>What happened? Why did that happen? What systems and processes underlie those proximate factors? (common cause variation here may lead to special cause variation in dependent processes)</p>	<p>To what degree is staff properly qualified and currently competent for their responsibilities?</p>				
	<p>How did actual staffing compare with ideal levels?</p>				
	<p>What are the plans for dealing with contingencies that would tend to reduce effective staffing levels?</p>				
	<p>To what degree is staff performance in the operating process (es) addressed?</p>				
	<p>How can orientation and in-service training be improved?</p>				

ROOT CAUSE ANALYSIS AND ACTION PLAN

Level of Analysis	Questions	Findings	Root Cause?	Ask Why?	Take Action?
Information management issues.	To what degree is all necessary information available when needed? Accurate? Complete? Unambiguous?				
	To what degree is communication among participants adequate?				
Environmental management issues.	To what degree was the physical environment appropriate for the processes being carried out?				
	What systems are in place to identify environmental risks?				
Leadership issues: -corporate culture -encouragement communication	What emergency and failure-mode responses have been planned and tested?				
	To what degree is the culture conducive to risk identification and reduction?				
- clear communication of priorities - uncontrollable factors	What are the barriers to communication of potential risk factors?				
	To what degree is the prevention of adverse outcome communicated as a high priority?				
	What can be done to protect against the effects of these uncontrollable factors?				

ROOT CAUSE ANALYSIS AND ACTION PLAN

Action Plan	Risk Reduction Strategies	Measures of Effectiveness
<p>For each of the findings identified in the analysis as reading an action, indicate the planned action expected, implementation data and associated measure of effectiveness OR</p>	ACTION ITEM #1	
<p>-If after consideration of such a finding a description is made not to implement as associated risk reduction strategy, indicate the rationale for not taking action at this time.</p>	ACTION ITEM #2	
<p>-Check to be sure that the selected measure will provide data that will permit assessment of the effectiveness of the action.</p>	ACTION ITEM #3	
<p>-Consider whether pilot testing of a planned improvement should be conducted.</p>	ACTION ITEM #4	
<p>-Improvements to reduce risk should ultimately be implemented in all areas where applicable, not just where the event occurred. Identify where the improvements will be implemented.</p>	ACTION ITEM #5	
	ACTION ITEM #6	
	ACTION ITEM #7	
	ACTION ITEM #8	
<p>Cite any books or journal articles that were considered in developing this analysis and action plans:</p>		

Spring Valley Surgery Center LLC

2016 Sentinel event reporting

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2705 W. Horizon Ridge Pkwy Henderson NV 89052 License #: 5491

7175 N. Durango Drive Las Vegas NV 89149 License #: 7592

1900 N. Nellis Blvd Las Vegas NV 89115 License #: 7891

1050 E. Sahara Ave Las Vegas NV 89104 License # 8688

Safety committee:

The Administration has established a “Life Safety Enterprise Safety Program” designed to keep patients, Physicians, employees and the public safe while on the premises of the Facility. This program consists of elements which meet the requirements as defined by the The Administration has established a “Life Safety Enterprise Safety Program” designed to keep patients, Physicians, employees and the public safe while on the premises of the Facility. This program consists of elements which meet the requirements as defined by the Federal, State, Local and OSHA guidelines. The “Safety Plan” includes identification, evaluation and prevention of workplace hazards relating to the elements and specific criteria. The safety management of the Facility is composed of several elements regarding the safety features necessary for the protection and security of its patients and healthcare workers.

These elements are composed of two parts; one “Life Safety Enterprise Safety Plan” which is wide in scope, organizational and effectiveness, and the “Environmental Safety Management” which oversees the working environment elements of the Facility. These areas overlap each other but also provide individual elements which manage the overall security and safety of the Facility. A report from the Safety Committee is provided quarterly to the Medical Executive Committee (MEC) and onto the Governing Board. The Safety Committee meets and discusses how to improve and/or maintain patient and employee well-being and safety, items discussed range from falls to how to properly lift boxes, and the execution of a disaster drills, etcetera. If any incidents have occurred they will be discussed in detail, and prevention and safety will be implemented.

Facility Name: Nevada Surgical Suites - 8322
Facility Name: Nevada Surgical Suites - 7661

2018 QUALITY AND PATIENT SAFETY PLAN

DATE: 02-05-2018
VERSION: 1.1



This plan was created and revised by the Nevada Surgical Suites Patient Safety committee/team. Implementation of this plan is intended to optimize the healthcare quality and patient safety outcomes, encourage recognition, reporting, and acknowledgment of risks to patient, visitor, and employee safety, as well as reduce the medical/healthcare errors and /or preventable events.

**Patient Safety Committee/Program
Nevada Surgical Suites**

2809 W. Charleston Blvd., Suite 100 Las Vegas, NV 89102 1569 E. Flamingo Road Las Vegas, NV 89119
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Commitment to Patient Safety

Nevada Surgical Suites is committed to a comprehensive approach to improving healthcare quality and patient safety by aligning with our Mission, Vision, and Values, creating an environment that supports a dynamic, proactive, and safe culture for patients, family members, visitors, and employees, through continuous learning and improving patient safety policies, systems, and processes.

Mission, Vision, and Values

In support of our mission, vision, and values, Nevada Surgical Suites Patient Safety and Quality Improvement program promotes:

- Collaboration of healthcare, leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high-quality healthcare.
- Communicate honestly and openly to foster trusting and cooperative relationships among healthcare providers, staff members, and patients and their families, to ensure accountability for the patient safety priorities.
- Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.
- Responsibility for every healthcare related decision and action.
- A focus on continuous learning and improving, system design, and the management of choices and changes, bringing the best possible outcomes or performances to the facility.
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare.
- Education of staff and physicians to assure participation of healthcare providers.

Scope and Purpose

The scope of this Quality and Patient Safety Plan is organizational-wide/hospital-wide/agency-wide which includes but is not limited to

- Patient safety
- Visitor safety
- Employee safety

All staff in Nevada Surgical Suites are required to fully support and participate in this plan, and devote their expertise to the patient safety and healthcare quality improvement process.

This plan is action oriented and solution focused. The purpose of this plan is to address patient safety related concerns, challenges and revise the program to better serve the patients and their families. To this end, Nevada Surgical Suites has developed this Patient Safety plan.

The plan focuses on the process rather than the individual, and recognizes both internal and external customers, as well as facilitates the need of analyzing and improving processes. The core principles of this plan include:

- All staff have the same goal and contribute their knowledge, vision, skill, and insight to improve the process of the Patient Safety Plan.
- Decisions will be based on data and facts, and staff will be encouraged to learn from the experiences.
- Customer based including patients, families, and visitors.
- Promote systems thinking.
- Employ well-trained and competent staff maintaining high healthcare quality.

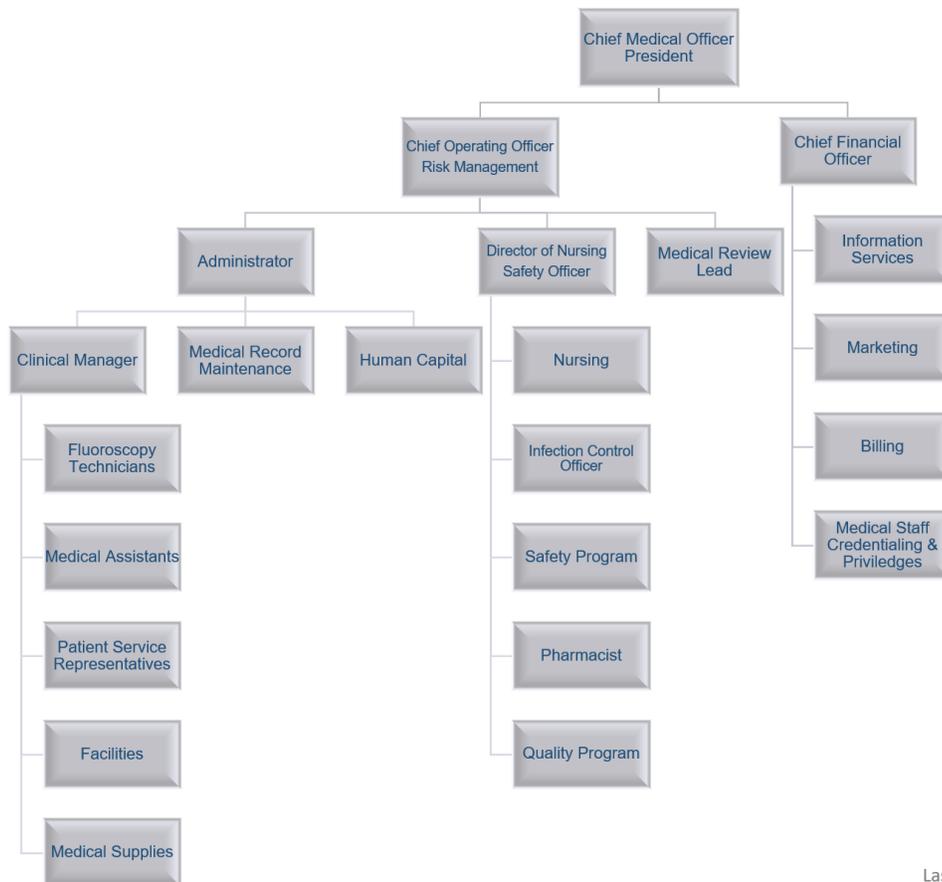
Roles and Responsibilities

According to [NRS 439.875](#), a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plan is promoted and executed successfully.

The Patient Safety Committee Organization



Organizational Chart



Last Revised: 03-01-2018

Roles and Responsibilities

- In accordance with [NRS 439.875](#), a patient safety committee must be comprised of:

Patient Safety and Quality Improvement Plan

- The infection control officer of the medical facility;
- The patient safety officer of the medical facility, if he or she is not designated as the infection control officer;
- At least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility; and
- One member of the executive or governing body of the medical facility.

Based on [NAC 439.920](#), a medical facility that has fewer than 25 employees and contractors must establish a patient safety committee comprised of:

- The patient safety officer of the medical facility;
- At least two providers of healthcare who treat patients at the medical facility, including but without limitation, one member of the medical staff and one member of the nursing staff of the medical facility; and
- The Chief Executive Officer (CEO) or Chief Financial Officer (CFO) of the medical facility.

The roles and responsibilities are defined below:

- Member 1: Medical Provider, Governing Board Member, Executive Team Member
- Member 2: Governing Board Member, Billing Manger
- Member 3: Governing Board Member, Pharmacist
- Member 4: Medical Provider, Governing Board Member, Executive Team Member
- Member 5: Clinical Manager
- Member 6: Chief Financial Officer, Governing Board Member, Executive Team Member
- Member 7: Governing Board Member, Director of Nursing, Infection Control & Safety Officer
- Member 8: Governing Board Member, Administrator

Patient Safety Committee Responsibilities (based on [NRS 439.875](#) and [NRS 439.877](#))

- Monitor and document the effectiveness of the patient identification policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the patient safety officer pursuant to [NRS 439.870](#).
- Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred.
- Review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- Review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the executive or governing body of the facility regarding:
 - (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);
 - (2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and

(3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.

- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

Root Cause Analysis (RCA) Team Responsibilities

- Root Cause interviews, analysis, investigation, and corrective action plan implementations.
- Participates in the RCA meetings and discussions.
- Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders.

Patient Safety Officer Responsibilities (based on [NRS 439.870](#))

- Serve on the patient safety committee.
- Supervise the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the patient safety committee regarding any action taken in accordance with the responsibilities above.

Infection Control Officer Responsibilities (based on [NRS 439.873](#))

- Serve on the patient safety committee.
- Monitor the occurrences of infections at the facility to determine the number and severity of infections.
- Report to the patient safety committee concerning the number and severity of infections at the facility.
- Take such action as determines is necessary to prevent and control infections alleged to have occurred at the facility.
- Carry out the provisions of the infection control program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program.

RCA team leader Responsibilities

- Organize and coordinate the RCA process.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA, and corrective action plan implementation process.
- Communicate the progress of the investigation, institutional barriers, and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.
- Provide training, education and direction to create RCA process that incorporate the Patient Safety and Quality Improvement elements.

Executive or Governing Body Staff Responsibilities

- Provide vision and leadership to Patient Safety and Quality Improvement process, and develop and foster a safe learning and improving culture.
- Provides oversight to the healthcare quality improvement processes and teams.
- Plan, discuss, and generate the organization patient safety goals and activities, in conjunction with the patient safety action plans

The Patient Safety Committee will meet monthly (or quarterly) to accomplish the following:

- Report and discuss sentinel events which include:
 - Number of sentinel events from previous calendar month (or quarter).
 - Number of severe infections that occurred in the facility.
- Corrective Action Plan for the sentinel events and infections
 - Evaluate the corrective action plan.
- Patient safety policies and checklists
 - At least annually evaluate Patient Safety policies and checklists
 - Revise the patient safety policies and checklists as needed.
 - Monitor and document the effectiveness of the patient safety policy.

A RCA meeting will meet as needed to accomplish the following:

- Define the healthcare issues or potential risks.
- Conduct Root Cause Analysis
 - Reviewing and analyzing the data.
 - Reviewing the RCA process and quality improvement related activities and timelines.
 - Brainstorming issues or the potential risks by using the fishbone diagrams.
 - Identify the contributing factors and conduct the Root Cause Analysis.
- Conduct Corrective Action Plan
 - Identifying the Plan-Do-Study-Act (PDSA) topics.
 - Discussing corrective action process and activities.
 - Discussing and presenting possible changes in procedure to improve areas indicated.
 - Identifying strengths and areas that need improvement.
 - Developing strategies, solutions, and steps to take next.
- Identify barriers and technical assistance needs for supporting the RCA efforts.

A meeting agenda and minutes noting follow-up tasks will be kept.

Objectives and Goals of the Quality and Patient Safety Plan

Objective	Goals	Plan	Planned Completion Date	Responsible Party
Medication Reconciliation	Increase accuracy to ≥ 95%	Increase chart audits with focused training	12-31-2018	Pharmacist
Allergy Documentation	Increase accuracy to ≥ 100%	Continue chart audits with focused training	12-31-2018	Pharmacist
Hand Washing	100% compliance	Observations, training	12-31-2018	Nurse Manager
Patient Privacy	Decrease complaints by ≥ 20%	Survey monitoring, training	12-31-2018	Director of Nursing

Components and Methods

Pursuant to [NRS 439.837](#), a medical facility shall, upon reporting a sentinel event pursuant to [NRS 439.835](#), conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event.”

Nevada Surgical Suites will use RCA process to determine the contributing factors and the underlying reasons for the deficiencies or failures. The Plan-Do-Study (check)-Act (PDSA or PDCA) is the model, which was developed by the Institute of Health Care Improvement, that we will use to test the changes.



Root Cause Analysis

A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals.

Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

Root cause analysis and action plan framework table, which was introduced by the Joint Commission. It contains 24 analysis questions. It guides the organization to the steps in a root cause analysis. Not all the questions apply to all the events or cases. This table can be used individually or with the fishbone diagram.

5 Whys technique will be used in Nevada Surgical Suites to explore the cause and effect relationship underlay a problem. One can find the root causes by asking “why” no less than five times. This technique can be used individually or as a part of the fishbone diagram.

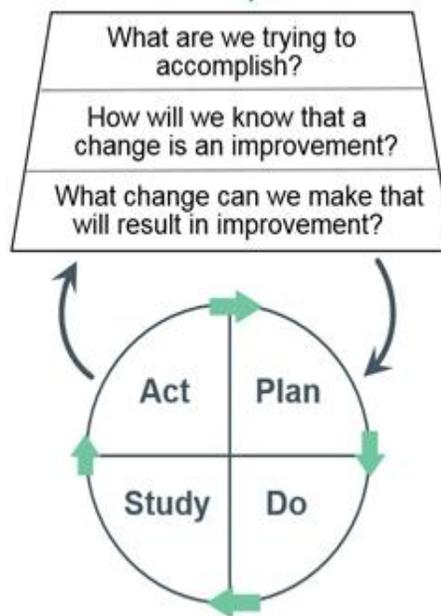
Fishbone Diagram

Once the problems are identified, a Fishbone Diagram (Appendix C) will be used for analyzing the problems. You can use the fishbone diagram individually to analyze the root causes, or use it with the root cause analysis and action plan framework table.

A Fishbone Diagram, also called a Cause-and-Effect diagram, is a useful tool for a team to structurally brainstorm by discovering possible underlying factors or root causes from different major categories for the chosen problems. General categories used include: people, methods, materials, measurements, education, procedures, process, location, environment, etc. RCA team members will brainstorm and ask multiple times, “why did this happen?” for each cause until all ideas are exhausted. The highest priority root causes will be chosen for PDSA topics. Once all the categories are established on the fishbone diagram, 5 Why’s technique also can be used to drill down the problem and find the root causes.

Model for Improvement

The Model for Improvement is a collaborative and ongoing effort model to improve the product and services quality and process. It provides multi-disciplinary quality team guidance from identifying the root causes; conducting the best tests to assess possible changes, and working in collaboration for implementation of the new approaches and solutions. It guides the test of a change to determine if the change is an improvement.



The cycle is defined as follows:

- Plan--collect data and establish appropriate goals. Identify the problem and the possible root causes and answer the following questions.
 - What is the objective of the test?
 - What are the steps for the test - who, what, when?
 - How will you measure the impact of the test?
 - What is your plan to collect the data needed?
 - What do you predict will happen?

- Do--make changes designed to correct or improve the situation. Use the following questions for the guidance.
 - What were the results of the test?
 - Was the cycle carried out as designed or planned?
 - What did you observe that was unplanned or expected?

- Study -- Study the effect of the changes on the situation. Data should be collected on the new process and compared to the baseline or expected results. Results should be evaluated and by using the following questions as guidance.
 - Did the results match your prediction?
 - What did you learn?
 - What do you need to do next?

- Act--If the result is successful or desirable, standardize the changes and then work on the next prioritized problem or the further improvements. If the outcome is not yet successful, look for different ways to identify the causes or change the testing process.

PDSA worksheet will be used to map the potential change strategies and to establish a course of action. The PDSA worksheet and the PDSA progress report are attached in Appendix D-1.

Data Collection and Reporting

Data should drive any quality and patient safety effort. Nevada Surgical Suites is using (data system names) for tracking the sentinel events, healthcare infection data, and (any other database) for internal data collection.

External data sources are those data sources which are collected outside the supervisory structure of the case. External data which will be utilized for Quality and Patient Safety plan include the data from:

- AHRQ: Agency for Healthcare Research & Quality
- CDC: Centers for Disease Control and Prevention
- CMS: Centers for Medicare & Medicaid Services
- NQF: National Quality Forum
- NHSN: National Healthcare Safety Network

- TJC: The Joint Commission



Ongoing Reporting and Review

Data points such as the following will be reviewed according to the schedule prescribed:

Monthly	Quarterly	Annually
1) Sentinel event monthly report 2) Severity of infection report 3) RCA assessment	1) Sentinel event quarterly report 2) Severity of infection report 3) Review and evaluate the measure of improvement of patient safety 4) Review and evaluate the measurement to prevent and control infections	1) Quality and Patient Safety Plan update 2) Checklists and Policies reviewing and revising

Assessment of the Quality and Patient Safety Plan

Quality and Patient Safety Plan is updated annually and submitted through the REDcap Sentinel Event Registry after approval by the organization governing board.

Patient Safety Checklists and Patient Safety Policies

By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

The patient safety checklists must follow protocols to improve the health outcomes of patients at the medical facility and must include, without limitation:

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.
- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - Proper instructions concerning prescription medications;
 - Instructions concerning aftercare;
 - Any other instructions concerning his or her care upon discharge; and
 - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include, the name and date of birth of the patient.
- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.

- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

Based on [NRS 439.865](#), the patient safety plan must also include an infection control program that carries out the infection control policy. The policy must consist of:

- The current guidelines appropriate for the facility's scope of service developed by a nationally recognized infection control organization as approved by the State Board of Health which may include, the Association for Professionals in Infection Control and Epidemiology (APIC), the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO) and the Society for Healthcare Epidemiology of America (SHEA); and
- Facility-specific infection control developed under the supervision of a certified Infection Preventionist.

The patient safety checklists are listed in Appendix E. (The following links provide some patient safety checklists for your reference— a checklist example is shown in **Appendix E.**)

http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf

<http://www.who.int/patientsafety/implementation/checklists/en/>

The patient safety policies are listed in Appendix F. (The following link provides you some patient safety policies for your reference—a policy example is shown in **Appendix F.**) <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>

Approval of Patient Safety Plan

According to [NRS 439.865](#), a medical facility shall submit its patient safety plan to the governing board of the facility for approval. After a facility's patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan.

The patient safety plan must be reviewed and **updated annually** in accordance with the requirements for approval set forth in this section.

According to [NRS 439.843](#), on or before March 1 of each year, a copy of the most current patient safety plan established to [NRS 439.865](#) must be submitted to the Division of Public and Behavioral Health.

Reference

- Root Cause Analysis Toolkit <http://www.health.state.mn.us/patientsafety/toolkit/>
- Quality and Service Improvement Tools http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html
- CQI 101 An Introduction to Continuous Quality Improvement: <https://www.coursehero.com/file/13827355/CQI-Overviewppt/>
- Quality Improvement <http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/>
- Root Cause Analysis <http://www.patientsafety.va.gov/professionals/onthejob/rca.asp>
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2 https://www.jointcommission.org/sentinel_event.aspx
- Hospital Policies <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>
- Checklists to Improve Patient Safety http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf
- Patient Safety Checklists <http://www.who.int/patientsafety/implementation/checklists/en/>
- Minutes of the Meeting of the Quality and Patient Safety Committee <http://www.cookcountyhhs.org/wp-content/uploads/2013/12/09-23-14-QPS-scan-Minutes.pdf>
- Title 40 – Public Health and Safety <https://www.leg.state.nv.us/NRS/NRS-439.html>

Appendix A: Terms and Definitions

Patient Safety: The Agency for Healthcare Research Quality (AHRQ) defines patient safety as “a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.”

http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

Sentinel event ([NRS 439.830](#))

1. Except as otherwise provided in subsection 2, “sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum.

2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:

(a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or

(b) July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published.

3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.

(Added to NRS by [2002 Special Session, 13](#); A [2005, 599](#); [2013, 217](#))

Institute for Healthcare Improvement (IHI) defines **medical harm** as “unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death.”

Facility-Associated Infection: ([NRS 439.802](#))

“Facility-acquired infection” means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections;
- Ventilator-associated pneumonia;
- Central line-related bloodstream infections;
- Urinary tract infections; and
- Other categories of infections as may be established by the State Board of Health by regulation pursuant to [NRS 439.890](#).

(Added to NRS by [2005, 599](#); A [2009, 553](#))

Medical facility ([NRS 439.805](#))

“Medical facility” means:

- A hospital, as that term is defined in [NRS 449.012](#) and [449.0151](#);

- An obstetric center, as that term is defined in [NRS 449.0151](#) and [449.0155](#);
- A surgical center for ambulatory patients, as that term is defined in [NRS 449.0151](#) and [449.019](#); and
- An independent center for emergency medical care, as that term is defined in [NRS 449.013](#) and [449.0151](#).

(Added to NRS by [2002 Special Session, 13](#))

Near miss: An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Mandatory reporting: Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985;254(6):796-800.)

Risk: Possibility of loss or injury. (Merriam-Webster's Online Dictionary, Risk, Available at <http://www.merriamwebster.com/dictionary/risk>. Last Accessed August 2009.)

Preventable event: Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Catheter Associated Urinary Tract Infection (CAUTI): A urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CUR_ENT_b.pdf.)

Central Line Associated Bloodstream Infections (CLABSI): Primary bloodstream infections that are associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection.

Appendix B: Master Study List

Master Study List – Quality Improvement Initiatives

(Infection Control, Patient Safety, Process Improvement)

Calendar Year/ Study Name	Start Date	Completion Date	Re-Assessment Date	Comments
2015 Study				
1 AAAHC Low Back Injection	01/2015	06/2015	Move to 2016	Evaluating clinical performance measurement and improvement opportunities
2 Medication Reconciliation	01/2015	12/2015	Move to 2016	Room for improvement – Study in 2016
3 Handwashing	01/2015	12/2015	Move to 2016	Room for improvement – Study in 2016
2016 Study				
1 AAAHC Low Back Injection	07/2016	12/2016	Move to 2017	Evaluating clinical performance measurement and improvement opportunities
2 Medication Reconciliation	01/2016	12/2016	Move to 2017	Room for improvement – Study in 2017
3 Handwashing	01/2016	12/2016	Move to 2017	Performing well – will not study in 2017
2017 Study				
1 AAAHC Low Back Study	04/2017	12/2017	Move to 2018	Evaluating clinical performance measurement and improvement opportunities
2 Medication Reconciliation	01/2017	12/2017	Move to 2018	Room for improvement – Study in 2018
3 Q1 2017 ASCA Benchmarking	01/2017	03/2017	Move to Q2	Limited
4 Q2 2017 ASCA Benchmarking	04/2017	06/2017	Move to Q3	Limited
5 Q3 2017 ASCA Benchmarking	07/2017	09/2017	Move to Q4	Limited
6 Q4 2017 ASCA Benchmarking	10/2017	12/2017	Move to 2018	GB approved re-participation in 2018
2018 Study				
1 Hand Hygiene	01/2018	12/2018	In Progress	
2 AAAHC Low Back Study	01/2018	06/2018	In Progress	Evaluating clinical performance measurement and improvement opportunities
3 Medication Reconciliation	01/2018	12/2018	In Progress	

4	Q1 2018 ASCA Benchmarking	01/2018	03/2018	In-Progress	
5	Q2 2018 ASCA Benchmarking	04/2018	06/2018		
6	Q3 2018 ASCA Benchmarking	07/2018	09/2018		
7	Q4 2018 ASCA Benchmarking	10/2018	12/2018		
2019 Study					
1					
2					
3					
4					

Appendix C-1: Safety Check List/ Time-Out



Safety Checklist

Patient:

Area	Done By	Patient or caregiver response
Sedation	<input type="checkbox"/> No Sedation	<input type="checkbox"/> 1. Pt/allergies/procedure confirmed. <input type="checkbox"/> 2. Pt. Verbalizes understanding of anesthesia options. <input type="checkbox"/> 3. Pt. Verbalizes understanding of anesthesia and possible post op pain
Operating Room		<input type="checkbox"/> 1. Pt/allergies/Procedure confirmed. <input type="checkbox"/> 2. Pt. verbalizes adequate understanding of procedure.
<input type="checkbox"/>	Pt. to RN with RN Assistance	<input type="checkbox"/> Ambulates <input type="checkbox"/> Stretcher <input type="checkbox"/> WC
<input type="checkbox"/>	Pt. is positioned upon the O.R. Table and safety strap(s) in use and necessary pillows/cushioning are in place.	<input type="checkbox"/> Prone <input type="checkbox"/> Supine <input type="checkbox"/> R Lateral <input type="checkbox"/> L Lateral
<input type="checkbox"/>	PREP site with:	<input type="checkbox"/> Chloraprep <input type="checkbox"/> Alcohol-prep with No Reaction noted
<input type="checkbox"/>	"TIMEOUT" Conducted to confirm proper patient, procedure, allergies and site	
<input type="checkbox"/>	Procedure Start time:	
<input type="checkbox"/>	Medications injected:	<input type="checkbox"/> Dexamethasone <input type="checkbox"/> Lidocaine <input type="checkbox"/> Marcaine (0.5) (0.25) <input type="checkbox"/> Omnipaque <input type="checkbox"/> Magnevist
<input type="checkbox"/>	Radio Frequency ground pad site:	<input type="checkbox"/> R / L Posterolateral thigh <input type="checkbox"/> R / L posterior thoracic <input type="checkbox"/> R / L Posterolateral buttocks
<input type="checkbox"/>	Radio Frequency Probe(s) Serial Number:	
<input type="checkbox"/>	SCS Trial/Implant Lot Number:	
<input type="checkbox"/>	SCS Trial/Implant Serial Number:	
<input type="checkbox"/>	Pt Tolerated procedure without complications	
<input type="checkbox"/>	Pt Transported via:	<input type="checkbox"/> stretcher (side rails up) <input type="checkbox"/> WC
<input type="checkbox"/>	Procedure End time:	
<input type="checkbox"/>	Pt. transferred to PACU without incident. Time:	

07/20/17 NSS

Appendix C-2: Surgical Handoff



PREPROCEDURE CHECK-IN	SIGN-IN	TIME-OUT	SIGN-OUT
Patient Received by Pre-op RN _____	Patient Received by Intra-op RN _____ Time _____	Time-out _____	Patient received by Post-op RN _____
In Holding Area	Before Induction of Anesthesia	Before Skin Incision	Before the Patient Leaves the Operating Room
Patient/patient representative actively confirms with Registered Nurse (RN):	RN and anesthesia care provider confirm:	Initiated by designated team member All other activities to be suspended (unless a life-threatening emergency)	RN confirms:
Identity <input type="checkbox"/> Yes Procedure and procedure site <input type="checkbox"/> Yes Consent(s) <input type="checkbox"/> Yes <input type="checkbox"/> N/A Site marked <input type="checkbox"/> Yes <input type="checkbox"/> N/A by person performing the procedure RN confirms presence of: History and physical <input type="checkbox"/> Yes Preanesthesia assessment <input type="checkbox"/> Yes Any special equipment, devices, implants <input type="checkbox"/> Yes <input type="checkbox"/> N/A	Confirmation of: identity, procedure, procedure site and consent(s) <input type="checkbox"/> Yes Site marked <input type="checkbox"/> Yes <input type="checkbox"/> N/A by person performing the procedure Patient allergies <input type="checkbox"/> Yes <input type="checkbox"/> N/A Difficult airway or aspiration risk? <input type="checkbox"/> No <input type="checkbox"/> Yes (preparation confirmed) Anesthesia safety check completed <input type="checkbox"/> Yes Briefing: All members of the team have discussed care plan and addressed concerns <input type="checkbox"/> Yes	All: Confirmation of the following: identity, procedure, incision site, consent(s) <input type="checkbox"/> Yes Site is marked and visible <input type="checkbox"/> Yes <input type="checkbox"/> N/A Relevant images properly labeled and displayed <input type="checkbox"/> Yes <input type="checkbox"/> N/A Any equipment concerns? Anesthesia Provider: <input type="checkbox"/> Antibiotic prophylaxis before incision <input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> Additional concerns? Scrub and circulating nurse: <input type="checkbox"/> Sterilization indicators have been confirmed <input type="checkbox"/> Additional concerns?	Name of operative procedure Any equipment problems to be addressed? <input type="checkbox"/> Yes <input type="checkbox"/> N/A

Surgical Handoff

12/06/2016 NSS

Appendix D: Policies

Chapter 5: Quality and Risk management

Chapter 7 Sub-Chapter 1 & 2: Infection Control and Safety

Chapter 8: Emergency Preparedness

Warm Springs Surgical Center

General Safety Program

Elements of the Program

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2.0 SCOPE & RELEVANCY	3
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1.0 OVERVIEW

The General Safety Program has been created to provide and maintain a safe and healthy environment for all staff members, patients and visitors.

2.0 SCOPE & RELEVANCY

The program has been designed to prevent or diminish accidents injuries and illnesses in the workplace. The personal safety and health of all visitors, patients and employees of the Center is of utmost importance.

3.0 DEFINITIONS

CENTER means Warm Springs Surgical Center.

4.0 DUTIES OF KEY MEMBERS

ADMINISTRATOR

The objective of the Administrator is to promote a safe, healthy environment throughout the Center. They are responsible for the overall implementation and maintenance of the Center's Injury and Illness Prevention Program. Duties include, but are not limited to:

- Education of all Managers on workplace safety and make them aware of potential workplace hazards to their employees.
- Monitoring compliance with training requirements of the program.
- Inspecting, recognizing, and evaluating workplace hazards on a continual basis.
- Developing and implementing methods for diminishing workplace hazards.
- Monitoring hazards to ensure they are taken care of in a timely manner.

MANAGERS

Each manager is responsible for developing within themselves and their employees a positive attitude toward safety. Managers must be familiar with workplace hazards associated with the scope of their employees.

EMPLOYEES

All employees are responsible for knowing policies and procedures as well as working safely and maintaining a safe and healthful work environment.

5.0 HAZARD ASSESSMENT

ENVIRONMENTAL SAFETY ROUNDS

Environmental safety hazards rounds are conducted through the shift. Each patient area is surveyed at least every 6 months. Other areas that may have a greater potential of a hazard are surveyed three times annually. All hazards are identified and corrective action is documented and enforced. Immediate hazards are corrected at the time they are noted; all others as soon as possible, no later than 15 days of discovery. Safety Committee may make unannounced rounds within any area of the Center. These rounds will focus on injury and illness hazards which may need further monitoring. Hazard communications, emergency preparedness, work place hazards and safety training audits will be conducted annually.

NEW MATTERS

The administrator will arrange for the inspection and investigation of any new substances, process, procedure or equipment that is introduced into the facility. This will to evaluate any potential occupational hazards the matter may contain.

HOUSEKEEPING

Good house keeping practices are an essential part of any effective safety program. Keeping the work area clean and neat reduces the risk of injury or accidents. To increase the ability of the workers to perform their jobs more efficiently, well organized work areas are encouraged. Each employee is responsible for their work area, keeping it neat and tidy. Managers are to make housekeeping rounds to ensure compliance.

Immediately Report the following:

1. Wet or Slippery Floors
2. Equipment or furniture left in the halls or obstructing an entrance or exit
3. Storage or use of combustibles near an open flame
4. Improper storage of hazardous waste.

HAZARD REPORTING BY EMPLOYEES

It is the responsibility of all employees to report any unsafe act or condition in their work environment.

Immediately Report the following:

1. Areas that may be Poorly Lit
2. Unattended Children
3. Defective Equipment
4. Smoking on the Premises
5. Careless Handling of the Equipment

There will be no disciplinary action resulting from reporting an unsafe condition. Employees do have the option to remain anonymous when filing a report.

IMMEDIATE HAZARDS

It is the intent of the Center to abate all hazards once they have been identified. When such a hazard is present and it cannot be resolved immediately, all employees, patients and visitors will be vacated from the area until the hazard can be addressed.

DOCUMENTATION

All rounds will be documented by the Safety Officer (Administrator). They will be maintained for a period of at least three (3) years. They will include the name of the Administrator conducting the rounds, the areas examined, date of the rounds, if any hazards were identified, recommended corrective action. Course taken, date of compliance and signature of manager overseeing the actions.

6.0 EMERGENCY ACTION PLAN

Warm Springs Surgical Center has put into place a Disaster Plan. This is available to all employees. It is kept in the Administrator's office in the OSHA binder under EMERGENCY PLAN.

7.0 POLICIES & PROCEDURES FOR SAFETY

Safety policies have been developed and implemented to address the issues that apply to all employees. The policies and procedures for safety are kept in the Administrator's office in the OSHA binder under GENERAL SAFETY. It is available to all employees. The need for changes to the safety policies and procedures are reviewed regularly.

8.0 COMMUNICATION

General communication for changes or modifications will be a posting on the bulletin board in the break room and annually during the safety meetings.

9.0 ENFORCEMENT

Enforcement of all safety policies and procedures is the primary responsibility of the Managers. Compliance is mandatory and any violation of this program could result in progressive disciplinary action.

10.0 TRAINING

Awareness of potential health and safety hazards is critical to maintaining a safe work environment and to avoid injuries, illnesses and accidents in the work place. Warm Springs Surgical center is dedicated to instruction all employees in health and safe work practices. To achieve this goal, the Center will provide training to each employee with regard to the general safety programs.

TRAINING SCHEDULES

1. All new employees will receive a general safety orientation according the Human Resource's policy.
2. Employees will receive appropriate safety training upon receiving a new assignment they are unfamiliar with.
3. An annual safety inservice will be conducted.
4. Additional training will be required if re-enforcement is needed.

TRAINING OF MANAGERS

It is the responsibility of Managers to be aware of potential health or safety hazards within their deposit. Annual safety program reviews will be conducted with the Administrator. All training records will be kept for a minimum of three (3) years.

11.0 ACCIDENT INVESTIGATION

POLICY

All occupational injuries and illnesses must be reported in a timely manner. Upon receipt of the incident report, the Administrator will start an investigation.

RESPONSIBILITY & PROCEDURE

Employee is responsible for reporting an occupational injury or illness to the Manager and the Administrator will start an investigation as outlined in the Human Resource Workman's Compensation Policy.

CORRECTIVE ACTION

All hazards are to be identified and corrective action taken as soon as possible to avoid re-occurrence of the same injury. Manager is responsible for compliance to correct the problem. All personal involved int eh correcting the hazardous condition will receive appropriate training on how to do so and will be provided with the necessary PPE and safeguards.

ADMINISTRATIVE APPROVAL

Date Created: 01/07/2014

Last Date Revised: _____

Last Date Reviewed: 02/05/2018

Date of Next Review: 02/2019

Approval signature(s) with title and date of signature:

Signature	Title	Date

SUBJECT: PATIENT SAFETY PLAN	REFERENCE #1067
	PAGE: 1 OF: 7
	EFFECTIVE: 1/15/2014
APPROVED BY: Governing Body	REVISED: 1/15/2018

PURPOSE:

- The purpose of the Organizational Patient Safety Plan at 215 Surgery Center is to improve patient safety and reduce risk to patients through an environment that encourages:
 - Recognition and acknowledgment of risks to patient safety and medical/health care errors;
 - The initiation of actions to reduce these risks;
 - The internal reporting of what has been found and the actions taken;
 - A focus on processes and systems;
 - Minimization of individual blame or retribution for involvement in a medical/health care error;
 - Organizational learning about medical/health care errors;
 - Support of the sharing of that knowledge to effect behavioral changes in itself and other healthcare organizations.
- The Patient Safety Plan provides a systematic, coordinated and continuous approach to the maintenance and improvement of patient safety through the establishment of mechanisms that support effective responses to actual occurrences; ongoing proactive reduction in medical/health care errors; and integration of patient safety priorities into the new design and redesign of all relevant organization processes, functions and services.
- As patient care, and therefore the maintenance and improvement of patient safety, is a coordinated and collaborative effort, the approach to optimal patient safety involves multiple departments and disciplines in establishing the plans, processes and mechanisms that comprise the patient safety activities at Seven Hills Surgery Center. The Patient Safety Plan, developed by the interdisciplinary Safety Committee and approved by the medical staff, Board of Managers and administration, outlines the components of the organizational Patient Safety Program.

SUBJECT: PATIENT SAFETY PLAN	REFERENCE #1067
	PAGE: 2 OF: 7
	EFFECTIVE: 1/15/2014
APPROVED BY: Governing Body	REVISED: 1/15/2018

PATIENT SAFETY PROGRAM:

- Scope of Activities:
 - The scope of the Patient Safety Program includes an ongoing assessment, using internal and external knowledge and experience, to prevent error occurrence, maintain and improve patient safety. Patient safety occurrence information from aggregated data reports and individual incident occurrence reports will be reviewed by the Safety Committee to prioritize organizational patient safety activity efforts. Types of patient safety or medical/health care errors included in data analysis are:
 - No Harm Errors - those unintended acts, either of omission or commission, or acts that do not achieve their intend outcome - that do not result in a physical or psychological negative outcome, or the potential for a negative outcome, for the patient.
 - Mild-Moderate Adverse Outcome Errors - those unintended acts, either of omission or commission, or acts that do not achieve their intend outcome, that result in an identified mild to moderate physical or psychological adverse outcome for the patient.
 - Any Medication Error
 - Any Adverse Drug Reaction
 - Hazardous Condition - any set of circumstances, exclusive of the disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious physical or psychological adverse patient outcome.
 - Sentinel Event – as defined in Appendix A of the National Quality Forum Serious Reportable Events in Health-Care-2011 Update: A Consensus Report
 - ◆ The event has resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient’s illness or underlying condition.
 - ◆ The event is one of the following (even if the outcome was not death or major permanent loss of function):

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- Rape (by another patient, visitor or staff)
 - Surgery on the incorrect patient or incorrect body part
 - Near Miss - any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome.
- The scope of the Patient Safety Program encompasses the patient population, visitors, volunteers and staff (including medical staff). The program addresses maintenance and improvement in patient safety issues in every department throughout the facility. There will be an emphasis on important facility and patient care functions of:
 - Patient Rights
 - Assessment of Patients
 - Care of Patients
 - Patient/Family Education
 - Continuum of Care
 - Leadership
 - Improving Organization Performance
 - Management of Information
 - Management of Human Resources
 - Surveillance, Prevention and Control of Infection
- Methodology:
 - The Interdisciplinary Safety Committee is responsible for the oversight of the Patient Safety Program. The Safety Officer will have administrative responsibility for the program, or the Safety Committee may assign this responsibility to another member of the committee.

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- **All departments** within the organization (patient care and non-patient care departments) are responsible to report patient safety occurrences and potential occurrences to the Safety Officer, who will aggregate occurrence information and present a report to the Safety Committee on a monthly basis. The report will contain aggregated information related to type of occurrence, severity of occurrence, number/type of occurrences per department, occurrence impact on the patient, remedial actions taken, and patient outcome. The Safety Committee will analyze the report information and determine further patient safety activities as appropriate.
- Description of mechanisms to ensure that all components of the healthcare organization are integrated into and participate in the organizationwide program.
- Upon identification of a medical/health care error, the patient care provider will immediately:
 - Perform necessary healthcare interventions to protect and support the patient's clinical condition.
 - As appropriate to the occurrence, perform necessary healthcare interventions to contain the risk to others - example: immediate removal of contaminated IV fluids from floor stock should it be discovered a contaminated lot of fluid solutions was delivered and stocked.
 - Contact the patient's attending physician and other physicians, as appropriate, to report the error, carrying out any physician orders as necessary.
 - Preserve any information related to the error (including physical information). Examples of preservation of physical information are: Preservation of IV tubing, fluids bags and/or pumps for a patient with a severe drug reaction from IV medication; preservation of medication label for medications administered to the incorrect patient. Preservation of information includes documenting the facts regarding the error on an occurrence report, and in the medical record as appropriate to organizational policy and procedure.
 - Report the medical/health care error to the staff member's immediate supervisor.
 - Submit the occurrence report to the designated individual or committee per organizational policy.

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- Any individual in any department identifying a potential patient safety issue will immediately notify his or her supervisor and document the findings on an occurrence report. The occurrence report will be submitted to the Quality Assurance Committee per organizational policy
- Staff response to medical/health care errors is dependent upon the type of error identified:
 - No harm errors - (including “no harm” medication errors) - staff will document appropriately in the medical record according to organizational policy, document the circumstances regarding the no harm error on an occurrence report form, submit the form to the Performance Improvement Department and notify their immediate supervisor.
 - Mild-Moderate Adverse Outcome Errors (including medication errors) - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then preserve any physical evidence as appropriate, notify his/her immediate supervisor, document facts appropriately in the medical record and on an occurrence report - submitting the report to the Performance Improvement Department per organizational policy.
 - ◆ Medication Errors - the staff member identifying a medication error (no harm and mild-moderate harm) will notify the Pharmacy Services Department of the event.
 - Adverse Drug Reaction - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then preserve any physical evidence as appropriate, notify his/her immediate supervisor, document facts appropriately in the medical record and on an occurrence report - submitting the report to the Performance Improvement Department per organizational policy. Staff will also notify the Pharmacy Services Department.
 - Hazardous Condition/Patient Safety Issue - as appropriate, and if possible, staff will contain the hazardous condition or patient safety issue. Staff identifying a hazardous condition or potential patient safety issue will immediately notify his or her supervisor and document the findings on an occurrence report. The occurrence report will be submitted to the Performance Improvement Department per organizational policy.

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- Sentinel Event - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then follow the organizational Sentinel Event Policy and Procedure.
 - Near Miss - staff will report the near miss event to his/her immediate supervisor, describe the facts of the near miss on an occurrence report and submit the report to the Performance Improvement Department.
- Established organizational policy (such as the Sentinel Event Policy) and/or the Safety Committee will determine the organizational response to medical/health care errors and occurrences. All sentinel events and near miss occurrences will have a root cause analysis conducted. The determination of the Safety Committee members, based on internal and external data analysis and prioritizing of patient safety criticality, will determine:
 - Further remedial action activities necessary for identified occurrences
 - Proactive occurrence reduction activities
 - Necessity and benefit of root cause analysis performance for identified occurrences or proactive reduction activities
- An effective Patient Safety Program cannot exist without optimal reporting of medical/health care errors and occurrences. Therefore, it is the intent of this institution to adopt a non-punitive approach in its management of errors and occurrences. All personnel are required to report suspected and identified medical/health care errors, and should do so without the fear of reprisal in relationship to their employment. This organization supports the concept that errors occur due to a breakdown in systems and processes, and will focus on improving systems and processes, rather than disciplining those responsible for errors and occurrences. A focus will be placed on remedial actions to assist rather than punish staff members, with the Safety Committee and the individual staff member's department supervisor determining the appropriate course of action to prevent error recurrence
 - Sentinel Events - staff members involved in a sentinel event occurrence will receive support from the Safety Committee regarding the staff member's professional and emotional reconciliation of the sentinel event. The Safety Committee encourages the staff member's involvement in the root cause analysis and action plan processes, to allow the staff member an active role

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in process resolution. Additionally, any staff member involved in a sentinel event or other medical/health care error may request and receive supportive personal counseling from his or her department supervisor.

- On at least an annual basis, staff will be queried regarding their willingness to report medical/health care errors.
- The Patient Safety Program includes a quarterly survey of patients, their families, volunteers and staff (including medical staff) opinions, needs and perceptions of risks to patients and requests suggestions for improving patient safety.
- Patients, and when appropriate, their families are informed about the outcomes of care, including unanticipated outcomes, or when the outcomes differ significantly from the anticipated outcomes. The Safety Committee will analyze error reporting data for evidence of this information.
- Staff will educate patients and their families about their role in helping to facilitate the safe delivery of care.
- Staff will receive education and training during their initial orientation process and on an ongoing basis regarding job-related aspects of patient safety, including the need and method to report medical/health care errors. And, because the optimal provision of healthcare is provided in an interdisciplinary manner, staff will be educated and trained on the provision of an interdisciplinary approach to patient care.
- Medical/health care errors and occurrences, including sentinel events, will be reported internally and externally, per facility policy and through the channels established by this plan. External reporting will be performed in accordance with all state, federal and regulatory body rules, laws and requirements.
- A quarterly patient safety report will be forwarded to the Board of Managers on the occurrence of medical/health care errors and actions taken to improve patient safety, both in response to actual occurrences and proactively.

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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.

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- As patient care, and therefore the maintenance and improvement of patient safety, is a coordinated and collaborative effort, the approach to optimal patient safety involves multiple departments and disciplines in establishing the plans, processes and mechanisms that comprise the patient safety activities at Mountain's Edge Hospital. The Patient Safety Plan, developed by the interdisciplinary Environment of Care Committee and approved by the medical staff, Governing Body and administration, outlines the components of the organizational Patient Safety Program.

PATIENT SAFETY PROGRAM:

- Scope of Activities:
 - The scope of the Patient Safety Program includes ongoing proactive risk assessments, using internal and external knowledge and experience, to prevent error incident, maintain and improve patient safety.
 - One high-risk process shall be selected at least every 18 months and a proactive risk assessment shall be performed.
 - Patient safety incident information from aggregated data reports and individual incident reports will be reviewed by the Safety/Environment of Care Committee to prioritize organizational patient safety activity efforts. Types of patient safety or medical/health care errors included in data analysis are:
 - No Harm Errors - those unintended acts, either of omission or commission, or acts that do not achieve their intend outcome - that do not result in a physical or psychological negative outcome, or the potential for a negative outcome, for the patient.
 - Mild-Moderate Adverse Outcome Errors - those unintended acts, either of omission or commission, or acts that do not achieve their intend outcome, that result in an identified mild to moderate physical or psychological adverse outcome for the patient.
 - Any Medication Error
 - Any Adverse Drug Reaction

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- 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 incident involving death or serious physical or psychological injury or the risk thereof - including any process variation for which a recurrence would carry a significant chance of serious adverse outcome. Serious injury specifically includes loss of limb or function. (Refer to the Sentinel Event Policy - #1507)
- Near Miss - any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome.
- Hospital Acquired Conditions (HACs), (those in accordance with Mountain's Edge Hospital Scope of Services):
 - ◆ Serious preventable event - object left in surgery (never event)
 - ◆ Serious preventable event - air embolism (never event)
 - ◆ Serious preventable event - blood incompatibility (never event)
 - ◆ Catheter-associated urinary tract infections
 - ◆ Pressure ulcers
 - ◆ Vascular catheter-associated infection
 - ◆ Surgical site infection
 - ◆ Surgical site infections following certain elective procedures, including certain orthopedic surgeries and bariatric surgery
 - ◆ Patient falls (fracture, dislocation, intracranial injury, crushing injury, burn, electric shock)

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- ◆ 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

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- 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

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- 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

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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 as appropriate to organizational policy and procedure.

- Report the process/system failure or medical/health care error to the staff member's immediate supervisor.
 - Submit the incident report to the Performance Improvement Department per organizational policy.
- Any individual in any department identifying a process/system failure and/or potential patient safety issue will immediately notify his or her supervisor and document the findings on an incident report. The incident report will be submitted to the Performance Improvement Department per organizational policy.
- Staff response to process/system failures and/or medical/health care errors is dependent upon the type of error identified:
 - No Harm Failures or Errors (including "no harm" medication errors) - staff will document appropriately in the medical record according to organizational policy, document the circumstances regarding the no harm error on an incident report form, submit the form to the Performance Improvement Department and notify their immediate supervisor.
 - Mild-Moderate Adverse Outcome Failures or Errors (including medication errors) - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then preserve any physical evidence as appropriate, notify his/her immediate supervisor, document facts appropriately in the medical record and on an incident report - submitting the report to the Performance Improvement Department per organizational policy.

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- ◆ 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.

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- 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 required to report suspected and identified medical/health care errors, and should do so without the fear of reprisal in relationship to their employment. This organization supports the concept that errors occur due to a breakdown in systems and processes, and will focus on improving systems and processes, rather than disciplining those responsible for errors and incidents. A focus will be placed on remedial actions to assist rather than punish staff members, with the Environment of Care Committee and the individual staff member's department supervisor determining the appropriate course of action to prevent error recurrence.
 - Sentinel Events - staff members involved in a sentinel event incident will receive support from the Environment of Care and Performance Improvement Committees regarding the staff member's professional and emotional reconciliation of the sentinel event. The Environment of Care and Performance Improvement Committees encourages the staff member's involvement in the root cause analysis and action plan processes, to allow the staff member an active role in process resolution. Additionally, any staff member involved in a sentinel event or other medical/health care error may request and receive supportive personal counseling from the Social Service Department, Human Resources Department and/or his or her department supervisor.

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- 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.

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- 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

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- 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&chkhNewsType=6&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date>

Section Title: Facilities And Environment	Section: 8
Subject : Safety Management Program	Policy: 8.3

POLICY

The purpose of this plan is to establish, support, and maintain a safety program that is based on monitoring and evaluation of organizational experience, applicable federal and state laws and regulations, and accepted practice within the healthcare industry.

Goal

The safety management plan goal is to provide a physical environment free of hazards and to manage staff activities to reduce the risk of human injuries that could affect employees, patients, visitors, and/or guests. To prepare facility's personnel to be able to demonstrate/conduct the evacuation of a patient.

Objectives

This plan is based on the following objectives:

1. Maintaining and supervising all grounds, buildings, and equipment, including special activity areas used by patients.
2. Ensuring that emergency service areas are clearly identified and easily accessible.
3. Establishing a risk-assessment program that proactively evaluates the impact on patient and public safety of the buildings, grounds, equipment, occupants, and internal physical systems.
4. Providing a safety officer, appointed by the administration, who is qualified by experience or education; responsible for developing, implementing, and monitoring the organization's safety program; and intervening whenever conditions exist that either pose an immediate threat to life or health or pose a threat of damage to equipment or buildings.
5. Reporting and investigating all incidents that involve property damage, occupational illness, and patient, employee, or visitor injury.
6. Requiring organization safety policies and procedures that are distributed, practiced, and enforced.
7. Reviewing the organizational safety policies and procedures as frequently as necessary, but no less than annually.
8. Promoting an ongoing hazard surveillance program, including response to product safety recalls.
9. Using safety-related information in the orientation of new employees and continuing education of employees.
10. Requiring an annual plan and evaluation of the objectives, scope, performance, and effectiveness of the documented safety management plan.

Policy elements

1. Safety management policy statement
2. Each employee is required to comply with safety and health standards and with the policies and procedures that apply to their job responsibilities in an effort to maintain a safe environment. Any violation of policy may result in disciplinary action.
3. Anesthesia personnel should review and be familiar with the facility's written emergency protocol for cardio-pulmonary emergencies and other internal and external disasters.
4. Maintenance and supervision of grounds and equipment

The Quality/Risk Management Committee will develop written policies and procedures to enhance safety within the facility and on the grounds. Monitor equipment and utility preventive maintenance and inspection procedures, and monitor the education and training of users to protect against failure or user error.

Equipment Safety Checklist includes but not limited to:

- Back-up emergency power system (UPS)
- Defibrillator
- Electrocautery or Bovie unit
- Laser
- Magnehelic Gauge
- Meds Refrigerator temperature
- Nurse annunciator system
- Operating or procedure table
- Oxygen / Nitrous gas cylinders, regulators, gauges
- Pulse oximeters
- Suction system or aspiration units
- Surgeon's headlights
- Surgery light or procedure lights in operating room(s)
- Vital signs monitores

An environment tour will be made of the buildings and grounds of the facility to ensure maintenance, supervision, and safe use of these buildings and grounds by patients, staff, and visitors. Patient areas will be assessed a minimum of twice yearly, non-patient areas a minimum of annually. All buildings shall comply with the appropriate provisions of the National Fire Protection Association's Life Safety Code®, 2000. Consideration will be given to parking lots/structures and the security and safety needs of these facilities, recreational areas, and special terrain problems. Plans and policies will be developed and implemented to cover security, safety, and the functional needs of patients, visitors, and employees.

Risk assessment

The safety management program, which proactively evaluates the impact of buildings, grounds, equipment, occupants, and internal physical systems on patient and public safety, is carried out by using incident reports, accident investigation, and reports from various agencies, such as insurance companies, state or county health agencies, and fire agencies.

Hazard surveillance

An ongoing hazard surveillance program, including response to product safety recalls, shall be maintained and reported through the Quality/Risk Management Committee.

Examination of safety issues

All safety-related issues shall be examined by the Quality/Risk Management Committee. The Quality/Risk Management Committee shall include representation from those areas deemed appropriate. Nonsupervisory employees will participate in activities of the safety program. All members of the Quality/Risk Management Committee are appointed by the administration/safety officer or designee. The Quality/Risk Management Committee shall evaluate the safety management program compliance by evaluation at least annually.

Incident/injury/illness reporting and investigation

The Quality/Risk Management Committee/risk management committee shall review all reports of accidents or injuries to patients, visitors, and/or personnel. Summary reports of incidents shall include description of the incident, cause, corrective actions taken, and preventive measures taken. Refer to the appropriate policies and procedures. The Quality/Risk Management Committee will establish an incident reporting system for investigating and evaluating all incidents reported and for documenting review of all such reports and actions taken.

Safety officer/designee

The safety officer and the Quality/Risk Management Committee are appointed by the administration. Administration has delegated to the Quality/Risk Management Committee the authority to take action when hazardous conditions or potential hazardous conditions exist that could result in personal injury to individuals or damage to equipment or buildings. This delegated authority has been approved by the administration and the board of directors of the facility.

New employee orientation and continuing education

1. An employee's orientation program shall address general safety processes, area-specific safety, and specific job-related hazards.
2. The Quality/Risk Management Committee will provide safety-related information through orientation of new employees
3. continuing education on employee and patient health issues
4. use of all means of communication to support the program requirements or to communicate safety issues
5. recommendation purchases of safety equipment and suggestions for any necessary physical changes to improve safety conditions

The Quality/Risk Management Committee shall coordinate the facility educational activities to effect improvements in the safety of patients, visitors, and staff. Educational programs shall include general safety procedures, department-specific safety procedures, and specific job-related hazards. Educational programs shall be based on industry standards and literature review and shall be continually adapted to reflect organizational experience and evaluation of effectiveness of training programs.

Performance improvement

The Quality/Risk Management Committee shall meet quarterly/when necessary and record the activities. A review of the safety program's performance shall be conducted at least annually. Summaries of all findings shall be forwarded to administration, the quality improvement (QI) department, and the appropriate oversight committee(s).

Performance indicators

The following indicators shall be utilized in evaluating the performance of the safety management program:

1. Environmental health and safety
2. Life safety management
3. Emergency preparedness
4. Security
5. Hazardous materials and waste
6. Infection control
7. Equipment management
8. Utilities management

Inspection, preventive maintenance, and testing of equipment

Monitor equipment and utilities for preventive maintenance and inspection procedures and monitor education and training of users to protect against failure or user error.

Safety policies and procedures

The Quality/Risk Management Committee or responsible department will develop written policies and procedures to enhance safety within the facility. All safety policies will be reviewed annually in accordance with facility policy. Any revisions, updates, or changes shall be submitted to the appropriate authority for approval. The ultimate responsibility for development and maintenance of current safety policies shall lie with the safety officer.

Annual evaluation

The safety management program will be evaluated at least annually for its effectiveness. Evaluation shall include all areas of safety management.

Responsibilities

1. Executive leadership
2. Toward fulfillment of the general and specific safety goals of the safety management plan, executive leadership shall
3. Appoint a safety officer(s) (of the Quality/Risk Management Committee) who is qualified to oversee the safety management program
4. The facility must have a written list of all equipment, materials and supplies necessary to properly carry out job assignments.

Safety officer

Toward fulfillment of the general and specific safety goals of the safety management plan, the safety officer shall provide oversight for the health and safety program at the facility

Management

Because good safety performance is an essential factor in effective cost and quality control, safety cannot be subordinated to other management interests. It must be considered as part of every operation and every function. Because they are responsible for the actions of persons reporting to them, each supervisor has the obligation to communicate safety policies and enforce safety procedures. To fulfill this responsibility, they shall enforce facility safety rules and regulations, documenting all violations. Supervise and evaluate employee performance with regard to safety on the job. Provide personal support for safety activities and safety procedures. Take prompt corrective action when unsafe acts or conditions are observed. Ensure that a safe work environment is provided for employees. Ensure that safety has been considered prior to the commencement of each task or function, not only for their own personnel, but for others who may be exposed or affected, including patients. When necessary, develop techniques and procedures relative to specific work operations or tasks, ensuring proper consideration of safety. Instruct each employee, during the orientation period and annually (or according to your accreditor or other regulating body), in the hazards associated with assigned duties and how to avoid injuries.

1. Ensure, through instruction and surveillance that each employee is aware that he or she is expected to work safely and that willful violations of safety rules will be cause for disciplinary actions, up to and including termination.
2. Instill safety awareness in each employee by personal example, regular personal contacts, and group meetings.
3. Motivate employee interest and participation in the safety program by setting an example and soliciting suggestions.
 - a. cooperate fully with safety officer/the Quality/Risk Management Committee in the promotion of safety activities.
 - b. Seek assistance from the safety officer relative to safe practices and procedures.
 - c. Ensure that employees receive all required safety training and education.
 - d. Assist in conducting training as needed.
 - e. Know and instruct employees in emergency actions, including evacuation procedures from all work areas.
 - f. Have new or relocated equipment and instrumentation checked and approved by facility services before it is placed in operation.
 - g. Ensure that adequate safety equipment and protective devices are provided for each job in each work area(s), as required, and that such equipment is properly used and maintained by the employees.
 - h. ensure that all injuries are reported and, if necessary, treated immediately.
 - i. investigate all accidents and incidents in their area to determine whether injuries resulted, and make the required reports.
 - j. participate actively when called on to serve on the Quality/Risk Management Committee. Further, appoint an alternate from the department who can attend committee meetings and represent the department in the absence of the department supervisor.

All Employees

For the safety program to be successful, each employee must know and utilize the contents of this policy to the best of his or her ability and with respect to each individual's job requirements. The absence of a safety standard on a specific job or task does not relieve employees of the safety responsibility concerning that job. If employees find that specific safety information is not available in this policy, they should contact their respective management and ask for the required information. Employees have been hired to perform their job safely and are expected to work as safely as possible and to support the safety management program.

They shall:

1. learn the safe and correct way to perform their assigned duties and shall ask their supervisor anything about which they are in doubt
2. perform their jobs in a safe, responsible manner using required safety devices and personal protective equipment provided by the health facility, following established procedures, and wearing proper, clean clothing suitable for the job they were hired to perform take no chances or short cuts in the performance of any task or procedure
3. report any accident, personal injury, or patient complaint regarding the health or safety practices, no matter how slight, to their supervisor
4. immediately report any hazard observed and suggest to the supervisor better and safer ways to perform tasks
5. always be fit for their assigned duties by practicing good health habits and personal cleanliness
6. practice good housekeeping at all times; keep equipment, tools, materials, instruments, and work areas clean and orderly
7. attend all required safety-related training
8. know what actions to take in case of fire or other emergency situation in their work area(s)
9. comply with no-smoking requirements in all patient care and hazardous areas

Spring Valley Surgery Center LLC

2016 Sentinel event reporting

3835 S. Jones Blvd. Las Vegas NV 89103 License #: 3421

2705 W. Horizon Ridge Pkwy Henderson NV 89052 License #: 5491

7175 N. Durango Drive Las Vegas NV 89149 License #: 7592

1900 N. Nellis Blvd Las Vegas NV 89115 License #: 7891

1050 E. Sahara Ave Las Vegas NV 89104 License # 8688

Safety committee:

The Administration has established a “Life Safety Enterprise Safety Program” designed to keep patients, Physicians, employees and the public safe while on the premises of the Facility. This program consists of elements which meet the requirements as defined by the The Administration has established a “Life Safety Enterprise Safety Program” designed to keep patients, Physicians, employees and the public safe while on the premises of the Facility. This program consists of elements which meet the requirements as defined by the Federal, State, Local and OSHA guidelines. The “Safety Plan” includes identification, evaluation and prevention of workplace hazards relating to the elements and specific criteria. The safety management of the Facility is composed of several elements regarding the safety features necessary for the protection and security of its patients and healthcare workers.

These elements are composed of two parts; one “Life Safety Enterprise Safety Plan” which is wide in scope, organizational and effectiveness, and the “Environmental Safety Management” which oversees the working environment elements of the Facility. These areas overlap each other but also provide individual elements which manage the overall security and safety of the Facility. A report from the Safety Committee is provided quarterly to the Medical Executive Committee (MEC) and onto the Governing Board. The Safety Committee meets and discusses how to improve and/or maintain patient and employee well-being and safety, items discussed range from falls to how to properly lift boxes, and the execution of a disaster drills, etcetera. If any incidents have occurred they will be discussed in detail, and prevention and safety will be implemented.

SUNSET RIDGE SURGERY CENTER, L.L.C.

MANUAL:	Policy & Procedure	Effective Date:	7/21/2014
SECTION:	Safety Management Plan	Reviewed Date:	7/1/2016
POLICY:	14.20 Patient Safety Program	Revised Date:	

PURPOSE: To provide quality, safe patient care, thus preventing errors and adverse events during the pre, peri, & post-operative phases of care.

PROCEDURE:

- A. The Administrator, Clinical Coordinator, Medical Director, and governing board will emphasize teamwork in building a culture of safety in this setting.
 1. The Center will take a proactive approach to identify and address activities for potential risk before errors occur.
 2. Effective communication will begin with the leaders and continue to other staff via memos, meetings, open discussions and networking.
 3. Educational tools will be given to the staff. In-service programs will be offered. Articles on safety related items will be distributed and maintained.
 4. Leadership will encourage and support cooperative openness and professionalism between the surgeon and nurses. When question arises, the team should stop and review the patient's chart for accurate information. No one should make assumptions.
 5. Leadership will be responsible to create a non-punitive environment that encourages all reporting
 6. The center will report *any incidents/ events resulting in a death or serious physical/psychological injury* or risk there of or near misses.
 7. The Administrator (or designee), Medical Director and or surgeon will be responsible to tell a patient if he or she has been harmed by the care received. There will always be two (2) people present when the patient is notified
 8. All incident reports will be reviewed, analyzed, and trended by the Safety/Risk Management and Continuous Performance Improvement Committee.
 9. The Medical Executive Committee will review the Center's Safety/Risk Management plan annually, & results of incidents as they occur or bi-annually.
- B. Staff members will participate in education and training to improve competence.
 1. Defining potential adverse events:
 - i. *An unexpected occurrence during a health care encounter involving patient death or serious physical or psychological injury or illness, including loss of limb or function, not related to the natural course of the patient's illness or underlying condition.*
 - ii. *Any process variation for which a recurrence carries a significant chance of a serious adverse outcome.*

- iii. *Events such as breaches in medical care, administrative procedures or other breaches resulting in a negative impact on a patient, even if death or loss of limb or function does not occur.*
 2. Immediate verbal and written reporting of any occurrence.
 3. Committee involvement to participate in analysis and possible change in processes to provide a safe patient environment.
 - C. Establish, maintain and review policies to comply with nationally recognized standards of care; i.e., AORN WHO CDC, AAHC, OSHA
 1. Policies include, but not limited to:
 - i. Ensure competency of the staff
 1. Registered nurses will maintain ACLS, BLS, & where appropriate, PALS certification.
 2. Non-professional clinical staff will maintain BLS certification
 3. Annually update & demonstrate competencies.
 4. Emergency drills are practiced annually
 - ii. Safety practices are in place to protect the patient during times of dependence.
 1. An identification bracelet is provided and visually checked before administration of medications or start of procedure
 2. The name of the patient's primary physician is documented on the medical record for reference in case of an emergency situation
 3. Safety devices are used; i.e., non-skid slippers, side rails, safety straps, locks on stretchers and chairs.
 4. Providers protect the patient from pressure and injury through knowledge of proper body mechanics, positioning, and padding of pressure points
 5. Patient asked for verbal identification of the type and site of surgery while in the pre-operative area. The site will be marked pre-operatively by the physician/surgeon while the patient is awake & oriented in the pre-operative area. An intraoperative "TIME OUT" is performed after draping, & prior to incision in presence of the surgeon, anesthesia provides, scrub and circulator.
 6. Sharp objects and unprotected needles are not placed in contact with or near the patient at any time.
 7. Sponges, needles, and instruments are accounted for before closing body cavity
 8. Radiopaque sponges are used intra-operatively
 9. The patient is appropriately protected from radiation, electrical and laser injuries.
 10. Suction is immediately available for unconscious patients.
 11. Patients with artificial airways in place are constantly attended.
 12. Two licensed providers are present at all times when a post-op patient is in the building.
 13. Two providers are available to help with the initial ambulation of patients who are at risk for falling.

14. Discharge of the patient who has received anesthesia or sedation is allowed only when a patient is accompanied by a responsible adult.
- iii. Medications are stored and administered safely
 1. Adequate stock of medications is maintained
 2. Security of medication from tampering, theft, and unauthorized use is ensured
 3. Expiration dates, color & clarity are checked before use.
 4. Outdated medications are removed from the storage area of medications in use
 5. Medication is stored in the appropriately controlled environment.
 6. Emergency drugs are checked for expiration dates at least monthly and are replaced immediately if used or outdated.
 7. Allergies are identified and consistently documented in a prominent and consistent location on all patient records.
 8. All patients with known allergies are identified with a red arm-band. Admitting nurse verifies allergies with the patient & notes allergy and known reaction on the red band.
 9. Nurses follow safe standards of practice identifying the drug, dose, route, time, patient's name and all allergies before administering medications.
 10. All patients are observed for untoward or allergic effects of medications administered.
 - iv. Ensure staff effectiveness
 1. The patient is appropriately attended.
 2. Heavily sedated or anesthetized patients and children are attended at all times.
 3. Patients have a method for summoning assistance within reach at all times
 4. Interventions are employed to prevent patient falls
 5. An anesthesia provider is immediately available until patients have been evaluated and discharged.
 - v. Appropriate and safe equipment is available
 1. All technical and electronic equipment is tested for safety and checked/and or calibrated by a Biomed Engineer bi-annually & records maintained in the administrator's office.
 2. Unsafe or questionable equipment is taken out of service, labeled and service call initiated.
 3. Directions are readily available for all equipment.
 4. Emergency equipment is checked daily for function and staff familiarity.
 5. Portable emergency equipment allows for safe transport to the hospital if necessary.
 6. Emergency generator is checked weekly, monthly and inspected at least twice a year by contracted maintenance personnel
 7. An internal and external communication system is available throughout the facility
 - vi. Principles of asepsis are maintained

1. All providers are knowledgeable of and practice proper techniques to prevent the spread of disease and germs
 2. Strict aseptic technique is followed in the OR and other nursing units for noninvasive or minimally invasive procedures.
 3. All personnel are truthful and ethical about any break in sterile technique
 4. Sterility of supplies is ascertained through ongoing monitoring of autoclave function, checking of expiration dates, rotating of stock, and monitoring of individual techniques of packaging for sterilization
 5. Providers with highly contagious disease will not be involved in the care of surgical patients.
- vii. Decisions about the healthcare are made thoughtfully and with regard to the individual
1. A physician knowledgeable of the patient directs the patient's care, including discharge.
 2. All pertinent and preoperative tests results are available and assessed before administration of anesthesia or the onset of the procedure.
- viii. Management recognizes the need to provide support to staff members involved in a sentinel event. Support systems will focus on the process rather than blaming individuals involved
- ix. Fire Safety- See 12.5- 12.9 in Section 12- Life Safety Management Plan

Ear Nose and Throat Surgery Center: QUALITY AND PATIENT SAFETY PLAN

DATE: 01/1/2018
VERSION: 01



This plan was created and revised by the Ear Nose and Throat Surgery Center Quality Improvement and Patient Safety committee/team. Implementation of this plan is intended to optimize the healthcare quality and patient safety outcomes, encourage recognition, reporting, and acknowledgment of risks to patient, visitor, and employee safety, as well as reduce the medical/healthcare errors and /or preventable events.

Quality Improvement and Patient Safety Committee/Program
Ear Nose and Throat Surgery Center:
8840 W. Sunset Rd. Suite B, Las Vegas, NV 89148
702-209-3377

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Commitment to Patient Safety

Ear Nose and Throat Surgery Center LLC is committed to a comprehensive approach to improving healthcare quality and patient safety by aligning with our Mission, Vision, and Values, creating an environment that supports a dynamic, proactive, and safe culture for patients, family members, visitors, and employees, through continuous learning and improving patient safety policies, systems, and processes.

Mission, Vision, and Values

In support of our mission, vision, and values, Ear Nose and Throat Surgery Center LLC Patient Safety and Quality Improvement program promotes:

- Collaboration of healthcare, leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high quality healthcare.
- Communicate honestly and openly to foster trusting and cooperative relationships among healthcare providers, staff members, and patients and their families, to ensure accountability for the patient safety priorities.
- Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.
- Responsibility for every healthcare related decision and action.
- A focus on continuous learning and improving, system design, and the management of choices and changes, bringing the best possible outcomes or performances to the facility.
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare.
- Education of staff and physicians to assure participation of healthcare providers.

Scope and Purpose

The scope of this Quality and Patient Safety Plan is organizational-wide/hospital-wide/agency-wide which includes but is not limited to

- Patient safety
- Visitor safety
- Employee safety

All staff in Ear Nose and Throat Surgery Center are required to fully support and participate in this plan, and devote their expertise to the patient safety and healthcare quality improvement process.

This plan is action oriented and solution focused. The purpose of this plan is to address patient safety related concerns, challenges and revise the program to better serve the patients and their families. To this end, Ear Nose and Throat Surgery Center has developed this Quality Improvement and Patient Safety plan.

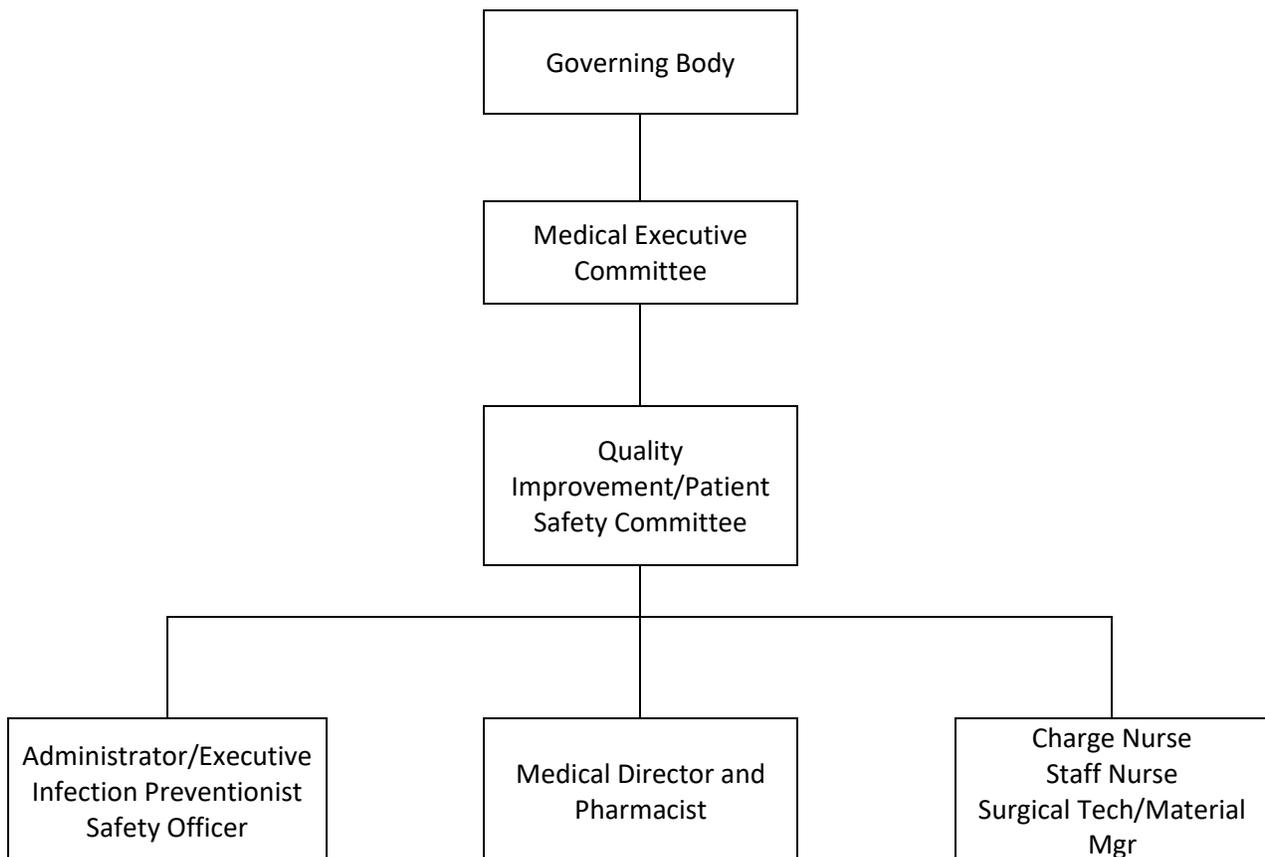
The plan focuses on the process rather than the individual, and recognizes both internal and external customers, as well as facilitates the need of analyzing and improving processes. The core principles of this plan include:

- All staff have the same goal and contribute their knowledge, vision, skill, and insight to improve the process of the Patient Safety Plan.
- Decisions will be based on data and facts, and staff will be encouraged to learn from the experiences.
- Customer based including patients, families, and visitors.
- Promote systems thinking.
- Employ well-trained and competent staff maintaining high healthcare quality.

Roles and Responsibilities

According to [NRS 439.875](#), a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plan is promoted and executed successfully.

The Patient Safety Committee Organization



Roles and Responsibilities

- In accordance with [NRS 439.875](#), a patient safety committee must be comprised of:
- The infection control officer of the medical facility;
- The patient safety officer of the medical facility, if he or she is not designated as the infection control officer;
- At least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility; and
- One member of the executive or governing body of the medical facility.

Patient Safety Committee Responsibilities (based on [NRS 439.875](#) and [NRS 439.877](#))

- Monitor and document the effectiveness of the patient identification policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the patient safety officer pursuant to [NRS 439.870](#).
- Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred.
- Review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- Review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the executive or governing body of the facility regarding:
 - (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);
 - (2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and
 - (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

Root Cause Analysis (RCA) Team Responsibilities

- Root Cause interviews, analysis, investigation, and corrective action plan implementations.
- Participates in the RCA meetings and discussions.
- Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders.

Patient Safety Officer Responsibilities (based on [NRS 439.870](#))

- Serve on the patient safety committee.
- Supervise the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the patient safety committee regarding any action taken in accordance with the responsibilities above.
- Monitors and reports to the Quality Improvement/Patient Safety Committee safety statistics.

Infection Control Officer Responsibilities (based on [NRS 439.873](#))

- Serve on the patient safety committee.
- Monitor the occurrences of infections at the facility to determine the number and severity of infections.
- Report to the patient safety committee concerning the number and severity of infections at the facility.
- Take such action as determines is necessary to prevent and control infections alleged to have occurred at the facility.
- Carry out the provisions of the infection control program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program.

RCA team leader/Facilitator Responsibilities

- Organize and coordinate the RCA process.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA, and corrective action plan implementation process.
- Communicate the progress of the investigation, institutional barriers, and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.
- Provide training, education and direction to create RCA process that incorporate the Patient Safety and Quality Improvement elements.

Executive or Governing Body Staff Responsibilities

- Provide vision and leadership to Patient Safety and Quality Improvement process, and develop and foster a safe learning and improving culture.
- Provides oversight to the healthcare quality improvement processes and teams.
- Plan, discuss, and generate the organization patient safety goals and activities, in conjunction with the patient safety action plans

The Patient Safety Committee will meet monthly to accomplish the following:

- Report and discuss sentinel events which include:

- Number of sentinel events from previous calendar month.
- Number of severe infections that occurred in the facility.
- Corrective Action Plan for the sentinel events and infections
 - Evaluate the corrective action plan.
- Patient safety policies and checklists
 - At least annually evaluate Patient Safety policies and checklists
 - Revise the patient safety policies and checklists as needed.
 - Monitor and document the effectiveness of the patient safety policy.

A RCA meeting will meet as needed to accomplish the following:

- Define the healthcare issues or potential risks.
- Conduct Root Cause Analysis
 - Reviewing and analyzing the data.
 - Reviewing the RCA process and quality improvement related activities and timelines.
 - Brainstorming issues or the potential risks by using the fishbone diagrams.
 - Identify the contributing factors and conduct the Root Cause Analysis.
- Conduct Corrective Action Plan
 - Identifying the Plan-Do-Study-Act (PDSA) topics.
 - Discussing corrective action process and activities.
 - Discussing and presenting possible changes in procedure to improve areas indicated.
 - Identifying strengths and areas that need improvement.
 - Developing strategies, solutions, and steps to take next.
- Identify barriers and technical assistance needs for supporting the RCA efforts.

A meeting agenda and minutes noting follow-up tasks will be kept.

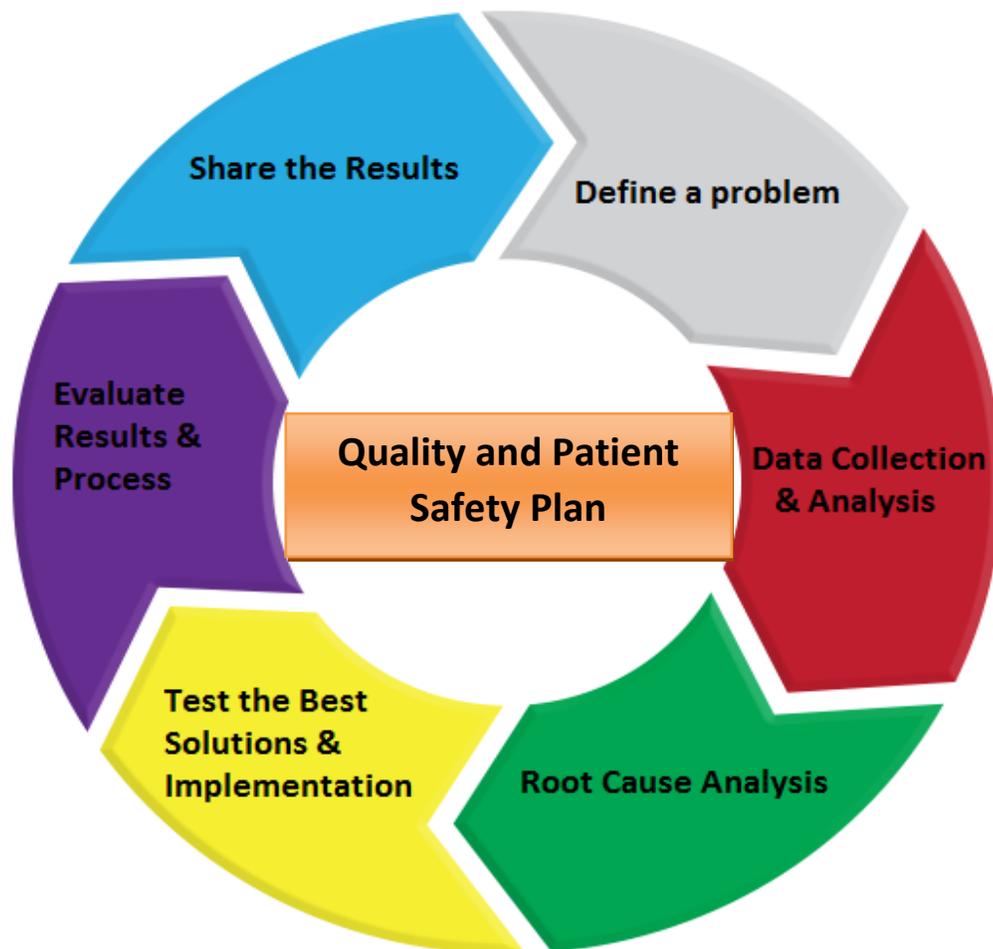
Objectives and Goals of the Quality and Patient Safety Plan

Objective	Goals	Plan	Planned Completion Date	Responsible Party

Components and Methods

Pursuant to [NRS 439.837](#), a medical facility shall, upon reporting a sentinel event pursuant to [NRS 439.835](#), conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event.”

Ear Nose and Throat Surgery Center will use RCA process to determine the contributing factors and the underlying reasons for the deficiencies or failures. The Plan-Do-Study (check)-Act (PDSA or PDCA) is the model, which was developed by the Institute of Health Care Improvement, that we will use to test the changes.



Root Cause Analysis

A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals.

Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

Root cause analysis and action plan framework table, which was introduced by the Joint Commission. It contains 24 analysis questions. It guides the organization to the steps in a root cause analysis. Not all the questions apply to all the events or cases. This table can be used individually or with the fishbone diagram.

5 Whys technique will be used in Ear Nose and Throat Surgery Center to explore the cause and effect relationship underlay a problem. One can find the root causes by asking “why” no less than five times. This technique can be used individually or as a part of the fishbone diagram.

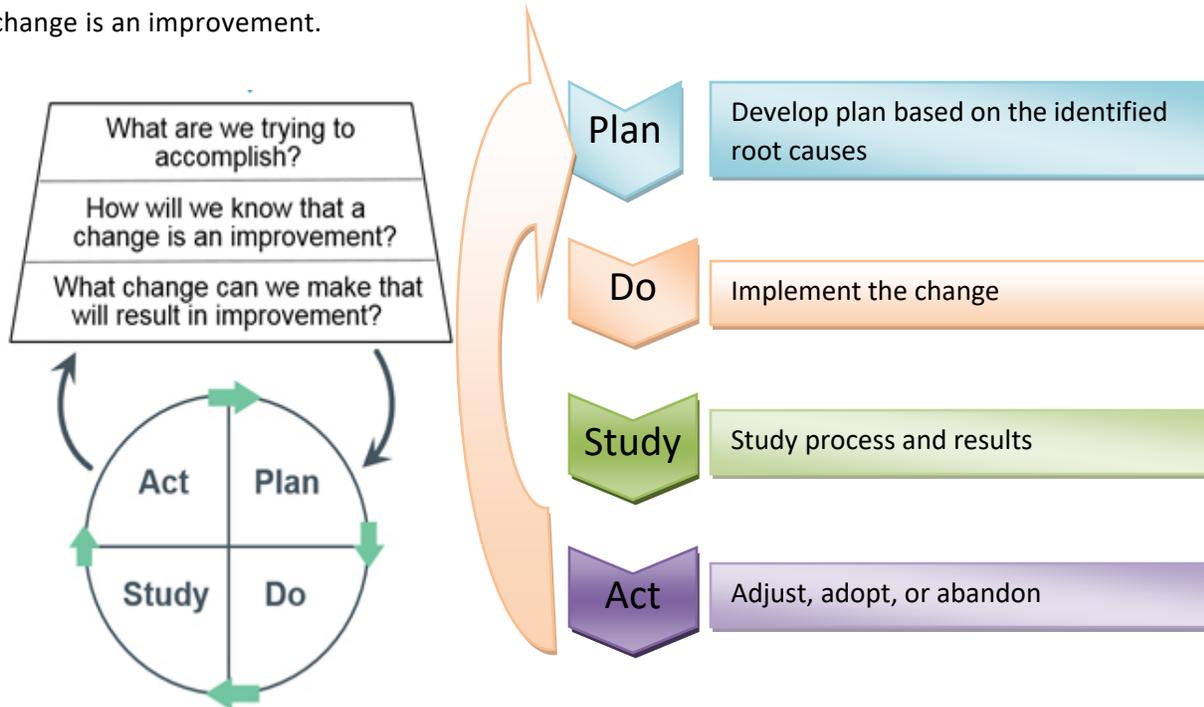
Fishbone Diagram

Once the problems are identified, a Fishbone Diagram (Appendix C) will be used for analyzing the problems. You can use the fishbone diagram individually to analyze the root causes, or use it with the root cause analysis and action plan framework table.

A Fishbone Diagram, also called a Cause-and-Effect diagram, is a useful tool for a team to structurally brainstorm by discovering possible underlying factors or root causes from different major categories for the chosen problems. General categories used include: people, methods, materials, measurements, education, procedures, process, location, environment, etc. RCA team members will brainstorm and ask multiple times, “why did this happen?” for each cause until all ideas are exhausted. The highest priority root causes will be chosen for PDSA topics. Once all the categories are established on the fishbone diagram, 5 Why’s technique also can be used to drill down the problem and find the root causes.

Model for Improvement

The Model for Improvement is a collaborative and ongoing effort model to improve the product and services quality and process. It provides multi-disciplinary quality team guidance from identifying the root causes; conducting the best tests to assess possible changes, and working in collaboration for implementation of the new approaches and solutions. It guides the test of a change to determine if the change is an improvement.



The cycle is defined as follows:

- Plan--collect data and establish appropriate goals. Identify the problem and the possible root causes, and answer the following questions.
 - What is the objective of the test?
 - What are the steps for the test - who, what, when?
 - How will you measure the impact of the test?
 - What is your plan to collect the data needed?
 - What do you predict will happen?

- Do--make changes designed to correct or improve the situation. Use the following questions for the guidance.
 - What were the results of the test?
 - Was the cycle carried out as designed or planned?
 - What did you observe that was unplanned or expected?

- Study -- Study the effect of the changes on the situation. Data should be collected on the new process and compared to the baseline or expected results. Results should be evaluated and by using the following questions as guidance.
 - Did the results match your prediction?
 - What did you learn?
 - What do you need to do next?
- Act--If the result is successful or desirable, standardize the changes and then work on the next prioritized problem or the further improvements. If the outcome is not yet successful, look for different ways to identify the causes or change the testing process.

PDSA worksheet will be used to map the potential change strategies and to establish a course of action. The PDSA worksheet and the PDSA progress report are attached in Appendix D-1.

Data Collection and Reporting

Data should drive any quality and patient safety effort. (Facility name) is using (data system names) for tracking the sentinel events, healthcare infection data, and (any other database) for internal data collection.

External data sources are those data sources which are collected outside the supervisory structure of the case. External data which will be utilized for Quality and Patient Safety plan include the data from:

- AHRQ: Agency for Healthcare Research & Quality
- CDC: Centers for Disease Control and Prevention
- CMS: Centers for Medicare & Medicaid Services
- NQF: National Quality Forum
- NHSN: National Healthcare Safety Network
- TJC: The Joint Commission



Ongoing Reporting and Review

Data points such as the following will be reviewed according to the schedule prescribed:

Monthly	Quarterly	Annually
1) Sentinel event monthly report 2) Severity of infection report 3) RCA assessment	1) Sentinel event quarterly report 2) Severity of infection report 3) Review and evaluate the measure of improvement of patient safety 4) Review and evaluate the measurement to prevent and control infections	1) Quality and Patient Safety Plan update 2) Checklists and Policies reviewing and revising

Assessment of the Quality and Patient Safety Plan

Please see the Patient Safety Assessment Tool (PSAT) from the VA National Center for Patient Safety for your reference.

Patient Safety Checklists and Patient Safety Policies

By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

The patient safety checklists must follow protocols to improve the health outcomes of patients at the medical facility and must include, without limitation:

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.
- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - Proper instructions concerning prescription medications;
 - Instructions concerning aftercare;
 - Any other instructions concerning his or her care upon discharge; and
 - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include, the name and date of birth of the patient.
- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.
- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

Based on [NRS 439.865](#), the patient safety plan must also include an infection control program that carries out the infection control policy. The policy must consist of:

- The current guidelines appropriate for the facility's scope of service developed by a nationally recognized infection control organization as approved by the State Board of Health which may include, the Association for Professionals in Infection Control and Epidemiology (APIC), the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO) and the Society for Healthcare Epidemiology of America (SHEA); and

- Facility-specific infection control developed under the supervision of a certified Infection Preventionist.

The patient safety checklists are listed in Appendix E. (The following links provide some patient safety checklists for your reference— a checklist example is shown in **Appendix E.**)

http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf

<http://www.who.int/patientsafety/implementation/checklists/en/>

The patient safety policies are listed in Appendix F. (The following link provides you some patient safety policies for your reference—a policy example is shown in **Appendix F.**)

<https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>

Approval of Patient Safety Plan

According to [NRS 439.865](#), a medical facility shall submit its patient safety plan to the governing board of the facility for approval. After a facility's patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan.

The patient safety plan must be reviewed and **updated annually** in accordance with the requirements for approval set forth in this section.

According to [NRS 439.843](#), on or before March 1 of each year, a copy of the most current patient safety plan established to [NRS 439.865](#) must be submitted to the Division of Public and Behavioral Health.

Reference

- Root Cause Analysis Toolkit <http://www.health.state.mn.us/patientsafety/toolkit/>
- Quality and Service Improvement Tools http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html
- CQI 101 An Introduction to Continuous Quality Improvement: <https://www.coursehero.com/file/13827355/CQI-Overviewppt/>
- Quality Improvement <http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/>
- Root Cause Analysis <http://www.patientsafety.va.gov/professionals/onthejob/rca.asp>
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2 https://www.jointcommission.org/sentinel_event.aspx
- Hospital Policies <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>
- Checklists to Improve Patient Safety http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf
- Patient Safety Checklists <http://www.who.int/patientsafety/implementation/checklists/en/>
- Minutes of the Meeting of the Quality and Patient Safety Committee <http://www.cookcountyhhs.org/wp-content/uploads/2013/12/09-23-14-QPS-scan-Minutes.pdf>
- Title 40 – Public Health and Safety <https://www.leg.state.nv.us/NRS/NRS-439.html>

Appendix A: Terms and Definitions

Patient Safety: The Agency for Healthcare Research Quality (AHRQ) defines patient safety as “a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.” http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

Sentinel event ([NRS 439.830](#))

1. Except as otherwise provided in subsection 2, “sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum.

2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:

(a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or

(b) July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published.

3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.

(Added to NRS by [2002 Special Session, 13](#); A [2005, 599](#); [2013, 217](#))

Institute for Healthcare Improvement (IHI) defines **medical harm** as “unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death.”

Facility-Associated Infection: ([NRS 439.802](#))

“Facility-acquired infection” means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections;
- Ventilator-associated pneumonia;
- Central line-related bloodstream infections;
- Urinary tract infections; and
- Other categories of infections as may be established by the State Board of Health by regulation pursuant to [NRS 439.890](#).

(Added to NRS by [2005, 599](#); A [2009, 553](#))

Medical facility ([NRS 439.805](#))

“Medical facility” means:

- A hospital, as that term is defined in [NRS 449.012](#) and [449.0151](#);
- An obstetric center, as that term is defined in [NRS 449.0151](#) and [449.0155](#);
- A surgical center for ambulatory patients, as that term is defined in [NRS 449.0151](#) and [449.019](#); and
- An independent center for emergency medical care, as that term is defined in [NRS 449.013](#) and [449.0151](#).

(Added to NRS by [2002 Special Session, 13](#))

Near miss: An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF),

Serious Reportable Events in Healthcare 2009 Update.)

Mandatory reporting: Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985;254(6):796-800.)

Risk: Possibility of loss or injury. (Merriam-Webster's Online Dictionary, Risk, Available at <http://www.merriamwebster.com/dictionary/risk>. Last Accessed August 2009.)

Preventable event: Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Catheter Associated Urinary Tract Infection (CAUTI): A urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CUR_RENT_b.pdf.)

Central Line Associated Bloodstream Infections (CLABSI): Primary bloodstream infections that are associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection.

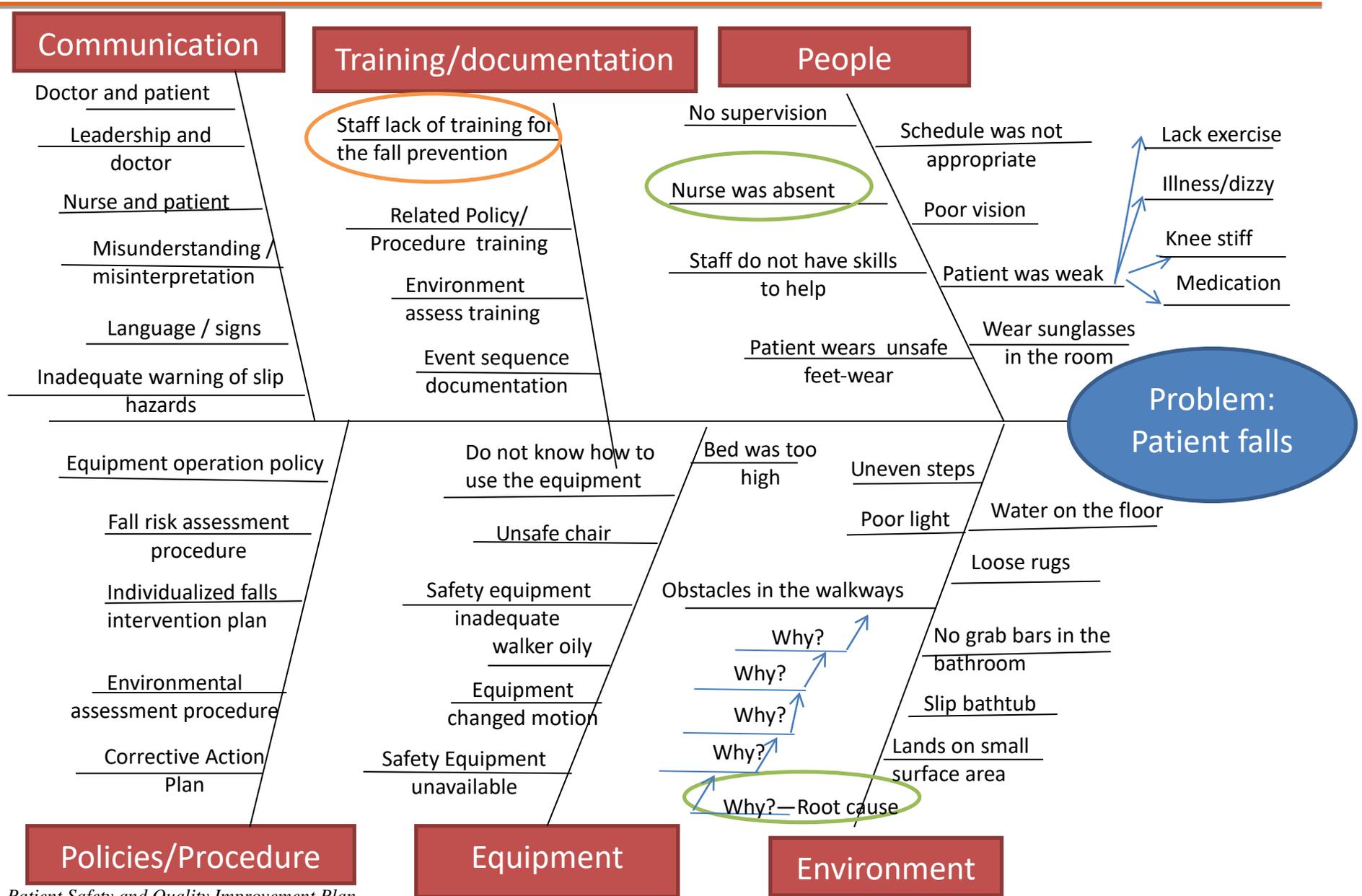
Appendix B: Patient Safety Goals

OBJECTIVE:	GOAL:	Q3 2014	Q4 2014	Q1 2015
ACTION PLAN:				
1. Create Systems that anticipate errors & either prevent or catch them before they cause harm.	a. Enhance retrospective chart review process. b. Establish an automated surveillance process. c. Conduct a proactive risk assessment in a high risk area.		Complete an in-depth analysis of risk point utilizing the methods of FMEA.	Implement Trigger Tools. Develop automated surveillance reports in Cerner.
		Implemented e-MERS & PSO with UHC.	Create process for reviewing & closing reports in e-MERS. Increase number of events reported by 10%. Create process for communicating outcome of reported events.	
2. Establish Structures for reporting and a process for managing reports in the event reporting system.	a. Implement new electronic Voluntary Reporting System & participate in Patient Safety Organization. b. Develop a structure to educate employees system-wide of the process for reporting hazards, errors and adverse events. c. Establish a process for providing feedback regarding reported events.			
3. Develop a Culture of Safety where providers feel safe and supported when they report medical errors or near misses & voice concerns about patient safety.	a. Provide education on patient safety plan that emphasizes importance of blending a systems focus with appropriate individual accountability. b. Establish a recognition program that rewards safe practices. c. Improve overall perceptions of safety as measured by the Culture of Safety Survey.		Educate Medical staff, Hospital Wide Oversight & the Quality Committees on the objectives and goals of the patient safety plan. Include patient safety presentation in monthly New Employee Orientation. Develop 'Great Catch' awards program.	Re-evaluate culture of safety and develop action plan.
4. Establish Safety Priorities & Targets.	a. Develop Patient Safety Dashboard that includes national measures and benchmarks. b. Facilitate the development of action plans associated with measures not meeting benchmarks. c. Assess and improve processes related to hand-off, transition and communication	Complete 2014 Leapfrog Safety Survey.	Present Patient Safety Dashboard monthly to Hospital Wide Oversight Committee. Establish & implement a plan to improve performance of each leap.	
		Develop method to track & report departmental progress and compliance of RCA action plans.		
5. Charter Safety Programs through teams, workgroups or projects.	a. Coordinate Improvement Efforts in order to ensure that capital, people, facilities & technologies are matched to strategic priorities for safe practices. b. Reduce and eliminate variation in care.		Establish Patient Safety Council. Establish workgroups focused on medication safety, reducing patient falls & hospital acquired pressure ulcers.	
			Revise or develop policies, procedures and protocols.	

Reference: Patient Safety Plan and Its Applicable Goals. 2014. Cook County Health and Hospitals System.

Patient Safety and Quality Improvement Plan

Appendix C: Fishbone Diagram



Appendix D-1: PDSA Worksheet

PDSA Worksheet

Topic:			
Person Completing Worksheet:		Date:	
Telephone/ Email:		Cycle:	
Patient Safety Committee Members			
CEOs/CFOs			
Patient Safety Officer			
Infection Control Officer			
Other Medical Staff			
Other team members			
Aim: (Describe the overall SMART goal that your team wishes to achieve.)			
Plan:			
1. List the tasks needed to set up this test of change.			
2. Predict what will happen when the test is carried out.			

3. List the steps to develop the test-who, what, and when.			
Steps	By Whom	By When	Desired Outcome
Do: (Describe what actually happened when you ran your test, including any problems and unexpected findings.)			
Study: (Describe what you learned and did you meet your measurement goal?)			
Did you meet your measurement goal? Explain.		Summarize what was learned: success, failure, unintended consequences, etc.	
Act: (Describe what you concluded from this cycle.)			
Based on what was learned, please indicate what action will be considered.		Describe what modifications to the plan will be made for the next cycle based on what you learned.	
<input type="checkbox"/> Adapt: modify changes and repeat PDSA Cycle			
<input type="checkbox"/> Adopt: expanding changes throughout organization			
<input type="checkbox"/> Abandon: change approach and repeat PDSA cycle			

Appendix D-2: PDSA Monthly / Quarterly Progress Report

Event:			
Person Complete Report:		Date:	
Patient Safety Officer		Contact Information:	
Monthly / Quarterly Report			
Items	Description		
1. What is your goal?			
2. Report on the PDSA cycle			
3. What system and practices are working well? Explain.			
4. What areas for improvement did the data identify?			
5. What barriers or system issues have been encountered implementing action activities?			
6. Action plans to address the barriers or system issues			
7. Lesson learned			
8. Support needed			
9. Additional discussion			
Notes:			

Appendix E: Checklist Example: Injuries from Falls and Immobility

Process Change	In Place	Not Done	Will Adopt	Notes (Responsible & By When?)
Conduct fall and injury risk assessment upon admission				
Reassess risk daily and with changes in patient condition				
Implement patient-specific intervention to prevent falls and injury				
Communicate risk across the team; use handoff forms, visual cues, huddles				
Round every 1 to 2 hours for high-risk patients; address needs (e.g., 3Ps: pain, potty, position-pressure). Combine with other tasks(vital signs)				
Individualize interventions. Use non-skid floor mats, hip protectors, individualized toileting schedule; adjust frequency of rounds				
Review medications (by pharmacist); avoid unnecessary hypnotics, sedatives				
Incorporate multidisciplinary input for falls				
Prevention from PT, OT, MD, RN and PharmD				
Include patients, families and caregivers in efforts to prevent falls. Educate regarding fall prevention measures; stay with patient				
Hold post-fall huddles immediately after event; analyze how and why; implement change to prevent other falls				

Reference: Checklists to Improve Patient Safety. June 2013. Health Research & Educational Trust.

Appendix F: Policy Example

[Reference: Hospital Policies. MERCY Hospital. <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>]

	HOSPITAL POLICY AND INFORMATION MANUAL	
<p>PERSONAL PROTECTIVE EQUIPMENT POLICY Page 1 of 2</p>	<p>Date Issued: 07/01 08/14 Date Last Revised: 08/17 Next Review Date: Approved By: Policy Committee</p>	

Key Words: personal protective equipment, PPE, safety equipment,

Policy Applies to:

- All staff employed by Mercy Hospital;
- Credentialed Specialists, Allied Health Professionals, patients, visitors and contractors will be supported in meeting policy requirements.

Related Standards:

- Infection and Prevention and Control Standards NZS 8134.3:2008
- Health and Safety in Employment Act 1992
- EQulP5 - 1.5.1 and 1.5.2 Infection Control
- EQulP5 - Standard 3.2 Criterion 3.2.1 Health and Safety

Rationale:

Mercy Hospital will provide suitable personal protective equipment (PPE) when the risk to health and safety cannot be eliminated or adequately controlled by other means.

Definitions:

Personal protective equipment (PPE) means all equipment which is intended to be worn or held by a person to protect them from risk to health and safety while at work.

Examples of PPE include: protective footwear, gloves, hard hats/helmets, clothing affording protection from the weather, visibility clothing, eye and face protection.

Objectives:

- To ensure appropriate PPE is identified to minimize hazards not able to be controlled by elimination or isolation;
- To ensure fit for purpose PPE is provided at Mercy Hospital for use by staff;
- To ensure adequate training in the use of PPE is provided;
- To monitor the use of PPE and evaluate effectiveness.

	HOSPITAL POLICY AND INFORMATION MANUAL	
<p>PERSONAL PROTECTIVE EQUIPMENT POLICY Page 2 of 2</p>	Date Issued: Date Last Revised: Next Review Date: Approved By:	07/01 08/14 08/17 Policy Committee

Implementation:

Risk Management

Department Managers, the Occupational Health/ Infection Prevention and Control Nurse (OH/IPC Nurse) and Health and Safety/ Infection Control Representatives (HSIC reps) will in consultation with staff:

Ensure PPE requirements are identified when carrying out risk assessments of activities;

- Regularly review the risk assessment of activities if substances or work processes change;
- Identify the most suitable type of PPE that is required;
- Ensure PPE is available to those who need it;
- Inform staff of the risks involved in their work and why PPE is required;
- Monitor compliance.

Process

Manager’s Responsibilities

Must ensure that:

- PPE requirements are considered when risks are assessed;
- Suitable PPE is provided and made accessible to employees;
- PPE is properly stored, maintained, cleaned repaired and replaced when necessary;
- Adequate information and training is provided to those who require PPE;
- PPE is properly used;
- Use of PPE is monitored and reviewed.

Employee’s Responsibilities All employees must ensure that:

- They use PPE whenever it is required;
- Attend and comply with training, instruction and information;
- Check the condition of their PPE;
- Store, clean and maintain their PPE;
- Report losses, defects or other problems with PPE to their manager.

Evaluation:

- Staff health and safety orientation
- Environmental audits
- Incident reports

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Purpose

To establish the role of hospital leadership, hospital staff and medical staff in an integrated 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 Plan
Tahoe Pacific Hospitals North
2018
Patient Safety Program

Purpose

Tahoe Pacific Hospital 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 Tahoe Pacific to foster a safe and safety-conscious environment that promotes wellbeing, acknowledges and addresses risks, and encourages interdisciplinary safety and education focusing on process improvement.

Scope

Overall Patient Safety 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:

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Tahoe Pacific Hospitals North
2018

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 multidisciplinary in nature with representatives from the hospital and medical staff. Imbedded in each performance improvement team are safety issues relevant to the team's focus. Reports from each performance improvement team are sent to the Quality Council, and reported to the Medical Executive Committee and the Governing Board.

The Patient Safety Committee is also multidisciplinary with representation from the following areas at a minimum: Clinical Departments, Pharmacy and Therapeutics Committee, Safety Committee, Quality/Risk Management and Infection Control.

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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 Tahoe Pacific Lifecare Hospital believes in a non-punitive reporting environment in order to maximize reporting of near misses, adverse outcomes, and sentinel events as it has been demonstrated that many errors are directly related to system and process failures. Disciplinary action may be considered when an involved individual takes action to hide the incident, is malicious or untruthful in reporting, when facts and circumstances suggest that the error was deliberate or in reckless disregard to patient and staff safety, or when the individual consistently fails in the detection, reporting or remedies to prevent mistakes. Reporting of patient safety issues to an outside agency will be done when required by regulation or as determined by the Administrator/CEO

The activities of the Patient Safety Program 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.

Patient Safety Program

Purpose

Tahoe Pacific has developed a Patient Safety Program in conjunction with the Performance Improvement Plan and Program, the Risk Management Plan and Program, and the Hospital Scope of Services, in order to provide guidelines for implementation of an integrated patient safety program throughout the hospital and to comply with the requirements of the state of Nevada. It is the intent of the leadership of the hospital to foster a safe and safety-conscious environment that promotes wellbeing, acknowledges and addresses risks, and encourages interdisciplinary safety and education focusing on process improvement.

Scope

Overall Patient Safety responsibilities include the following:

- 1. Improve the accuracy of patient identification.** 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 for safe 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

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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.

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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 multidisciplinary in nature with representatives from the hospital and medical staff. Imbedded in each performance improvement team are safety issues relevant to the team's focus. Reports from the performance improvement teams are sent to the Quality Council and reported to the Medical Executive Committee and the Governing Board.

In compliance with State of Nevada Regulations, the Patient Safety Committee is comprised of:

- (1) The patient safety officer of the medical facility.
- (2) At least three providers of health care who treat patients at the medical facility, including, without limitation, at least one member of the medical, nursing, and pharmaceutical staff of the medical facility.
- (3) One member of the executive or governing body of the medical facility.

The Patient Safety Committee is also multidisciplinary with representation from the following areas: Clinical Departments, Pharmacy and Therapeutics Committee, Safety Committee, Quality/Risk Management, and the Hospital's Infection Control Preventionist.

The Patient Safety Committee functions include but are not limited to:

1. Review and evaluate internal and external patient safety data from the following sources for opportunities for improvement in the safety of patient care processes:
 - a. Risk and Safety Management
 - b. External Data Reports
 - c. Sentinel Event Alerts from the Joint Commission

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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 Hospital believe in a non-punitive reporting environment in order to maximize reporting of near misses, adverse outcomes, and sentinel events as it has been demonstrated that many errors are directly related to system and process failures. Disciplinary action may be considered when an involved individual takes action to hide the incident, is malicious or untruthful in reporting, when facts and circumstances suggest that the error was deliberate or in reckless disregard to patient and staff safety, or when the individual consistently fails in the detection, reporting or remedies to prevent mistakes. Reporting of patient safety issues to an outside agency will be done when required by regulation or as determined by the Administrator/CEO.

The activities of the Patient Safety Program and an annual review of the Patient Safety Plan, appropriate policies, forms, checklists and best practices will be reported to the Patient Safety Committee, the Medical Executive Committee, and the Governing Board as outlined in the Performance Improvement Plan and the LifeCare Reporting Calendar. Communication within the hospital and medical staff is the key to a successful patient safety program and will be encouraged.

Education and training is an important and effective tool in assuring that the Patient Safety Program is clearly understood, particularly error identification and reporting and the basic approaches to Patient Safety. Education and training on patient safety is included in new employee general and department orientation and reviewed annually. Additionally, education will be provided to patients and their families about their role in helping to facilitate the safe delivery of care.

Facility Name:

QUALITY AND PATIENT SAFETY PLAN Template

DATE: 01/06/2017
VERSION:1



This plan was created and revised by the Siena Heights Surgery Center Patient Safety committee/team. Implementation of this plan is intended to optimize the healthcare quality and patient safety outcomes, encourage recognition, reporting, and acknowledgment of risks to patient, visitor, and employee safety, as well as reduce the medical/healthcare errors and /or preventable events.

Patient Safety Committee/Program
Siena Heights Surgery Center
2865 Siena Heights Dr Suite 200
Henderson, NV 89052

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Commitment to Patient Safety

Siena Heights Surgery Center is committed to a comprehensive approach to improving healthcare quality and patient safety by aligning with our Mission, Vision, and Values, creating an environment that supports a dynamic, proactive, and safe culture for patients, family members, visitors, and employees, through continuous learning and improving patient safety policies, systems, and processes.

Mission, Vision, and Values

In support of our mission, vision, and values, Siena Heights Surgery Center Patient Safety and Quality Improvement program promotes:

- Collaboration of healthcare, leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high quality healthcare.
- Communicate honestly and openly to foster trusting and cooperative relationships among healthcare providers, staff members, and patients and their families, to ensure accountability for the patient safety priorities.
- Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.
- Responsibility for every healthcare related decision and action.
- A focus on continuous learning and improving, system design, and the management of choices and changes, bringing the best possible outcomes or performances to the facility.
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare.
- Education of staff and physicians to assure participation of healthcare providers.

Scope and Purpose

The scope of this Quality and Patient Safety Plan is organizational-wide/hospital-wide/agency-wide which includes but is not limited to

- Patient safety
- Visitor safety
- Employee safety

All staff in Siena Heights Surgery Center are required to fully support and participate in this plan, and devote their expertise to the patient safety and healthcare quality improvement process.

This plan is action oriented and solution focused. The purpose of this plan is to address patient safety related concerns, challenges and revise the program to better serve the patients and their families. To this end, Siena Heights Surgery Center has developed this Patient Safety plan.

The plan focuses on the process rather than the individual, and recognizes both internal and external customers, as well as facilitates the need of analyzing and improving processes. The *Patient Safety and Quality Improvement Plan*

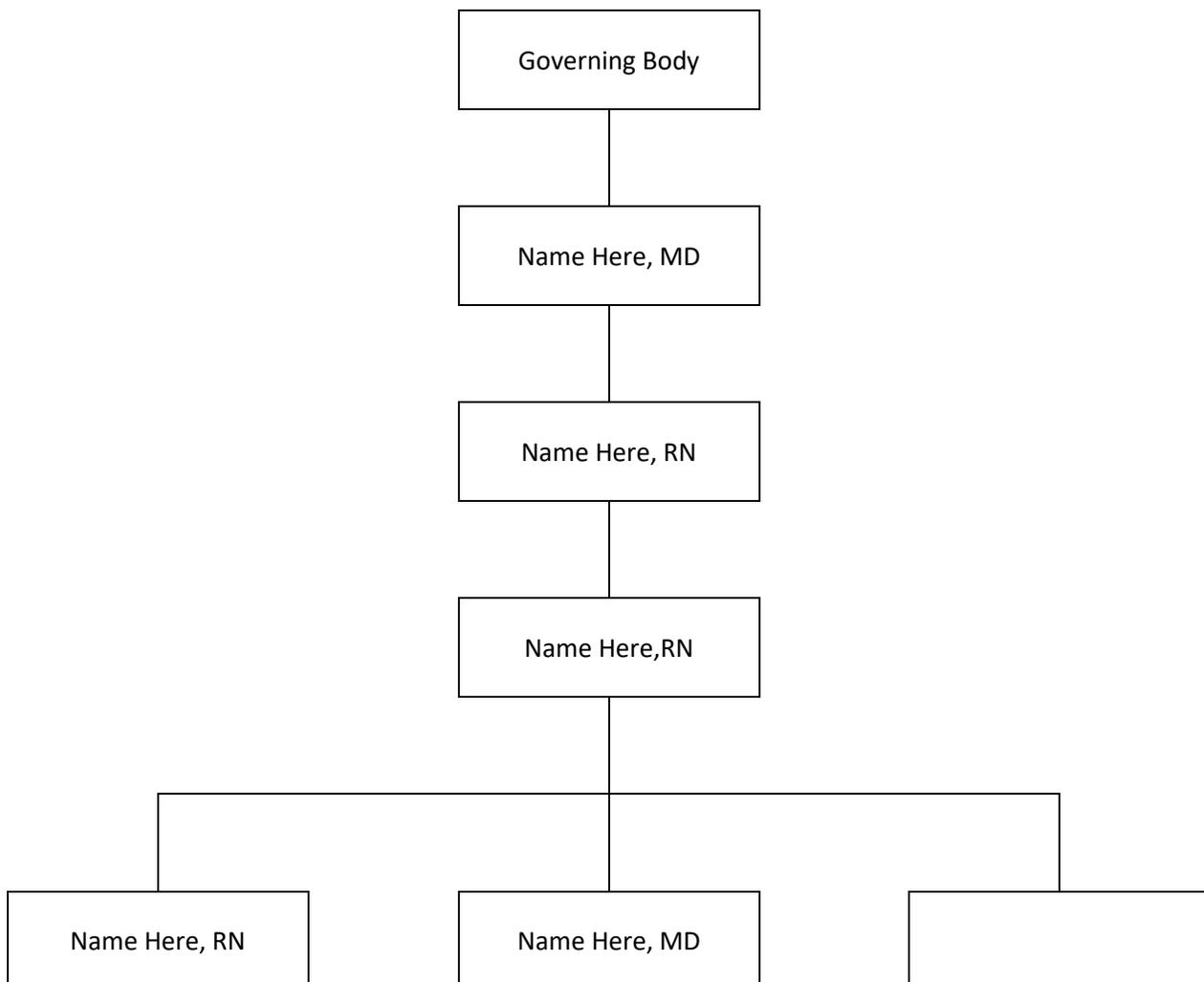
core principles of this plan include:

- All staff have the same goal and contribute their knowledge, vision, skill, and insight to improve the process of the Patient Safety Plan.
- Decisions will be based on data and facts, and staff will be encouraged to learn from the experiences.
- Customer based including patients, families, and visitors.
- Promote systems thinking.
- Employ well-trained and competent staff maintaining high healthcare quality.

Roles and Responsibilities

According to [NRS 439.875](#), a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plan is promoted and executed successfully.

The Patient Safety Committee Organization



Roles and Responsibilities

- In accordance with [NRS 439.875](#), a patient safety committee must be comprised of:
- The infection control officer of the medical facility;
- The patient safety officer of the medical facility, if he or she is not designated as the infection control officer;
- At least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility; and
- One member of the executive or governing body of the medical facility.

Based on [NAC 439.920](#), a medical facility that has fewer than 25 employees and contractors must establish a patient safety committee comprised of:

- The patient safety officer of the medical facility;
- At least two providers of healthcare who treat patients at the medical facility, including but without limitation, one member of the medical staff and one member of the nursing staff of the medical facility; and
- The Chief Executive Officer (CEO) or Chief Financial Officer (CFO) of the medical facility.

The roles and responsibilities are defined below (Please modify them as needed.)

Patient Safety Committee Responsibilities (based on [NRS 439.875](#) and [NRS 439.877](#))

- Monitor and document the effectiveness of the patient identification policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the patient safety officer pursuant to [NRS 439.870](#).
- Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred.
- Review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- Review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the executive or governing body of the facility regarding:
 - (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);
 - (2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and
 - (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.

- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

Root Cause Analysis (RCA) Team Responsibilities (please revise as needed)

- Root Cause interviews, analysis, investigation, and corrective action plan implementations.
- Participates in the RCA meetings and discussions.
- Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders.

Patient Safety Officer Responsibilities (based on [NRS 439.870](#))

- Serve on the patient safety committee.
- Supervise the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the patient safety committee regarding any action taken in accordance with the responsibilities above.

(Additional responsibilities here if needed)

Infection Control Officer Responsibilities (based on [NRS 439.873](#))

- Serve on the patient safety committee.
- Monitor the occurrences of infections at the facility to determine the number and severity of infections.
- Report to the patient safety committee concerning the number and severity of infections at the facility.
- Take such action as determines is necessary to prevent and control infections alleged to have occurred at the facility.
- Carry out the provisions of the infection control program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program.

(Additional responsibilities here if needed)

RCA team leader Responsibilities (please revise as needed)

- Organize and coordinate the RCA process.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA, and corrective action plan implementation process.
- Communicate the progress of the investigation, institutional barriers, and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.

- Provide training, education and direction to create RCA process that incorporate the Patient Safety and Quality Improvement elements.

RCA Facilitator Responsibilities

(Please provide the responsibilities here)

Executive or Governing Body Staff Responsibilities (please revise as needed)

- Provide vision and leadership to Patient Safety and Quality Improvement process, and develop and foster a safe learning and improving culture.
- Provides oversight to the healthcare quality improvement processes and teams.
- Plan, discuss, and generate the organization patient safety goals and activities, in conjunction with the patient safety action plans

(Please provide additional responsibilities here if needed)

The Patient Safety Committee will meet monthly (or quarterly) to accomplish the following:

- Report and discuss sentinel events which include:
 - Number of sentinel events from previous calendar month (or quarter).
 - Number of severe infections that occurred in the facility.
- Corrective Action Plan for the sentinel events and infections
 - Evaluate the corrective action plan.
- Patient safety policies and checklists
 - At least annually evaluate Patient Safety policies and checklists
 - Revise the patient safety policies and checklists as needed.
 - Monitor and document the effectiveness of the patient safety policy.

A RCA meeting will meet as needed to accomplish the following:

- Define the healthcare issues or potential risks.
- Conduct Root Cause Analysis
 - Reviewing and analyzing the data.
 - Reviewing the RCA process and quality improvement related activities and timelines.
 - Brainstorming issues or the potential risks by using the fishbone diagrams.
 - Identify the contributing factors and conduct the Root Cause Analysis.
- Conduct Corrective Action Plan
 - Identifying the Plan-Do-Study-Act (PDSA) topics.
 - Discussing corrective action process and activities.
 - Discussing and presenting possible changes in procedure to improve areas indicated.
 - Identifying strengths and areas that need improvement.
 - Developing strategies, solutions, and steps to take next.
- Identify barriers and technical assistance needs for supporting the RCA efforts.

A meeting agenda and minutes noting follow-up tasks will be kept.

Objectives and Goals of the Quality and Patient Safety Plan

Objective	Goals	Plan	Planned Completion Date	Responsible Party
Minimize risks and hazards of patient care	Attain zero burn injuries	Ensure all jewelry is removed preoperatively when ESU is to be used. Ensure grounding pad is properly placed. Assess patient's skin pre and post procedure. Allow prep to completely dry prior to draping.	3/05/2018	All preop and OR nurses.
Reduction of patient infections	Attain zero infection rate	Ensure antibiotic is given within 1 hour of incision time. Ensure skin is properly prepped prior to procedure start. Maintain greater than 90% compliance in hand hygiene.	3/05/2018	All staff
Prevent surgical mistakes	Maintain zero surgical mistakes	Develop reference cards to promote consistency among staff in time out procedure. Ensure surgeon marks site prior to procedure.	3/05/2018	All preop and OR nurses.

Components and Methods

Pursuant to [NRS 439.837](#), a medical facility shall, upon reporting a sentinel event pursuant to [NRS 439.835](#), conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event."

(Facility name) will use RCA process to determine the contributing factors and the underlying reasons for the deficiencies or failures. The Plan-Do-Study (check)-Act (PDSA or PDCA) is the model, which was developed by the Institute of Health Care Improvement, that we will use to test the changes.



Root Cause Analysis

A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals.

Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

Root cause analysis and action plan framework table, which was introduced by the Joint Commission. It contains 24 analysis questions. It guides the organization to the steps in a root cause analysis. Not all the questions apply to all the events or cases. This table can be used individually or with the fishbone diagram.

5 Whys technique will be used in Siena Heights Surgery Center to explore the cause and effect relationship underlay a problem. One can find the root causes by asking “why” no less than five times. This technique can be used individually or as a part of the fishbone diagram.

Fishbone Diagram

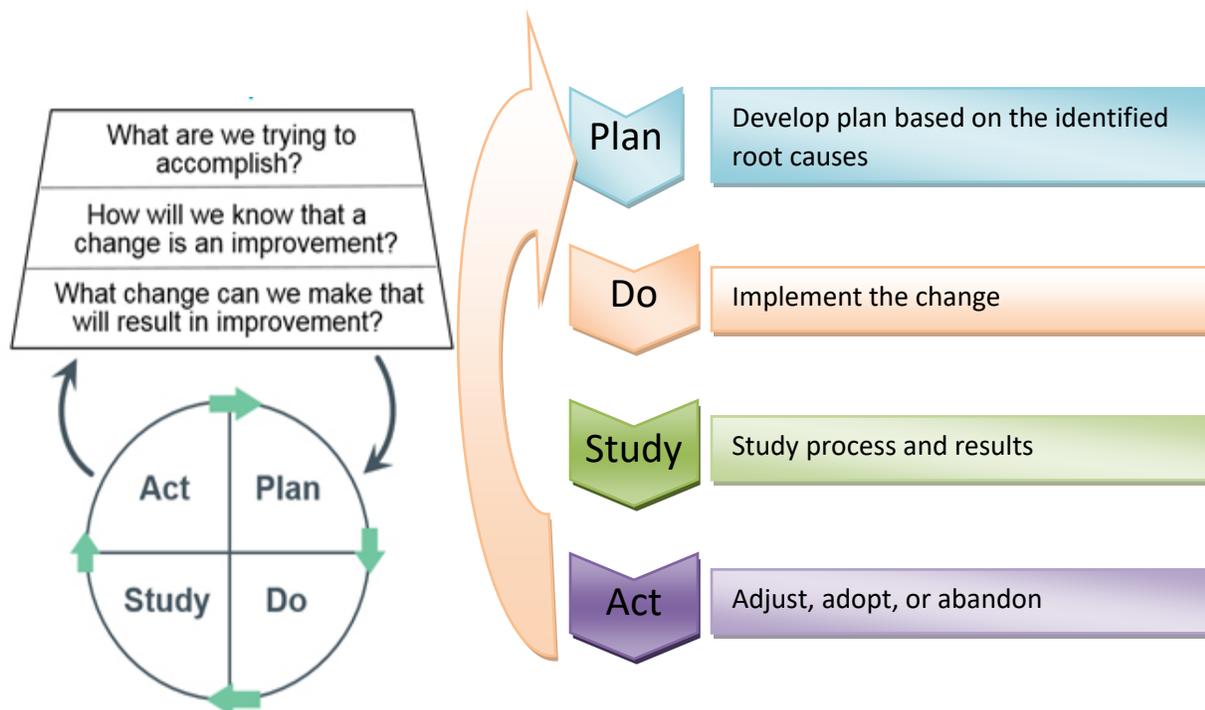
Patient Safety and Quality Improvement Plan

Once the problems are identified, a Fishbone Diagram (Appendix C) will be used for analyzing the problems. You can use the fishbone diagram individually to analyze the root causes, or use it with the root cause analysis and action plan framework table.

A Fishbone Diagram, also called a Cause-and-Effect diagram, is a useful tool for a team to structurally brainstorm by discovering possible underlying factors or root causes from different major categories for the chosen problems. General categories used include: people, methods, materials, measurements, education, procedures, process, location, environment, etc. RCA team members will brainstorm and ask multiple times, “why did this happen?” for each cause until all ideas are exhausted. The highest priority root causes will be chosen for PDSA topics. Once all the categories are established on the fishbone diagram, 5 Why’s technique also can be used to drill down the problem and find the root causes.

Model for Improvement

The Model for Improvement is a collaborative and ongoing effort model to improve the product and services quality and process. It provides multi-disciplinary quality team guidance from identifying the root causes; conducting the best tests to assess possible changes, and working in collaboration for implementation of the new approaches and solutions. It guides the test of a change to determine if the change is an improvement.



The cycle is defined as follows:

- Plan--collect data and establish appropriate goals. Identify the problem and the possible root causes, and answer the following questions.
 - What is the objective of the test?

- What are the steps for the test - who, what, when?
 - How will you measure the impact of the test?
 - What is your plan to collect the data needed?
 - What do you predict will happen?
- Do--make changes designed to correct or improve the situation. Use the following questions for the guidance.
 - What were the results of the test?
 - Was the cycle carried out as designed or planned?
 - What did you observe that was unplanned or expected?
 - Study -- Study the effect of the changes on the situation. Data should be collected on the new process and compared to the baseline or expected results. Results should be evaluated and by using the following questions as guidance.
 - Did the results match your prediction?
 - What did you learn?
 - What do you need to do next?
 - Act--If the result is successful or desirable, standardize the changes and then work on the next prioritized problem or the further improvements. If the outcome is not yet successful, look for different ways to identify the causes or change the testing process.

PDSA worksheet will be used to map the potential change strategies and to establish a course of action. The PDSA worksheet and the PDSA progress report are attached in Appendix D-1.

Data Collection and Reporting

Data should drive any quality and patient safety effort. Siena Heights Surgery Center is using (data system names) for tracking the sentinel events, healthcare infection data, and (any other database) for internal data collection.

External data sources are those data sources which are collected outside the supervisory structure of the case. External data which will be utilized for Quality and Patient Safety plan include the data from:

- AHRQ: Agency for Healthcare Research & Quality
- CDC: Centers for Disease Control and Prevention
- CMS: Centers for Medicare & Medicaid Services
- NQF: National Quality Forum
- NHSN: National Healthcare Safety Network
- TJC: The Joint Commission



Ongoing Reporting and Review

Data points such as the following will be reviewed according to the schedule prescribed:

Monthly	Quarterly	Annually
1) Sentinel event monthly report 2) Severity of infection report 3) RCA assessment	1) Sentinel event quarterly report 2) Severity of infection report 3) Review and evaluate the measure of improvement of patient safety 4) Review and evaluate the measurement to prevent and control infections	1) Quality and Patient Safety Plan update 2) Checklists and Policies reviewing and revising

Assessment of the Quality and Patient Safety Plan

Please see the Patient Safety Assessment Tool (PSAT) from the VA National Center for Patient Safety for your reference.

Patient Safety Checklists and Patient Safety Policies

By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

The patient safety checklists must follow protocols to improve the health outcomes of patients at the medical facility and must include, without limitation:

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.
- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - Proper instructions concerning prescription medications;
 - Instructions concerning aftercare;
 - Any other instructions concerning his or her care upon discharge; and
 - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include, the name and date of birth of the patient.

- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.
- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

Based on [NRS 439.865](#), the patient safety plan must also include an infection control program that carries out the infection control policy. The policy must consist of:

- The current guidelines appropriate for the facility's scope of service developed by a nationally recognized infection control organization as approved by the State Board of Health which may include, the Association for Professionals in Infection Control and Epidemiology (APIC), the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO) and the Society for Healthcare Epidemiology of America (SHEA); and
- Facility-specific infection control developed under the supervision of a certified Infection Preventionist.

The patient safety checklists are listed in Appendix E. (The following links provide some patient safety checklists for your reference— a checklist example is shown in **Appendix E.**)

http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf

<http://www.who.int/patientsafety/implementation/checklists/en/>

The patient safety policies are listed in Appendix F. (The following link provides you some patient safety policies for your reference—a policy example is shown in **Appendix F.**)

<https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>

Approval of Patient Safety Plan

According to [NRS 439.865](#), a medical facility shall submit its patient safety plan to the governing board of the facility for approval. After a facility's patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan.

The patient safety plan must be reviewed and **updated annually** in accordance with the requirements for approval set forth in this section.

According to [NRS 439.843](#), on or before March 1 of each year, a copy of the most current patient safety plan established to [NRS 439.865](#) must be submitted to the Division of Public and Behavioral Health.

Reference

- Root Cause Analysis Toolkit <http://www.health.state.mn.us/patientsafety/toolkit/>
- Quality and Service Improvement Tools
http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html
- CQI 101 An Introduction to Continuous Quality Improvement:
<https://www.coursehero.com/file/13827355/CQI-Overviewppt/>
- Quality Improvement <http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/>
- Root Cause Analysis <http://www.patientsafety.va.gov/professionals/onthejob/rca.asp>
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2
https://www.jointcommission.org/sentinel_event.aspx
- Hospital Policies <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>
- Checklists to Improve Patient Safety http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf
- Patient Safety Checklists <http://www.who.int/patientsafety/implementation/checklists/en/>
- Minutes of the Meeting of the Quality and Patient Safety Committee
<http://www.cookcountyhhs.org/wp-content/uploads/2013/12/09-23-14-QPS-scan-Minutes.pdf>
- Title 40 – Public Health and Safety <https://www.leg.state.nv.us/NRS/NRS-439.html>

Appendix A: Terms and Definitions

Patient Safety: The Agency for Healthcare Research Quality (AHRQ) defines patient safety as “a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.”
http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

Sentinel event ([NRS 439.830](#))

1. Except as otherwise provided in subsection 2, “sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum.

2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:

(a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or

(b) July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published.

3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.

(Added to NRS by [2002 Special Session, 13](#); A [2005, 599](#); [2013, 217](#))

Institute for Healthcare Improvement (IHI) defines **medical harm** as “unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death.”

Facility-Associated Infection: ([NRS 439.802](#))

“Facility-acquired infection” means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections;
- Ventilator-associated pneumonia;
- Central line-related bloodstream infections;
- Urinary tract infections; and
- Other categories of infections as may be established by the State Board of Health by regulation pursuant to [NRS 439.890](#).

(Added to NRS by [2005, 599](#); A [2009, 553](#))

Medical facility ([NRS 439.805](#))

“Medical facility” means:

- A hospital, as that term is defined in [NRS 449.012](#) and [449.0151](#);
- An obstetric center, as that term is defined in [NRS 449.0151](#) and [449.0155](#);
- A surgical center for ambulatory patients, as that term is defined in [NRS 449.0151](#) and [449.019](#); and
- An independent center for emergency medical care, as that term is defined in [NRS 449.013](#) and [449.0151](#).

(Added to NRS by [2002 Special Session, 13](#))

Near miss: An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Mandatory reporting: Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985;254(6):796-800.)

Risk: Possibility of loss or injury. (Merriam-Webster’s Online Dictionary, Risk, Available at <http://www.merriamwebster.com/dictionary/risk>. Last Accessed August 2009.)

Preventable event: Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Catheter Associated Urinary Tract Infection (CAUTI): A urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CUR_RENT_b.pdf.)

Central Line Associated Bloodstream Infections (CLABSI): Primary bloodstream infections that are associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection.

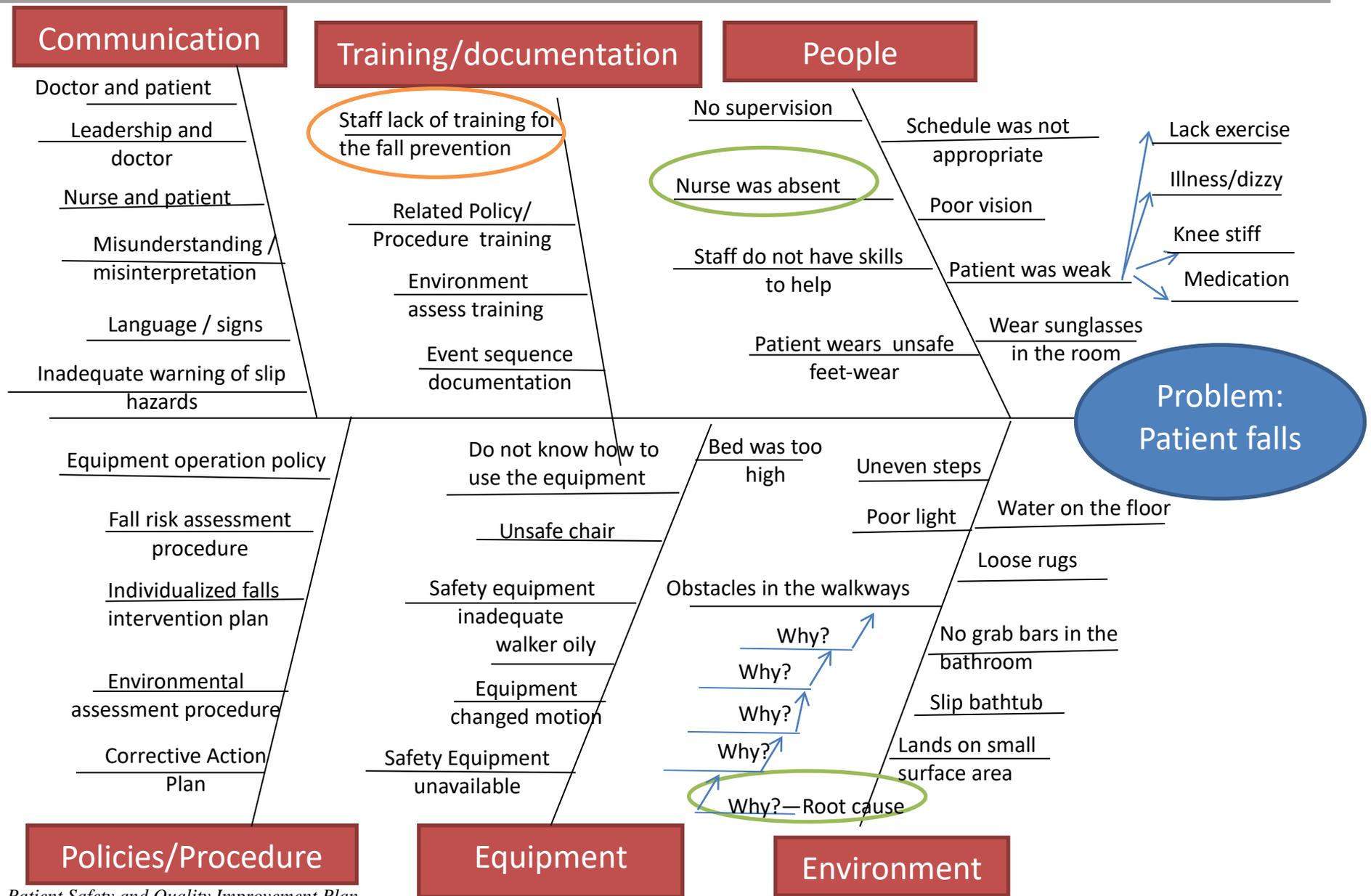
Appendix B: Patient Safety Goals

OBJECTIVE:	GOAL:	Q3 2014	Q4 2014	Q1 2015
ACTION PLAN:				
1. Create Systems that anticipate errors & either prevent or catch them before they cause harm.	a. Enhance retrospective chart review process. b. Establish an automated surveillance process. c. Conduct a proactive risk assessment in a high risk area.		Complete an in-depth analysis of risk point utilizing the methods of FMEA.	Implement Trigger Tools. Develop automated surveillance reports in Cerner.
		Implemented e-MERS & PSO with UHC.	Create process for reviewing & closing reports in e-MERS. Increase number of events reported by 10%. Create process for communicating outcome of reported events.	
2. Establish Structures for reporting and a process for managing reports in the event reporting system.	a. Implement new electronic Voluntary Reporting System & participate in Patient Safety Organization. b. Develop a structure to educate employees system-wide of the process for reporting hazards, errors and adverse events. c. Establish a process for providing feedback regarding reported events.			
3. Develop a Culture of Safety where providers feel safe and supported when they report medical errors or near misses & voice concerns about patient safety.	a. Provide education on patient safety plan that emphasizes importance of blending a systems focus with appropriate individual accountability. b. Establish a recognition program that rewards safe practices. c. Improve overall perceptions of safety as measured by the Culture of Safety Survey.		Educate Medical staff, Hospital Wide Oversight & the Quality Committees on the objectives and goals of the patient safety plan. Include patient safety presentation in monthly New Employee Orientation. Develop 'Great Catch' awards program.	Re-evaluate culture of safety and develop action plan.
4. Establish Safety Priorities & Targets.	a. Develop Patient Safety Dashboard that includes national measures and benchmarks. b. Facilitate the development of action plans associated with measures not meeting benchmarks. c. Assess and improve processes related to hand-off, transition and communication	Complete 2014 Leapfrog Safety Survey.	Present Patient Safety Dashboard monthly to Hospital Wide Oversight Committee. Establish & implement a plan to improve performance of each leap.	
		Develop method to track & report departmental progress and compliance of RCA action plans.		
5. Charter Safety Programs through teams, workgroups or projects.	a. Coordinate Improvement Efforts in order to ensure that capital, people, facilities & technologies are matched to strategic priorities for safe practices. b. Reduce and eliminate variation in care.		Establish Patient Safety Council. Establish workgroups focused on medication safety, reducing patient falls & hospital acquired pressure ulcers.	
			Revise or develop policies, procedures and protocols.	

Reference: Patient Safety Plan and Its Applicable Goals. 2014. Cook County Health and Hospitals System.

Patient Safety and Quality Improvement Plan

Appendix C: Fishbone Diagram



Appendix D-1: PDSA Worksheet

PDSA Worksheet

Topic:			
Person Completing Worksheet:		Date:	
Telephone/ Email:		Cycle:	
Patient Safety Committee Members			
CEOs/CFOs			
Patient Safety Officer			
Infection Control Officer			
Other Medical Staff			
Other team members			
Aim: (Describe the overall SMART goal that your team wishes to achieve.)			
Plan:			
1. List the tasks needed to set up this test of change.			
2. Predict what will happen when the test is carried out.			

3. List the steps to develop the test-who, what, and when.			
Steps	By Whom	By When	Desired Outcome
Do: (Describe what actually happened when you ran your test, including any problems and unexpected findings.)			
Study: (Describe what you learned and did you meet your measurement goal?)			
Did you meet your measurement goal? Explain.		Summarize what was learned: success, failure, unintended consequences, etc.	
Act: (Describe what you concluded from this cycle.)			
Based on what was learned, please indicate what action will be considered.		Describe what modifications to the plan will be made for the next cycle based on what you learned.	
<input type="checkbox"/> Adapt: modify changes and repeat PDSA Cycle			
<input type="checkbox"/> Adopt: expanding changes throughout organization			
<input type="checkbox"/> Abandon: change approach and repeat PDSA cycle			

Appendix D-2: PDSA Monthly / Quarterly Progress Report

Event:			
Person Complete Report:		Date:	
Patient Safety Officer		Contact Information:	
Monthly / Quarterly Report			
Items	Description		
1. What is your goal?			
2. Report on the PDSA cycle			
3. What system and practices are working well? Explain.			
4. What areas for improvement did the data identify?			
5. What barriers or system issues have been encountered implementing action activities?			
6. Action plans to address the barriers or system issues			
7. Lesson learned			
8. Support needed			
9. Additional discussion			
Notes:			

Appendix E: Checklist Example: Injuries from Falls and Immobility

Process Change	In Place	Not Done	Will Adopt	Notes (Responsible & By When?)
Conduct fall and injury risk assessment upon admission				
Reassess risk daily and with changes in patient condition				
Implement patient-specific intervention to prevent falls and injury				
Communicate risk across the team; use handoff forms, visual cues, huddles				
Round every 1 to 2 hours for high-risk patients; address needs (e.g., 3Ps: pain, potty, position-pressure). Combine with other tasks(vital signs)				
Individualize interventions. Use non-skid floor mats, hip protectors, individualized toileting schedule; adjust frequency of rounds				
Review medications (by pharmacist); avoid unnecessary hypnotics, sedatives				
Incorporate multidisciplinary input for falls				
Prevention from PT, OT, MD, RN and PharmD				
Include patients, families and caregivers in efforts to prevent falls. Educate regarding fall prevention measures; stay with patient				
Hold post-fall huddles immediately after event; analyze how and why; implement change to prevent other falls				

Reference: Checklists to Improve Patient Safety. June 2013. Health Research & Educational Trust.

Appendix F: Policy Example

[Reference: Hospital Policies. MERCY Hospital. <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>]

	HOSPITAL POLICY AND INFORMATION MANUAL	
<p>PERSONAL PROTECTIVE EQUIPMENT POLICY Page 1 of 2</p>	<p>Date Issued: 07/01 08/14 Date Last Revised: 08/17 Next Review Date: Policy Committee Approved By:</p>	

Key Words: personal protective equipment, PPE, safety equipment,

Policy Applies to:

- All staff employed by Mercy Hospital;
- Credentialed Specialists, Allied Health Professionals, patients, visitors and contractors will be supported in meeting policy requirements.

Related Standards:

- Infection and Prevention and Control Standards NZS 8134.3:2008
- Health and Safety in Employment Act 1992
- EQulP5 - 1.5.1 and 1.5.2 Infection Control
- EQulP5 - Standard 3.2 Criterion 3.2.1 Health and Safety

Rationale:

Mercy Hospital will provide suitable personal protective equipment (PPE) when the risk to health and safety cannot be eliminated or adequately controlled by other means.

Definitions:

Personal protective equipment (PPE) means all equipment which is intended to be worn or held by a person to protect them from risk to health and safety while at work.

Examples of PPE include: protective footwear, gloves, hard hats/helmets, clothing affording protection from the weather, visibility clothing, eye and face protection.

Objectives:

- To ensure appropriate PPE is identified to minimize hazards not able to be controlled by elimination or isolation;
- To ensure fit for purpose PPE is provided at Mercy Hospital for use by staff;
- To ensure adequate training in the use of PPE is provided;
- To monitor the use of PPE and evaluate effectiveness.

	HOSPITAL POLICY AND INFORMATION MANUAL	
<p>PERSONAL PROTECTIVE EQUIPMENT POLICY Page 2 of 2</p>	Date Issued: Date Last Revised: Next Review Date: Approved By:	07/01 08/14 08/17 Policy Committee

Implementation:

Risk Management

Department Managers, the Occupational Health/ Infection Prevention and Control Nurse (OH/IPC Nurse) and Health and Safety/ Infection Control Representatives (HSIC reps) will in consultation with staff:

Ensure PPE requirements are identified when carrying out risk assessments of activities;

- Regularly review the risk assessment of activities if substances or work processes change;
- Identify the most suitable type of PPE that is required;
- Ensure PPE is available to those who need it;
- Inform staff of the risks involved in their work and why PPE is required;
- Monitor compliance.

Process

Manager’s Responsibilities

Must ensure that:

- PPE requirements are considered when risks are assessed;
- Suitable PPE is provided and made accessible to employees;
- PPE is properly stored, maintained, cleaned repaired and replaced when necessary;
- Adequate information and training is provided to those who require PPE;
- PPE is properly used;
- Use of PPE is monitored and reviewed.

Employee’s Responsibilities All employees must ensure that:

- They use PPE whenever it is required;
- Attend and comply with training, instruction and information;
- Check the condition of their PPE;
- Store, clean and maintain their PPE;
- Report losses, defects or other problems with PPE to their manager.

Evaluation:

- Staff health and safety orientation
- Environmental audits
- Incident reports

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Policy Name: PATIENT SAFETY PLAN	Page 1 of 7	
Approved:	Revised:	

POLICY:

The LV Surgery Center will institute and administer a comprehensive and continuous Patient Safety Plan for all patients to improve patient safety and reduce risk to patients through an environment that encourages:

- Recognition of risks to patient safety and medical/health care errors
- Actions to reduce these risks
- Internal reporting of incidents and potential incidents and actions taken
- Focus on processes and systems rather than individual blame

PURPOSE:

The Patient Safety Plan provides a systematic, coordinated and continuous approach to maintenance and improvement of patient safety by using established mechanisms to support responses to actual occurrences, have an ongoing proactive plan to reduce medical/health errors, and integrate patient safety as a high priority in all relevant organizational processes and services.

RESPONSIBILITY:

As with patient care, it is a coordinated and collaborative effort of the entire organization to maintain and improve patient safety.

The Governing Body approves the data-driven Patient Safety Plan and ensures the plan reflects the complexity of the facility’s organization and services, including those services furnished under contract or arrangement and focuses on the prevention and reduction of medical/health errors and adverse effects.

The Clinical Director is the Patient Safety Officer and is responsible for the management of the Patient Safety Plan by:

- Coordinating all patient safety activities
- Facilitating assessment and appropriate responses to reportable events
- Monitoring Root Cause Analysis and resulting action plans

Section 6 Patient Safety	The LV Surgery Center
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- Serving as a liaison among the departments to assure facility wide integration of the Patient Safety Plan.

Each individual employee within the organization acts as a patient advocate for safety and is responsible to report patient safety occurrences and potential occurrences to the QAPI Coordinator/Patient Safety Officer/Clinical Director, who will aggregate the occurrence information and report to the Governing Body.

PLAN:

The scope of the Patient Safety Plan includes an ongoing assessment to prevent error occurrence, maintain and improve patient safety.

Patient Safety occurrence information from aggregated data reports and individual incident occurrence reports will be reviewed to prioritize organizational patient safety efforts.

Types Of Patient Safety Or Medical/Health Care Errors:

- No Harm Errors – those unintended acts, either of omission or commission, or acts that do not achieve their intended outcome, that do not result in a physical or psychological negative outcome, or the potential for a negative outcome, for the patient.
- Mild-Moderate Adverse Outcome Errors – those unintended acts, either of omission or commission, or acts that do not achieve their intended outcome, that result in an identified mild to moderate physical or psychological adverse outcome for the patient.
- Any Medication Error
- Any Adverse Drug Reaction
- Any Transfusion Reaction
- Hazardous Condition – any set of circumstances, exclusive of the disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious physical or psychological adverse patient outcome.
- Sentinel Event – an unexpected occurrence involving death or serious physical or psychological injury or the risk thereof, including any process variation for which a recurrence would carry a significant chance of serious adverse outcome. Serious injury specifically includes loss of limb or function. Sentinel event criteria includes:

- The event has resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition.
- The event is one of the following (even if the outcome was not death or major permanent loss of function):
 - Suicide of a patient.
 - The sexual assault of a patient during treatment or while the patient was on the premises of the facility.
 - A hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities.
 - Medication error resulting in a patient's unanticipated death or major permanent loss of bodily function in circumstances unrelated to the natural course of the illness or underlying condition of the patient.
 - A surgical procedure on the wrong patient or on the wrong body part of a patient.
 - A foreign object accidentally left in a patient during a procedure.
 - A patient death or serious disability associated with the use or function of a device designed for patient care that is used or functions other than as intended.
 - Near Miss – any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome.

What To Do When A Patient Safety Error Occurs

Upon identification of a medical/health care error, the patient care provider will immediately:

- Perform necessary healthcare interventions to protect and support the patient's clinical condition.
- As appropriate to the occurrence, perform necessary healthcare interventions to contain the risk to others – example: immediate removal of contaminated IV fluids from supply should it be discovered a contaminated lot of fluid solutions was delivered and stocked.
- Contact the patient's attending physician and other physicians, as appropriate, to report the error, carrying out any physician orders as necessary.

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- Preserve any information related to the error (including physical information).
Examples of preservation of physical information are: Removal and preservation of blood unit for a suspected transfusion reaction; preservation of IV tubing, piggyback fluid for a patient with a severe drug reaction from IV medication; preservation of medication label for medications administered to the incorrect patient. Preservation of information includes documenting the facts regarding the error on an occurrence report, and in the medical record as appropriate to organizational policy and procedure.
- Report the medical/health care error to the staff member's immediate supervisor.
- Submit the incident occurrence report to the QAPI Committee per organizational policy.

Internal Reporting Of The Error/Event

Staff response to medical/health care errors is dependent upon the type of error identified:

- **No Harm Errors** – (including “no harm medication errors), staff will document appropriately in the medical record according to organizational policy, document the circumstances regarding the no harm error on an incident occurrence report form, submit the form to the QAPI Committee and notify their immediate supervisor.
- **Mild-Moderate Adverse Outcome Errors** (including medication errors), staff will perform any necessary clinical interventions to support and protect the patient and notify the physician responsible for the patient, carrying out any necessary physician orders. Staff will then preserve any physical evidence as appropriate, notify their immediate supervisor, document facts in the medical record and on an incident occurrence report, submitting the report to the QAPI Committee per policy.
- **Adverse Drug Reaction** – staff will perform any necessary clinical interventions to support and protect the patient and notify the physician responsible for the patient, carrying out any necessary physician orders. Staff will then preserve any physical evidence as appropriate, notify their immediate supervisor, document facts appropriately in the medical record and on an incident occurrence report, submitting the report to QAPI Committee per organizational policy.
- **Transfusion Reaction** – staff will perform any necessary clinical interventions to support and protect the patient and notify the physician responsible for the patient, carrying out any necessary orders. Staff will then follow the organization policy and procedure for this event.

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- **Hazardous Condition/Patient Safety Issue** - as appropriate, and if possible, staff will contain the hazardous condition or patient safety issue. Staff identifying a hazardous condition or potential patient safety issue will immediately notify their supervisor and document the findings on an incident occurrence report which is then submitted to QAPI Committee
- **Sentinel Event** – staff will perform any necessary clinical interventions to support and protect the patient and notify the physician responsible for the patient, carrying out any necessary physician orders. Staff will then follow the organizational Sentinel Event Policy and Procedure, which includes a root cause analysis and action plan.
- **Near Miss** – staff will report the near miss event to their immediate supervisor, describe the facts of the near miss on an occurrence report and submit the report to QAPI Committee.
- It is the intent of this facility to adopt a non-punitive approach in its management of errors and occurrences. All personnel are required to report suspected and identified medical/health care errors, and should do so without the fear of reprisal in relationship to, their employment. This organization supports the concept that errors occur due to a breakdown in systems and processes, and will focus on improving systems and processes, rather than disciplining those responsible for errors and occurrences. A focus will be placed on remedial actions to assist rather than punish staff members, with the individual staff member’s supervisor determining the appropriate course of action to prevent error recurrence.

Root Cause Analysis

- All sentinel events and near miss occurrences will have a root cause analysis conducted to examine the cause and effect of the event through an impartial process
- A Root Cause Analysis is an interdisciplinary review process for identifying the basic or contributing causal factors that underlie a variation in performance associated with an adverse event or reportable patient safety event. It focuses primarily on systems and processes, includes an analysis of underlying cause and effect, progresses from special causes in clinical processes to common causes in organizational processes, and identifies potential improvements in processes or systems.
- The QAPI Committee is responsible for conducting the root cause analysis. It will be completed within 45 days of becoming aware of one of the reportable events. They will encourage the staff members’ involvement in the root cause analysis and action plan processes, to allow the staff member an active role in process resolution.

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A written Root Cause Analysis and “Action Plan” will be created which includes specific measures to correctly identify problems or areas of concern, identify strategies for implementing system improvements; and also includes outcome measures to indicate the effectiveness of system improvements in reducing, controlling or eliminating identified problem areas. The action plan must specifically address responsibility for implementation and oversight, time frames for implementation, and the strategy for measuring the effectiveness of the actions.

- The Joint Commission recommended “A Framework for a Root Cause Analysis and Action Plan In Response to a Sentinel Event” format may be used. See attached.
- Results of the entire Root Cause Analysis will be presented to the Governing Body for evaluation.

Communication of Action Plans and Root Cause Analysis

- Action Plans related to a Root Cause Analysis will be shared with the entire staff upon Completion by the QAPI Committee. Possible recommendations to update or change policy and procedures may be presented to the staff, management and Governing Body to improve patient safety.
- Staff will educate patients and their families about their role in helping to facilitate the safe delivery of care. There will be a random record review verifying compliance with this educational process.
- Root Cause Analysis and Action Plans will be made available to the state health department representatives during onsite reviews.

Reporting Obligations

- Medical/Health care errors and occurrences, including sentinel events, will be reported internally and externally, through the channels established by this plan. External reporting will be performed in accordance with all state, federal and regulatory body rules, laws and requirements.

Patient Safety Plan Staff Education/Training

- Staff will receive education and training during their initial orientation process and on an ongoing basis regarding job-related aspects of patient safety, including the need and method to report medical/health care errors. And, because the optimal provision of healthcare is provided in an interdisciplinary manner, staff will be educated and trained on the provision of an interdisciplinary approach to patient care.

- Medical errors results from multiple factors. Flawed systems or processes can combine with active failures by caregivers in the clinical setting to produce accidents and errors. Some contributing factors are:
 - Inadequate communication among team members
 - Incomplete review of patient health records and diagnostic studies
 - Traditional hierarchical and autocratic cultures
 - Patient – related decisions made only by physicians
 - Unclear instructions
 - Confusing packaging of medications and supplies
 - Time pressures and constraints, Multi-tasking
 - Failure to include the patient and family members in assessment and decision-making

- Staff will be trained about error reduction, which requires the commitment of all members of the health care team. Besides correcting the identified factors above, the following individual and facility changes will be focused on:
 - Reduce reliance on memory by using checklists and protocols.
 - Standardize processes as much as possible for procedures and other activities.
 - Focus on the safety aspects of products during the selection and evaluation process.
 - Promote safety related clinical competency.
 - Educate employees about the potential for errors and how to avoid them.
 - Creating a “Culture of Safety” whereby there is a change of environment from blaming individuals for errors to one in which errors are treated as opportunities to improve systems. This is accomplished by:
 - establishing a sense of trust among team members;
 - dissemination and verifying receipt of information to all levels of staff and management;
 - developing and supporting a proactive approach rather than a reactive approach;
 - making a sincere commitment to affirming safety as the first priority.

- Quarterly Patient Safety Plan meetings will be incorporated into the QAPI Program and conducted to review any incident occurrence reports and review any new patient safety recommendations or alerts.

Facility Name: Nevada Surgical Suites - 8322
Facility Name: Nevada Surgical Suites - 7661

2018 QUALITY AND PATIENT SAFETY PLAN

DATE: 02-05-2018
VERSION: 1.1



This plan was created and revised by the Nevada Surgical Suites Patient Safety committee/team. Implementation of this plan is intended to optimize the healthcare quality and patient safety outcomes, encourage recognition, reporting, and acknowledgment of risks to patient, visitor, and employee safety, as well as reduce the medical/healthcare errors and /or preventable events.

**Patient Safety Committee/Program
Nevada Surgical Suites**

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Commitment to Patient Safety

Nevada Surgical Suites is committed to a comprehensive approach to improving healthcare quality and patient safety by aligning with our Mission, Vision, and Values, creating an environment that supports a dynamic, proactive, and safe culture for patients, family members, visitors, and employees, through continuous learning and improving patient safety policies, systems, and processes.

Mission, Vision, and Values

In support of our mission, vision, and values, Nevada Surgical Suites Patient Safety and Quality Improvement program promotes:

- Collaboration of healthcare, leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high-quality healthcare.
- Communicate honestly and openly to foster trusting and cooperative relationships among healthcare providers, staff members, and patients and their families, to ensure accountability for the patient safety priorities.
- Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.
- Responsibility for every healthcare related decision and action.
- A focus on continuous learning and improving, system design, and the management of choices and changes, bringing the best possible outcomes or performances to the facility.
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare.
- Education of staff and physicians to assure participation of healthcare providers.

Scope and Purpose

The scope of this Quality and Patient Safety Plan is organizational-wide/hospital-wide/agency-wide which includes but is not limited to

- Patient safety
- Visitor safety
- Employee safety

All staff in Nevada Surgical Suites are required to fully support and participate in this plan, and devote their expertise to the patient safety and healthcare quality improvement process.

This plan is action oriented and solution focused. The purpose of this plan is to address patient safety related concerns, challenges and revise the program to better serve the patients and their families. To this end, Nevada Surgical Suites has developed this Patient Safety plan.

The plan focuses on the process rather than the individual, and recognizes both internal and external customers, as well as facilitates the need of analyzing and improving processes. The core principles of this plan include:

- All staff have the same goal and contribute their knowledge, vision, skill, and insight to improve the process of the Patient Safety Plan.
- Decisions will be based on data and facts, and staff will be encouraged to learn from the experiences.
- Customer based including patients, families, and visitors.
- Promote systems thinking.
- Employ well-trained and competent staff maintaining high healthcare quality.

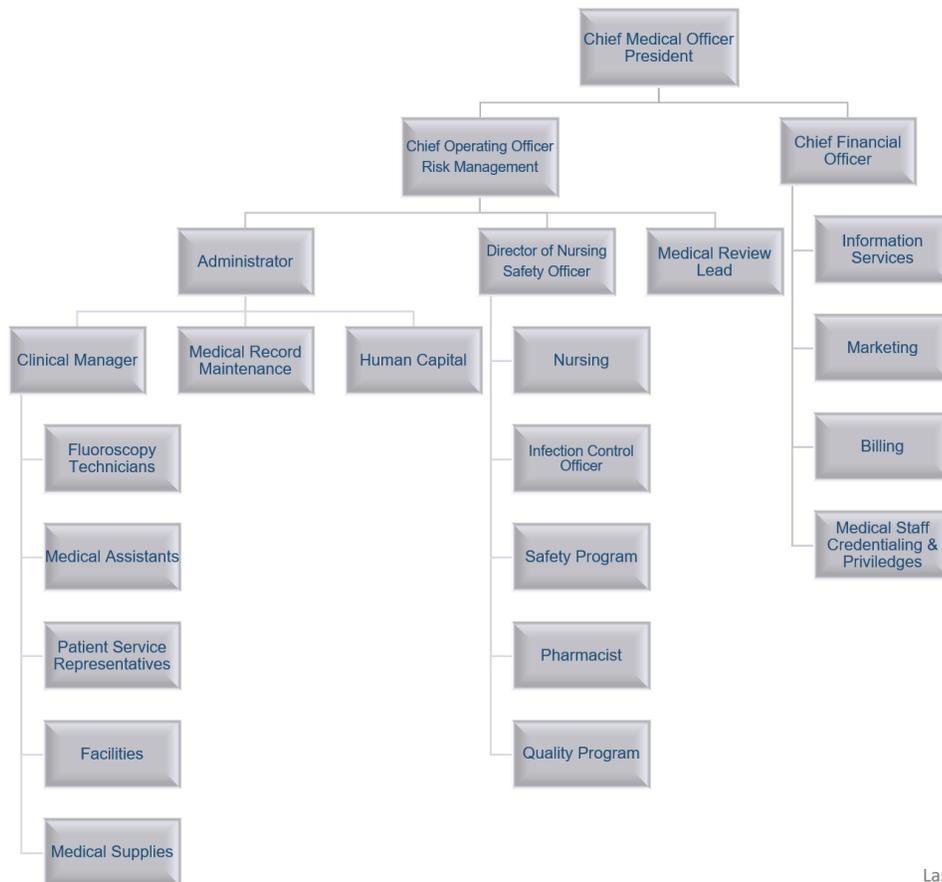
Roles and Responsibilities

According to [NRS 439.875](#), a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plan is promoted and executed successfully.

The Patient Safety Committee Organization



Organizational Chart



Last Revised: 03-01-2018

Roles and Responsibilities

- In accordance with [NRS 439.875](#), a patient safety committee must be comprised of:

Patient Safety and Quality Improvement Plan

- The infection control officer of the medical facility;
- The patient safety officer of the medical facility, if he or she is not designated as the infection control officer;
- At least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility; and
- One member of the executive or governing body of the medical facility.

Based on [NAC 439.920](#), a medical facility that has fewer than 25 employees and contractors must establish a patient safety committee comprised of:

- The patient safety officer of the medical facility;
- At least two providers of healthcare who treat patients at the medical facility, including but without limitation, one member of the medical staff and one member of the nursing staff of the medical facility; and
- The Chief Executive Officer (CEO) or Chief Financial Officer (CFO) of the medical facility.

The roles and responsibilities are defined below:

- Member 1: Medical Provider, Governing Board Member, Executive Team Member
- Member 2: Governing Board Member, Billing Manger
- Member 3: Governing Board Member, Pharmacist
- Member 4: Medical Provider, Governing Board Member, Executive Team Member
- Member 5: Clinical Manager
- Member 6: Chief Financial Officer, Governing Board Member, Executive Team Member
- Member 7: Governing Board Member, Director of Nursing, Infection Control & Safety Officer
- Member 8: Governing Board Member, Administrator

Patient Safety Committee Responsibilities (based on [NRS 439.875](#) and [NRS 439.877](#))

- Monitor and document the effectiveness of the patient identification policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the patient safety officer pursuant to [NRS 439.870](#).
- Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred.
- Review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- Review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the executive or governing body of the facility regarding:
 - (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);
 - (2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and

(3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.

- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

Root Cause Analysis (RCA) Team Responsibilities

- Root Cause interviews, analysis, investigation, and corrective action plan implementations.
- Participates in the RCA meetings and discussions.
- Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders.

Patient Safety Officer Responsibilities (based on [NRS 439.870](#))

- Serve on the patient safety committee.
- Supervise the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the patient safety committee regarding any action taken in accordance with the responsibilities above.

Infection Control Officer Responsibilities (based on [NRS 439.873](#))

- Serve on the patient safety committee.
- Monitor the occurrences of infections at the facility to determine the number and severity of infections.
- Report to the patient safety committee concerning the number and severity of infections at the facility.
- Take such action as determines is necessary to prevent and control infections alleged to have occurred at the facility.
- Carry out the provisions of the infection control program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program.

RCA team leader Responsibilities

- Organize and coordinate the RCA process.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA, and corrective action plan implementation process.
- Communicate the progress of the investigation, institutional barriers, and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.
- Provide training, education and direction to create RCA process that incorporate the Patient Safety and Quality Improvement elements.

Executive or Governing Body Staff Responsibilities

- Provide vision and leadership to Patient Safety and Quality Improvement process, and develop and foster a safe learning and improving culture.
- Provides oversight to the healthcare quality improvement processes and teams.
- Plan, discuss, and generate the organization patient safety goals and activities, in conjunction with the patient safety action plans

The Patient Safety Committee will meet monthly (or quarterly) to accomplish the following:

- Report and discuss sentinel events which include:
 - Number of sentinel events from previous calendar month (or quarter).
 - Number of severe infections that occurred in the facility.
- Corrective Action Plan for the sentinel events and infections
 - Evaluate the corrective action plan.
- Patient safety policies and checklists
 - At least annually evaluate Patient Safety policies and checklists
 - Revise the patient safety policies and checklists as needed.
 - Monitor and document the effectiveness of the patient safety policy.

A RCA meeting will meet as needed to accomplish the following:

- Define the healthcare issues or potential risks.
- Conduct Root Cause Analysis
 - Reviewing and analyzing the data.
 - Reviewing the RCA process and quality improvement related activities and timelines.
 - Brainstorming issues or the potential risks by using the fishbone diagrams.
 - Identify the contributing factors and conduct the Root Cause Analysis.
- Conduct Corrective Action Plan
 - Identifying the Plan-Do-Study-Act (PDSA) topics.
 - Discussing corrective action process and activities.
 - Discussing and presenting possible changes in procedure to improve areas indicated.
 - Identifying strengths and areas that need improvement.
 - Developing strategies, solutions, and steps to take next.
- Identify barriers and technical assistance needs for supporting the RCA efforts.

A meeting agenda and minutes noting follow-up tasks will be kept.

Objectives and Goals of the Quality and Patient Safety Plan

Objective	Goals	Plan	Planned Completion Date	Responsible Party
Medication Reconciliation	Increase accuracy to ≥ 95%	Increase chart audits with focused training	12-31-2018	Pharmacist
Allergy Documentation	Increase accuracy to ≥ 100%	Continue chart audits with focused training	12-31-2018	Pharmacist
Hand Washing	100% compliance	Observations, training	12-31-2018	Nurse Manager
Patient Privacy	Decrease complaints by ≥ 20%	Survey monitoring, training	12-31-2018	Director of Nursing

Components and Methods

Pursuant to [NRS 439.837](#), a medical facility shall, upon reporting a sentinel event pursuant to [NRS 439.835](#), conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event.”

Nevada Surgical Suites will use RCA process to determine the contributing factors and the underlying reasons for the deficiencies or failures. The Plan-Do-Study (check)-Act (PDSA or PDCA) is the model, which was developed by the Institute of Health Care Improvement, that we will use to test the changes.



Root Cause Analysis

A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals.

Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

Root cause analysis and action plan framework table, which was introduced by the Joint Commission. It contains 24 analysis questions. It guides the organization to the steps in a root cause analysis. Not all the questions apply to all the events or cases. This table can be used individually or with the fishbone diagram.

5 Whys technique will be used in Nevada Surgical Suites to explore the cause and effect relationship underlay a problem. One can find the root causes by asking “why” no less than five times. This technique can be used individually or as a part of the fishbone diagram.

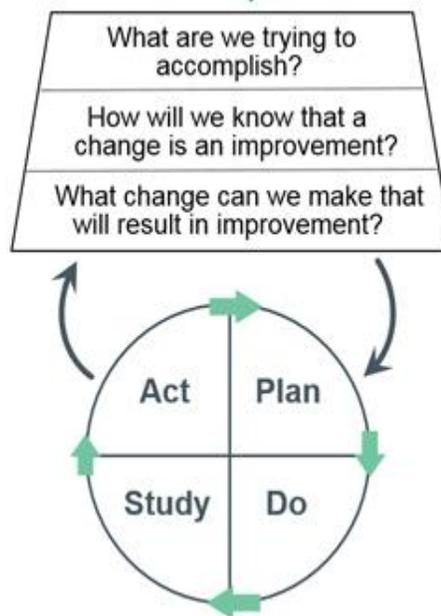
Fishbone Diagram

Once the problems are identified, a Fishbone Diagram (Appendix C) will be used for analyzing the problems. You can use the fishbone diagram individually to analyze the root causes, or use it with the root cause analysis and action plan framework table.

A Fishbone Diagram, also called a Cause-and-Effect diagram, is a useful tool for a team to structurally brainstorm by discovering possible underlying factors or root causes from different major categories for the chosen problems. General categories used include: people, methods, materials, measurements, education, procedures, process, location, environment, etc. RCA team members will brainstorm and ask multiple times, “why did this happen?” for each cause until all ideas are exhausted. The highest priority root causes will be chosen for PDSA topics. Once all the categories are established on the fishbone diagram, 5 Why’s technique also can be used to drill down the problem and find the root causes.

Model for Improvement

The Model for Improvement is a collaborative and ongoing effort model to improve the product and services quality and process. It provides multi-disciplinary quality team guidance from identifying the root causes; conducting the best tests to assess possible changes, and working in collaboration for implementation of the new approaches and solutions. It guides the test of a change to determine if the change is an improvement.



The cycle is defined as follows:

- Plan--collect data and establish appropriate goals. Identify the problem and the possible root causes and answer the following questions.
 - What is the objective of the test?
 - What are the steps for the test - who, what, when?
 - How will you measure the impact of the test?
 - What is your plan to collect the data needed?
 - What do you predict will happen?

- Do--make changes designed to correct or improve the situation. Use the following questions for the guidance.
 - What were the results of the test?
 - Was the cycle carried out as designed or planned?
 - What did you observe that was unplanned or expected?

- Study -- Study the effect of the changes on the situation. Data should be collected on the new process and compared to the baseline or expected results. Results should be evaluated and by using the following questions as guidance.
 - Did the results match your prediction?
 - What did you learn?
 - What do you need to do next?

- Act--If the result is successful or desirable, standardize the changes and then work on the next prioritized problem or the further improvements. If the outcome is not yet successful, look for different ways to identify the causes or change the testing process.

PDSA worksheet will be used to map the potential change strategies and to establish a course of action. The PDSA worksheet and the PDSA progress report are attached in Appendix D-1.

Data Collection and Reporting

Data should drive any quality and patient safety effort. Nevada Surgical Suites is using (data system names) for tracking the sentinel events, healthcare infection data, and (any other database) for internal data collection.

External data sources are those data sources which are collected outside the supervisory structure of the case. External data which will be utilized for Quality and Patient Safety plan include the data from:

- AHRQ: Agency for Healthcare Research & Quality
- CDC: Centers for Disease Control and Prevention
- CMS: Centers for Medicare & Medicaid Services
- NQF: National Quality Forum
- NHSN: National Healthcare Safety Network

- TJC: The Joint Commission



Ongoing Reporting and Review

Data points such as the following will be reviewed according to the schedule prescribed:

Monthly	Quarterly	Annually
1) Sentinel event monthly report 2) Severity of infection report 3) RCA assessment	1) Sentinel event quarterly report 2) Severity of infection report 3) Review and evaluate the measure of improvement of patient safety 4) Review and evaluate the measurement to prevent and control infections	1) Quality and Patient Safety Plan update 2) Checklists and Policies reviewing and revising

Assessment of the Quality and Patient Safety Plan

Quality and Patient Safety Plan is updated annually and submitted through the REDcap Sentinel Event Registry after approval by the organization governing board.

Patient Safety Checklists and Patient Safety Policies

By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

The patient safety checklists must follow protocols to improve the health outcomes of patients at the medical facility and must include, without limitation:

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.
- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - Proper instructions concerning prescription medications;
 - Instructions concerning aftercare;
 - Any other instructions concerning his or her care upon discharge; and
 - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include, the name and date of birth of the patient.
- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.

- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

Based on [NRS 439.865](#), the patient safety plan must also include an infection control program that carries out the infection control policy. The policy must consist of:

- The current guidelines appropriate for the facility's scope of service developed by a nationally recognized infection control organization as approved by the State Board of Health which may include, the Association for Professionals in Infection Control and Epidemiology (APIC), the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO) and the Society for Healthcare Epidemiology of America (SHEA); and
- Facility-specific infection control developed under the supervision of a certified Infection Preventionist.

The patient safety checklists are listed in Appendix E. (The following links provide some patient safety checklists for your reference— a checklist example is shown in **Appendix E**.)

http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf

<http://www.who.int/patientsafety/implementation/checklists/en/>

The patient safety policies are listed in Appendix F. (The following link provides you some patient safety policies for your reference—a policy example is shown in **Appendix F**.) <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>

Approval of Patient Safety Plan

According to [NRS 439.865](#), a medical facility shall submit its patient safety plan to the governing board of the facility for approval. After a facility's patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan.

The patient safety plan must be reviewed and **updated annually** in accordance with the requirements for approval set forth in this section.

According to [NRS 439.843](#), on or before March 1 of each year, a copy of the most current patient safety plan established to [NRS 439.865](#) must be submitted to the Division of Public and Behavioral Health.

Reference

- Root Cause Analysis Toolkit <http://www.health.state.mn.us/patientsafety/toolkit/>
- Quality and Service Improvement Tools http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html
- CQI 101 An Introduction to Continuous Quality Improvement: <https://www.coursehero.com/file/13827355/CQI-Overviewppt/>
- Quality Improvement <http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/>
- Root Cause Analysis <http://www.patientsafety.va.gov/professionals/onthejob/rca.asp>
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2 https://www.jointcommission.org/sentinel_event.aspx
- Hospital Policies <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>
- Checklists to Improve Patient Safety http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf
- Patient Safety Checklists <http://www.who.int/patientsafety/implementation/checklists/en/>
- Minutes of the Meeting of the Quality and Patient Safety Committee <http://www.cookcountyhhs.org/wp-content/uploads/2013/12/09-23-14-QPS-scan-Minutes.pdf>
- Title 40 – Public Health and Safety <https://www.leg.state.nv.us/NRS/NRS-439.html>

Appendix A: Terms and Definitions

Patient Safety: The Agency for Healthcare Research Quality (AHRQ) defines patient safety as “a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.”

http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

Sentinel event ([NRS 439.830](#))

1. Except as otherwise provided in subsection 2, “sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum.

2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:

(a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or

(b) July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published.

3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.

(Added to NRS by [2002 Special Session, 13](#); A [2005, 599](#); [2013, 217](#))

Institute for Healthcare Improvement (IHI) defines **medical harm** as “unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death.”

Facility-Associated Infection: ([NRS 439.802](#))

“Facility-acquired infection” means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections;
- Ventilator-associated pneumonia;
- Central line-related bloodstream infections;
- Urinary tract infections; and
- Other categories of infections as may be established by the State Board of Health by regulation pursuant to [NRS 439.890](#).

(Added to NRS by [2005, 599](#); A [2009, 553](#))

Medical facility ([NRS 439.805](#))

“Medical facility” means:

- A hospital, as that term is defined in [NRS 449.012](#) and [449.0151](#);

- An obstetric center, as that term is defined in [NRS 449.0151](#) and [449.0155](#);
- A surgical center for ambulatory patients, as that term is defined in [NRS 449.0151](#) and [449.019](#); and
- An independent center for emergency medical care, as that term is defined in [NRS 449.013](#) and [449.0151](#).

(Added to NRS by [2002 Special Session, 13](#))

Near miss: An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Mandatory reporting: Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985;254(6):796-800.)

Risk: Possibility of loss or injury. (Merriam-Webster's Online Dictionary, Risk, Available at <http://www.merriamwebster.com/dictionary/risk>. Last Accessed August 2009.)

Preventable event: Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Catheter Associated Urinary Tract Infection (CAUTI): A urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CUR_ENT_b.pdf.)

Central Line Associated Bloodstream Infections (CLABSI): Primary bloodstream infections that are associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection.

Appendix B: Master Study List

Master Study List – Quality Improvement Initiatives

(Infection Control, Patient Safety, Process Improvement)

Calendar Year/ Study Name	Start Date	Completion Date	Re-Assessment Date	Comments
2015 Study				
1	AAAHC Low Back Injection	01/2015	06/2015	Move to 2016 Evaluating clinical performance measurement and improvement opportunities
2	Medication Reconciliation	01/2015	12/2015	Move to 2016 Room for improvement – Study in 2016
3	Handwashing	01/2015	12/2015	Move to 2016 Room for improvement – Study in 2016
2016 Study				
1	AAAHC Low Back Injection	07/2016	12/2016	Move to 2017 Evaluating clinical performance measurement and improvement opportunities
2	Medication Reconciliation	01/2016	12/2016	Move to 2017 Room for improvement – Study in 2017
3	Handwashing	01/2016	12/2016	Move to 2017 Performing well – will not study in 2017
2017 Study				
1	AAAHC Low Back Study	04/2017	12/2017	Move to 2018 Evaluating clinical performance measurement and improvement opportunities
2	Medication Reconciliation	01/2017	12/2017	Move to 2018 Room for improvement – Study in 2018
3	Q1 2017 ASCA Benchmarking	01/2017	03/2017	Move to Q2 Limited
4	Q2 2017 ASCA Benchmarking	04/2017	06/2017	Move to Q3 Limited
5	Q3 2017 ASCA Benchmarking	07/2017	09/2017	Move to Q4 Limited
6	Q4 2017 ASCA Benchmarking	10/2017	12/2017	Move to 2018 GB approved re-participation in 2018
2018 Study				
1	Hand Hygiene	01/2018	12/2018	In Progress
2	AAAHC Low Back Study	01/2018	06/2018	In Progress Evaluating clinical performance measurement and improvement opportunities
3	Medication Reconciliation	01/2018	12/2018	In Progress

4	Q1 2018 ASCA Benchmarking	01/2018	03/2018	In-Progress	
5	Q2 2018 ASCA Benchmarking	04/2018	06/2018		
6	Q3 2018 ASCA Benchmarking	07/2018	09/2018		
7	Q4 2018 ASCA Benchmarking	10/2018	12/2018		
2019 Study					
1					
2					
3					
4					

Appendix C-1: Safety Check List/ Time-Out



Safety Checklist

Patient:

Area	Done By	Patient or caregiver response
Sedation	<input type="checkbox"/> No Sedation	<input type="checkbox"/> 1. Pt/allergies/procedure confirmed. <input type="checkbox"/> 2. Pt. Verbalizes understanding of anesthesia options. <input type="checkbox"/> 3. Pt. Verbalizes understanding of anesthesia and possible post op pain
Operating Room		<input type="checkbox"/> 1. Pt/allergies/Procedure confirmed. <input type="checkbox"/> 2. Pt. verbalizes adequate understanding of procedure.
<input type="checkbox"/>	Pt. to RN with RN Assistance	<input type="checkbox"/> Ambulates <input type="checkbox"/> Stretcher <input type="checkbox"/> WC
<input type="checkbox"/>	Pt. is positioned upon the O.R. Table and safety strap(s) in use and necessary pillows/cushioning are in place.	<input type="checkbox"/> Prone <input type="checkbox"/> Supine <input type="checkbox"/> R Lateral <input type="checkbox"/> L Lateral
<input type="checkbox"/>	PREP site with:	<input type="checkbox"/> Chloraprep <input type="checkbox"/> Alcohol-prep with No Reaction noted
<input type="checkbox"/>	"TIMEOUT" Conducted to confirm proper patient, procedure, allergies and site	
<input type="checkbox"/>	Procedure Start time:	
<input type="checkbox"/>	Medications injected:	<input type="checkbox"/> Dexamethasone <input type="checkbox"/> Lidocaine <input type="checkbox"/> Marcaine (0.5) (0.25) <input type="checkbox"/> Omnipaque <input type="checkbox"/> Magnevist
<input type="checkbox"/>	Radio Frequency ground pad site:	<input type="checkbox"/> R / L Posterolateral thigh <input type="checkbox"/> R / L posterior thoracic <input type="checkbox"/> R / L Posterolateral buttocks
<input type="checkbox"/>	Radio Frequency Probe(s) Serial Number:	
<input type="checkbox"/>	SCS Trial/Implant Lot Number:	
<input type="checkbox"/>	SCS Trial/Implant Serial Number:	
<input type="checkbox"/>	Pt Tolerated procedure without complications	
<input type="checkbox"/>	Pt Transported via:	<input type="checkbox"/> stretcher (side rails up) <input type="checkbox"/> WC
<input type="checkbox"/>	Procedure End time:	
<input type="checkbox"/>	Pt. transferred to PACU without incident. Time:	

07/20/17 NSS

Appendix D: Policies

Chapter 5: Quality and Risk management

Chapter 7 Sub-Chapter 1 & 2: Infection Control and Safety

Chapter 8: Emergency Preparedness



Sunset Surgery Center
Infection Control Guidelines
Revised 1/29/2018

Sunset Surgery Center
INFECTION CONTROL POLICY

This policy is consistent with Centers for Disease Control Recommendations for Standard Precautions. The policy is established to maintain a program for the prevention and control of infections and communicable diseases.

A. General Principles

1. Designed to reduce possible infection while performing surgical procedures as outlined in our policies and procedures.
2. Takes into consideration the health status of our patients.
3. Consider all patients' blood, and bodily fluids as infectious materials.
4. In order to reduce the possibility of infection we hold a 2:1 Nurse to Patient ratio. All RN's are licensed in the state of Nevada.
5. Equipment, instruments, and utensils which come in contact with patient excretions, secretions and bodily fluids are considered contaminated.
6. Infectious waste includes, but is not limited to, the following:
 - a. All dressings
 - b. Used soiled pads/diapers
 - c. Intravenous tubing/catheters
 - d. All used needles/sharps

- e. Trash, gloves, gowns, masks, etc. from isolation room.
- f. Sanitary napkins
- g. Used suction containers and tubing
- h. Specimens
- i. Disposable equipment and supplies once used on a patient
- j. Endotracheal tube, laryngoscope blades, airways

B. Precautions

All health-care workers should routinely use appropriate barrier precautions to prevent skin and mucous-membrane exposure when contact with blood or other body fluids of any patient is anticipated. The purpose of protective equipment is to keep blood and other potentially infectious material from contacting skin, eyes, and mucous membranes. In some cases, adequate protection is provided solely by gloves. In other cases, masks and eye protection will also be needed. And in still other situations, gowns, aprons, and head covering may be required. All staff will be trained on an annual basis and retrained if needed.

C. Procedures

1. Wash hands frequently and always between patients and after glove removal. Gloves should be changed after contact with each patient and immediately if they're torn or punctured.
2. Wear gloves when exposed to any patient's blood and body excretions and/or secretions such as when touching mucous membranes or non-intact skin, handling soiled equipment or vascular access procedures such as finger or heel sticks and venipunctures. (Other examples include):
 - a. Collecting specimens
 - b. Cleaning up fecal/urinary incontinence or handling linen and soiled garments
 - c. Bathing a patient
 - d. Mouth care and eye care
 - e. Removing soiled bed linens

- f. Beginning/discontinuing/converting intravenous and intraosseous therapies
 - g. Administering parenteral injections
 - h. Emptying Foleys, bedpans, urinals, emesis basins, NG drainage and wound drainage, sitz baths
 - i. Changing dressings, perineal pads, and diapers
 - j. Cleaning any surface the patient has contact with, spills of blood or body fluids
 - k. Handling tissues or clothing contaminated with tears or perspiration
 - l. Performing suctioning or intubation
3. Place disposable syringes and needles, scalpel blades, and other sharp items into designated, puncture-resistant containers. Do not recap, bend or break off needles.
 4. Place all infectious waste not suitable for disposal in "sharps" container into red (biohazard) plastic bags.
 5. Wear gowns if splashing or soiling by blood and body fluids is likely. After exposure, remove protective clothing to avoid contaminating self. Place in the assigned area or container.
 6. Wear other protective covering (e.g. masks, goggles, face shields, etc.) as indicated by particular situations such as patients with infections, during invasive procedures, or when splashing is likely. Wash after removing protective equipment and as soon as possible after blood contact with skin, eyes, or mucous membranes.
 7. Individuals with exudative lesions or exposed skin surfaces should refrain from direct patient care and from handling patient-care equipment. Small cuts and scrapes should be covered with an occlusive adhesive dressing or bandage and monitored closely for integrity during patient care activities.

D. CPR

Although saliva has not been implicated in HIV transmission, mouth-to-mouth resuscitation should not be performed. Use available resuscitation bags, mouthpieces and ventilation devices when resuscitating patients.

E. Exposure Incident

1. A significant exposure is defined as:
 - a. A needle stick or cut caused by a needle or sharp that was actually or potentially contaminated with blood or body fluids.
 - b. A mucous membrane exposure (i.e. splash to the eye or mouth) to blood or body fluids.
 - c. A cutaneous exposure involving large amounts of blood or prolonged contact with blood- especially when the exposed skin was chapped, abraded, or afflicted with dermatitis.

If you are directly exposed, **report it immediately** to your supervisor.

2. Use a specific solution such as alcohol or Fertisafe if contaminated with blood or body fluids from a patient with, or at risk for, HIV infection, Hepatitis B or C virus.
3. If an accidental exposure occurs staff should follow CDC guidelines for occupational exposure: if needle stick, test for HIV to establish seronegativity first, then retest at 6 weeks, 3 months, 6 months, and 1 year.
4. You will be directed to your personal physician for any treatment and follow-up required as a result of any exposure you encounter. Sunset Surgery Center is not responsible for covering the costs of any associated treatments. Employees are strongly urged to obtain their own health insurance.



Department of Health Notification

Purpose: To comply with the Department of Health's regulations for notification.

Procedure:

1. If our health care facility is aware of information which shows that the facility is not in compliance with any of the Department's regulations applicable to our health care facility, and that noncompliance seriously compromises quality assurance or patient safety, we will immediately act to correct the noncompliance.
2. If our health care facility is aware of a situation or the occurrence of an event at our facility which could seriously compromise quality assurance or patient safety, we will follow all laws requiring proper notification of proper authorities. The notification will include sufficient detail and information to alert the Department as to the reason for its occurrence and the steps that our health care facility will take to rectify the situation.
3. For purposes of subsections, (1) and (2) events which seriously compromise quality assurance or patient safety include, but are not limited to, the following:
 - a. Deaths occurring at the facility.
 - b. Rape occurring at the facility.
 - c. Surgery performed on the wrong patient or on the wrong body part.
 - d. Notification of termination of any services vital to the continued safe operation of the facility or the health and safety of its patients and personnel, including, but not limited to, the anticipated or actual termination of electric, gas, steam heat, water, sewer and local exchange telephone service.
 - e. Unlicensed practice of a regulated professional.



Policy: Mandatory Reporting of Infectious Diseases by Clinicians/Lab Personnel

It is the policy of all Employees at SSC to adhere to the Nevada State and Local laws regarding the mandatory reporting of infectious diseases and infectious disease-related conditions to the appropriate state health departments and Centers for Disease Control.

Nevada State Department and Human Resources Division of Health

505 E. King St. Room 201

Capitol Complex

Carson City, NV 89710

Phone: 1-702-885-4740

I adhere to the State and Local policies of reporting infectious disease and infectious disease related conditions to the appropriate state health departments and CDC.



Airborne precautions

Purpose: To provide guidance to perioperative personnel for using and implementing airborne precautions if necessary in perioperative areas.

Policy: Elective surgery will be postponed for perioperative patients requiring airborne precautions until the patient is determined to be noninfectious.

Procedure:

- A. The following steps will be followed when using and implementing airborne precautions for perioperative patients:
 - a. When a patient suspected of measles infection enters the facility, all personnel will use respiratory protection if available.
 - b. When a patient with confirmed or suspected varicella infection enters the facility, airborne and contact precautions will be implemented and followed, and only personnel with evidence of immunity will provide care to the patient.
 - c. When caring for a perioperative patient who requires airborne precautions, perioperative personnel will don a surgical mask or an N95 respirator, depending on the disease-specific recommendations, before entering the room of the patient don personal protective equipment (PPE) before entering the room discard PPE and perform hand hygiene when exiting the room.
 - d. Infected skin lesions will be covered and contained.
 - e. Standard cleaning and disinfection procedures will be followed after surgery on a patient requiring airborne precautions, but only after the appropriate amount of time for air ventilation.
 - i. Personal respiratory protective equipment is not necessary for cleaning an OR if the appropriate ventilation time has been allowed.
 - ii. If room cleaning activities must begin before the appropriate amount of time for air ventilation, cleaning personnel will wear an N95 or powered air-purifying respirator.
 - f. When transporting perioperative patients who require airborne precautions from an airborne infection isolation room to the OR, the patient will wear a surgical mask if clinically appropriate.
 - i. Patients will be transported directly to the OR, bypassing the preoperative area, and at the end of the procedure transferred directly to an airborne infection isolation room in the post anesthesia care unit or other designated area of the facility.
 - g. Documentation
 - i. The perioperative RN will document in the patient's chart the care of the patient known or suspected to be infected or colonized with microorganisms that are transmitted by airborne droplet nuclei and the physiologic responses throughout the continuum of care, including patient assessment, plan of care, nursing diagnoses, desired outcomes, and interventions.



Contact precautions

Purpose: To provide guidance to perioperative personnel for using and implementing contact precautions in perioperative areas. The expected outcome is that the patient will be free from signs and symptoms of infection

Policy:

- A. It is the policy of Sunset Surgery Center not to schedule patients who are known or suspected to be infected or colonized with microorganisms that are transmitted by direct or indirect contact (eg, methicillin-resistant *Staphylococcus aureus*, vancomycin-resistant *Enterococci*, *Clostridium difficile*).
- B. An infection preventionist will be consulted for guidance when measures are indicated to prevent the spread of highly transmissible or epidemiologically important pathogens.

Procedure:

- A. If a patient is discovered to have a potential infection, contact precautions by the staff will be mandatory.
- B. When caring for a patient who requires contact precautions, perioperative personnel will don personal protective equipment (PPE) before entering the room and discard PPE and perform hand hygiene when exiting the room.
- C. When patient transport is necessary, precautions will be taken to reduce the opportunity for transmission of microorganisms to other patients, personnel, and visitors, and to reduce contamination of the environment.
 - a. Use appropriate barriers to cover affected areas if infectious skin lesions or drainage are present.
 - b. Before transporting the patient:
 - c. The perioperative nurse will notify the receiving team members that the patient is coming and what precautions to take to prevent transmission.
 - i. Contaminated PPE will be removed and discarded and then hand hygiene performed.
 - ii. Clean PPE will be donned to handle the patient at the transport destination.
- D. Unscrubbed personnel (eg, anesthesia professionals, circulating RNs) will wear gloves whenever touching the patient's skin or items that are in close proximity to the patient, wear a gown when it can be anticipated that clothing will come into contact with the patient or contaminated environmental surfaces, don a gown before entering the room, and remove the gown and perform hand hygiene when exiting the room.
- E. Preoperative personnel will hold the patient in a single patient room, if possible, or keep a separation of at least 3 feet between patients.
- F. Environmental cleaning will be implemented to help control the spread of microorganisms that are transmitted by direct or indirect contact.



- a. Routine cleaning of perioperative environmental surfaces (eg, floors, walls) will be performed according to Terminal Cleaning Policy.
 - b. Thorough cleaning and disinfection practices will be implemented for frequently touched surfaces (eg, bedrails, doorknobs).
 - c. All noncritical equipment (eg, IV pumps, ventilators) will be cleaned and disinfected before use on another patient and will be handled in a manner to prevent provider or environmental contact with potentially infectious materials.
 - i. Dedicated noncritical items such as stethoscopes, blood pressure cuffs, and electronic thermometers may be used.
- G. Perioperative RNs will evaluate and manage any negative patient outcomes potentially caused by using contact precautions (eg, reduced patient-to-provider contact, increased symptoms of depression and anxiety, decreased satisfaction with care).

Documentation:

- A. The perioperative RN will document the care of the patient known or suspected to be infected or colonized with microorganisms that are transmitted by direct contact or indirect contact and the physiologic responses throughout the continuum of care, including: patient assessment, plan of care, nursing diagnoses, desired outcomes, and interventions.



Tuberculosis precautions

Purpose: To establish guidelines to identify and handle tuberculosis within the facility..

Reference: U. S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC) Recommendations and Reports (December 30, 2005, 54 (#RR-17):i-147), Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings.

Definitions: None

Policy: Sunset Surgery Center will not knowingly admit a patient with tuberculosis or similar symptoms.

1. Signs and Symptoms of tuberculosis include:
 - a. A cough lasting for three (3) weeks or longer
 - b. Bloody sputum
 - c. Chest pain
 - d. Night sweats
 - e. Weight Loss
 - f. Anorexia
 - g. Fever
 - h. Easily fatigued
2. Susceptible groups include:
 - a. Medically under-served populations including some African-Americans, Hispanics,
 - b. Asians and Pacific Islanders, American Indians and Alaskan Natives
 - c. Homeless persons
 - d. Current or past prison inmates
 - e. Alcoholics
 - f. Intravenous (IV) drug users
 - g. Elderly
 - h. Foreign-horn persons from Asia, Africa, the Caribbean, Latin America and the former
 - i. Soviet Republic areas
 - j. Contacts with persons having active TB
 - k. Chronic steroid use (as in arthritis patients)
3. All employees and physicians are required to have tuberculosis screening annually.
4. All new employees must present tuberculosis screening within 10 days of employment.
5. All physicians practicing within the Center must maintain annual screening for tuberculosis.



Procedure:

- A. All patients are screened by the referring physician prior to surgery. If it is discovered that a patient has been diagnosed or shows potential symptoms, any surgical procedures will be cancelled. Once the patient is free from all signs/symptoms, the surgery can be rescheduled.
- B. Any patient suspected to have tuberculosis will be masked and transported to the hospital for treatment in an Isola.
- C. Clinic receptionist staff should immediately notify the nurse if they observe patient or visitor in the lobby exhibiting suspicious respiratory symptoms. Patients suspected of, or known to have active TB should be given a surgical mask and be shown how to wear it. All patients should be asked to cover their mouth and nose with tissues when coughing/sneezing and dispose of used tissues in a lined trash receptacle. Arrangements should be made to transfer the patient to an appropriate isolation room as soon as possible.
- D. Any employee suspected of tuberculosis will be suspended until such treatment can be completed and all signs/symptoms are resolved.
- E. If the employee fails to show proof of tuberculosis screening, they will be suspended until current proof can be provided.
- F. If a possible exposure is reported by an employee:
- G. Employees with previous negative TB tests:
 - a. All previous negative reactor employees should have a baseline TB skin test done as soon as possible after an exposure has occurred.
 - b. Eight to Ten weeks after the exposure, these employees should be retested and assessed for conversion.
 - c. If an employee begins showing symptoms of active TB, the Infection Control Nurse should be notified immediately.
- H. Employees with previous positive TB tests:
 - a. TB Questionnaire will be done as soon as possible after exposure.
 - b. Eight to Ten weeks after a TB exposure, employees should complete a follow-up TB Questionnaire.
 - c. If an employee begins showing symptoms of active TB or notes positive symptoms on the TB Questionnaire, the Infection Control Nurse (or designee) should be notified immediately.

Documentation:

- A. If a procedure is cancelled due to suspected tuberculosis, it is to be documented in the patient's chart
- B. All proof of employee and physician's tuberculosis screening is to be filed in their medical chart.
- C. If exposure is discovered, an Event Report will be documented and the employee will be sent for Medical treatment



SUNSET SURGERY CENTER
INFECTION CONTROL
EMPLOYEE COMMUNICABLE DISEASE POLICY

**CATEGORY: INFECTION CONTROL PRECAUTIONS FOR EMPLOYEES
WITH COMMUNICABLE DISEASE**

PURPOSE: The purpose of this policy is to control and prevent the spread of communicable disease from employees in the health care setting to patients, visitors, other employees and third parties. Sunset Surgery Center Infection Control will monitor those employees or contract employees who have an unscheduled absence. The CDC guidelines on communicable diseases will be followed to determine when an employee on contract employee is free of communicable disease and may return to work.

PROCEDURE:

1. An employee is required to follow department guidelines when due to a medical reason he/she is unable to work as scheduled. The employee will be advised to follow the communicable disease policy if symptomatic of infectious disease(s).
2. Department managers are responsible for having a sick call-in process in place to identify employees with signs and symptoms of communicable diseases. Infection Control is available for consultation (Julie Smink, R.N.)
3. Employees and contract employees are to notify Infection Control immediately if diagnosed with one of the diseases listed or if he/she develops symptoms of an infectious/communicable disease.

4. An employee who is absent due to communicable disease must be deemed free of the communicable disease and/or non-transmissible to others at the work place before returning to work. Infection Control will notify the manager that the employee is required to have return to work permission from IC. IC will not disclose the disease to the manager.
5. CDC Guidelines will be posted in each department for determining when an employee is free of communicable disease.
6. All employees who report a communicable disease medical diagnosis to Infection Control, are required to comply with the IC instructions for return to work.
7. Managers will not allow any employee on restriction from IC to work until notified by IC that the employee is allowed to return to work.
8. All employees are required to read this policy and attachments, which list all the communicable disease that must be reported to the manager and Infection Control Coordinator. Review of this policy will be done at the time of hire or before providing patient care services, and an acknowledgement will be signed at the time. An annual review will be conducted of all employees.
 - a. Infection Control will log and document all communicable disease process, reported by all employees.
 - b. All managers will notify the Infection Control Coordinator of unusual occurrences or trends in communicable disease occurrence that require further investigation.
 - c. Infection Control will report occurrences by listed disease annually to the Infection Control and Safety Committee and provide an evaluation of the program's effectiveness.



INFECTION CONTROL

MANAGEMENT RESPONSIBILITIES

1. Teach employees that all patients' blood and body fluids are considered potentially infectious for human immunodeficiency virus (HIV), hepatitis B (HBV), hepatitis C (HCV) and other blood borne pathogens.
2. Provide a general explanation of the epidemiology, modes of transmission, and symptoms of blood borne pathogens. Exposure incidents can lead to infection from HIV, HBV, or HCV. Early symptoms of HIV include: fever, sore throat, lethargy, swollen glands. Early symptoms of HBV are: fever, runny nose, flu-like symptoms, skin rash, loss of appetite, fatigue, headache, nausea, vomiting, and diarrhea.
3. Demonstrate/describe protective barriers such as gloves, gowns, goggles and masks/face shields including use, location, removal, handling, decontamination, and disposal of personal protective equipment.
4. Emphasize that it is mandatory that Standard Precautions be followed as outlined in the Infection Control Policy.
5. Provide information on appropriate actions to take if an exposure incident occurs including the method of reporting that incident and the medical follow-up.
 - Document the circumstances of the incident and route of exposure.
 - The source individual's blood is tested for HIV, HBV, and HCV as soon as feasible, after consent is obtained.
 - The results of the source individual's blood test are made available to the exposed person.
 - The exposed person's blood is collected as soon as practical and tested after consent is obtained.
 - Post-exposure follow-up may be indicated.
6. Provide an opportunity for interactive questions and answers. Management must work closely with inexperienced staff and choose assignments for which the employee is prepared in terms of both knowledge and skill level.

7. Management and staff should understand and follow rules of confidentiality pertaining to test results and health records.
8. Career counseling should be initiated in a situation in which an employee refused to care for any client.



Sunset Surgery Center
EXPOSURE CONTROL PLAN
For
PROCEDURE SKILLS

Employee Preparation

Employees attend a required practice session to prepare for this skill.

A review of precautions includes instructing employees to wash their hands thoroughly with soap and water and to wear gloves.

After "sharps" are used, the invasive piece of equipment is placed in a standard hospital "sharps" box. Supplies are "red bagged." Contaminated materials are disposed of at an approved site at the end of the day or as needed.

If suspected contamination occurs, the employee is instructed to soak the area with a 1:50 Clorox solution followed by thoroughly washing with soap and water. He/she is then referred to his/her physician or health care agency for follow-up testing. An incident report is filed through the program coordinator/director. Sunset Surgery Center is not responsible for covering the costs of any associated testing or treatments. Employees are strongly urged to obtain their own health insurance.



Sunset Surgery Center

OCCUPATIONAL EXPOSURE INFECTION CONTROL POLICY

CATEGORY: PREVENTING TRANSMISSION OF PATHOGENIC MICROORGANISMS

SUBJECT: HAND HYGIENE

DEFINITION:

A general term that applies to hand wash, antiseptic hand rub or surgical hand antisepsis.

The major concern of any infection control program is the prevention of infection. Because many types of infections may be caused by organisms transmitted on the hands of healthcare personnel, *hand hygiene is generally considered the single most important procedure in preventing the spread of infection.* For this reason guidelines are being provided for the use of appropriate hand hygiene procedures.

General Information: This includes patient care and non-patient care areas.

1. Hands are washed when visibly soiled with either an antimicrobial soap or a regular soap and tepid water. (Hot water can irritate skin.)
 2. An alcohol based hand sanitizer product (60-95% alcohol) can be utilized if hands are not visible soiled. This kind of product is not appropriate for use when hands are visibly dirty or contaminated with proteinaceous material.
-
- I. Non-patient Contact Areas (e.g. public rest rooms, break rooms, laboratories and/or other research areas, etc.)
 - a. Hand-washing facilities including sinks with running water (hot and cold), waste receptacles, soap and disposable paper towel dispensers should be conveniently located for frequent use by all personnel.
 - b. A hand washing product that is generally acceptable to personnel is to be provided.
 - c. Hand washing is done after going to the bathroom, before eating, etc.

 - II. Patient Care Areas
 - a. Hand-washing facilities including sinks with running water (hot and cold), waste receptacles, soap, and disposable paper towel dispensers should be conveniently located for frequent use by personnel.
 - b. For routine patient contacts and procedures, cleaning of patient care equipment involves a vigorous rubbing together of all surfaces of soap lathered hands for at least

fifteen seconds, followed by a rinsing under a stream of water is recommended, using a product which is generally acceptable to personnel. After drying hands thoroughly with a disposable paper towel, discard the used paper towel in the waste receptacle and use a dry paper towel to turn off faucets and open the exam room door.

Rationale: Using a wet paper towel to turn off faucets and open exam room doors creates a "strike through" where bacteria on these surfaces can cross over the wet paper towel and re-contaminate clean hands.

- c. In the absence of a true emergency, personnel must always wash their hands, even when gloves are used:
 1. Before putting on gloves and after removing gloves.
 2. Before direct care of patients when the potential for contamination by blood/body fluids exists. This is mandated by OSHA.
 3. After contact with intact skin such as after taking blood pressure, lifting patients, taking temperatures, etc. This prevents cross-examination from one site to another on the patient. (Patients carry microorganisms on their intact skin and may be colonized with infectious microbes.)
 4. Before performing invasive procedures, such as urinary catheter placement or manipulations, peripheral intravenous line placement, etc.
 5. Before taking care of particularly susceptible patients, such as those who are severely immune-compromised (HIV, transplant, chemotherapy, radiation patients, etc.) and newborns.
 6. Before and after touching wounds, whether surgical, traumatic, or associated with an invasive device.
 7. After situations during which microbial contamination of hands is likely to occur, especially those involving contact with mucous membranes, blood or body fluids, secretions, or excretions.
 8. After touching inanimate sources that are likely to be contaminated with virulent or epidemiologically important microorganisms. These sources include urinary measuring devices or secretion collection apparatus, and any inanimate objects in immediate vicinity of patients (e.g. exam tables, chairs, sinks, desk tops, etc.)
 9. After taking care of an infected patient or one who is likely to be colonized with microorganisms of special clinical or epidemiological significance; i.e. multiply-resistant organisms.
 10. Between tasks and procedures in the same patient to prevent cross contamination of different body sites-- such as wound dressing and then placing a peripheral IV site.
 11. Between contacts with different patients.
 12. After gloves are removed.

- d. Healthcare worker's fingernails
 1. Healthcare workers working in patient care areas must not wear artificial fingernails or nail extenders.

2. Healthcare workers working in patient care areas must keep natural nail tips at or less than $\frac{1}{4}$ of an inch long.
3. Nail polish should be intact. If chipped the nail polish should be removed.
4. No current recommendation can be made regarding wearing rings in health-care settings. This is an unresolved issue at present.



Sunset Surgery Center
HANDWASHING TECHNIQUE

1. If necessary, push up sleeves and your watch.
2. Turn faucets on and adjust water to as warm a temperature as you can tolerate.
3. Wet hands with water. Spread a thin film of soap over the entire skin surface. Wash thoroughly, rubbing all the surfaces of the hands together briskly for at least 30 seconds.
4. Rinse under running water with hands pointed downwards.
5. Dry with paper towels.
6. Turn off faucets using a dry paper towel and use a paper towel to open the door to exit.

Examples of: WHEN TO WASH YOUR HANDS

1. Before beginning work.
2. Before and after caring for each patient.
3. After collecting a urine specimen, giving a bedpan, or handling a commode.

4. After sneezing or coughing into your hand or using a Kleenex.
5. Before and after taking a temperature, either oral or rectal.
6. Before eating.
7. Before and after using the bathroom.
8. After any contaminated contact.
9. After finishing work—before leaving.

Sunset Surgery Center

PROCEDURES FOR HAND HYGIENE

A. Hand washing procedure for soap and water:

1. When washing hands with soap and water, wet hands first with water (preferably warm water), apply an amount of product recommended by the manufacturer to hands, and rub hands together vigorously covering all surfaces of hands and fingers and around fingernails.
2. Rinse hands with water and dry thoroughly with a disposable towel. Dispose of wet paper towel in waste receptacle.
3. Use dry towel to turn off the faucets and to open exam room door or restroom door.
4. Avoid using hot water because repeated exposure to hot water may increase the risk of dermatitis.

B. Hand hygiene with alcohol based products for routine care:

1. When decontaminating hands with an alcohol-based hand rub, apply product to palm of one hand and rub hands together, covering all surfaces of hands and fingers until hands are dry.
2. Follow the manufacturer's recommendations regarding the volume of product to use.
3. Store supplies of alcohol-based hand rubs in cabinets or areas approved for flammable materials.

Hands contaminated with spores such as bacillus anthracis (anthrax) should be washed with soap and water; because alcohol based products as well as other antiseptics have poor activity against spores.

Antiseptics

- A. Antiseptics used in the clinics and research areas/laboratories must be approved by the Infection Control and Safety Committee.
- B. All hand soaps have antimicrobial activity.
- C. Antiseptics are used to decontaminate the skin and other superficial tissues. They do not sterilize the skin but they can reduce microbial contamination depending on the amount and type of contamination, the antiseptic agent

used, the length of exposure to the agent, the presence of residual activity and the technique used.

- D. Alcohol based antiseptics, hand sanitizers that do not require water to use (e.g. foams, gels, and rinses) are adjuncts for either hand washing or the surgical scrub. However, these products may be used in the following instances:
1. As a supplement to the surgical scrub (applied after the first routine scrub for identical procedures).
 2. In the event that there is no soap and running warm water available.
 3. De-germing of hands after gloves are removed in the procedure/patient exam room cleaning process.
 4. Hands must be visibly free of soil/debris.
 5. Hands must be washed with soap and running warm water after the alcohol based hand sanitizer/antiseptic is used two or three consecutive times, based on the manufacturer's guidelines for their prospective products.
- E. Antiseptics approved by the Infection Control and Safety Committee for hand scrubs are:
1. Alcohol
 2. Alcohol gels or foams (at least 60-95% alcohol)
 3. 4% chlorhexidine gluconate
 4. Hexachlorophene
 5. Iodine/Iodophors
 6. Para-chloro-meta-xylene (PCMX)
 7. Triclosan (or Irgasan DP-300)

References:

1. Centers for Disease Control, "Guidelines for Hand washing". Website: www.cdc.gov
2. APIC Guidelines for Infection Control Practice, "Guideline for Use of Topical Antimicrobial Agents", Larson, Ed, 1988. Website: www.apic.org
3. APIC Guideline for Hand Hygiene in Health-Care Settings, "Recommendations Of the Healthcare Infection Control Practices Advisory Committee and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force"

Sunset Surgery Center

COMMUNICABLE DISEASE POLICY FOR EMPLOYEES: LIST OF DISEASES

CALL INFECTION CONTROL COORDINATOR IF YOU ARE DIAGNOSED WITH ANY OF THE FOLLOWING ILLNESSES:

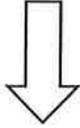
Diseases named as or caused by:

- Chicken pox
- Chicken pox, if you have been exposed and not had Chicken pox
- Diarrhea caused by Amebiasis, Cholera, Cryptosporidiosis, E. coli 0-157, Giardia, Salmonella, Shigella, C. Diff.
- Draining wound caused by Staphylococcus aureus (both MRSA/MSSA)
- Hepatitis A
- Herpes simplex on the hand- like a cold sore on the hand
- Impetigo
- Influenza
- Lice
- Measles
- Mumps, active
- Mumps, if you have been exposed and not had Mumps
- Pink eye- conjunctivitis (viral)
- Resistant organisms colonized or infected such as MRSA, VRE, others
- Rubella, active
- Rubella, if you have been exposed and not had Rubella
- Scabies
- Shingles
- Shingles, if you have been exposed and not had Chicken pox
- Strep throat caused by Group A Streptococcus
- Tuberculosis (TB)
- Anthrax
- Boils caused by Staphylococcus aureus (Staph)
- Brucellosis
- Diphtheria
- Leprosy (Hansen disease)
- Meningitis caused by Neisseria meningitis
- Typhoid fever
- Whooping cough
- Noro Virus

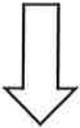
Sunset Surgery Center

COMMUNICABLE DISEASE POLICY FOR EMPLOYEES FLOWCHART OF PROCESS

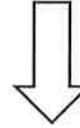
Employee ill at work



Supervisor reminds employee of Communicable Disease Policy and Sends employee home



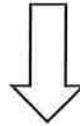
Employee call in ill



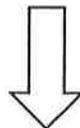
Supervisor reminds employee of Communicable Disease Policy



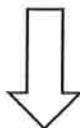
If employee is diagnosed with communicable disease listed he/she is to call immediately. Leave a message if IC is not available. Phone number: (702) 262-0079 ext. 234



Infection Control notifies employee supervisor that employee has restrictions before he/she can return to work.



Employee takes document to meet the disease criteria to return to work to IC prior to returning to work. Copies of document will be given to HR.



IC will notify the employee's supervisor that the employee can return to work.

SUNSET SURGERY CENTER
INFECTION CONTROL
EMPLOYEE COMMUNICABLE DISEASE POLICY

**CATEGORY: INFECTION CONTROL PRECAUTIONS FOR EMPLOYEES
WITH COMMUNICABLE DISEASE**

PURPOSE: The purpose of this policy is to control and prevent the spread of communicable disease from employees in the health care setting to patients, visitors, other employees and third parties. Sunset Surgery Center Infection Control will monitor those employees or contract employees who have an unscheduled absence. The CDC guidelines on communicable diseases will be followed to determine when an employee or contract employee is free of communicable disease and may return to work.

PROCEDURE:

1. An employee is required to follow department guidelines when due to a medical reason he/she is unable to work as scheduled. The employee will be advised to follow the communicable disease policy if symptomatic of infectious disease(s).
2. Department managers are responsible for having a sick call-in process in place to identify employees with signs and symptoms of communicable diseases. Infection Control is available for consultation (Julie Smink, R.N.)
3. Employees and contract employees are to notify Infection Control immediately if diagnosed with one of the diseases listed or if he/she develops symptoms of an infectious/communicable disease.
4. An employee who is absent due to communicable disease must be deemed free of the communicable disease and/or non-transmissible to others at the work place before returning to work. Infection Control will notify the manager that the employee is required to have return to work permission from IC. IC will not disclose the disease to the manager.
5. CDC Guidelines will be posted in each department for determining when an employee is free of communicable disease.
6. All employees who report a communicable disease medical diagnosis to Infection Control, are required to comply with the IC instructions for return to work.

7. Managers will not allow any employee on restriction from IC to work until notified by IC that the employee is allowed to return to work.
8. All employees are required to read this policy and attachments, which list all the communicable disease that must be reported to the manager and Infection Control Coordinator. Review of this policy will be done at the time of hire or before providing patient care services, and an acknowledgement will be signed at the time. An annual review will be conducted of all employees.
 - a. Infection Control will log and document all communicable disease process, reported by all employees.
 - b. All managers will notify the Infection Control Coordinator of unusual occurrences or trends in communicable disease occurrence that require further investigation.
 - c. Infection Control will report occurrences by listed disease annually to the Infection Control and Safety Committee and provide an evaluation of the program's effectiveness.



Contaminated Needle Stick HIV/HIB Awareness Policy

Purpose: To provide for the safety of the employees and patients of the Center.

Policy: A uniform routine will be followed after an occurrence of an employee of the Center being pricked by a contaminated needle.

Procedure:

- Routine:
 1. Break scrub as soon as is compatible with patient safety.
 2. Wash thoroughly with hand scrub solution, "milking" the wound.
 3. Normal wound treatment, including tetanus prophylaxis, if indicated.
 4. Inform patient, or next of kin, and obtain permission for HIV/HIB screening.

- Abraded Skin:
 1. Break scrub as soon as possible.
 2. Clean area thoroughly with scrub solution.
 3. Apply occlusive dressing if further patient contact is necessary.
 4. If mucous membranes exposed (eye, oral, cavity), flush with saline.
 5. Obtain permission from patient, or next of kin, for HIV/HIB screening.

- High Risk Patients:
 1. Break scrub as soon as possible.
 2. Clean area thoroughly.
 3. Inform patient, or next of kin, and obtain permission for HIV/HIB screening.
 4. Obtain personal HIV screening.
 5. Begin AZT 600 mg/day for six weeks.
 6. CBC every two weeks while taking AZT.
 7. If patient not available for further screening (negative HIV), health care worker should be tested at six weeks, twelve weeks, and six months.



Contaminated Patient Policy

Policy:

- Due to the nature of our practice, FDA infectious disease panels are required and performed prior to admission.
- If it is found that the patient is positive for any transmittable/contagious infectious disease, the patient is referred to seek care from their primary care physician and admission to Sunset Surgery Center is at the discretion of the Governing body.
- If admission is approved all universal precautions per the CDC and OSHA are implemented and followed by all staff.



Cleaning Blood and Bodily Fluid Spills and Blood-borne Pathogens

Purpose: A protocol for the proper clean-up of bodily fluids has been universally established to ensure the safety of all those who are potentially exposed. Blood and other bodily fluids should be immediately cleaned up to lessen the danger of spreading HIV and Hepatitis B and C

Principles:

1. All human blood and certain human body fluids are treated as if known to be infectious for HIV, HBV, and other airborne pathogens. (i.e. the concept of Universal Precautions). A bodily fluid spill kit for SSC is kept in the clean room under the sink.

Procedure:

1. Cover the spill with absorbent paper towels to avoid stepping in it.
2. Block off the area of the body fluids spill to prevent further spread.
3. Put on vinyl gloves and carefully wipe up the spill with the paper towels and carefully place the mess in a biohazard bag.
4. Pour a mixture of 1 part household bleach to 10 parts of water carefully on the area of the spill. Avoid splashing. The bleach and water solution should remain in contact with the spill area for at least 20 minutes.
5. Carefully wipe up the area with paper towels and avoiding dripping.
6. Double-bag all towels from the body fluids spill along with the gloves used to clean the mess and tie the bags closed.
7. Dispose of the double-bagged materials in red biohazard bags and place in the biohazard bins located in the closet marked with biohazard stickers and wash your hands thoroughly with soap and warm water.

Tips and Warnings

1. Many companies make bodily fluids spill kits that can be hung on the wall and contain all the needed supplies to clean up these spills quickly and easily.
2. All bodily fluid spills should be treated as potentially dangerous and need to be cleaned up immediately to ensure the safety of others.



Principles of Aseptic Technique

Purpose: To define the principles of aseptic technique:

1. Pathogenic organisms: those microorganisms that may cause infection or disease.
2. Sterile: free from microorganisms.
3. Asepsis: absence of infection by mechanical and chemical methods of cleanliness.
4. Aseptic technique: manner in which objects are kept sterile.
5. Sterilization: any process by means of which all bacterial, including spores, can be destroyed.
6. "Disinfection:" any process by means of which all, except the spore-bearing pathogenic organisms, are destroyed.
7. Surgically clean: mechanically cleansed but not sterile.
8. Antiseptics: chemical substances, which inhibit the growth and multiplication of bacteria without necessarily destroying them.
9. Deodorants: substances, which neutralize disagreeable odors.

I. Principles of Aseptic Technique:

A. Skin cannot be sterilized, therefore:

1. Patient's skin over operative area is thoroughly scrubbed in surgery or just prior to surgery.
2. All operators scrub their hands and arms thoroughly before sterile gowning and gloving.
3. Nurses and doctors gown and glove without touching outside of gown and gloves with skin.
4. If a glove gets a hole in it during an operation, it is to be changed at once.

B. Persons who sterile touch only sterile articles; persons who are not sterile touch only unsterile articles.

C. Non-sterile persons should avoid reaching over a sterile field. Sterile persons should avoid leaning over an unsterile field.

D. If in doubt as to sterility, consider an article not sterile. Examples may be:

1. If uncertain about actual timing of a sterilizer.
2. If a non-sterile person brushed close to a sterile table and vice versa.
3. If an autoclave tape looks as if the color has not been changed or if the control has not melted.
4. Any sterile package dropped on the floor is contaminated.
5. Re-autoclave all sterile equipment when questionable contamination has occurred.

E. Although entire gown was sterilized, consider a person sterile only from waist to axilla level, and only in front.

1. Tables are sterile only at table level.
2. Things dropped below waist level are considered contaminated.



3. Sterile persons should keep hands always in sight and above waist level.
 4. Do not fold arms when sterile as armpits may be damp from perspiration.
 5. Always face sterile areas. In passing other persons, use back-to-back, front-to-front technique.
 6. Sterile person is to keep contact with sterile areas to a minimum. Do not lean elbows on table. Stand back a few inches and work on table with hands.
 7. Sterile person is to keep work at a non-sterile field to a minimum:
 - a. In gloving, pick up sterile glove and step away from the table to pull it on.
 - b. Pick up total contents of package rather than one article to a time.
- F. Consider edges (table cover, wrappers, etc.) as unsterile.
1. Avoid touching edges of a wrapper when lifting contents from packages. Lift all contents by reaching down and lifting them up straight.
 2. If linen falls over side of table, discard it.
 3. If suture falls over the side of the table, cut it off at the table height or discard it.
- G. Wet areas are considered contaminated.
1. If a solution soaks through a sterile area to an unsterile area, the sterile area becomes contaminated when this is done.
 2. Be careful to lay sterile packages on dry areas.
 3. Cover a damp area on a sterile table with a thick sterile towel.
 4. Put Vaseline and lubricating jelly on a sponge on sterile table. Place wet ampoules, instruments, needles, etc. on double thickness or in sterile basin.
 5. In checking rooms, dry shelf well after damp dusting before replacing sterile packages.
- H. Keep air contamination at minimum.
1. Mask worn over nose as well as mouth.
 2. Keep all main corridor doors closed as much as possible.
- I. Sterile persons must keep within their sterile field and allow a wide margin of safety when passing unsterile areas.
1. Scrub nurse stands back away from operating table when drapes are being applied.
 2. Ask an unsterile person to step aside rather than trying to squeeze past them.
- J. Articles must be submerged when soaking. A floating article does not become sterile. If necessary, put a piece of gauze over the article so that it stays damp.
- K. Wrapping sterile packages.
1. Article to be completely covered and corners of the wrapper turned inside the wrapper.
 2. Leave a small cuff or underfold of wrapper so that the package may be opened without contaminating any part of it.



- L. A foolproof method of distinction between sterile and unsterile articles must be used.
 - 1. Sterile articles or equipment must be labeled, dated and kept within their own area.
 - 2. Unsterile articles and supplies must be clearly labeled and kept within their own area.
- M. In gloving, use skin to skin, outside of glove to outside of glove technique.
- N. In draping, the gloved hand should be on top of the drape and protected by a cuff of the drape.
- O. Grossly contaminated operative areas include:
 - 1. Any infected tissue.
 - 2. Purulent material or fluid.
 - 3. Gas gangrene or active pulmonary tuberculosis.
- P. Sterile tables are first considered contaminated to a case when the patient first enters the rooms.

II. What to do about contamination:

- A. Stop what you are doing and step away from the sterile field. Remove contaminated instruments if they are cause of contamination as with a needle stick.
- B. Discard contaminated articles.
- C. Request a new gown, gloves, drape, etc.
- D. Regown, reglove, or redrape. If glove contaminated let unsterile person remove the gloves so that you do not contaminate the other glove.

III. Instruments:

- A. Check instruments and supplies for each case, especially if someone else has picked them. If you are circulating, you are responsible for having all the necessary equipment. Checking in advance avoids unnecessary trips out of the room.
- B. Check preference cards and update frequently.
- C. Be careful with sharps (scissors, etc.) and do not put heavy instruments on smaller and more delicate instruments.
- D. Scrub nurses are to be sure that doctors' special instruments are cleaned, counted, and returned to the doctor.
- E. No scrubbed personnel are to leave the room during surgery except to obtain instruments from the autoclave.

Sunset Surgery Center TB Skin Test Policy

It is the policy of SSC to identify those healthcare workers with latent TB (LTBI) or active TB. Importantly, TST helps identify those who require preventative therapy to prevent latent infection from progressing to clinically active TB.

For practical purposes, the Mantoux PPD skin test is used.

Administer the Mantoux skin test, intradermally, injecting 0.1 ml of 5TU purified protein derivative (PPD) tuberculin on the inner forearm. Two PPD preparations are currently available in the US: Tubersol (Pasteur Merieux-Connaught) and Aplisol (Parkdale Pharmaceuticals). Administer the tuberculin syringe with the bevel facing up.

Test all healthcare workers in your facility that could be exposed to a patient with symptoms of TB. Include all employees who have patient contact, including paid and unpaid persons, part-time personnel, volunteer workers, maintenance and clerical staff, as well as temporary or contract workers. Exclude only those employees in your practice who have never had patient contact, such as certain billing staff.

Recommendations for Tuberculin Skin Testing (TST) for Healthcare Workers

	Low Risk	Medium Risk	Potential Ongoing transmission
Baseline TST	Yes, 2-step (PPD skin test) upon hire	Yes, 2-step (PPD skin test) upon hire	Yes, 2-step (PPD skin test) upon hire
Ongoing serial/screening TST	No	Every 12 months	Administer one TST (2-step PPD skin test) as soon as possible after exposure to <i>M. tuberculosis</i> . If negative, re-test 8-10 weeks after exposure.

Baseline Employee TST: The Two-step PPD Skin Test

It is the policy of SSC to provide an initial baseline two-step PPD skin test to every healthcare worker that has patient contact, at no charge to the employee.

The two-step method differentiates boosted reactions for reactions due to new infections. Two-step testing also reduces the likelihood that a LTBI is misinterpreted as a new infection. For some people who are infected with *M. tuberculosis*, delayed-type hypersensitivity to tuberculin may wane over the years. When tested many years later, they may have a negative skin test. However, this initial skin test may boost their ability to react to tuberculin, causing a positive reaction to subsequent PPD tests. This boosted reaction may be misinterpreted as a new infection.

To prevent this misinterpretation, perform two-step PPD testing on all newly employed healthcare workers who have *not* had a documented negative PPD test result during the previous 12 months. Perform a second test within 1-3 weeks after the first test. If the second test result is positive, this is most likely a boosted reaction and the healthcare worker should be classified as previously infected. If the second test result remains negative, classify the healthcare worker as uninfected; a positive reaction on a subsequent PPD test is likely to represent a new infection with *M. tuberculosis*.

Two-step TST Interpretation

- If the first test is positive, consider the person infected.
- If the first test is negative, test again one to three weeks later.
- If the second test is positive, consider person infected (boosted reaction).
- If the second test is negative, consider person uninfected.

Interpreting the TST

After 48 to 72 hours, measure the diameter of induration (palpable swelling). A negative test should produce a discrete, pale elevation (a wheal) 6 mm to 10 mm in diameter in most individuals, and a wheal of 0 mm to 5 mm in high-risk individuals.

A positive test is:

- ≥ 5 mm for very high-risk groups (HIV, persons with recent contact with an infected individual, injecting drug users whose HIV status is unknown, etc.).
- ≥ 10 mm for other high-risk groups (foreign born persons from high-risk areas, healthcare workers who serve high-risk groups, medically underserved, low-income populations including ethnic minorities such as blacks, Hispanics, and Native Americans, residents of long-term institutions, persons with conditions that increase the risk of TB (silicosis, more than 10% below body weight, chronic renal failure, diabetes mellitus, high dose corticosteroid and immunosuppressive therapy, some leukemias and lymphomas, and some other malignancies).
- ≥ 15 mm for those with no risk factors for TB.

False Positive/False Negative TB Tests

False Positive Results

Some causes of false positive TB skin test results are:

- A boosted reaction in an adult from childhood exposure to TB.
- Infection with other non-tuberculous mycobacteria.
- Previous vaccination with BCG. (i.e., BCG, or bacilli Calmette-Guerin, is a TB vaccine used in many countries with a high prevalence of TB. BCG is generally not used in the U.S.)

False Negative Results

Anergy can sometimes cause false negative TB skin test results. Consider anergy in persons with no reaction and those:

- With HIV (33%) and AIDS (60%).
- With overwhelming miliary or pulmonary TB.

- Who have severe or febrile illness.
- Who have measles or other viral infections.
- With Hodgkin's disease or sarcoidosis.

Detect anergy by administering at least two other delayed-type hypersensitivity antigens, such as tetanus toxoid, mumps, or Candida, by the Mantoux technique, in conjunction with TB skin testing.

Those with reactions of ≥ 3 mm to any antigens, including PPD, are NOT anergic. Record results as mm of induration, not positive or negative. If anergy testing is less than 3 mm, patient is anergic. Assess the probability of infection. If risk is high (known contact of persons with TB or persons from a group of high prevalence of TB), evaluate for preventive therapy.

Periodic Retesting of Employees

Based on risk assessment: If your facilities falls into the medium risk category, provide TB skin testing to all employees annually.

Based on exposure to a person with TB: If there is employee exposure to an individual with infectious TB, repeat skin testing as soon as possible after the exposure and if that TST is negative, perform another TST 8-10 weeks afterwards. It takes 2 to 10 weeks from the time of infection for an exposed person to react to the skin test.

Do not repeat TSTs annually or after an exposure for employees with positive skin test. For those employees, it's necessary to rely on chest x-rays and symptoms to see if they have tuberculosis. Require them to get a chest x-ray if they have a cough lasting for 3 weeks and 2 or more TB symptoms. Routine yearly chest x-rays are not necessary.

TUBERCULOSIS TEST FORM

I hereby request that I be given a PPD test through the Practice in order to meet the state public health requirements of a screening test for tuberculosis. I understand that the Practice assumes no liability for this test and that if I have a positive reaction, I will consult my primary care physician.

Date: _____

(Employee's signature)

(Employee's printed name)

Date of birth: _____

Department: _____

Date test given: _____ Date test read: _____

Read by: _____

Results: _____ Negative _____ Positive Arm: _____ Left _____ Right

Lot #:



Sunset Surgery Center

HEPATITIS B VACCINATION FACT SHEET

WHAT IS HBV?

Hepatitis B virus (HBV) is a potentially life-threatening bloodborne pathogen. It causes hepatitis, an inflammation of the liver and although most people with hepatitis B recover completely, approximately 6-10% become chronic carriers and 1-2% die. In the group of chronic carriers, many have no symptoms but can transmit the virus. Carriers also face a significantly higher risk for other liver ailments such as cirrhosis of the liver and liver cancer.

HBV infection is transmitted through exposure to blood and other infectious body fluids and tissues including semen, tears, saliva, urine, breast milk, and vaginal secretions. Health workers and students are at high risk of acquiring Hepatitis B because of frequent contact with blood and potentially contaminated body fluids. Approximately 8,700 health care workers each year contract Hepatitis B. Health care persons must use work practices and protective clothing and equipment to prevent exposure to potentially infectious materials. These procedures are described in the HCC Health Sciences Division Infection Control Policy. However, the best defense against hepatitis B is vaccination.

WHAT DOES VACCINATION INVOLVE?

The hepatitis B vaccination is a noninfectious, yeast-based vaccine given in three injections in the arm. It is prepared from recombinant yeast cultures, rather than human blood or plasma. Thus, there is no risk of contamination from other blood borne pathogens nor is there any chance of developing HBV from the vaccine.

The second injection should be given one month after the first, and the third injection six months after the initial dose. More than 90 percent of those vaccinated will develop immunity to the hepatitis B virus. To insure immunity, it is important for individuals to receive all three injections. At this point it is unclear how long the immunity lasts so booster shots may be required at some point in the future.

No serious side effects or allergic reactions have been reported during the course of clinical trials. A few persons experience tenderness and redness at the site of the injection. Low-grade fever may occur. Rash, nausea, diarrhea, joint pain, fatigue/weakness and headache have also been reported. Other more serious adverse reactions have occurred infrequently.

Each employee should receive counseling from a health care professional before making a decision about vaccination. This discussion should help the employee make an informed decision.

WHAT IF I DECLINE VACCINATION?

A person who initially declines to receive the vaccine, must sign and return the attached waiver. If the employee later chooses to take the vaccine, the verification must be submitted to the coordinator/director.

Sunset Surgery Center

Single Use Vial Policy

The transmission of bloodborne viruses and other microbial pathogens to patients during routine healthcare procedures continues to occur due to unsafe and improper injection, infusion, and medication vial practices being used by healthcare professionals within various clinical settings throughout the United States.

Breaches in safe injection, infusion and medication vial handling practices continue to result in unacceptable and devastating events for patients. More than 35 outbreaks of viral hepatitis have occurred in the United States in the past 10 years due to these unsafe practices and other breaches of infection prevention procedures. These outbreaks have resulted in the transmission of either hepatitis B or C to more than 500 patients. The unsafe practices that were used by physicians and/or nurses in these outbreaks can be categorized by:

- a) Syringe reuse between patients during parenteral medication administration to multiple patients
- b) Contamination of medication vials or intravenous (IV) bags by accessing them with a used syringe and/or needle
- c) Failure to follow basic injection safety practices when preparing and administering parenteral medications to multiple patients
- d) Inappropriate use of finger stick devices and glucometer equipment between patients

APIC strongly supports adherence to the following safe injection, infusion, and medication vial practices.

Aseptic Technique

- Perform hand hygiene prior to accessing supplies, handling vials and IV solutions, and preparing or administering medications.
- Use aseptic technique in all aspects of parenteral medication administration, medication vial use, injections, and glucose monitoring procedures.
- Store and prepare medications and supplies in a clean area on a clean surface.
- Never store needles and syringes unwrapped as sterility cannot be assured.
- Discard all opened vials, IV solutions, and prepared or opened syringes that were involved in an emergency situation.

IV Solutions

- Never use intravenous solution containers (e.g. bags or bottles) to obtain flush solutions, etc. for more than one patient.
- Never use infusion supplies such as needles, syringes, flush solutions, administration sets or intravenous fluids on more than one patient.

- Being/initiate administration of spiked IV solutions (IV bag entered by the spiking tube) within one hour of preparation. If administration is not begun within 1 hour of spiking the bag, the IV and tubing shall be promptly discarded.
- For unspiked IV solutions (not accessed by IV tubing spike) follow the pharmacy prepared or manufacturer prepared IV solution expiration date.
- Use a USP 797 pharmacy clean room (ISO 5) to prepare admixtures of IV solutions.
- Disinfect IV ports using friction and 70% alcohol, an iodophor or an approved antiseptic agent. Allow to dry prior to accessing.
- Always use single-dose containers for flush solutions .

Syringes

- Remove sterile needle/cannula and/or syringe from package just prior to use.
- Never use medication in a syringe for more than one patient even if the needle is changed between patients. Changing the needle but not the syringe is unacceptable.
- Utilize sharps safety devices whenever possible.
- Discard syringes, needles and cannulas after used directly on an individual patient or in their IV administration system.
- Dispose of used needles at the point of use in an approved sharps container.
- Do not prepare medication in one syringe to transfer to another syringe, i.e. nurse draws up solution into syringe then transfers the solution to a syringe with plunger removed or injected into the bevel of the syringe to then be injected into the patient.

Vials

- Always follow the manufacturer's instructions for storage and use.
- Use single-use or single-dose vials only.
- Always use a sterile syringe and needle/cannula when entering a vial. Never enter a vial with a syringe or needle/cannula that has been used on a patient.
- Cleanse the access diaphragm of vials using friction and 70% alcohol or other antiseptic. Allow to dry before inserting a device into the vial.
- Discard single-dose vials after use. Never use them again for another patient.
- Never store vials in clothing or pockets.
- Use filter needles to withdraw solution from an ampule.
- Never pool or combine leftover contents of vials for later use.
- Never leave a needle, cannula, or spike device inserted into a medication vial rubber stopper because it leaves the vial vulnerable to contamination.
- Inspect vials and discard if sterility has been, or is thought to be compromised. Examine the vial for any particular matter, discoloration or turbidity. If present, do not use and discard immediately. All vials used during an emergency should be discarded as sterility cannot be guaranteed.

Healthcare Workers

- Provide the hepatitis B vaccination series to all previously-unvaccinated healthcare personnel whose activities involve contact with blood or body fluids.
- Check and document post-vaccination titers one to two months after completion of the vaccination series.
- Report body fluid and needle-stick/sharps injuries immediately.
- Evaluate needle-stick/sharps injuries for preventability.
- Use safety devices for liquid injection syringes. Sharps (syringes/needles) with attached safety devices must be activated prior to disposal.
- Ensure staff preparing or administering injections or other parenteral medications are competent to aseptically perform these tasks.
- Periodically assess compliance with safe injection practices by observing and evaluating personnel performing these procedures.

Conclusion:

Use of safe injection practices is critical to prevent microbial contamination of products administered to patients. The ongoing reports in the United States of hepatitis B and C transmission to patients and outbreaks of bacterial infections associated with unsafe injection practices is an indication that diligence is needed to assure that these preventative practices are being scrupulously followed in all healthcare settings. Healthcare workers and their managers must understand, practice and promote safe injection, infusion and medication vial practices. Administrators of medical facilities must support safe injection practices and provide resources to ensure employees have the training and equipment to safely implement these procedures. The role of the Infection Preventionist is to assess procedures for safety, develop programs, train, and implement safe injection, infusion and medication vial practices so they are the absolute standard of care throughout the variety of healthcare settings that exist today. The health and safety of our patients require adherence to infection prevention practices by all healthcare workers. These infection prevention practices should prevent cross contamination, transmission, and outbreaks of infection due to unsafe injection, infusion and medication handling, and preparation and administration practices.



SAFE INJECTION PRACTICES and SINGLE and MULTI-DOSE VIALS:

In order to maintain compliance it is the policy of Sunset Surgery Center to adhere to the following rules and ensure all medications, vials and usage of liquid or solid medications be dispensed and administered in compliance with CDC guidelines.

1. **Single Use:** Single needle and single syringe are used for a single patient. Medications, regardless of single dose or multi dose, are always drawn up utilizing sterile technique into a new needle and new syringe.
2. **Intravenous Tubing:** New intravenous tubing and connectors shall be used for each patient.
3. **Intravenous Solution:** Bags of Intravenous solution are used per patient and are discarded in compliance with CDC regulations when the solution runs out or the IV is discontinued from the patient. No bag of intravenous solution shall be used on multi patients at any time.
4. **Single Dose Vials:** single dose vials are for single patient and single dose usage. These should be opened sterilely and administered in a single dose to a single patient. Any unused medication should be discarded.
5. **Multi-dose vials definition:** A multi-dose vial is a vial of liquid medication intended for injection or infusion that contains more than one dose of medication. Multi-dose vials are labeled as such by manufacturers. No vial shall be considered multi-dose unless labeled as such by the manufacturer.
6. **Usage of Multi-Dose Vials:** multi-dose vials should be dedicated to a single patient whenever possible. When a multi-dose vial is used for more than one dose or used for more than one patient, strict sterile policy must be used.
7. **Sterile technique for usage of Multi-Dose vials.** Strict sterile technique is always used when giving any medication. For multi-dose vials, the injection port must always be cleaned with alcohol prior to withdrawal of the medication. Always a completely new sterile syringe and sterile needle must be used to draw up the medication. For each dosage withdrawn, a completely new syringe and completely new needle must be used. For example, it is not appropriate to withdraw medication inject into a patient and then withdraw from the bottle again with the same syringe, even if the needle is changed. To withdraw from the multi-dose vial, always a completely empty and new sterile syringe must be used with a completely new and sterile needle.
8. **Pre-Drawn Medications:** Medications pre-drawn at the beginning of the day must be specially labelled with the time drawn, initials of the individual drawing up the medication, name of the medication, strength of the medication and expiration date of the medication.
9. **Manufactured Pre-filled medications:** Regardless of the amount of medication present in the pre-filled syringe, they must only be used on one patient and discarded.



10. **All medications must be discarded according to expiration date.** The only exception to this is if a lifesaving medication is on back order or not readily available. All attempts must be made to replace any expired medication in a timely fashion.
11. **Opened multi-dose vials:** if a multi-dose vial has been opened or accessed, the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for the opened vial.
12. **Multi-dose vials should not be mixed:** multi-dose vial should not be mixed with other multi-dose vials unless directly specified by the manufacturer.
13. **Injections are to be given only by trained personnel:** all injections are to be given only under the direction of a physician by trained personnel. Personnel must have a valid state license to give injections and/or be under the direct supervision of the physician. All laws regarding the administration of medications are to be followed strictly.
14. **Sterility must be maintained.** Whenever sterility is compromised or questionable the vial must be discarded.
15. **Disposal of sharps:** All sharps are disposed of in a puncture resistant sharps container. Sharps containers should be replaced when the fill-line is reached or when the container is 2/3 full.
16. **Point-of-care devices, e.g. blood glucose monitoring devices or machines.** Point of care devices need to be cleaned with an EPA registered disinfectant/germicidal wipe.



Continuity and Excellence of Care Policy

(Physical Examination and Pre-surgical Evaluation, Intraoperative, and Postoperative Policy)

Policy: To ensure that each patient of the center is under the proper care of a physician, each patient admitted to the center receives a:

1. Physical Examination, which must include a medical history of the patient, within the 30 days immediately preceding the date of the patient's surgery
2. Pre-surgical Evaluation conducted by a physician on the day of the patient's surgery or with the 7 days immediately preceding the date of the patient's surgery
3. Consent forms should be completed on the day of the patient's surgery or within the 7 days immediately preceding the date of the patient's surgery
4. Any clinical observations of the patient, such as the notes of the physician, a nurse, or any professional person in attendance
5. Reports of all studies ordered, including laboratory and radiological examinations
6. Confirmation of the original diagnosis, or diagnosis at the time of discharge
7. A report of any surgery performed by the surgeon on the patient, prepared by the operating surgeon.
8. A description of the procedure followed in any administration of anesthesia to the patient
9. A recovery report for the patient
10. A summary of discharge, including without limitations, the disposition of the patient and any recommendations and instructions given to the patient
11. Documentation that a member of the nursing staff interviewed the patient 72 hours after the patient was discharged from the center to determine the condition of the patient and whether or not the patient was satisfied with the services provided, and to receive any complaints of problems the patient may have



Admission Criteria/Patient Selection

Purpose: To provide the highest quality of healthcare to patients, while ensuring their safety. It shall be the responsibility of the physician to correctly evaluate the patient and the procedure preoperatively for suitability for outpatient surgery

Policy: In order for Sunset Surgery Center to deliver the highest quality of care, our services will be provided according to the highest standards of professional practice through adherence to the following:

1. Medical Clearance

- a. If applicable, medical clearance should be recorded. A current history and physical examination by the surgeon, anesthesia provider, or the patient's personal physician is recorded within thirty (30) days of surgery on all patients for major surgery, and for those patients for minor surgery who require a physical exam. The medical record must contain a current medical history taken on the same day as the surgical procedure, and recorded by the surgeon or anesthesia provider prior to the admission of anesthesia.
- b. Not more than 30 days before the date of scheduled surgery, each patient must have a comprehensive medical history and physical assessment completed by a physician, or other qualified practitioner in accordance with applicable State health and safety laws, standards of practice and ASC policy.
- c. The center will ensure that each patient has the appropriate pre-surgical and post-surgical assessments completed and all the elements of the discharge requirements are completed.
 - i. The patient can tolerate a surgical experience;
 - ii. The patient's anesthesia risk and recovery are properly evaluated
 - iii. The patient's post-operative recovery is adequately evaluated;
 - iv. The patient received effective discharge planning; and
 - v. The patient is successfully discharged from the ASC
- d. The purpose of the comprehensive medical history and physical assessment is to determine whether there is anything in the patient's overall condition that would affect the planned surgery, such as a medication allergy, or a new or existing co-morbid condition that requires additional interventions to reduce risk to the patient, or which may even indicate that an ASC setting might not be the appropriate setting for the patient's surgery. The H & P must be comprehensive in order to allow assessment of the patient's readiness for surgery and is required regardless of the type of surgical procedure. The H & P should specifically indicate that the patient is cleared for surgery in an ambulatory setting.
- e. It is a requirement of the facility that the H & P be completed and documented for each ASC patient no more than 30 calendar days prior to date the patient is scheduled for surgery in the ASC.
- f. In cases where the patient is scheduled for two surgeries in the ASC within a short period of time, the H & P may be used so long as it is completed no more than 30 calendar days before each surgery.



- g. Other qualified licensed individuals are those licensed practitioners who are authorized in accordance with their State scope of practice laws or regulations to perform an H & P and who are also formally authorized by the ASC to conduct an H & P. Other qualified licensed practitioners could include nurse practitioners and physician assistants.

2. Admission and Pre-Surgical Assessment

- a. Upon admission, each patient must have a pre-surgical assessment completed by a physician or other qualified practitioner in accordance with applicable State health and safety laws, standards or practice, and ASC policy that includes an updated medical record entry documenting an examination for any changes in the patient's condition since completion of the most recently documented medical history and physical assessment, including documentation of any allergies to drugs and biologicals.
- b. In accordance with requirement 416.42 (a) (1), the physician will examine the patient immediately before surgery to evaluate the risk of the anesthesia and of the procedure for that patient. The patient must be assessed for any changes in his/her condition since the patient's H & P was performed that might be significant for the planned surgery. Any changes in health and medication can have an impact on the patient's ability to tolerate the surgery or anesthesia, and the post-admission pre-surgical assessment is designed to identify these changes and take appropriate action, up to and including postponing or cancellation of the surgery. Further, if the practitioner finds that the H & P done before admission is incomplete, inaccurate, or otherwise unacceptable, the practitioner reviewing the H & P, examining the patient, and completing the update may disregard the existing H & P, and conduct and document in the medical record a new H & P prior to the surgery.
- c. If upon examination, the licensed practitioner finds no change in the patient's condition since the H & P was completed, he/she may indicate in the patient's medical record that the H & P was reviewed, the patient was examined, and that "no change" has occurred in the patient's condition since the H & P was completed. Likewise, any changes in the patient's condition must be documented by the practitioner in the update note prior to the start of surgery.
- d. The comprehensive H & P must be submitted to the ASC prior to the patient's scheduled surgery date, in order to allow sufficient time for review of the H & P by the ASC's medical staff and adjustments if necessary. At a minimum, the H & P must be placed in the patient's medical record prior to the pre-surgical assessment required under 416.52 (a) (2), since that assessment must first consider the findings of the H & P before examining the patient for changes. Both the H & P and the pre-surgical assessment must be placed in the patient's medical record before the surgery.



3. The following conditions do not warrant admission to the facility:

- a. Cases where compromise of the airways is expected
- b. Cases where considerable blood loss is expected
- c. Cases where considerable postoperative pain is expected
- d. Cases where the patient is not ASA I or ASA II
 - i. ASA-I patients are those without any organic, physiologic, biochemical, or metabolic disturbance.
 - ii. ASA-II patients are those with a systemic disturbance which may be of a mild to moderate degree but which is either controlled or has not changed in its severity for some time.
- e. ASA III patients may be done at the discretion of the anesthesiologist
 - i. ASA-III patients may be operated upon in Plastic Surgery Institute on a case-by-case basis, determined by the medical director and the anesthesiologist
- f. Cases where anesthesia is expected to be prolonged; i.e. over 6 hours



Patient Identification Policy

Policy: Valid Identification will be checked for every procedure performed at Sunset Surgery Center.

Procedure:

1. When a patient signs in to Sunset Surgery Center for procedures, they will be asked for their valid picture ID
2. The valid Picture ID will be scanned into the system. If for some reason the patient refuses to present a valid picture ID, their social security number is to be used as another identifying marker.
3. Arm bands are required for both the patient and their partner when performing IVF procedures.
4. The name and date of birth indicated on the valid photo ID will be compared against the arm band. If there is a discrepancy, the supervisor is to be notified immediately, and the check in process is to be stopped until a resolution has been found.
5. The ID number and expiration date will be entered into the computer to document that valid identification was checked.
6. The receptionist will place the arm band on the patient having the procedure. For IVF procedures, the receptionist will place an arm band on the patient's partner and send this patient to the RRFC for sample collection.
7. Once completed, the supervisor shall be notified to begin the consent signing process.



Discharge of a Patient

Purpose: To set guidelines to establish criteria for discharging a patient that has been determined to have fully recovered from anesthesia. To ensure a safe transition of the post anesthesia patient in an outpatient setting.

Policy/Procedure:

1. Minimum Requirements – Length of Stay

- a. Patients undergoing general anesthesia will be monitored in the PACU area until criteria has been met. Minimum length of stay 30 minutes.
- b. Patients must remain in PACU for a minimum of 15 minutes after IV narcotics have been administered.

2. Discharge Criteria

- a. A numeric score of at least eight (8) using the Aldrete Evaluation Scale must be met prior to discharge.
- b. A numeric score of less than eight (8) on the Aldrete Evaluation scale will be observed until a proper discharge score can be reached.
- c. Patient's temperature must be greater than 96F to be discharged.
- d. A numeric score of less than five (5) without any improvements over time warrants the patient to be transferred to outside facility for further monitoring or treatment.

3. Physician Available

- a. Because anesthesia is administered, a physician is immediately available until the patient is discharged from the PACU.

4. Post-Surgical

- a. The patient's post-surgical condition will be assessed and documented in the medical record by a physician, other qualified practitioner, or a registered nurse with a minimum, post-operative care experience in accordance with applicable State health and safety laws, standards of practice and ASC policy.
- b. Patient will be given adequate written post-operative instructions to include the procedures to follow if complications or emergency situations occurs. The instructions will be given to an adult who is responsible for the patient's care and transportation.
- c. Follow-up appointments will be made at time of discharge and overnight supplies given if applicable.

5. Discharge – from Center

- a. Patients must be discharged in the company of a responsible adult.
- b. Center personnel will assist with discharge from the recovery area; every patient is discharged by wheel chair.
- c. For any patient receiving anesthesia in the Center, the staff ensures that the patient is transported in a vehicle with a responsible adult.
- d. Patients receiving local anesthesia can transport themselves.



6. Documentation

- a. At discharge, the following will be documented: ambulatory status, instructions given with copy for the chart and patient, any postop meds or prescriptions given, IV/HL removed, post-op appointment made, discharge to care of responsible adult, and discharge nurse's signature.
- b. Each patient is provided a discharge order signed by the physician who performed the surgery or procedure. The discharge instruction sheet will be reviewed with the patient and the responsible adult who transports the patient home.
- c. Documentation will be completed in the patient's chart.



Handling the Unruly Patient or Significant Other

Purpose:

Sunset Surgery Center would like to handle unruly patients and/or significant others in the most humane manner possible while maintaining a level of decorum in the Center that makes patients, significant others, and staff comfortable.

Policy: Should a patient/significant other become disruptive for any reason, staff are to act immediately and without hesitation. As there are different areas where patients may be in the office, different procedures must be undertaken to manage each situation.

Procedure:

1. Don't respond in kind to the patient (don't fight fire with fire). BE CALM.
2. GET HELP. While you don't want to "gang up" on the individual, you don't want to try to resolve the situation without help, or at least, without a witness.
3. Convince the patient to move to a pre-designated area where there is no contact (or at least reduced contact) with other patients/significant others.
4. Listen to the patient's demands, requests, and desires. Most people get upset when they believe they are being misunderstood or their needs are not being responded to.
5. Find the manager of the area where the disruption occurred (Business Manager for the waiting area, Clinic Director for the exam area, Operating Room supervisor for the OR area) and a physician
6. If you are concerned regarding anyone's physical safety, call 911

The designated areas for patient amelioration are as follows

:

If the person is in the	WAITING AREA	direct them to the SURGERY SCHEDULERS
If the person is in the	PRE-OP/PACU	direct them to the OFFICE
If the person is in the	OPERATING ROOM	KEEP THEM IN THE OR



Emergency Return of Patient to Operating Room

Purpose: To ensure patient safety at all times.

Procedure:

If the patient has been discharged from Sunset Surgery's Care

- Patient is instructed to report to the nearest Emergency Department and the Surgeon is notified immediately.
- Anesthesia must be alerted immediately to provide emergency cover.
- If possible patient and partner or accompanying adult must be informed of the need and purpose for the return to the operating room.
- In an emergency situation the patient should be moved to the operating room and all monitoring equipment set up. Any medication likely to be required by the anesthesiologist should be available.
- An RN or MD should monitor the patient until the anesthesiologist arrives.
- Surgical prep and draping can take place before anesthesiologist arrives.
- It is as the surgeon's discretion whether or not to move patient to the operating room before the arrival of the anesthesiologist.

If the patient is under Sunset Surgery's Care Post Operatively and the notification is received that a patient needs to return to the Operating Room after a procedure, the following steps are to be followed:

- Notify the Surgeon immediately.
- The Surgeon/Physician notifies the Surgery Scheduler and instructs her about the time the patient needs to return to the Operating Room.
- The Surgery Scheduler then notifies the following personnel:
 - Anesthesiologist
 - Certified Surgical Technician
 - Registered Nurse
 - Surgery Center Administrator



Transfer of a Patient to the Hospital

Purpose: To ensure that a patient can be transferred safely and efficiently to the nearest E.R. with least amount of trauma and risk to patient. The following problems fit the criteria for transfer to a hospital:

1. Preoperative complications
2. Patients needing postop IM or IV pain control
3. Patients with intra-operative complications
4. Patients with post-operative complications
5. Patients with an exacerbation of a comorbidity such as uncontrolled diabetic reaction or hypertension

Policy: The need to transfer a patient will be decided by an M.D. The M.D. must state Routine, Urgent or Emergency transfer.

1. For routine transfers:
 - a. Notify the emergency department at Southern Hills Hospital: (702) 880-2800.
 - b. After the physician has discussed the patient's transfer with the family, the office staff will maintain communication with family members to alleviate anxiety.
 - c. Notify the ER that the patient is ready for transport and give a brief report to the nurse or physician including but not limited to:
 - i. Doctor's name
 - ii. Patient's name and DOB
 - iii. Diagnosis
 - iv. Vitals
 - d. Ambulance service will be notified to transport the patient to the hospital.
 - e. For Quality Assurance purposes, the pre/postop nurse makes a follow-up telephone call within 24 hours to evaluate patient's progress or the patient will be visited at the hospital by a staff member or physician on staff.
2. For Urgent transfers, which require transfer of the patient within 30 minutes to the ER:
 - a. Call Ambulatory Service:
 - b. Give all information requested.
 - c. Do not hang up until instructed to do so.
 - d. Call Southern Hills Hospital: (702) 880-2800
 - e. Give Doctor's name
 - f. Give patient's name
 - g. Give patient's DOB
 - h. Give diagnosis
 - i. Patient fit for interview or not?
 - j. Insurance information.
3. **For emergency transfers which require the immediate transfer of the patient to the ER:**
 - a. Call 911 for immediate transfer and give all information that is requested. Do not hang up until instructed to do so
 - b. Call Southern Hills Hospital: (702) 880-2800
 - i. Give Doctor's name



- ii. Give patient's name and DOB
 - iii. Give diagnosis
 - iv. Give vitals (is OR required?)
 - c. Provide appropriate medical care (according to BLS/ACLS protocol) until emergency personnel arrive.
 - d. Provide assistance to emergency personnel as needed.
 - e. Maintain communication with family members.
 - f. For Quality Assurance purposes, the pre/post-op nurse or physician makes a follow-up telephone call within 24 hours to evaluate patient's progress or visit the patient in the hospital.

- 4. The nurse responsible for the patient needing transfer will fill out an incident report.



Unexpected Blood Loss Policy

Policy: In the event of an unexpected blood loss great enough to cause hypotension lower than 80/60 combined with a tachycardia whose rate is greater than 120, it is the responsibility of the anesthesiologist or nurse anesthetist to notify the surgeon if the operative procedure is still taking place. If the patient were to develop hypotension/tachycardia in the recovery room, it is the responsibility of the recovery room nurse to notify the surgeon and anesthesiologist or nurse anesthetist.

If it is felt that a significant blood loss may have occurred, procedures will begin to transfer the patient immediately to Southern Hills Hospital. (See Emergency Transfer Procedure.)



Incident Report Policy

POLICY:

Documentation of all unusual incidents in the Center will be made for future reference by completion of an appropriate Incident Report Form.

INCIDENTS (defined):

All incidents that are considered controversial or unusual in nature.

1. Major complaints of any nature made by a patient or visitor.
2. Loss of personal belongings.
3. Accidents occurring in the Center.
4. Incorrect administration of drugs.
5. Serious reactions.

PROCEDURE:

1. Complete a patient incident report with all pertinent information, i.e.:
 - a. All accidents
 - b. Incorrect drug administration
2. Completed incident report will be given to the Director of Nursing.



Malignant Hyperthermia (M.H.) Protocol

Prepared By: The Malignant Hyperthermia Association of the United States (MHAUS)

Policy: To maintain a cart stocked with all drugs and supplies needed during a malignant hyperthermia crisis. This may be included with the other emergency supplies. In addition, every patient shall be screened for a personal or family history of malignant hyperthermia. In the event a patient develops Malignant Hyperthermia it is policy that the staff of Sunset Surgery Center follow the Malignant Hyperthermia algorithm and manual along with the clearly labeled kit that is located in OR 1 next to anesthesia machine.

Purpose: To assure patient care and to minimize confusion during a malignant hyperthermia crisis.

Procedure:

Malignant Hyperthermia Cart:

1. M.H. supplies should be checked after each use and routinely every six months.
2. The refrigerator temperature should be checked regularly.
3. Drugs and fluids on the cart are to be checked for expiration dates and replaced immediately, if outdated.

Drugs and Equipment for Treatment of M.H.:

1. Ensure that the following are available for immediate use in the OR suite:
 - a. ECG monitor
 - b. Pulse oximeter, electronic temperature measuring device with appropriate probes for monitoring central temperature (e.g. nasal, rectal, axillary, (esophageal).
 - c. Capnograph
 - d. A bag of ice will be kept in the refrigerator
2. Drugs in M.H. cart:
 - a. Dantrolene sodium IV – 18 vials*
 - b. 3,000 ml sterile water for injection USP (without a bacteriostatic agent to reconstitute Dantrolene.
 - c. 50 cc vials sodium bicarbonate 8.4% x 3
 - d. Amiodarone x 3
 - e. 50% glucose 50 ml x 2
 - f. Regular insulin 100 units/ml x 1 (refrigerated)
 - g. 10% calcium chloride x 2

** An additional 18 vials are available with Dr. Andrew Cash at West Sunset Surgery Center



Cooling Equipment:

1. 60 ml syringe x 5
2. 60CC Toomey syringe x 2
3. 16F Nasogastric tube x 2
3. Ice Packs

Equipment:

1. IV supplies
 - 16G x 4
 - 18G x 4
 - 20G x 4
 - 22G x 4
 - 24G x 4
 - IV Tubing x 2
2. Tympanic Membrane Thermometer x 1
- 3.. Dynaesthetics Vapor Clean Charcoal Filters X 4

Training

1. An annual in service will be conducted to train and re-educate staff on what to do in a malignant hyperthermia crisis. A mock drill will be conducted at the conclusion of the in service.

Clinical Management/Procedure:

- Use Emergency Alarm System (800#). All available nurses and doctors must report.
- Call 911
- Call West Sunset Surgery and instruct them to bring the other 18 vials of Dantrolene immediately.
- Note time of diagnosed malignant hyperthermia.
- Stop all inhalational anesthetics.
- Hyperventilate with 100% oxygen.
- Obtain crash cart (located in recovery) and MH box (located in OR 2)
- Start mixing Dantrium with 60 ml sterile water for injection per vial. Two nurses should be allocated to this task.
- Obtain fluids and ice.
 - IV n/saline 1000 ml—in fridge in OR
 - NaCl for irrigation 500 cc—also in fridge in OR
 - Bags of ice—in freezer in staff lounge
- One RN must keep written record of all medications and procedures.
- Start cooling with bags of ice in axilla, groin, and as much body surface as possible.



- Lavage stomach, bladder, rectum if possible—have nasogastric tube available with 60 ml Toomey syringe.
- Change anesthesia circuit and bag. Disconnect vaporizers from fresh gas circuit.
- Have available blood sample tubes
 - Red top
 - Lavender
 - Blue
 - Green
- Have sodium bicarbonate ready
- When temperature stabilized, transfer to hospital with anesthesiologist and RN in attendance.



Medication Policy

Policy: In order to maintain compliance with all state, federal, regulatory and accrediting Agencies, Sunset Surgery Center shall adhere to the following:

- IV fluids such as Lactated Ringers and normal saline, tubing needles will be readily available in the facility as a single use supply
- Emergency medications are located and readily available in the locked crash cart located in the nursing station, PACU, as well as in the locked anesthesia carts in each operating room.
- Any medications that need to be refrigerated must be stored in a locked refrigerator. Food must not be stored in this refrigerator except if the food is used as a vehicle for the administration of drugs.
- All narcotic drugs must be logged into and checked out of stock only by a licensed health care professional. The dated narcotic logbook, which includes the use of narcotics on individual patients, is kept in the locked narcotic cabinet in the nurse's station. This logbook has sequentially numbered pages in a bound journal.
- The Director of Nursing will oversee the control of dangerous drugs and controlled substances. Controlled substances are stored in a double locked narcotics cabinet which is fastened to the wall which is located in the nurse's station. The narcotic inventory is verified by two licensed members of the surgery center at least weekly and on every day that narcotics are used.
- All drugs must be prescribed by a physician and administered by a physician or a Registered Nurse.
- All drugs are checked monthly for expiration. All drugs that are expired are disposed of properly and recorded in the "discard log" located in the narcotics cabinet. Any narcotics that are to be wasted are logged and signed by two licensed health care providers.
- If medication or treatment orders are given verbally by qualified physicians to the RN, the RN will get signed written orders by the end of the business day. If the doctor calls the order in on the phone, the order will be written, and read it back to verify the order. When the RN charts it, the RN writes (TO) to signify this is a telephone order.
- The RN prepares any medication using aseptic technique at the nurse's station. The medication syringe will be labeled with the patient's name, medication, dosage, the date and time prepared, by whom the medication was prepared, and the expiration date and time of the medication that was drawn. Whoever prepares the medications will be the same person giving the medications. The patient ID armband will be checked and verified before administering any medications.
- All IV insertion and monitoring will be done by a trained and licensed Registered Nurse.



- Whenever an adverse effect of medication occurs that the medication infusion be immediately stopped and the physician notified. The RN will stay with the patient, monitor the patient and treat any symptoms until the physician arrives.
- All medications will be prepared and administered in a safe and effective manner in accordance with the program of infections and communicable diseases and in accordance with manufacturer's instructions. It is the policy of SSC that all medication vials are single use only.
- A copy of the current ACLS algorithm is kept with the AED on the code cart located in the PACU station. The following medication must be kept within the crash cart as required by ACLS algorithm:
 - Epinephrine
 - Plain lidocaine
 - Vasopressors other than epinephrine, such as neosynephrine and ephedrine
 - Narcotic antagonists such as narcan
 - Seizure arresting medication such as Dilantin or Valium
 - Bronchospasm arresting medications such as albuterol or aminophylline
 - IV corticosteroids such as dexamethasone
 - Antihistamines
 - Anti-hypertensives
 - Non-depolarizing muscle relaxants such as rocuronium or vecuronium
 - Benzodiazepine revering agent such as flumazenil
 - Atropine



Medication/ Product Recall

Purpose: To establish procedures which are to be implemented **immediately** upon receipt of a notice of a medication or medical device alert or notification from a manufacturer or the Food and Drug Administration (FDA) issuing a caution or recall of a product.

Principles:

1. Products affected by a FDA or manufacturer's recall should **not** be used for patients and should be discarded or sent back to the company upon request and in accordance with instruction from the issuing agency.
2. All recalled products should be collected immediately and taken to the Office Manager.
3. Defective products/medication used on patients prior to recall notification must be tracked and findings documented.
4. Manufacturers are responsible for products affected by a recall.

Procedure: Receipt of all recall notices by the FDA, Manufacturers, distributors or other vendors shall be handled by the Director of Nursing. Upon receipt, the Director of Nursing will:

1. Verify that the particular item is stocked in the center.
2. If stocked:
 - a. Alert all personnel.
 - b. Issue instructions to collect all recalled products.
 - c. Assist with the collection.
 - d. Record all recalled products collected, including numbers of each, and initial and date documentation to include all staff involved.
 - e. If instructions for return or destruction are provided in the recall notice, they shall be followed.
 - g. Investigate situations where the product had been utilized by patients prior to the recall
 - h. If possible, trace the disposition of potential stock that may have been used under recall and notify the physician to address patient safety concerns.
3. If not stocked:
 - a. It will be noted that the product was not in inventory.
4. If the recalled product is a medication:
 - a. Record it on the Medication Supply Inventory Record that the product was returned, due to a product recall.
 - b. Fill out the Product Return form to accompany the package, and make a copy for our records.
 - c. Return the medication to the appropriate company and locatio



- d. If the medication to be returned is a controlled substance, **two** staff members **must package and seal** the delivery device. This will be recorded on the narcotic count sheet as "returned for product recall." It will be documented on the Medication Supply Inventory Record and a **Narcotic Return Form** will accompany the package.



Personal Protective Equipment Policy

Purpose: To ensure the employee is protected from possible contamination with potentially hazardous materials. To comply with OSHA recommendations for dealing with blood borne pathogens. PPE includes:

- Disposable, impervious gloves
- Gloves
- Shoe covers
- Masks
- Goggles
- Mask with eye shield
- Head coverings

Policy: All staff will use the appropriate personal protective equipment when performing certain tasks throughout the surgery center.

Procedure:

1. Employees working in the decontamination area should wear full PPE, to include but not limited to head coverings, shoe covers, eye protection, gown, and gloves, as the possibility of contamination by splashing is very likely. Tasks included are:
 - a. Washing instruments/equipment after surgery
 - b. Washing basins
 - c. Loading washer/disinfector
 - d. Emptying suction canisters
 - e. Mixing solutions
 - f. Pouring out expired solutions
 - g. Gathering up soiled disposables after surgery
 - h. Decontamination of the OR suite
2. Employees cleaning the autoclaves should wear full PPE, as the possibility of contamination by splashing is likely. In addition, fumes from the cleaners can be irritating to the airway passages.
3. For those performing surgical procedures, the employee should utilize:
 - a. Sterile Gloves
 - b. Face Mask to cover mouth and nose
 - c. Gown
 - d. Head covering
 - e. Shoe covers
4. For those performing tasks in pre-op and /or PACU:
 - a. When conducting any patient care or invasive procedures
 - b. Gown/mask if deemed necessary or bodily fluid splashes are anticipated



- c. Gathering trash for disposal
 - d. Gathering linen for disposal
 - e. Damp dusting with germicidal solution

5. Glove should ALWAYS BE WORN when:
 - a. Picking up any item used on a patient
 - b. When conducting any patient care or invasive procedures
 - c. Gathering trash for disposal
 - d. Gathering linen for disposal
 - e. Damp dusting with germicidal solution

6. Employees should review the OSHA manual and familiarize themselves with all the tasks that have been identified as hazardous.

7. Removed PPE should be disposed of in the appropriate waste receptacle.

8. Employees should thoroughly wash their hands and forearms after removal of PPE

9. Non-disposable PPE should be cleaned and disinfected as needed.



Risk Management/ Patient Safety Plan

Nevada Acute Care Division

Revised 1/2018

I. Overview

HENDERSON HOSPITAL endorses an integrated, system-wide patient safety program designed to improve patient safety and reduce risk to patients.

Patient safety is a cornerstone of quality care and is a leadership priority. **HENDERSON HOSPITAL** operates as a Patient Safety Organization to further its commitment in promoting patient safety and assuring that **HENDERSON HOSPITAL** remains at the forefront in the delivery of safe and effective clinical care. The Member Patient Safety Evaluation System (PSES) is utilized by **HENDERSON HOSPITAL** to track safety information, generate Patient Safety Work Product (PSWP) analysis of safety and clinical performance, and promote best practices. This Acute Care Division Risk Management/Patient Safety Plan (“Plan”) provides the general framework to identify, manage, reduce, and eliminate patient safety risks.

The Plan identifies the mechanisms to continually assess and improve the patient safety systems at **HENDERSON HOSPITAL**. It is our strategy to utilize statistical tools and defined project work to achieve breakthrough gains in patient safety. Performance improvement tools are used in developing and delivering consistent processes and services. The cultural aspect of the Plan is to promote a non-punitive approach to identifying and reporting adverse events. This is consistent with the “Just Culture” concept to promote patient safety practices by instituting a culture of safety and embracing concepts of teamwork and communication.

Most patient safety events are due to a failure of systems; therefore, a systems analysis approach is utilized in evaluations. The goal is to identify and track errors, deficiencies, and problematic trends in order to continuously improve the underlying systems and to intervene as necessary to improve system processes. Although a non-punitive culture is promoted, this approach is balanced by holding caregivers personally responsible for at-risk behaviors and failures to meet the standard of care. When warranted, discipline measures will be initiated as needed consistent with **HENDERSON HOSPITAL** policies. **HENDERSON HOSPITAL** employees, contractors, vendors, and members of each facility’s medical staff share responsibility to participate in detection, reporting, and remediation to prevent errors.

GENERAL STATEMENTS ON GOALS AND OBJECTIVES

To support, maintain and enhance the quality of patient care delivered by:

- Systematic and objective monitoring and evaluation of reports of injuries, accidents, patient safety issues, safety hazards, and/or clinical services findings.
- Identification and assessment of general areas of actual or potential risk in the clinical aspects of the delivery of patient care and safety.
- Implementation of appropriate corrective action, to the extent possible, to alleviate and resolve identified problems or concerns with patient safety issues.
- Evaluation and documentation of the effectiveness of actions implemented.

- Aggregation of data/information collected for integration in information management systems and use in managerial decisions and operations.

II. Mission and Vision

HENDERSON HOSPITAL mission, vision and values drive the Plan and serve as the foundation in identifying strategic goals, objectives and priorities. Our mission is to improve patient safety and the quality of health care delivery through the provision of excellence in clinical care while fostering safe care to our communities, that our patients will recommend to their families and friends, physicians prefer for their patients, purchasers select for their clients, employees are proud of, and investors seek for long-term results. The vision is to be recognized as the provider of choice for healthcare services in the local community where we are trusted by our patients, families and physicians to create a safe, caring and compassionate experience.

In support of our mission, vision, and values, the Plan promotes:

- Collaboration of administrative leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high quality healthcare.
- Communicate honestly and openly to foster trusting and cooperative relationships among healthcare providers, staff members, and patients along with their families, to ensure accountability for the patient safety priorities.
- Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.
- Accountability for every healthcare related decision and action based on the level of risk-taking or egregious behavior identified.
- A focus on continuous learning and improving, system design, and the management of choices and changes, bringing the best possible outcomes or performances to the facility.
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare.
- Education of staff and physicians to assure coordination and integration of care across disciplines and specialties.

HENDERSON HOSPITAL recognizes that providing safe patient care requires significant coordination and collaboration. The optimal approach to patient safety involves multiple departments and disciplines to establish and effectively implement the processes and mechanisms that comprise this plan.

III. ROLES AND RESPONSIBILITIES

A. Risk Management/Patient Safety Officer

HENDERSON HOSPITAL has a designated risk director/manager responsible for patient safety risk identification and reduction for their respective facilities. The designated Risk

Director/Manager is also the Patient Safety Officer. Each facility is required to submit scheduled reports to the Board of Governors describing risk reduction efforts associated with facility specific, or industry identified risk exposures, including environmental risks and emergency management. Reports are thoroughly reviewed and analyzed by the risk staff to determine effectiveness and follow-through of identified corrective action plans.

The Patient Safety Officer responsibilities based upon [NRS 439.870](#) includes:

- Serving on the Patient Safety Committee (PSC)
- Supervising the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Taking action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the PSC regarding any action taken in accordance with the responsibilities above.

B. Infection Control Officer

The infection control officer designated for each facility, based on [NRS 439.873](#), responsibilities include:

- Serving on the Patient Safety Committee
- Monitoring the occurrences of infections at the facility to determine the number and severity of infections.
- Reporting to the PSC concerning the number and severity of infections at the facility each month.
- Taking such action as determined necessary to prevent and control infections alleged to have occurred at the facility.
- Carrying out the provisions of the Infection Control Program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program.

Based on [NRS 439.865](#), the patient safety plan must also include an infection control program that carries out the infection control policy. The policy must consist of:

- The current guidelines appropriate for the facility's scope of service developed by a nationally recognized infection control organization as approved by the State Board of Health which may include, the Association for Professionals in Infection Control and Epidemiology (APIC), the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO) and the Society for Healthcare Epidemiology of America (SHEA); and

- Facility-specific infection control developed under the supervision of a certified Infection Preventionist.

C. Patient Safety

HENDERSON HOSPITAL has an established Patient Safety Councils (PSC) to support patient safety activities. The PSC should ensure that its Patient Safety Plan is promoted and executed successfully. **HENDERSON HOSPITAL** has also assembled participants to serve in the Member Workforce and to utilize the Member PSES to generate PSWP and exchange analysis and recommendations with the Acute Care PSO Workforce. The main vehicles for these analytic activities occurring within the Member PSES and the member facility Patient Safety Council meetings. The Member PSES is made up of both electronic and physical spaces for the reporting, storing, and generation of PSWP, including secure SharePoint site, and other electronic databases (including but not limited to ClearSight (STARS) and Midas) to maintain and manage PSWP.

According to [NRS 439.875](#), a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plans are promoted and executed successfully.

I. Facility Patient Safety Committee

Each facility establishes a Patient Safety Committee (PSC) that meets on a regular basis and at least monthly.

Membership:

In accordance with [NRS 439.875](#), the committee core membership consists of the following Key Members: (CEO, CNO, Physician, Risk/ Patient Safety Officer, Infection Prevention Nurse, Pharmacy, and Quality). The COO, CMO and Regional CMO attend, as applicable. NRS requires that at least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing, and pharmaceutical staff of the medical facility. In addition, the infection control officer, patient safety officer, and one member of the executive or governing body of the medical facility.

Based on [NAC 439.920](#), a medical facility that has fewer than 25 employees and contractors must establish a patient safety committee comprised of: the Patient Safety Officer, at least two providers of healthcare who treat patients at the medical facility, including but without limitation, one member of the medical staff and one member of the nursing staff of the medical facility; and the Chief Executive Officer (CEO) or Chief Financial Officer (CF) of the medical facility.

Meetings:

The required members attend the meetings on a monthly basis. If a required member is absent, the facility makes a suitable replacement with someone that has authority to implement actions identified by the PSC.

Duties and Responsibilities:

HENDERSON HOSPITAL PSC is charged with the assessment and improvement of high-risk processes related to patient safety. This is to be carried out using a four-step methodology.

- **Issue Identification:** The primary issue is the most important risk issue facing the facility and is determined by reviewing the facility's claims history, claims history unique to the facility, patient safety concerns, industry claims, and through discussions with the risk staff. Other issues may be related to process initiatives.
- **Best Practice:** Once identified, the primary issue is dissected to determine its component issues. For each component issue, a best practice is selected. Best practices represent the most appropriate method for performing the delineated process and should not be selected until the PSC is assured that it is truly the "Best Practice."
- **Implementation:** Implementation strategies are those methods used to put the best practices into place. Often this includes revising policies, education, newsletters, phone calls, meetings, formal training, etc. Responsible parties and dates for completion are identified to ensure success.
- **Monitoring and Accountability:** Monitoring is essential to ensure that the strategies identified have been effective. Improvement should be demonstrated statistically whenever possible.

Additional Patient Safety Committee Responsibilities, based upon [NRS 439.875](#) and [NRS 439.877](#), include:

- Monitor and document the effectiveness of the Patient Identification Policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the Patient Safety Officer pursuant to [NRS 439.870](#).
- Evaluate actions of the Patient Safety Officer in connection with all reports of sentinel events alleged to have occurred.
- The Quality member of the PSC will review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- The Quality member in conjunction with the Infection Control Officer will review and evaluate the quality of measures carried out by the facility to prevent and control infections.

- Make recommendations to the Board of Directors of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the Board of Directors of the facility regarding:

(1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);

(2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and

(3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.

- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

In addition to the work done on the primary issue, the PSC is charged with addressing issues identified through claims reporting, Safety Watch Newsletters, the Joint Commission (Sentinel Event Alerts) and others, HRUs and from the TERM evaluation or other surveys, such as the OBHRU Site Assessments. Feedback is provided on an ongoing basis as to the functioning of the Patient Safety Committee.

II. Patient Safety Advisories

When an untoward event occurs at a facility or in the industry, it is important that we respond in a positive manner. Systems that lead to failure at one facility can be assessed at other facilities to avoid the same or similar occurrence. To this end, the Acute Care PSO distributes Safety Watch newsletters. These alerts detail the circumstances that lead to the negative outcome and facilities are charged with assessment and improvement of their own processes.

HENDERSON HOSPITAL is required to address the Safety Watch newsletters via their Patient Safety Council and this is evidenced in their monthly minutes. Responses to the Safety Watch are reviewed for the opportunity to generate a best practice to implement.

C. TERM Program

The facility has utilized its formalized risk management program identified as TERM: the Technical Elements of Risk Management. Each element focuses on a separate organizational function and details specific strategies for managing risk in these areas. These elements are summarized as follows:

Element I. Administration of the Risk Management Program: The tenets outlined in Element 1 lay the foundation for an effective risk management program. The Risk Manager/Director must be seen as a resource to administration, facility, and medical staff. Written plans, goals, and objectives provide a clear vision to meet the purpose of the risk program. Although the TERM program uses the title “Risk Manager,” this applies equally to Risk Directors.

Element II. Risk Identification: Risk identification is essential in order to avoid, mitigate, and eliminate risk-generating practices. This Element focuses on those steps taken to identify exposures faced by the facility.

Element III. Risk Education: Education is a cornerstone of the TERM program. Risk management education is intended to reduce and eliminate risk-generating practices and to promote best practices that enhance the provision of safe patient care.

Element IV. Patient Safety Initiative: Imperative to a comprehensive RM program is one that focuses on the improvement of patient and staff safety through the creation of an environment that maximizes safety and reduces liability claims exposure. The mechanism used to drive the culture of safety is the Patient Safety Committee (PSC) at each facility. The PSC operates using a four-step process. These steps include: identification of the problem, determining best practice, implementing the recommendations, and monitoring and accountability. Corrective actions are discussed, monitored, and validated by the PSC.

Element V. Patient Safety Priority: Root Cause Analysis (RCA): The cornerstones of an effective Patient Safety and Risk Management Program are (i) the performance of a thorough and credible RCA when a serious, sentinel, never event or a significant near miss event occurs; and (ii) implementation of systemic improvements to enhance patient safety and improve healthcare outcomes going forward.

Element VI. Environment of Care; Safety and Security Programs: The safety and security programs in the facility serve to protect and preserve both life and property. Areas of safety include licensing, accreditation and federal, state, and local safety practices and programs, including the EPA, TJC, etc.

Element VII. Claims and Litigation Management: The risk manager serves as the on-site representative of the insurance program in the management of general and professional claims and litigation.

Element VIII. Patient Safety Organization (PSO): Participants of the Member Workforce are expected to perform identified patient safety activities and to be trained in their responsibilities. They must also understand and acknowledge their obligations, including maintaining the confidentiality of PSWP, as required by the Patient Safety and Quality Improvement Act (PSQIA), and of Protected Health Information, as required by the

Health Insurance Portability and Accountability Act (HIPAA) and its regulations, and other federal and state laws.

Element IX. Measuring the Effectiveness of the Risk Management Program: In order to assure the effectiveness of the Risk Management Program, certain activities should be conducted to ensure that implementation of the TERM program has been successful. This includes, but is not limited to, data analysis and trending of events and potential claims, which are shared with the respective oversight committees.

D. MIDAS

The MIDAS system is the electronic event reporting system utilized by the facilities to report patient and visitor safety events. The risk management module allows for the collection, categorization, and analysis of incident data using electronic reporting functions (Remote Data Entry - RDE). The facility enters incidents into MIDAS through identification of the type of incident and characteristics of the event using risk parameters and outcomes. Additional information can be attributed to a department, physician, or individual, along with further details of the event. This allows the retrieval of information in a variety of ways for analysis and review.

E. ClearSight (STARS)

STARS is an integrated claims management program that allows for complete claims management, including extensive analysis of reportable fields associated with reported claims. STARS also provides for the electronic submission of potential claims by user facilities.

Delineation of issues featured in the probable claim module allows for the facility staff to identify causation factors associated with any reported event. The system also provides for the entry of details that will describe the event and liability concerns.

Trending of claim information is performed on a scheduled basis to operations leadership metrics to form strategies on facilitating risk reduction efforts. Previous examples of this function include the formation of an OB HRU and Perioperative concepts. Quarterly reports should be provided by the Facility's RM to the Governing Board of all claims activities.

F. Event Notification Site

The Risk Department developed the Event Notification Site or ENS, a web-based system that allows for contemporaneous reporting of serious adverse events and key near miss sentinel events to facility and corporate management. The ENS also provides an environment in which stakeholders can post questions and additional information to the

facility reporting the event. Updates to the event are reported in real-time to all identified facility and stakeholders via the ENS. The Risk Management staff reviews each ENS to determine if follow-up is needed; if follow-up is indicated, it is to be completed within 45 days.

G. Root Cause Analysis (RCA)

Pursuant to [NRS 439.837](#), a medical facility shall, upon reporting a sentinel event pursuant to [NRS 439.835](#), conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both of the sentinel event.

A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals. Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

It is recommended that the Joint Commission's root cause analysis and actions plan framework table are utilized. It contains analysis questions and guides the organization in the steps of a root cause analysis. Not all of the questions apply to all of the events or cases.

Utilization of the "5 Whys" technique should be used to explore the cause and effect relationship underlying a problem. One can find the root causes by asking "why" no less than five times.

RCA Responsibilities

- Organize and coordinate the RCA process. For Serious OB events, RCAs are to be done within 72Hrs. of the event.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA and corrective action plan implementation process.
- Communicate the progress of the investigation, institutional barriers and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.



H. Patient Safety Checklists

By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

The patient safety checklists must follow protocols to improve the health outcomes of patients at the medical facility and must include, without limitation:

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.

- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - Proper instructions concerning prescription medications;
 - Instructions concerning aftercare;
 - Any other instructions concerning his or her care upon discharge; and
 - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety checklists are listed in Appendix C. (The following links provide some patient safety checklists for your reference— a checklist example is shown in **Appendix B.**)

http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf

<http://www.who.int/patientsafety/implementation/checklists/en/>

I. Patient Safety Policies

The patient safety policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include, the name and date of birth of the patient.
- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.
- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

J. MEMBER PATIENT SAFETY EVALUATION SYSTEM (PSES)

The Patient Safety and Quality Improvement Act of 2005 (PSQIA) and its regulations govern the operations and activities of the UHS Acute Care PSO and its Members. This includes assembling a “workforce” of employees, volunteers, trainees, contractors, and other persons who carry out patient safety activities on behalf of the Members within the Member Patient Safety Evaluation System (“Member PSES”). Participants in the Member Workforce are expected to perform identified patient safety activities and to be well trained in their responsibilities. They must also understand and acknowledge their obligations, including maintaining the confidentiality of PSWP, as required by the PSQIA, and of Protected Health Information, as required by the Health Insurance Portability and Accountability Act (HIPAA) and its regulations, and other federal and state laws. The Member PSES serves as a means by which patient safety information is collected, maintained, reported, and analyzed for the UHS Acute Care PSO for the purposes of improving patient safety.

K. Training and Education

Training is essential to successful implementation of the Patient Safety and TERM program. All facility risk managers undergo extensive orientation and education related to Patient Safety, TERM program and other healthcare, risk-related topics. Newly hired risk managers receive both on-site and collaborative corporate-based education and training to afford them the requisite skills to manage their facility assignment. Each risk manager is provided a copy of the TERM source documents and other reference materials that guide the risk management function. In addition, formalized supplemental training is provided to all facility risk managers as needed, including quarterly risk management meetings. Risk leadership provides ongoing support and consultation to their assigned facility to facilitate the minimization of liability exposures and enhancement of safe patient care.

The leadership risk management staff provides consultative services to each facility and as members of designated projects. These activities include on-site assistance, research, and consulting from off-site. Examples of designated projects are as follows.

- Facility specific risk Issues
- Safety Watch newsletters
- MIDAS Focus advisories

IV. Risk Management Goals and Objectives 2018

- Surgical and Procedural Safety
 - Monitor compliance through tracer methodology and report monthly with oversight by leadership.

- Goal: Zero harm events: Prevent mistakes in surgeries and procedures
- OB HRU-Zero Preventable Harm
 - Goal: Reduction/ Elimination of Maternal Hemorrhage
 - Goal: Reduction/ Elimination of Serious Harm from Shoulder Dystocia
 - Goal: Reduction/ Elimination of Serious Harm by decreasing response time to changes in Fetal Monitoring Tracings
- Emergency Department
 - Goal: Reduction/ Elimination of Workplace Violence
- Medication Safety
 - Goal: Implement an effective Opioid – Pain Management strategy, as evidenced by compliance with Assembly Bill 474, NRS 233B.066, regarding prescribing of controlled substances and reporting of controlled substance overdoses.
- Perform monthly *Safety Watch* Gap Analysis and complete within 90 days.
- Reduce the 2018 fall rate to 1.65 with ultimate target of zero.
- Improve moderate sedation compliance to 100%.

V. Monitoring and Accountability

A. Evaluation of TERM Program

These evaluations consist of both a core risk and clinical risk review. The facility is required to submit a written corrective action plan for noted deficiencies determined during the TERM evaluation. All information is shared with senior staff and monitored through the facility PSC.

B. Patient Safety Council Coaching

As detailed above, each facility is required to post their monthly reports or minutes that details the work conducted by their Patient Safety Committee to the facility PSES site. These are then reviewed minutes and detailed feedback is provided to coach the committee on their form and function.

C. Dashboards

The Risk Management/Patient Safety Dashboard and the Environment of Care Dashboard include multiple indicators to demonstrate the facility's performance as to these markers. These include: event reporting statistics, fall rate including harmful event rate, medication event rate including harmful medication events, timeliness of event review and closure, risk management education, events that meet the ECRI Top Patient Safety Concerns, and environment of care concerns.

VI. Evaluation/Review:

The risk staff reviews the effectiveness of the Patient Safety/Risk Management Plan to ensure activities are appropriately focused on improving patient safety, decreasing harmful errors, decreasing rate of compensable events, facility risk program consistency/functionality and support of clinical delivery in the field. Evaluation will include the following:

- The culture supports the identification and reporting of “Near Miss” events
- There is a framework that advances a “Just Culture”
- Accountability is promoted when acts of “at risk” or “reckless behavior” occur resulting in potential/actual adverse outcomes;
- Comparison of trended incident data to include analysis of performance to stated targets, submission of incident data in compliance to SOX stipulations and review of trended data submitted to the PSC for potential action;
- Review of annualized and prior year’s probable claim reports to determine needs for corporate-based projects designed to improve outcomes in an identified service line;
- Review of educational products distributed for the concluding operating year that were intended to improve outcomes associated with a particular clinical emphasis;
- Review information, analyses and reports from the Acute Care PSO for integration into the Patient Safety Evaluation System.

VII. Confidentiality

All patient safety/risk management work products are considered Patient Safety Work Products (PSWP) as defined by federal guidelines governing Patient Safety Organizations (PSO). All PSWP reported, stored, or generated in the Member PSES is confidential and privileged under Federal law. The Member PSES will only be accessed by authorized staff. Workforce participants will be trained on policies and procedures governing their patient safety activities and responsibilities.

VIII. Approval of Patient Safety Plan

According to [NRS 439.865](#), a medical facility shall submit its patient safety plan to the governing board of the facility for approval. After a facility’s patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan.

The patient safety plan must be reviewed and **updated annually** in accordance with the

requirements for approval set forth in this section.

According to [NRS 439.843](#), on or before March 1 of each year, a copy of the most current patient safety plan established to [NRS 439.865](#) must be submitted to the Division of Public and Behavioral Health.

Appendix A: Terms and Definitions

Patient Safety: The Agency for Healthcare Research Quality (AHRQ) defines patient safety as “a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.”

http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

Sentinel event ([NRS 439.830](#))

1. Except as otherwise provided in subsection 2, “sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum.

2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:

(a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or

(b) July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published.

3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.

(Added to NRS by [2002 Special Session, 13](#); A [2005, 599](#); [2013, 217](#))

Institute for Healthcare Improvement (IHI) defines **medical harm** as “unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death.”

Facility-Associated Infection: ([NRS 439.802](#))

“Facility-acquired infection” means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections;
- Ventilator-associated pneumonia;

- Central line-related bloodstream infections;
- Urinary tract infections; and
- Other categories of infections as may be established by the State Board of Health by regulation pursuant to [NRS 439.890](#).

(Added to NRS by [2005, 599](#); A [2009, 553](#))

Medical facility ([NRS 439.805](#))

“Medical facility” means:

- A hospital, as that term is defined in [NRS 449.012](#) and [449.0151](#);
- An obstetric center, as that term is defined in [NRS 449.0151](#) and [449.0155](#);
- A surgical center for ambulatory patients, as that term is defined in [NRS 449.0151](#) and [449.019](#); and
- An independent center for emergency medical care, as that term is defined in [NRS 449.013](#) and [449.0151](#).

(Added to NRS by [2002 Special Session, 13](#))

Near miss: An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Mandatory reporting: Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985;254(6):796-800.)

Risk: Possibility of loss or injury. (Merriam-Webster’s Online Dictionary, Risk, Available at <http://www.merriamwebster.com/dictionary/risk>. Last Accessed August 2009.)

Preventable event: Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Catheter Associated Urinary Tract Infection (CAUTI): A urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at

http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CUR_RENT_b.pdf.)

Central Line Associated Bloodstream Infections (CLABSI): Primary bloodstream infections that are associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection.

Appendix B: Checklist Example: Injuries from Falls and Immobility

Process Change	In Place	Not Done	Will Adopt	Notes (Responsible & By When?)
Conduct fall and injury risk assessment upon admission				
Reassess risk daily and with changes in patient condition				
Implement patient-specific intervention to prevent falls and injury				
Communicate risk across the team; use handoff forms, visual cues, huddles				
Round every 1 to 2 hours for high-risk patients; address needs (e.g., 3Ps: pain, potty, position-pressure). Combine with other tasks(vital signs)				
Individualize interventions. Use non-skid floor mats, hip protectors, individualized toileting schedule; adjust frequency of rounds				
Review medications (by pharmacist); avoid unnecessary hypnotics, sedatives				
Incorporate multidisciplinary input for falls				
Prevention from PT, OT, MD, RN and PharmD				
Include patients, families and caregivers in efforts to prevent falls. Educate regarding fall prevention measures; stay with patient				
Hold post-fall huddles immediately after event; analyze how and why; implement change to prevent other falls				

Reference: Checklists to Improve Patient Safety. June 2013. Health Research & Educational Trust.

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POLICY

- This policy applies to all employees, medical staff, contractors, patients, visitors and patients of this hospital.
- All unexpected events or occurrences involving death or serious physical or psychological injury or risk thereof are to be reported to the administrative team immediately upon identification (regardless of time of day or night).
- Any and all adverse event or medical errors require immediate action to examine the event in-depth to determine why the incident occurred and how to reduce the likelihood of recurrence.
- The governing body must ensure that the Patient Safety Program (PSP) reflects the complexity of the hospital's organization and services, including those services furnished under contract or arrangement, and focuses on the prevention and reduction of medical errors and adverse events.
- All adverse events or medical errors are errors; but not all errors are adverse events or medical errors.
- Failure to report an adverse event or medical error will be addressed through the Disciplinary process
- Event data will be preserved and collected per hospital policy.¹
- Event equipment will be preserved and removed from patient care until cleared

PATIENT SAFETY SYSTEM:

- To have a means for establishing clear expectations for identifying and detecting the prevalence and severity of incidents that impact or threaten patient safety. This includes medical errors and adverse patient events.
- To identify, implement and regularly assess the means by which incidents are prevented or when they occur. The incidents are studied to detect nonconformance and where risk points or failures are an inherent part of the process and work to remove these risk points or failures from the system.
- To address customer (patient) communication when such incidents occur, how the patients are informed and their right to know the circumstances of events.

DEFINITIONS:

- Administrative Team: Interdisciplinary organizational team, whose members have specific knowledge and authority to determine and correct the identified causative factors of the adverse event or medical error.
- Adverse Event: An Adverse Event shall be defined as an unexpected occurrence or variation that led to death or serious physical or psychological harm. This definition includes the National Quality Forum (NQF) "never or adverse events" that are errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients.² An event that results in unintended harm to the patient by an act of commission or omission rather than by underlying disease or condition of the patient.

¹ Control of Internal and External Documents (#7067)

² NIAHO Standard; QM.7 (p 16) Adverse Event definition

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- Medical Error: The failure of a planned action to be completed as intended, the use of a wrong plan to achieve an aim, or the failure of an unplanned action that should have been completed, that results in an adverse event.
- Reportable Event: A medical error or adverse event or occurrence which the hospital is required to report to the State.
- Root Cause Analysis: An interdisciplinary review process for identifying the basic or contribution causal factors that underlie a variation in performance associated with an adverse event or reportable event. It focuses primarily on systems and processes, includes an analysis of underlying cause and effect, progresses from special causes in clinical processes to common causes in organizational processes, and identifies potential improvements in processes or systems.

SCOPE:

List of events and occurrences to report:

- No Harm Errors: those unintended acts, either of omission or commission, or acts that do not achieve their intended outcome-that do not result in a physical or psychological negative outcome or the potential for a negative outcome, for the patient.
- Hospital Acquired Infection/Condition: infections/conditions that are a result of treatment in a hospital or healthcare service unit.
- Patient Fall
- Mild/Moderate Adverse Outcome Errors: those unintended acts, either of omission or commission, or acts that do not achieve their intended outcome, that result in an identified mild to moderate physical or psychological adverse outcome for the patient.
- Any Medication Error
- Any Adverse Drug Reaction
- Hazardous Condition: any set of circumstances, exclusive of the disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious physical or psychological adverse patient outcome.
- Near Miss: any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome.
- Reportable Events to the State:
 - (i) a medication error resulting in a patient's unanticipated death or major permanent loss of bodily function in circumstances unrelated to the natural course of the illness or underlying condition of the patient;
 - (ii) a perinatal death unrelated to a congenital condition in an infant with a birth weight greater than 2,500 grams;
 - (iii) the suicide of a patient in a setting in which the patient received care 24 hours a day;
 - (iv) the abduction of a newborn infant patient from the hospital or the discharge of a newborn infant patient from the hospital into the custody of an individual in circumstances in which the hospital knew, or in the exercise of ordinary care should have known, that the individual did not have legal custody of the infant;

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- (v) the sexual assault of a patient during treatment or while the patient was on the premises of the hospital or facility;
 - (vi) a hemolytic transfusion reaction in a patient resulting from the administration of blood or blood products with major blood group incompatibilities;
 - (vii) a surgical procedure on the wrong patient or on the wrong body part of a patient;
 - (viii) a foreign object accidentally left in a patient during a procedure; and
 - (ix) a patient death or serious disability associated with the use or function of a device designed for patient care that is used or functions other than as intended.
- Required by the State: a health care-associated adverse condition or event for which the Medicare program will not provide additional payment to the facility under a policy adopted by the federal Centers for Medicare and Medicaid.
 - Other events: as included in the list of adverse events identified by the National Quality Forum that is not included in the list required by the State (see Appendix A for National Quality Forum events).

PROCEDURE:

- Upon the identification of an adverse event or medical error, after the patient is safe (as applicable), the administrative team has been notified prior to leaving duty, employees, members of the medical staff and any witnesses must complete an incident occurrence and submit it to their immediate supervisor who will follow the incident reporting process.³
- Adverse events or medical errors will be reviewed by the Administrative Team within 24 hours of incident notification. The administrative team will determine if the incident warrants conducting a root cause analysis.
- The licensed independent practitioner responsible for managing the patient's care, treatment, and services, or his/her designee, shall inform the patient or their representative, within 24 hours of the adverse events or medical errors about unanticipated outcomes of care, treatment, and services related to adverse events or medical errors when the patient or their representative is not already aware of the occurrence or when further discussion is needed.
- If it is determined by the administrative team that an RCA is warranted, it will commence within five (5) business days of the decision.
- The RCA will be conducted by the administrative team, staff and licensed independent practitioners who have specific knowledge and authority to determine and correct the identified causative factors of the adverse event or medical error.

Specifically the administrative team will:

- Complete an RCA to examine the cause and effect of the event through an impartial process.
- The RCA will focus primarily on the systems and processes, not individual performance. It will include the following elements:
 - A clear definition of the issue(s) pertaining to the event, that is, a determination of the human and other factors most directly associated with the event, and the process (es) and systems related to its occurrence.

³ Corrective/Preventive Action Plan (#7070)

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- Identification of risk points and their potential contributions to the type of event
 - Develop an action plan identifying the strategies that the hospital intends to employ to reduce the risk of similar events occurring in the future.
 - The action plan must:
 - Designate responsibility for implementation and oversight;
 - Specify time frames for implementation, analysis and follow-up
 - Include a strategy for measuring the effectiveness of the actions taken.
 - The administrative team will not, in any circumstance, delay implementation of the action plan or, as appropriate, elements of its components, over seven (7) days from the date of the completion of the RCA.
 - The administrative team will be afforded the time and resources by Quality Management Oversight to implement the approved plan.
 - If the RCA determines that the adverse event or medical error is related to an organizational systems approach or process challenge, the team will utilize the PDCA (Plan, Do, Check, Act) to design, implement and evaluate an improvement plan to correct the system issue and/or problem.⁴
- Reporting requirements:
 - The administrative team or their designee will report any and all activities of the RCA to the Quality Management Oversight
 - The administrative team or their designee will report any and all findings of the RCA to the Medical Executive Committee, and any other committees, teams, workgroups, or individuals within the organization, as appropriate to the defined issue.
 - The adverse event or medical error and/or the corrective action plan will be communicated to other organizations or individuals at sole discretion of the Chief Executive Officer or his/her designee.
- Other issues related to the RCA:
 - If the RCA finds the adverse event or medical error is to be caused by the performance and/or competence of an independent licensed practitioner holding clinical privileges, the corrective action will be managed through the supervision and direction of the Medical Executive Committee.
 - If the RCA finds the adverse event or medical error to be caused by the performance and/or competence of a clinical staff member not holding clinical privileges, or of a non-clinical staff member, then the corrective action shall be managed by the facility administrative team.

⁴ Quality Manual (#7075)

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**Appendix A
National Quality Forum
Serious Reportable Events**

1. SURGICAL OR INVASIVE PROCEDURE EVENTS

1A. Surgery or other invasive procedure performed on the wrong site (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1B. Surgery or other invasive procedure performed on the wrong patient (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1C. Wrong surgical or other invasive procedure performed on a patient (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1D. Unintended retention of a foreign object in a patient after surgery or other invasive procedure (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1E. Intraoperative or immediately postoperative/postprocedure death in an ASA Class 1 patient (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices

2. PRODUCT OR DEVICE EVENTS

2A. Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

2B. Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

2C. Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, long-term care/skilled nursing facilities

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3. PATIENT PROTECTION EVENTS

3A. Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

3B. Patient death or serious injury associated with patient elopement (disappearance) (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

3C. Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4. CARE MANAGEMENT EVENTS

4A. Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration) (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4B. Patient death or serious injury associated with unsafe administration of blood products (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4C. Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers

4D. Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy (new)

Applicable in: hospitals, outpatient/office-based surgery centers

4E. Patient death or serious injury associated with a fall while being cared for in a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

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4F. Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, long-term care/skilled nursing facilities

4G. Artificial insemination with the wrong donor sperm or wrong egg (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices

4H. Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen (new)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4I. Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results (new)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

5. ENVIRONMENTAL EVENTS

5A. Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

5B. Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

5C. Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

5D. Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

6. RADIOLOGIC EVENTS

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6A. Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area (new)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices

7. POTENTIAL CRIMINAL EVENTS

7A. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

7B. Abduction of a patient/resident of any age (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

7C. Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

7D. Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

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POLICY

- This policy applies to all employees, medical staff, contractors, patients, visitors and patients of this facility.
- All unexpected events or occurrences involving death or serious physical or psychological injury or risk thereof are to be reported to the administrative team immediately upon identification (regardless of time of day or night).
- Any and all adverse event or medical errors require immediate action to examine the event in-depth to determine why the incident occurred and how to reduce the likelihood of recurrence.
- The governing body must ensure that the Patient Safety Program (PSP) reflects the complexity of the facility organization and services, including those services furnished under contract or arrangement, and focuses on the prevention and reduction of medical errors and adverse events.¹
- All adverse events or medical errors are errors; but not all errors are adverse events or medical errors.
- Failure to report an adverse event or medical error will be addressed through the Disciplinary process
- Event data will be preserved and collected per facility policy.²
- Event equipment will be preserved and removed from patient care until cleared

PATIENT SAFETY SYSTEM:

- To have a means for establishing clear expectations for identifying and detecting the prevalence and severity of incidents that impact or threaten patient safety. This includes medical errors and adverse patient events.
- To identify, implement and regularly assess the means by which incidents are prevented or when they occur. The incidents are studied to detect nonconformance and where risk points or failures are an inherent part of the process and work to remove these risk points or failures from the system.
- To address customer (patient) communication when such incidents occur, how the patients are informed and their right to know the circumstances of events.

DEFINITIONS:

- Administrative Team: Interdisciplinary organizational team, whose members have specific knowledge and authority to determine and correct the identified causative factors of the adverse event or medical error.
- Adverse Event: An Adverse Event shall be defined as an unexpected occurrence or variation that led to death or serious physical or psychological harm. This definition includes the National Quality Forum (NQF) "never or adverse events" that are errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients.³ An event that results in unintended harm to the patient by an act of commission or omission rather than by underlying disease or condition of the patient.⁴

¹ Title 25, Texas Administrative Code, 133.48 (2) (A)

² Control of Internal and External Documents (#7067)

³ NIAHO Standard; QM.7 (p 16) Adverse Event definition

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- Medical Error: The failure of a planned action to be completed as intended, the use of a wrong plan to achieve an aim, or the failure of an unplanned action that should have been completed, that results in an adverse event.⁵
- Reportable Event: A medical error or adverse event or occurrence which the facility is required to report to the State.⁶
- Root Cause Analysis: An interdisciplinary review process for identifying the basic or contribution causal factors that underlie a variation in performance associated with an adverse event or reportable event. It focuses primarily on systems and processes, includes an analysis of underlying cause and effect, progresses from special causes in clinical processes to common causes in organizational processes, and identifies potential improvements in processes or systems.⁷

SCOPE:

List of events and occurrences to report:

- No Harm Errors: those unintended acts, either of omission or commission, or acts that do not achieve their intended outcome-that do not result in a physical or psychological negative outcome or the potential for a negative outcome, for the patient.
- Facility Acquired Infection/Condition: infections/conditions that are a result of treatment in a facility or healthcare service unit.
- Patient Fall
- Mild/Moderate Adverse Outcome Errors: those unintended acts, either of omission or commission, or acts that do not achieve their intended outcome, that result in an identified mild to moderate physical or psychological adverse outcome for the patient.
- Any Medication Error
- Any Adverse Drug Reaction
- Hazardous Condition: any set of circumstances, exclusive of the disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious physical or psychological adverse patient outcome.
- Near Miss: any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome.

- Reportable Events to the State⁸:
 - (i) a medication error resulting in a patient's unanticipated death or major permanent loss of bodily function in circumstances unrelated to the natural course of the illness or underlying condition of the patient;

⁴Title 25, Texas Administrative Code; 133.2 (4)

⁵Title 25, Texas Administrative Code; 133.48 (a) (1)(A)

⁶Title 25, Texas Administrative Code; 133.48 (a) (1)(B)

⁷Title 25, Texas Administrative Code; 133.48 (a) (1)(C)

⁸Title 25, Texas Administrative Code; 133.48(b)(1)(A)(i-ix)

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- (ii) a perinatal death unrelated to a congenital condition in an infant with a birth weight greater than 2,500 grams;
- (iii) the suicide of a patient in a setting in which the patient received care 24 hours a day;
- (iv) the abduction of a newborn infant patient from the facility or the discharge of a newborn infant patient from the facility into the custody of an individual in circumstances in which the facility knew, or in the exercise of ordinary care should have known, that the individual did not have legal custody of the infant;
- (v) the sexual assault of a patient during treatment or while the patient was on the premises of the facility or facility;
- (vi) a hemolytic transfusion reaction in a patient resulting from the administration of blood or blood products with major blood group incompatibilities;
- (vii) a surgical procedure on the wrong patient or on the wrong body part of a patient;
- (viii) a foreign object accidentally left in a patient during a procedure; and
- (ix) a patient death or serious disability associated with the use or function of a device designed for patient care that is used or functions other than as intended.

- Required by the State: a health care-associated adverse condition or event for which the Medicare program will not provide additional payment to the facility under a policy adopted by the federal Centers for Medicare and Medicaid.⁹
- Other events: as included in the list of adverse events identified by the National Quality Forum that is not included in the list required by the State (see Appendix A for National Quality Forum events).¹⁰

PROCEDURE:

- Upon the identification of an adverse event or medical error, after the patient is safe (as applicable), the administrative team has been notified prior to leaving duty, employees, members of the medical staff and any witnesses must complete an incident occurrence and submit it to their immediate supervisor who will follow the incident reporting process.¹¹
- Adverse events or medical errors will be reviewed by the Administrative Team within 24 hours of incident notification. The administrative team will determine if the incident warrants conducting a root cause analysis.
 - The licensed independent practitioner responsible for managing the patient's care, treatment, and services, or his/her designee, shall inform the patient or their representative, within 24 hours of the adverse events or medical errors about unanticipated outcomes of care, treatment, and services related to adverse events or medical errors when the patient or their representative is not already aware of the occurrence or when further discussion is needed.
- If it is determined by the administrative team that an RCA is warranted, it will commence within five (5) business days of the decision.
- The RCA will be conducted by the administrative team, staff and licensed independent practitioners who have specific knowledge and authority to determine and correct the identified causative factors of the adverse event or medical error.

⁹ Title 2, Texas Health and Safety Code; 98.1045 (1)

¹⁰ Title 25, Texas Administrative Code; 98.1045 (2)

¹¹ Corrective/Preventive Action Plan (#7070)

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Specifically the administrative team will:¹²

- Complete an RCA to examine the cause and effect of the event through an impartial process.
- The RCA will focus primarily on the systems and processes, not individual performance. It will include the following elements:
 - A clear definition of the issue(s) pertaining to the event, that is, a determination of the human and other factors most directly associated with the event, and the process (es) and systems related to its occurrence.
 - Identification of risk points and their potential contributions to the type of event
- Develop an action plan identifying the strategies that the facility intends to employ to reduce the risk of similar events occurring in the future.
- The action plan must:
 - Designate responsibility for implementation and oversight;
 - Specify time frames for implementation, analysis and follow-up
 - Include a strategy for measuring the effectiveness of the actions taken.
- The administrative team will not, in any circumstance, delay implementation of the action plan or, as appropriate, elements of its components, over seven (7) days from the date of the completion of the RCA.
- The administrative team will be afforded the time and resources by Quality Management Oversight to implement the approved plan.
- If the RCA determines that the adverse event or medical error is related to an organizational systems approach or process challenge, the team will utilize the PDCA (Plan, Do, Check, Act) to design, implement and evaluate an improvement plan to correct the system issue and/or problem.¹³
- Reporting requirements:
 - The administrative team or their designee will report any and all activities of the RCA to the Quality Management Oversight
 - The administrative team or their designee will report any and all findings of the RCA to the Medical Executive Committee, and any other committees, teams, workgroups, or individuals within the organization, as appropriate to the defined issue.
 - The adverse event or medical error and/or the corrective action plan will be communicated to other organizations or individuals at sole discretion of the Chief Executive Officer or his/her designee.
- Other issues related to the RCA:
 - If the RCA finds the adverse event or medical error is to be caused by the performance and/or competence of an independent licensed practitioner holding clinical privileges, the corrective action will be managed through the supervision and direction of the Medical Executive Committee.

¹²Title 25, Texas Health and Safety Code; 133.48a-b

¹³Quality Manual (#7075)

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- If the RCA finds the adverse event or medical error to be caused by the performance and/or competence of a clinical staff member not holding clinical privileges, or of a non-clinical staff member, then the corrective action shall be managed by the facility administrative team.

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**Appendix A
National Quality Forum
Serious Reportable Events**

1. SURGICAL OR INVASIVE PROCEDURE EVENTS

1A. Surgery or other invasive procedure performed on the wrong site (updated)

Applicable in: facilities, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1B. Surgery or other invasive procedure performed on the wrong patient (updated)

Applicable in: facilities, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1C. Wrong surgical or other invasive procedure performed on a patient (updated)

Applicable in: facilities, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1D. Unintended retention of a foreign object in a patient after surgery or other invasive procedure (updated)

Applicable in: facilities, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1E. Intraoperative or immediately postoperative/postprocedure death in an ASA Class 1 patient (updated)

Applicable in: facilities, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices

2. PRODUCT OR DEVICE EVENTS

2A. Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting (updated)

Applicable in: facilities, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

2B. Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended (updated)

Applicable in: facilities, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

2C. Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting (updated)

Applicable in: facilities, outpatient/office-based surgery centers, long-term care/skilled nursing facilities

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3. PATIENT PROTECTION EVENTS

3A. Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person (updated)

Applicable in: facilitys, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

3B. Patient death or serious injury associated with patient elopement (disappearance) (updated)

Applicable in: facilitys, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

3C. Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting (updated)

Applicable in: facilitys, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4. CARE MANAGEMENT EVENTS

4A. Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration) (updated)

Applicable in: facilitys, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4B. Patient death or serious injury associated with unsafe administration of blood products (updated)

Applicable in: facilitys, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4C. Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting (updated)

Applicable in: facilitys, outpatient/office-based surgery centers

4D. Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy (new)

Applicable in: facilitys, outpatient/office-based surgery centers

4E. Patient death or serious injury associated with a fall while being cared for in a healthcare setting (updated)

Applicable in: facilitys, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

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4F. Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting (updated)

Applicable in: facilities, outpatient/office-based surgery centers, long-term care/skilled nursing facilities

4G. Artificial insemination with the wrong donor sperm or wrong egg (updated)

Applicable in: facilities, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices

4H. Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen (new)

Applicable in: facilities, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4I. Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results (new)

Applicable in: facilities, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

5. ENVIRONMENTAL EVENTS

5A. Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting (updated)

Applicable in: facilities, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

5B. Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances (updated)

Applicable in: facilities, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

5C. Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting (updated)

Applicable in: facilities, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

5D. Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting (updated)

Applicable in: facilities, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

6. RADIOLOGIC EVENTS

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6A. Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area (new)

Applicable in: facilities, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices

7. POTENTIAL CRIMINAL EVENTS

7A. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider (updated)

Applicable in: facilities, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

7B. Abduction of a patient/resident of any age (updated)

Applicable in: facilities, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

7C. Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting (updated)

Applicable in: facilities, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

7D. Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting (updated)

Applicable in: facilities, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

Red Rock Pain Surgery Center

QUALITY AND PATIENT SAFETY PLAN



VERSION: 2

This plan was created and revised by the Red Rock Pain Surgery Center Patient Safety committee/team. Implementation of this plan is intended to optimize the healthcare quality and patient safety outcomes, encourage recognition, reporting, and acknowledgment of risks to patient, visitor, and employee safety, as well as reduce the medical/healthcare errors and /or preventable events.

Patient Safety Committee/Program
Red Rock Pain Surgery Center
5915 S. Rainbow Blvd. Ste 108
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Commitment to Patient Safety

Red Rock Pain Surgery Center is committed to a comprehensive approach to improving healthcare quality and patient safety by aligning with our Mission, Vision, and Values, creating an environment that supports a dynamic, proactive, and safe culture for patients, family members, visitors, and employees, through continuous learning and improving patient safety policies, systems, and processes.

Patient Safety and Quality Improvement Plan

Mission, Vision, and Values

In support of our mission, vision, and values, Red Rock Pain Surgery Center Patient Safety and Quality Improvement program promotes:

- Collaboration of healthcare, leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high quality healthcare.
- Communicate honestly and openly to foster trusting and cooperative relationships among healthcare providers, staff members, and patients and their families, to ensure accountability for the patient safety priorities.
- Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.
- Responsibility for every healthcare related decision and action.
- A focus on continuous learning and improving, system design, and the management of choices and changes, bringing the best possible outcomes or performances to the facility.
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare.
- Education of staff and physicians to assure participation of healthcare providers.

Scope and Purpose

The scope of this Quality and Patient Safety Plan is organizational-wide/hospital-wide/agency-wide which includes but is not limited to

- Patient safety
- Visitor safety
- Employee safety

All staff in Red Rock Pain Surgery Center are required to fully support and participate in this plan, and devote their expertise to the patient safety and healthcare quality improvement process.

This plan is action oriented and solution focused. The purpose of this plan is to address patient safety related concerns, challenges and revise the program to better serve the patients and their families. To this end, Red Rock Pain Surgery Center has developed this Patient Safety plan.

The plan focuses on the process rather than the individual, and recognizes both internal and external customers, as well as facilitates the need of analyzing and improving processes. The core principles of this plan include:

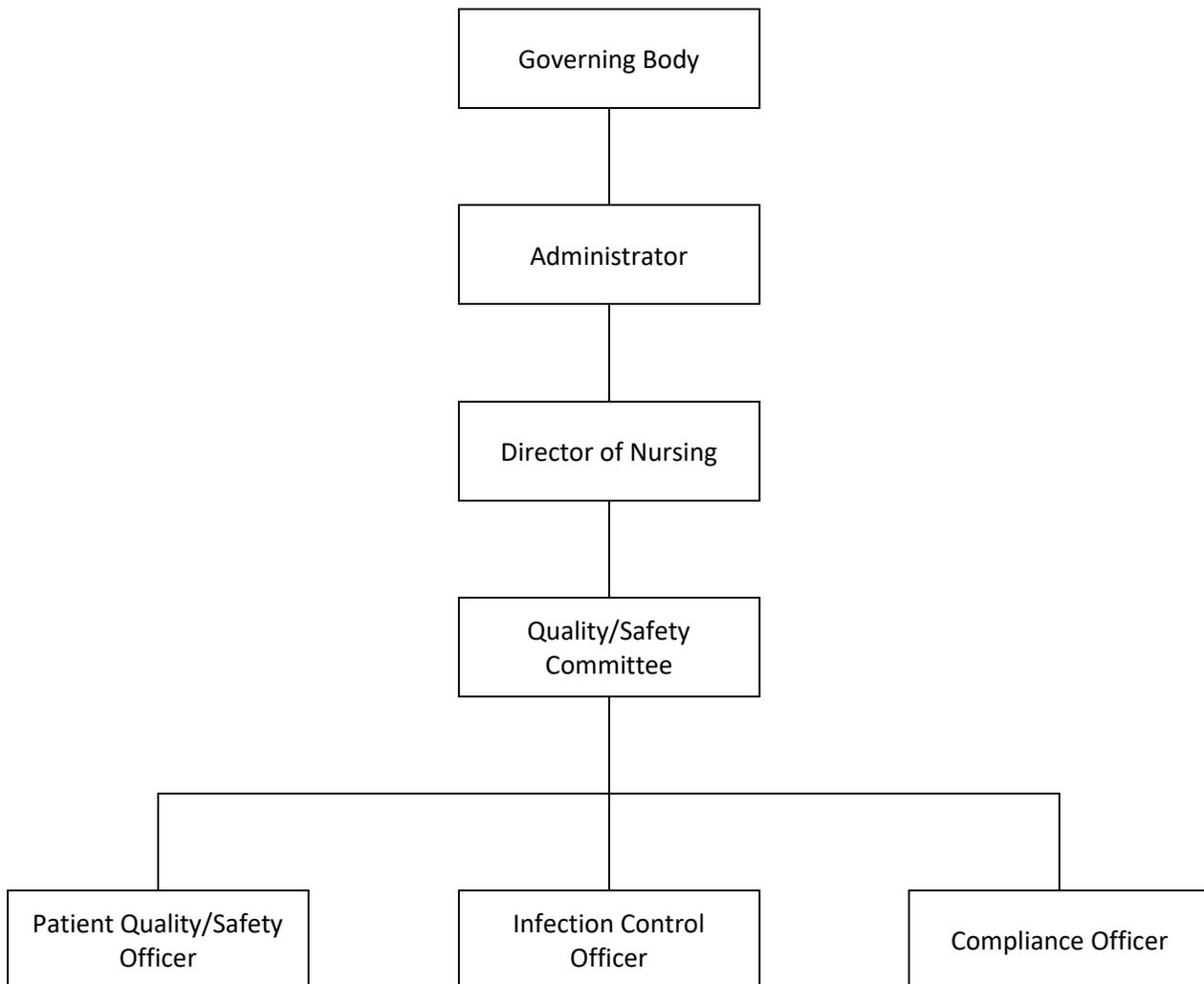
- All staff have the same goal and contribute their knowledge, vision, skill, and insight to improve the process of the Patient Safety Plan.
- Decisions will be based on data and facts, and staff will be encouraged to learn from the experiences.
- Customer based including patients, families, and visitors.
- Promote systems thinking.

- Employ well-trained and competent staff maintaining high healthcare quality.

Roles and Responsibilities

According to [NRS 439.875](#), a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plan is promoted and executed successfully.

The Patient Safety Committee Organization



Roles and Responsibilities

- In accordance with [NRS 439.875](#), a patient safety committee must be comprised of:
- The infection control officer of the medical facility;
- The patient safety officer of the medical facility, if he or she is not designated as the infection control officer;

- At least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility; and
- One member of the executive or governing body of the medical facility.

Based on [NAC 439.920](#), a medical facility that has fewer than 25 employees and contractors must establish a patient safety committee comprised of:

- The patient safety officer of the medical facility;
- At least two providers of healthcare who treat patients at the medical facility, including but without limitation, one member of the medical staff and one member of the nursing staff of the medical facility; and
- The Chief Executive Officer (CEO) or Chief Financial Officer (CFO) of the medical facility.

The roles and responsibilities are defined below (Please modify them as needed.)

Patient Safety Committee Responsibilities (based on [NRS 439.875](#) and [NRS 439.877](#))

- Monitor and document the effectiveness of the patient identification policy.
- **On or before July 1** of each year, submit a report to the Board of Managers for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the patient safety officer pursuant to [NRS 439.870](#).
- Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred.
- Review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- Review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the executive or governing body of the facility regarding:
 - (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);
 - (2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and
 - (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

Root Cause Analysis (RCA) Team Responsibilities

- Root Cause interviews, analysis, investigation, and corrective action plan implementations.

Patient Safety and Quality Improvement Plan

- Participates in the RCA meetings and discussions.
- Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders.

Patient Safety Officer Responsibilities (based on [NRS 439.870](#))

- Serve on the patient safety committee.
- Supervise the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the patient safety committee regarding any action taken in accordance with the responsibilities above.

(Additional responsibilities here if needed)

Infection Control Officer Responsibilities (based on [NRS 439.873](#))

- Serve on the patient safety committee.
- Monitor the occurrences of infections at the facility to determine the number and severity of infections.
- Report to the patient safety committee concerning the number and severity of infections at the facility.
- Take such action as determines is necessary to prevent and control infections alleged to have occurred at the facility.
- Carry out the provisions of the infection control program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program.

(Additional responsibilities here if needed)

RCA team leader Responsibilities

- Organize and coordinate the RCA process.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA, and corrective action plan implementation process.
- Communicate the progress of the investigation, institutional barriers, and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.
- Provide training, education and direction to create RCA process that incorporate the Patient Safety and Quality Improvement elements.

Executive or Governing Body Staff Responsibilities

- Provide vision and leadership to Patient Safety and Quality Improvement process, and develop and foster a safe learning and improving culture.

Patient Safety and Quality Improvement Plan

- Provides oversight to the healthcare quality improvement processes and teams.

Plan, discuss, and generate the organization patient safety goals and activities, in conjunction with the patient safety action plans

The Patient Safety Committee will meet quarterly to accomplish the following:

- Report and discuss sentinel events which include:
 - Number of sentinel events from previous calendar Quarter.
 - Number of severe infections that occurred in the facility.
- Corrective Action Plan for the sentinel events and infections
 - Evaluate the corrective action plan.
- Patient safety policies and checklists
 - At least annually evaluate Patient Safety policies and checklists
 - Revise the patient safety policies and checklists as needed.
 - Monitor and document the effectiveness of the patient safety policy.

A RCA meeting will meet as needed to accomplish the following:

- Define the healthcare issues or potential risks.
- Conduct Root Cause Analysis
 - Reviewing and analyzing the data.
 - Reviewing the RCA process and quality improvement related activities and timelines.
 - Brainstorming issues or the potential risks by using the fishbone diagrams.
 - Identify the contributing factors and conduct the Root Cause Analysis.
- Conduct Corrective Action Plan
 - Identifying the Plan-Do-Study-Act (PDSA) topics.
 - Discussing corrective action process and activities.
 - Discussing and presenting possible changes in procedure to improve areas indicated.
 - Identifying strengths and areas that need improvement.
 - Developing strategies, solutions, and steps to take next.
- Identify barriers and technical assistance needs for supporting the RCA efforts.

A meeting agenda and minutes noting follow-up tasks will be kept.

Objectives and Goals of the Quality and Patient Safety Plan

Objective	Goals	Plan	Planned Completion Date	Responsible Party
Timely reporting of all variances	All staff will be able to independently complete variance	Educate all staff to the variance reporting system and forms	3/1/2018	Patient Safety Officer

	reports			
Garner greater physician participation	Have physicians report all variances reported outside of the facility	Educate physicians to the patient safety plan. Encourage reporting of all variances regardless of cause.	3/15 /2018	Patient Safety Officer
Increase accountability of the Quality/Safety Committee	Increase the number of quality and safety projects at the facility	Create sub-Committees within the group to specialize in projects related to their areas.	3/15/2018	Patient Safety Officer

Components and Methods

Pursuant to [NRS 439.837](#), a medical facility shall, upon reporting a sentinel event pursuant to [NRS 439.835](#), conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event.”

Red Rock Pain Surgery Center will use RCA process to determine the contributing factors and the underlying reasons for the deficiencies or failures. The Plan-Do-Study (check)-Act (PDSA or PDCA) is the model, which was developed by the Institute of Health Care Improvement that we will use to test the changes.



Root Cause Analysis

A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals.

Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

Root cause analysis and action plan framework table, which was introduced by the Joint Commission. It contains 24 analysis questions. It guides the organization to the steps in a root cause analysis. Not all the questions apply to all the events or cases. This table can be used individually or with the fishbone diagram.

5 Whys technique will be used in (facility name) to explore the cause and effect relationship underlay a problem. One can find the root causes by asking “why” no less than five times. This technique can be used individually or as a part of the fishbone diagram.

Fishbone Diagram

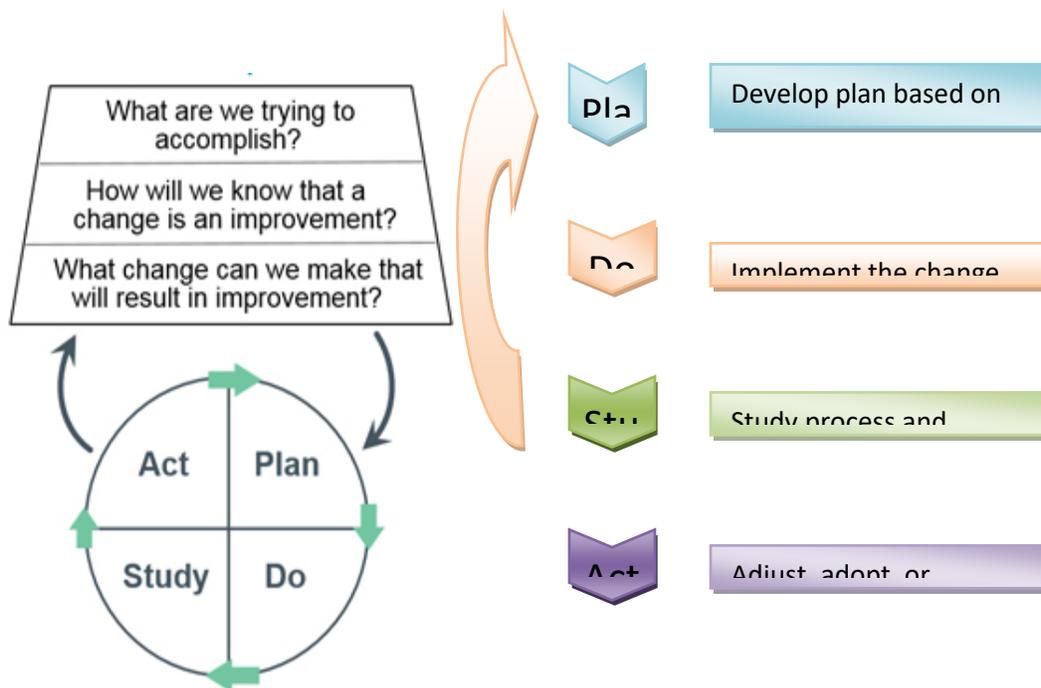
Patient Safety and Quality Improvement Plan

Once the problems are identified, a Fishbone Diagram (Appendix C) will be used for analyzing the problems. You can use the fishbone diagram individually to analyze the root causes, or use it with the root cause analysis and action plan framework table.

A Fishbone Diagram, also called a Cause-and-Effect diagram, is a useful tool for a team to structurally brainstorm by discovering possible underlying factors or root causes from different major categories for the chosen problems. General categories used include: people, methods, materials, measurements, education, procedures, process, location, environment, etc. RCA team members will brainstorm and ask multiple times, “why did this happen?” for each cause until all ideas are exhausted. The highest priority root causes will be chosen for PDSA topics. Once all the categories are established on the fishbone diagram, 5 Why’s technique also can be used to drill down the problem and find the root causes.

Model for Improvement

The Model for Improvement is a collaborative and ongoing effort model to improve the product and services quality and process. It provides multi-disciplinary quality team guidance from identifying the root causes; conducting the best tests to assess possible changes, and working in collaboration for implementation of the new approaches and solutions. It guides the test of a change to determine if the change is an improvement.



The cycle is defined as follows:

- Plan--collect data and establish appropriate goals. Identify the problem and the possible root causes, and answer the following questions.
 - What is the objective of the test?

- What are the steps for the test - who, what, when?
- How will you measure the impact of the test?
- What is your plan to collect the data needed?
- What do you predict will happen?

- Do--make changes designed to correct or improve the situation. Use the following questions for the guidance.
 - What were the results of the test?
 - Was the cycle carried out as designed or planned?
 - What did you observe that was unplanned or expected?

- Study -- Study the effect of the changes on the situation. Data should be collected on the new process and compared to the baseline or expected results. Results should be evaluated and by using the following questions as guidance.
 - Did the results match your prediction?
 - What did you learn?
 - What do you need to do next?

- Act--If the result is successful or desirable, standardize the changes and then work on the next prioritized problem or the further improvements. If the outcome is not yet successful, look for different ways to identify the causes or change the testing process.

PDSA worksheet will be used to map the potential change strategies and to establish a course of action. The PDSA worksheet and the PDSA progress report are attached in Appendix D-1.

Data Collection and Reporting

Data should drive any quality and patient safety effort. Red Rock PainSurgery Center is using a paper system for tracking the sentinel events, healthcare infection data, and for internal data collection.

External data sources are those data sources which are collected outside the supervisory structure of the case. External data which will be utilized for Quality and Patient Safety plan include the data from:

- AHRQ: Agency for Healthcare Research & Quality
- CDC: Centers for Disease Control and Prevention
- CMS: Centers for Medicare & Medicaid Services
- NQF: National Quality Forum
- NHSN: National Healthcare Safety Network
- TJC: The Joint Commission



Ongoing Reporting and Review

Data points such as the following will be reviewed according to the schedule prescribed:

Monthly	Quarterly	Annually
<ul style="list-style-type: none"> 1) Sentinel event monthly report 2) Severity of infection report 3) RCA assessment 	<ul style="list-style-type: none"> 1) Sentinel event quarterly report 2) Severity of infection report 3) Review and evaluate the measure of improvement of patient safety 4) Review and evaluate the measurement to prevent and control infections 	<ul style="list-style-type: none"> 1) Quality and Patient Safety Plan update 2) Checklists and Policies reviewing and revising

Patient Safety Checklists and Patient Safety Policies

By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

The patient safety checklists must follow protocols to improve the health outcomes of patients at the medical facility and must include, without limitation:

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.
- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - Proper instructions concerning prescription medications;
 - Instructions concerning aftercare;
 - Any other instructions concerning his or her care upon discharge; and
 - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction

with a provider of healthcare. The personal identifiers may include, the name and date of birth of the patient.

- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.
- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

Based on [NRS 439.865](#), the patient safety plan must also include an infection control program that carries out the infection control policy. The policy must consist of:

- The current guidelines appropriate for the facility's scope of service developed by a nationally recognized infection control organization as approved by the State Board of Health which may include, the Association for Professionals in Infection Control and Epidemiology (APIC), the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO) and the Society for Healthcare Epidemiology of America (SHEA); and

The patient safety checklists are listed in Appendix E. (The following links provide some patient safety checklists for your reference— a checklist example is shown in **Appendix E.**)

http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf

<http://www.who.int/patientsafety/implementation/checklists/en/>

The patient safety policies are listed in Appendix F. (The following link provides you some patient safety policies for your reference—a policy example is shown in **Appendix F.**)

Approval of Patient Safety Plan

According to [NRS 439.865](#), a medical facility shall submit its patient safety plan to the governing board of the facility for approval. After a facility's patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan.

The patient safety plan must be reviewed and **updated annually** in accordance with the requirements for approval set forth in this section.

According to [NRS 439.843](#), on or before March 1 of each year, a copy of the most current patient safety plan established to [NRS 439.865](#) must be submitted to the Division of Public and Behavioral Health.

Reference

- Root Cause Analysis Toolkit <http://www.health.state.mn.us/patientsafety/toolkit/>
- Quality and Service Improvement Tools
http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html
- CQI 101 An Introduction to Continuous Quality Improvement:
<https://www.coursehero.com/file/13827355/CQI-Overviewppt/>
- Quality Improvement <http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/>
- Root Cause Analysis <http://www.patientsafety.va.gov/professionals/onthejob/rca.asp>
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2
https://www.jointcommission.org/sentinel_event.aspx
- Checklists to Improve Patient Safety http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf
- Patient Safety Checklists <http://www.who.int/patientsafety/implementation/checklists/en/>
- Title 40 – Public Health and Safety <https://www.leg.state.nv.us/NRS/NRS-439.h>

Appendix A: Terms and Definitions

Patient Safety: The Agency for Healthcare Research Quality (AHRQ) defines patient safety as “a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.”
http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

Sentinel event (NRS 439.830)

1. Except as otherwise provided in subsection 2, “sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum.

2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:

(a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or

(b) July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published.

3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.

(Added to NRS by [2002 Special Session, 13](#); A [2005, 599](#); [2013, 217](#))

Institute for Healthcare Improvement (IHI) defines **medical harm** as “unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death.”

Facility-Associated Infection: ([NRS 439.802](#))

“Facility-acquired infection” means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections;
- Other categories of infections as may be established by the State Board of Health by regulation pursuant to [NRS 439.890](#).

(Added to NRS by [2005, 599](#); A [2009, 553](#))

Medical facility ([NRS 439.805](#))

“Medical facility” means:

- A hospital, as that term is defined in [NRS 449.012](#) and [449.0151](#);
- An obstetric center, as that term is defined in [NRS 449.0151](#) and [449.0155](#);
- A surgical center for ambulatory patients, as that term is defined in [NRS 449.0151](#) and [449.019](#); and
- An independent center for emergency medical care, as that term is defined in [NRS 449.013](#) and [449.0151](#).

(Added to NRS by [2002 Special Session, 13](#))

Near miss: An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Mandatory reporting: Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985;254(6):796-800.)

Risk: Possibility of loss or injury. (Merriam-Webster’s Online Dictionary, Risk, Available at <http://www.merriamwebster.com/dictionary/risk>. Last Accessed August 2009.)

Preventable event: Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Appendix D-1: PDSA Worksheet

PDSA Worksheet

Topic:			
Person Completing Worksheet:		Date:	
Telephone/ Email:		Cycle:	
Patient Safety Committee Members			
CEOs/CFOs			
Patient Safety Officer			
Infection Control Officer			
Other Medical Staff			
Other team members			
Aim: (Describe the overall SMART goal that your team wishes to achieve.)			
Plan:			
1. List the tasks needed to set up this test of change.			
2. Predict what will happen when the test is carried out.			

3. List the steps to develop the test-who, what, and when.

Steps	By Whom	By When	Desired Outcome

Do: (Describe what actually happened when you ran your test, including any problems and unexpected findings.)

Study: (Describe what you learned and did you meet your measurement goal?)

Did you meet your measurement goal? Explain.	Summarize what was learned: success, failure, unintended consequences, etc.

Act: (Describe what you concluded from this cycle.)

Based on what was learned, please indicate what action will be considered.	Describe what modifications to the plan will be made for the next cycle based on what you learned.
<input type="checkbox"/> Adapt: modify changes and repeat PDSA Cycle	
<input type="checkbox"/> Adopt: expanding changes throughout organization	
<input type="checkbox"/> Abandon: change approach and repeat PDSA cycle	

Appendix D-2: PDSA Monthly / Quarterly Progress Report

Event:			
Person Complete Report:		Date:	
Patient Safety Officer		Contact Information:	
Monthly / Quarterly Report			
Items	Description		
1. What is your goal?			
2. Report on the PDSA cycle			
3. What system and practices are working well? Explain.			
4. What areas for improvement did the data identify?			
5. What barriers or system issues have been encountered implementing action activities?			
6. Action plans to address the barriers or system issues			
7. Lesson learned			
8. Support needed			
9. Additional discussion			
Notes:			

Appendix E: Checklist Example: Injuries from Falls and Immobility

Process Change	In Place	Not Done	Will Adopt	Notes (Responsible & By When?)
Conduct fall and injury risk assessment upon admission				
Reassess risk daily and with changes in patient condition				
Implement patient-specific intervention to prevent falls and injury				
Communicate risk across the team; use handoff forms, visual cues, huddles				
Round every 1 to 2 hours for high-risk patients; address needs (e.g., 3Ps: pain, potty, position-pressure). Combine with other tasks(vital signs)				
Individualize interventions. Use non-skid floor mats, hip protectors, individualized toileting schedule; adjust frequency of rounds				
Review medications (by pharmacist); avoid unnecessary hypnotics, sedatives				
Incorporate multidisciplinary input for falls				
Prevention from PT, OT, MD, RN and PharmD				
Include patients, families and caregivers in efforts to prevent falls. Educate regarding fall prevention measures; stay with patient				
Hold post-fall huddles immediately after event; analyze how and why; implement change to prevent other falls				

Appendix F: Policy Example

<p>PERSONAL PROTECTIVE EQUIPMENT POLICY Page 1 of 2</p>	<p>Date Issued: Date Last Revised: Next Review Date: Approved By:</p>	<p>Policy Committee</p>

Key

Words: personal protective equipment, PPE, safety equipment,

Policy Applies to:

- All staff
- Credentialed Specialists, Allied Health Professionals, patients, visitors and contractors will be supported in meeting policy requirements.

Related Standards:

- Infection and Prevention and Control Standards NZS 8134.3:2008
- Health and Safety in Employment Act 1992
- EQulP5 - 1.5.1 and 1.5.2 Infection Control
- EQulP5 - Standard 3.2 Criterion 3.2.1 Health and Safety

Rationale:

Mercy Hospital will provide suitable personal protective equipment (PPE) when the risk to health and safety cannot be eliminated or adequately controlled by other means.

Definitions:

Personal protective equipment (PPE) means all equipment which is intended to be worn or held by a person to protect them from risk to health and safety while at work.

Examples of PPE include: protective footwear, gloves, hard hats/helmets, clothing affording protection from the weather, visibility clothing, eye and face protection.

Objectives:

- To ensure appropriate PPE is identified to minimize hazards not able to be controlled by elimination or isolation;
- To ensure fit for purpose PPE is provided at Mercy Hospital for use by staff;
- To ensure adequate training in the use of PPE is provided;
- To monitor the use of PPE and evaluate effectiveness.

<p>PERSONAL PROTECTIVE EQUIPMENT POLICY Page 2 of 2</p>	<p>Date Issued: Date Last Revised: Next Review Date: Approved By:</p>	<p>Policy Committee</p>

Implementation:

Risk Management

Department Managers, the Occupational Health/ Infection Prevention and Control Nurse (OH/IPC Nurse) and Health and Safety/ Infection Control Representatives (HSIC reps) will in consultation with staff:

Ensure PPE requirements are identified when carrying out risk assessments of activities;

- Regularly review the risk assessment of activities if substances or work processes change;
- Identify the most suitable type of PPE that is required;
- Ensure PPE is available to those who need it;
- Inform staff of the risks involved in their work and why PPE is required;
- Monitor compliance.

Process

Manager’s Responsibilities

Must ensure that:

- PPE requirements are considered when risks are assessed;
- Suitable PPE is provided and made accessible to employees;
- PPE is properly stored, maintained, cleaned repaired and replaced when necessary;
- Adequate information and training is provided to those who require PPE;
- PPE is properly used;
- Use of PPE is monitored and reviewed.

Employee’s Responsibilities All employees must ensure that:

- They use PPE whenever it is required;
- Attend and comply with training, instruction and information;
- Check the condition of their PPE;
- Store, clean and maintain their PPE;
- Report losses, defects or other problems with PPE to their manager.

Evaluation:

- Staff health and safety orientation
- Environmental audits
- Incident reports

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Approved: AUG 22 2017	Revised:	

POLICY:

Green Valley Surgery Center will institute and administer a comprehensive and continuous Patient Safety Program for all patients to improve patient safety and reduce risk to patients through an environment that encourages:

- Recognition of risks to patient safety and medical/health care errors
- Actions to reduce these risks
- Internal reporting of incidents and potential incidents and actions taken
- Focus on processes and systems rather than individual blame

PURPOSE:

The Patient Safety Program provides a systematic, coordinated and continuous approach to maintenance and improvement of patient safety by using established mechanisms to support responses to actual occurrences, have an ongoing proactive plan to reduce medical/health errors, and integrate patient safety as a high priority in all relevant organizational processes and services.

RESPONSIBILITY:

As with patient care, it is a coordinated and collaborative effort of the entire organization to maintain and improve patient safety.

The Governing Body approves the data-driven Patient Safety Program and ensures the program reflects the complexity of the facility's organization and services, including those services furnished under contract or arrangement and focuses on the prevention and reduction of medical/health errors and adverse effects.

The Clinical Director is responsible for the management of the Patient Safety Program by:

- Coordinating all patient safety activities
- Facilitating assessment and appropriate responses to reportable events
- Monitoring Root Cause Analysis and resulting action plans

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- Serving as a liaison among the departments to assure facility wide integration of the Patient Safety Program.

Each individual employee within the organization acts as a patient advocate for safety and is responsible to report patient safety occurrences and potential occurrences to the QAPI Coordinator and the Clinical Director, who will aggregate the occurrence information and report to the Governing Body.

PROGRAM:

The scope of the Patient Safety Program includes an ongoing assessment to prevent error occurrence, maintain and improve patient safety.

Patient Safety occurrence information from aggregated data reports and individual incident occurrence reports will be reviewed to prioritize organizational patient safety efforts.

Types Of Patient Safety Or Medical/Health Care Errors:

- No Harm Errors – those unintended acts, either of omission or commission, or acts that do not achieve their intended outcome, that do not result in a physical or psychological negative outcome, or the potential for a negative outcome, for the patient.
- Mild-Moderate Adverse Outcome Errors – those unintended acts, either of omission or commission, or acts that do not achieve their intended outcome, that result in an identified mild to moderate physical or psychological adverse outcome for the patient.
- Any Medication Error
- Any Adverse Drug Reaction
- Any Transfusion Reaction
- Hazardous Condition – any set of circumstances, exclusive of the disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious physical or psychological adverse patient outcome.
- Sentinel Event – an unexpected occurrence involving death or serious physical or psychological injury or the risk thereof, including any process variation for which a recurrence would carry a significant chance of serious adverse outcome. Serious injury specifically includes loss of limb or function. Sentinel event criteria includes:

- The event has resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition.
- The event is one of the following (even if the outcome was not death or major permanent loss of function):
 - Suicide of a patient.
 - The sexual assault of a patient during treatment or while the patient was on the premises of the facility.
 - A hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities.
 - Medication error resulting in a patient's unanticipated death or major permanent loss of bodily function in circumstances unrelated to the natural course of the illness or underlying condition of the patient.
 - A surgical procedure on the wrong patient or on the wrong body part of a patient.
 - A foreign object accidentally left in a patient during a procedure.
 - A patient death or serious disability associated with the use or function of a device designed for patient care that is used or functions other than as intended.
 - Near Miss – any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome.

What To Do When A Patient Safety Error Occurs

Upon identification of a medical/health care error, the patient care provider will immediately:

- Perform necessary healthcare interventions to protect and support the patient's clinical condition.
- As appropriate to the occurrence, perform necessary healthcare interventions to contain the risk to others – example: immediate removal of contaminated IV fluids from supply should it be discovered a contaminated lot of fluid solutions was delivered and stocked.
- Contact the patient's attending physician and other physicians, as appropriate, to report the error, carrying out any physician orders as necessary.

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- Preserve any information related to the error (including physical information). Examples of preservation of physical information are: Removal and preservation of blood unit for a suspected transfusion reaction; preservation of IV tubing, piggyback fluid for a patient with a severe drug reaction from IV medication; preservation of medication label for medications administered to the incorrect patient. Preservation of information includes documenting the facts regarding the error on an occurrence report, and in the medical record as appropriate to organizational policy and procedure.
- Report the medical/health care error to the staff member's immediate supervisor.
- Submit the incident occurrence report to the QAPI Committee per organizational policy.

Internal Reporting Of The Error/Event

Staff response to medical/health care errors is dependent upon the type of error identified:

- **No Harm Errors** – (including “no harm medication errors), staff will document appropriately in the medical record according to organizational policy, document the circumstances regarding the no harm error on an incident occurrence report form, submit the form to the QAPI Committee and notify their immediate supervisor.
- **Mild-Moderate Adverse Outcome Errors** (including medication errors), staff will perform any necessary clinical interventions to support and protect the patient and notify the physician responsible for the patient, carrying out any necessary physician orders. Staff will then preserve any physical evidence as appropriate, notify their immediate supervisor, document facts in the medical record and on an incident occurrence report, submitting the report to the QAPI Committee per policy.
- **Adverse Drug Reaction** – staff will perform any necessary clinical interventions to support and protect the patient and notify the physician responsible for the patient, carrying out any necessary physician orders. Staff will then preserve any physical evidence as appropriate, notify their immediate supervisor, document facts appropriately in the medical record and on an incident occurrence report, submitting the report to QAPI Committee per organizational policy.
- **Transfusion Reaction** – staff will perform any necessary clinical interventions to support and protect the patient and notify the physician responsible for the patient, carrying out any necessary orders. Staff will then follow the organization policy and procedure for this event.

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- **Hazardous Condition/Patient Safety Issue** - as appropriate, and if possible, staff will contain the hazardous condition or patient safety issue. Staff identifying a hazardous condition or potential patient safety issue will immediately notify their supervisor and document the findings on an incident occurrence report which is then submitted to QAPI Committee
- **Sentinel Event** – staff will perform any necessary clinical interventions to support and protect the patient and notify the physician responsible for the patient, carrying out any necessary physician orders. Staff will then follow the organizational Sentinel Event Policy and Procedure, which includes a root cause analysis and action plan.
- **Near Miss** – staff will report the near miss event to their immediate supervisor, describe the facts of the near miss on an occurrence report and submit the report to QAPI Committee.
- It is the intent of this facility to adopt a non-punitive approach in its management of errors and occurrences. All personnel are required to report suspected and identified medical/health care errors, and should do so without the fear of reprisal in relationship to, their employment. This organization supports the concept that errors occur due to a breakdown in systems and processes, and will focus on improving systems and processes, rather than disciplining those responsible for errors and occurrences. A focus will be placed on remedial actions to assist rather than punish staff members, with the individual staff member’s supervisor determining the appropriate course of action to prevent error recurrence.

Root Cause Analysis

- All sentinel events and near miss occurrences will have a root cause analysis conducted to examine the cause and effect of the event through an impartial process
- A Root Cause Analysis is an interdisciplinary review process for identifying the basic or contributing causal factors that underlie a variation in performance associated with an adverse event or reportable patient safety event. It focuses primarily on systems and processes, includes an analysis of underlying cause and effect, progresses from special causes in clinical processes to common causes in organizational processes, and identifies potential improvements in processes or systems.
- The QAPI Committee is responsible for conducting the root cause analysis. It will be completed within 45 days of becoming aware of one of the reportable events. They will encourage the staff members’ involvement in the root cause analysis and action plan processes, to allow the staff member an active role in process resolution.

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A written Root Cause Analysis and “Action Plan” will be created which includes specific measures to correctly identify problems or areas of concern, identify strategies for implementing system improvements; and also includes outcome measures to indicate the effectiveness of system improvements in reducing, controlling or eliminating identified problem areas. The action plan must specifically address responsibility for implementation and oversight, time frames for implementation, and the strategy for measuring the effectiveness of the actions.

- The Joint Commission recommended “A Framework for a Root Cause Analysis and Action Plan In Response to a Sentinel Event” format may be used. See attached.
- Results of the entire Root Cause Analysis will be presented to the Governing Body for evaluation.

Communication of Action Plans and Root Cause Analysis

- Action Plans related to a Root Cause Analysis will be shared with the entire staff upon Completion by the QAPI Committee. Possible recommendations to update or change policy and procedures may be presented to the staff, management and Governing Body to improve patient safety.
- Staff will educate patients and their families about their role in helping to facilitate the safe delivery of care. There will be a random record review verifying compliance with this educational process.
- Root Cause Analysis and Action Plans will be made available to the state health department representatives during onsite reviews.

Reporting Obligations

- Medical/Health care errors and occurrences, including sentinel events, will be reported internally and externally, through the channels established by this plan. External reporting will be performed in accordance with all state, federal and regulatory body rules, laws and requirements.

Patient Safety Program Staff Education/Training

- Staff will receive education and training during their initial orientation process and on an ongoing basis regarding job-related aspects of patient safety, including the need and method to report medical/health care errors. And, because the optimal provision of healthcare is provided in an interdisciplinary manner, staff will be educated and trained on the provision of an interdisciplinary approach to patient care.

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- Medical errors results from multiple factors. Flawed systems or processes can combine with active failures by caregivers in the clinical setting to produce accidents and errors. Some contributing factors are:
 - Inadequate communication among team members
 - Incomplete review of patient health records and diagnostic studies
 - Traditional hierarchical and autocratic cultures
 - Patient – related decisions made only by physicians
 - Unclear instructions
 - Confusing packaging of medications and supplies
 - Time pressures and constraints, Multi-tasking
 - Failure to include the patient and family members in assessment and decision-making

- Staff will be trained about error reduction, which requires the commitment of all members of the health care team. Besides correcting the identified factors above, the following individual and facility changes will be focused on:
 - Reduce reliance on memory by using checklists and protocols.
 - Standardize processes as much as possible for procedures and other activities.
 - Focus on the safety aspects of products during the selection and evaluation process.
 - Promote safety related clinical competency.
 - Educate employees about the potential for errors and how to avoid them.
 - Creating a “Culture of Safety” whereby there is a change of environment from blaming individuals for errors to one in which errors are treated as opportunities to improve systems. This is accomplished by:
 - establishing a sense of trust among team members;
 - dissemination and verifying receipt of information to all levels of staff and management;
 - developing and supporting a proactive approach rather than a reactive approach;
 - making a sincere commitment to affirming safety as the first priority.

- Quarterly Patient Safety Program meetings will be incorporated into the QAPI Program and conducted to review any incident occurrence reports and review any new patient safety recommendations or alerts.

ROOT CAUSE ANALYSIS AND ACTION PLAN

Level of Analysis		Questions	Findings	Root Cause?	Ask Why?	Take Action?
What happened?	Sentinel Event	What are the details of the event? (Brief Description)				
		When did the event occur? (Date, day of week, time)				
		What area/service was impacted?				
Why did it happen?	The process or activity in which the event occurred.	What were the steps in the process, as designed? (A flow diagram may be helpful here)				
		What steps were involved in (contributed to) the event?				
	Human factors	What human factors were relevant to the outcome?				
What were the proximate factors?	Equipment factors	How did the equipment performance affect the outcome?				
	Controllable environmental factors	What factors directly affected the outcome?				
	Uncontrollable external factors	Are they truly beyond the organization's control?				
	Other	Are there any other factors that have directly influences this outcome?				
		What other areas of services are impacted?				

ROOT CAUSE ANALYSIS AND ACTION PLAN

The following template is provided as an aid in organizing the steps in a root cause analysis. Not all possibilities and questions will apply in every case and there may be others that will emerge in the course of the analysis. However, all possibilities and questions should be fully considered in your quest for “root cause” and risk reduction.

As an aid to avoiding “loose ends” the three columns on the right are provided to be checked off for later reference.

- **“Root Cause?”** - should be answered “yes” or “no” for each finding. A root cause is typically a finding related to a process or system that has a potential for redesign to reduce risk. If a particular finding that is relevant to the event is not a root cause, be sure that is addressed later in the analysis with a “why?” question. Each finding that is identified as a root cause should be considered for an action and addressed in the action plan.
- **“Ask Why?”** - should be checked off whenever it is reasonable to ask why the particular finding occurred (or didn’t occur when it should have (in other words, to drill down further). Each item checked in this column should be addressed in the analysis with a “Why?” question. If it is expected that any significant finding that are not identified as root causes themselves have “roots.”
- **“Take Action?”** - should be checked for any finding that can reasonably be considered for a risk reduction strategy. Each item checked in this column should be addressed later in the action plan. It will be helpful to write down the number of the associated Action item on page 3 in the “Take Action?” column for each of the findings that requires action.

ROOT CAUSE ANALYSIS AND ACTION PLAN

Level of Analysis		Questions	Findings	Root Cause?	Ask Why?	Take Action?
<p>What happened?</p> <p>Why did that happen? What systems and processes underlie those proximate factors?</p> <p>(common cause variation here may lead to special cause variation in dependent processes)</p>	<p>Human Resources Issues.</p>	<p>To what degree is staff properly qualified and currently competent for their responsibilities?</p>				
		<p>How did actual staffing compare with ideal levels?</p>				
		<p>What are the plans for dealing with contingencies that would tend to reduce effective staffing levels?</p>				
		<p>To what degree is staff performance in the operating process (es) addressed?</p>				
		<p>How can orientation and in-service training be improved?</p>				

ROOT CAUSE ANALYSIS AND ACTION PLAN

Level of Analysis	Questions	Findings	Root Cause?	Ask Why?	Take Action?
Information management issues.	To what degree is all necessary information available when needed? Accurate? Complete? Unambiguous?				
	To what degree is communication among participants adequate?				
	To what degree was the physical environment appropriate for the processes being carried out?				
	What systems are in place to identify environmental risks?				
	What emergency and failure-mode responses have been planned and tested?				
Leadership issues: -corporate culture	To what degree is the culture conducive to risk identification and reduction?				
-encouragement communication	What are the barriers to communication of potential risk factors?				
- clear communication of priorities	To what degree is the prevention of adverse outcome communicated as a high priority?				
- uncontrollable factors	What can be done to protect against the effects of these uncontrollable factors?				

ROOT CAUSE ANALYSIS AND ACTION PLAN

Action Plan	Risk Reduction Strategies	Measures of Effectiveness
<p>For each of the findings identified in the analysis as reading an action, indicate the planned action expected, implementation data and associated measure of effectiveness OR</p>	ACTION ITEM #1	
<p>-If after consideration of such a finding a description is made not to implement as associated risk reduction strategy, indicate the rationale for not taking action at this time.</p>	ACTION ITEM #2	
<p>-Check to be sure that the selected measure will provide data that will permit assessment of the effectiveness of the action.</p>	ACTION ITEM #3	
<p>-Consider whether pilot testing of a planned improvement should be conducted.</p>	ACTION ITEM #4	
<p>-Improvements to reduce risk should ultimately be implemented in all areas where applicable, not just where the event occurred. Identify where the improvements will be implemented.</p>	ACTION ITEM #5	
	ACTION ITEM #6	
	ACTION ITEM #7	
	ACTION ITEM #8	
<p>Cite any books or journal articles that were considered in developing this analysis and action plans:</p>		

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POLICY

- This policy applies to all employees, medical staff, contractors, patients, visitors and patients of this facility.
- All unexpected events or occurrences involving death or serious physical or psychological injury or risk thereof are to be reported to the administrative team immediately upon identification (regardless of time of day or night).
- Any and all adverse event or medical errors require immediate action to examine the event in-depth to determine why the incident occurred and how to reduce the likelihood of recurrence.
- The governing body must ensure that the Patient Safety Program (PSP) reflects the complexity of the facility organization and services, including those services furnished under contract or arrangement, and focuses on the prevention and reduction of medical errors and adverse events.¹
- All adverse events or medical errors are errors; but not all errors are adverse events or medical errors.
- Failure to report an adverse event or medical error will be addressed through the Disciplinary process
- Event data will be preserved and collected per facility policy.²
- Event equipment will be preserved and removed from patient care until cleared

PATIENT SAFETY SYSTEM:

- To have a means for establishing clear expectations for identifying and detecting the prevalence and severity of incidents that impact or threaten patient safety. This includes medical errors and adverse patient events.
- To identify, implement and regularly assess the means by which incidents are prevented or when they occur. The incidents are studied to detect nonconformance and where risk points or failures are an inherent part of the process and work to remove these risk points or failures from the system.
- To address customer (patient) communication when such incidents occur, how the patients are informed and their right to know the circumstances of events.

DEFINITIONS:

- Administrative Team: Interdisciplinary organizational team, whose members have specific knowledge and authority to determine and correct the identified causative factors of the adverse event or medical error.
- Adverse Event: An Adverse Event shall be defined as an unexpected occurrence or variation that led to death or serious physical or psychological harm. This definition includes the National Quality Forum (NQF) "never or adverse events" that are errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients.³ An event that results in unintended harm to the patient by an act of commission or omission rather than by underlying disease or condition of the patient.⁴

¹ Title 25, Texas Administrative Code, 133.48 (2) (A)

² Control of Internal and External Documents (#7067)

³ NIAHO Standard; QM.7 (p 16) Adverse Event definition

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- Medical Error: The failure of a planned action to be completed as intended, the use of a wrong plan to achieve an aim, or the failure of an unplanned action that should have been completed, that results in an adverse event.⁵
- Reportable Event: A medical error or adverse event or occurrence which the facility is required to report to the State.⁶
- Root Cause Analysis: An interdisciplinary review process for identifying the basic or contribution causal factors that underlie a variation in performance associated with an adverse event or reportable event. It focuses primarily on systems and processes, includes an analysis of underlying cause and effect, progresses from special causes in clinical processes to common causes in organizational processes, and identifies potential improvements in processes or systems.⁷

SCOPE:

List of events and occurrences to report:

- No Harm Errors: those unintended acts, either of omission or commission, or acts that do not achieve their intended outcome-that do not result in a physical or psychological negative outcome or the potential for a negative outcome, for the patient.
- Facility Acquired Infection/Condition: infections/conditions that are a result of treatment in a facility or healthcare service unit.
- Patient Fall
- Mild/Moderate Adverse Outcome Errors: those unintended acts, either of omission or commission, or acts that do not achieve their intended outcome, that result in an identified mild to moderate physical or psychological adverse outcome for the patient.
- Any Medication Error
- Any Adverse Drug Reaction
- Hazardous Condition: any set of circumstances, exclusive of the disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious physical or psychological adverse patient outcome.
- Near Miss: any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome.

- Reportable Events to the State⁸:
 - (i) a medication error resulting in a patient's unanticipated death or major permanent loss of bodily function in circumstances unrelated to the natural course of the illness or underlying condition of the patient;

⁴Title 25, Texas Administrative Code; 133.2 (4)

⁵Title 25, Texas Administrative Code; 133.48 (a) (1)(A)

⁶Title 25, Texas Administrative Code; 133.48 (a) (1)(B)

⁷Title 25, Texas Administrative Code; 133.48 (a) (1)(C)

⁸Title 25, Texas Administrative Code; 133.48(b)(1)(A)(i-ix)

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- (ii) a perinatal death unrelated to a congenital condition in an infant with a birth weight greater than 2,500 grams;
- (iii) the suicide of a patient in a setting in which the patient received care 24 hours a day;
- (iv) the abduction of a newborn infant patient from the facility or the discharge of a newborn infant patient from the facility into the custody of an individual in circumstances in which the facility knew, or in the exercise of ordinary care should have known, that the individual did not have legal custody of the infant;
- (v) the sexual assault of a patient during treatment or while the patient was on the premises of the facility or facility;
- (vi) a hemolytic transfusion reaction in a patient resulting from the administration of blood or blood products with major blood group incompatibilities;
- (vii) a surgical procedure on the wrong patient or on the wrong body part of a patient;
- (viii) a foreign object accidentally left in a patient during a procedure; and
- (ix) a patient death or serious disability associated with the use or function of a device designed for patient care that is used or functions other than as intended.

- Required by the State: a health care-associated adverse condition or event for which the Medicare program will not provide additional payment to the facility under a policy adopted by the federal Centers for Medicare and Medicaid.⁹
- Other events: as included in the list of adverse events identified by the National Quality Forum that is not included in the list required by the State (see Appendix A for National Quality Forum events).¹⁰

PROCEDURE:

- Upon the identification of an adverse event or medical error, after the patient is safe (as applicable), the administrative team has been notified prior to leaving duty, employees, members of the medical staff and any witnesses must complete an incident occurrence and submit it to their immediate supervisor who will follow the incident reporting process.¹¹
- Adverse events or medical errors will be reviewed by the Administrative Team within 24 hours of incident notification. The administrative team will determine if the incident warrants conducting a root cause analysis.
 - The licensed independent practitioner responsible for managing the patient's care, treatment, and services, or his/her designee, shall inform the patient or their representative, within 24 hours of the adverse events or medical errors about unanticipated outcomes of care, treatment, and services related to adverse events or medical errors when the patient or their representative is not already aware of the occurrence or when further discussion is needed.
- If it is determined by the administrative team that an RCA is warranted, it will commence within five (5) business days of the decision.
- The RCA will be conducted by the administrative team, staff and licensed independent practitioners who have specific knowledge and authority to determine and correct the identified causative factors of the adverse event or medical error.

⁹ Title 2, Texas Health and Safety Code; 98.1045 (1)

¹⁰ Title 25, Texas Administrative Code; 98.1045 (2)

¹¹ Corrective/Preventive Action Plan (#7070)

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Specifically the administrative team will:¹²

- Complete an RCA to examine the cause and effect of the event through an impartial process.
- The RCA will focus primarily on the systems and processes, not individual performance. It will include the following elements:
 - A clear definition of the issue(s) pertaining to the event, that is, a determination of the human and other factors most directly associated with the event, and the process (es) and systems related to its occurrence.
 - Identification of risk points and their potential contributions to the type of event
- Develop an action plan identifying the strategies that the facility intends to employ to reduce the risk of similar events occurring in the future.
- The action plan must:
 - Designate responsibility for implementation and oversight;
 - Specify time frames for implementation, analysis and follow-up
 - Include a strategy for measuring the effectiveness of the actions taken.
- The administrative team will not, in any circumstance, delay implementation of the action plan or, as appropriate, elements of its components, over seven (7) days from the date of the completion of the RCA.
- The administrative team will be afforded the time and resources by Quality Management Oversight to implement the approved plan.
- If the RCA determines that the adverse event or medical error is related to an organizational systems approach or process challenge, the team will utilize the PDCA (Plan, Do, Check, Act) to design, implement and evaluate an improvement plan to correct the system issue and/or problem.¹³
- Reporting requirements:
 - The administrative team or their designee will report any and all activities of the RCA to the Quality Management Oversight
 - The administrative team or their designee will report any and all findings of the RCA to the Medical Executive Committee, and any other committees, teams, workgroups, or individuals within the organization, as appropriate to the defined issue.
 - The adverse event or medical error and/or the corrective action plan will be communicated to other organizations or individuals at sole discretion of the Chief Executive Officer or his/her designee.
- Other issues related to the RCA:
 - If the RCA finds the adverse event or medical error is to be caused by the performance and/or competence of an independent licensed practitioner holding clinical privileges, the corrective action will be managed through the supervision and direction of the Medical Executive Committee.

¹²Title 25, Texas Health and Safety Code; 133.48a-b

¹³Quality Manual (#7075)

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- If the RCA finds the adverse event or medical error to be caused by the performance and/or competence of a clinical staff member not holding clinical privileges, or of a non-clinical staff member, then the corrective action shall be managed by the facility administrative team.

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**Appendix A
National Quality Forum
Serious Reportable Events**

1. SURGICAL OR INVASIVE PROCEDURE EVENTS

1A. Surgery or other invasive procedure performed on the wrong site (updated)

Applicable in: facilities, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1B. Surgery or other invasive procedure performed on the wrong patient (updated)

Applicable in: facilities, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1C. Wrong surgical or other invasive procedure performed on a patient (updated)

Applicable in: facilities, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1D. Unintended retention of a foreign object in a patient after surgery or other invasive procedure (updated)

Applicable in: facilities, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1E. Intraoperative or immediately postoperative/postprocedure death in an ASA Class 1 patient (updated)

Applicable in: facilities, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices

2. PRODUCT OR DEVICE EVENTS

2A. Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting (updated)

Applicable in: facilities, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

2B. Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended (updated)

Applicable in: facilities, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

2C. Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting (updated)

Applicable in: facilities, outpatient/office-based surgery centers, long-term care/skilled nursing facilities

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3. PATIENT PROTECTION EVENTS

3A. Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person (updated)

Applicable in: facilitys, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

3B. Patient death or serious injury associated with patient elopement (disappearance) (updated)

Applicable in: facilitys, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

3C. Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting (updated)

Applicable in: facilitys, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4. CARE MANAGEMENT EVENTS

4A. Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration) (updated)

Applicable in: facilitys, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4B. Patient death or serious injury associated with unsafe administration of blood products (updated)

Applicable in: facilitys, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4C. Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting (updated)

Applicable in: facilitys, outpatient/office-based surgery centers

4D. Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy (new)

Applicable in: facilitys, outpatient/office-based surgery centers

4E. Patient death or serious injury associated with a fall while being cared for in a healthcare setting (updated)

Applicable in: facilitys, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

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4F. Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting (updated)

Applicable in: facilities, outpatient/office-based surgery centers, long-term care/skilled nursing facilities

4G. Artificial insemination with the wrong donor sperm or wrong egg (updated)

Applicable in: facilities, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices

4H. Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen (new)

Applicable in: facilities, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4I. Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results (new)

Applicable in: facilities, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

5. ENVIRONMENTAL EVENTS

5A. Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting (updated)

Applicable in: facilities, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

5B. Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances (updated)

Applicable in: facilities, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

5C. Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting (updated)

Applicable in: facilities, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

5D. Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting (updated)

Applicable in: facilities, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

6. RADIOLOGIC EVENTS

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6A. Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area (new)

Applicable in: facilities, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices

7. POTENTIAL CRIMINAL EVENTS

7A. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider (updated)

Applicable in: facilities, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

7B. Abduction of a patient/resident of any age (updated)

Applicable in: facilities, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

7C. Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting (updated)

Applicable in: facilities, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

7D. Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting (updated)

Applicable in: facilities, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

PAM Rehabilitation Hospital of Centennial Hills

QUALITY AND PATIENT SAFETY PLAN

DATE: 02/19/2018



This plan was created by the PAM Rehabilitation Hospital of Centennial Hills Patient Safety committee/team. Implementation of this plan is intended to optimize the healthcare quality and patient safety outcomes, encourage recognition, reporting, and acknowledgment of risks to patient, visitor, and employee safety, as well as reduce the medical/healthcare errors and /or preventable events.

Patient Safety Committee/Program
PAM Rehabilitation Hospital of Centennial Hills
6166 North Durango Drive
Las Vegas, Nevada 89189
Name Here, R.N., C.P.H.Q.
Director of Quality Management
Patient Safety Officer

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Commitment to Patient Safety

PAM Rehabilitation Hospital of Centennial Hills is committed to a comprehensive approach to improving healthcare quality and patient safety by aligning with our Mission, Vision, and Values, creating an environment that supports a dynamic, proactive, and safe culture for patients, family members, visitors, and employees, through continuous learning and improving patient safety policies, systems, and processes.

Mission, Vision, and Values

In support of our mission, vision, and values, PAM Rehabilitation Hospital of Centennial Hills Patient Safety and Quality Improvement program promotes:

- Collaboration of healthcare, leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high quality healthcare.
- Communicate honestly and openly to foster trusting and cooperative relationships among healthcare providers, staff members, and patients and their families, to ensure accountability for the patient safety priorities.
- Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.
- Responsibility for every healthcare related decision and action.
- A focus on continuous learning and improving, system design, and the management of choices and changes, bringing the best possible outcomes or performances to the facility.
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare.
- Education of staff and physicians to assure participation of healthcare providers.

Scope and Purpose

The scope of this Quality and Patient Safety Plan is organizational-wide/hospital-wide/agency-wide which includes but is not limited to

- Patient safety
- Visitor safety
- Employee safety

All staff in PAM Rehabilitation Hospital of Centennial Hills are required to fully support and participate in this plan, and devote their expertise to the patient safety and healthcare quality improvement process.

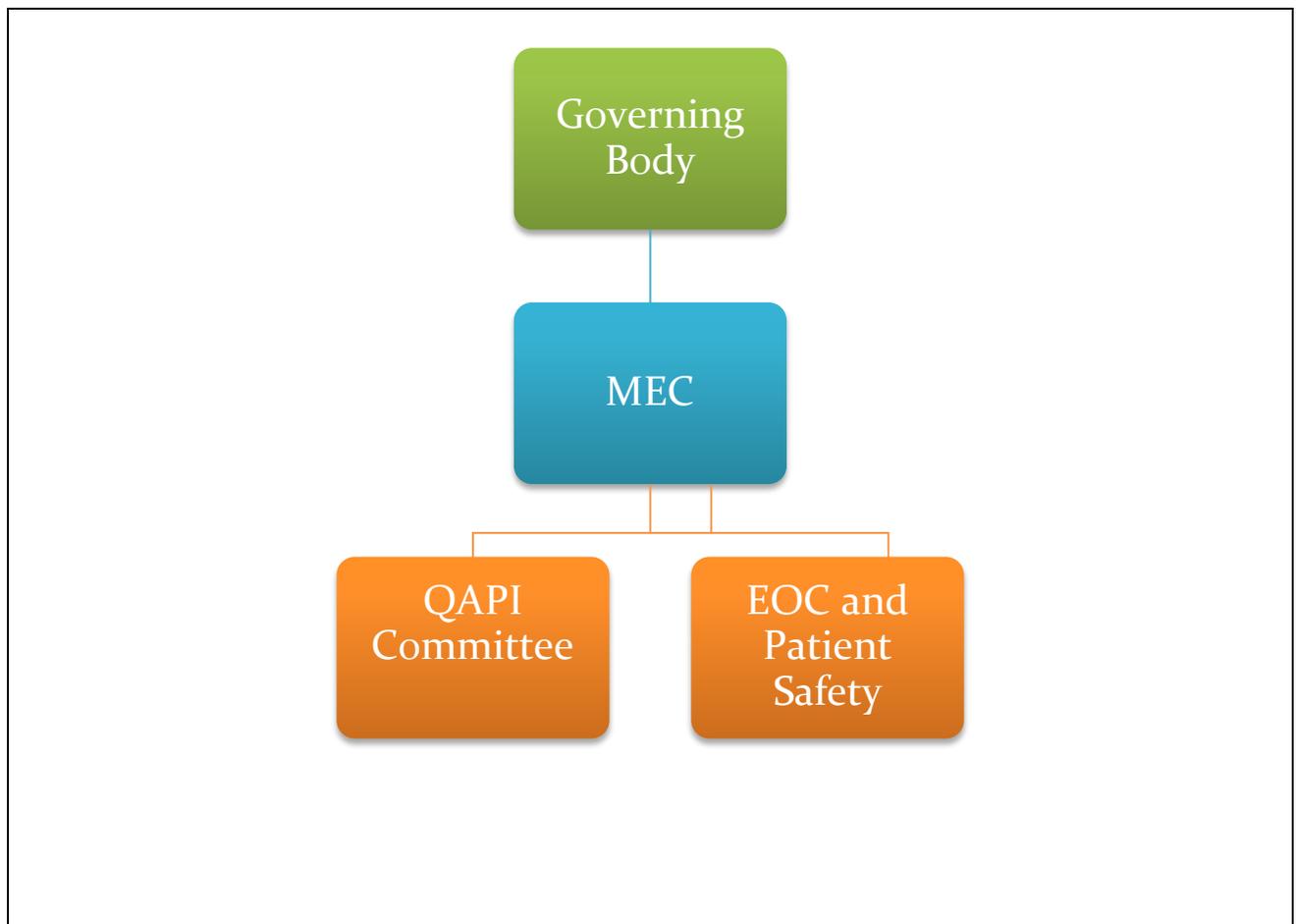
This plan is action oriented and solution focused. The purpose of this plan is to address patient safety related concerns, challenges and revise the program to better serve the patients and their families. To this end, PAM Rehabilitation Hospital of Centennial Hills has developed this Patient Safety plan.

The plan focuses on the process rather than the individual, and recognizes both internal and external customers, as well as facilitates the need of analyzing and improving processes. The core principles of this plan include:

- All staff have the same goal and contribute their knowledge, vision, skill, and insight to improve the process of the Patient Safety Plan.
- Decisions will be based on data and facts, and staff will be encouraged to learn from the experiences.
- Customer based including patients, families, and visitors.
- Promote systems thinking.
- Employ well-trained and competent staff maintaining high healthcare quality.

Roles and Responsibilities

According to [NRS 439.875](#), a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plan is promoted and executed successfully.



Roles and Responsibilities

- In accordance with [NRS 439.875](#), a patient safety committee must be comprised of:
- The infection control officer of the medical facility;
- The patient safety officer of the medical facility, if he or she is not designated as the infection control officer;
- At least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility; and
- One member of the executive or governing body of the medical facility.

Based on [NAC 439.920](#), a medical facility that has fewer than 25 employees and contractors must establish a patient safety committee comprised of:

- The patient safety officer of the medical facility;
- At least two providers of healthcare who treat patients at the medical facility, including but without limitation, one member of the medical staff and one member of the nursing staff of the medical facility; and
- The Chief Executive Officer (CEO) or Chief Financial Officer (CFO) of the medical facility.

The roles and responsibilities are defined below.

Patient Safety Committee Responsibilities (based on [NRS 439.875](#) and [NRS 439.877](#))

- Monitor and document the effectiveness of the patient identification policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\) \(b\)](#).
- Receive reports from the patient safety officer pursuant to [NRS 439.870](#).
- Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred.
- Review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- Review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the executive or governing body of the facility regarding:
 - (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);
 - (2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and
 - (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.

- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

Root Cause Analysis (RCA) Team Responsibilities (please revise as needed)

- Root Cause interviews, analysis, investigation, and corrective action plan implementations.
- Participates in the RCA meetings and discussions.
- Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders.

Patient Safety Officer Responsibilities (based on [NRS 439.870](#))

- Serve on the patient safety committee.
- Supervise the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the patient safety committee regarding any action taken in accordance with the responsibilities above.

Infection Control Officer Responsibilities (based on [NRS 439.873](#))

- Serve on the patient safety committee.
- Monitor the occurrences of infections at the facility to determine the number and severity of infections.
- Report to the patient safety committee concerning the number and severity of infections at the facility.
- Take such action as determines is necessary to prevent and control infections alleged to have occurred at the facility.
- Carry out the provisions of the infection control program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program.

RCA team leader/facilitator Responsibilities

- Organize and coordinate the RCA process.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA, and corrective action plan implementation process.
- Communicate the progress of the investigation, institutional barriers, and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.
- Provide training, education and direction to create RCA process that incorporate the Patient Safety and Quality Improvement elements.

Executive or Governing Body Staff Responsibilities

- Provide vision and leadership to Patient Safety and Quality Improvement process, and develop and foster a safe learning and improving culture.
- Provides oversight to the healthcare quality improvement processes and teams.
- Plan, discuss, and generate the organization patient safety goals and activities, in conjunction with the patient safety action plan.

The Patient Safety Committee will meet monthly to accomplish the following:

- Report and discuss sentinel events which include:
 - Number of sentinel events from previous calendar month (or quarter).
 - Number of severe infections that occurred in the facility.
- Corrective Action Plan for the sentinel events and infections
 - Evaluate the corrective action plan.
- Patient safety policies and checklists
 - At least annually evaluate Patient Safety policies and checklists
 - Revise the patient safety policies and checklists as needed.
 - Monitor and document the effectiveness of the patient safety policy.

A RCA meeting will meet as needed to accomplish the following:

- Define the healthcare issues or potential risks.
- Conduct Root Cause Analysis
 - Reviewing and analyzing the data.
 - Reviewing the RCA process and quality improvement related activities and timelines.
 - Brainstorming issues or the potential risks by using the fishbone diagrams.
 - Identify the contributing factors and conduct the Root Cause Analysis.
- Conduct Corrective Action Plan
 - Identifying the Plan-Do-Study-Act (PDSA) topics.
 - Discussing corrective action process and activities.
 - Discussing and presenting possible changes in procedure to improve areas indicated.
 - Identifying strengths and areas that need improvement.
 - Developing strategies, solutions, and steps to take next.
- Identify barriers and technical assistance needs for supporting the RCA effort

Objectives and Goals of the Quality and Patient Safety Plan

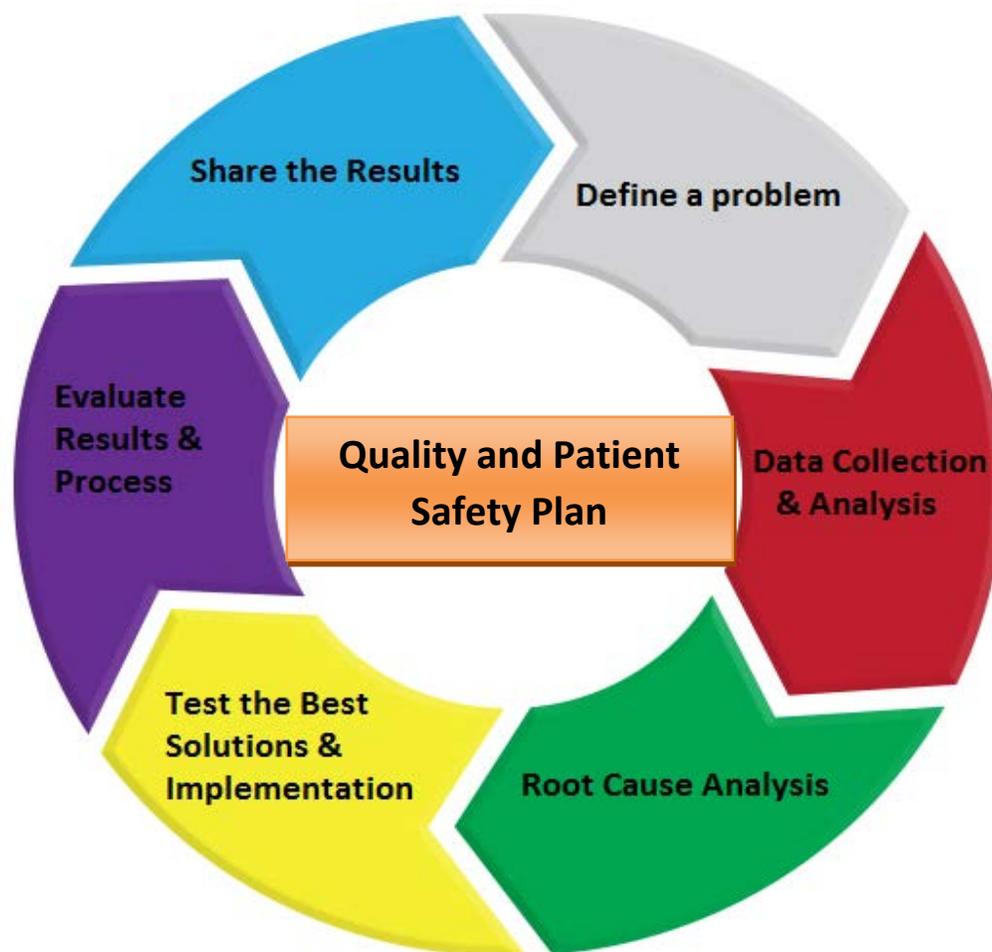
Objective	Goals	Plan	Planned Completion Date	Responsible Party
Hand hygiene compliance	90%	Observations and training, one on one coaching if indicated	12/31/2018	Entire clinical team

Patient Safety with scanning medications	100%	Scan all medications, all medications will have barcode and be scanned; education and monitoring	12/31/18	Pharmacy and Nursing
Keep falls at a minimum; no injuries	Fall rate ≤ 3.99	Risk assessments; fall precautions implemented; monitoring	12/31/18	Nursing, therapy
Safe and successful discharges, keep LOA and acute transfers out to a minimum	Rate <9.0	Hourly rounding; rapid responses if indicated and change in condition, post-acute huddles for information	12/31/18	Entire clinical team
No hospital acquired pressure ulcers	Zero	Daily and weekly skin assessments; education;	12/31/18	Nursing

Components and Methods

Pursuant to [NRS 439.837](#), a medical facility shall, upon reporting a sentinel event pursuant to [NRS 439.835](#), conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event.”

PAM Rehabilitation Hospital of Centennial Hills will use RCA process to determine the contributing factors and the underlying reasons for the deficiencies or failures. The Plan-Do-Study (check)-Act (PDSA or PDCA) is the model, which was developed by the Institute of Health Care Improvement that we will use to test the changes.



Root Cause Analysis

A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals.

Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

Root cause analysis and action plan framework table, which was introduced by the Joint Commission. It contains 24 analysis questions. It guides the organization to the steps in a root cause analysis. Not all the questions apply to all the events or cases. This table can be used individually or with the fishbone diagram.

5 Whys technique will be used in PAM Rehabilitation Hospital of Centennial Hills to explore the cause and effect relationship underlay a problem. One can find the root causes by asking “why” no less than five times. This technique can be used individually or as a part of the fishbone diagram.

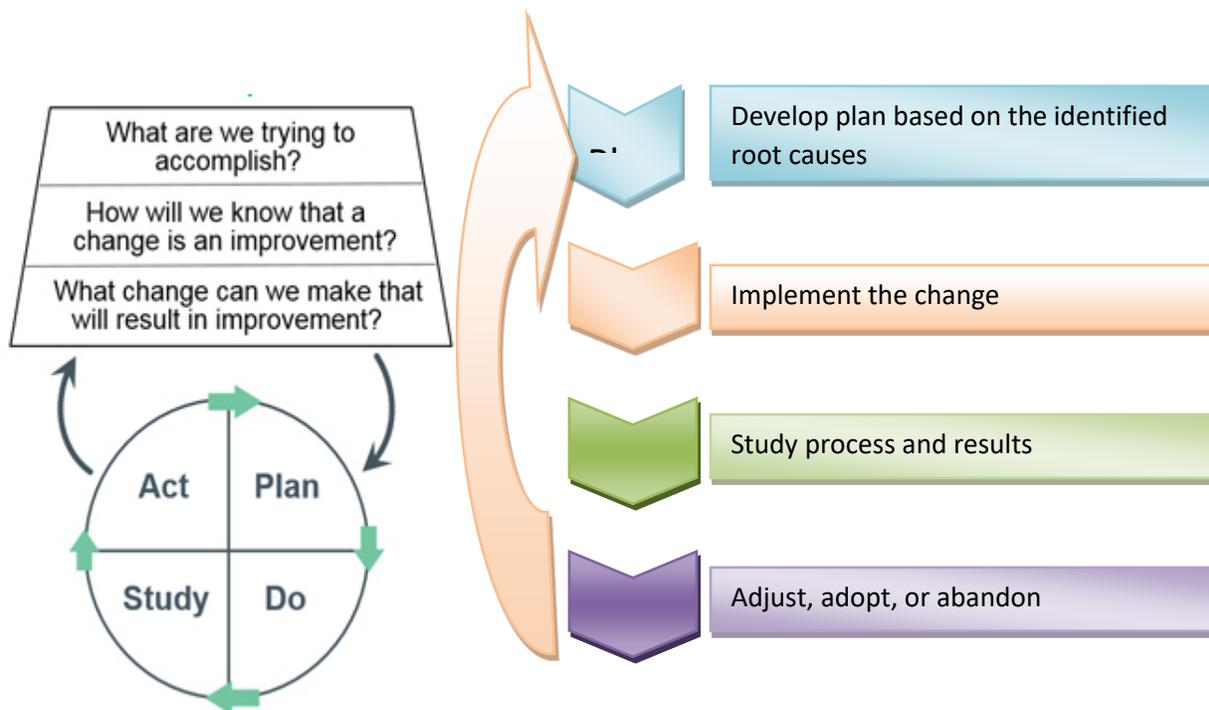
Fishbone Diagram

Once the problems are identified, a Fishbone Diagram (Appendix C) will be used for analyzing the problems. You can use the fishbone diagram individually to analyze the root causes, or use it with the root cause analysis and action plan framework table.

A Fishbone Diagram, also called a Cause-and-Effect diagram, is a useful tool for a team to structurally brainstorm by discovering possible underlying factors or root causes from different major categories for the chosen problems. General categories used include: people, methods, materials, measurements, education, procedures, process, location, environment, etc. RCA team members will brainstorm and ask multiple times, “why did this happen?” for each cause until all ideas are exhausted. The highest priority root causes will be chosen for PDSA topics. Once all the categories are established on the fishbone diagram, 5 Why’s technique also can be used to drill down the problem and find the root causes.

Model for Improvement

The Model for Improvement is a collaborative and ongoing effort model to improve the product and services quality and process. It provides multi-disciplinary quality team guidance from identifying the root causes; conducting the best tests to assess possible changes, and working in collaboration for implementation of the new approaches and solutions. It guides the test of a change to determine if the change is an improvement.



The cycle is defined as follows:

- Plan--collect data and establish appropriate goals. Identify the problem and the possible root causes, and answer the following questions.
 - What is the objective of the test?
 - What are the steps for the test - who, what, when?
 - How will you measure the impact of the test?
 - What is your plan to collect the data needed?
 - What do you predict will happen?
- Do--make changes designed to correct or improve the situation. Use the following questions for the guidance.
 - What were the results of the test?
 - Was the cycle carried out as designed or planned?
 - What did you observe that was unplanned or expected?
- Study -- Study the effect of the changes on the situation. Data should be collected on the new process and compared to the baseline or expected results. Results should be evaluated and by using the following questions as guidance.
 - Did the results match your prediction?
 - What did you learn?
 - What do you need to do next?
- Act--If the result is successful or desirable, standardize the changes and then work on the next prioritized problem or the further improvements. If the outcome is not yet successful, look for different ways to identify the causes or change the testing process.

PDSA worksheet will be used to map the potential change strategies and to establish a course of action. The PDSA worksheet and the PDSA progress report are attached in Appendix D-1.

Data Collection and Reporting

Data should drive any quality and patient safety effort. PAM Rehabilitation Hospital of Centennial Hills is using from RMPRO, erehab, meridian, for tracking the sentinel events, healthcare infection data, and internal data collection.

External data sources are those data sources which are collected outside the supervisory structure of the case. External data which will be utilized for Quality and Patient Safety plan include the data from:

- AHRQ: Agency for Healthcare Research & Quality
- CDC: Centers for Disease Control and Prevention
- CMS: Centers for Medicare & Medicaid Services
- NQF: National Quality Forum
- NHSN: National Healthcare Safety Network
- TJC: The Joint Commission

Ongoing Reporting and Review

Data points such as the following will be reviewed according to the schedule prescribed:

Monthly	Quarterly	Annually
1) Sentinel event monthly report 2) Severity of infection report 3) RCA assessment	1) Sentinel event quarterly report 2) Severity of infection report 3) Review and evaluate the measure of improvement of patient safety 4) Review and evaluate the measurement to prevent and control infections	1) Quality and Patient Safety Plan update 2) Checklists and Policies reviewing and revising

Assessment of the Quality and Patient Safety Plan

Please see the Patient Safety Assessment Tool (PSAT) from the VA National Center for Patient Safety for your reference.

Patient Safety Checklists and Patient Safety Policies

By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and

- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

The patient safety checklists must follow protocols to improve the health outcomes of patients at the medical facility and must include, without limitation:

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.
- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - Proper instructions concerning prescription medications;
 - Instructions concerning aftercare;
 - Any other instructions concerning his or her care upon discharge; and
 - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include, the name and date of birth of the patient.
- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.
- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

Based on [NRS 439.865](#), the patient safety plan must also include an infection control program that carries out the infection control policy. The policy must consist of:

- The current guidelines appropriate for the facility's scope of service developed by a nationally recognized infection control organization as approved by the State Board of Health which may

include, the Association for Professionals in Infection Control and Epidemiology (APIC), the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO) and the Society for Healthcare Epidemiology of America (SHEA); and

- Facility-specific infection control developed under the supervision of a certified Infection Preventionist.

The patient safety checklists are listed in Appendix E. (The following links provide some patient safety checklists for your reference— a checklist example is shown in **Appendix E.**)

http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf

<http://www.who.int/patientsafety/implementation/checklists/en/>

The patient safety policies are listed in Appendix F. (The following link provides you some patient safety policies for your reference—a policy example is shown in **Appendix F.**)

<https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>

Approval of Patient Safety Plan

According to [NRS 439.865](#), a medical facility shall submit its patient safety plan to the governing board of the facility for approval. After a facility's patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan.

The patient safety plan must be reviewed and **updated annually** in accordance with the requirements for approval set forth in this section.

According to [NRS 439.843](#), on or before March 1 of each year, a copy of the most current patient safety plan established to [NRS 439.865](#) must be submitted to the Division of Public and Behavioral Health.

Reference

- Root Cause Analysis Toolkit <http://www.health.state.mn.us/patientsafety/toolkit/>
- Quality and Service Improvement Tools
http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html
- CQI 101 An Introduction to Continuous Quality Improvement:
<https://www.coursehero.com/file/13827355/CQI-Overviewppt/>
- Quality Improvement <http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/>
- Root Cause Analysis <http://www.patientsafety.va.gov/professionals/onthejob/rca.asp>
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2
https://www.jointcommission.org/sentinel_event.aspx

- Hospital Policies <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>
- Checklists to Improve Patient Safety http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf
- Patient Safety Checklists <http://www.who.int/patientsafety/implementation/checklists/en/>
- Minutes of the Meeting of the Quality and Patient Safety Committee
<http://www.cookcountyhhs.org/wp-content/uploads/2013/12/09-23-14-QPS-scan-Minutes.pdf>
- Title 40 – Public Health and Safety <https://www.leg.state.nv.us/NRS/NRS-439.html>

Appendix A: Terms and Definitions

Patient Safety: The Agency for Healthcare Research Quality (AHRQ) defines patient safety as “a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.”
http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

Sentinel event ([NRS 439.830](#))

1. Except as otherwise provided in subsection 2, “sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum.

2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:

(a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or

(b) July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published.

3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.

(Added to NRS by [2002 Special Session, 13](#); A [2005, 599](#); [2013, 217](#))

Institute for Healthcare Improvement (IHI) defines **medical harm** as “unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death.”

Facility-Associated Infection: ([NRS 439.802](#))

“Facility-acquired infection” means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections;
- Ventilator-associated pneumonia;
- Central line-related bloodstream infections;

- Urinary tract infections; and
- Other categories of infections as may be established by the State Board of Health by regulation pursuant to [NRS 439.890](#).

(Added to NRS by [2005, 599](#); A [2009, 553](#))

Medical facility ([NRS 439.805](#))

“Medical facility” means:

- A hospital, as that term is defined in [NRS 449.012](#) and [449.0151](#);
- An obstetric center, as that term is defined in [NRS 449.0151](#) and [449.0155](#);
- A surgical center for ambulatory patients, as that term is defined in [NRS 449.0151](#) and [449.019](#); and
- An independent center for emergency medical care, as that term is defined in [NRS 449.013](#) and [449.0151](#).

(Added to NRS by [2002 Special Session, 13](#))

Near miss: An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Mandatory reporting: Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985; 254(6):796-800.)

Risk: Possibility of loss or injury. (Merriam-Webster’s Online Dictionary, Risk, Available at <http://www.merriamwebster.com/dictionary/risk>. Last Accessed August 2009.)

Preventable event: Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Catheter Associated Urinary Tract Infection (CAUTI): A urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CUR_RENT_b.pdf.)

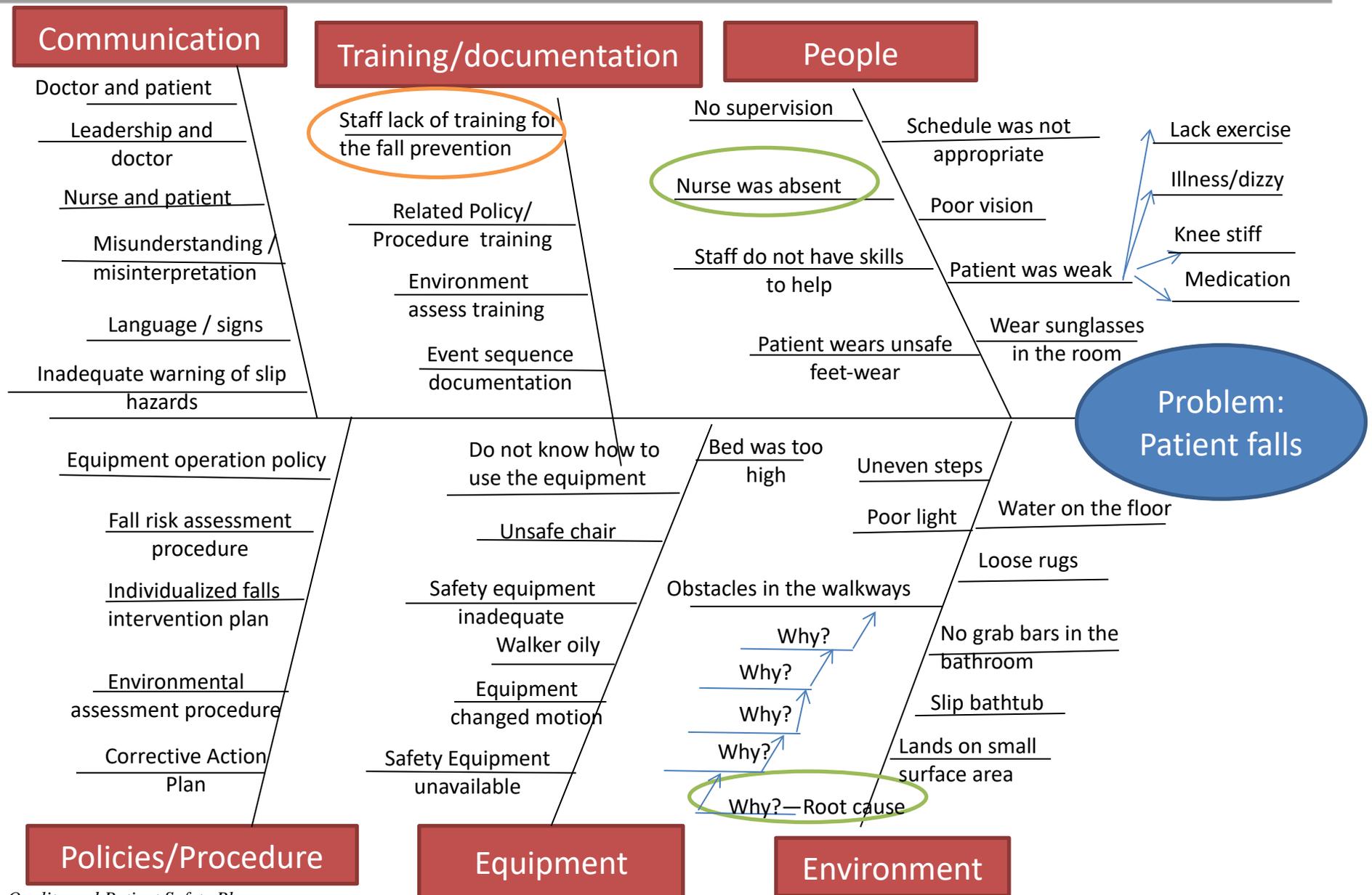
Central Line Associated Bloodstream Infections (CLABSI): Primary bloodstream infections that are associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection.

Appendix B: Patient Safety Goals

OBJECTIVE:	GOAL:	Q3 2014	Q4 2014	Q1 2015
ACTION PLAN:				
1. Create Systems that anticipate errors & either prevent or catch them before they cause harm.	a. Enhance retrospective chart review process.			Implement Trigger Tools. Develop automated surveillance reports in Cerner.
	b. Establish an automated surveillance process.		Complete an in-depth analysis of risk point utilizing the methods of FMEA.	
2. Establish Structures for reporting and a process for managing reports in the event reporting system.	a. Implement new electronic Voluntary Reporting System & participate in Patient Safety Organization.	Implemented e-MERS & PSO with UHC.	Create process for reviewing & closing reports in e-MERS.	
	b. Develop a structure to educate employees system-wide of the process for reporting hazards, errors and adverse events.		Increase number of events reported by 10%.	
	c. Establish a process for providing feedback regarding reported events.		Create process for communicating outcome of reported events.	
3. Develop a Culture of Safety where providers feel safe and supported when they report medical errors or near misses & voice concerns about patient safety.	a. Provide education on patient safety plan that emphasizes importance of blending a systems focus with appropriate individual accountability.		Educate Medical staff, Hospital Wide Oversight & the Quality Committees on the objectives and goals of the patient safety plan.	
	b. Establish a recognition program that rewards safe practices.		Include patient safety presentation in monthly New Employee Orientation.	
	c. Improve overall perceptions of safety as measured by the Culture of Safety Survey.		Develop 'Great Catch' awards program.	
				Re-evaluate culture of safety and develop action plan.
4. Establish Safety Priorities & Targets.	a. Develop Patient Safety Dashboard that includes national measures and benchmarks.		Present Patient Safety Dashboard monthly to Hospital Wide Oversight Committee.	
	b. Facilitate the development of action plans associated with measures not meeting benchmarks.	Complete 2014 Leapfrog Safety Survey.	Establish & implement a plan to improve performance of each leap.	
	c. Assess and improve processes related to hand-off, transition and communication	Develop method to track & report departmental progress and compliance of RCA action plans.		
5. Charter Safety Programs through teams, workgroups or projects.	a. Coordinate Improvement Efforts in order to ensure that capital, people, facilities & technologies are matched to strategic priorities for safe practices.		Establish Patient Safety Council.	
	b. Reduce and eliminate variation in care.		Establish workgroups focused on medication safety, reducing patient falls & hospital acquired pressure ulcers.	
			Revise or develop policies, procedures and protocols.	

Reference: Patient Safety Plan and Its Applicable Goals. 2014. Cook County Health and Hospitals System.

Appendix C: Fishbone Diagram



Appendix D-1: PDSA Worksheet

PDSA Worksheet

Topic:			
Person Completing Worksheet:		Date:	
Telephone/ Email:		Cycle:	
Patient Safety Committee Members			
CEOs/CFOs			
Patient Safety Officer			
Infection Control Officer			
Other Medical Staff			
Other team members			
Aim: (Describe the overall SMART goal that your team wishes to achieve.)			
Plan:			
1. List the tasks needed to set up this test of change.			
2. Predict what will happen when the test is carried out.			

3. List the steps to develop the test-who, what, and when.			
Steps	By Whom	By When	Desired Outcome
Do: (Describe what actually happened when you ran your test, including any problems and unexpected findings.)			
Study: (Describe what you learned and did you meet your measurement goal?)			
Did you meet your measurement goal? Explain.		Summarize what was learned: success, failure, unintended consequences, etc.	
Act: (Describe what you concluded from this cycle.)			
Based on what was learned, please indicate what action will be considered.		Describe what modifications to the plan will be made for the next cycle based on what you learned.	
<input type="checkbox"/> Adapt: modify changes and repeat PDSA Cycle			
<input type="checkbox"/> Adopt: expanding changes throughout organization			
<input type="checkbox"/> Abandon: change approach and repeat PDSA cycle			

Appendix D-2: PDSA Monthly / Quarterly Progress Report

Event:			
Person Complete Report:		Date:	
Patient Safety Officer		Contact Information:	
Monthly / Quarterly Report			
Items	Description		
1. What is your goal?			
2. Report on the PDSA cycle			
3. What system and practices are working well? Explain.			
4. What areas for improvement did the data identify?			
5. What barriers or system issues have been encountered implementing action activities?			
6. Action plans to address the barriers or system issues			
7. Lesson learned			
8. Support needed			
9. Additional discussion			
Notes:			

Appendix E: Checklist Example: Injuries from Falls and Immobility

Process Change	In Place	Not Done	Will Adopt	Notes (Responsible & By When?)
Conduct fall and injury risk assessment upon admission				
Reassess risk daily and with changes in patient condition				
Implement patient-specific intervention to prevent falls and injury				
Communicate risk across the team; use handoff forms, visual cues, huddles				
Round every 1 to 2 hours for high-risk patients; address needs (e.g., 3Ps: pain, potty, position-pressure). Combine with other tasks(vital signs)				
Individualize interventions. Use non-skid floor mats, hip protectors, individualized toileting schedule; adjust frequency of rounds				
Review medications (by pharmacist); avoid unnecessary hypnotics, sedatives				
Incorporate multidisciplinary input for falls				
Prevention from PT, OT, MD, RN and PharmD				
Include patients, families and caregivers in efforts to prevent falls. Educate regarding fall prevention measures; stay with patient				
Hold post-fall huddles immediately after event; analyze how and why; implement change to prevent other falls				

Reference: Checklists to Improve Patient Safety. June 2013. Health Research & Educational Trust.

Appendix F: Policy Example

[Reference: Hospital Policies. MERCY Hospital. <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>]

HOSPITAL POLICY AND INFORMATION MANUAL		
PERSONAL PROTECTIVE EQUIPMENT POLICY Page 1 of 2	Date Issued: Date Last Revised: Next Review Date: Approved By:	07/01 08/14 08/17 Policy Committee

Key Words: personal protective equipment, PPE, safety equipment,

Policy Applies to:

- All staff employed by Mercy Hospital;
- Credentialed Specialists, Allied Health Professionals, patients, visitors and contractors will be supported in meeting policy requirements.

Related Standards:

- Infection and Prevention and Control Standards NZS 8134.3:2008
- Health and Safety in Employment Act 1992
- EQulP5 - 1.5.1 and 1.5.2 Infection Control
- EQulP5 - Standard 3.2 Criterion 3.2.1 Health and Safety

Rationale:

Mercy Hospital will provide suitable personal protective equipment (PPE) when the risk to health and safety cannot be eliminated or adequately controlled by other means.

Definitions:

Personal protective equipment (PPE) means all equipment which is intended to be worn or held by a person to protect them from risk to health and safety while at work.

Examples of PPE include: protective footwear, gloves, hard hats/helmets, clothing affording protection from the weather, visibility clothing, eye and face protection.

Objectives:

- To ensure appropriate PPE is identified to minimize hazards not able to be controlled by elimination or isolation;
- To ensure fit for purpose PPE is provided at Mercy Hospital for use by staff;
- To ensure adequate training in the use of PPE is provided;
- To monitor the use of PPE and evaluate effectiveness.

HOSPITAL POLICY AND INFORMATION MANUAL		
PERSONAL PROTECTIVE EQUIPMENT POLICY Page 2 of 2	Date Issued: Date Last Revised: Next Review Date: Approved By:	07/01 08/14 08/17 Policy Committee

Implementation:

Risk Management

Department Managers, the Occupational Health/ Infection Prevention and Control Nurse (OH/IPC Nurse) and Health and Safety/ Infection Control Representatives (HSIC reps) will in consultation with staff:

Ensure PPE requirements are identified when carrying out risk assessments of activities;

- Regularly review the risk assessment of activities if substances or work processes change;
- Identify the most suitable type of PPE that is required;
- Ensure PPE is available to those who need it;
- Inform staff of the risks involved in their work and why PPE is required;
- Monitor compliance.

Process

Manager's Responsibilities

Must ensure that:

- PPE requirements are considered when risks are assessed;
- Suitable PPE is provided and made accessible to employees;
- PPE is properly stored, maintained, cleaned repaired and replaced when necessary;
- Adequate information and training is provided to those who require PPE;
- PPE is properly used;
- Use of PPE is monitored and reviewed.

Employee's Responsibilities All employees must ensure that:

- They use PPE whenever it is required;
- Attend and comply with training, instruction and information;
- Check the condition of their PPE;
- Store, clean and maintain their PPE;
- Report losses, defects or other problems with PPE to their manager.

Evaluation:

- Staff health and safety orientation
- Environmental audits
- Incident reports

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POLICY

- This policy applies to all employees, medical staff, contractors, patients, visitors and patients of this hospital.
- All unexpected events or occurrences involving death or serious physical or psychological injury or risk thereof are to be reported to the administrative team immediately upon identification (regardless of time of day or night).
- Any and all adverse event or medical errors require immediate action to examine the event in-depth to determine why the incident occurred and how to reduce the likelihood of recurrence.
- The governing body must ensure that the Patient Safety Program (PSP) reflects the complexity of the hospital's organization and services, including those services furnished under contract or arrangement, and focuses on the prevention and reduction of medical errors and adverse events.
- All adverse events or medical errors are errors; but not all errors are adverse events or medical errors.
- Failure to report an adverse event or medical error will be addressed through the Disciplinary process
- Event data will be preserved and collected per hospital policy.¹
- Event equipment will be preserved and removed from patient care until cleared

PATIENT SAFETY SYSTEM:

- To have a means for establishing clear expectations for identifying and detecting the prevalence and severity of incidents that impact or threaten patient safety. This includes medical errors and adverse patient events.
- To identify, implement and regularly assess the means by which incidents are prevented or when they occur. The incidents are studied to detect nonconformance and where risk points or failures are an inherent part of the process and work to remove these risk points or failures from the system.
- To address customer (patient) communication when such incidents occur, how the patients are informed and their right to know the circumstances of events.

DEFINITIONS:

- Administrative Team: Interdisciplinary organizational team, whose members have specific knowledge and authority to determine and correct the identified causative factors of the adverse event or medical error.
- Adverse Event: An Adverse Event shall be defined as an unexpected occurrence or variation that led to death or serious physical or psychological harm. This definition includes the National Quality Forum (NQF) "never or adverse events" that are errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients.² An event that results in unintended harm to the patient by an act of commission or omission rather than by underlying disease or condition of the patient.

¹ Control of Internal and External Documents (#7067)

² NIAHO Standard; QM.7 (p 16) Adverse Event definition

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	REFERENCE #: 7046-NVREG

- Medical Error: The failure of a planned action to be completed as intended, the use of a wrong plan to achieve an aim, or the failure of an unplanned action that should have been completed, that results in an adverse event.
- Reportable Event: A medical error or adverse event or occurrence which the hospital is required to report to the State.
- Root Cause Analysis: An interdisciplinary review process for identifying the basic or contribution causal factors that underlie a variation in performance associated with an adverse event or reportable event. It focuses primarily on systems and processes, includes an analysis of underlying cause and effect, progresses from special causes in clinical processes to common causes in organizational processes, and identifies potential improvements in processes or systems.

SCOPE:

List of events and occurrences to report:

- No Harm Errors: those unintended acts, either of omission or commission, or acts that do not achieve their intended outcome-that do not result in a physical or psychological negative outcome or the potential for a negative outcome, for the patient.
- Hospital Acquired Infection/Condition: infections/conditions that are a result of treatment in a hospital or healthcare service unit.
- Patient Fall
- Mild/Moderate Adverse Outcome Errors: those unintended acts, either of omission or commission, or acts that do not achieve their intended outcome, that result in an identified mild to moderate physical or psychological adverse outcome for the patient.
- Any Medication Error
- Any Adverse Drug Reaction
- Hazardous Condition: any set of circumstances, exclusive of the disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious physical or psychological adverse patient outcome.
- Near Miss: any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome.
- Reportable Events to the State:
 - (i) a medication error resulting in a patient's unanticipated death or major permanent loss of bodily function in circumstances unrelated to the natural course of the illness or underlying condition of the patient;
 - (ii) a perinatal death unrelated to a congenital condition in an infant with a birth weight greater than 2,500 grams;
 - (iii) the suicide of a patient in a setting in which the patient received care 24 hours a day;
 - (iv) the abduction of a newborn infant patient from the hospital or the discharge of a newborn infant patient from the hospital into the custody of an individual in circumstances in which the hospital knew, or in the exercise of ordinary care should have known, that the individual did not have legal custody of the infant;

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- (v) the sexual assault of a patient during treatment or while the patient was on the premises of the hospital or facility;
 - (vi) a hemolytic transfusion reaction in a patient resulting from the administration of blood or blood products with major blood group incompatibilities;
 - (vii) a surgical procedure on the wrong patient or on the wrong body part of a patient;
 - (viii) a foreign object accidentally left in a patient during a procedure; and
 - (ix) a patient death or serious disability associated with the use or function of a device designed for patient care that is used or functions other than as intended.
- Required by the State: a health care-associated adverse condition or event for which the Medicare program will not provide additional payment to the facility under a policy adopted by the federal Centers for Medicare and Medicaid.
 - Other events: as included in the list of adverse events identified by the National Quality Forum that is not included in the list required by the State (see Appendix A for National Quality Forum events).

PROCEDURE:

- Upon the identification of an adverse event or medical error, after the patient is safe (as applicable), the administrative team has been notified prior to leaving duty, employees, members of the medical staff and any witnesses must complete an incident occurrence and submit it to their immediate supervisor who will follow the incident reporting process.³
- Adverse events or medical errors will be reviewed by the Administrative Team within 24 hours of incident notification. The administrative team will determine if the incident warrants conducting a root cause analysis.
- The licensed independent practitioner responsible for managing the patient’s care, treatment, and services, or his/her designee, shall inform the patient or their representative, within 24 hours of the adverse events or medical errors about unanticipated outcomes of care, treatment, and services related to adverse events or medical errors when the patient or their representative is not already aware of the occurrence or when further discussion is needed.
- If it is determined by the administrative team that an RCA is warranted, it will commence within five (5) business days of the decision.
- The RCA will be conducted by the administrative team, staff and licensed independent practitioners who have specific knowledge and authority to determine and correct the identified causative factors of the adverse event or medical error.

Specifically the administrative team will:

- Complete an RCA to examine the cause and effect of the event through an impartial process.
- The RCA will focus primarily on the systems and processes, not individual performance. It will include the following elements:
 - A clear definition of the issue(s) pertaining to the event, that is, a determination of the human and other factors most directly associated with the event, and the process (es) and systems related to its occurrence.

³ Corrective/Preventive Action Plan (#7070)

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- Identification of risk points and their potential contributions to the type of event
 - Develop an action plan identifying the strategies that the hospital intends to employ to reduce the risk of similar events occurring in the future.
 - The action plan must:
 - Designate responsibility for implementation and oversight;
 - Specify time frames for implementation, analysis and follow-up
 - Include a strategy for measuring the effectiveness of the actions taken.
 - The administrative team will not, in any circumstance, delay implementation of the action plan or, as appropriate, elements of its components, over seven (7) days from the date of the completion of the RCA.
 - The administrative team will be afforded the time and resources by Quality Management Oversight to implement the approved plan.
 - If the RCA determines that the adverse event or medical error is related to an organizational systems approach or process challenge, the team will utilize the PDCA (Plan, Do, Check, Act) to design, implement and evaluate an improvement plan to correct the system issue and/or problem.⁴
- Reporting requirements:
 - The administrative team or their designee will report any and all activities of the RCA to the Quality Management Oversight
 - The administrative team or their designee will report any and all findings of the RCA to the Medical Executive Committee, and any other committees, teams, workgroups, or individuals within the organization, as appropriate to the defined issue.
 - The adverse event or medical error and/or the corrective action plan will be communicated to other organizations or individuals at sole discretion of the Chief Executive Officer or his/her designee.
- Other issues related to the RCA:
 - If the RCA finds the adverse event or medical error is to be caused by the performance and/or competence of an independent licensed practitioner holding clinical privileges, the corrective action will be managed through the supervision and direction of the Medical Executive Committee.
 - If the RCA finds the adverse event or medical error to be caused by the performance and/or competence of a clinical staff member not holding clinical privileges, or of a non-clinical staff member, then the corrective action shall be managed by the facility administrative team.

⁴ Quality Manual (#7075)

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**Appendix A
National Quality Forum
Serious Reportable Events**

1. SURGICAL OR INVASIVE PROCEDURE EVENTS

1A. Surgery or other invasive procedure performed on the wrong site (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1B. Surgery or other invasive procedure performed on the wrong patient (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1C. Wrong surgical or other invasive procedure performed on a patient (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1D. Unintended retention of a foreign object in a patient after surgery or other invasive procedure (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1E. Intraoperative or immediately postoperative/postprocedure death in an ASA Class 1 patient (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices

2. PRODUCT OR DEVICE EVENTS

2A. Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

2B. Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

2C. Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, long-term care/skilled nursing facilities

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3. PATIENT PROTECTION EVENTS

3A. Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

3B. Patient death or serious injury associated with patient elopement (disappearance) (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

3C. Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4. CARE MANAGEMENT EVENTS

4A. Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration) (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4B. Patient death or serious injury associated with unsafe administration of blood products (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4C. Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers

4D. Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy (new)

Applicable in: hospitals, outpatient/office-based surgery centers

4E. Patient death or serious injury associated with a fall while being cared for in a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

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4F. Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, long-term care/skilled nursing facilities

4G. Artificial insemination with the wrong donor sperm or wrong egg (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices

4H. Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen (new)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4I. Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results (new)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

5. ENVIRONMENTAL EVENTS

5A. Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

5B. Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

5C. Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

5D. Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

6. RADIOLOGIC EVENTS

SUBJECT: PATIENT SAFETY PLAN	Page 8 of 8
	REFERENCE #: 7046- NVREG

6A. Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area (new)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices

7. POTENTIAL CRIMINAL EVENTS

7A. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

7B. Abduction of a patient/resident of any age (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

7C. Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

7D. Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

Spring Valley Surgery Center LLC

2016 Sentinel event reporting

3835 S. Jones Blvd. Las Vegas NV 89103 License #: 3421

2705 W. Horizon Ridge Pkwy Henderson NV 89052 License #: 5491

7175 N. Durango Drive Las Vegas NV 89149 License #: 7592

1900 N. Nellis Blvd Las Vegas NV 89115 License #: 7891

1050 E. Sahara Ave Las Vegas NV 89104 License # 8688

Safety committee:

The Administration has established a “Life Safety Enterprise Safety Program” designed to keep patients, Physicians, employees and the public safe while on the premises of the Facility. This program consists of elements which meet the requirements as defined by the The Administration has established a “Life Safety Enterprise Safety Program” designed to keep patients, Physicians, employees and the public safe while on the premises of the Facility. This program consists of elements which meet the requirements as defined by the Federal, State, Local and OSHA guidelines. The “Safety Plan” includes identification, evaluation and prevention of workplace hazards relating to the elements and specific criteria. The safety management of the Facility is composed of several elements regarding the safety features necessary for the protection and security of its patients and healthcare workers.

These elements are composed of two parts; one “Life Safety Enterprise Safety Plan” which is wide in scope, organizational and effectiveness, and the “Environmental Safety Management” which oversees the working environment elements of the Facility. These areas overlap each other but also provide individual elements which manage the overall security and safety of the Facility. A report from the Safety Committee is provided quarterly to the Medical Executive Committee (MEC) and onto the Governing Board. The Safety Committee meets and discusses how to improve and/or maintain patient and employee well-being and safety, items discussed range from falls to how to properly lift boxes, and the execution of a disaster drills, etcetera. If any incidents have occurred they will be discussed in detail, and prevention and safety will be implemented.

FACILITY NAME

Risk Management/ Patient Safety Plan

Nevada Acute Care Division

Revised 1/2018

I. Overview

Desert View Hospital endorses an integrated, system-wide patient safety program designed to improve patient safety and reduce risk to patients.

Patient safety is a cornerstone of quality care and is a leadership priority. **Desert View Hospital** operates as a Patient Safety Organization to further its commitment in promoting patient safety and assuring that **Desert View Hospital** remains at the forefront in the delivery of safe and effective clinical care. The Member Patient Safety Evaluation System (PSES) is utilized by **Desert View Hospital** to track safety information, generate Patient Safety Work Product (PSWP) analysis of safety and clinical performance, and promote best practices. This Acute Care Division Risk Management/Patient Safety Plan (“Plan”) provides the general framework to identify, manage, reduce, and eliminate patient safety risks.

The Plan identifies the mechanisms to continually assess and improve the patient safety systems a **Desert View Hospital**. It is our strategy to utilize statistical tools and defined project work to achieve breakthrough gains in patient safety. Performance improvement tools are used in developing and delivering consistent processes and services. The cultural aspect of the Plan is to promote a non-punitive approach to identifying and reporting adverse events. This is consistent with the “Just Culture” concept to promote patient safety practices by instituting a culture of safety and embracing concepts of teamwork and communication.

Most patient safety events are due to a failure of systems; therefore, a systems analysis approach is utilized in evaluations. The goal is to identify and track errors, deficiencies, and problematic trends in order to continuously improve the underlying systems and to intervene as necessary to improve system processes. Although a non-punitive culture is promoted, this approach is balanced by holding caregivers personally responsible for at-risk behaviors and failures to meet the standard of care. When warranted, discipline measures will be initiated as needed consistent with **Desert View Hospital** policies. **Desert View Hospital** employees, contractors, vendors, and members of each facility’s medical staff share responsibility to participate in detection, reporting, and remediation to prevent errors.

GENERAL STATEMENTS ON GOALS AND OBJECTIVES

To support, maintain and enhance the quality of patient care delivered by:

- Systematic and objective monitoring and evaluation of reports of injuries, accidents, patient safety issues, safety hazards, and/or clinical services findings.
- Identification and assessment of general areas of actual or potential risk in the clinical aspects of the delivery of patient care and safety.
- Implementation of appropriate corrective action, to the extent possible, to alleviate and resolve identified problems or concerns with patient safety issues.
- Evaluation and documentation of the effectiveness of actions implemented.

- Aggregation of data/information collected for integration in information management systems and use in managerial decisions and operations.

II. Mission and Vision

Desert View Hospital mission, vision and values drive the Plan and serve as the foundation in identifying strategic goals, objectives and priorities. Our mission is to improve patient safety and the quality of health care delivery through the provision of excellence in clinical care while fostering safe care to our communities, that our patients will recommend to their families and friends, physicians prefer for their patients, purchasers select for their clients, employees are proud of, and investors seek for long-term results. The vision is to be recognized as the provider of choice for healthcare services in the local community where we are trusted by our patients, families and physicians to create a safe, caring and compassionate experience.

In support of our mission, vision, and values, the Plan promotes:

- Collaboration of administrative leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high quality healthcare.
- Communicate honestly and openly to foster trusting and cooperative relationships among healthcare providers, staff members, and patients along with their families, to ensure accountability for the patient safety priorities.
- Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.
- Accountability for every healthcare related decision and action based on the level of risk-taking or egregious behavior identified.
- A focus on continuous learning and improving, system design, and the management of choices and changes, bringing the best possible outcomes or performances to the facility.
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare.
- Education of staff and physicians to assure coordination and integration of care across disciplines and specialties.

Desert View Hospital recognizes that providing safe patient care requires significant coordination and collaboration. The optimal approach to patient safety involves multiple departments and disciplines to establish and effectively implement the processes and mechanisms that comprise this plan.

III. ROLES AND RESPONSIBILITIES

A. Risk Management/Patient Safety Officer

Desert View Hospital has a designated risk director/manager responsible for patient safety risk identification and reduction for their respective facilities. The designated Risk Director/Manager is also the Patient Safety Officer. Each facility is required to submit scheduled reports to the Board of Governors describing risk reduction efforts associated with facility specific, or industry identified risk exposures, including environmental risks and emergency management. Reports are thoroughly reviewed and analyzed by the risk staff to determine effectiveness and follow-through of identified corrective action plans.

The Patient Safety Officer responsibilities based upon [NRS 439.870](#) includes:

- Serving on the Patient Safety Committee (PSC)
- Supervising the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Taking action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the PSC regarding any action taken in accordance with the responsibilities above.

B. Infection Control Officer

The infection control officer designated for each facility, based on [NRS 439.873](#), responsibilities include:

- Serving on the Patient Safety Committee
- Monitoring the occurrences of infections at the facility to determine the number and severity of infections.
- Reporting to the PSC concerning the number and severity of infections at the facility each month.
- Taking such action as determined necessary to prevent and control infections alleged to have occurred at the facility.
- Carrying out the provisions of the Infection Control Program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program.

Based on [NRS 439.865](#), the patient safety plan must also include an infection control program that carries out the infection control policy. The policy must consist of:

- The current guidelines appropriate for the facility's scope of service developed by a nationally recognized infection control organization as approved by the State Board of

Health which may include, the Association for Professionals in Infection Control and Epidemiology (APIC), the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO) and the Society for Healthcare Epidemiology of America (SHEA); and

- Facility-specific infection control developed under the supervision of a certified Infection Preventionist.

C. Patient Safety

Desert View Hospital has an established Patient Safety Councils (PSC) to support patient safety activities. The PSC should ensure that its Patient Safety Plan is promoted and executed successfully. **Desert View Hospital** has also assembled participants to serve in the Member Workforce and to utilize the Member PSES to generate PSWP and exchange analysis and recommendations with the Acute Care PSO Workforce. The main vehicles for these analytic activities occurring within the Member PSES and the member facility Patient Safety Council meetings. The Member PSES is made up of both electronic and physical spaces for the reporting, storing, and generation of PSWP, including secure SharePoint site, and other electronic databases (including but not limited to ClearSight (STARS) and CCD) to maintain and manage PSWP.

According to [NRS 439.875](#), a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plans are promoted and executed successfully.

I. Facility Patient Safety Committee

Each facility establishes a Patient Safety Committee (PSC) that meets on a regular basis and at least monthly.

Membership:

In accordance with [NRS 439.875](#), the committee core membership consists of the following Key Members: (CEO, CNO, Physician, Risk/ Patient Safety Officer, Infection Prevention Nurse, Pharmacy, and Quality). The COO, CMO and Regional CMO attend, as applicable. NRS requires that at least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing, and pharmaceutical staff of the medical facility. In addition, the infection control officer, patient safety officer, and one member of the executive or governing body of the medical facility.

Based on [NAC 439.920](#), a medical facility that has fewer than 25 employees and contractors must establish a patient safety committee comprised of: the Patient Safety Officer, at least two providers of healthcare who treat patients at the medical facility, including but without limitation, one member of the medical staff and one member of

the nursing staff of the medical facility; and the Chief Executive Officer (CEO) or Chief Financial Officer (CF) of the medical facility.

Meetings:

The required members attend the meetings on a monthly basis. If a required member is absent, the facility makes a suitable replacement with someone that has authority to implement actions identified by the PSC.

Duties and Responsibilities:

Desert View Hospital PSC is charged with the assessment and improvement of high-risk processes related to patient safety. This is to be carried out using a four-step methodology.

- **Issue Identification:** The primary issue is the most important risk issue facing the facility and is determined by reviewing the facility’s claims history, claims history unique to the facility, patient safety concerns, industry claims, and through discussions with the risk staff. Other issues may be related to process initiatives.
- **Best Practice:** Once identified, the primary issue is dissected to determine its component issues. For each component issue, a best practice is selected. Best practices represent the most appropriate method for performing the delineated process and should not be selected until the PSC is assured that it is truly the “Best Practice.”
- **Implementation:** Implementation strategies are those methods used to put the best practices into place. Often this includes revising policies, education, newsletters, phone calls, meetings, formal training, etc. Responsible parties and dates for completion are identified to ensure success.
- **Monitoring and Accountability:** Monitoring is essential to ensure that the strategies identified have been effective. Improvement should be demonstrated statistically whenever possible.

Additional Patient Safety Committee Responsibilities, based upon [NRS 439.875](#) and [NRS 439.877](#), include:

- Monitor and document the effectiveness of the Patient Identification Policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the Patient Safety Officer pursuant to [NRS 439.870](#).
- Evaluate actions of the Patient Safety Officer in connection with all reports of sentinel events alleged to have occurred.

- The Quality member of the PSC will review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- The Quality member in conjunction with the Infection Control Officer will review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- Make recommendations to the Board of Directors of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the Board of Directors of the facility regarding:
 - (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);
 - (2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and
 - (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
 - Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

In addition to the work done on the primary issue, the PSC is charged with addressing issues identified through claims reporting, Safety Watch Newsletters, the Joint Commission (Sentinel Event Alerts) and others, HRUs and from the TERM evaluation or other surveys, such as the OBHRU Site Assessments. Feedback is provided on an ongoing basis as to the functioning of the Patient Safety Committee.

II. Patient Safety Advisories

When an untoward event occurs at a facility or in the industry, it is important that we respond in a positive manner. Systems that lead to failure at one facility can be assessed at other facilities to avoid the same or similar occurrence. To this end, the Acute Care PSO distributes Safety Watch newsletters. These alerts detail the circumstances that lead to the negative outcome and facilities are charged with assessment and improvement of their own processes.

Desert View Hospital is required to address the Safety Watch newsletters via their Patient Safety Council and this is evidenced in their monthly minutes. Responses to the Safety Watch are reviewed for the opportunity to generate a best practice to implement.

C. TERM Program

The facility has utilized its formalized risk management program identified as TERM: the Technical Elements of Risk Management. Each element focuses on a separate organizational function and details specific strategies for managing risk in these areas. These elements are summarized as follows:

Element I. Administration of the Risk Management Program: The tenets outlined in Element 1 lay the foundation for an effective risk management program. The Risk Manager/Director must be seen as a resource to administration, facility, and medical staff. Written plans, goals, and objectives provide a clear vision to meet the purpose of the risk program. Although the TERM program uses the title “Risk Manager,” this applies equally to Risk Directors.

Element II. Risk Identification: Risk identification is essential in order to avoid, mitigate, and eliminate risk-generating practices. This Element focuses on those steps taken to identify exposures faced by the facility.

Element III. Risk Education: Education is a cornerstone of the TERM program. Risk management education is intended to reduce and eliminate risk-generating practices and to promote best practices that enhance the provision of safe patient care.

Element IV. Patient Safety Initiative: Imperative to a comprehensive RM program is one that focuses on the improvement of patient and staff safety through the creation of an environment that maximizes safety and reduces liability claims exposure. The mechanism used to drive the culture of safety is the Patient Safety Committee (PSC) at each facility. The PSC operates using a four-step process. These steps include: identification of the problem, determining best practice, implementing the recommendations, and monitoring and accountability. Corrective actions are discussed, monitored, and validated by the PSC.

Element V. Patient Safety Priority: Root Cause Analysis (RCA): The cornerstones of an effective Patient Safety and Risk Management Program are (i) the performance of a thorough and credible RCA when a serious, sentinel, never event or a significant near miss event occurs; and (ii) implementation of systemic improvements to enhance patient safety and improve healthcare outcomes going forward.

Element VI. Environment of Care; Safety and Security Programs: The safety and security programs in the facility serve to protect and preserve both life and property. Areas of safety include licensing, accreditation and federal, state, and local safety practices and programs, including the EPA, TJC, etc.

Element VII. Claims and Litigation Management: The risk manager serves as the on-site representative of the insurance program in the management of general and professional claims and litigation.

Element VIII. Patient Safety Organization (PSO): Participants of the Member Workforce are expected to perform identified patient safety activities and to be trained in their responsibilities. They must also understand and acknowledge their obligations, including maintaining the confidentiality of PSWP, as required by the Patient Safety and Quality Improvement Act (PSQIA), and of Protected Health Information, as required by the Health Insurance Portability and Accountability Act (HIPAA) and its regulations, and other federal and state laws.

Element IX. Measuring the Effectiveness of the Risk Management Program: In order to assure the effectiveness of the Risk Management Program, certain activities should be conducted to ensure that implementation of the TERM program has been successful. This includes, but is not limited to, data analysis and trending of events and potential claims, which are shared with the respective oversight committees.

D. CCD

The CCD system is the electronic event reporting system utilized by the facilities to report patient and visitor safety events. The risk management module allows for the collection, categorization, and analysis of incident data using electronic reporting functions (Remote Data Entry - RDE). The facility enters incidents into CCD through identification of the type of incident and characteristics of the event using risk parameters and outcomes. Additional information can be attributed to a department, physician, or individual, along with further details of the event. This allows the retrieval of information in a variety of ways for analysis and review.

E. ClearSight (STARS)

STARS is an integrated claims management program that allows for complete claims management, including extensive analysis of reportable fields associated with reported claims. STARS also provides for the electronic submission of potential claims by user facilities.

Delineation of issues featured in the probable claim module allows for the facility staff to identify causation factors associated with any reported event. The system also provides for the entry of details that will describe the event and liability concerns.

Trending of claim information is performed on a scheduled basis to operations leadership metrics to form strategies on facilitating risk reduction efforts. Previous examples of this function include the formation of an OB HRU and Perioperative

concepts. Quarterly reports should be provided by the Facility's RM to the Governing Board of all claims activities.

F. Event Notification Site

The Risk Department developed the Event Notification Site or ENS, a web-based system that allows for contemporaneous reporting of serious adverse events and key near miss sentinel events to facility and corporate management. The ENS also provides an environment in which stakeholders can post questions and additional information to the facility reporting the event. Updates to the event are reported in real-time to all identified facility and stakeholders via the ENS. The Risk Management staff reviews each ENS to determine if follow-up is needed; if follow-up is indicated, it is to be completed within 45 days.

G. Root Cause Analysis (RCA)

Pursuant to [NRS 439.837](#), a medical facility shall, upon reporting a sentinel event pursuant to [NRS 439.835](#), conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both of the sentinel event.

A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals. Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

It is recommended that the Joint Commission's root cause analysis and actions plan framework table are utilized. It contains analysis questions and guides the organization in the steps of a root cause analysis. Not all of the questions apply to all of the events or cases.

Utilization of the "5 Whys" technique should be used to explore the cause and effect relationship underlying a problem. One can find the root causes by asking "why" no less than five times.

RCA Responsibilities

- Organize and coordinate the RCA process.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA and corrective action plan implementation process.
- Communicate the progress of the investigation, institutional barriers and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.



H. Patient Safety Checklists

By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

The patient safety checklists must follow protocols to improve the health outcomes of patients at the medical facility and must include, without limitation:

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.

- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - Proper instructions concerning prescription medications;
 - Instructions concerning aftercare;
 - Any other instructions concerning his or her care upon discharge; and
 - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety checklists are listed in Appendix E. (The following links provide some patient safety checklists for your reference— a checklist example is shown in **Appendix B.**)

http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf

<http://www.who.int/patientsafety/implementation/checklists/en/>

I. Patient Safety Policies

The patient safety policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include, the name and date of birth of the patient.
- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.
- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

J. MEMBER PATIENT SAFETY EVALUATION SYSTEM (PSES)

The Patient Safety and Quality Improvement Act of 2005 (PSQIA) and its regulations govern the operations and activities of the UHS Acute Care PSO and its Members. This includes assembling a “workforce” of employees, volunteers, trainees, contractors, and other persons who carry out patient safety activities on behalf of the Members within the Member Patient Safety Evaluation System (“Member PSES”). Participants in the Member Workforce are expected to perform identified patient safety activities and to be well trained in their responsibilities. They must also understand and acknowledge their obligations, including maintaining the confidentiality of PSWP, as required by the PSQIA, and of Protected Health Information, as required by the Health Insurance Portability and Accountability Act (HIPAA) and its regulations, and other federal and state laws. The Member PSES serves as a means by which patient safety information is collected, maintained, reported, and analyzed for the UHS Acute Care PSO for the purposes of improving patient safety.

K. Training and Education

Training is essential to successful implementation of the Patient Safety and TERM program. All facility risk managers undergo extensive orientation and education related to Patient Safety, TERM program and other healthcare, risk-related topics. Newly hired risk managers receive both on-site and collaborative corporate-based education and training to afford them the requisite skills to manage their facility assignment. Each risk manager is provided a copy of the TERM source documents and other reference materials that guide the risk management function. In addition, formalized supplemental training is provided to all facility risk managers as needed, including quarterly risk management meetings. Risk leadership provides ongoing support and consultation to their assigned facility to facilitate the minimization of liability exposures and enhancement of safe patient care.

The leadership risk management staff provides consultative services to each facility and as members of designated projects. These activities include on-site assistance, research, and consulting from off-site. Examples of designated projects are as follows.

- Facility specific risk Issues
- Safety Watch newsletters
- MIDAS Focus advisories

IV. Risk Management Goals and Objectives 2018

- Surgical and Procedural Safety
 - Monitor compliance through tracer methodology and report monthly with oversight by leadership.

- Goal: Zero harm events: Prevent mistakes in surgeries and procedures
- OB HRU-Zero Preventable Harm
 - Goal: Reduction/ Elimination of Maternal Hemorrhage
 - Goal: Reduction/ Elimination of Serious Harm from Shoulder Dystocia
 - Goal: Reduction/ Elimination of Serious Harm by decreasing response time to changes in Fetal Monitoring Tracings
- Emergency Department
 - Goal: Reduction/ Elimination of Workplace Violence
- Medication Safety
 - Goal: Implement an effective Opioid – Pain Management strategy, as evidenced by compliance with Assembly Bill 474, NRS 233B.066, regarding prescribing of controlled substances and reporting of controlled substance overdoses.
- Perform monthly *Safety Watch* Gap Analysis and complete within 90 days.
- Reduce falls with injury by 10%.
-

V. Monitoring and Accountability

A. Evaluation of TERM Program

These evaluations consist of both a core risk and clinical risk review. The facility is required to submit a written corrective action plan for noted deficiencies determined during the TERM evaluation. All information is shared with senior staff and monitored through the facility PSC.

B. Patient Safety Council Coaching

As detailed above, each facility is required to post their monthly reports or minutes that details the work conducted by their Patient Safety Committee to the facility PSES site. These are then reviewed minutes and detailed feedback is provided to coach the committee on their form and function.

C. Dashboards

The Risk Management/Patient Safety Dashboard and the Environment of Care Dashboard include multiple indicators to demonstrate the facility's performance as to these markers. These include: event reporting statistics, fall rate including harmful

event rate, medication event rate including harmful medication events, timeliness of event review and closure, risk management education, events that meet the ECRI Top Patient Safety Concerns, and environment of care concerns.

VI. Evaluation/Review:

The risk staff reviews the effectiveness of the Patient Safety/Risk Management Plan to ensure activities are appropriately focused on improving patient safety, decreasing harmful errors, decreasing rate of compensable events, facility risk program consistency/functionality and support of clinical delivery in the field. Evaluation will include the following:

- The culture supports the identification and reporting of “Near Miss” events
- There is a framework that advances a “Just Culture”
- Accountability is promoted when acts of “at risk” or “reckless behavior” occur resulting in potential/actual adverse outcomes;
- Comparison of trended incident data to include analysis of performance to stated targets, submission of incident data in compliance to SOX stipulations and review of trended data submitted to the PSC for potential action;
- Review of annualized and prior year’s probable claim reports to determine needs for corporate-based projects designed to improve outcomes in an identified service line;
- Review of educational products distributed for the concluding operating year that were intended to improve outcomes associated with a particular clinical emphasis;
- Review information, analyses and reports from the Acute Care PSO for integration into the Patient Safety Evaluation System.

VII. Confidentiality

All patient safety/risk management work products are considered Patient Safety Work Products (PSWP) as defined by federal guidelines governing Patient Safety Organizations (PSO). All PSWP reported, stored, or generated in the Member PSES is confidential and privileged under Federal law. The Member PSES will only be accessed by authorized staff. Workforce participants will be trained on policies and procedures governing their patient safety activities and responsibilities.

VIII. Approval of Patient Safety Plan

According to [NRS 439.865](#), a medical facility shall submit its patient safety plan to the governing board of the facility for approval. After a facility's patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan. The patient safety plan must be reviewed and **updated annually** in accordance with the requirements for approval set forth in this section.

According to [NRS 439.843](#), on or before March 1 of each year, a copy of the most current patient safety plan established to [NRS 439.865](#) must be submitted to the Division of Public and Behavioral Health.

Appendix A: Terms and Definitions

Patient Safety: The Agency for Healthcare Research Quality (AHRQ) defines patient safety as “a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.”

http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

Sentinel event ([NRS 439.830](#))

1. Except as otherwise provided in subsection 2, “sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum.

2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:

(a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or

(b) July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published.

3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.

(Added to NRS by [2002 Special Session, 13](#); A [2005, 599](#); [2013, 217](#))

Institute for Healthcare Improvement (IHI) defines **medical harm** as “unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death.”

Facility-Associated Infection: ([NRS 439.802](#))

“Facility-acquired infection” means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections;
- Ventilator-associated pneumonia;

- Central line-related bloodstream infections;
- Urinary tract infections; and
- Other categories of infections as may be established by the State Board of Health by regulation pursuant to [NRS 439.890](#).

(Added to NRS by [2005, 599](#); A [2009, 553](#))

Medical facility ([NRS 439.805](#))

“Medical facility” means:

- A hospital, as that term is defined in [NRS 449.012](#) and [449.0151](#);
- An obstetric center, as that term is defined in [NRS 449.0151](#) and [449.0155](#);
- A surgical center for ambulatory patients, as that term is defined in [NRS 449.0151](#) and [449.019](#); and
- An independent center for emergency medical care, as that term is defined in [NRS 449.013](#) and [449.0151](#).

(Added to NRS by [2002 Special Session, 13](#))

Near miss: An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Mandatory reporting: Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985;254(6):796-800.)

Risk: Possibility of loss or injury. (Merriam-Webster’s Online Dictionary, Risk, Available at <http://www.merriamwebster.com/dictionary/risk>. Last Accessed August 2009.)

Preventable event: Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Catheter Associated Urinary Tract Infection (CAUTI): A urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at

http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CUR_RENT_b.pdf.)

Central Line Associated Bloodstream Infections (CLABSI): Primary bloodstream infections that are associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection.

Appendix B: Checklist Example: Injuries from Falls and Immobility

Process Change	In Place	Not Done	Will Adopt	Notes (Responsible & By When?)
Conduct fall and injury risk assessment upon admission				
Reassess risk daily and with changes in patient condition				
Implement patient-specific intervention to prevent falls and injury				
Communicate risk across the team; use handoff forms, visual cues, huddles				
Round every 1 to 2 hours for high-risk patients; address needs (e.g., 3Ps: pain, potty, position-pressure). Combine with other tasks(vital signs)				
Individualize interventions. Use non-skid floor mats, hip protectors, individualized toileting schedule; adjust frequency of rounds				
Review medications (by pharmacist); avoid unnecessary hypnotics, sedatives				
Incorporate multidisciplinary input for falls				
Prevention from PT, OT, MD, RN and PharmD				
Include patients, families and caregivers in efforts to prevent falls. Educate regarding fall prevention measures; stay with patient				
Hold post-fall huddles immediately after event; analyze how and why; implement change to prevent other falls				

Reference: Checklists to Improve Patient Safety. June 2013. Health Research & Educational Trust.

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SUBJECT	PATIENT SAFETY PROGRAM
PURPOSE	To promote the health and safety of patients; to review and evaluate the quality of patient safety measures used by the facility; to assist in the implementation of patient safety processes; to reduce errors; to educate patients and staff; to strengthen the culture of safety; to increase communication among the members of the healthcare team, to provide oversight of patient safety from “no harm” to frequently occurring to serious adverse outcomes.
SCOPE	Patient Safety Officer, QA/PI Coordinator/Risk Manager, Board & MAC Members, Safety Officer
FORMS	Patient Safety Program: Patient Safety Random Review tool
POLICY	<p>The safety of patients undergoing procedures is a primary responsibility of the peri-operative staff, Administration and the attending physician. As such, this organization is adopting a zero tolerance for breakdowns in patient safety practices. This organization is declaring “high reliability” as a mantra in patient safety. This organization promotes and monitors patient safety and has defined these parameters in this program. The Board shall appoint both a Patient Safety Officer and a Patient Safety Advocate. The Patient Safety Officer shall complete a quarterly report for submission to the QA/PI/Risk Management Committee. The QA/PI/RM Committee shall function as the Patient Safety Committee by reviewing, monitoring and assessing patient safety issues through observation, data collection, aggregation and analysis, planning, implementation and outcome analysis at its quarterly meeting. Reports will be forwarded to the MAC and Board. In addition, the Patient Safety Officer completes an annual Patient Safety Review and submits this to these committees.</p> <p>Furthermore, this organization embraces the National Patient Safety Goals identified by the Joint Commission. These goals are inserviced annually to all staff members to include an overview of past National Patient Safety Goals, but also present goals and those being proposed for the upcoming year. These goals are incorporated into our Patient Safety Program as well as the policies and procedures approved for use in this organization.</p> <p>One aspect of the Patient Safety Program is the appointment of a Patient Safety Officer by the Governing Board of this organization. The Patient Safety Officer performs internal patient safety review along with the Risk Manager Designee. In addition, a licensed Risk</p>

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Manager is contracted to review, among other things, patient safety issues.

The Patient Safety Advocate is a volunteer from the community who is neither employed nor contracted with this organization who attends the Annual Board Meetings.

Error reduction is a critical aspect of patient safety and requires the commitments of all members of the healthcare team. Identifying and reducing contributing factors are paramount in promoting patient safety. Contributing factors for errors occurring include:

- Inadequate communication among team members
- Incomplete review of patient health records and diagnostic studies
- Traditional hierarchical and autocratic cultures
- Patient-related decisions made only by physicians
- Rapidly and frequently changing technology
- Intimidating management styles
- Absent or inconsistently applied policies and procedures
- Fatigue
- Multitasking
- Time pressures and constraints
- Emergency surgery
- Cultural differences between patients and staff members and among staff members
- Staffing shortages
- A blaming culture
- Confusing packaging of medications and supplies
- Unclear instructions
- Insufficient orientation and training
- Patient characteristics requiring unusual setup or requirements, and
- Failure to include the patient and family members in assessment and decision making

Error-reduction strategies

Error reduction requires the commitment of all members of the surgical team. In addition to the contributing factors identified above, individual and institutional strategies can also include the following actions.

- Reduce reliance on memory by using checklists, protocols and computerized decision aids.
- Improve information access of patient records

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- Support contracts for new equipment and supplies that include clauses providing staff member education on the use of the equipment and supplies
- Standardize processes as much as possible for **instrument tables and setups**, medication doses, pre-operative procedures, and other activities
- Establish mechanisms to update procedure / preference cards.
- Participate in quality and process improvement initiatives.
- Develop policies and procedures that address unsafe practices.
- Focus on the safety aspects of products during the selection and evaluation process.
- Promote safety-related clinical competency
- Include the patient and family members (when possible) in confirming the correct patient identity, the correct surgical procedure, and the correct surgical site.
- Educate employees about the potential for errors and how to avoid them.

One of the most effective team strategies is to create and nurture a culture of safety. Such a culture is founded on a sense of trust among team members and a feeling of safety when the need for change or improvement must be addressed. Establishing a culture of safety and trust is a process of changing a culture from one of blaming individuals for errors to one in which errors are treated not as personal failures but as opportunities to improve the system and prevent harm. Success in the creation of a safety culture depends on the commitment of all team members to report, address, and correct system failures. Four elements are required to create such an environment:

- A sense of trust among team members;
- Disseminating and verifying receipt of information to all levels of staff and management;
- Developing and supporting a proactive approach rather than a reactive, blaming approach; and
- Making a sincere commitment to affirming safety as the first priority.

Staff members who have been involved in a sentinel event shall be provided support services commiserate with the event to include professional counseling and support.

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PROGRAM/PROCESS The Patient Safety Program encompasses multiple processes to include the caregiver(s), the patient and the systems and policies implemented within the organization:

The Healthcare Provider

The healthcare provider utilizes a mental checklist using the "I'm Safe" acronym to check themselves out to assure he/she is safe and fit for duty. The caregiver is accountable to ask him/herself:

- **Illness:** Am I feeling well enough to carry out my duties effectively?
- **Medication:** Am I taking any medications that might cloud my thinking, such as a tranquilizer or even an antihistamine?
- **Stress:** What is going on in my personal or work environment that might interfere with my performing well?
- **Alcohol or drugs:** Am I impaired in a way that might jeopardize patient care?
- **Fatigue:** Am I too tired to function well?
- **Emotions and eating:** Am I doing what I need to do to take care of myself emotionally and physically?

Note: Staff members have the right, too, to contact the state licensing agency, Medicare and The Joint Commission should they have concerns regarding patient safety and/or the quality of care.

The Patient

Patient safety includes the patients responsibilities as defined in the posted Patient's Rights and Responsibilities to include the responsibility to report physical and mental health conditions, medication usage, allergies, and life situations which could adversely effect the outcome of the procedure.

The patient's safety responsibilities further include his/her agreement to follow instructions to ask questions for clarification and to report any unanticipated or unusual occurrence, reaction or symptom.

Patients and their caregivers are educated regarding their right to contact the Joint Commission regarding any issues concerning the quality of care and/or patient safety.

The systems and processes used by this organization to assure, implement and measure patient safety include:

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- Providing qualified staff in the correct numbers for the correct ratios
- Staff orientation, competency evaluation, staff education, measuring staff orientation and education effectiveness
- Falls Prevention Program and Risk to Fall Assessment
- Identifying correct patient, site **and** procedure
- Preventing medication errors
- Medication Administration programs
- Discharge planning and instruction
- Pre-Operative assessment, instruction and teaching
- Controlling heat sources to reduce the possibility of fires
- Safe use of infusion pumps
- Use of patient identifiers to include a “time out” process
- The identification of dangerous drugs
- Improving effectiveness and clarification of hands-off communication
- The proper labeling of medications and solutions
- The verification and validation of verbal orders
- Reconciling patient medication inventories
- Reducing the risk of healthcare associated infections
- Use of protective devices
- Patient ambulation and transportation
- Follow-up phone calls
- Physician credentialing, privileging and competency assessment
- Anesthesia Safety
- Equipment Safety Programs/Safe Medical Device
- Hazard mitigation and vulnerability assessment
- Preventive maintenance programs
- Domestic Violence/Abuse Assessment
- Infection Prevention/Sterilization Practice Assessment
- Interpreter and Sensory Impaired Services
- Risk Management Program
- Root Cause Analysis
- **Staff competency assessments**

Data Collection Forms used in the Patient Safety Program are used to collect and to preserve factual information for subsequent analysis as per the policies and procedures adopted by this organization addressing these processes. The data collected is aggregated by the Patient Safety Officer and presented to the QA/PI/RM Committee for process analysis, planning, implementation and outcome analysis. The QA/PI/RM Committee submits these reports to the MAC and Board for further input and recommendations.

- Medical chart forms to include especially:

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- Pre-Op Instructions/Telephone Interview
- Pre-Anesthesia & Surgery Assessment
- Risk to Fall Assessment
- Discharge Plan
- Discharge Instructions
- Consent for Procedure/Informed Consent
- Privacy Notice
- Patient Medication Inventory
- Patient education regarding the prevention of surgical site infections
- Safety Environmental Checklist
- Security Environmental Checklist
- Hazard Mitigation Assessment Tools
- Annual Hazard Vulnerability Assessment
- Annual Security Crime Vulnerability
- Life Safety Logs (Surgery Unit Log Book)
- Monthly Infection Prevention Assessment Tools
- Chart Review Tools
- Sterilization Logs
- Alarm Logs
- Infection Complication and Incident Report Logs
- Incident Reports/Adverse Incidents/Sentinel Events
- Inservice Records
- Employee Health Records
- QA/PI/RM Periodic Assessment Tools
- Anesthesia Review
- Tissue Review
- Pre-Op, OR, Recovery Review
- Medical Necessity/Clinical Practice Guidelines and Peer Review Activities
- Mitigation Assessment Tool
- Patient Safety Random Review
- Perception of Care Survey Tools

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PROCEDURE

1. Where a system or process failure either occurs and causes harm or has the potential to cause harm involving services, care or treatment, or where a risk or potential risk is identified, the discoverer completes an incident report and follows that process through completion.
2. The Patient Safety Officer forwards the Patient Safety Random Review tool to the Patient Safety Advocate for review and comments and recommendations at least annually.
3. Where an adverse event/unanticipated sequela has occurred, the discoverer attains that completed form and follows the process defined.

Source: CMS ASC recommendations 416.50, 2009

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SUBJECT	VOLUNTEER SAFETY
PURPOSE	To identify general safety practices for "volunteer" staff members.
SCOPE	Volunteer Staff Members
POLICY	Although volunteers are not employees, it is the responsibility of the Facility to provide a safe work environment and to orient and train these staff persons.
PROCEDURE	<ol style="list-style-type: none">1. Orient to rules that governs the staff.2. Train to lift, transport and escort patients; to direct visitors and/or patients; and to handle an upset guest.3. Attend safety inservices, fire and disaster drills.4. Wear identification tags, protective low-heel shoes and avoid jewelry that catches on equipment.

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SUBJECT	VISITOR SAFETY
PURPOSE	To provide a broad base for the overall safety surveillance program and to assure that the possibility of injuries is minimized.
SCOPE	All Staff Members and Visitors
POLICY	The accident and fire prevention program includes all visitors to the Facility and will encompass both internal and external safety rules. Visitors in this organization include vendors, consultants, maintenance and repair persons, i.e., persons who will be in the Center longer than persons with deliveries.
PROCEDURE	<ol style="list-style-type: none">1. Demand identification of vendors; i.e., a picture ID and a business card.2. Restrict visitors to defined areas such as Waiting, Conference, Lounge, Lavatories and Pre-Op/Recovery.3. Orient visitors/observers in the patient care areas to basic safety rules and regulations.4. Provide ID cards or tags for persons authorized to go into otherwise restricted zones; e.g., vendors, physicians, consultants, maintenance persons.5. Scan the area periodically for the presence of unwanted or unsavory visitors.6. Provide a sign-in log for visitors/vendors—other than patient sponsors and vendors merely dropping off or picking up supplies, equipment, linen, etc.; i.e., any vendor who will be present in the Center for a period of time.7. Advise staff to watch all guests for possible untoward events that would warrant immediate intervention and documentation.8. Provide immediate medical first aid, if and when applicable.9. Advise Administrative Director and Medical Director should an injury occur.

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SUBJECT	SAFETY IN OR
PURPOSE	To instill consciousness of hazards peculiar to the operating room suite. To prevent the occurrence of accidents in the high activity area of the surgical suite.
SCOPE	All OR Personnel
POLICY	Basic safety techniques and policies will be strictly inserviced and enforced within the OR environment. Staff members will be routinely monitored for compliance to these. Staff members will be corrected instantly when deviation from good safety practices are made.
PROCEDURE	<ol style="list-style-type: none">1. Follow basic policies for cuts, punctures, body mechanics and electrical safety to include mild shocks.2. Report damaged or defective equipment immediately, remove from use and tag "Not For Use".3. Keep traffic areas free of clutter.4. Stabilize equipment and supplies to prevent injury from falling.5. Before using check for damaged electric cords, plugs or receptacles and report immediately. Never use extension cords. Have surge protectors checked for safety and routinely inspected.6. Inservice new equipment and supplies prior to their use and document.7. Know the location of fire exits from the OR. Know location of nearest fire extinguishers and alarms to the OR.8. Know location of emergency equipment.9. Follow procedures for sponge, instrument and needle care and counts.10. Handle specimens, sharps and linens according to established procedure.11. If battery operated equipment is in use, observe the battery condition indicator prior to the patient being brought into the room. If batteries are low, recharge by plugging the equipment into a main outlet. Most equipment may be used while being charged.12. To prevent tipping of OR tables, do not exceed the maximum load specifications provided by the manufacturer. Lock the table.13. Before articulating the table, check the patient and staff are clear of all pinch points.14. Check for currency of biomedical checks on all electrical equipment and outlets.15. Label all medication presented to the sterile table(s).

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16. Clearly identify the full name of the drug when handing off to another staff member.
17. Distinguish monitoring alarms ranges specific to each patient.
18. Check patient's ID, site and procedure with the pre-op nurse, the surgeon, the patient and the pre-operative consent.
19. Assure that any radiographic films are authenticated in the OR by the attending surgeon.
20. Check safety alarms on all infusion pumps.
21. Label dangerous drugs as "dangerous" and store away from other general drugs; e.g., succinylcholine, anectine, concentrated electrolyte solutions.
22. Perform safety checks to determine trace gases are properly eliminated.
23. Safety check all equipment prior to beginning the procedure.
24. Use safety syringes/scalpels/sharps.
25. Use "lay down/pick up" to pass sharps. Do not pass hand to hand.
26. Never lay hot scopes or electro surgical pencils on patient or on paper drapes.
27. Remove flammable agents from the room immediately after use; e.g., alcohol, betadine scrub/paint and let alcohol and/or betadine dry prior to using ESU.

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SUBJECT	SAFETY IN ANESTHESIA
PURPOSE	To ensure the safe administration of anesthetic gases.
SCOPE	All Anesthesia Practitioners
POLICY	Controls shall be established to minimize electrical, fire or explosion hazards in all anesthetizing areas and to maximize safety in anesthesia management.
PROCEDURE	<ol style="list-style-type: none">1. Inspect anesthetizing equipment before each use.2. Use only non-flammable agents.3. Use only fabrics that are flame retardant in the area.4. Plug electrical equipment into receptacles connected to the Line Isolation Monitor.5. Move anesthesia equipment with extreme care.6. Routinely inspect air exchanges and document.7. Perform at least one annual functioning test on lines and machines and document.8. Perform a complete pre-anesthesia assessment and develop a comprehensive anesthesia management plan with the patient.9. Label and secure all dangerous anesthesia drugs.10. Secure all anesthesia cart medications. Never leave syringes containing medications on the top of the cart.11. Label multi-dose syringes. Draw up medications for one patient at a time.12. Do not "tent" patient's face with oxygen being administered unless a scavenger/exhaust system is in place.13. Remove oxygen prior to ESU being used on face or in throat.14. Do not draw drugs up for more than one patient at a time.15. Secure drugs between cases in the anesthesia cart.16. Do not allow "tenting" and oxygen under drapes.17. Ensure the scavenging system for waste gases is in good working order.18. Always receive a "hand-off" communication from the pre-op nurse.19. Participate actively in the "time-out" process20. Provide a complete "hand-off" communication to the recovery nurse.21. Check the patient's IV site regularly during the procedure.22. Check pressure points periodically throughout the patient's procedure.23. Never turn off alarms or turn them down to a dangerously low level.24. Keep distractions to a minimum.

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SUBJECT	SAFETY IN PHARMACEUTICALS
PURPOSE	To identify safe practices in handling and storing pharmaceutical supplies.
SCOPE	Licensed Personnel, Medication Management Nurse
POLICY	<p>All licensed persons handling pharmaceuticals will practice standards as follows:</p> <ol style="list-style-type: none">1. Store disinfectants and drugs for external use separately from oral and injectable medications and solutions.2. Check drug inserts for proper storage requirements.3. Store biological and thermolabile medications in a refrigerator used solely for that purpose and capable of maintaining the required temperature. Check temperature daily. Be aware and monitor drugs needing refrigeration once removed from the refrigerator to ensure they are administered within the acceptable time frame. Check temperature in the drug storage area if it seems too warm or too cold.4. Destroy or return outdated drugs. Maintain Expired Drug Log.5. Destroy drugs in an environmentally safe way.6. Document distribution and administration of controlled drugs.7. Stock emergency drugs in adequate and appropriate supply.8. Lock storage and controlled drug preparation areas.9. Keep intravenous solutions and other solutions classified as a medication—in a secured area/cupboard.10. Flammables, caustics, corrosives and poisons must be so labeled and handled accordingly. These should be stored in secured areas that meet local fire regulations.11. Pour liquids at eye level and check to determine the proper dosage has been poured.12. Identify and secure dangerous drugs and solutions such as succinylcholine, anectine, concentrated electrolytes and anesthetic drugs.13. Store similarly shaped and/or labeled drugs apart from one another.14. Label any drug or solution poured from one container to another with name and dosage.15. Label syringes of medication prepared in advance in readiness for the patient with name and dosage.16. Check orders. If uncertain of dose or unaware of a drug's side-effects, dosages, etc., check the PDR. Notify the physician. If unfamiliar with a drug, check the PDR before administering it.

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17. Know signs and symptoms and observe for adverse reactions. Check patient history and query patient regarding drug allergies before administering any drug.
18. Be aware of time limits on drugs that are time sensitive once pulled up for administration and label syringes with the time limit.
19. Label all multi-dose vials as per that policy.
20. Be aware of all expiration dates. Label drugs and solutions accordingly and check for expirations.
21. Only spike intravenous solutions on the day to be administered and make every effort to use as near the "spike" time as possible.
22. Label intravenous solutions to be administered with your initials, date and time.
23. Never give a drug drawn up by another person.

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SUBJECT	SAFETY IN SUPPORT SERVICES
PURPOSE	To provide effective safety guidelines relevant to the needs of support service employees.
SCOPE	All Support Service Personnel
POLICY	<p>Safety rules, procedures and standards will be applied to support service staff areas as follows:</p> <ul style="list-style-type: none">A. Administrative Offices<ul style="list-style-type: none">1. Furniture will be arranged without hindering traffic flow.2. Floors will be as maintenance-free as possible and will be resistant to slipping. Defective tiles, boards or carpet shall be repaired or replaced immediately. Anti-slip protection will be used on stairs or at elevators as appropriate.3. Aisles will be four (4) feet wide.4. File drawers will not open into aisles.5. Adequate lighting will be provided.6. Duplicating equipment will be properly vented.7. Electrical cords are not stretched across floors.8. Stacks of materials will be stable and secure. If stored on shelves, heavy objects will be on lower shelves.9. Chairs will be steady with at least a 20-inch base.10. Equipment and desks will be examined for burrs and splinters.11. Drawers will have safety stops.12. File drawers:<ul style="list-style-type: none">a. Close with handle. Avoid curling fingers on top of drawer.b. Open one drawer at a time to prevent tipping.c. Warn others when drawers are open.d. Do not climb on drawers.B. Corridors and public areas<ul style="list-style-type: none">1. Glass doors should display an emblem at the level of 4¹/₂ feet (eye level) and should be of safety rather than plate glass.2. Whenever possible, corridor doors shall be equipped with vision panels.

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SUBJECT	SAFETY EDUCATION AND PROMOTION PROGRAM
PURPOSE	To provide Safety Education as an essential component in the Environment of Care Program; to provide for the safety of the staff and the maintenance of a safe environment to be in compliance with required standards of regulatory agencies.
SCOPE	All ASC Staff/Safety and Security Officer
POLICY	<ol style="list-style-type: none">1. All staff (i.e., associates and students) are required to participate in safety education programs as part of new employee orientation and on an annual basis thereafter.2. The Surgery Director is responsible for assuring that the staff participate, to the extent required, in safety education; that they receive safety education and training specific to job related functions and that documentation as to safety education participation is maintained.3. The specific safety education requirements will be detailed by the QA/PI Committee and approved by the Board.4. Facility staff is expected to participate fully in all required safety education programs and training; and to perform their assigned duties in a safe manner; and abide by all rules, policies and procedures; etc., relating to safety.5. Standard forms of documentation will be used to record attendance and content of educational sessions to create continuity in the preservation and presentation of records.
PROCEDURE	<ol style="list-style-type: none">1. The orientation program for new staff members will consist of the following safety related segments:<ol style="list-style-type: none">a. Safety and Security Management Planb. Essential Utility Management Planc. Emergency Preparedness Management Plan (CEMP)d. Life Safety Management Plane. Hazardous Material and Wastef. Medical Equipment2. All documentation regarding safety education and orientation will be maintained in the Medical Staff, Allied Health and Center Staff personnel files and is available for inspection by safety personnel or regulatory agency surveyors. Specific documentation forms to be used are available through Inservice Coordinator.3. Failure by ASC staff to participate in required safety education programs or to perform their job related duties in a safe manner or to abide by facility and department safety policies is grounds for disciplinary action.

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SUBJECT	PRISONERS AS PATIENTS
PURPOSE	To provide maximum safety of all occupants while delivering safe, effective, quality care.
SCOPE	All staff members
POLICY	This organization will, on occasion, admit prisoners for outpatient care. Such prisoners will be accompanied by armed guards throughout their stay.
PROCEDURE	<ol style="list-style-type: none">1. Follow normal process for pre-op assessment through the physicians practice.2. If possible, contact the correctional institution for specific pre-op instructions advising the health care guardian to arrive with the prisoner as near the procedure time as possible.3. Upon arrival escort the guard and the prisoner to a private waiting area, if possible allowing the guard to maintain his/her weapon securely holstered.4. Advise both the guard and prisoner of the sequence of events.5. Follow the procedure for pre-op care with the guard in attendance.6. Transport the patient to the OR, again, with the guard in attendance.7. Advise the guard of safe non-sterile area in the OR and events to occur.8. At the end of the procedure transport the patient escorted by the guard to the recovery area.9. Discharge per protocol in the care of the attending guard.10. Contact the correctional institution within 72 hours for a post-op assessment or collect assessment from the physician's office.

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SUBJECT	RISK OF HARM TO SELF AND/OR OTHERS
PURPOSE	To ensure the safety and welfare of facility patients and anyone they may encounter in the event of a mental health crisis.
SCOPE	All clinical staff
POLICY	Patients who are at risk of harming themselves or others are managed in such a way to prevent the patient from harming themselves and/or others.
PROCEDURE	<ol style="list-style-type: none">1. Once a staff member identifies a patient who may be at risk to himself/herself or others, the staff member will immediately notify the Administrative Director, the contracted social worker and/or the Medical Director.2. Initiate measures to promote the immediate safety and well being of the patient and others in the immediate area (other patients, staff, and community).3. Do not leave the patient unattended until the social worker is consulted and asked to provide a mental health assessment for guidance. When possible, ask the patient to sign a safety contract/agreement to not hurt themselves or others. Make an appropriate referral for mental health treatment and/or transfer arrangements to hospital.4. If patient's behavior becomes unmanageable or the patient leaves the facility against medical advice, call 911 immediately for intercession. <p>Telephone Patient Contact</p> <p>If the patient is on the phone, the receiver of the call will keep said patient on the line while alerting any available staff member to inform the Medical Director and or Administrative Director of the situation. If possible, hand off the telephone to the Medical Director to perform a mental health assessment. Contact 911 if deemed advisable.</p>

**Southwest Medical,
Part of Optum Care**

PATIENT SAFETY PLAN

MARCH 1 2018



Southwest Medical™
Part of OptumCare™

The Southwest Medical Patient Safety committee/team created the plan and revises/updates it annually. Implementation of this plan is intended to optimize healthcare quality and patient safety outcomes, encourage recognition, reporting, and acknowledgment of risks to patient, visitor, and employee safety, and reduce the medical/healthcare errors and /or preventable events

Patient Safety Committee/Program
Southwest Medical, Part of Optum Care
Las Vegas, Nevada

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Commitment to Patient Safety

Southwest Medical is committed to a comprehensive approach to improving healthcare quality and patient safety by aligning with our Mission, Vision, and Values, creating an environment that supports a dynamic, proactive, and safe culture for patients, family members, visitors, and employees, through continuous learning and improving patient safety policies, systems and processes.

Mission, Vision, and Values

In support of our mission, vision and values, Southwest Medical's Patient Safety and Quality Improvement program promotes:

- Collaboration of healthcare, leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high quality healthcare
- Open and honest communication to foster trusting and cooperative relationships among healthcare providers, staff members and patients and their families and to ensure accountability for the patient safety priorities
- Preservation of dignity and value for each patient, family member, employee, and other healthcare providers
- Responsibility for every healthcare related decision and action
- A focus on continuous learning and improving, system design and the management of choices and changes, bringing the best possible outcomes or performances to the facility
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare
- Education of staff and physicians to assure participation of healthcare providers

Plan Scope and Purpose

The scope of the Patient Safety Committee organizational-wide and includes but is not limited to

- Patient safety
- Visitor safety
- Employee safety

The Committee provides oversight for patient safety activities, infection control activities, initiatives to promote patient safety and monitoring and review of medical/healthcare errors/potential errors involving patients, visitors, SMA staff, students and volunteers

All staff members at Southwest Medical are expected to fully support and participate in this plan and devote their expertise, knowledge, vision, skill, and insight to the patient safety and healthcare quality improvement process

Leadership assumes a role in establishing a culture of safety that minimizes hazards and patient harm by focusing on processes of care. The leaders of the organization are responsible for fostering a culture of safety through personal example by:

- Emphasizing patient safety as an organizational priority
- Providing education to medical and facility staff regarding the commitment to reduction of medical errors
- Supporting proactive reduction in medical/health care errors
- Integrating patient safety priorities into the new design and redesign of all relevant organization processes, functions and services

The purpose of the Patient Safety Plan is:

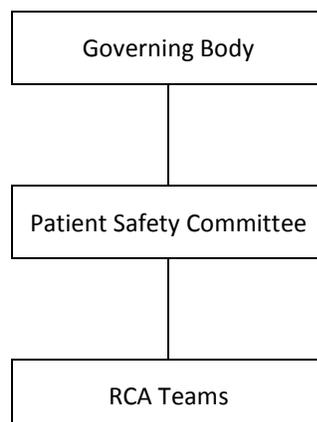
- To address patient safety related concerns and challenges
- To reduce risk
- To respect the dignity of those Southwest Medical serves by assuring a safe environment
- To periodically evaluate and revise the program to better serve patients and their families

Roles and Responsibilities

Southwest Medical created an organization-wide Patient Safety Plan that includes the medical facilities (Surgery Centers) as directed by [NRS 439.875](#) a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plan is promoted and executed successfully

The Southwest Medical Patient Safety Committee

- Is a standing confidential interdisciplinary committee formed to manage the Southwest Medical’s Patient Safety Program and Infection Prevention and Control Program through a systematic, coordinated, continuous approach
- Will meet monthly to assure maintenance and improvement of patient safety with the establishment of plans, processes and mechanisms involved in the provision of the patient care
- Will report and discuss events including:
 - Number of sentinel events from previous calendar quarter
 - Number of severe infections from previous calendar quarter
 - Corrective action plans
 - Corrective action plan evaluation
 - Patient safety policies and checklists
- Will monitor and document the effectiveness of the patient safety policy
- Will evaluate patient safety policies and checklists at least annually
- Will revise patient safety policies and checklists as needed
- Will convene a RCA meeting/team as necessary
- Review the RCA process and quality improvement related activities and timelines
- Identify barriers and technical assistance needs for supporting the RCA efforts
- Discuss corrective action process and activities



Patient Safety Committee Membership

In accordance with [NRS 439.875](#), the Patient Safety Committee will include:

- The Patient Safety Officer
- The Infection Prevention and Employee Health Medical Director

- At least three providers of healthcare who treat patients , including but, without limitation, at least one member of the medical, nursing and pharmaceutical staff
 - Medical Director Specialties
 - Medical Director Primary Care
 - Medical Director On Demand Medicine
 - Medical Director Clinical Education Programs
 - Medical Director Surgery Centers
 - Associate Vice President Surgery Centers (RN and Administrator)
 - Chief Nursing Officer
 - RN Executive Director On-Demand Medicine
 - RN Director Specialties
 - Director Imaging Services
 - Pharmacy Consultant (PharmD)
 - RN Managers Surgery Centers
 - RN Clinical Quality
 - Infection Prevention RN
- One member of the governing body
- Optum Legal
- Vice Presidents Clinic Operations
- UHG Safety Regional Manager

Patient Safety Committee Responsibilities_(based on [NRS 439.875](#) and [NRS 439.877](#))

The Patient Safety Committee is a standing confidential interdisciplinary committee formed that manages the Southwest Medical’s Patient Safety Program and Infection Prevention and Control Program through a systematic, coordinated, continuous approach

- Evaluating and improving the quality of care rendered by Southwest Medical
- Collecting data and evaluating aggregate data related to individual occurrences in order to utilize performance improvement methodologies to promote patient safety and infection prevention
- Maintaining and improving patient safety with the establishment of plans, processes and mechanisms involved in the provision of the patient care
- Monitoring and documenting the effectiveness of the patient identification policy
- On or before July 1 of each year, submitting a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#)
- Receiving reports from the Patient Safety Officer pursuant to [NRS 439.870](#)
- Evaluating actions of the Patient Safety Officer in connection with all reports of potential or actual sentinel events
- Reviewing and evaluating the quality of measures carried out by Southwest Medical to improve the safety of patients who receive treatment
- Reviewing and evaluating the quality of measures carried out by Southwest Medical to prevent and control infections
- Making recommendations to the governing body to reduce the number and severity of sentinel events and infections that occur
- At least once each quarter, reporting to the governing body regarding
 - The number of sentinel events at the medical facility (Surgery Centers) during the preceding calendar quarter
 - The number and severity of infections at the medical facility (Surgery Centers) during the preceding calendar quarter
 - Any recommendations to reduce the number and severity of sentinel events and infections

- Adopting patient safety checklists and patient safety policies as required by [NRS 439.877](#), reviewing checklists and policies annually and revising the checklists and policies as necessary
- Directing root cause analysis teams when indicated
- Providing oversight/direction for Surgery Centers QAPI program and quality studies
- Providing oversight/direction for the Surgery Centers participation in NHSN
- Providing oversight and monitoring for the Optum Practice Health and Safety Clinical Assessment Process

Patient Safety Officer Responsibilities (based on [NRS 439.870](#))

- Chair the Patient Safety Committee
- Supervise the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#)
- Take such action as necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility
- Report to the Patient Safety Committee regarding any action taken in accordance with the responsibilities above
- Promote compliance with patient safety standards and initiatives
- Reinforce expectations of the Patient Safety Plan
- Accept accountability for measurably improving safety and reducing errors
- Liaison with Southwest Medical clinical leadership including surgery center leadership, other quality committees and the Board of Directors

Infection Prevention Officer Responsibilities (based on [NRS 439.873](#))

- Serve on the Patient Safety Committee
- Liaison with Southwest Medical clinical leadership including surgery center leadership, other quality committees and the Board of Directors
- Provide medical direction as indicated (for both patient and employee infection control issues)
- Monitor the occurrences of infections to determine the number and severity of infections
- Report to the Patient Safety Committee concerning the number and severity of infections
- Take such action as necessary to prevent and control infections alleged to have occurred
- Carry out the provisions of the infection control program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program
- Ensure compliance with current infection prevention and control standards
- Direct infection prevention initiatives
- Reinforce expectations of the Infection Control program
- Complete at least four hours of continuing education each year on topics relating to current practices in infection control and prevention
- Be a certified Infection Preventionist or complete a nationally recognized basic training program in infection control

RCA Team/Meeting

Will meet as needed to:

- Define the healthcare issues or potential risks
- Conduct Root Cause Analysis
- Review and analyze data
- Brainstorm issues or the potential risks by using the fishbone diagrams
- Identify the contributing factors
- Develop Corrective Action Plan
- Identify Plan-Do-Check -Act (PDCA) topics

- Discuss and present possible changes in procedure to improve areas indicated
- Identify strengths and areas that need improvement
- Develop strategies, solutions, and next steps

RCA Team Leader Responsibilities

- Organize and coordinate the RCA process
- Assemble and encourage a supportive and proactive team
- Assign investigative and implementation tasks to the team members
- Conduct and be actively involved in the investigation, RCA, and corrective action plan implementation process
- Communicate the progress of the investigation, institutional barriers, and finalized action plan to executive leadership
- Monitor goals and progress towards completion of the Corrective Action Plans
- Provide training, education and direction to create RCA process that incorporate the Patient Safety and Quality Improvement elements

Root Cause Analysis (RCA) Team Responsibilities

- Root cause interviews, analysis, investigation and corrective action plan implementations
- Participate in the RCA meetings and discussions
- Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders

Governing Body Staff Responsibilities

- Provide vision and leadership to Patient Safety and Quality Improvement process
- Develop and foster a safe learning and improving culture
- Provide oversight to healthcare quality improvement processes and teams
- Plan, discuss and generate patient safety goals and activities

Quality Studies -Process Analysis (Surgery Centers)

The Surgery Centers will complete quality studies each year that include:

1. A statement of the purpose of the QI activity that includes a description of the known or suspected problem and explained significance to the SSC
2. Identification of the performance goal against which SSC will compare current performance
3. Description of the data that will be collected in order to determine the SSC's current performance
4. Evidence of Data Collection
5. Data analysis that describes findings about the frequency, severity and source of issue
6. Comparison of the SSC's current performance against identified performance goal
7. Implementation of corrective action
8. Re-measurement to objectively determine whether corrective actions achieved and sustained improvement
9. Implementation of any additional corrective action to achieve and/or sustain improved performance (and plan for on-going re-measurement)
10. Communication of findings to SSC Leadership, The Patient Safety Committee, the Board of Directors and SSC staff and incorporating findings into educational activities

For quality studies, the Surgery Center(s) may base topic selection on information published by accrediting bodies, National Patient Safety Goals and/or other sources of information including risk management, performance improvement, quality assurance, infection prevention and control, patient/family suggestions/expectations or process outcomes

The Surgery Centers quality studies will focus on redesign or implementation of new processes to incorporate patient safety principles and will place an emphasis on the important facility and patient care functions of:

- Rights of Patients
- Governance
- Administration
- Quality of Care
- Quality Management and Improvement
- Clinical Records and Health Information
- Infection Prevention and Control and Safety
- Facilities and Environment
- Anesthesia Services
- Surgical and Related Services
- Pharmaceutical Services
- Pathology and Medical Laboratory Services
- Diagnostic and Other Imaging Services

Infection Prevention Program

- The purpose of the Infection Control Programs is to prevent and control infections
- The Infection Control Program and the surgery Centers Infection Control Program (SSC and SCT 1600-3 Infection Control Program for Southwest Medical Surgery Center) are components of the Patient Safety Plan
- The Infection Control Programs are based on current guidelines developed by nationally recognized infection control organizations
- The Infection Control Professionals will report regularly on the number and severity of infections that occurred in the prior quarter

Infection Prevention RN

Southwest Medical will maintain at least one Registered Nurse with training and education in infection prevention and control. While supporting the entire organization, the Infection Prevention RN will dedicate specific hours to the SSC

NHSN

- The medical facilities (Surgery Centers) will participate in the CDC's National Healthcare Surveillance Network
- Infection Prevention staff will report aggregate data and patient follow-up to the Patient Safety Committee at regularly scheduled intervals

Medical/Health Care Error

- Staff will immediately report the event to supervisor

The supervisor will:

- Immediately communicate the event through appropriate channels to the Patient Safety Officer; should this occur during off-hours, the supervisor/designee will leave a voice mail message for the Patient Safety Officer
- Initiate investigation and follow-up actions
- Staff will complete the Incident/Occurrence Report or Quality of Care form
- Staff will obtain required orders to support the patient's clinical condition
- Staff/supervisor will notify the UHG Safety Liaison of any situations of potential risk to others
- The Patient Safety Officer will follow usual protocols to investigate the error and coordinate the factual information/investigation for presentation, review and action by the Patient Safety Committee and/or other quality committees as applicable

Identification and Reporting

- SMA Policy # 1600-29 (Sentinel Event Policy) and SMA Policy 190-4 (Incident Occurrence Reporting Policy) will describe the mechanism for identification and reporting a Sentinel Event/other medical error
- Southwest Medical will promote willingness of staff to report and will support a Just Culture that focuses on process not individuals

Root Cause Analysis

- The Patient Safety Committee/Patient Safety Officer will provide oversight and direction for any root cause analysis of facility processes conducted for either Sentinel Events or near miss events
- The Patient Safety Officer will act as the liaison to quality committees and the Board of Directors for review/recommendations

Staff Involvement

As Southwest Medical actively supports the concept that errors occur due to a breakdown in systems and processes, staff involved in an event with an adverse outcome will be supported by:

- A non-punitive approach and without fear of reprisal
- Voluntary participation in the root-cause analysis for educational purposes and prevention of further occurrences

Reporting Requirements/Sentinel Event Reporting

- The Patient Safety Officer will report sentinel events to the Patient Safety Committee
- The Patient Safety Officer will direct reporting of any sentinel event at a medical facility per state of Nevada requirements as defined in NRS (Nevada Revised Statutes) and NAC (Nevada Administrative Code)
- The Patient Safety Officer will report the number of sentinel events and recommendations to reduce the number or severity of sentinel events to the SMA Board of Directors
- The Patient Safety Officer/Committee will provide education and support to providers to ensure providers report the occurrence of a sentinel event resulting from any surgery to the Board within fourteen days after the occurrence of the sentinel event
- The Patient Safety Committee shall evaluate the actions of the Patient Safety Officer in connection with the reporting of sentinel events
- The Patient Safety Committee shall make recommendations to the SMA Board of Directors to reduce the number and severity of sentinel events and infections that occur at the facility

HealthCare Acquired Infections (HAI) Reporting

The Patient Safety Officer/Committee will provide education and support to providers to ensure if a provider identifies a patient with an infection, the provider will notify, within five days or as soon as practicable, the patient or the legal guardian or other person authorized by the patient to receive such information that the patient has an infection

The Patient Safety Officer/Committee will provide education and support to providers so that providers understand the notification may be delayed if the patient does not have a legal guardian, has not authorized any other person to receive such information and:

- Is not capable of understanding the information
- Is not conscious
- In the provider's judgment, the notification is likely to result in the patient harming himself

The Patient Safety Officer/Committee will provide education and support to providers so that providers understand if the notification is delayed, the information must be provided as soon as practicable after:

- The patient is capable of understanding the information

- The patient regains consciousness
- In the judgment of the provider, the patient is not likely to harm himself if informed about the infection
- A legal guardian or other person authorized to receive such information is available

Internal Reporting

The Patient Safety Committee will report internally to provide a comprehensive view of both the clinical and operational safety activity of the organization by submitting Patient Safety Committee minutes/reports to the SMA Board of Directors

The Patient Safety Committee will include ongoing activities such as data collection and analysis, actions taken and monitoring for the effectiveness of actions

External Reporting

The Patient Safety Committee will report externally in accordance with all state, federal and regulatory body rules, regulations and requirements.

- On or before March 1 of each year, The Patient Safety Committee will submit an annual sentinel event report to the Office of Public Health Informatics and Epidemiology, Bureau of Health Statistics, Planning, Epidemiology and Response, Nevada State Health Division
- The Surgery Centers will participate in the CDC National Healthcare Surveillance Network per State of Nevada NRS and NAC

Annual Report

The Patient Safety Officer will report to the SMA Board of Directors and will include:

- Defining the scope of occurrences including sentinel events, near misses and serious occurrences
- Demonstrating a pro-active component of the patient safety program through selection of high risk or problem prone processes for ongoing measurement and analysis
- Reporting results ongoing measurement and analysis of the high-risk or error-prone processes
- Describing how the function of process design incorporates patient safety using specific examples of process design or redesign that include patient safety principles
- Describing the process for soliciting and obtaining input for improving patient safety from patient/families
- Describing staff willingness to report medical/health care errors
- Describing the procedures for communication with patients/families about adverse events or unanticipated outcomes of care
- Describing examples of ongoing in-service, education and training programs to maintain and improve staff competence and support an interdisciplinary approach to patient care

Medical Facility (Surgery Centers) Reporting Requirements

The Patient Safety Officer/Committee will report to the appropriate licensing Board, within five days, after a change in the privileges of a physician, perfusionist, physician assistant or practitioner of respiratory care that is based on:

- An investigation of the mental, medical or psychological competency of the physician, perfusionist, physician assistant or practitioner of respiratory care
- Suspected or alleged substance abuse in any form by a physician, perfusionist, physician assistant or practitioner of respiratory care

Public Disclosure

The Surgery Centers will provide the name of each physician who performed a surgical procedure at the Surgery Centers, the total number of surgical procedures performed by the physician, reported by type of medical treatment, principal diagnosis, if the information is available, by principle surgical procedure and secondary surgical procedure (SB340)

Objectives Patient Safety Plan

Objective
Encourage organizational learning about medical/health care errors
Incorporate recognition of patient safety as an integral job responsibility
Include patient safety into job specific competencies
Encourage recognition and reporting of medical/health care errors and risks to patient safety without judgment or placement of blame
Involve patients in decisions about their health care and promote open communication about medical errors/consequences which occur
Collect and analyze data, evaluate care processes for opportunities to reduce risk and initiate actions
Report internally what has been found and the actions taken with a focus on processes and systems to reduce risk
Support sharing of knowledge to effect behavioral changes in and within SMA

Components and Methods

Pursuant to [NRS 439.837](#), a medical facility shall, upon reporting a sentinel event pursuant to [NRS 439.835](#), conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event.”

Southwest Medical will use RCA process to determine the contributing factors and the underlying reasons for the deficiencies or failures. Southwest Medical will use the Plan-Do-Study (check)-Act (PDSA or PDCA) model, developed by the Institute of Health Care Improvement, to test changes



Root Cause Analysis

- A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals
- Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis
- Root Cause Analysis and action plan framework table was introduced by the Joint Commission. It contains 24 analysis questions. It guides the organization to the steps in a root cause analysis. Not all the questions apply to all the events or cases. This table can be used individually or with the fishbone diagram.

5 Whys technique will be used at Southwest Medical to explore the cause and effect relationship underlay a problem. One can find the root causes by asking “why” no less than five times. This technique can be used individually or as a part of the fishbone diagram.

Fishbone Diagram

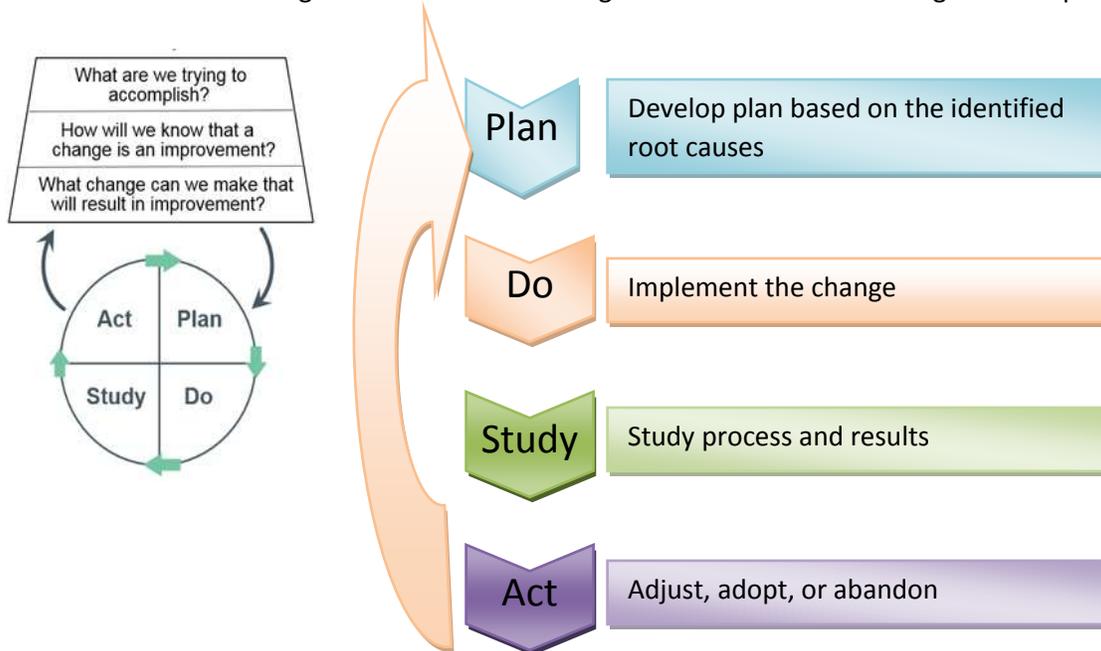
Once the problems are identified, a Fishbone Diagram can be used for analyzing the problems. Southwest Medical can use the fishbone diagram individually to analyze the root causes or can use it with the Root Cause Analysis and action plan framework table

A Fishbone Diagram, also called a Cause-and-Effect diagram, is a useful tool for a team to structurally brainstorm by discovering possible underlying factors or root causes from different major categories for the chosen problems. General categories include: people, methods, materials, measurements, education, procedures, process, location and environment.

RCA team members will brainstorm and ask multiple times, “why did this happen?” for each cause until all ideas are exhausted. The highest priority root causes will be chosen for PDSA topics. Once all the categories are established on the fishbone diagram, 5 Why’s technique also can be used to drill down the problem and find the root causes

Model for Improvement

The Model for Improvement is a collaborative and ongoing effort model to improve the product and services quality and process. It provides multi-disciplinary quality team guidance from identifying the root causes; conducting the best tests to assess possible changes, and working in collaboration for implementation of the new approaches and solutions. It guides the test of a change to determine if the change is an improvement.



The cycle is defined as follows:

- Plan--collect data and establish appropriate goals. Identify the problem and the possible root causes, and answer the following questions:
- Do--make changes designed to correct or improve the situation. Use the following questions for the guidance:
- Study -- Study the effect of the changes on the situation. Data should be collected on the new process and compared to the baseline or expected results. Results should be evaluated and by using the following questions as guidance:
- Act--If the result is successful or desirable, standardize the changes and then work on the next prioritized problem or the further improvements. If the outcome is not yet successful, look for different ways to identify the causes or change the testing process.

Data Collection and Reporting

Data should drive any quality and patient safety effort. Southwest Medical will track sentinel events, healthcare infection data and other internal data collection

External data sources are those data sources which are collected outside the supervisory structure of the case. Southwest Medical may use external data from:

- AHRQ: Agency for Healthcare Research & Quality
- CDC: Centers for Disease Control and Prevention
- CMS: Centers for Medicare & Medicaid Services
- NQF: National Quality Forum
- NHSN: National Healthcare Safety Network
- TJC: The Joint Commission

Ongoing Reporting and Review

The Patient safety committee will review Elements of the Patient Safety Plan at scheduled intervals

Monthly	Quarterly	Annually
<ol style="list-style-type: none"> 1. Sentinel event monthly report 2. Severity of infection report 3. RCA assessment 4. Optum Practice Health and Safety Clinical Compliance and Infection Prevention Clinic Assessments 	<ol style="list-style-type: none"> 1. Incidents-including sentinel event quarterly report 2. Severity of infection report 3. Review and evaluate the measure of improvement of patient safety 4. Review and evaluate the measurement to prevent and control infections 5. Quality reports including: <ul style="list-style-type: none"> • Environment of Care Standards • GI Staff Performance and HLD • Hand Hygiene • Infection Prevention • Sterilization • Pharmacy Standards 	<ol style="list-style-type: none"> 1. Quality and Patient Safety Plan update 2. Checklists and Policies reviewing and revising

Assessment of the Quality and Patient Safety Plan

Southwest Medical will review and evaluate the Patient Safety Plan at least annually

Patient Safety Checklists and Patient Safety Policies

By [NRS 439.865](#), the Patient Safety Plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility
- Other personnel of the facility who provide treatment or assistance to patients
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, environmental services at any medical facility
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients

The patient safety checklists must follow protocols to improve the health outcomes of patients at the medical facility and must include, without limitation:

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare
- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary
- A checklist used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - Proper instructions concerning prescription medications
 - Instructions concerning aftercare
 - Any other instructions concerning his or her care upon discharge
 - Any other checklists which may be appropriate to ensure the safety of patients at the facility

The patient safety policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. The policy will require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers are full patient name and date of birth
- A policy regarding the nationally recognized standard precautionary protocols utilized by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene
- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials

Based on [NRS 439.865](#), the patient safety plan must also include an infection control program that carries out the infection control policy. The policy must consist of:

- The current guidelines appropriate for the facility's scope of service developed by a nationally recognized infection control organization as approved by the State Board of Health which may include, the Association for Professionals in Infection Control and Epidemiology (APIC), the Centers for Disease Control and

Prevention (CDC), the World Health Organization (WHO) and the Society for Healthcare Epidemiology of America (SHEA)

- Facility-specific infection control developed under the supervision of a certified Infection Preventionist

Approval of Patient Safety Plan

According to [NRS 439.865](#), Southwest Medical will submit its Patient Safety Plan to the Governing Board for approval. After the patient safety plan is approved, Southwest Medical will notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan

Southwest Medical will review and update the plan annually in accordance with State of Nevada requirements

Southwest Medical, according to [NRS 439.843](#), will submit the most current copy of the Patient Safety Plan on or before March 1 of each year, to the Division of Public and Behavioral Health

References

- Root Cause Analysis Toolkit <http://www.health.state.mn.us/patientsafety/toolkit/>
- Quality and Service Improvement Tools http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html
- CQI 101 An Introduction to Continuous Quality Improvement: <https://www.coursehero.com/file/13827355/CQI-Overviewppt/>
- Quality Improvement <http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/>
- Root Cause Analysis <http://www.patientsafety.va.gov/professionals/onthejob/rca.asp>
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2 https://www.jointcommission.org/sentinel_event.aspx
- Hospital Policies <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>
- Checklists to Improve Patient Safety http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf
- Patient Safety Checklists <http://www.who.int/patientsafety/implementation/checklists/en/>
- Minutes of the Meeting of the Quality and Patient Safety Committee <http://www.cookcountyhhs.org/wp-content/uploads/2013/12/09-23-14-QPS-scan-Minutes.pdf>
- Title 40 – Public Health and Safety <https://www.leg.state.nv.us/NRS/NRS-439.html>

Terms and Definitions

Patient Safety

The Agency for Healthcare Research Quality (AHRQ) defines patient safety as “a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.”

http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

Sentinel event (NRS 439.830)

1. Except as otherwise provided in subsection 2, “sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum
2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:
 - January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or
 - July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published
3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist

(Added to NRS by [2002 Special Session, 13](#); A [2005, 599](#); [2013, 217](#))

Medical Harm

The Institute for Healthcare Improvement (IHI) defines medical harm as “unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death.”

Facility-Associated Infection: (NRS 439.802)

“Facility-acquired infection” means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections
- Ventilator-associated pneumonia
- Central line-related bloodstream infections
- Urinary tract infections
- Other categories of infections as may be established by the State Board of Health by regulation pursuant to [NRS 439.890](#)

(Added to NRS by [2005, 599](#); A [2009, 553](#))

Medical Facility (NRS 439.805)

“Medical facility” means:

- A hospital, as that term is defined in [NRS 449.012](#) and [449.0151](#);
- An obstetric center, as that term is defined in [NRS 449.0151](#) and [449.0155](#);
- A surgical center for ambulatory patients, as that term is defined in [NRS 449.0151](#) and [449.019](#); and
- An independent center for emergency medical care, as that term is defined in [NRS 449.013](#) and [449.0151](#).

(Added to NRS by [2002 Special Session, 13](#))

Near Miss

An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update)

Mandatory Reporting

Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985;254(6):796-800.)

Risk

Risk is the possibility of loss or injury. (Merriam-Webster's Online Dictionary, Risk, Available at <http://www.merriamwebster.com/dictionary/risk>. Last Accessed August 2009.)

Preventable Event

Preventable event describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Catheter Associated Urinary Tract Infections (CAUTI)

A CAUTI is a urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CURRENT_b.pdf.)

Central Line Associated Bloodstream Infections (CLABSI)

A CLABSI is a primary bloodstream infection that is associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection

	Subject: Patient Safety Program and Plan	
	Date of Origin: 12/20/2017	POLICY NO: 15.027
	Revision Date:	
	Department: Safety	
	Medical Director:	
Page 1 of 8	Chief Nursing Officer:	
	Administrator:	

PURPOSE:

It is the intent of the Patient Safety Program to create a culture that values safety, disclosure of errors, and process improvement. The program will provide for a nonpunitive process that encourages the reporting of medical errors, the use of quality and system analysis to identify, analyze, and design measures to prevent patient safety events from occurring, the creation of knowledge from accident learning, and the sharing of the knowledge to improve patient safety.

Policy:

The Patient Safety Program shall be organization wide and shall apply to all department and services of the hospital. The types of events to be addressed will be patient occurrences ranging from “no-harm” to “near misses” to sentinel events.

Mission, Vision, Values

Sana Behavioral Healthcare Hospital (SBH) is dedicated to meeting the health care needs of its community and region. SBH will work with its medical staff to provide a continuum of high quality health care and life enhancement services.

In carrying out its mission, SBH will emphasize personalized, patient centered care, manage its human and financial resources in a professional, prudent, and just manner: seek to be an early adopter of new, proven technology; explore and develop innovative approaches to health care delivery; conduct appropriate educational programs for staff and community; and nurture its tradition of values and caring.

Vision

It is our belief that if people are willing to invest in therapy and commit to learning new coping skills, the Program will be of proportionate benefit to the people we serve. SBH is created specially to help the geriatric population of Las Vegas and surrounding areas live healthier and happier lives and maintain a positive balance regarding mental health needs.

Our Program’s Values

In all that we do, to all whom we serve, we promise caring and compassion, dignity and respect, responsiveness and courtesy, and we will strive for excellence, consistent with the values on which this Hospital was founded

SCOPE:

The types of occurrences to be addressed include, but are not limited to, sentinel events, near misses, and actual events related to:

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- a) Patient safety
- b) Adverse drug events (medication errors and adverse drug reactions)
- c) Health acquired infections
- d) Patient falls
- e) Restraints / seclusion
- 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)
 The Joint Commission (TJC)
 Institute for Healthcare Improvement (IHI)
 Institute for Safe Medication Practices (ISMP)
 Occupational Safety and Health Administration (OSHA)
 Nevada State Health Division
 Published literature

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DEFINITIONS

- **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.
- **Failure Mode Effect Analysis (FMEA):** A systematic way of examining a process to eliminate the possibility of failure before it harms, or minimize the consequences of the failure.
- **Medical Accident:** An unintended event in the system of care with actual or potentially negative consequences to the patient.
- **Near-Miss Medical Accident:** An event that would have constituted a medical accident but that was intercepted at the point of patient care service before it actually reached the patient.
- **Patient Safety:** Freedom from injury while receiving health care services.
- **Patient Safety Event:** Any identified defect, error, medical accident, near-miss medical accident, sentinel event, medication error, significant procedural variance, or other threat to safety that could result in patient injury.
- **Proactive Risk Assessment:** Evaluation of institutional policies and practices against accepted standards of care.
- **Root Cause Analysis(RCA):** A process for identifying the basic or casual factors 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. This includes any process variation from which a recurrence carries a significant chance of a serious adverse outcome.

Responsibility:

A. **Board of Trustees:** The authority for the Patient Safety Plan rests with the Hospital Board of Trustees. The Board of Trustees delegates the authority to implement and maintain the activities described herein to the Chief Executive Officer (CEO) of the hospital.

B. **Quality Assurance/Risk Management Board Committee:** Is responsible for reviewing and approving patient safety issues.

C. **Hospital Quality Committee:** This is the hospital oversight committee. The Patient Safety Committee is chartered by the hospital Quality Committee.

D. **Medical Executive Committee (MEC):** The MEC will advise and consult on matters relative to patient safety.

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E. **Patient Safety Committee:** Is responsible for implementation of the Patient Safety Plan. The committee membership includes Quality Officer, Medical Staff Director, Chief Nursing Officer, Chief Executive Officer, Risk Manager, Director of Pharmacy, Safety Officer and Infection Preventionist. Other individuals will be invited to attend the meetings on an as needed basis.

F. **Chief Executive Officer:** The CEO of the hospital, through the management and administrative staff, will support ongoing efforts to identify risks to patient safety and reduce the likelihood of injury.

G. **Risk Manager:** The Risk Manager will oversee the activities of the Patient Safety Program, gather information from organizational experience, and identify, coordinate, and resolve issues related to patient safety.

H. **Directors and Managers:** Will be responsible for correcting work conditions, processed, and procedures that increase the chance a patient will be harmed; ensure that employees under their direction received relevant information and education concerning the Patient Safety Program; ensure prompt reporting of events or situations of actual or potential patient harm; and promote a climate of nonpunitive error reporting and continuous patient safety improvement.

STRUCTURE

The authority for the Patient Safety Plan rests with the CEO, CNO, Quality Improvement Coordinator, Patient Safety Officer, and Medical Chief of Staff and has delegate the authority to implement and maintain activities described in this plan to the Safety Committee.

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 and Safety Committees. Per Nevada Revised Statute (NRS49.265) that protects all quality work documents, these must be labeled as a Quality Review document. This protects any attempt to acquire Quality Review documents during the discovery phase. All documents will be marked "PSWP".

Reporting of Patient Safety Events

Nonpunitive Reporting Policy

The hospital recognizes that if we are to succeed in creating a safe environment for our patients, we must create an environment in which it is safe for caregivers to report and learn from errors. For hospital wide safety improvements to occur, events must be reported, analyzed, and lessons learned must be broadly communicated. The hospital will promote openness and require that mistakes be reported, while ensuring that reported mistakes are handled without a threat of punitive action.

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- The hospital recognizes that most clinical incidents are due to a failure of systems. Our goal is to identify and track errors in order to continuously improve the system.
- All incidents, particularly clinical errors, need to be reported, with the desire that systemwide improvements, rather than individual disciplinary action, will occur. Initiation of additional education and training for individuals may be warranted. This policy will not protect individuals who consistently fail to participate in the detection, reporting, and remedies to prevent errors, nor will it protect individuals where there is reason to believe criminal activity or criminal intent may be involved. Employees who knowingly fail to report a clinical error will be subject to disciplinary action in accordance with existing hospital policies.

Event Reporting

Employees and professional staff members are required to report any defect, error, medical accident, near-miss medical accident, event, significant procedural variance, other risk to safety that could result in patient injury, hazardous condition, or risk in the environment of care.

A Patient Safety Event form should be completed and submitted to the Risk Manager in accordance with the policy on the patient safety event reporting. The area manager is responsible for ensuring completion of the patient safety event form. Any manager receiving a report of a possible sentinel event or near-miss sentinel event will ensure that the Risk Manager and the Department Director are promptly notified to determine the status of the event.

- The employee(s) and professional staff and manager(s) involved in an event or accident will take immediate action to ensure safety of the patient, staff, and others in the environment. Preservation of all items involved in the incident will be undertaken. If an immediate procedural change is determined to be necessary, the involved manager(s) and professional staff members will work with Risk Management to communicate a safety alert and immediate changes that might be required.
- When an event or accident has occurred with significant consequences for the patient, appropriate support from within the hospital should be mobilized in a coordinated fashion to assist the patient, family, and the caregiver.
- When a sentinel event or an outcome occurs that differs significantly from the anticipated outcome, the patient, and when appropriate, his or her family should be informed. This fact-based disclosure should occur as soon as reasonably possible after consultation with the physician.
- Disclosure should, in most instances, be handled by the physician who has responsibility for overall care of the patient.

Proactive Risk Assessment

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Leaders will provide direction and resources to conduct the following proactive activities to reduce risk to patients.

- At least annually, select one high-risk process for proactive risk assessment; such selection to be based, in part, on information published periodically by the Joint Commission that identifies the most frequently occurring types of sentinel events and patient safety risk factors.
- Assess the intended and actual implementation of the process to identify the steps in the process where there is, or may be, undesirable variation (what engineers call potential “failure modes”).
- For each “failure mode” identify the possible effects on patients (what engineers call the effect”), and how serious the possible effects on the patient would be (what engineers call the “criticality” of the effect).
- For the most critical effects, conduct an analysis to determine why the variation (the 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.
- Implement a strategy for maintaining the effectiveness of the redesigned process over time.

New Process Design

Whenever a process, function, or service is designed or redesigned, a guiding document for planning, implementing, and evaluating the program must be utilized. Questions on this guide should address these critical elements: the mission and values of the hospital, the needs of the community, and whether the program is clinically sound, is based on sound business practices and is designed to meet performance expectations. A variety of information sources from within and outside the organization about the potential risks to patient’s safety, including the occurrence of sentinel events and sentinel event alerts, are considered to minimize risks to patients affected by the new or redesigned process, function, or service. Analysis and/or pilot testing may occur prior to widespread implementation to determine whether the proposed design or redesign is an improvement.

Performance Improvement/Patient Safety/Risk Management Operational Linkage

There is an operational linkage between performance improvement, patient safety, and risk management functions to facilitate identification, follow-up, and corrective action or prevention of potential problems or needs in patient care and safety, and visitor untoward events. The same data

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sources are utilized, such as Quality Screens and Occurrence Reporting, as well as the same peer-review process to assess individual occurrences and process problems and trends.

Data Collection and Assessment

The goal of data collection and risk assessments are to compile data about error frequency and type to identify and reduce the likelihood of patient incidents or negative experiences, which have the potential to result in injury, accident, or other loss to patients.

Evaluation of collected data will be promptly undertaken to monitor and identify levels of performance, trends or patterns that vary significantly from what is expected, and the need for possible change or improvement in systems or processes. This evaluation will occur as part of the peer-review process by established work teams.

When undesirable variations are identified, the hospital will use appropriate resources and involve those individuals, disciplines, and department or services closest to the process for improvement initiatives. There will be a specific set of actions generated through the analysis process, including recommendations for process redesign and communication plan for lessons learned that will be disseminated throughout the organization.

Education / Communication

The organization will disseminate internally and externally generated data and information to health care workers to ensure that the lessons are communicated and utilized to reduce the risk of patient error.

When possible, de-identified (absent any identifiers such as names) case study will be produced to communicate lessons learned.

Information on the Patient Safety Program will be included in employee orientation. Education in the form of a refresher course (relative to patient safety) is mandatory for all staff on an annual basis.

PROGRAM EVALUATION

The Patient Safety Officer will submit a monthly report to the Safety Committee, Medical Staff and The Board of Trustees.

1. Definition of the scope of occurrences including sentinel events, near misses and serious occurrences, that occurred at Sana Behavioral Healthcare during the preceding month:
 - Employee injuries
 - Potential lawsuits
 - Resolutions

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- Recommendations to the decrease of the number and severity of Sentinel Events

Annual Evaluation

Annual appraisal of the Patient Safety Program will address the effectiveness of the program in:

- Improving quality of care to patients and improving outcomes
- Identifying risks
- Resolving problems
- Reducing liabilities
- Achieving liabilities

The written plan may be modified at any time with the approval of the Hospital Quality Committee and the Board of Trustees

PRECISION SURGERY CENTER

Chapter Name: 7 - Infection Prevention and Control and Safety	Policy#: 7.35	AAAHC Standard: 2I-H.18, 5II-B, 7II-A, 7II-B
Title: Safety Program and Safety Officer	Date: 04/2017 Rev.05/18	Medicare CfC:

Policy Statement

It is a goal of the Precision Surgery Center to insure that every employee is provided safe and healthful working conditions free from recognized hazards.

The Precision Surgery Center will maintain a comprehensive safety / environmental control program relative to safety and sanitation that involves staff, equipment operation, and maintenance in order to provide a functional and environmentally safe atmosphere for patients, personnel, and visitors.

The Governing Board has adopted the following policy.

Safety Officer

The Board has designated Ada Ezeanolue, Director of Nursing and Zar Quassani, Assistant Administrator, as the center's designated safety officer.

Refer to policy # 2.12, Appointment of Administrative Officers.

Responsibilities of Safety Officer:

1. Conduct the following drills:
 - a. Fire and Evacuation, Quarterly
 - b. Cardiopulmonary resuscitation (CPR) technique drill, Annually
 - c. Malignant Hyperthermia (if applicable), Annually
 - d. One disaster plan drill such as bomb threat, tornado etc., Annually
2. Document all fire drills and report to Safety Committee and QI Management Committee.
3. Counsel staff on any fire drill errors.
4. In the event of a real fire situation, the Fire Marshall shall coordinate the efforts of all personnel until the Fire Department arrives.
5. Ensure that all members of the Fire/Disaster Team are trained and can fulfill the role of the Fire Marshall if necessary.
6. Assures that halls and doorways are clear of obstruction.
7. Document function of all exit lights monthly on the FIRE SAFETY MONITOR.
8. Check fire extinguishers monthly and document on the FIRE SAFETY MONITOR.
9. Check emergency generator and fuel level monthly and document on the FIRESAFETY MONITOR.
10. Check vacuum pump and oil level monthly and document on the FIRE SAFETY MONITOR.
11. Arrange for the following annual checks and document on the FIRE SAFETY MONITOR:
 - a. Fire extinguisher, sprinkler, and smoke alarm checks.
 - b. Preventive maintenance on emergency generator and vacuum pump.

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All employees will participate in implementing the safety and environmental control program of the Outpatient Surgery Center ("Center").

1. All employees will collaborate with the Safety Officer as needs are identified.
2. There will be an annual group meeting to address safety issues.
3. The Safety Officer will be responsible for conducting the business of the Safety meeting.
4. All employees are expected to:
 - a. Implement and review policies and procedures concerning functional safety and environmental control annually.
 - b. Maintain communication with the Safety and Infection Control Officers.
 - c. Participate in the conduction of hazard surveillance including all accidents or near accidents.
 - d. Investigate all accidents and evaluate findings and recommend action. Follow up is essential to make certain that corrective action has been implemented and is appropriate.
 - e. Participate in the in-service education and orientation program as they apply to new and existing employees.
 - f. Be familiar with community safety oriented agencies, especially those involved with fire and other disasters.
5. Findings of the safety meeting and recommended action will be reported to the Quality Management Committee.

I. STAFF RESPONSIBILITIES

- A. Management – In effectively executing their safety responsibilities, Management will:
 1. Familiarize them with the safety program and ensure its effective implementation.
 2. Be aware of all safety considerations when introducing a new process, procedure, machine, or material to the workplace.
 3. Give maximum support to all programs and committees whose function is to promote safety and health.
 4. Review serious accidents to ensure that proper reports are completed and appropriate action is taken to prevent repetition.
- B. Supervisors – Supervisors' responsibilities are to:
 1. Familiarize themselves with the Surgery Center's safety policies, programs and procedures.
 2. Provide complete safety training to employees prior to the assignment of duties.
 3. Consistently and fairly enforce all safety rules.
 4. Investigate injuries to determine cause, then take action to prevent repetition.
 5. See that all injuries, no matter how minor, are treated immediately and referred to the Administrator and/or Director of Nursing to ensure prompt reporting to the insurance carrier.
 6. Inspect work areas often to detect unsafe conditions and work practices.
- C. Employees – All Surgery Center employees shall:
 1. Adhere to all safety rules and regulations.
 2. Wear appropriate safety equipment as required.
 3. Maintain equipment in good condition, with all safety guards in place when in operation.
 4. Report all injuries, no matter how minor, immediately to a supervisor.
 5. Encourage co-workers to work safely.
 6. Report unsafe acts and conditions to a supervisor.

II. SURGERY CENTER SAFETY RULES

- A. All injuries, no matter how slight, *must be reported at once* to your immediate supervisor.

PRECISION SURGERY CENTER

- B. Defective equipment and unsafe conditions and practices must be reported to your supervisor as soon as possible.
- C. All electrical or mechanical equipment must be shut down when it becomes necessary to make repairs or adjustments.
- D. Do not tamper with electrical or mechanical equipment. Adjustments or repairs of electrical equipment will not be permitted, except by authorized persons.
- E. Where safety guards are provided on equipment, guards must be in place before operating equipment.
- F. Wear proper eye protection, if required.
- G. "Horse play" in the Center is prohibited.
- H. Avoid lifting objects that may be too heavy for you. Get help if needed.
- I. Special equipment or instruments must be used only as designated by supervisors and may not be taken off Center property for personal use.
- J. Loose clothing must not be worn around mechanical equipment.
- K. Equipment must be maintained in a satisfactory working condition.
- L. Equipment and supplies must always be stored in a careful manner.
- M. Aisles, storage space and work areas must be clear and clean. You are responsible for your own work area. It is dangerous to leave supplies or equipment in aisles or doorways.
- N. It is mandatory that all employees wear sturdy shoes with proper soles and or heels. Rubber soled shoes are preferable for safety reasons.
- O. Know location of safety and fire protection equipment.
- P. When handling hazardous materials, follow prescribed Safety Procedures and use required safety equipment. When using secondary containers filled by others, ensure that they are labeled as to their contents and hazards.
- Q. Unnecessary and excessive haste is the cause of many accidents. Exercise caution at all times. WALK, DON'T RUN!!

Your cooperation is requested in making the Surgery Center a safer place to work. You should feel free at all times to call the attention of your supervisor to conditions and unsafe practices which may cause injury. The Center will make every effort to eliminate mechanical and physical hazards, but it is up to you to protect yourself and others by developing and maintaining safe work habits. Learn your job thoroughly. The more you know about your job, the more safely you can perform it. Violation of safety rules may be subject to disciplinary action up to and including discharge.

III. HAZARD COMMUNICATION

- A. Hazard Evaluation - Chemical manufacturers and importers are required to review the available scientific evidence concerning the hazards of the chemicals they produce, then report that information to employers who purchase their product. In most cases, the Surgery Center will choose to rely on the evaluations performed by our suppliers. If we have cause to distrust the evaluation of a particular manufacturer, we will arrange for additional testing.
- B. Labels and Other Forms of Warning
 - 1. We will ensure that containers are adequately labeled to identify the hazardous chemicals contained therein, and will show hazard warnings appropriate for employee protection. The warnings will employ a combination of words, pictures and symbols which convey the hazards of the chemical(s) in the container. The labels will be legible and prominently displayed.
 - 2. Exceptions to this rule are as follows:
 - a) We are permitted to post signs which convey the hazard information when there are a number of stationary containers in a given area with similar contents and hazards.
 - b) We are not required to label portable containers, as long as the transferred chemical is for immediate use by the employee who made the transfer.

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3. Our employee-training program will include instruction on how to read and interpret label information.

IV. SAFETY DATA SHEETS (SDS)

- A. The Surgery Center management is responsible for obtaining or developing a SDS for each chemical used in the workplace. Each SDS includes the specific chemical identity of the chemical involved and the common names. Each data sheet will provide information on the physical and chemical characteristics of the chemical; known acute and chronic health effects and related health information; exposure limits; whether the chemical is considered to be a carcinogen; precautionary measures; emergency and first aid procedures; and the identification of the organization responsible for preparing the sheet.
- B. Our employee-training program will include instruction on how to read and interpret information on an SDS, and how employees can obtain and use the available hazard information.

V. EMPLOYEE TRAINING

- A. The Surgery Center's goal is to provide hazard communication upon initial orientation and whenever a new chemical is introduced to a given work area annually. Training will be conducted by the Director of Nursing or another who has been properly trained.
- B. The Training Program will consist of:
 1. How the hazard communication program is implemented, how to read and interpret information on labels and MSDS, and how employees can obtain and use the available hazard information.
 2. The hazards of chemicals in the work area.
 3. Measures employees can take to protect themselves from the hazards.
 4. Specific procedures put into effect by the Center to provide protection, such as personal protective equipment.
 5. Methods and observations, such as visual appearance or smell, workers can use to detect the presence of a hazardous chemical they may be exposed to.

VI. RIGHT-TO-KNOW PROGRAM

- A. Explain applicable safety and health requirements mandated by OSHA and state standards.
- B. Explain how to recognize potential health and safety hazards and review monitoring techniques used to detect potential health hazards.
- C. Explain how to read MSDSs and related information (labels).
- D. Explain safety precautions to be taken by the individual worker.
- E. Explain in detail the labeling system used by the Center.

Who Should Know this Policy:

- | | | |
|--|--|--|
| <input checked="" type="checkbox"/> All Employees | <input type="checkbox"/> All Clinical Staff | <input type="checkbox"/> All Medical Staff |
| <input type="checkbox"/> OR Staff | <input type="checkbox"/> Pre-Op Staff | <input type="checkbox"/> Post-Op Staff |
| <input type="checkbox"/> Administrator | <input type="checkbox"/> Medical Director | <input type="checkbox"/> Nurse Manager |
| <input type="checkbox"/> All Business Office Staff | <input type="checkbox"/> Business Office Manager | |

POLICY AND PROCEDURE MANUAL

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IMPROVEMENT**

SECTION V. ENVIRONMENTAL SAFETY

SECTION VI. MEDICAL STAFF

SECTION VII. HUMAN RESOURCES

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PRECISION SURGERY CENTER

STATEMENT OF APPROVAL

POLICY AND PROCEDURE MANUAL

VOLUME TWO

PRECISION SURGERY CENTER

Volume Two of The Policy and Procedure Manual of Precision Surgery Center consisting of "Quality Assessment and Performance Improvement, Environmental Safety, Medical Staff, Human Resources, Medical Records, Ancillary Services, and Infection Prevention and Control Program" has been approved for implementation as of (April 1st, 2017).

MEDICAL DIRECTOR/ADMINISTRATOR

CLINICAL DIRECTOR

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 - L. New Employee Orientation
 - M. Employee Requests for Time Off
 - N. In-service Education Program
 - O. Sexual Harassment
 - P. Personal Telephone Calls
 - Q. Disciplinary Procedure
 - R. Termination of Employment

- 2. Employee Health**
 - A. Objectives
 - B. Employee Health Program
 - C. Exposure Control Plan
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 - I. General Safety for All Employees
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- 3. Nursing Services**
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 - B. Clinical Director
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- 4. Policies of Administrative Personnel**
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PRECISION SURGERY CENTER

SECTION IV

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT

PRECISION SURGERY CENTER

SECTION IV

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT

1. Governing Body Responsibilities

PRECISION SURGERY CENTER
IV. QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT
1. Governing Body Responsibilities
A. Preamble

I. PREAMBLE:

1. The Governing Body of Precision Surgery Center has developed, defined, implemented, and continues to maintain an ongoing, data-driven Quality Assessment and Performance Improvement (QAPI) Program by addressing the Precision Surgery Center's priorities and that all improvements are evaluated for effectiveness; specifying data collection methods, frequency, and details; by clearly establishing its expectations for safety; and by adequately allocating sufficient staff, time, information systems, and training to implement the QAPI program.
2. The Governing Body has established a Quality Improvement Coordinator to assess and improve the quality of care provided. The Governing Body has also established an Infection Control Program Coordinator, to pursue opportunities to improve patient care with the resolution of identified problems.

II. OBJECTIVES

1. The Governing Body strives to improve the quality of care provided by requiring and supporting the establishment and maintenance of an effective organization-wide QAPI program.
2. The Governing Body sets the expectations, develops plans, and implements procedures to assess and improve the quality of the Center's government, management, clinical and support processes.
 - A. The leaders of the Center undertake education responsibilities concerning the approaches and the methods of QAPI.
 - B. The Governing Body sets priorities for organization-wide QAPI activities that are designed to improve patient outcomes.
 - C. The Governing body ensures to allocate adequate resources for management and improvement of the Center, government, managerial, clinical, and support processes through assignment of needed personnel, provision for adequate time to participate in these activities, and information systems and appropriate data management processes to facilitate the collection, management, and analysis of data needed for QAPI activities.
4. The QAPI program is ongoing and not just a one-time effort.
 - A. Precision Surgery Center, apart from collecting quality data at regular intervals, analyzes the data at regular intervals, and updates records of actions taken to address quality problems identified in the analysis, as well as collects new data to determine if the corrective actions were effective.

5. The QAPI program is data-driven as it identifies in a systematic manner what data it will collect to measure various aspects of quality of care; the frequency of data collection; how the data will be collected and analyzed; and evidence that the program uses the data collected to assess quality and stimulate performance improvement.
6. The Governing Body ensures that the Center's staff is trained in assessing and improving the process that contributes to improved patient outcomes.
7. The Governing Body, in conjunction with staff members, individually and jointly develops and participates in mechanisms designed to foster communication among individuals and among components of the Center and to coordinate internal activities.
8. The Governing Body, with the Medical Director and other staff members analyzes and evaluates the effectiveness of contributions to improving quality.
9. Clinical and administrative staff monitors and evaluates the quality and appropriateness of patient care and clinical performance, resolve identified problems and give the Governing Body the information it needs to fulfill its responsibilities for the quality of patient care.
10. The Center maintains a plan that describes the QAPI program, objectives, organization, scope and mechanisms for overseeing the effectiveness of monitoring, evaluation, and improvement of problem solving activities.
11. Implementation of the QAPI program is the responsibility of Quality Improvement Coordinator and the Governing Body of the Center.

PRECISION SURGERY CENTER
IV. QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT
1. Governing Body Responsibilities
B. Scope of the program

I. PREAMBLE

1. The QAPI program is a comprehensive data-driven program designed to objectively and systematically evaluate the quality and appropriateness of services provided, opportunities to improve care, identify things that warrant evaluation or action, modify processes to improve care in a continuous manner and to resolve identified problems.
2. The program includes, but is not limited to, an ongoing program that demonstrates measurable improvement in patient health outcomes, and improves patient safety by using quality indicators or performance measures associated with improved health outcomes and by the identification and reduction of medical errors.
3. The program also measures, analyzes, and tracks quality indicators, adverse patient events, infection control and other aspects of performance that includes care and services furnished by the Center.

II. SCOPE:

1. The quality and appropriateness of diagnostic and treatment procedures are evaluated on a continual basis.
2. The Center delivers health care services that demonstrate a high quality of care and this service is provided in a manner consistent with principles of professional practice and concern for accessibility, availability, and cost of services.
3. The quality of treatment is that consistent with the clinical impression or working diagnosis.
4. Content, completeness, and quality of medical record entries are evaluated.
5. Quality of care in various departments including pain management and ambulatory surgery outcomes are included..
6. The patient's satisfaction is evaluated on a continual basis by various means.
7. Review of cases of patients who require hospitalization following ambulatory surgery are reviewed.
8. Evaluation of the quality and appropriateness of all ancillary services.
9. Monitoring and evaluation of all the services provided at the Center in accordance with; A planned, systematic, and ongoing process for monitoring, evaluating, and improving the quality of care in governing, managerial, and support activities.
10. Evaluation of those aspects of care that are most important to the health and safety of the patient are identified, with frequency or affect large numbers of patients, place patients at risk, substantial benefits when the care is not provided correctly, when care is not provided but is indicated, or the care is provided but is not indicated and/or tend to produce problems for patients or staff.

PRECISION SURGERY CENTER

SECTION IV

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT

2. The Program Activities and Data Synthesis

PRECISION SURGERY CENTER
IV. QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT
2. The Program Activities and Data Synthesis
A. The Program Activities

I. PURPOSE

1. The purpose of the QAPI program is to ensure that patients are provided high quality care in an environment of minimal risk. The program has the responsibility for monitoring every aspect of patient care in order to identify and rectify breakdowns that result in suboptimal care and/or safety while striving to continuously improve and facilitate positive patient outcomes.
 - A. There is a planned, systematic, collaborative ongoing process for monitoring, evaluating, and improving the quality and appropriateness of patient care.
 - B. When patient care problems or opportunities to improve care are identified, actions are taken and the effectiveness of the actions are evaluated.
 - C. The Governing Body will support and have the final authority and responsibility for the assurance of a flexible, comprehensive and integrated QAPI program and will delegate the authority and accountability for the operation of the program to the administration and medical staff.
 - D. Administration shall provide the resources, equipment, and personnel reasonably required to maintain and support the program.

II. OBJECTIVES

1. Maintain an ongoing performance improvement program conducted in a cost effective manner that include mechanisms for monitoring and evaluating the quality and appropriateness of patient care.
2. Focus of quality assessment data at a central point for examination analysis and documentation on ongoing implementation.
3. Improvement of existing processes and functions through a systematic approach that includes identifying potential improvement, testing the strategy for change assessing data from the test to determine if the change produced improved performance, and implementing the improvement strategy system-wide.
4. Review of adverse outcomes in order to ensure systems and procedure correction.
5. Assurance of effective communication systems for reporting QAPI activities to Medical Staff and Governing Body.
6. Assurance of compliance with the requirements of all federal, state, and accrediting agencies in regard to QAPI activities.
7. To identify and evaluate all urgent situations requiring immediate action.

III. GOALS

To ensure the following:

1. That clinical and administrative staffs monitor and evaluate the quality and appropriateness

of patient care and clinical performance, resolve identified problems, and report information to the Governing Body that the Governing Body needs to assist it in fulfilling its responsibility for the quality of patient care.

2. That the necessary information is communicated among departments/services when problems or opportunities to improve patient care involve more than one department/service.
3. The status of identified problems is tracked to ensure improvement and resolution.
4. Information from departments/services and the findings of discrete quality improvement activities are used to detect trends, patterns of performance or potential problems that affect more than one department/service.
5. The objective, scope, organization, and mechanisms for overseeing effectiveness of monitoring, evaluation, and problem-solving activities in the performance improvement program are evaluated annually and revised as necessary.
6. Important aspects of care to the health and safety of patients include those that occur frequently or affect large numbers of patients; place patients at risk of serious consequences or deprivation of substantial benefit if care is not provided correctly or not provided when indicated; or care provided was not indicated or tends to produce problems for patient or staff, are identified.

IV. PRIORITIES

1. The Precision Surgery Center has set priorities for its performance improvement activities by:
 - A. Focusing on high risk, high volume, and problem-prone areas.
 - B. Considering incidence, prevalence, and severity of problems in those areas.
 - C. Evaluating health outcomes, patient safety, and quality of care.

V. SCOPE OF ACTIVITIES

1. Performance measures are identified to monitor the quality and appropriateness of key performance areas of care. The measures are objective, measurable, and based on current knowledge and clinical experience. Collaborative and specific indicators of both key processes and outcomes of care are designed, measured, and assessed by all appropriate departments/services and disciplines of the Center in an effort to improve performance.
2. Assessment of the performance of the following functions will be included:
 - A. Assessment of patients
 - B. Education of patients and family
 - C. Management of information
 - D. Infection control
 - E. Utilization management
 - F. Safety management
 - G. Risk management
 - H. The monitoring and evaluation of the quality and appropriateness of patient care and clinical performance of all individuals with clinical privileges will be accomplished through the following activities:
 - I. Surgical and invasive procedure monitoring
 - J. Medication usage evaluation

- K. Medical record review
- L. Peer reviews performed by health care professionals

VI. INDICATORS (BENCHMARKING)

Multiple indicators utilized are outcome indicators, process of care indicators, and patient perception indicators.

1. Outcome indicators: These measure results of care. The outcome measures in the Precision Surgery Center focus on adverse incidents, pain relief and increase in functional status. Data will be collected on each of these benchmarks for comparison with previous data and data obtained from other ambulatory surgical centers. Data will be analyzed quarterly and presented to the Governing Body at the scheduled quarterly meetings.
 - A. Examples of internal benchmarks Precision Surgery Center monitors routinely;
 - a. pain relief
 - b. same day cancellations
 - c. peer review data
 - d. chart audits
 - e. results of patient satisfaction surveys
 - f. adverse events/incidents;
 - infections
 - hospital transfer
 - medication errors
 - wrong side surgeries/procedures
 - B. Examples of external benchmarks Precision Surgery Center uses (all data are obtained from valid and reliable local, state or national data):
 - a. Cost utilization measurements
 - b. Procedure/Operating room time utilization
 - c. Staff utilization measurements
 - d. Number of procedures performed
 - e. Adverse events (infections, transfers,ect.)
2. Process of care indicators: These measure how often the standard of care was met for patients with a diagnosis related to that standard. At Precision Surgery Center, this is evaluated based on the diagnosis for interventional techniques with an algorithmic approach based on the patient's symptomatology, physical examination, and diagnostic probabilities and repeat treatments are provided based on return of pain and deterioration in functional status.
 - A. Precision Surgery Center also measures the administration and time of prophylactic antibiotics. But, this is only in a small number of cases.
3. Patient perception indicators: These measure a patient's experience of the care they received in our Center.
 - A. Patient care surveys are offered routinely with each visit during postoperative follow-up, and all patients are encouraged to participate. *All the outcome measures are data driven and ongoing.*

VII. DATA SOURCES

1. Quality Improvement flow sheets reflecting trends
2. Risk Management data
3. Patient/family complaints/patient survey results
4. Patient charts
5. Data from third party payers/fiscal intermediaries
6. Data from peer reviews performed by health care professionals
7. Calculated data from studies conducted
8. Information obtained from outside benchmarking sources via reliable local, state or national data(ie other ASCs)

VIII. OVERSIGHT RESPONSIBILITY

1. Problem identification, assessment, and resolution will be monitored by the Quality Improvement Coordinator.
2. The monitoring mechanism for the Medical Staff activities shall be through the Quality Improvement Coordinator and Governing Body. Problems identified concerning Medical Staff Members shall be referred to the Medical Director.
3. The administration and coordination of the Center's overall QAPI Program are designed to ensure that the activities described are accomplished and that each of the monitoring and evaluation activities outlined are also performed appropriately and effectively.
4. The Administrator will be responsible for monitoring problems identified. If a department's problems remain unsolved, it will be reviewed and resolved by the Chief Executive Officer (CEO). If the problem still remains unresolved after administrative review, it will be forwarded as an unresolved problem to the Governing Body.

IX. ACTIONS THAT MAY BE TAKEN TO SOLVE PROBLEMS OR IMPROVE CARE

1. System problems: Changes in communication channels, changes in organizational structure, adjustments in staffing, and changes in equipment.
2. Knowledge problems: In-service education/training, continuing education, and circulating informational material.
3. Behavior problems: Informal or formal counseling, changes in assignments, and disciplinary action.

X. ANNUAL EVALUATION

1. The program shall be reappraised annually by the Governing Body.

PRECISION SURGERY CENTER
IV. QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT
2. The Program Activities and Data Synthesis
B. The Program Data and Activities

I. PREAMBLE

Precision Surgery Center implements preventive strategies throughout the Center targeting adverse patient events and ensures that all staff are familiar with these strategies.

1. The QAPI program of the Precision Surgery Center incorporates quality indicator data, including patient care and other relevant data regarding services furnished in the Precision Surgery Center.
2. Precision Surgery Center uses the data collected to:
 - A. To monitor the effectiveness and safety of its services and quality of its care.
 - B. Identify opportunities that could lead to improvements and changes in its patient care.
3. Precision Surgery Center's performance improvement activities track adverse events, examine their causes, implement improvements, and ensure that improvements are sustained over time.
4. Specific components within the Center's QAPI program include:
 - A. The ongoing monitoring of performance indicators to systematically assess and evaluate the department's performance in relation to appropriateness and quality of important aspects of care provided. This includes pain relief, amount of time in the center for a procedure, results of patient surveys, ect.
 - B. Systematic evaluation of care provided by personnel employed herein.
 - C. Ongoing evaluation, study, and modification of processes within the department to continue to improve the services provided.

Whenever appropriate and possible, interdepartmental study of processes involved in the provision of services will be conducted, and activities will be reported to the Governing Body by all during routinely scheduled quarterly meetings.

II. SPECIFIC PROGRAM

Specific program description is as follows:

1. Monitoring and evaluation process – This process is designed to help the Center effectively utilize its management resources by focusing on high priority quality of care services. The responsibility of the Quality Improvement Coordinator with the Medical Director is associated with the implementation and ongoing management of the program or delegated to various administrative staff. Employees from within the departments who are knowledgeable about the care/services provided are actually involved in the entire QAPI program.

2. The monitoring and evaluation activities of all the departments and services provided are performed in accordance with a:
 - A. Planned, systematic, and ongoing process for monitoring, evaluating, and improving the quality of care and all key governing, managerial, and support activities herein.
 - B. Those efforts of care that are most important to the health and safety of the patients are identified. These important aspects of care are those that occur frequently or affect large numbers of patients herein, place patients at risk of serious consequences or of deprivation of substantial benefits when the care is not provided correctly, the care is not provided but is indicated, or the care is provided but is not indicated herein, and/or tends to produce problems for patients or staff.
3. In order to accomplish the above, the monitoring and evaluation process involves:
 - A. Identifying the most important aspects of care provided at the Center which includes procedures and treatments (high risk, high volume, problem prone areas);
 - B. Using measurable indicators to systematically monitor those aspects of care in an ongoing way (outcome indicators, process of care indicators, and patient perception indicators);
 - C. Evaluating the care at least when level, patterns or trends and indicator data by identifying incidence, prevalence, and severity of the problem to improve the quality of care; and
 - D. Taking actions to improve care and evaluating the effectiveness of these actions.

Because the use of indicators to monitor the important aspects of care involve the collection and aggregation of data about a series of events or activities, the monitoring and evaluation process can be used to identify trends or patterns of care that may not be evident when only a case by case review is performed. Indicators can also be used to identify important similarities that warrant further evaluation.

III. DELINEATION OF THE SCOPE OF CARE/SERVICES PROVIDED

The Center provides the following services:

1. Ambulatory Surgical Services
2. Pharmaceutical Services for procedures/surgeries

These services are provided to ambulatory, adult patients. Precision Surgery Center does not admit children under the age of 18. These are provided in the following locations:

1. Operating/Procedure rooms
2. Recovery Rooms
3. Pre and postoperative Holding Areas

The services are regularly provided 5 days per week by qualified physician(s), physician's assistant(s), nurse practitioner(s), certified registered nurse anesthetist(s), registered nurse(s), medical assistant(s), and other personnel within the various service areas.

IV. IDENTIFICATION OF IMPORTANT ASPECTS OF CARE

Main key functions and/or processes/procedures that are the most important to the patients served

at the Center have been identified by teams of employees from within the Center including staff, specific employees, physicians and other personnel involved in this process who are identified within QAPI meeting minutes. Important aspects of care identified in each department have been further prioritized based upon the recommendations of the Governing Body which the following list was compiled from. The key functions/processes/procedures of ambulatory care include:

1. Procedural Appropriateness
2. Appointments
3. Patient Education
4. Patient Recovery

V. IDENTIFICATION INDICATORS FOR MONITORING MAJOR ASPECTS OF CARE

Indicators that will assist in monitoring the quality and appropriateness of major aspects of care provided have been identified. These indicators have been designed to be objective, measurable, based upon current knowledge and clinical experience, and may relate to the structure of care/service, processes of care/service or outcome of care/service.

VI. DATA COLLECTION AND ANALYSIS

1. After identification of the indicators for monitoring important and major aspects of care or measures of quality and patient safety, Precision Surgery Center collects data actively related to those measures at the intervals called for by the QAPI program.
 - A. The staff responsible for collection of the data are trained in appropriate techniques to collect and maintain the data.
 - B. Once data has been collected, it is analyzed to monitor the Precision Surgery Center performance to determine what the data suggests about the Precision Surgery Center's quality of care and the effectiveness and safety of its services.
 - C. Analysis takes place at regular intervals, in order to avoid too much time elapsing before the Precision Surgery Center is able to detect problem areas.
 - D. In the case of data related to adverse events, the Precision Surgery Center uses the data to analyze cause(s) of the adverse events.
 - E. Data collection and analysis is conducted by personnel with appropriate qualifications to collect and interpret quantitative data.
2. The Precision Surgery Center conducts a thorough analysis that focuses on systematic issues such as medication errors, serious injuries to a patient, and infections.
3. The derived data is incorporated for improvements and preventive strategies.
 - A. Any adverse event or "near miss" is considered a threshold that triggers further evaluation to validate the existence of the problems so that corrective measures designed to eliminate potential negative impact on patient care/service may be instituted, as dictated by the Quality Improvement Coordinator.

VII. IMPORTANT ASPECTS OF CARE

Monitoring that important aspects of care are carried out is accomplished by collecting and organizing data for each indicator in an ongoing and systematic manner. Data is collected through a systematic process and organized on the Quality Assurance Data Sheet, in addition to other

forms. Organization of data in this manner assists with the identification of events warranting further evaluation and identification of patterns or things that are at variance with established thresholds.

Specific sources of data suggested by various departments and the clinical personnel include:

1. Clinical observation.
2. Medical records review.
3. Review of data generated through risk management activities.
4. Ambulatory surgery and recovery room flow sheets; and
5. Review of physician orders.

VIII. INITIATE FURTHER EVALUATION WHENEVER AN EVENT OCCURS

Initiation of further evaluation whenever an adverse event occurs is performed to identify either opportunities to improve care/processes or problems in the provision of care.

Further evaluation must be conducted whenever an event occurs, a pattern or trend that may negatively impact care/services is identified, or an opportunity to improve care is recognized. Additionally, further evaluation of any indicator may be triggered by associated customer complaint, department comparison of their performance with that of another institution (external benchmarking), or when there is a desire by the department to improve performance.

Whenever initiated the evaluation of an important aspect of care includes:

1. A more detailed analysis of patterns/trends in the data collected on the indicators.
2. Consistent review of any single occurrence through the use of "secondary screen."
3. Identification of specific processes involved.
4. Flow charting of processes involved.
5. Review by peers when analysis of the care provided by a practitioner is undertaken.

All evaluation activities are reported to the Governing Body by the Quality Improvement Coordinator during the quarterly meeting.

IX. ACTIONS TO IMPROVE CARE OR CORRECT IDENTIFIED PROBLEMS

Whenever an opportunity to improve or a problem in the quality of care is identified, appropriate action is taken to improve the care or correct the problem. The action taken may be either a testing of a strategy on a limited basis prior to full implementation, if appropriate, or the immediate implementation in all departments or services to each that may be applicable.

The effectiveness of the action taken is assessed by monitoring of the care. The actions taken may reflect systems change, process change, educational intervention, or human resource management. Emphasis is placed on the correction/improvement or systems/processes involved.

Actions taken, as well as follow up plans, are included within the Quality Improvement Coordinator's study report along with documentation of suggestions and implementation of actions, which are considered as vital to the success of the program.

X. ASSESSMENT OF EFFECTIVENESS OF THE MONITORING AND EVALUATION

The monitoring and evaluation activities are used primarily to study and improve processes that affect patient care and outcome and, when relevant to the performance of an individual or used as a complement of the evaluation of the individual's capabilities.

In monitoring the evaluation activities, findings may relate to:

1. Factors not easily changed by the Center, such as patient age or severity of illness.
2. Systems or processes of care such as standards of patient care on staffing levels.
3. How individuals, including independent practitioners, exercise judgment and carry out clinical activities.
4. Findings that fall into this category dealing with the knowledge, skill, and judgment of individuals are relevant to individual performance. Findings of this nature may lead to such actions as changing the support systems around the individual, providing the individual with education and/or assessing the individual's clinical privileges or assignments.

As an ongoing process and part of the annual reappraisal of the Center's QAPI program, the effectiveness of the monitoring of evaluation processes are assessed.

Effectiveness of problem resolution and care improvement activities are assessed and documented through the ongoing QAPI program.

Administration and coordination of the overall QAPI program of the center is designed to ensure quality, competence and ease by monitoring an evaluation of activities appropriately and effectively by communicating necessary information among departments, services, or programs when opportunities to improve problems in patient care involves more than one department, service, or program.

The problem resolution is achieved by:

1. Tracking the status of identified problems to ensure improvement or resolution.
2. Utilizing interdepartmental strategy and collecting information from departments, services, or programs and findings of management and improvement activities to detect trends, patterns of performance, or potential problems that affect more than one department, service or program.

Following the implementation of actions to improve the care or correct the problem, the findings, conclusions, recommendations or actions taken, and the results of the actions taken are:

1. Documented
2. Reported through established channels to the Quality Improvement Coordinator and the Governing Body.

XI. COMMUNICATION OF THE RESULTS

Findings, conclusions, recommendations, actions taken and the results/effectiveness of action taken are communicated through:

1. Reporting on a quarterly basis to the Governing Body.
2. Inclusion of a report on QAPI activities at each staff meeting.
3. Additionally, it is the responsibility of the department members to assist with dissemination of quality improvement information to the staff.

XII. ANNUAL EVALUATION OF THE QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT (QAPI) PROGRAM

The effectiveness of the QAPI program of the center is evaluated on an annual basis as part of the total facility appraisal. The report of this evaluation is submitted to the Governing Body. This report includes:

1. Problems identified in care provided or opportunities to improve care identified.
2. Corrective actions and preventative measures taken to resolve the issues identified. All actions are communicated to every staff member involved.
3. Educational programs related to continual QAPI activities; and
4. Program changes planned as a result of the annual evaluation (changes in scope, organization, objectives, etc.).
5. Sustained improvements – a method to ensure that the improvements made are sustained over time by demonstrating that whatever solution is adopted to address the problem, continues to work over time, which indicates that Precision Surgery Center collects data on indicators that measure those aspects of care.

PRECISION SURGERY CENTER

SECTION IV

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT

3. Performance Improvement Projects and Evaluation

PRECISION SURGERY CENTER
IV. QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT
3. Performance Improvement Projects and Evaluation
A. Scope

I. PREAMBLE

1. The number and scope of distinct improvement projects conducted annually by the Precision Surgery Center reflects the scope and complexity of our services and operations.
2. The Precision Surgery Center documents the projects that are being conducted.
3. The documentation, at a minimum, includes the reason(s) for implementing the project and a description of the project's results.

II. THE FOCUS

The focus of Precision Surgery Center is on high risk, high volume, and problem-prone areas.

III. ANALYSIS

1. The Precision Surgery Center will analyze the data for incidence, prevalence, and severity of problems in those areas.
2. The Precision Surgery Center will evaluate the health outcomes, patient safety and quality of care.

IV. INDICATORS (BENCHMARKING)

The Precision Surgery Center will utilize outcome indicators, process of care indicators, and patient perception indicators. These include but are not limited to;

1. Patient satisfaction survey results
2. Pain scores/pain relief
3. Hospital transfers
4. Healthcare associated infections
5. Cancellation of procedure/surgery (same day)
6. Medication errors resulting in patient injury (or possibility of injury)

PRECISION SURGERY CENTER
IV. QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT
3. Performance Improvement Projects and Evaluation
B. Program Evaluation

The Center's program evaluation system enables the Center to identify the results of services and the effects of the program on the person's served. Program evaluation information is integrated into the Center's decision making at all levels.

1. The relationship between the needs of the persons served and the services being provided is reviewed and evaluated at least annually by the Center's staff and Governing Body.
2. The Center has a program evaluation system which meets the following criteria:
 - A. Measures results of all services and procedures.
 - B. Includes all persons served or a represented sample. When sampling of these served is used to assess performance, the methods used are consistent with acceptable sampling procedures.
 - C. Evaluates post-discharge information
3. The program evaluation includes the following:
 - A. Admission criteria
 - B. A listing of services offered
 - C. Measurable objectives
 - D. Measures of effectiveness and efficiency
 - E. Measures of satisfaction of patients/ persons served
4. The system maintains the following
 - A. Case load character states, example diagnosis, functional limitations, types of disabilities
 - B. Services rendered
 - C. Dates of services, including admission and discharge
 - D. Results of services provided
5. Program evaluation management reports reflect the following
 - A. Measures of effectiveness, example benefits achieved by persons served
 - B. Measures of efficiency, for example, time cost utilization etc.
 - C. Measures of satisfaction of persons served with the program
 - D. Case load character states the interpretation of the results
6. Information produced by the program evaluation system is made available to all appropriate levels of management and staff on a timely basis. Such information is used by management to discontinue, maintain, or improve the program.

- A. The Center has the means to determine when performance is less than acceptable
 - B. When performance falls below the acceptable level, the reasons are identified
 - C. Management takes the action to improve the program performance to an acceptable level
 - D. Follow up monitoring of current directions takes place at specific times along with documentation of the results.
7. There is a systematic procedure for professional and administrative staff with review of the nature of the case load. This review occurs annually and includes:
- A. Consideration of the appropriateness of the case load for the intensity and type of services provided.
 - B. Result in determination as to whether changes are occurring in the service population which indicates a need for service modification or expansion.
 - C. The Center protects itself and its services in a manner which is accurate such as what the Center reports to accomplish in brochures, advertisements etc. is consistent with the results shown in the Center's program evaluation system.
8. A mechanism to provide for continual review of the adequacy of the program evaluation system is also maintained. The mechanism ensures that:
- A. Formal reviews take place on an annual basis
 - B. Staff affected by the evaluation system have an opportunity to recommend or make modification.
 - C. An assessment of the system's success occurs relative to increasing benefits controlling or reducing program costs, and maintaining or improving community support.
 - D. A determination of the adequacy of the program evaluation system is made.

PRECISION SURGERY CENTER
IV. QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT
3. Performance Improvement Projects and Evaluation
C. Utilization Review

I. PURPOSE

To Monitor ambulatory care activity for appropriateness, effective scheduling of resources, over and under utilization of available resources.

II. PROCEDURE

1. A minimum of 5% or 30 (whichever is greater) of relevant medical records will be reviewed.
2. Incomplete records will be referred to Medical Records for completion and then re-reviewed.
3. Records reflecting inadequate documentation to perform procedures will be referred to a physician member of the Governing Body.
4. Records which reflect a patient complication resulting from a procedure will be referred to the Quality Improvement Coordinator and Governing Body.
5. Records complete and with medical necessity documented will be noted on the review sheet and returned to Medical Records.
6. The Physician Reviewer will refer charts that do not meet the criteria to the Quality Improvement Coordinator.
7. The following guidelines will be utilized as screening criteria in the review.

III. CRITERIA

1. History and Physical
 - A. Completed timely; by physician within 30 days of scheduled procedure/operation
 - B. Reflects indications for procedure/operation
 - C. Must include any known allergies, any medication reactions, list of current medications.
 - D. Documentation reflective of type of anesthesia planned (if applicable)
 - E. Documentation of care or lack of care that potentially places patient at risk. (if applicable)
 - F. Documentation of relevant comorbidities

2. Lab, X-ray, and EKG reports
 - A. On chart as ordered.
 - B. Abnormal results addressed prior to surgery.
 - C. Necessary/relevant to the patient's health status and for procedure being performed.
3. Informed Consent
 - A. Signed, dated, and witnessed.
 - B. Same as procedure performed.
 - C. Surgeon identified on consent.
4. Blood Pressure, pulse, respiratory rate and temperature within 30 minutes of actual start of surgery and prior to surgery.
5. Mental status noted.
6. Discharge instructions given, documented, with discharge plan including patient education and provisions for follow-up care.
7. Seen by physician prior to discharge.
8. Postoperative Stability
 - A. Vital signs documented within normal limits
 - B. Absence of respiratory difficulty or hypoxia.
 - C. Wound condition noted.
 - D. Mental status noted.
 - E. Serious or potentially serious complication noted and addressed.

Lack of documentation in these areas is a quality issue.

PRECISION SURGERY CENTER
IV. QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT
3. Performance Improvement Projects and Evaluation
D. Quality of Care

I. PREAMBLE

The Center develops health services that demonstrate a high quality of care which is provided in a manner consistent with principles of professional practice and reflect concern for the accessibility, availability, and cost of services.

II. POLICY

1. The Center provides high quality of care services by demonstrating availability and accessibility of health services. This is shown by the scope of services which include surgical/procedural services, physician services, radiology, physical therapy, nursing, psychological and administrative services. Part of the laboratory, physical therapy, radiology and psychological services are provided indirectly (referred), to meet patients' needs. All referrals and consultations are clinically appropriate and timely based on the working diagnosis. This is also demonstrated by adequate coverage which exists for planned and unplanned staff absences.
2. All health care services provided at the Center are and within the current standards of care, with appropriate timely diagnosis based on findings of current history and physical examination.
2. The hours of operation of the Center reflect the needs of the patients and convenience. Waiting times for elective and scheduled cases are monitored and maintained at a reasonable level, as per the policies of the Governing Body. The Center provides an intake and assessment system for patients during normal hours of operation.
3. The Center has a written description of the mechanisms by which patients obtain care – including appointments, walk-ins, referrals – during the Center's normal hours of operation. No patients are accepted after hours of operation except in case of emergency and they are cared for at the hospital via transfer agreement. The patients are also able to get information by telephone regarding access to the services at the Center. The Center and its physicians have made provisions for emergency and after hours care. The Center provides written information about emergency and after hours care to the patients. The patients are also able to get information by telephone to such services.
4. The Center provides the mechanism for informing patients of names, professions, and titles of the professionals providing and/or responsible for their care by the Center properly identifying both orally and in writing the professionals involved in the care.
5. The Center utilizes appropriate diagnostic procedures including laboratory and radiology studies when indicated. Patients are contacted as quickly as possible for follow-up regarding any abnormal findings with diagnostic reports.

6. The Center provides treatment that is consistent with the clinical impression or working diagnosis. Medication reconciliation is performed at each patient visit.
7. The Center utilizes appropriate specialty consultations and makes them available when needed.
8. All professionals at the Center instruct and educate the patients with regards to their diagnosis and treatment program including the use of medication, appropriate preventive measures, and use of the health care system.
9. All health care professionals of the Center are encouraged to participate in educational programs and activities that are consistent with the Center's mission, goals and objectives. The Center provides access to reliable, up-to-date information pertinent to the and educational and administrative services provided.
10. The Center strives for timely and adequate transfer of appropriate documents and information when patients are transferred to us from other health care providers within and/or outside the Center. The transferred information includes any advance directives given by the patient to the Center, documents and other evidence of continuity of care. Referral to another health care professional is clearly outlined to the patient and arranged with the accepting health care professional.
11. The Center also maintains reasonable continuity of care with patient follow up regarding patient adherence to the plan of care and post-operative status.
12. The Center identifies and notifies the patients who require additional follow up for significant problems or illnesses including results of laboratory and radiology studies.
13. The Center uses performance measures to improve outcomes and assesses patient satisfaction with their care. Corrective action is taken when necessary.
14. The Center provides the resources to respond to medical emergencies which may arise in connection with services provided to patients and emergency carts are kept in adequate and proper supply and written policies address the time and review inspection of each cart. At least one physician certified in advanced cardiac life support (ACLS) is present in the facility when a patient is in the facility.
15. The Center is a cost conscious facility and the concern for the cost of care is demonstrated by:
 - A. Relevance of health care services provided and ancillary services used to the needs of patients
 - B. Avoiding duplicate diagnostic procedures
 - C. Appropriate treatment frequency
 - D. Using the least expensive alternative resources when suitable
 - E. Evaluation of cost benefit factors by appropriate personnel to determine which, if any, routine laboratory and extra studies are required.

PRECISION SURGERY CENTER
IV. QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT
3. Performance Improvement Projects and Evaluation
E. Peer Review

The Center maintains an active, integrated and organized process of peer review as part of its peer-based QAPI program as shown by the following characteristics:

1. The professional and administrative staff understands, supports, and participates in programs of QAPI, through an organized mechanism responsible to the Governing Body.
2. At least two physicians are involved in QAPI activities in order to provide peer-based review.
3. The Medical Director and other physicians along with other health care providers also participate in the QAPI program.
4. The Center provides ongoing monitoring of important aspects of the care provided.
5. All health care practitioners participate in the development and application of the criteria used to evaluate the care they provide.
6. Data related to established criteria are collected in an ongoing and defined manner. Each physician is responsible to perform 3 random peer reviews per quarter of another physician of similar qualifications.
7. Collected data are evaluated quarterly to identify unacceptable or unexpected trends or occurrences that influence patient outcomes.
8. The results of peer review are used as part of the basis for granting continuation of clinical privileges.
9. The results of peer review activities are reported to the Governing Body, and are used as part of the granting continuation of clinical privileges.

PRECISION SURGERY CENTER
IV. QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT
3. Performance Improvement Projects and Evaluation
F. Quality Improvement

The Center maintains an active, integrated, organized, peer based quality improvement program as shown below:

1. The quality improvement program addresses clinical, administrative, and cost of care issues as well as actual patient outcomes (results of care).
2. Quality improvement activities conducted by specific clinical disciplines within the Center (i.e. pain management, physical therapy, ambulatory surgery, nursing etc) are consistent with the characteristics of the overall quality improvement program.
3. Quality improvement activities incorporate the following:
 - A. Important problems or concerns in the care of patients are identified. Sources of identifiable problems include, but are not limited to:
 - ? Unacceptable or unexpected results of ongoing monitoring of care, such as complications, hospital transfers, malpractice cases, lack of follow up on abnormal test results, prescribing errors for medications, specific diagnoses, ect.
 - ◆ The clinical performance and practice patterns of all health care practitioners
 - ◆ Medical records review for quality of care and completeness of entries
 - ◆ Quality controls for and use of diagnostic imaging, pathology, medical laboratory and pharmaceutical services
 - ◆ Other professional and technical services provided
 - ◆ Assessment of patient satisfaction
 - ◆ Direct observation
 - ◆ Staff concerns
 - ◆ Accessibility
 - ◆ Medical/legal issues
 - ◆ Wasteful and undesirable practices
 - ◆ Over-utilization and under-utilization of diagnostic and therapeutic services
 - B. The frequency, severity, and source of suspected problems or concerns are evaluated. Health care practitioners participate in the evaluation of identified problems or concerns.
 - C. Measures are implemented to resolve important problems or concerns that have been identified. Health care practitioners as well as administrative staff participate in the resolution of the problems or concerns that are identified.

- D. The problems or concerns are re-evaluated to determine objectively whether the corrective measures have achieved and sustained the desired result. If the problem remains, alternative corrective actions are taken as needed to resolve the problem.
 - E. Through the designated mechanisms of the Center quality improvement activities are reported as appropriate to the Governing Body.
4. Findings of quality improvement activities are incorporated into the Center's educational activities.
 5. Appropriate records of quality improvement activities are maintained.

PRECISION SURGERY CENTER
IV. QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT
3. Performance Improvement Projects and Evaluation
G. Risk Management

The Center has developed and maintains a program of risk management designed to protect the life and welfare of its patients and employees, with the following characteristics:

1. The Governing Body of the Center is responsible for oversight of the risk management program. The Risk Manager and Safety and Maintenance Coordinator is responsible for consistent application, implementation and ongoing maintenance of the program throughout the Center.
2. Education in risk management, safety and infection control policies and procedures is provided to all staff members within 30 days of commencement of employment, annually thereafter, and when there is an identified need.
3. All risk management program processes are consistently implemented throughout the Center, addressing patient safety and other issues, including;
 - A. The definition of an adverse event which is: (Sentinel Events defined as per the Nevada State regulations in section IV.3.H)
 1. An unexpected occurrence during a health care encounter involving patient death or serious physical or psychological injury or illness, including loss of limb or function, not related to the natural course of the patient's illness or underlying condition.
 2. Any process variation for which a recurrence carries a significant chance of a serious adverse outcome.
 3. Events such as actual breaches in medical care, administrative procedures, or other events resulting in an outcome that is not associated with the standard of care or acceptable risks associated with the provision of care and service for a patient.
 4. All events involving reactions to drugs and materials.
 5. Circumstances or events that could have resulted in an adverse event.
 - B. The identification, reporting, and appropriate analysis of all adverse events. This analysis involves basic or causal factors underlying the incident and identifies potential improvements in processes to reduce the likelihood of such events in the future.
 - C. Near miss events are reported to the Risk Manager for evaluation.
 - D. Periodic review of all litigation involving the organization and its staff and health care professionals is performed by the Governing Body at regular quarterly meetings.
 - E. All patient complaints and grievances are reviewed promptly by the Administrator per the grievance policy. (Section
 - F. Periodic review of clinical records and clinical record policies.

G. Documentation of timely notification to the professional liability insurance carrier when adverse or reportable events occur.

H. Methods by which a patient is discharged against medical advice, dismissed from care or refused care.

I. Established guidelines for managing a situation in which a physician becomes incapacitated during medical or surgical procedures, and a process for communicating concerns regarding an impaired health care professional.
(Section III.7.J and VI.3.B)

J. Reporting and reviewing all incidents reported by employees, visitors, or patients.

K. Establishment of responsibility for, and documentation of coverage after normal working hours.

4. The Center has written policies restricting observers in patient care areas and addressing those persons authorized by the governing body to perform or assist in the procedure area.
5. The Center has established a requirement for evidence of patient consent for all other persons allowed in patient care areas that are not authorized staff members. This includes students, physicians, health care industry representatives, surveyors, ect.
6. The Center has established methods of dealing with inquiries from governmental agencies, attorneys, consumer advocate groups, reporters, and the media.
7. The Center has established guidelines to deal with methods for complying with all applicable government regulations, and to deal with methods for prevention of unauthorized prescribing.
8. Collection of unpaid accounts is always reviewed before referral to a collection agency with consideration of multiple factors including patient financial status.

PRECISION SURGERY CENTER
IV. QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT
3. Performance Improvement Projects and Evaluation
H. Sentinel Events Policy

I. PREAMBLE

An integral part of any risk management program is the establishment of a sentinel event intervention plan. This plan is designed to ensure maximum risk-prevention and loss-reduction activities on the part of the health system in response to a sentinel event.

II. DEFINITION OF A SENTINEL EVENT

The Nevada Division of Public and Behavioral Health has previously defined a sentinel event as any unexpected occurrence involving death or serious physical or psychological injury or the risk thereof. The phrase “the risk thereof” includes “any process variance for which a recurrence would carry a significant chance of an adverse outcome.” Assembly Bill 28 was passed and became effective October 1st, 2013. It replaced the former definition of a sentinel event (above) with those defined in the National Quality Forum's (NQF) Serious Reportable Events in Healthcare – 2011 Update: A Consensus Report. The following is the new definition of a sentinel event as per “Appendix A.” Some of the events below do not apply to the ambulatory surgical healthcare setting specifically but are included for completeness. All events listed below are reportable to the Nevada Division of Public and Behavioral Health via their Sentinel Event Registry. Contact and event forms are located online at: http://health.nv.gov/SER_forms.htm

1. Surgery or invasive procedure performed on the wrong patient, wrong side or site.
Or wrong procedure performed on a patient.
2. Unintended retention of a foreign object in a patient after surgery or invasive procedure.
3. Intraoperative or immediate postoperative death in and ASA Class I patient.
4. Patient death or serious injury associated with the use of contaminated drugs, devices or biologics provided by the healthcare setting. Or associated with the use of function of a device in patient care, in which the device is used or functions other than as intended. Or associated with intravascular air embolism that occurs while being cared for in a healthcare setting.
5. Discharge or release of a patient who is unable to make decisions, to other than an authorized person. (ex. of such person, child or adult with Alzheimer's)
6. Patient death or serious injury associated with patient elopement or disappearance.
7. Patient suicide, attempted suicide or self-harm that results in serious injury while being cared for in a healthcare setting.
8. Patient death or serious injury associated with a medication error (i.e. wrong drug, wrong preparation, wrong patient, wrong dose, wrong time, wrong route)
9. Patient death or serious injury associated with unsafe administration of blood products.
10. Maternal death or serious injury associated with labor or delivery in a low risk pregnancy while being cared for in a healthcare setting. Or death or serious injury of a neonate associated with labor and delivery in a low risk pregnancy.
11. Patient death or serious injury associated with a fall while being cared for in a healthcare setting.

12. Any Stage 3, Stage 4 or unstageable pressure ulcer acquired after admission to a healthcare setting.
13. Artificial insemination with the wrong donor sperm or wrong egg
14. Patient death or serious injury associated with loss of irreplaceable biological specimen. Or from failure to follow up or communicate laboratory, pathology or radiology test results.
15. Patient or staff death or serious injury associated with an electric shock in the course of patient care in a healthcare setting.
16. 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.
17. Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care in a healthcare setting.
18. Patient death or serious injury associated with the use of physical restraints or bed rails while being cared for in a healthcare setting
19. Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area
20. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider
21. Abduction of a patient/resident of any age
22. Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting
23. 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.

III. RESPONSIBILITY

Upon notification of the incident, the initiation of the sentinel event intervention plan is the responsibility of the Administrator (if unavailable, the Medical Director, or Clinical Director) who has the authority to implement any of the following procedures applicable to the nature of the event.

Any member of the medical or Center staff may report the incident.

1. Stage I: Immediately after the event (the first 24 hours)
 - A. Make sure the Center is doing everything possible to provide follow-up care/services to ensure the best possible outcome for injured parties/property and/or staff members.
 - B. Ensure that all parties to the event receive appropriate information (for example, the patient's attending physician, the patient, family members, staff members) to avoid miscommunications. Establish a mechanism for updates as needed, using a designated spokesperson for consistency. The spokesperson should be someone familiar to and trusted by the patient and family, such as the Administrator, Clinical Director or Medical Director.
 - C. Inform the appropriate members of the administration and public/media relations so they can consistently provide information to the appropriate outside parties.

- D. Follow any immediate regulatory reporting requirements, such as the Nevada Division of Public and Behavioral Health, Occupational Safety and Health Administration in the case of an employee injury/death, ect. Further information can be found in the Injury and Illness Prevention Program Manual.

The Institutional Review Board will receive information if the event involves a research patient or experimental procedure.

- ◆ Determine if the event fits the Nevada Division of Public and Behavioral Health's definition of a reportable sentinel event. The Medical Director and Assistant Medical Director are ultimately responsible for determining if the event necessitates reporting to the accreditation agency and the State reporting agency. If a sentinel event meets this criteria, the Center will notify the Accreditation Agency within three business days of the occurrence (or within three business days of our Center's awareness of the event).

- E. Document all information in the medical record.
- F. Consult with legal counsel and other resources as needed.
- G. Obtain, sequester, or preserve appropriate evidence (for example, photographs of the location of the injury or the equipment that malfunctioned).
- H. Gather detailed information about the event.
- I. Remind staff of the confidentiality surrounding the incident and the patient.

2. Stage II: Within 24 hours to one week of the event

- A. Interview all parties to the event. Obtain written statements to gather an accurate description of the sequence of events. The team may invite involved staff to the meeting to review what happened, provide an opportunity for shared feelings about the event, promote a "business as usual" approach to patient care, and jointly work together to do a root-cause analysis and action plan. This would be at the discretion of the staff member's or members' department-head and is optional for staff who already provided information via an interview.
- B. Determine the root cause(s) of the event, including analysis of all processes and systems related to its occurrence. Involve all appropriate staff in this analysis. See the Accreditation Agency framework for conducting a root-cause analysis to use as a guideline for discussion.
- C. Determine the potential improvements in processes or systems that would tend to decrease the likelihood of such events occurring in the future. Examples may include a change in communications, forms, training, equipment, policies, and procedures. If none exist, indicate the analysis with the determination that no such opportunities exist.
- D. Establish a plan to address identified opportunities for improvement or formulation of a rationale for not undertaking such changes. Indicate time frame, person responsible, and criteria to evaluate effectiveness of the actions.
- E. If a piece of equipment is involved in the incident, the risk manager will submit the

appropriate forms to the Food and Drug Administration and manufacturer within 10 days. The risk manager will preserve the equipment in its last-used state and have an objective, third-party vendor review the equipment.

- F. The risk manager will initiate the Bill Forgiveness Protocol if applicable to the nature of the event.
 - G. The Risk Manager or Medical Director will notify all appropriate insurance carriers and plan for the proper handing and protection of the medical record and other potential evidence (including log books, policies, procedures, or schedules) needed in anticipation of possible litigation.
3. Stage III: Post-event reporting
- A. If the event meets the Accreditation Agency definition of a sentinel event, the Center will submit a report of the root-cause analysis and process improvement plans to the Accreditation Agency within 30 days of the event.
 - B. The risk manager will, on a quarterly basis, provide a summary to the Governing Body, on all incidents managed through the sentinel event intervention action plan.

IV. DEFINITION OF ADVERSE EFFECT

In medicine, an adverse effect is a harmful and undesired effect resulting from a medication or other intervention such as surgery. An adverse effect may be termed a “side-effect,” when judged to be secondary to a main or therapeutic effect, and may result from an unsuitable or incorrect dosage or procedure, which could be due to medical error. Some adverse effects only occur when starting, increasing or discontinuing a treatment. Using a drug or other medical intervention which is contraindicated may increase the risk of adverse effects. Adverse effects may cause medical complications of a disease or procedure and negatively affect its prognosis. They may also lead to noncompliance with a treatment regimen.

V. PREVENTION

- 1. To prevent an adverse effect/reaction:
 - A. Verify allergies.
 - B. Mark on the patient’s wrist band.
 - C. Double check medication list with another registered nurse.
- 2. In the event that an adverse effect occurs, watch for the following signs:
 - A. Rash
 - B. Itching
 - C. Anaphylaxis
 - D. Cardiac arrhythmias
 - E. Cutaneous eruptions

VI. MONITORING

- 1. In the event that an adverse reaction occurs:
 - A. Alert physician.
 - B. Monitor all patient vitals.

- C. Follow orders given by physician.
- D. Investigate all medications given.
- E. Document all symptoms.
- F. Document the event by completing incident report.
- G. Discharge patient per physician's orders.
- H. Follow up with post-op phone call same day/next day

VII. DEFINITIONS OF TERMINOLOGY

1. Incidence: The incidence is a technical term used in epidemiology, referring to the frequency with which something, such as a disease, appears in a particular population or area.
 - A. In this epidemiology, the incidence is the number of newly diagnosed cases during a specific time period.
 - B. As an example, the annual incidence of surgical site infections in Precision Surgery Center would be the rate that results when dividing the number of such infections that occurred in a calendar year by the total number of surgical cases in the Precision Surgery Center during that same year.
 - C. An annual incidence of emergency transfers to a hospital would be the rate that results when dividing the number of such transfers by the total number of surgical cases during the same year.
 - D. The annual incidence of falls would be the rate that results when dividing the number of such falls by the total number of surgical cases during the same year.
 - E. The annual incidence of any type of complication would be the rate that results when dividing the number of such a complication by the total number of surgical cases during the same year.
2. Prevalence: The prevalence is a technical term used in epidemiology, and is a statistical concept referring to the number of cases of a disease that are present in a particular population at a given time.
 - A. The prevalence may be measured by observing the hand hygiene practices of all staff providing direct patient care, in order to assess the prevalence of good versus deficient practices.
 - B. The prevalence of facet joint pain in the population presenting to interventional pain management programs may be determined by performing appropriate diagnostic blocks.
 - C. The prevalence of illicit drug use, drug abuse, or lack of compliance may be determined by appropriate history, by review prescription monitoring program results, and urine drug testing.
3. Severity of Problems: Any single incident of a transfer of a patient to a hospital represents a serious, adverse, unplanned outcome of the surgical procedure.
 - A. Precision Surgery Center tracks and evaluates all such cases, due to their severity, even if they are low volume incidences.
 - B. Any patient death, paralysis, coma, or other major permanent loss of function associated with a procedure or medication error are considered as severe and are monitored, even though they are low volume.

4. Error: An error is defined as the failure of a planned action to be completed as intended (i.e., error of execution) or the use of a wrong plan to achieve an aim (i.e., error of planning).
5. Adverse event: An unexpected occurrence during a health care encounter involving patient death or serious physical or psychological injury or illness, including loss of limb or function, not related to the natural course of the patient's illness or underlying condition. This includes all events involving reactions to drugs and materials, and circumstances that could have resulted in an adverse event.

Any process variation for which a recurrence carries a significant chance of a serious adverse outcome.

Events such as actual breaches in medical care, administrative procedures, or other events resulting in an outcome that is not associated with the standard of care or acceptable risks associated with the provision of care and service for a patient.

- A. An adverse event attributable to error is a preventable adverse event.
- B. Example; a surgeon operates on the right shoulder of a patient with a left shoulder rotator cuff injury requiring surgery, this is an error resulting in sentinel event.
- C. Not every adverse event or sentinel event is the result of an error. If the result is due to the unknown nature of the patient's reaction, then even if the procedure was performed appropriately or a particular medication was administered appropriately, it is an adverse event.
- D. Not every error results in an adverse event. Even then it is considered an error.
 - ◆ Precision Surgery Center employs a time-out procedure to verify the identity of the patient and site of surgery and recognizes the error before surgery begins.
- E. Precision Surgery Center tracks all patient adverse events in order to determine through subsequent analysis whether they were the result of errors that should have been preventable, to reduce the likelihood of such events in the future.
 - ◆ Precision Surgery Center also identifies errors that result in near misses, since such errors have the potential to cause further adverse events.

PRECISION SURGERY CENTER

SECTION V

ENVIRONMENTAL SAFETY

PRECISION SURGERY CENTER

SECTION V

ENVIRONMENTAL SAFETY

1. Purposes

PRECISION SURGERY CENTER

V. ENVIRONMENTAL SAFETY

1. Purposes

A. Principles

I. PREAMBLE

1. The Governing Body strives to ensure a safe and sanitary environment, properly constructed, equipped, and maintained to protect the health and safety of patients and personnel. All facilities are operated in a safe and secure manner, with written policies addressing safety and security practices. Further safety and emergency information is provided by Compliance Alliance, LLC, and is located in the employee Injury and Illness Prevention Manual.
2. Precision Surgery Center provides a safe, functional and sanitary environment for the provision of surgical services.
 - A. Precision Surgery Center has separate operating/procedure rooms, recovery rooms and waiting area. Each operating room is designed and equipped so that the types of surgery conducted can be performed in a manner that protects the lives and assures the physical safety of all individuals in the area.
 - B. Reception areas, toilets, and telephones are provided in accordance with patient and visitor volume.
 - C. Examination rooms, dressing rooms and reception areas are constructed and maintained in a manner that ensure patient privacy during interviews, examinations, treatment and consultation as applicable.
3. Precision Surgery Center has established a program for identifying and preventing infections and environmental hazards that could lead to injury of patients, visitors or staff members. The program focuses on maintaining a safe and sanitary environment, and reporting the any issues to appropriate authorities.
4. Precision Surgery Center has established a program for providing safety from fire.
5. Precision Surgery Center provides appropriate emergency equipment in the operating/procedure, and recovery rooms.
6. Personnel trained in the use of emergency equipment and in advanced cardiac life support (ACLS) are available whenever there is a patient in Precision Surgery Center and during hours of operation.
7. Necessary personnel, equipment and procedures are established and available to deliver safe care, and to handle medical and other emergencies that may arise.

II. PRINCIPLES

1. The policies and procedures are approved in writing by the Chief Executive Officer (CEO) who with the Governing Body evaluates the safety management program on an annual basis and if necessary revises the objectives, scope, organization, and effectiveness of the safety management program.
2. The Center has designed a safe, accessible effective and efficient environment of care consistent with its mission, vision, values, services, and objectives as well as law and

regulation.

- A. All the facilities in which patients receive treatment comply with all applicable local, state and federal building codes and regulations. The facilities are also in compliance with applicable state and local fire prevention regulations, published by the National Fire Protection Association 101, *Life Safety Code*.
 - B. During the design and construction of these buildings (environment of care) the Center used appropriate guidelines for construction of medical facilities meeting the local, state Department of Human Health and Services, Division of Licensing and Regulation as well as Medicare regulations as established by the Health Care Financing Administration.
 - C. The Center provides a life safety management program which exists to protect patients, personnel, visitors, and property from fire and products of combustion and to provide for the safe use of buildings and grounds. This is established and maintained by regulations in compliance with appropriate provisions of the current edition of NFPA 99 Health Care Facilities Code of the National Fire Protection Association.
 - D. The Center maintains an ongoing program designed to ensure the building and grounds are suitable to the nature of the services provided and the ages and other characteristics of the patient population served.
 - E. The Center also establishes safe use of buildings and grounds for physically disabled individuals by providing reasonable accommodations.
 - F. The Center maintains emergency services which are readily identifiable and easily accessible.
 - G. The Center maintains an ongoing program to establish and maintain fire safety. Periodic inspection by the local fire control agency is done at the discretion of the Las Vegas Fire Department, as appropriate.
3. The Center ensures that its facilities and its personnel are adequately protected from fire or other disasters. This is achieved by;
- A. Fire-fighting equipment is appropriately maintained and fire extinguishers are placed in adequate numbers and are the proper type for each potential type of fire.
 - B. All staff members are provided with documented periodic instruction in the proper use of safety, emergency and fire-extinguishing equipment.
 - C. All exits are prominently illuminated with a sign that operates on emergency 1 power, including exits from each floor or hall.
 - D. Emergency lighting is present as appropriate throughout the facility to provide adequate illumination for evacuation of patients and staff in case of an emergency.
 - E. Stairwells are protected by fire doors, as appropriate, and smoking is prohibited within the Center. The designated smoking area is located in the vacant lot 30 feet from the building's entrance.
 - F. At least one drill is conducted every quarter for evaluation and training of the internal emergency and disaster preparedness plan. At least one drill is for fire evacuation and one drill is for Code 99 procedure evaluation for CPR techniques. Each drill is documented and evaluated to promptly implement any necessary

corrections or modifications to the plan.

4. Safety is the utmost priority of the Center. Safety management is achieved by:
 - A. Maintaining and supervising all grounds and equipment by qualified personnel.
 - B. Conducting risk assessments that proactively evaluate the impact of buildings, grounds, equipment, patients and internal physical systems on patient and public safety by periodic inspections and other means such as examining safety issues by appropriate representatives from various departments including administrative, clinical, and support services.
 - C. Hazards that might lead to slipping, falling, electrical shock, burns, poisoning or other trauma are identified and addressed appropriately. Processes for the management of identified hazards, potential threats, near misses and other safety concerns are established.
 - D. Reporting and appropriately investigating all incidents of property damage, occupational illness, and patient, personal or visitor injury in conjunction with continued and ongoing hazardous surveillance, including response to product safety recalls.
 - E. Appointing a Safety and Maintenance Coordinator to oversee the development, implementation, and monitoring of safety issues. It is the responsibility of the Administrator to intervene whenever conditions pose an immediate threat to life or health or threaten damage to equipment or buildings.
 - F. The Center also has established an orientation and education program which addresses:
 - ◆ General safety processes.
 - ◆ Department specific safety.
 - ◆ Specific job-related hazards
 - ◆ Provision of safety-related information through new employee orientation.
 - ◆ Provision of safety-related information and education through inservice and continuing education.
 - F. The Center has requested total staff participation in safety management activities.
 - G. The Governing Body monitors the inspection activities.
 - H. The Governing Body has established emergency and incident reporting procedures and communication. It has also established a process for reporting known adverse incidents to appropriate state and federal agencies when required by law.
 - I. The Governing Body has assigned appropriate inspection, preventive maintenance and testing of safety equipment on a periodic basis.
 - J. Safety policies have been established for the prevention of falls or physical injuries involving patients, staff and visitors. The reporting of falls or injuries is accurate and timely as required by Nevada State regulations.
5. The Center recognizes that security of the Center's staff and patients is of paramount importance. The safety coordinator manages an ongoing organization-wide process to collect and evaluate information about hazards and safety practices that is used to identify

safety management issues. The information collection and evaluation system includes:

- A. Summaries of safety management, life safety management, equipment management, and utilities management problems, failures, usage errors and relevant published reports of hazards associated with any of these areas.
 - B. Documented service, performed at least semi-annually, of all areas of the Center to identify environmental hazards and unsafe practices.
 - C. A system for reporting and investigating all incidents that involve property damage, occupational illness, outpatient, personnel, risk and;
 - D. Summaries of actions taken as a result of other organization-wide monitoring activities, including Quality Assessment and Performance Improvement (QAPI) activities.
 - E. The safety coordinator analyzes identified safety management issues and develops recommendations for resolving them by working with the appropriate staff to implement recommendations and to monitor the effectiveness of the changes. The results of monitoring are important to the safety coordinator.
 - F. Summaries of all identified safety management issues are communicated at least annually to the Governing Body, CEO, directors of all departments/services, and those responsible for other monitoring activities, including QAPI.
 - G. All new personnel including medical staff members, allied health providers and other employees are oriented to the employee Injury and Illness Prevention Program Manual, and all personnel take part in continuing safety education and training and in compliance with all requirements.
 - H. Policies, procedures, and different criteria for identifying, handling, storing, using, and disposing of hazardous materials including its use as well as generation and disposal of hazardous waste. These policies are detailed in the employee Injury and Illness Prevention Program Manual.
 - I. Training for and, as appropriate, monitoring of personnel who manage and/or regularly come into contact with hazardous materials and/or waste.
 - J. Monitoring of compliance with the program's requirements.
6. All equipment is evaluated for inclusion in the safety program, and its evaluation is documented prior to this usage. This is performed by:
- A. Equipment and testing procedures and user training programs designed to manage clinical and physical risk.
 - B. By testing each piece of equipment prior to its use and at least annually thereafter, per manufacturer's recommendations
 - C. Orientation and at least annual continuing education of individuals who use and/or maintain the equipment is also performed. All newly acquired equipment and devices for patient use are tested and staff is educated appropriately to their use prior to use on patients.
 - D. In general the equipment management program is used to identify and document

equipment problems, failures, and user errors that have or might have an adverse effect on patient safety and/or quality of care.

- E. When problems are identified, appropriate actions are taken to resolve these issues and such actions are documented.
 - F. The Center has a policy whenever information is received that reasonably suggests the medical equipment may have caused or contributed to the death, serious injury, or serious illnesses of patients or other individuals. The Center reports this information as required by the State of Nevada Department of Public and Behavioral Health.
7. The Center maintains a utilities management program designed to ensure the operation's reliability, assess the special needs, and respond to failures of utility systems that support the patient care environment. These include:
- A. Criteria which include utilities for life support, infection control, environmental support, and equipment support elements.
 - B. Summary of the evaluation, including identified problems, failures, user errors, and published information about environmental and occupational hazards is reported to the safety coordinator.
 - C. Adequate lighting and ventilation are provided in all areas of the Center, all facilities are clean and properly maintained.

PRECISION SURGERY CENTER

V. ENVIRONMENTAL SAFETY

1. Purposes

B. Environmental Security

I. POLICY

1. The Safety and Maintenance Coordinator shall be responsible for maintaining the following, in order to provide increased security for patients, visitors, personnel, and property.
2. The Safety and Maintenance Coordinator will be responsible for tracking and reporting all security incidents involving employees or patients to the Governing Body at least quarterly, or more often when indicated.

II. RESPONSIBILITY OF SAFETY AND MAINTENANCE COORDINATOR

1. Building and grounds patrol
2. Investigation of thefts, disturbances, suspicious activity
3. Facility access, including locking, unlocking, and restricting traffic at various times
4. Monitoring systems response
5. Staff assistance with patient restraint and intervention in disruptions by patients, visitors, and staff
6. Safety responsibilities, including disaster, fire, and hazard surveillance
7. Record keeping and incident reports
8. All facility areas not in use during evening and night hours, weekends, and holidays are to be locked.

III. IDENTIFICATION

1. Facility name badges shall be worn by all employees and staff.

IV. EMPLOYEE RESPONSIBILITIES

1. Employees shall be responsible for knowing who should legitimately be in their work area and request that all facility staff display their name badge.
2. Secure offices not in use, secure lockers, and lock desks.
3. Observe and report suspicious activities or personnel and confront unauthorized personnel.
4. Direct any individuals who are without visible form of identification to the appropriate place.
5. Whenever possible, not only provide directions, but take time to escort visitors to their destination.
6. Notifying Safety and Maintenance Coordinator immediately when a person is observed not wearing name badge who acts suspicious.

PRECISION SURGERY CENTER

V. ENVIRONMENTAL SAFETY

1. Purposes

C. Risk Management

I. PURPOSE

1. The Center has developed and maintains a safe program of risk management designed to protect the life and welfare of its patients and employees, as well as to provide high quality patient care.
2. The Risk Management Program shall be responsible to assist patient care processes and outcomes and to improve them where indicated.
3. The Risk Management Program shall identify risks to patient safety, physician liability, facility, property damage, and theft, and to minimize these risks.

II. POLICY

1. The Governing Body delegated the Risk Manager and Safety and Maintenance Coordinator, who are responsible for investigating and determining applicable standards of care as per national, state, and local requirements.
2. The Risk Manager, Safety and Maintenance Coordinator, and Quality Improvement Coordinator are established for purposes of complying with the risk management statutes and to evaluate and improve the quality of health care services provided in this Center.
3. The reports, statements, memorandums, proceedings, findings, and other records related to this and the Center in evaluating and improving the quality of health care services provided by the Center or peer review records, are privileged and shall not be subject to discovery, subpoena, or used as evidence in any judicial or administrative proceeding, except as otherwise provided by statute.
4. It is the policy of the Center that all records and reports of the Risk Manager, Safety and Maintenance Coordinator or Quality Improvement Coordinator are confidential and privileged.

III. OBJECTIVES

The Risk Management Program is designed to:

1. Identify areas of risk in the clinical aspects of patient care and safety, as well as employee safety.
2. Identify criteria for screening cases with risk potential regarding clinical aspects of patient care and safety, as well as employee safety.
3. Establish the investigative and evaluative process applied to cases with risk potential.
4. Ensure timely intervention in events that fall below standards of practice.
5. Develop policies and programs to reduce risk in clinical aspects of patient care and safety, as well as employee safety.

6. Establish communication between Risk Management and Quality Assurance functions in the Center.
7. Report risk management activities to the appropriate local, state, and national authorities, as well as licensing agencies as mandated by the law.

IV. PROCEDURE

1. Consistent application of the risk management program throughout the Center, including all departments and service locations.
2. Methods by which a patient is discharged against medical advice.
3. Collection of unpaid accounts is always reviewed before referral to a collection agency with consideration of multiple factors including patient financial status.
4. Reporting and reviewing all incidents reported by employees, visitors, or patients.
5. Periodic review of all litigation involving the Center and its staff and independent health care practitioners.
6. Review of all deaths, trauma, adverse events, and patient complaints.
7. The Center has established methods of dealing with inquiries from governmental agencies, attorneys, consumer advocate groups, reporters, and the media.
8. The Center has established guidelines for managing a situation in which a physician becomes incapacitated during a medical or surgical procedure.
9. The Center has established guidelines to deal with methods for complying with all applicable government regulations, and to deal with methods for prevention of unauthorized prescribing.
10. The risk management program at the Center conducts a periodic review of clinical records and clinical record policies, as well as provides education in risk management activities to all staff.

V. METHODS OF OBSERVATION

1. Variance Reports – the form used to report “significant incidents.”
2. Frequent review of logs for equipment maintenance, emergency carts, automated external defibrillator (AED), monitors, etc.
3. Maintenance of volume and cost statistics.
4. Post-operative follow-up calls to patients – all adverse comments referred to the Risk Manager and/or Quality Improvement Coordinator.
5. Patient satisfaction surveys – with a high return rate – adverse comments reviewed and followed up by the Quality Improvement Coordinator.
6. Use of appropriate credentialing requirements for the staff.
7. Continuous monitoring of patient care areas.
8. Peer review by chart sampling review for compliance with staff physician and nursing standards.

9. The Risk Manager will be responsible for surveying variance reports, active litigation files, potential litigation incidents, and reporting to the Governing Body.
10. All reports submitted to the Governing Body, all complications submitted to the Risk Manager and Quality Improvement Coordinator. All hospital transfers should be reviewed in detail.

PRECISION SURGERY CENTER

SECTION V

ENVIRONMENTAL SAFETY

2. Physical Environment

PRECISION SURGERY CENTER

V. ENVIRONMENTAL SAFETY

2. Physical Environment

A. Preamble

I. POLICY

The Precision Surgery Center provides a safe, functional and sanitary environment for the provision of surgical services.

II. PROCESS

1. Each operating/procedure room is designed and equipped so that the type of surgery/procedure conducted can be performed in a manner that protects lives and ensures the physical safety of all individuals in the area.
 - A. Operating rooms are designed in accordance with industry standards and state licensure requirements with specifications for the operating room design and construction for the types of surgical procedures performed in the room.
 - B. The operating room temperature and humidity are monitored and maintained in accordance with the accepted standards of practice.
 - C. The entire surgery center is appropriately equipped for the types of surgery performed in Precision Surgery Center with appropriate facility equipment including lighting, generators, air handlers, medical gas systems, air compressors, vacuum systems, and medical equipment.
 - D. The operating room equipment is inspected, tested, and maintained by Precision Surgery Center in accordance with federal and state laws including regulations and manufacturers' recommendations.
 - E. Prior to use, appropriate education and training is provided to intended operators of all equipment, including newly acquired devices or products used in the care of patients. The Safety Coordinator and Clinical Director are responsible to ensure that appropriate clinical education occurs prior to use of a newly acquired device in the care of patients.
2. Precision Surgery Center has a separate recovery area and waiting area.
 - A. The waiting room and recovery are not shared with the physician's office.
 - B. Precision Surgery Center has a separate "Phase 1" recovery area equipped with 4 recovery beds and appropriate equipment. It also has a step down area for "Phase 2" recovery with 4 patient chairs. It has a separate area for preoperative preparation of patients which also has appropriate equipment.
 - C. The recovery area is not used as a general waiting area and is semi-restricted.
3. Precision Surgery Center has established a program for identifying and preventing infections, maintaining a sanitary environment, and reporting to appropriate authorities as required.
 - A. Precision Surgery Center has a program to follow-up on each patient after discharge, in order to identify and track infections associated with the patient's stay

in the Precision Surgery Center.

- B. Precision Surgery Center has not established routine post surgical laboratory testing for infectious diseases. However, if the information becomes available of an infection in the post-discharge period from the patient or patient's physician, Precision Surgery Center will inquire whether there is a lab confirmation of infectious disease, and, if there are indications that the infection was associated with the patient's stay in Precision Surgery Center.
 - C. If it is a reportable disease, the case will be reported to the appropriate state authorities.
4. Precision Surgery Center has delegated a portion of the follow-up responsibility to the physicians on Precision Surgery Center's staff who will see the patients in their office post-discharge.
- A. Further, Precision Surgery Center's program includes a mechanism for ensuring that the results of follow-up are reported back to Precision Surgery Center and documented in the patient's medical record.
5. During times of construction, demolition or renovation, the Center will perform a proactive and ongoing risk assessment for existing or potential environmental hazards. implement, document and enforce Interim Life Safety Measure (ILSM), to temporarily compensate for hazards posed by Life Safety Code (LSC) deficiencies or construction activities.
5. Emergency Equipment
- A. Appropriate emergency equipment and supplies are located in the crash cart(s) and are readily accessible to all areas of each patient care area. All emergency equipment is checked and maintained by appropriate staff members and contracted companies. It includes at least the following:
 - B. Emergency call system
 - C. Oxygen
 - D. Mechanical ventilatory assistance equipment including airways, manual breathing bag (AMBU bag)
 - E. Cardiac defibrillator
 - F. Cardiac monitoring equipment
 - G. Tracheostomy set (Nu-Trake)
 - H. Laryngoscope and endotracheal tube suction equipment
 - I. Emergency medical equipment and supplies specified by the medical staff
7. Precision Surgery Center consists of multiple operating rooms and ensures that there is sufficient equipment to handle multiple simultaneous emergencies.
8. Precision Surgery Center's medical staff has adopted a policy, in writing, that addresses

additional emergency equipment and supplies, such as medications routinely used in emergencies, which are immediately available in the operating rooms and crash carts.

9. Emergency Personnel

- A. Policy: Precision Surgery Center has at all times when a patient is in the Precision Surgery Center, personnel trained in the use of emergency equipment and in advanced cardiac life support (ACLS).

III. PROCESS OF PROCEDURE

1. Whenever there is a patient who has been registered in the reception area and not yet discharged from Precision Surgery Center, including patients in the waiting area, in preoperative preparation, in surgery, or in the recovery area, Precision Surgery Center has clinical personnel present who have appropriate training and competence in the use of required emergency equipment and supplies.
2. There is a staff member present in Precision Surgery Center who is trained in CPR techniques, including ACLS.
3. The Center provides training facilities for all employees. Thus, there are multiple nurses and physicians trained in advanced cardiac life support techniques.
4. The training personnel are in sufficient numbers in multiple areas.

PRECISION SURGERY CENTER

V. ENVIRONMENTAL SAFETY

2. Physical Environment

B. Physical Facilities

The location of the program in the community ensures accessibility to persons served, to the staff and visitors. There is adequate parking, driving areas, and other common services. The physical area is adequate in size and design to promote efficiency and flexibility in operations and is equipped to meet established standards of all professional, industrial, or general services. Size, design and equipment reflects appropriate professional and legal requirements for safe and efficient operations and promotes the dignity and self-worth of persons served.

Suitable locations are designated within the office building for activities such as interviews, case dictations, staff conferences, psychometric testing, etc to provide for confidentiality of information of the persons served. The physical space allocated for a specific function or service is adequate for the activities performed.

The building has adequate lighting to allow safe exit from the building in the event of a power failure. Since functions are held during evening hours and since power outages frequently occur during storms which reduce natural lighting, the physical plant has an alternate system of lighting which is not dependent on the primary source of power. This is accomplished by emergency lighting all over the Center, along with an emergency generator for major hallways and the entire Precision Surgery Center.

This building has installed equipment for fire detection and warning devices which are appropriate to the needs of the patients and staff. Testing of fire alarm and inspection of fire suppression systems, including verification of signal transmission is performed and documented.

Environmental hazards associated with safety are identified and safe practices are implemented throughout the Center. Daily operations reflect an awareness of the need to maintain a safe and healthy environment.

Equipment used in all programs is calibrated and maintained in accordance with manufacturer's recommendations. All personnel received adequate education and training for use of all equipment, supplies and medical devices during orientation. Any newly acquired equipment obtained at the Center will not be used for patient care until appropriate education and training has been provided to all staff members involved with its use. The Safety Coordinator and Clinical Director are responsible to ensure this training is performed and documented. Vendor representatives are not used as a sole source of clinical education and training.

PRECISION SURGERY CENTER

SECTION V

ENVIRONMENTAL SAFETY

3. Fire Safety

PRECISION SURGERY CENTER

V. ENVIRONMENTAL SAFETY

3. Fire Safety

A. Introduction

I. FORWARD

When fire strikes, the actions taken during the first few minutes make the difference between containment and disaster. The following general and specific instructions shall be followed as closely as possible by all Center personnel. Additional guidelines for disaster preparedness are in the employee Illness and Injury Prevention Program Manual.

II. TO EACH AND EVERY EMPLOYEE

Each employee should know the following: where fire extinguishers and alarm pulls are located and how to use them, and where the oxygen shut-off valves are located. This is reviewed with each employee upon initial orientation and at least annually.

III. FIRE EXTINGUISHERS

The Center is equipped with general purpose portable fire extinguishers that can safely be used on any type of fire. They are in multiple locations throughout the Center. Each employee is provided documented periodic instruction in the proper use of emergency and fire-extinguishing equipment.

IV. OXYGEN SHUT-OFF

The main shut-off is located in the surgery center's medical gas supply room. It is the responsibility of the Clinical Director or the Administrator to shut this valve off if he/she deems it necessary. No other employee is to touch the valve without specific instructions from the Administrator, Clinical Director or Medical Director. Patients on oxygen could be endangered if the oxygen supply is shut down before portable units are enacted.

V. FIRE EMERGENCY PRE-PLAN

1. Know the location of the nearest fire alarm, fire extinguishers, and exits.
2. Dial 911.

VI. DUTIES AND TRAINING

1. The Safety and Maintenance Coordinator, with the advisory support of the Fire Department, and in conjunction with Compliance Alliance, LLC, undertakes the organization and training of all Center employees in a Fire-Safety Program. All medical staff members and other employees are educated in fire prevention, fire hazard reduction and the Center's policies and procedures of fire safety and response. Compliance Alliance, LLC manages the employee Injury and Illness Prevention Program and further disaster preparedness instructions are located in the employee Manual.

2. The Administrator and Clinical Director will be responsible to see that all employees under their supervision are completely informed and trained, and that each person knows his/her duties and responsibilities in the event of a fire. All training and education is done during initial orientation and annually, or more often as needed.
3. Fire drills are performed at least one per quarter with annual updates in fire safety and prevention. These are performed by the Safety and Maintenance Coordinator in conjunction with other members of the Governing Body, as appropriate.

VII. IN CASE OF FIRE

R = Rescue patients immediately from fire and/or smoke area.

A = Pull fire alarm station and call emergency number – 911. Give exact location.

C = Contain the smoke or fire by closing all doors to rooms and corridors.

E = Extinguish the fire (when safe to do so).

VIII. DIRECT FIRE DEPARTMENT

One person shall be dispatched to the front entrance to direct the Fire Department to the fire area.

IX. GENERAL INSTRUCTIONS FOR ALL EMPLOYEES

1. Turn off all electrically operated equipment, except lights. Safety personnel will shut off air conditioning and ventilation systems if necessary.
2. Keep telephone lines clear for fire control.
3. Make sure all fire, corridor and room doors are closed.
4. Clear all corridors and exits of unnecessary traffic and obstructions.
5. If the fire is in another department or area of the building, all personnel shall report to the nurses station and remain there for instructions. If the fire is located inside the surgery center, begin evacuation protocol (V.3.C) starting with patients first. All employees are to meet in the vacant lot across the street from the building.
6. Assure patients, if any are aware of the fire. Inform them that the alarm has been turned on, the emergency plan is in effect, there is an abundance of help to assist as needed.

X. EVACUATION

If evacuation is required, expect to fully assist with the evacuation under the direction of any of the following persons (full evacuation procedure detailed in V.3.C):

1. Fire Department
2. Administrator
3. Clinical Director
5. Safety and Maintenance Coordinator

PRECISION SURGERY CENTER

V. ENVIRONMENTAL SAFETY

3. Fire Safety

B. Prevention of Fire in an Oxygen Enriched Atmosphere

1. There is a need for the establishment and continuous use of safety practices concerning oxygen administration.
2. Materials not normally considered to be combustible may be so in an oxygen enriched atmosphere.
3. The following precautions shall be observed to eliminate sources of ignition:
 - A. Smoking materials (matches, cigarettes, lighters, lighter fluid, etc.,) removed from patients receiving oxygen therapy and from the area of administration.
 - B. No source of open flame shall be permitted in the area of oxygen administration.
 - C. Patients, visitors, and personnel in the area shall be advised of the hazards and regulations.
 - D. Precautionary signs shall be conspicuously displayed at the site of administration.
 - E. There is no smoking of any kind in or around the surgery center for fire safety purposes. All visitors and staff who smoke will be informed of the designated smoking area 30 feet away from the building near the vacant lot on the south side.

PRECISION SURGERY CENTER

V. ENVIRONMENTAL SAFETY

3. Fire Safety

C. Evacuation Procedures

I. GENERAL CONSIDERATION

Patients in most immediate danger shall be moved first.

If evacuation is required, expect to fully assist with the evacuation under the direction of any of the following persons:

1. Fire Department
2. Administrator
3. Clinical Director
5. Safety and Maintenance Coordinator

II. METHODS OF EVACUATION

1. Non-Ambulatory Patients

- A. Stretchers or blankets, if possible
- B. Carrying patients – the following apply
 - ◆ Small patients – one person piggyback
 - ◆ Two-man extremity
 - ◆ Bring patient to sitting position
 - One person locks arms under patient's shoulders from behind and another carries the legs.
 - Three-man horizontal carry
 - ◆ Pull patient to edge of stretcher
 - Three persons side-by-side slip arms under patient
 - At a given signal, lift patient together with patient facing rescuers; holding close, carry to safety.

2. Wheelchair Patients

- A. Move to nearest exit.

3. Ambulatory Patients

- A. Have patients line up and follow a lead person to safety.

III. PROCEDURES

1. Teams to be assigned by Clinical Director to the fire area as follows:

- A Loading Teams

- Bring all available stretchers, wheelchairs, or blankets to area.
- ◆ Assist with preparing all non-ambulatory patients to be moved.

B. Moving and Carrying Teams

- ◆ Transport all patients through the nearest safe exit to a vacant lot that is a safe distance from the burning area.

C. Receiving Teams

- ◆ Accurate accounting of patients
- ◆ Objective of receiving teams is to provide for continuation of care
 - ◆ Nurse to evaluate condition of patients in receiving area
 - Administer O₂ to those requiring it as well as any other form of respiratory maintenance and see that all patients have blankets over and/or under them as needed.

PRECISION SURGERY CENTER

V. ENVIRONMENTAL SAFETY

3. Fire Safety

D. Responsibilities: Front Office Clerk/Receptionist

1. Upon being notified of a fire:
 - A. By telephone – ask the area and location of the fire, or
 - B. By the speaker system – ask the area and location of the fire.
 - C. Announce over the speaker system "CODE RED _____ AREA" (give area name).
Make announcement three times.
2. Call the Fire Department by dialing **911**. Give the following information:
 - A. Name of the Facility: Precision Surgery Center
Apex Medical Center
 - B. Phone Number – (702)-(310-9110)
 - C. Location of the Facility – (1701 Bearden Dr. Suite 202)
 - D. Cross Street - (Bearden Drive and Shadow Lane)
3. Dispatch an office employee to the street to direct the Fire Department to the area.
4. Notify: The Fire Marshall and the CEO/Medical Director.
5. Keep phone lines open in fire area. Do not permit any unnecessary phone calls.
6. If phone systems are out, send office personnel to a neighboring building or outside public phone to call the Fire Department; stand by your phone system.
7. If the speaker system does not function, use office personnel as runners.
8. Upon receiving "ALL CLEAR" announce "CANCEL CODE RED". Repeat 3 times, every 15 seconds.

PRECISION SURGERY CENTER

SECTION V

ENVIRONMENTAL SAFETY

4. Emergency Policies

PRECISION SURGERY CENTER

V. ENVIRONMENTAL SAFETY

4. Emergency Policies

A. Emergency Equipment

I. Standard Emergency Equipment

1. Emergency call system
2. Oxygen with face masks
3. Respiratory assistance equipment including airways, resuscitation (AMBU) bag
4. Cardiac defibrillator/AED
5. Crash cart – stocked with emergency medications per ACLS protocols
6. Cardiac monitoring equipment
7. Tracheostomy set (Nu-Trake)
8. Laryngoscopes and endotracheal tubes (multiple sizes) and combitube
9. Suction equipment including portable suction machine, tubing, suction tips, canisters.
10. Emergency medical equipment and supplies specified by the medical staff.

PRECISION SURGERY CENTER

V. ENVIRONMENTAL SAFETY

4. Emergency Policies

B. Emergency Personnel

I. POLICY:

1. It is the policy of Precision Surgery Center that a physician trained in basic and advanced cardiac life support is physically present in the center and is trained in the use of all emergency equipment. The physician is present until all patients have been discharged and are physically off the property.
2. All licensed practical nurses and registered nurses have current training in BLS. All certified registered nurse anesthetists (CRNAs), physician's assistants, nurse practitioners and physicians have current training in ACLS.
3. A physician is present at all times until all patients are discharged from the Center and off the property.
4. Nursing staff has appropriate training in malignant hyperthermia, although there is no general anesthesia used in Precision Surgery Center and no triggers are used in daily practice. Succinylcholine is the only known trigger kept on property and would only be used for emergency intubation purposes.

PRECISION SURGERY CENTER

SECTION V

ENVIRONMENTAL SAFETY

5. General Safety

PRECISION SURGERY CENTER

V. ENVIRONMENTAL SAFETY

5. General Safety

A. Statement of Policy

I. STATEMENT

1. Precision Surgery Center shall be functionally safe and sanitary for all patients, staff and visitors.
2. In keeping with this commitment, the center has established a Safety Program. The Safety and Maintenance Coordinator has been delegated responsibility for administering and implementing the program. Further details of this program is outlined in the employee Injury and Illness Prevention Program Manual, provided by Compliance Alliance, LLC. The program will include, but is not limited to:
 - A. Selecting, training and continuing safety education for all employees.
 - B. Developing safe techniques and procedures for specific operations.
 - C. Stimulating all employees' interest in participation in the Safety Program.
 - D. Eliminating all unsafe conditions and unsafe acts.
 - E. Designating a Safety and Maintenance Coordinator for promotion of activities of the Safety Program.
 - F. Maintaining an ongoing preventative maintenance program on all equipment.

II. DUTIES OF SAFETY AND MAINTENANCE COORDINATOR

The Safety and Maintenance Coordinator shall represent the Center in all safety activities. The Safety and Maintenance Coordinator develops, implements, and administers the complete safety program in accordance with management's policies and Compliance Alliance, LLC. The Safety and Maintenance Coordinator's duties include, but are not limited to:

1. Providing leadership and stimulation necessary to ensure and maintain full employee interest and participation.
2. Developing and recommending new procedures and approaches to safety and loss prevention based on reports of incidents, accidents and other relevant information.
3. Disseminating information regarding toxic and hazardous waste and materials, safe medical devices and supplies, emergency preparedness and other safety information.
4. Developing reviews and participating in safety training (annual update) for personnel.
5. Assisting department heads and administration in enforcing safety regulations and codes.

6. Conducting building and group hazard surveillance surveys on a periodic basis to detect code violations, hazards and incorrect work practices and procedures.
7. Measuring and evaluating effectiveness of safety program, using established goals and eliminating all unsafe acts and conditions in the department.
8. Advising management on the development and progress of the Safety Program.
9. In conjunction with Compliance Alliance, LLC, train all new hires on safe procedures and operation of equipment within the department. Training shall be updated annually and whenever new devices are acquired.
10. Be responsible for the degree to which his/her employees have gained knowledge and skills necessary to perform safely and effectively in their particular position.

III. AUTHORITY OF SAFETY AND MAINTENANCE COORDINATOR

The Governing Body of the Center and its CEO has authorized the Safety and Maintenance Coordinator to enforce the Safety Regulations and take corrective action as deemed necessary.

IV. DUTIES OF EMPLOYEE

1. The employee shall be the one most concerned for his/her own safety as well as the safety of fellow employees, volunteers, patients and visitors. Each employee has certain duties to ensure this on-the-job safety which include:
 - A. Knowing job requirements and following the rules of safe work practices.
 - B. Becoming familiar with the equipment and machinery used on the job.
 - C. Recognizing job hazards and taking precautions to ensure safety to self and others.
 - D. Avoiding poor safety attitudes that set the stage for accidents, such as:
 - Forgetfulness
 - ◆ Ignorance
 - ◆ Laziness
 - ◆ Overconfidence
 - E. Informing supervisors of hazards and recommending how to eliminate them or improve safety performance.
 - F. Knowing what to do in an emergency, including the following Emergency Codes:
 - ◆ Code 99 – Cardiac arrest or respiratory arrest
 - ◆ Triage I – Internal Disaster --The following Emergency Color Code System is utilized as the recognized code message system used to differentiate Triage I disasters at the Facility; the codes are:
 - Code Red- Fire
 - Code Adam- Infant/Child Abduction
 - Code Black- Bomb/Bomb Threat Terrorism
 - Code Orange- Hazardous Material Spill/Release
 - Code 99 - Medical Emergency- Adult cardiac arrest
 - Code Silver – Person with weapon/violent situation

◆ Triage II – External Disaster (Example: Earthquake, Tornado)

- G. Emergency Number: 911
 - H. Reading and understanding the employee Infection Control Manual and the employee Injury and Illness Prevention Program Manual with all disaster plans and protocols.
 - I. Actively participating in and cooperating with the Safety Program.
 - J. Maintaining cleanliness and good personal health habits.
2. Employees must understand that compliance with safety requirements is a condition of employment and will be evaluated, together with other aspects of an employee's performance, as part of the performance appraisal process. Employees who are particularly effective in following safe and healthful work practices may receive recognition for their effectiveness. Due to the importance of safety considerations to the Center, employees who violate safety standards, who cause hazardous or dangerous situations, or who allow such conditions to remain when they could be effectively remedied, may be subject to disciplinary action, up to and possibly including termination.
 3. It is therefore essential that all employees comply fully with the standards and practices of the Center that are designed to promote a safe and healthful working environment. As part of the policy, programs have been established through Compliance Alliance, LLC to train and retrain employees as appropriate to assist them to avoid dangerous or unhealthful conditions and to remedy problems or hazards before they cause accidents or injuries.
 4. Whenever an employee identifies an unsafe condition or an occupational safety and health risk, the employee shall report the matter immediately to their supervisor if he/she is unable to remedy the situation himself. If the supervisor is not readily available, the employee shall immediately inform the Safety and Maintenance Coordinator so that any dangerous condition can be corrected. Employees are strongly encouraged to report any situations of this nature and need not fear any form of reprisal as a result of their compliance with this policy. Employees who identify any hazards in the workplace can also choose to report the situation anonymously to the Safety and Maintenance Coordinator if they prefer not to identify themselves.

PRECISION SURGERY CENTER

V. ENVIRONMENTAL SAFETY

5. General Safety

B. Safety Education

- I. Continuous and repetitious methods are necessary to obtain the acceptance of the basic principles of safe work performance. Methods for dissemination of information pertaining to safety shall include:
 - A. Quarterly Meetings – a formal meeting of the Governing Body scheduled quarterly where safety policies and procedures are discussed and the current Safety Program is evaluated and updated as needed. Any safety issues or variances are discussed as appropriate.
 - B. Individual Evaluations – conference between the department head and an employee to correct a specific safety problem.
2. Visual aids may include posters, the employee Injury and Illness Prevention Manual, payroll inserts, newsletter articles, signs, and films.
3. All employees will review the safety and disaster policies in the new hire orientation sessions held for all new hires. They will also receive on-the-job training from their supervisors or fellow workers as they orient into their new departments. Ongoing training will occur from time to time if new equipment/machinery is introduced onto the department, or a new hazard is discovered. Refresher training sessions will be held departmentally, as often as deemed necessary, at least yearly.

PRECISION SURGERY CENTER

V. ENVIRONMENTAL SAFETY

5. General Safety

C. Safety Surveillance Program

I. PURPOSE

To ensure that each area is inspected monthly and appropriate corrective measures are taken to correct cited areas in a timely manner.

II. GENERAL GUIDELINES

1. Identification and reporting of hazards is the responsibility of all employees and is an on-going, daily process.
2. It is the specific responsibility of the Safety and Maintenance Coordinator to ensure that inspections are completed and documented, and appropriate actions are taken.
3. It is the responsibility of the Administrator to ensure requisitions of repair and/or other action is completed.

III. GENERAL SAFETY CRITERIA

1. Ceilings
 - A. Vents/grates
 - ◆ Fire hazard due to lint build-up and foreign-body source.
 - B. Lights covered (to include fluorescent and light bulbs)
2. Floors/Walls/Halls
 - A. Thermostat/other wall mounted items secure
 - ◆ May fall
 - B. Air shafts/other opening secure
 - ◆ May provide inappropriate exit/exploration possibility
 - C. Floor free of debris, spills, slippery areas
 - ◆ Source of slips and falls
 - D. Handrails secure
 - ◆ Handrails: patient care services and stairwells, patient bathrooms
 - E. Hazardous signage appropriate
 - ◆ For example, Oxygen in use, Radiation Caution, Bio-hazardous Waste, Authorized Personnel Only.
3. Patient Transport Equipment

- A. Beds, stretchers, wheelchairs equipped with safety devices (i.e. locking rails and brakes)
4. Personal Safety
- A. Employees identified by name badge.
 - B. Others such as sales representatives, outside agency workers, etc., identified with uniform and identification/business card

IV. FIRE AND ELECTRICAL SAFETY CRITERIA

- 1. Doors and Exits
 - A. Unobstructed by beds, carts, pallets
 - B. Exit lights operable – not even a flicker. If flickering, notify maintenance immediately.
 - C. Exit directions posted.
- 2. Specific Fire/Electrical Safety
 - A. Fire extinguisher checked quarterly
 - ◆ Card attached shall be dated and initialed by safety personnel
 - B. Approved waste containers
 - ◆ Larger than office size shall be covered.
 - C. Employees in area able to verbalize/identify
 - ◆ Nearest fire exit
 - ◆ Nearest fire alarm pull
 - ◆ Nearest extinguisher
 - D. Storage shelves are 4" to 6" bottom clearance or sealed to floor with 18" top clearance so items are not flush with the ceiling.
 - ◆ Lint build-up is a fire and sanitary hazard.
 - F. Electrical equipment labeled appropriately as indicated
 - G. Extension cords appropriate – must be approved by Safety Coordinator
 - H. Outlet face plates intact and secure
 - I. Floor outlets covered
 - J. Gas cylinders chained or in carts to prevent tipping/falling over.

V. NURSING UNITS/CLINICAL AREAS

1. Soiled linen contained appropriately in plastic bag in covered hamper frames.
2. Sharps containers adequate and placed appropriately, i.e., medication prep. areas, soiled utility room by hopper for draining IVs, patient care, common areas.
3. Alcohol based hand rub dispensers are installed and maintained in a manner that minimizes leaks or spills that could lead to falls, and protects against inappropriate access, and in accordance with dispenser manufacturer guidelines.
3. Crash cart accessible and readily mobile and not blocked with equipment nor used for storage on top.
4. All solutions/liquids labeled including liquids found in utility rooms, exam rooms, and housekeeping carts.
5. Medication and food refrigerators maintained at approximately 40 degrees with temperature logged daily and adjusted as needed. Refrigerators will be dedicated to either food or medication and labeled appropriately. Compliance with all local, state and federal guidelines is required regarding preparation, serving, disposal and storing of food and drink for patient use.
6. Needles and syringes secured at all times

VI. GROUNDS AND PARKING LOT

1. Pavement/sidewalk free of debris, broken glass, potholes
2. Handicapped areas identified and accessible
3. Emergency entrance identified and accessible
4. Fire lane(s) identified and accessible

PRECISION SURGERY CENTER

SECTION V

ENVIRONMENTAL SAFETY

6. Environmental Control

PRECISION SURGERY CENTER

V. ENVIRONMENTAL SAFETY

6. Environmental Control

A. Safety

I. OBJECTIVES

To adopt, implement and monitor a comprehensive Center-wide environmental control program relative to safety and sanitation which involves staff, equipment operation and maintenance; the establishment of written policies, rules and regulations; the orientation and education of all employees in safety and sanitation, in order to provide a functionally and environmentally safe atmosphere for patients, personnel and visitors.

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B. Safety and Security Management

I. POLICY

1. The Center has designed a safe, accessible, effective, and efficient environment of care consistent with its mission, services, law and regulations.
2. The Center has designed a management plan to provide a safe, accessible, effective, and efficient environment of care consistent with its mission, services, and law and regulations.

II. PRINCIPLES

1. All facilities and personnel of the Center are designed and maintained to comply with the life safety code.
2. The Center has used acceptable guidelines and standards in the design of the facilities.
3. The Center has designed management plans as follows:
 - A. Safety Management Plan – The Center’s plan provides a physical environment free of hazards and manages staff activities to reduce the risk of injuries.
 - B. Security Plan – The Center’s security management plan describes the Center’s responsibilities and management to protect staff, patients, and visitors from harm.
 - C. Hazardous Materials and Waste Management – The Center has developed hazardous materials and waste management safety with processes for selection, handling, storing, using, and disposing of hazardous materials and wastes from receipt or generation through the use of final disposal.
 - D. Emergency Preparedness – The Center has addressed the Emergency Preparedness Management Plan to ensure effective response to disasters or emergencies affecting the environment of care.
 - E. The Center has established a management plan addressing life safety.
 - F. The Center has established a plan addressing medical equipment to promote safe and effective use of medical equipment.

G. The Center has designed a management plan addressing the utility systems. This plan was established and maintains a utilities system management plan to:

- ◆ Promote a safe, controlled, comfortable environment of care;
- ◆ Access and minimize risks of utility failures;
- ◆ Ensure operational reliability of utility systems.

The Center's management plan provides various processes for:

- ◆ Establishing criteria for identifying, evaluating, and taking inventory of critical operating components of systems to be included in the utility management plan. These criteria address the impact of utility systems on life support systems, infection control systems, environmental support systems, equipment support systems, and communications systems.

III. UTILITY BACKUP SYSTEMS

1. The Center is always equipped with a cellular phone with a fully charged battery and a two – way communication system for use in case of loss of the telephone system during bad weather.
2. The Center maintains a routine schedule for testing the emergency lights in the hallways that guide patients and staff to exits in cases of full power loss.
3. In case of an emergency with loss of electrical power, the generator will automatically pick up and the emergency lighting throughout the facility, which is a battery pack independent of the emergency generator, will function automatically.
4. The Center also keeps fully loaded battery pack flashlights in each operating room, reception area, recovery room, medication room, and mechanical and storage equipment room.
5. To ensure appropriate functioning of the emergency power with the generator, its capabilities and limitations are accessed on a regular basis with evaluation of the generator on a weekly basis, along with testing of the generator on a dynamic or full load on a once a year basis.
6. In case of a failure of the water supply, bottled water will be utilized temporarily until the situation is controlled and additional water supply is obtained.
7. Utility systems management plan also established:
 - A. An orientation and education that addresses various issues to all staff members on an annual basis and also at the time of orientation for new employees.
 - B. This plan addresses various capabilities of the utilities systems along with limitations and spatial applications. These include utility equipment, as well as medical equipment.

- C. The staff understands that any equipment can fail and result in disastrous consequences. Hence, a multitude of backup systems are installed and the staff are educated on various aspects of the backup systems.
 - D. Utility management policies, procedures, and maintenance are performed by the Safety and Maintenance Coordinator. All the employees should report any problems or questions to this person.
8. In the event of generator failure, the Center has established a generator failure plan to ensure safety for all patients and personnel. All staff members are provided with appropriate information and trained with the skills necessary to perform assigned maintenance responsibilities in case of generator failure or any type of other utility failure.
 9. The Center has provided all appropriate information and training to all employees to locate the emergency shut-off controls and they have been instructed on the use of shut-off controls.
 10. Utility system management problems, failures, and user errors are reported to the Safety and Maintenance Coordinator and appropriately addressed with the appropriate training.
 11. All utility systems for disruptions or failures are promptly addressed.

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6. Environmental Control

C Safety and Maintenance Coordinator

I. BASIC FUNCTION

Provides staff safety support to management and supervisors; assists in review of implementation of safety programs; participates in hazard evaluation problem-solving and decision making; acquires knowledge of the requirements of applicable codes, standards, and regulations pertaining to safety and loss control; interacts with other members of the safety team; participates in planning, developing and conducting safety meetings; evaluates and audits all safety programs.

II. RESPONSIBILITIES

1. Adheres to and supports the mission, vision, values, goals, philosophy, objectives, policies, and procedures of the Center.
2. Develop and implement programs to enhance employee safety and promote safety awareness.
3. Interpret and evaluate regulatory documents and establish methods to ensure compliance.
4. Provide advice and assistance to all personnel which serve to prevent accidents.
5. Ensure that data and records are properly collected, documented, maintained in a manner which meets regulatory requirements and permits an understanding of the status of the safety program.
6. Promote professional and ethical practices.
7. Perform any and all duties as assigned.

III. MACHINES, TOOLS, EQUIPMENT, AND WORK AIDS

A working knowledge of all equipment used in the operation of the Precision Surgery Center. This includes but is not limited to the computer systems, equipment technology used, corporate updates and awareness of policy changes as relates to a specific entity.

IV. WORKER TRAITS: APTITUDES, INTERESTS AND TEMPERAMENTS

1. Aptitudes:

- A. Effective communication skills with staff, physicians, and others as it relates to the business.
- B. Necessary skills required to enable effective understanding of various emergency evacuation procedures and all necessary safety precautions.
- C. Necessary skills for effective and appropriate maintenance.

2. Interests:

- A. An interest in continuous self-development and professional growth.
- B. Continued education on various aspects of safety and the maintenance of all facility equipment to aid in the operations of the business (i.e. necessary seminars to increase understanding and awareness of hazards and necessary precautions.)

3. Temperament:

- A. Ability to perform in situations requiring limited supervision for successful execution of daily operations.
- B. Exhibit confidentiality and good judgment when aware of information requiring discretion.

V. PHYSICAL DEMANDS AND WORKING CONDITIONS

Ability to be flexible enough to meet the demands and conditions of situations as they arise.

VI. POSITION ROLE

The role of this position includes: 1) to manage, separate, direct, and administer the human, physical, and financial resources provided for safety and maintenance 2) assign priorities within the department based on resources, and 3) to ensure that the safety program anticipates, identifies, evaluates and recommends controls for accident potentials arising in the workplace.

VII. QUALIFICATIONS

- 1. High school or college graduate
- 2. Good understanding of safety and maintenance issues.

PRECISION SURGERY CENTER

V. ENVIRONMENTAL SAFETY

6. Environmental Control

D. Departmental Safety: Maintenance

I. GENERAL

1. Safety and Maintenance Coordinator is responsible for maintenance and safety.
2. The grounds are kept free from refuse and litter. Areas around the buildings, sidewalks, gardens, and patios are kept clear of dense undergrowth. Walkways, entrances and exits are checked daily and kept safe for traffic.
3. All outside traffic areas are kept free of ice and other hazards.

II. PREVENTIVE MAINTENANCE PROGRAM

Preventive maintenance is carried out on an annual basis (or more often as required) on all systems, equipment and facilities. For all medical equipment, use is standardized and preventative maintenance and safety checks are performed by a contracted company who performs all checks according to manufacturer's recommendations. A log is kept and updated of all equipment checks and repairs. The log includes the piece of equipment or system, location, type of maintenance or repair performed, testing procedure, inspection interval.

III. ELECTRICAL AND ELECTRONIC SAFETY

1. All personnel are trained in safety appropriate to the areas in which they work and the equipment they use, operate or are exposed to through orientation and instruction when they are hired and at required in-service meetings for updates on any new equipment..
2. Regulations concerning the use of electric or electronic systems, devices, equipment, appliances, outlets, etc. are strictly enforced. Special precautions must be taken when the care of patients requires the use of any type of electrical or electronic device.
3. Prior to placement into service (when newly installed, or after relocation, or significant alteration) all equipment and systems shall be tested and checked for proper functioning and safety-device requirements by qualified outside contractors under service agreements, or factory representatives.
4. Manufacturers' safety regulations must be kept on all equipment used in the center., these are kept in the administration office. All equipment safety inspections are to include the following: voltage, current resistance, macro-shock hazard, fault current, leakage current, radiation leakage, proper calibration. Each piece of equipment must be tagged with appropriate inspection labels.

IV. ELECTRICAL AND ELECTRONIC PATIENT CARE EQUIPMENT

1. This equipment is tested annually or more often based on manufacturer's instructions. Critical equipment (life supporting) is tested quarterly by the contracted biomedical engineer company per regulation. New electrical and electronic patient care equipment is tested and evaluated upon installation. The Safety and Maintenance Coordinator keeps a log of each piece of patient care electrical equipment tested with the following information recorded:
 - A. Date of test
 - B. Name of equipment and department where located
 - C. Name of employee or company conducting test
 - D. Type of test conducted
 - E. Results of test
2. Each piece of equipment is appropriately tagged with date of inspection and by whom. Documentation of inspection and repair is also kept on file in the administration office. The Safety and Maintenance Coordinator is informed in writing of any untoward results of tests or repairs needed.
3. In the event of malfunction of a piece of equipment or medical device, the vendor or manufacturer responsible for repair of the device will be contacted by the Safety Coordinator. The device will be cleaned with an appropriate disinfectant prior to transport/pickup for repair by the appropriate individual. A log will be kept of all devices sent for inspection/repair and the dates sent out.

V. ELECTRICAL POWER DISTRIBUTION SYSTEM

1. All electrical power distribution systems (Generator) in the Facility are checked every week. Evaluation of power systems is in accordance with manufacturers' instructions. The Safety and Maintenance Coordinator keeps a log of each system evaluated with the following information recorded:
 - A. Date of evaluation
 - B. Name of system
 - C. Name of employee or individual conducting evaluation
 - D. Results of evaluation
2. The following are connected to the emergency power system:
 - A. Center's communication system
 - B. All egress illumination
 - C. Exit signs and exit directional signs
 - D. All alarm systems
 - E. Operating rooms, recovery rooms, mechanical storage and gas storage areas in surgery
 - F. Designated refrigerators
 - G. Central suction systems servicing medical and surgical functions

VI. FIRE PROTECTION

1. Construction and Compartmentation Requirements

- A. The Center meets construction requirements for the protection from fire hazards, according to National Fire Protection Association's (NFPA's) definition of acceptable types of fire-safe construction for this type of institution.
- B. The Center meets compartmentation requirements for protection from fire hazards according to Life Safety Code, NFPA 99. Floor is divided into fire sections with main fire doors which close upon activation of fire alarm.
- C. There are exits which lead to the outside of the building. Doors close by activation methods specified by NFPA and can be manually controlled. Exit doors are equipped with panic hardware so they can be kept closed to outside access if desired.
- D. All vertical openings are protected in accordance with NFPA 99 standards.
- E. Doors in fire partitions, smoke stop partitions, and horizontal exits are not equipped with hold-open devices, are self-closing and normally kept in a closed position. If open, fire and smoke doors are automatically closed by electronic activation of fire and sprinkler alarm system.
- G. Doorways, corridors and stairwells are kept free of obstruction at all times.
- H. Louvers in corridor doors are made smoke-tight through the installation of non-combustible materials.
- I. There are appropriate signs at all fire exits such as stairwell doors, indicating that it is a fire exit.
- J. Exits are sufficiently illuminated to permit safe evacuation of patients.

VII. FIRE WARNING AND SAFETY SYSTEMS

- 1. Every building has an electrically supervised, manually opened fire alarm system installed to transmit an alarm automatically. Fire detection and safety systems and alarms are regularly serviced and all components of the warning and safety system is tested quarterly by the contracted fire maintenance company. Results of tests are kept on file by the Safety and Maintenance Coordinator in the administration office.
- 2. A copy of each test conducted is forwarded to the Safety and Maintenance Coordinator along with a statement of any repairs, replacement of equipment or work done and any recommendations for future action.
- 3. All smoke and fire detectors are tested annually. Fire extinguishers are inspected monthly and records are maintained as above by the Safety and Maintenance Coordinator..

VIII. STORAGE, HANDLING, AND USE OF GASES, FLAMMABLE LIQUIDS AND COMBUSTIBLES

1. Compressed gas cylinders must properly be identified "full or empty" and always capped when not in use or connected to a delivery system. All personnel handling compressed gas cylinders are trained and oriented in the proper use and transportation. Freestanding cylinders must be chained to a firm support or supported in appropriate cart or stand.
2. Oxidizing gases, such as oxygen are stored in a locked area. This storage area is separated from all flammable gases and/or liquids and will be kept free of combustible materials. It is the responsibility of the Safety and Maintenance Coordinator to inspect and maintain storage areas daily. Inspection and maintenance will include responsibility to keep all storage areas free of fire hazards. If hazards are found during daily inspections, the hazards shall be removed, corrected and reported to the Safety and Maintenance Coordinator. A record of each hazard found will be kept on file in the administration office.
3. The only anesthetizing locations in the Center will be the operating suites. No general anesthesia will be performed per state regulations. Each operating suite is equipped with its own humidifier with a digital read out and humidity will be maintained at or above 40% per regulations.

IX. SANITATION AND ENVIRONMENT MAINTENANCE SERVICES

1. The Safety and Maintenance Coordinator is involved in environmental maintenance through coordinating any structural repair and refinishing work; including repair of furnishings; furniture and facilities; and heavy duty custodial work and waste collection and removal. Outside companies and/or contractors will be used for the majority of repair work.
2. Only approved products are used for furniture, wall, ceiling, and floor finishes.
3. Pest control involves screening of apertures as necessary.

X. IDENTIFICATION SIGNS FOR DOORS, PASSAGES, STAIRWAYS, ETC.

Doors, passages and stairways which are not exits nor lead to exits are identified by signs reading "NOT AN EXIT," or "TO STAIRWAY-EMPLOYEES ONLY". Restricted areas or rooms are identified by signs.

XI. FACILITIES FOR THE HANDICAPPED

1. Parking spaces located in the first floor parking garage of the Center have been provided for handicapped persons. These parking spaces are identified by appropriate signage.
2. The following facilities and provisions have also been provided for handicapped persons: access to fountains, toilets, and hand washing facilities.

XII. MISCELLANEOUS FACILITIES AND SERVICES

1. Flushing facilities are available for emergency care in cases of chemicals and burns, located in the Laboratory. (nurses' station.)
2. Entrances, exits, walks, roadways, and parking lots are kept free of ice, debris, and hazards.

XIII. POWER FAILURE

1. All personnel are responsible for knowing the procedure to follow in case of power failure.
2. The Clinical Director and personnel of the surgery department are responsible for coordination of activities in the event of power failure. The activities in the surgery center will be coordinated with other activities occurring in the facility.
3. All personnel are responsible for providing for patient safety as the first priority.
4. Back-up generator is inspected once a week.
5. Back-up generator is manually tested once a month.
6. Back-up generator panel is inspected daily and if warning lights are activated, generator service department called.
7. In the event of power failure in the Center, the following procedures will be followed:
 - A. Back-up generator turns on within 10 seconds after failure occurs, without interruption.
 - B. All emergency lights turn on appropriately.
 - C. Safety and Maintenance Coordinator initiates search to locate the reason(s) for failure – city, in-house, etc.
 - D. Safety and Maintenance Coordinator takes appropriate action (e.g., if in-house failure correct or call electrician, etc.

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6. Environmental Control

E. Medical Device Problem and Recall

I. POLICY

To establish a uniform policy for addressing recall of medical items, including medication, vaccines, blood products, medical devices, equipment, supplies and food products, as applicable to the Center. This is to ensure that product problems and recall information are properly documented, disseminated and reported as per federal guidelines and recalled products do not present a safety risk to patients and personnel.

II. PROCEDURE

1. Product hazards regarding defective equipment or recalls may come from the following sources and are to be managed as follows:
 - A. Patient Incidents
 - ◆ Fill out Incident Report
 - ◆ Notify Administrator, Clinical Director and Medical Director
 - ◆ Notify Safety and Maintenance Coordinator
 - B. Employee Injuries
 - ◆ Notify Clinical Director and Administrator
 - ◆ Fill out Incident Report
 - ◆ Notify Safety and Maintenance Coordinator
 - C. Equipment Malfunctions
 - Notify Safety and Maintenance Coordinator
 - ◆ Contact Biomedical engineering company for repaired
 - D. Product Recalls from Manufacturer
 - Notify Safety and Maintenance Coordinator
 - ◆ Forwarded to Clinical Director or Administrator.
 - E. Possible Defective Product
 - ◆ Report to Safety and Maintenance Coordinator
 - ◆ Fill out Incident Report
 - ◆ Safety and Maintenance Coordinator/Administrator contacts manufacturer to investigate problem.
 - F. Medical Device Action Items from the Food and Drug Administration (FDA) Notices, CDC warnings, corporate or manufacturer warnings or any other third party (including local, state and federal sources)
 - ◆ Alerts are received by the Administrator
 - ◆ Forwarded to the Safety and Maintenance Coordinator who reviews the Alerts involving equipment.

- ◆ Safety and Maintenance Coordinator forwards the Alerts to the Clinical Director for review of stock of medication .

2. The following steps shall be performed by the Safety and Maintenance Coordinator and the Clinical Director for all reported product alerts and problems:

A. Determine if the facility has an affected product by searching inventory of equipment, supplies and medication and supply orders.

B. If an affected product is in the facility, take appropriate action. This should be done per manufacturers recommendations may include:

- ◆ Removal from service/use and return of the product
- ◆ Modification of product, if appropriate, as determined by recall notice
- ◆ Change in use instructions, if appropriate, as determined by recall notice
- ◆ Warning to users; including staff members or patients if affected
- ◆ Determination of availability of alternate product.

C All staff members involved with the use of the equipment, device or medication recalled should be immediately notified of any changes in use or removal from use on patients. This should be done in the form of a written memo or staff meeting with signatures by all staff of acknowledgment. The Clinical Director and the Safety Coordinator will be responsible for such meetings/memos.

D. The Clinical Director will be responsible for contacting patients via phone or written notice describing the recalled product if utilized during their care, what they can expect and the manufacturer's contact information for further questions.

E. Notify the Product Manufacturer for return of the recalled item. All medical devices or equipment previously in contact with patients will be appropriately disinfected prior to return to vendor/manufacturer.

F. If a medical device has in all probability caused a death, serious injury or serious illness of a patient, the FDA must also be notified.

G. The report to the FDA must be made within ten (10) working days after the facility becomes aware of the problem. In addition, summaries of user reports must be submitted to the FDA on January 1 and July 1 of each year. The summary report, as well as the initial FDA notification is the responsibility of the Safety and Maintenance Coordinator.

- ◆ The Summary shall contain the following information: Facility name; the device's name, serial number and model number; the manufacturer's name and address; and a brief description of the event reported to the manufacturer.

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V. ENVIRONMENTAL SAFETY

6. Environmental Control

F. Departmental Safety: Business Office, Front Desk

1. The Safety and Maintenance Coordinator will over see that all equipment is kept in good working order at all times. It must be checked for electrical, and mechanical safety prior to initial use by the contracted biomedical engineering company and annually thereafter, or more often per manufacturers' instructions. All equipment must be properly maintained according to manufacturers' directions and preventive maintenance schedules. Any equipment found defective must be removed from use, repaired and rechecked by appropriate personnel.
2. Instruction in the proper use, care, and maintenance of department equipment is given to each new employee during the first few weeks of employment by the person in charge of orientation and instruction, and to all employees as new equipment is introduced. Equipment operational and maintenance manuals must be on file in the department, and special safety instructions (if any) must be kept on each piece of equipment where the operator can see them. Personnel must be warned of any potential hazards in the use and/or handling of equipment and they must be instructed on how to avoid accidents, and measures to be taken should an accident occur.
3. Improper lifting, reaching, climbing and carrying are discouraged because of potential injuries to oneself or others.
4. Traffic areas must be kept clear of equipment.
5. Spills must be wiped up immediately.
6. Broken glass must be disposed of properly as soon as it is discovered.
7. Broken furniture must be removed from use until it is repaired.
8. Sharp edges on desks, tables, drawers, etc. shall be filed or covered.
9. Do not obstruct fire fighting equipment.
10. Any and all accidents are reported the Safety and Maintenance Coordinator and Administrator. The employee Injury Report will be completed, and employees are treated at the Center or sent to another facility for treatment. Review employee Injury and Illness Prevention Program Manual for further details of this policy.

PRECISION SURGERY CENTER

SECTION V

ENVIRONMENTAL SAFETY

7. Utility Systems Management

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V. ENVIRONMENTAL SAFETY

7. Utility Systems Management

A. Responsibilities

1. The building is inspected monthly by the Safety and Maintenance Coordinator with a walk through check list.
2. The emergency generator is tested on a weekly basis and documented.
3. If there is a utility system problem, report to the Safety and Maintenance Coordinator and/or Administrator.
4. Safety and Maintenance Coordinator is responsible to assess the problem, try to resolve or contact a contracted company for repair.
5. If utility systems have failed, immediate service will take place by personnel or a local company.
6. If utility system problems were found to be user error; the Safety and Maintenance Coordinator will address the issue with an in-service for all personnel involved.
7. The utility systems management plan will be evaluated annually by the Safety and Maintenance Coordinator.
 - A. All targeted personnel will demonstrate and/or be tested on the location of all safety valves.
 - B. All targeted personnel will demonstrate proper sequence of turning off valves.
 - C. All personnel will be reviewed on their role in utility systems failure.
8. The Governing Body will also review the Utility systems management plan annually. The Governing Body will evaluate and reevaluate objectives, scope, performance, and effectiveness of the utility management plan. Appropriate additions, deletions, or revisions will be made on an annual basis based on the requirements and performance to meet the objectives.

PRECISION SURGERY CENTER

V. ENVIRONMENTAL SAFETY

7. Utility Systems Management

B. Emergency Shut-Off Controls

I. POLICY

In the event of electrical, natural gas, or water hazards, follow the procedures to properly shut off areas to ensure safety to the building.

1. In the event of an emergency that all outside electrical power needs to be disconnected from the building.
 - A. The Safety and Maintenance Coordinator or Administrator will contact the electric company for services. Keys to the main electrical room are kept secure in the administration office.
 - B. In the event the back up generators need to be disconnected, the generator company will be contacted for immediate service. Keys to the generator enclosure are kept secure in the administration office.
 - C. If any staff or patients are at risk by remaining in the building, follow the evacuation procedure as detailed in the disaster plan.
2. In the event of an emergency that the natural gas needs to be disconnected from the building.
 - A. The Safety and Maintenance Coordinator or Administrator will contact the gas company for appropriate service. Keys to all service closets are kept secure in the administration office.
 - B. The main gas meter is located outside the first floor parking garage to the left. In the event of a gas leak follow evacuation procedures as detailed in the disaster plan.
3. In the event of an emergency that the water supply needs to be disconnected from the building.
 - A. The Safety and Maintenance Coordinator or Administrator will contact the water company for appropriate service. Keys to all service closets are kept secure in the administration office.
 - B. In the event of flooding of the building due to plumbing issues, follow the evacuation procedures as detailed in the disaster plan.

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V. ENVIRONMENTAL SAFETY

7. Utility Systems Management

C. Generator Failure

I. POLICY

The generator failure plan is to ensure safety for all patients and personnel.

1. If in the event there is an electrical failure and the emergency generator failed to turn on or has stopped working, the Administrator, Safety and Maintenance Coordinator, and Clinical Director will activate the following plan to ensure safety.
 - A. All personnel locate flashlights.
 - B. First attend to the patients if they are under sedation.
 - C. Staff personnel will be assigned to each patient to ensure safety and attend to their needs.
 - D. Evacuate all patients as directed by supervisors.
 - E. Notify company of generator failure to assess the situation and repair.
 - F. Front desk notified to cancel all remaining cases.
 - G. Resume all function once electricity is restored.

PRECISION SURGERY CENTER

V. ENVIRONMENTAL SAFETY

7. Utility Systems Management

D. Failure of Utilities

I. PROCEDURE

In the event of utility system failure (i.e. electrical, water, gas):

1. Follow instructions from the Administrator and assist patients from the affected areas.
2. Evacuate building as instructed by Medical Director, Safety and Maintenance Coordinator, and Administrator.
3. Safety and Maintenance Coordinator and/or Administrator contact appropriate company for immediate service. Keys to all service closets are kept in the administrative office.
4. Secretary personnel will be notified if necessary and to cancel all patients until all systems are cleared.
5. Utilize alternate sources if available. (i.e. flashlights, ect.)

II. UTILITY BACKUP SYSTEMS:

1. The Center is always equipped with a cellular phone with a fully charged battery and a two-way communication system for use in case of loss of the telephone system.
2. The Center maintains a routine schedule for testing the emergency lights in the hallways that guide patients and staff to exits in cases of full power loss.
3. In case of an emergency with loss of electrical power, the generator will automatically pick up and the emergency lighting throughout the facility will illuminate.
4. The Center also keeps flashlights equipped with batteries in each operating room, reception area, recovery room, medication room, and mechanical and storage equipment room.
5. To ensure appropriate functioning of the emergency power with the generator, its capabilities and limitations are accessed on a regular basis with evaluation of the generator on a weekly basis, along with testing of the generator on a dynamic or full load on an annual basis per regulation.
6. In case of a failure of the water supply, bottled water will be utilized temporarily until the situation is controlled and additional water supply is obtained.
7. Utility systems management plan is also established:
 - A. New staff orientation and education that addresses basic issues of utility management will occur at initial hire and annually.

- B. This plan addresses various capabilities of the utilities systems along with limitations and spatial applications. These include utility equipment, as well as medical equipment.
 - C. The staff understands that any equipment can fail and result in disastrous consequences. Hence, a multitude of backup systems are installed and the staff are educated on various aspects of the backup systems.
 - D. Utility management policies, procedures, and maintenance are performed by the Safety and Maintenance Coordinator. All the employees should report any problems or questions to this person.
8. In the event of generator failure, the Center has established a generator failure plan to ensure safety for all patients and personnel. All staff members are provided with appropriate information and trained with the skills necessary to perform assigned responsibilities in case of generator or any other type of utility failure.
9. Utility system management problems, failures, and user errors are reported to the Director of Safety and Maintenance Coordinator and appropriately addressed with the additional training.

PRECISION SURGERY CENTER

SECTION V

ENVIRONMENTAL SAFETY

8. Hazardous Materials Management

PRECISION SURGERY CENTER

V. ENVIRONMENTAL SAFETY

8. Hazardous Materials Management

A. Hazardous Materials

I. PURPOSE

To establish a policy and procedures to develop and implement a system for the proper identification, management, handling, transport and disposal of hazardous materials and wastes, whether liquids, solids or gas. Also to develop an employee information and training program so that all employees will have the knowledge necessary to perform their work safely with or around any material or substances that could potentially be hazardous. A hazard material analysis will be conducted annually by Compliance Alliance, LLC in conjunction with the Safety Coordinator. Additional guidelines for the Hazard Communication Plan are located in the Injury and Illness Prevention Program Manual.

II. PROCEDURE

1. A list of hazardous substances present at the workplace is determined and documented by a thorough assessment of all areas of the Center.
2. Hazardous materials are labeled hazardous and stored separate from other substances. Disposal of hazardous waste are done appropriately into hazard containers for pickup by contracted company..
2. Maintain Material Safety Data Sheets (MSDSs) are located on CD inside the Injury and Illness Prevention Program Manual. The MSDS Manual is checked on a regular basis for current information. Components for the Safety Coordinator to monitor include: proper labeling of materials i.e., containers, sharps, storage containers, contaminated materials from procedures, and others as indicated.
3. All employees are informed of potential exposure to hazardous materials. The Center provides secure, environmentally controlled hazardous materials and waste storage spaces as well as personal protective equipment (PPE) for those personnel who must work near or come into contact with hazardous materials and waste.
4. Training will be conducted periodically by Compliance Alliance, LLC so that employees will have the knowledge necessary to perform their work safely with or around any materials or substances that could be potentially hazardous.

III. EMPLOYEE TRAINING AND EDUCATION

1. Initial hazardous substances information and training will be provided for each employee during orientation by Compliance Alliance, LLC, in conjunction with their direct supervisor.
2. Information or training must subsequently be provided to each employee prior to assignment to any work area in which the employee has not received previous information and training.

3. Employees must be furnished with an explanation of what an MSDS is, either in written form or through a training program.
4. Employees who may be exposed to a hazardous substance must be furnished with information on the contents of the MSDS for that hazardous substance, equivalent information either in written form or through training programs. This information shall include as a minimum:
 - A. Any health hazards known to be associated with exposure to the hazardous substance(s).
 - B. Proper instructions for handling; necessary personal protective equipment; or other safety precautions necessary to prevent or minimize exposure to the hazardous substance(s).
 - C. In an emergency situation, the Local Fire Department or nearest emergency treatment center will be contacted.
5. Training programs will be conducted periodically as required; at a minimum, such programs will be conducted on an annual basis. As new employees enter the workplace, training in regards to hazardous materials and waste management will be the responsibility of the Safety and Maintenance Coordinator, in conjunction with Compliance Alliance, LLC. Training must be accomplished during initial orientation at the time of employment. Records of employee attendance will be maintained in the administration office.

IV. Material Safety Data Sheet (MSDS) UPDATING

Whenever a new or revised MSDS is received, such information shall be provided to employees on a timely basis, not to exceed 30 days after receipt. The MSDS file is kept on CD and available to all employees upon request. The CD is kept inside the Injury and Illness Prevention Program Manual.

PRECISION SURGERY CENTER

V. ENVIRONMENTAL SAFETY

8. Hazardous Materials Management

B. Chemical Waste

I. PURPOSE

1. To describe procedures for the identification and disposal of chemical wastes within the confines of the Center.
2. To ensure that these wastes are handled and disposed of in accordance with the Environmental Protection Agency (EPA), Department of Transportation (DOT), and state regulations.

II. GENERAL INFORMATION

1. Hazardous chemical waste is defined as any chemicals that are toxic, flammable, corrosive, or reactive, or capable of causing harm or serious injury to humans, animals or the environment.
2. The Safety and Maintenance Coordinator has authority to institute the Emergency Plan in the event of a major chemical waste accident or incident.
3. A MSDS is to be completed on every chemical used in the Center and identified as hazardous.
4. A master file of the MSDS information sheets is maintained in the Injury and Illness Prevention Program Manual.
5. It is the responsibility of the Administrator and Safety and Maintenance Coordinator using a hazardous chemical to determine if a less hazardous one may be substituted.
7. All persons required to handle hazardous chemical wastes shall have written specific policies and procedures that contain information pertinent to that department. These policies and procedures shall be reviewed annually and approved by the Governing Body.

III. IDENTIFICATION

1. At a minimum, certain chemical wastes from the following departments shall be classified as hazardous by the Safety and Maintenance Coordinator.
 - A. Safety
 - B. Grounds
 - C. Housekeeping/Janitorial
2. All drums, buckets, jugs, pails, or any other container containing a hazardous chemical substance, shall have a clear, complete, conspicuous, and durable label identifying the chemical used.

3. A MSDS shall be completed on all hazardous chemicals identifying the generic and trade name of the product.

IV. STORAGE AND HANDLING

1. Regular inspections shall be made of the storage site to ensure there are no leaking or spilled containers. If a spill or leak is found, the following actions shall be taken:
 - A. Before attempting to clean up any hazardous chemical spill or splash, know what the chemical is.
 - B. Follow the directions according to the established procedures for cleaning up that kind of chemical spill or leak.
 - C. Evacuate all personnel from the area.
 - D. Extinguish all flames.
 - E. Ensure adequate ventilation.
 - F. Call the Safety and Maintenance Coordinator.
 - G. If a fire occurs, set off the alarm and evacuate the area.
 - H. If no fire occurs, wait by the spill area, out of danger, until help arrives. Avoid tracking through the spill.
 - I. Obtain appropriate protective safety equipment.
 - J. Clean up the spill according to manufacturers' instructions provided in the MSDS manual.
 - K. If it is inside the building, contact Safety and Maintenance Coordinator for cleaning the area.
 - L. Any major spills, splashes, leaks, burns, etc., from a hazardous chemical substance shall be reported to the Safety Coordinator.
2. Materials which ignite easily under normal conditions (flammables) are considered fire hazards and shall be stored in a cool, dry, well ventilated storage space, well away from areas of fire hazard.
3. Highly flammable materials shall be kept in an area separate from oxidizing agents (material susceptible to spontaneous heating; explosives, etc.)
4. The storage area for flammables shall be supplied with fire fighting equipment, either automatic or manual. There is no smoking allowed in these areas.
 - A. Oxidizers shall not be stored close to liquids of low flash point.
 - B. Acids and acid fume sensitive materials shall be stored in cool, dry, well ventilated areas.
 - C. Materials which are toxic as stored or which can decompose into toxic components from contact with heat, moisture, acids, or acid fumes shall be stored in a cool, well ventilated place out of the direct rays of the sun. Incompatible toxic materials shall be isolated from each other.
 - D. Corrosive materials shall be stored in a cool, well ventilated area (above their freeze point). The containers shall be inspected at regular intervals to ensure they are labeled and kept closed.
 - E. Corrosives shall be isolated from other materials.

- F. Protective clothing and equipment shall be available for use when handling these materials.

V. DISPOSAL

1. Disposal of small amounts of liquid chemical wastes (60 cc, 20 oz.) may be disposed of by diluting 1 part chemical to 100 parts water and flushed down the sewer system. These amounts shall be diluted and flushed down the sewer at varying times during the day (varying times during the day shall be approximated according to the quantity of chemicals needing dilution.)
2. In diluting chemicals from flushing down the sewer system, always add one part chemical to 100 parts water. Never add the water to the chemical container.
3. Wear rubber gloves, fume mask, and/or other safety equipment as required when preparing liquid chemicals for disposal.
4. No empty drums, buckets, jugs, pails, or any other container that has held toxic or corrosive materials or chemicals shall ever be reused for anything.
5. The Safety and Maintenance Coordinator will be responsible for disposal of all hazardous chemicals in the surgery center.

PRECISION SURGERY CENTER

SECTION VI

MEDICAL STAFF

PRECISION SURGERY CENTER

SECTION VI

MEDICAL STAFF

1. Organization

PRECISION SURGERY CENTER

VI. MEDICAL STAFF

1. Organization

A. Goals

The purpose of the individual practitioner is to provide appropriate care, while the purposes of the Medical Staff organization shall be:

1. To reflect, influence and maintain the professional nature of medical practice through such organizational activities as collegial discussion, continuing medical education, participation in providing educational opportunities to residents in training (as applicable), nursing, medical assistants and the community.
2. To perform the following functions including, but not necessarily limited to:
 - A. Provide recommendations to the Governing Body regarding applications for Medical Staff membership and clinical privileges.
 - B. Establish rules, regulations, policies, and methods related to professional prerogatives and obligations of Medical Staff members.
 - C. Through Medical Staff leadership with the assistance of qualified support personnel, develop and use physician-specific performance data including objective conclusions.
 - D. Establish mechanisms whereby Medical Staff members have input to the Center's affairs.
 - E. Through the Medical Director, provide periodic reports to the Governing Body, and perform independent peer reviews of other physicians cases done at the center for quality assurance and performance improvement purposes.

PRECISION SURGERY CENTER

VI. MEDICAL STAFF

1. Organization

B. Objectives and Bylaws

I. OBJECTIVES:

These Bylaws, which originate with the Medical Staff, are adopted in order to provide for the organization of the Medical Staff of Precision Surgery Center, and to provide a framework for self-governance and accountability in order to permit the Medical Staff to discharge its responsibilities in matters involving the standards for and appropriateness of medical care, and to govern the orderly resolution of those purposes.

These Bylaws provide the professional and legal structure for Medical Staff operations, organized Medical Staff relations with the Governing Body of the Center, and relations with applicants to and members of the Medical Staff.

These Bylaws provide the vehicle wherein issues relating to medical care and administrative functions of the Center can be resolved through the mutual efforts of the Medical Staff and Governing Body.

These Bylaws as adopted or amended create a system of mutual rights and responsibilities between members of the Medical Staff and the Center.

II. ADOPTION OF BYLAWS, RULES, AND REGULATIONS

The Medical Staff shall adopt such Bylaws, Rules, and Regulations as may be necessary for the proper conduct of its work. Such Rules and Regulations as pertaining to the Medical Staff as a whole shall be a part of these Bylaws. These Rules and Regulations, or amendments to them, shall become effective when approved by the Governing Body.

III. AMENDMENTS OR REVISIONS

To revise or amend the Bylaws of the Medical Staff, it requires a 2/3 vote of the active medical staff with at least one year of good standing membership present, with notice provided to the entire membership, in addition to approval of any amendments or revisions by the Governing Body.

IV. ADOPTION

These Bylaws, together with the Rules and Regulations, shall be adopted at any regular meeting of the Medical Staff and shall become effective when approved by the Governing Body of the Precision Surgery Center. They shall, when adopted and approved, be equally binding on the Governing Body and the Medical Staff.

PRECISION SURGERY CENTER

VI. MEDICAL STAFF

1. Organization

C. Non-Physician Clinical Staff

I. PREAMBLE

The Governing Body makes provisions for non-physician practitioners providing patient care services under the supervision and/or direction of a physician when required.

II. CREDENTIALING

Non-physician practitioners licensed to provide patient care with supervision of the physician and the practitioners who are not employees of the Center undergo credentialing by the Governing Body. These practitioners are granted as per their qualifications, privileges consistent with their individual training and experience and other qualifications. Credentialing is performed by the Governing Body and re-appointments will be reviewed every year upon recommendation of the medical staff. A credential file is maintained on each practitioner containing at least the following documents:

1. Current staff application
2. Current (Nevada) licensure
3. Current malpractice insurance certificate
4. Name of supervising physician(s), if applicable
5. Current delineation of privileges
6. Proof of educational training
7. Competence of practitioner and supervisor as indicated by relevant findings of QAPI activities and other reasonable indicators of current qualifications.

III. ELIGIBILITY

Successful applicants for Clinical Staff appointment must:

1. Hold a current and unrestricted license or certification in respective discipline to practice in the State of (Nevada) and;
2. Provide evidence of training, experience, current clinical competence, good reputation and the character, mental, physical, and emotional stability, and ability to work with and relate well to others to the extent required by the provision of these Bylaws;

IV. EFFECTS AND OTHER AFFILIATIONS

No practitioner shall be automatically entitled to membership on the Staff, or to the exercise of particular clinical privileges, merely because he/she is licensed or certified to practice in this or in any other state, or because he/she is a member of any professional organization, or because he/she is certified by any clinical board, or because he/she is a member of a faculty, or because he/she had or presently has, Staff membership or privileges at another health care facility or in another practice setting. Nor shall any practitioner be automatically entitled to appointment, reappointment, of particular privileges merely because he/she has or presently has staff membership or those particular privileges at this Center.

V. ETHICS AND CONDUCT

Professional conduct shall be governed by the Code of Ethics of this Center.

In addition, every practitioner (physician and non-physician), at the time of appointment and reappointment and at any time during the appointment period, must demonstrate, to the satisfaction of the Medical Staff and Governing Body, a willingness and capability, based on current attitude and evidence of performance, to work with and relate to other Medical Staff members, members of other health disciplines, the Center's management and employees, patients, and the community in general, in a cooperative, professional manner that is essential for maintaining the Center's operations to provide appropriate patient care.

VI. INITIAL APPLICATION

1. Each applicant shall provide in writing, on a form developed by the Medical Staff for the Clinical Staff, and approved by the Governing Body, at least the following:
 - A. Names of at least three (3) professional references, only one of whom may be from his/her group, employment, or organization;
 - B. Verified information regarding professional diploma, training, current license or certification in the State of (Nevada) and Drug Enforcement Administration (DEA) registration if applicable;
 - C. Information as to whether the applicant's professional license, certification, or DEA registration, or Staff appointment or clinical privileges at another hospital or other health care entity (e.g. Precision Surgery Center) have ever been reduced, revoked, suspended, not renewed, or voluntarily relinquished, and if applications for Medical Staff appointment and/or privileges at other hospitals or other health care entity have been denied.
 - D. Information about the applicant's physical and mental health;
 - E. Evidence of current professional liability insurance coverage in reasonable amounts that may be determined from time to time and at any time by the Governing Body with Medical Staff input;
 - F. Information about malpractice judgments, suits, claims and settlements within the last five (5) years;
 - G. Name(s) of supervising physicians if applicable
 - H. Any additional information required by the Medical Staff or Governing Body to adequately evaluate the applicant, including the applicant's professional conduct.

Failure by the applicant to provide requested information within sixty (60) days of the written request for the information shall result in the application being null and void, with no further processing required and no right to appeal.

Failure by the applicant to provide truthful, accurate, and complete information shall in itself be grounds for denial or revocation of Medical Staff membership/appointment and clinical privileges.

2. Application Process

All the appropriate documents along with completed application shall be submitted to the Administrator and once information is verified and the credentials file is deemed complete, it shall be forwarded to the Medical Director for review and/or request for additional information. The Governing Body shall approve, disapprove or defer recommendation and grant privileges accordingly.

VII. APPLICANT'S BURDEN

In all matters pertaining to any application for initial appointment and privileges and pertaining to obtaining of supporting information for reappointment, renewal, or updating of privileges, the burden is the applicant's. Processing of the application cannot begin until all required information is on file and validated.

VIII. COMPLETED APPLICATION WHETHER INITIAL OR RENEWAL

Applications shall not be considered until they have been declared complete by the Medical Director..

"Completed Application" includes all information the applicant has been called upon to provide and validation of the information by a third party verification if required.

When the application has been deemed complete, the applicant will be so notified, but advised that further information may be requested when the Medical Director considers the application.

The next step is the opportunity for the Medical Director to review information concerning education, training, and recent clinical experience, and provide a report on the applicant's qualifications.

An applicant's appointment is effective upon action by the Governing Body.

If the Medical Director issues a favorable recommendation, and the Governing Body action concurs, the Governing Body's action shall be final. If the Governing Body's action is unfavorable, it shall not be final until the applicant has exercised or waived his rights to a hearing under these Bylaws.

If the Medical Staff's action is unfavorable to the applicant, the hearing rights under these Bylaws shall apply. If the applicant waives his/her rights, the Medical Staff's recommendation shall be forwarded to the Governing Body for final action which shall adopt the Medical Staff's action unless there is insufficient reasonable data to support it. If the applicant exercises his/her hearing rights, the Governing Body shall not take final action until the applicant's rights under these bylaws have been exhausted or waived.

When the final action has been taken by the Governing Body, the Medical Director must transmit this decision in writing to the applicant for appointment or reappointment.

PRECISION SURGERY CENTER

SECTION VI

MEDICAL STAFF

2. Membership and Clinical Privileges

PRECISION SURGERY CENTER

VI. MEDICAL STAFF

2. Membership and Clinical Privileges

A. Organization of Medical Staff

The physicians practicing at Precision Surgery Center hereby are organized in conformity with the Bylaws, and Rules and Regulations hereinafter stated.

For the purpose of these Bylaws, Rules and Regulations, the following definitions are given:

The term "President of the Governing Body" shall mean the Governing Director of the Center and ultimate authority. He also shall act as Medical Director and Chief Executive Officer of the Center.

The term "Center" shall mean Precision Surgery Center.

The term "Administrator" is the employee of the Center who has overall responsibility for the management of the Center.

The Governing Body, in addition to the Quality Improvement Coordinator, will assume all responsibilities and duties of a QAPI Committee, and manage all aspects of the QAPI Program.

The Center will limit diagnostic and therapeutic procedural activity to treatment of ambulatory patients. It will be staffed and equipped to meet the needs of the patient, support staff and care providers.

The Center will be designed to serve the patients of the practice and the Medical Staff will be limited to physicians of the said practice.

PRECISION SURGERY CENTER

VI. MEDICAL STAFF

2. Membership and Clinical Privileges

B. Medical Staff Membership

1. Nature of Medical Staff Membership

Membership on the medical staff or the exercise of temporary privileges shall be extended only to professionally competent practitioners who continuously meet the qualifications, standards and requirements set forth in these Bylaws. Appointment to and membership on the staff shall confer on the appointee or member only such clinical privileges and prerogatives as have been granted by the Governing Body in accordance with these Bylaws. No practitioner shall admit or provide services to patients in the Center unless he or she is a member of the staff or has been granted temporary privileges in accordance with the procedures set forth.

2. Basic Qualification for Membership

Only practitioners licensed to practice medicine, dentistry, or podiatry in the State of (Nevada) shall:

- A. Be of ethical and professional integrity;
- B. Be of such background, experience, training and demonstrated competence as to assure the Medical Staff that any patient treated by such applicant will be given a high quality of medical care;
- C. Practice within the community within a reasonable distance of the surgery center;
- D. Maintain membership and either admitting or refer and follow privileges in good standing at one of the local accredited acute care hospitals;
- E. Maintain Professional Liability Insurance; and
- F. Be Board Certified or Board Eligible in their particular specialty.

3. Effect on Other Affiliations

No practitioner shall be automatically entitled to membership on the medical staff or to the exercise of particular clinical privileges merely because he/she is licensed to practice in this or in any other state, or because he/she is a member of any professional organization or because he/she is certified by any clinical board, or because he/she had, or presently has, staff membership or privileges at a hospital or at another health care facility or in another practice setting.

4. Nondiscrimination

No aspect of MEDICAL staff membership or particular clinical privileges shall be denied on the basis of sex, race, age, creed, color, or national origin or on the basis of any other criterion unrelated to the delivery of quality patient care in the Center, to professional qualifications, to the Center's purposes, needs and capabilities, or to community need.

5. Basic Responsibilities of Individual Staff Membership

Each member of the medical staff shall:

- A. Provide all patient care at the generally recognized professional level of quality and

- efficiency.
- B. Abide by the medical staff Bylaws and all other lawful standards, policies and rules of the Center.
- C. Discharge such staff, and Center functions as required.
- D. Prepare and complete in timely fashion the medical and other required records for all patients he/she admits or in any way provides care to in the center.
- E. Abide by the ethical principles of his/her profession.

6. Duration of Appointment

All initial appointments are granted by the Governing Body for a period of one year.

7. Reappointments

Reappointments are also granted by the Governing Body and shall be for a period of not more than one year.

8. Staff Qualifications

The active staff shall consist of physicians, each of whom:

- A. Meets the basic qualifications.
- B. Regularly is involved in the care of patients in the Center.

9. Staff Prerogatives

The prerogatives of a staff member shall be to:

- A. Admit patients without limitation, unless otherwise provided in the medical staff rules and regulations.
- B. Exercise granted clinical privileges.
- C. Vote on all matters presented at general and special meetings of the medical staff, unless otherwise provided by resolution of the staff and approved by the Medical Board.
- D. Hold office in the staff organization unless otherwise provided by resolution of the staff, and approved by the Medical Board.

10. Staff Responsibilities

Each member of the staff shall:

- A. Meet the basic responsibilities.
- B. Retain responsibility within his/her area of professional competence for the continuous care and supervision of each patient in the center for whom he/she is providing services.
- C. Actively participate in the patient care evaluation and other quality evaluation and monitoring activities required of the staff, in supervising initial appointees of the same profession, and in discharging such other staff functions as may be required from time to time.
- D. Satisfy the requirements for attendance at meetings as necessary.

11. Temporary Privileges

A. Circumstances

The Medical Director or the Chief of Medical Staff may grant temporary privileges in the following circumstances:

- ◆ Pendency of Application: An appropriately licensed applicant may be granted temporary privileges for an initial period of 20 days, with subsequent renewals at the discretion of the Medical Director.
- ◆ Care of Specific Patients: An appropriately licensed physician who is not an applicant for membership may be granted privileges on a temporary basis for the care of one or more specific patients.
- ◆ Locum Tenens: An appropriately licensed physician may be given temporary privileges for a period of 90 days under these circumstances.

B. Conditions

Temporary privileges shall be granted only when the information available reasonably supports a favorable determination regarding the requesting practitioner's qualifications, ability and judgment to exercise the privileges requested, and only after the practitioner has satisfied the requirements of Section 2 and 5.

C. Termination

On the discovery of any information or the occurrence of any event of a nature which raises question about a practitioner's professional qualifications or ability to exercise any of the temporary privileges granted, the Medical Director may terminate such practitioner's temporary privileges, without recourse.

D. Rights of the Practitioner

A practitioner shall not be entitled to the procedural rights afforded because of his/her request for temporary privileges is refused or because all or any portion of his/her temporary privileges are terminated or suspended.

12. Emergency Privileges

For the purposes of this Section, an "emergency" is defined as a condition in which serious or permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger. In the case of an emergency, any practitioner, to the degree permitted by his/her license and regardless of service, staff status or clinical privileges, shall be permitted to do, and shall be assisted by Center personnel in doing, everything possible to save the life of a patient from serious harm.

13. Corrective Action

A. Routine Corrective Action

- ◆ Criteria for Initiation
- ◆ Whenever the activities or professional conduct of any practitioner with clinical privileges are, or are reasonably likely to be, detrimental to patient safety or to the delivery of quality patient care are, or are reasonably likely to be, disruptive to Center operations, corrective action against such practitioner may be initiated by any member of the medical staff or by the Medical Director.

B. Requests and Notices

- ◆ All requests for corrective action shall be in writing, submitted to the Medical Director, and supported by reference to the specific activities or conduct which constitute the grounds for the request. The Medical Director shall promptly notify the Administrator of all requests for corrective action received and shall continue to keep them fully informed of all action taken in conjunction therewith.

C. Investigation

- ◆ The Medical Director shall immediately investigate the matter or appoint an ad hoc committee to investigate it. As soon as is practicable after the receipt of the request, the Medical Director shall forward a written report of the investigation to the medical staff. The investigative procedures may include consultation with the practitioner involved.

D. Governing Body Action

- ◆ As soon as practicable after the receipt of the report, the Governing Body shall take action upon the request.
- ◆ Such action may include:
 - ◆ Rejecting the request for corrective action.
 - Issuing a warning, a letter of admonition, or a letter of reprimand.
 - Recommending terms of probation or individual requirements of consultation.
 - Recommending reduction, suspension or revocation of clinical privileges.
 - Recommending limitation of any staff prerogatives directly related to patient care.
 - Recommending suspension or revocation of staff membership.

E. Summary Suspension

- ◆ Criteria and Initiation
 - ◆ Whenever a practitioner's conduct requires that immediate action be taken to protect the life of any patient(s) or to reduce the substantial likelihood of

immediate injury or damage to the health or safety of any patient, employee or other person present in the Center, the Medical Director, shall have the authority to summarily suspend the medical staff membership status or all or any portion of the clinical privileges of such practitioner. Such summary suspension shall become effective immediately upon imposition and the Medical Director shall promptly give special notice of the suspension to the practitioner. In the event of any such suspension, the practitioner's patients then in the Center whose treatment by such practitioner is terminated by the summary suspension shall be assigned to another practitioner by the Medical Director. The wishes of the patient shall be considered when choosing a substitute practitioner.

F. Automatic Suspension

- License - A staff member whose license is revoked or suspended shall immediately and automatically be suspended from practicing in the Center.
- Drug Enforcement Administration (DEA)– A staff member whose DEA is revoked or suspended shall immediately and automatically lose his/her right.
- Medical Records
 - ◆ An automatic suspension shall, after warning of delinquency, be imposed for failure to complete medical records in a timely fashion. For the purpose of enforcing this Section, justified reasons for delay in completing medical records may include:
 - Unavailability of a physician or other physician due to illness for a period of time due to circumstances beyond his/her control.
 - ◆ Waiting for the results of late reports and the record is otherwise complete.
 - ◆ A practitioner has dictated reports and is waiting for Center personnel to transcribe them.
 - ◆ A practitioner has left town.

G. Professional Liability

A practitioner who fails to maintain the amount of professional liability insurance required by the Governing Body (1 million/3 million) shall immediately be suspended from practicing in the Center.

14. Hearing

When the Governing Body initiates an adverse action concerning a practitioner, the practitioner may be afforded his/her due process rights for a review.

15. Hearings and Appellate Review

A. Exceptions

- ◆ Neither the issuance of a warning, a letter of admonition, or a letter of reprimand, nor the denial, termination or reduction of temporary privileges shall give rise to any right to a hearing or a review.

PRECISION SURGERY CENTER

VI. MEDICAL STAFF

2. Membership and Clinical Privileges

C. Medical Staff Credentialing

As stated in Governing Body Responsibilities, physicians and non-physicians will be granted privileges consistent with their individual training and experience and other qualifications. Credentialing will be performed by the Governing Body following the recommendations of the Medical Director. Re-appointments will be reviewed every year. Primary or secondary source verification will be performed on every applicant.

1. Eligibility

Successful applicants for Medical Staff appointment must:

- ◆ Hold a current and unrestricted license to practice in the State of (Nevada), and current DEA registration
- ◆ Provide evidence of training, experience, current clinical competence, good reputation and the character, mental, physical, and emotional stability, and ability to work with and relate well to others to the extent required by the provision of these Bylaws;
- ◆ Have satisfactorily completed a full graduate residency program which is as required of him or her in order to take the appropriate Board Certification Examination in his or her medical specialty, or the equivalent for dentists.

Successful applicants for non-physician practitioner appointment must:

- ◆ Hold a current and unrestricted license to practice in the State of (Nevada), and current DEA registration, if applicable.
- ◆ Provide evidence of training, experience, current clinical competence, good reputation and the character, mental, physical, and emotional stability, and ability to work with and relate well to others to the extent required by the provision of these Bylaws;

2. Effects and Other Affiliations

No practitioner shall be automatically entitled to membership on the Medical Staff, or to the exercise of particular clinical privileges, merely because he/she is licensed to practice in this or in any other state, or because he/she is a member of any professional organization, or because he/she is certified by any clinical board, or because he/she is a member of a medical school faculty, or because he/she had or presently has, Medical Staff membership or privileges at another health care facility or in another practice setting. Nor shall any practitioner be automatically entitled to appointment or reappointment of particular privileges merely because he/she has or presently has Medical Staff membership or those particular privileges at this Center.

3. Ethics and Conduct

Professional conduct shall be governed by the Code of Ethics of this Center.

In addition, every practitioner, at the time of appointment and reappointment and at any time during the appointment period, must demonstrate, to the satisfaction of the Medical Staff and Governing Body, a willingness and capability, based on current attitude and evidence of performance, to work with and relate to other Medical Staff members, members of other health disciplines, Center's management and employees, patients, and the community in general, in a cooperative, professional manner that is essential for maintaining the Center's operations to provide appropriate patient care.

4. Initial Application

A. Each applicant shall provide in writing, on a form developed by the Medical Staff and approved by the Governing Body, at least the following:

- ◆ Names of at least three (3) professional references, only one of whom may be from his/her practice group;
- ◆ Verified information regarding professional school diploma, postgraduate training, current license to practice in the State of (Nevada), and DEA registration;
- ◆ Information as to whether the applicant's professional license, or DEA registration, or Medical Staff appointment or clinical privileges at another hospital or other health care entity (e.g. Precision Surgery Center) have ever been reduced, revoked, suspended, not renewed, or voluntarily relinquished, and if applications for Medical Staff appointment and/or privileges at other hospitals or other health care entity have been denied.
- ◆ Information about the applicant's physical and mental health;
- ◆ Evidence of current professional liability insurance coverage in reasonable amounts that may be determined from time to time and at any time by the Governing Body with Medical Staff input;
- ◆ Information about malpractice judgments, suits, claims and settlements within the last five (5) years;
- ◆ Any additional information required by the Medical Staff or Governing Body to adequately evaluate the applicant, including the applicant's professional conduct.

Failure by the applicant to provide requested information within sixty (60) days of written request for the information shall result in the application being null and void, with no further processing required and no right to Hearing and Appeal.

Failure by the applicant to provide truthful, accurate, and complete information shall in itself be grounds for denial or revocation of Medical Staff membership/appointment and clinical privileges.

B. Application Process

All the appropriate documents along with completed application shall be submitted to the Administrator and once information is verified and the credentials file is deemed complete, it shall be forwarded to the Medical Director for review and/or request for additional

information. Information from the National Practitioner Data Bank (NPDB) will also be reviewed during the initial application process. Upon recommendation of the Medical Staff, the Governing Body shall approve, disapprove or defer recommendation and grant privileges accordingly. When final action has been taken by the Governing Body, the Medical Director shall be authorized to transmit the decision to the applicant for membership, and if he/she is accepted, to secure his/her signature to those Bylaws, Rules and Regulations. Such signature shall constitute his/her agreement to be governed and abide by the said Bylaws, Rules, and Regulations.

5. Applicant's Burden

In all matters pertaining to any application for initial appointment and privileges and pertaining to obtaining of supporting information for reappointment, renewal, or updating of privileges, the burden is the applicant's. Processing of the application cannot begin until all required information is on file and validated.

6. Completed Application Whether Initial or Renewal

Applications shall not be considered until they have been declared complete by the Medical Director.

"Completed Application" includes all information the applicant has been called upon to provide and validation of the information.

When the application has been deemed complete, the applicant will be so notified, but advised that further information may be requested when the Medical Staff considers the application.

The next step is the opportunity for the Medical Director to review information concerning education, training, and recent clinical experience, and provide a report on the applicant's qualifications. An applicant's appointment is effective upon action by the Governing Body.

If the Medical Staff issues a favorable recommendation, and the Governing Body action concurs, the Governing Body's action shall be final. If the Governing Body's action is unfavorable, it shall not be final until the applicant has exercised or waived his rights to a hearing under these Bylaws.

If the Medical Staff's action is unfavorable to the applicant, the hearing rights under these Bylaws shall apply. If the applicant waives his/her rights, the Medical Staff's recommendation shall be forwarded to the Governing Body or final action which shall adopt the Medical Staff's action unless there is insufficient reasonable data to support it. If the applicant exercises his/her hearing rights, the Governing Body shall not take final action until the applicant's right under these Bylaws have been exhausted or waived.

When the final action has been taken by the Governing Body, the Medical Director must transmit this decision in writing to the applicant for appointment or reappointment.

PRECISION SURGERY CENTER

VI. MEDICAL STAFF

2. Membership and Clinical Privileges

D. Appraisals of Physicians and Non-Physician Members of Medical Staff

I. REAPPOINTMENT AND RENEWAL OF PRIVILEGES

Appointments and clinical privileges are renewable every year. The following will hold for both Physician Members of the Medical Staff and Non-Physician Members, as applicable.

The purpose of reappointment is not to resolve issues but is to review established facts for the purpose of reappointment and renewal of privileges.

The Governing Body reviews and acts on the Medical Director's recommendations regarding reappointment and renewal of clinical privileges.

Applications for renewal of Medical Staff membership and clinical privileges shall be acted upon only as set forth in these Bylaws and on an annual basis, or by recommendation from the Medical Director.

If the Medical Director issues a favorable recommendation, and the Governing Body action concurs, the Governing Body's action shall be final. If the Governing Body's action is unfavorable, it shall not be final until the applicant has exercised or waived his/her rights to a hearing under these Bylaws.

If the Medical Director's action is unfavorable to the applicant, the hearing rights under these Bylaws shall apply. If the applicant waives his/her rights, the Medical Director's recommendation shall be forwarded to the Governing Body for final action which shall adopt the Medical Director's action unless there is insufficient reasonable data to support it. If the applicant exercises his/her hearing rights, the Governing Body shall not take final action until the applicant's rights under these Bylaws have been exhausted or waived.

At a regularly specified time, each Medical Staff member receives an application for renewal of his/her appointment and clinical privileges. The reappointment/renewal application process includes or elicits at least:

1. Opportunity to request continuation of present Medical Staff status;
2. Opportunity to request a change in Medical Staff category assignment;
3. Opportunity to request either an addition to or a deletion from specific clinical privileges;
4. Opportunity to request that Medical Staff membership and privileges be terminated.
5. Revalidation of licensure and DEA registration.
6. Summary of performance and information accumulated by the Quality Improvement Coordinator, reflecting clinical knowledge, judgment skills, relationship with other physicians, with the Center and its employees and with patients, availability, mental and physical stability, and technical proficiency. Peer reviews are taken into consideration and current competence is verified and

documented.

7. Verification of the practitioner's mental and physical health shall be provided upon request by the Medical Staff.
8. Evidence of continued liability insurance coverage in reasonable amounts established by the Governing Body and information about malpractice judgments, suits, claims, settlements.
9. Information from the National Practitioner Data Bank (NPDB) will also be reviewed during the reappointment process.
10. Information about changes in Medical Staff membership and/or privilege status at other health care entities; such information may be required to perform current performance.

II. BETWEEN ROUTINE REAPPOINTMENT DATES

Practitioners shall immediately furnish to the Medical Director, whenever applicable:

1. Information if the practitioner's professional license in any state has been limited, revoked, restricted, suspended, not renewed or voluntarily relinquished.
2. Information if professional liability insurance is canceled or lapses without renewal.
3. Information about restrictions on, relinquishment of, or revocation of Medical Staff membership and/or privileges at another institution.
4. Information about a significant change in health status that adversely affects the practitioner's ability to practice medicine.
5. Any information reasonably required by the Medical Staff to adequately evaluate the Medical Staff member.

III. REAPPOINTMENTS

1. The procedure for reappointment shall be as follows:

The physician shall submit a Request for Reappointment and Renewal of Clinical Privileges. The Administrator shall, at least 60 days prior to the expiration date of the present staff appointment of each medical staff member, provide such staff member with a Request for Reappointment for use in considering his or her reappointment. Each staff member who desires reappointment shall, at least 30 days prior to such expiration date, send his/her Request for Reappointment to the Administrator.

2. The Administrator shall compile information and submit completed request to the Medical Director. After the Medical Director has reviewed the request, he shall upon recommendation of the Medical Staff, submit recommendation to Governing Body. After the Governing Body has reviewed the request for re-appointment, the Administrator shall be authorized to transmit a decision to the applicant. Any additions, deletions or restrictions to the privileges granted, will be put in writing to the applicant. A notice of change in delineation of privileges shall be forwarded to the scheduling office.

3. Medical staff members not meeting criteria will be informed by a letter of non-compliance.

IV. HEARING AND APPEALS PROCESS

Recommendation to the Governing Body for withdrawal of any privileges or dismissal from the Medical Staff shall be made only after a thorough investigation, with the subject member being given the right of hearing before the Governing Body.

An appeals process will follow these guidelines:

1. All notification and communication between a physician and Precision Surgery Center will be by certified mail, return receipt requested.
2. Initial correspondence between Precision Surgery Center and the physician will advise the practitioner of his right to a hearing, review and right to review specific charges against him.
3. Failure to request a hearing or review within fourteen (14) days of proper notification by certified mail will constitute a waiver of rights for hearing or review.
4. The administrator will be present at all formal hearings and review.
5. The formal nature of a hearing or review will state in concise language, acts of omission or commission with which the physician or other health related professionals are charged.
6. A record of proceedings will be maintained.
7. Either party will be allowed to have an attorney present at the hearing or review. Should either party elect to have an attorney present, then the other party should be so notified prior to the meeting.
8. Notification and hearing will be conducted within thirty days, the beginning date to commence with the date notification is posted. Review will be conducted and notification delivered within ten (10) days following hearing.

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2. Membership and Clinical Privileges

E. Clinical Privileges

Diagnostic and treatment privileges for specific procedures to be performed are determined and approved by the Governing Body. A current copy of each physician's Delineation of Privileges form will be maintained in each physician's credentials file identifying which procedures they will be performing and will be updated annually.

PRECISION SURGERY CENTER

VI. MEDICAL STAFF

2. Membership and Clinical Privileges

F. Medical Staff File

A credentials file will be maintained on each physician containing at least the following:

1. Current Medical Staff Application
2. Current (Nevada) Medical License
3. Current DEA License
4. Current Malpractice Insurance Certificate
5. Current Delineation of Privileges
6. Proof of Educational Training (i.e. medical school, residency, fellowship)
7. Verification of either admitting or refer and follow privileges in one of the nearby hospitals.
8. Competence of Medical Staff Member, as indicated in part by relevant findings of QAPI activities and other reasonable indicators of current qualifications.
9. American Medical Association (AMA) Master Profile
10. National Practitioner Data Bank Profile, updated annually
11. Name(s) of supervising physicians for non-physician practitioners, if applicable

All credentials of the Medical Staff of Precision Surgery Center will be primary or secondary source verified by the Administrator or one of his/her designees.

PRECISION SURGERY CENTER

SECTION VI

MEDICAL STAFF

3. Staff Management Policies

PRECISION SURGERY CENTER

VI. MEDICAL STAFF

3. Staff Management Policies

A. Medical Staff Management

I. PROBLEM IDENTIFICATION

Confirmed and documented patterns of practice or behavior, or single incidents that adversely affect, or could adversely affect patients, the Medical Staff, the Center or its employees, including its orderly operations, are addressed by the Medical Director and/or Governing Body, with the affected individual in a relevant and timely manner.

Problem identification relating to a practitioner's clinical judgment or skills, compliance with Center and/or Medical Staff rules, physical or mental status, ethical behavior or conduct may be by information developed routinely in the course of performance evaluation activities, or by an incident report, or by complaint from a Medical Staff member, patient or Center employee.

If necessary for fact-finding purposes, or if requested by the affected practitioner, by any member of the Medical Staff, or by the Governing Body, in a written request to the Medical Staff including grounds for the request, then a formal study (review, investigation) shall be conducted. In that event, this procedure shall be used.

1. The initial meeting of Medical Staff shall be held within seven (7) days of the decision to review or investigate, except that the initial meeting shall be held within three (3) days if the practitioner has been summarily suspended.
2. The affected practitioner shall be informed by the Medical Staff of the review or investigation and may be invited to attend its initial meeting.
3. Legal counsel should be asked to advise proper procedure and to evaluate the appropriateness of any resulting recommendation.
4. Within seven (7) days following its initial meeting, the Medical Staff either (a) is ready (has enough reliable information) to report its finding(s) and recommendation(s) to the Governing Body, or (b) obtains further information, from whatever sources, prior to framing its findings and recommendations.

II. MEDICAL STAFF OBLIGATION

1. The Medical Staff:
 - A. Develops and evaluates reliable, objective information to determine whether there are reasonable grounds to conclude that a problem exists;
 - B. Includes information about resolving the problem in the reports to the Governing Body.

III. GOVERNING BODY'S OBLIGATION

If the Medical Staff fails to investigate or take disciplinary action contrary to the weight of the evidence, the Governing Body will initiate an investigation or disciplinary action. If the Medical Staff fails to take action as directed by the Governing Body, the Governing Body may initiate corrective action but such corrective action must comply with the terms of Bylaws.

IV. PROBATIONARY STATUS

Probation, when imposed, is for a specified time period, and may apply to membership, clinical privileges, or one or more specific clinical privileges. Probationary status is removed as soon as the Medical Staff and the Governing Body are satisfied that the problem necessitating the imposition of probationary status is resolved.

V. PRECAUTIONARY SUSPENSION

In the event that an individual practitioner's action may pose a danger to the health of any person, the Medical Director shall have the authority to suspend all or any portion of the clinical privileges of the Medical Staff member in question. Such suspension does not imply final finding of fact or responsibility for the situation that caused the suspension. Such precautionary suspension shall be deemed an interim precautionary step in the professional review activity and not a complete professional review action.

Such precautionary suspension is immediately effective, is immediately reported to all the individuals named above, and remains in effect until a remedy is affected.

As soon as practical, but in no event later than three (3) days after a precautionary suspension, the Medical Staff shall convene to review the action. The affected practitioner may request to be present at this meeting which is not a Hearing and is not to be construed as such.

Within thirty (30) days the Medical Staff will determine whether to continue or revoke the suspension, or take another action. If the action taken entitles the affected practitioner to a Hearing, then the Hearing and Appeals Procedure shall apply.

VI. AUTOMATIC EFFECTS OF ACTIONS OF MEDICAL STAFF MEMBERS

1. Failure to Complete Medical Records

- A. Incomplete Medical Records – All portions of each patient's medical record shall be completed within the time period after the patient's discharge as previously stated. Failure to do so (unless there are acceptable extenuating circumstances) automatically results in (a) the record being defined as delinquent, and (b) notification to the practitioner.

- B. Delinquent Medical Records – Failure to complete all aspects of any patient's delinquent medical record within twenty-one (21) additional days after written notice that the record is delinquent (see (b) above), shall constitute voluntary relinquishment of Medical Staff membership and of all clinical privileges.

Reinstatement to the Medical Staff is immediate upon completion of the delinquent record.

VII. ACTIONS AFFECTING STATE LICENSE TO PRACTICE OR DEA REGISTRATION

If a practitioner's actions result in his/her state license to practice or DEA registration being revoked, suspended, limited for disciplinary reasons, not renewed by the relevant agency, or voluntarily relinquished by the individual, then Medical Staff Appointment and clinical privileges are automatically revoked, suspended or limited to at least the same extent, subject to reapplication by the practitioner when/if his license is reinstated, or limitations are removed, whatever the case.

VIII. LAPSE OF LIABILITY INSURANCE

If the Governing Body, with Medical Staff input, have established a requirement for liability insurance coverage for practitioners with clinical privileges, and if a Medical Staff member's liability insurance lapses or is canceled without renewal, then the practitioner's Medical Staff membership privileges and clinical privileges are automatically suspended until the effective date of his/her new liability insurance coverage unless otherwise determined by the Governing Body and the Medical Staff.

IX. RIGHT TO HEARING AND APPEAL

Circumstances under which a Medical Staff applicant or member is entitled to (a) a Hearing on the facts and/or (b) an Appeal of the Governing Body's decision, and the specific procedure to be followed for Hearings and Appeal, are described in the Hearing and Appeal Procedure.

PRECISION SURGERY CENTER

VI. MEDICAL STAFF

3. Staff Management Policies

B. Impaired Physician or Non-Physician Practitioner

1. **General Policy:** The Medical Staff recognizes that impaired providers are individuals who have dedicated their lives to helping others and are now in need of help; and recognizes that providing this help must remain a primary goal of the Impaired Provider Policy. This policy, therefore, follows a non-punitive approach, in which the Medical Staff works as an advocate for, rather than an adversary of, the provider, while seeking to protect patients from harm. The Medical Staff further recognizes that when the provider denies a problem, necessary action must be taken for the protection of both the provider and the patient.
2. **Definitions:** An "impaired provider" is a physician or non-physician practitioner who because of psychiatric or other medical conditions or because of the use of alcohol, illegal drugs or prescribed or over-the counter drugs which impair clinical judgment or ability, may be unable to provide appropriate patient care or may otherwise constitute a direct and immediate threat to the health, welfare, and safety of patients, other staff members, and the Center's personnel.

A "reasonable suspicion" is one based on documentation of specific, contemporaneous physical, behavioral, or performance indicators consistent with probable substance abuse or psychiatric or other medical conditions.

A "positive result" of an alcohol or other drug test means the detection of alcohol or another drug in concentrations deemed significant by the United States Department of Health and Human Resources on both an initial screening test and a confirmatory test of the same specimen.

An "approved treatment program" is a program for alcoholism or substance abuse treatment that is approved by the Nevada State Board of Medicine and Committee on Physician Impairment.

3. **Promotion:** This impaired provider evaluation and intervention policy should be promoted to Medical Staff members and Center employees to ensure visibility and use. The promotion should emphasize the advocacy program and non-punitive nature of the policy. In addition, confidentiality of reports should be stressed to encourage reporting of potentially impaired providers.
4. **Reports**
 - A. **Third Party Reports:** Reports about an individual who may be an impaired provider should be encouraged and accepted from nurses, colleagues, other Center personnel, patients and family members. Anonymous reports will be accepted, with appropriate consideration given to the inherent benefits and detriments of such reports.

Reports of suspected impairment shall be submitted to the Medical Director. The Director will notify the person making the report that the report has been received, reviewed and appropriately acted upon. Such notification shall be made orally and shall generally not specify the action taken. The Medical Director shall be entitled to review substantiated reports of possible impairment as well as follow-up reports of treatment, recovery and wellness.

- B. Self-reporting: All providers must submit a written report to the Medical Staff of any change in the provider's psychiatric or other medical status which might possibly affect the quality of patient care rendered by the provider within the limits of his or her clinical privileges. Such reports should be made immediately upon the provider becoming aware of the change. If the provider desires to continue providing patient care at the Center, he or she must comply with the evaluation, reporting and follow-up procedures set forth in this policy.

5. Requests for Testing or Evaluation

- A. Reasonable Suspicion Testing: If any Medical Staff member, based on a personal review and evaluation of the report, finds a basis for a reasonable suspicion of impairment, the Medical Director may request that the individual provide specimens for the purpose of determining the alcohol or other drug content of the individual's system or submit to other appropriate psychiatric or other medical evaluation.
- B. Post-incident Testing: A provider whose performance either is reasonably believed to have contributed to an accident or incident or cannot be discounted as a contributing factor to an accident or incident, may be tested for the presence of alcohol or other drugs in his or her system upon request of any member. Such testing shall be performed immediately upon request and as soon as possible following the accident or incident, with a goal of collecting the specimen within twenty-four hours of the accident or incident in order to obtain more accurate information regarding the provider's status at the time of the accident or incident.

6. Procedures for Testing or Evaluation

- A. Substance Abuse: Specimen collection shall comply with applicable procedures from time to time established by the Center, which shall be in accordance, to the extent reasonably possible, with guidelines published by the U.S. Department of Health and Human Services. This indicates referring the provider to Apex Medical Center for all specimen collection. All persons involved in the collection, testing and reporting under this procedure shall respect the privacy and confidentiality of the information obtained and report information relating to the collection and testing in a manner to observe such confidentiality.

Specimens for alcohol or other drug testing may include a person's blood or urine. The Medical Director or his or her designee shall collect or monitor the collection of the specimens and shall document in the provider's medical staff file the collection procedures followed, assignment of confidentiality code, and the provider's written acknowledgment of the specimen and assigned code. The specimen shall be labeled using the confidentiality code to avoid identification of the individual involved.

If the individual to be tested refuses to cooperate with the collection process, such refusal shall be communicated to the Medical Director. Such refusal shall be documented in the medical staff file and may be grounds for suspension or revocation of any or all parts of the provider's clinical privileges or medical staff membership.

All specimens will be tested by an independent laboratory that is certified by and in compliance with guidelines from time to time established by the United States Department of Health and Human Services.

Any specimens for which positive results are found shall be preserved and retained for at least 2 years, or until resolution of all legal or administrative challenges involving such specimen, whichever is longer.

Reports of positive test results shall be maintained and securely filed by the Medical Director or his or her designee for a period of at least five years or until all legal and administrative challenges to the test results are resolved. Reports of negative results shall be retained for at least one year or for such longer time period as may be requested by the provider. All such records shall be treated confidentially.

- B. **Psychiatric Disorders:** Psychiatric evaluation must be performed by a psychiatrist approved by the Medical Director. The evaluating psychiatrist will report to the Medical Director the provider's failure to cooperate with the evaluation or refusal to consent to release of reports. Such action may be grounds for suspension or revocation of any or all parts of a provider's clinical privileges or medical staff membership. Based on the evaluation, the psychiatrist must determine the extent of impairment and assist the Medical Director in determining the appropriate level of restrictions on the provider's clinical privileges.
- C. **Physical Disorders:** Evaluation of possible physical disorders must be performed by an appropriate physician or physicians approved by the Medical Director. The evaluating physician will report to the Medical Director of the provider's refusal to consent to evaluation or to release of reports. Such refusal may be grounds for suspension or revocation of any or all parts of a provider's clinical privileges or medical staff membership. The evaluating or treating physician(s) shall assist the Medical Director in determining the appropriate level of restrictions on the provider's clinical privileges.

7. Intervention

- A. **Substance Abuse:** Upon receipt of a report of positive test results, the Medical Director shall select a group of physicians or other providers to contact the impaired provider and attempt intervention.

If the intervention is successful, the impaired provider shall enter an approved treatment program for assessment and such treatment or other follow-up as may be recommended by such program. The provider's clinical privileges will be temporarily suspended and he or she will be relieved of any of the Center's responsibilities or duties while receiving assessment and treatment.

The treatment physician(s) at the approved treatment program shall submit a written report of successful completion of treatment to the Medical Director. Such report shall be made available to the Governing Body. Upon receipt of the report, execution of a "Relapse Contract" by the treatment provider and submission of a Limited Reappointment Application, the provider's clinical privileges may be reinstated.

- B. **Psychiatric Disorders:** Following evaluation and diagnosis of a psychiatric disorder resulting in impairment, an approved psychiatrist shall determine the frequency and nature of psychiatric care. The approved psychiatrist shall report to the Medical Director when the provider is sufficiently stable for removal of restrictions on clinical privileges. Such report shall be made available to the Governing Body.

- C. **Physical Disorders:** Following evaluation and diagnosis of a physical disorder resulting in impairment, an approved physician shall provide ongoing evaluation and management of the disorder. The approved physician shall report to the Medical Director when the provider is sufficiently stable for removal of restrictions on clinical privileges. Such report shall be made available to the Governing Body.

8. Reinstatement

Upon receipt of the treating physician's report and other documentation required above, the provider's clinical privileges may be reinstated.

- A. **Substance Abuse:** Following reinstatement of clinical privileges, the provider must receive follow-up assessment at an approved treatment program. Such assessment must include random monitored urine drug screens. A written, non-restricted report of assessment must be submitted by the treatment program at least every four months to the Medical Director. Such report shall be available to the Governing Body. The provider must complete and submit to the Medical Director a Limited Reappointment Application every 6 months for 2 years following reinstatement and annually for an additional three years. The assessments, reports, and applications required by this paragraph may be discontinued after a minimum of 2 years of recovery and with the written release of the approved physician.
 - B. **Psychiatric or Other Medical Disorders:** The treating psychiatric or other physician shall determine the frequency of follow-up care or assessments following reinstatement of clinical privileges. The psychiatric or other physician shall send a written, non-restricted report regarding the individual's status to the Medical Director at least every four months while follow-up care continues. Such reports will be available for review by the Governing Body. If the individual's condition remains stable for 2 years, the report's frequency may be changed to yearly or at the discretion of the psychiatric or other physician.
- 9. **Relapse:** Upon receipt of evidence of relapse of a substance abuse problem or recurrence of a psychiatric or other medical condition resulting in impairment, or a physician's statement of pending relapse or recurrence, the provider must re-enter an approved treatment program or resume psychiatric or other medical treatment. Refusal to re-enter a treatment program or to resume psychiatric or other medical treatment shall result in automatic removal from the Medical Staff.
 - 10. **Refusal:** A provider's refusal to cooperate with substance abuse testing or psychiatric or other medical evaluations, refusal to consent to release of non-restricted reports of treatment or follow-up, or refusal to cooperate with treatment shall constitute grounds for suspension or revocation of all or any part of the provider's clinical privileges or medical staff membership.
 - 11. **Hearing Rights:** Action taken with respect to a physician's Medical Staff membership or clinical privileges or application for membership or clinical privileges as a result of refusal to cooperate with testing, treatment or follow-up shall give the affected physician the right to a hearing and appellate review as provided in Medical Staff Bylaws.
 - 12. **Medical Review:** The Quality Improvement Coordinator and, ultimately, the Governing Body is responsible for evaluating and improving the quality of care rendered at the Center and for determining that health services rendered were performed in compliance with applicable standards of care. All actions, reports, and proceedings of the Governing Body in connection with this

procedure shall be made and conducted in furtherance of those responsibilities, and all information given in that context and shall be entitled to the maximum confidentiality and protection afforded by law.

PRECISION SURGERY CENTER

VI. MEDICAL STAFF

3. Staff Management Policies

C. Patient Management

I. ADMISSION AND DISCHARGE OF PATIENTS

1. A patient may be admitted only by a practitioner with clinical privileges.
2. The physician's responsibilities include:
 - A. Care and treatment of the patient;
 - B. Prompt completeness and accuracy of the patient's care;
 - C. Instructions to Center personnel regarding the patient's care;
 - D. Providing reports of the condition of the patient for the patient's relatives.
3. The admitting practitioner is responsible for providing information necessary to ensure the protection of other patients and the Center staff (Example: communicable diseases) and to provide such information as may be necessary to ensure the protection of the patient from self harm.
4. All practitioners cooperate with the utilization review function by being sure that the patient record includes at least: "Reason for admission."
5. Patients are discharged only on the order of the attending practitioner, unless the patient does so "against medical advice."

II. INFORMED CONSENT

It is the attending physician's responsibility to obtain the signature of the patient, or his/her authorized representative, on a consent form, after the patient's condition, planned procedure/surgery and other treatment options and risks and benefits of the selected treatment have been explained. The patient will always have the opportunity to ask questions prior to signing the consent form.

III. ORDERS AND PRESCRIPTIONS

All orders for treatment shall be in writing, signed and dated.

Orders which are illegible or improperly written will not be carried out by the nursing staff until rewritten or explained.

A "verbal order" is appropriate if the verbal order is:

1. Dictated to a duly licensed person functioning within his/her sphere of competence;
2. Signed by the responsible practitioner within forty-eight (48) hours.

V. PATIENT'S MEDICAL RECORD

1. The patient's medical record, like the patient, is the responsibility of the attending practitioner. The record's contents must be legible and include at least:
 - A. Identification data;
 - B. Complaint or condition; admitting diagnosis
 - C. History;
 - D. Results of physical examination;
 - E. Provisional diagnosis;
 - F. Planned medical and/or surgical treatment;
 - G. Reports, such as laboratory and radiology reports, consultations, ect.
 - H. Informed consent form;
 - I. Final diagnosis.
2. Symbols and abbreviations may be used in the patient's record only when they have been approved by the Center.
3. Written consent of the patient or the patient's legally qualified representative is required for release of medical information to persons not otherwise authorized to receive this information.
4. Medical records not completed within fourteen (14) days following the patient's discharge are classified as delinquent.
5. Medical record forms may be modified or substituted only with the approval of the Quality Improvement Coordinator and/or Medical Director.

V. CONSULTATIONS

Except in emergency, consultation is recommended in the following situations:

1. When the patient or his/her family requests a consultation.
2. If a nurse has any reason to doubt or question the care provided to any patient or feels that appropriate consultation is needed and has not been obtained, he/she shall first consult with the attending physician, then call this to the attention of his/her supervisor who in turn may refer the matter to the Medical Director. Where circumstances are such to justify such action, the Medical Director may request a consultation.

PRECISION SURGERY CENTER

VI. MEDICAL STAFF

3. Staff Management Policies

D. Medical Director

I. BASIC FUNCTION

Responsible for the management of all activities of the Center that directly or indirectly affect patient care and administration.

II. QUALIFICATIONS

1. Licensed to practice medicine in the State of Nevada. Board Certification in the practice of Physical Medicine and Rehabilitation, or an ABMS specialty with sub-specialty certification in interventional pain management.
2. Knowledge of and previous experience in developing clinical pathways, clinical protocols; disease management paths is preferred.
3. Documented training, education, and/or experience in management of patients receiving services within the ambulatory surgery, including pain management, physical therapy and rehabilitation.
4. Member of the medical staff with clinical privileges and/or experience in the ambulatory surgery, pain management, and physical therapy.
5. Excellent verbal and written communication skills; a comprehensive range of medical knowledge; the ability to educate, influence, and deal with difficult issues; and the ability to analyze/interpret data, communicate results to providers, and implement corrective action with peers are all required.
6. Ability to function in a leadership role and take initiative when necessary. Ability to work within a total quality management environment is essential.

III. DUTIES AND RESPONSIBILITIES

1. The Medical Director provides strong medical leadership in the development and ongoing monitoring of all clinically-based activities. These activities are focused in the areas of practice management analysis and improvement, case management, traditional utilization review, and continuous quality improvement.
2. Strong interpersonal skills, systems thinking, financial and management experience, and comprehensive clinical and medical skills to engender confidence in the Center by customers and physicians.
3. Innovation, creativity, and the ability to effect change are prominent characteristics of the position.
4. The Medical Director is highly visible with the medical community, as well as the community at large.
5. The Medical Director will work in partnership with the staff in utilization of review functions.

6. Provide consultation in the Center as requested by medical staff.
- 7.. Oversee and actively participate in performance improvement activities.
8. Participate in the development and approval of policies and procedures associated with patient care.
9. Participate in the continuing education program for medical and Center's staff.
10. Participate in the identification and resolution of issues associated with the provision of ambulatory care.
11. Make recommendations regarding the numbers, qualifications, and competencies of staff providing the ambulatory care services.
12. Make recommendations regarding resources needed to provide ambulatory care.
13. Works collaboratively with the medical staff in the credentialing and recruitment of physicians. Develops and implements physician orientation.
14. Supervises and evaluates the Clinical Director.
15. Provides oversight and direction to Medical Staff and Administrative Staff.
16. Works collaboratively with non-physician administrative staff on operational issues.
17. Ensures compliance with vision statement, corporate policies, and Bylaws.

IV. AUTHORITY

1. The Medical Director reports to the Governing Body.
2. The authority of the Medical Director is substantially and sufficiently pervasive to permit the physician in this role to adequately undertake the responsibility expectations by the Board of Directors. This authority includes, but may not be limited to the following:
 - A. Responsible for policies affecting medical practice and judgment.
 - B. Responsible for providing medical input into planning.
 - C. Maintains the right to review and recommend changes affecting clinical practice.

V. MARKETING/CUSTOMER SERVICE

1. Collaborates with the Board of Directors and the staff in developing and implementing a customer quality service plan.
2. Participates in marketing efforts and contract negotiations.

VI. QUALITY ASSURANCE/UTILIZATION MANAGEMENT

1. Leads the development of practice guidelines and other methods for improvement, implementing changes and corrective actions as needed.
2. Works collaboratively with the medical staff in the areas of case management and utilization management, as limited to our patient care.
3. Supports the requirements of the QAPI Work Plan. Analyzes and evaluates outcomes and other data.
4. Responsible for the investigation of patient complaints and handles unresolved issues.
5. Implements physician discipline process and documents physician personnel problems. Makes disciplinary recommendations to the Board.

VII. COMMUNITY RELATIONS

1. Acts as the internal and external medical spokesperson.
2. Provides the interface between the medical organization and the public and represents the Center in media contacts.
3. Participates in meeting the community's local needs for health education.

VIII. STRATEGIC PLANNING

1. Develops organization growth plans.
2. Provides effective interface between the Center, the physicians, and the community.

IX. FISCAL

1. Performs ongoing analysis of practice patterns, costs, and other information.
2. Works with physicians and other staff in meeting financial parameters.
3. Approves capital expenses.

X. OVERALL MANAGEMENT

1. Attends all meetings of the Governing Body. (Board of Directors)
2. Attends educational activities to maintain knowledge on current state of the art treatment protocols, break-through technology, alternative site care, etc.
3. Maintains knowledge in a broad range of medical practice.
4. Participates in professional organizations at state, regional, and national levels.
5. Assumes additional responsibilities as directed by the Governing Body.

PRECISION SURGERY CENTER

VI. MEDICAL STAFF

3. Staff Management Policies

E. Physician Policies

I. BASIC FUNCTION

Responsible for conducting and management of clinical activities of the Center that directly or indirectly affect patient care.

II. RESPONSIBILITIES

1. Adheres to mission, vision, values, goals, philosophy, objectives, policies and procedures of the Center.
2. Actively participates in the long-range planning of the center regarding financial, personnel, patient care and marketing.
 - A. Assists in development and/or revision of standard operating procedures for gathering, processing, and evaluating information important to the Center.
 - B. Assists in determination of the need to replace existing or purchase of additional medical and non-medical equipment.
- C. Assists in developing capital budget.
- D. Interprets policy and clarifies procedures for staff.
- E. Assists in recruiting and hiring physician members, nurses, and medical assistants to fill openings in the Center.
- F. Assists in orientation of new employees (physician and non-physician).
- G. Disciplines non-physician staff when necessary.
- H. Assists conducting job performance evaluations for non-physician staff.
- I. Assists in the formulation of the Center's position on issues related to the practice of medicine at the Center (peer review, accountability, and licensure).
- J. Assists in approving criteria for quality care; participates in QAPI to improve quality of care and appropriate utilization of services.
- K. Assists approved standard operation procedures for delivering patient care.
- N. Provides medical support services and consultations for those persons admitted to the Center's for surgical care or procedures.
- O. Participates as a member of the disciplinary health care team.

III. QUALIFICATIONS

1. Licensed to practice medicine in the State of (Nevada).
2. Board certified or qualified eligible in medical specialty of individual training.
3. Evidence of education, training, professional ethics, references, and health status sufficient to meet requirements of position.

IV. REQUIREMENTS

1. Participates in active education at a local or national level in primary specialty.

PRECISION SURGERY CENTER

SECTION VII

HUMAN RESOURCES

PRECISION SURGERY CENTER

SECTION VII

HUMAN RESOURCES

1. General Principles

PRECISION SURGERY CENTER

VII. HUMAN RESOURCES

1. General Principles

A. General Policies

I. POLICIES

1. The Center is an equal opportunity employer to all qualified persons and applicants based on their qualifications and ability to perform job tasks without regard to race, color, sex, religion, national origin, physical disabilities, age, or veteran status.
2. The Center recognizes that it needs an appropriate number of qualified personnel to fulfill its mission and meet the needs of the patients it serves. This is achieved by human resources planning, appropriate orientation and education of the staff, assessment of competency and credentialing and privileging of licensed independent practitioners and by information management.
3. All professional licensed members of Precision Surgery Center have their credentials primary or secondary source verified, as applicable. This includes members of the medical staff and nursing staff as required.

II. PLANNING

1. The Center has defined qualifications and job expectations for their staff, and established a system for evaluating job performance by considering the following factors:
 - A. The Center's mission, vision, values, goals and objectives.
 - B. The case mix of patients served and the degree and complexity of care they require.
 - C. The scope of services provided by the Center.
 - D. Assessment of technology used in patient care.
 - E. Expectations of the Center, staff, patients and community.
2. To achieve the above needs an adequate number of qualified staff are provided. This is determined by:
 - A. Evaluating the needs of each department by evaluating, education, and training required by applicable law, regulation, and the policies of the Center.
 - B. By qualifications of personnel with current licensure, certification, registration, and experience.
 - C. Knowledge and expertise necessary to carry out the responsibilities assigned.
 - D. By credentialing process and
 - E. By appropriate evaluation of personnel in training, in usage of emergency equipment and in CPR, BLS and ACLS, specifically in the surgery area.
3. To achieve the Center's mission, vision, goals, objectives and provide ongoing competent services the Center has established policies to evaluate the competence of all staff members on a continual basis to maintain, demonstrate and improve their skills. These are achieved by:

- A. Initial orientation.
 - B. Ongoing in-services, arranged by the Clinical Director as needed.
 - C. Empowering the employees to develop a sense of ownership and accountability for their work.
 - D. Requesting the employees to participate in internal and external continuing education activities.
 - E. Participating in professional associations and by continually enhancing their performance within the Center by periodic measurement of job performance, clinical competencies, and skills which are objective.
4. Recognizing human resources planning, the Center encourages staff self development and learning. The Center preaches that staff performance results from a combination of components and nature of the work environment. Hence, the Center has created an environment and culture that helps staff members discover what they need to learn and assist them, as appropriate, in acquiring the new knowledge and skills. The Center requests feedback from its staff to manage its efforts to create a competent and enhanced work environment.

III. ORIENTATION, EVALUATION AND EDUCATION OF STAFF

1. Recognizing the importance of staff performance in the success of the Center, the Governing Body has established standards for:
- A. New staff orientation which provides initial job training and information, at the same time it provides to the Center the capability to assess the abilities of the individual in fulfilling the job responsibilities.
 - B. Ongoing inservice or other education and training to maintain and improve staff competence.
 - C. Competence assessment is evaluated by ongoing data collection about staff. Competence patterns, and trends are used to respond to staff learning needs by continual ongoing evaluation of the staff which is collected from competency inventories in which deficiencies are noted for specific categories.
 - D. The Center has developed its philosophy noting each individual's responsibilities and their comfort level in providing patient care. In rare circumstances the Center through the Medical Director, will excuse an employee from performing certain aspects of patient care based on that staff member's values, ethics, or religious beliefs. Such policies are:
 - ◆ Any other reasonable values, ethics, or religious beliefs that will make the staff member uncomfortable.

In all cases appropriate substitution of staff members will be provided so that patient care is not compromised when such requests are granted.

IV. MANAGEMENT OF INFORMATION

The Center relies on information about the scientific aspects of care, individual patients, quality of care provided, results of care, as well as its performance to provide, coordinate, and integrate services.

It is the Center's goal to obtain, manage and use information to improve patient outcomes and individual and Center performance in patient care, governance, management, and support processes. To achieve this goal, the Center has established policies to:

1. Identify information needs
2. Design the structure of the information management system
3. Define and capture data and information
4. Analyze data and transform the information
5. Integrate, transmit, and report the data

To achieve these goals and objectives the Center:

1. Ensures timely and easy access to complete information throughout the Center
2. Improves data accuracy
3. Balances requirements of security and ease of access
4. Uses aggregated and comparative data to pursue opportunities for improvement
5. Redesigns information-related processes to improve efficacy and
6. Increases collaboration and information sharing to enhance patient care whenever feasible.

PRECISION SURGERY CENTER

VII. HUMAN RESOURCES

1. General Principles

B. Employment

I. PREAMBLE

Philosophy of the Center is to provide all qualified individuals with the opportunity to seek employment.

II. APPLICATIONS FOR EMPLOYMENT

1. Applications for employment are obtained from the Administrator or Clinical Director. No individual will be considered for employment without first submitting the Application for Employment to the Administrator or Clinical Director.
2. Although it is the Center's policy to accept these Applications for Employment, there may be those times when no employment opportunities exist. In this case, the right is reserved not to accept applications until position vacancies occur.
3. Completed applications for employment will be maintained by the Administrator and are considered to be the sole property of the Center and its authorized agents. Applications for Employment are considered to be "active" for a period of 30 days, in which the document may be sent to one or more interviewers. After this period, the application is filed according to the area of employment desired and kept in storage areas for a period of one year.

III. NOTIFICATION OF JOB VACANCIES (INTERNAL & EXTERNAL)

1. It is the policy of this Center to utilize internal resources whenever possible for job openings. For this reason, a list of existing job openings may be obtained by employees at any time upon request from the Administrator or Clinical Director.
2. Any outside advertising or other recruitment attempts will be conducted by the Administrator.

IV. EMPLOYEE RECRUITMENT

1. It is the policy of this Center to conduct internal and external recruiting programs when necessary and in accordance with all Federal, State and local regulations governing such activities.
2. In keeping with our status as an Equal Opportunity Employer, we will authorize recruitment efforts by outside parties only when they demonstrate their ability to recruit and refer applicants in a manner acceptable to this Center.
3. Individuals who are recruited by this Center or any outside agency will be subject to the same employment criteria as those who seek employment individually.

V. PROCEDURE

1. External
 - A. When the need for recruitment is approved by the Governing Body, the Administrator will begin the procedure.
 - B. The Administrator will initiate local external recruiting efforts, such as advertising in local newspapers and/or internet resources, as necessary.
 - C. Outside agencies will be contacted only with the approval of the Medical Director and all such agreements will be outlined in the form of a contract prior to recruitment efforts.
 - E. Normal recruitment efforts will be coordinated between the Administrator and the State Employment Department (or other appropriate state agencies) as necessary.
2. Internal
 - A. In most instances, internal recruitment will be conducted as directed by the policy governing internal employee requests for transfers.
 - B. In those instances where an individual is known by the Administrator or other employees to have special qualifications for a job opening, that individual may be contacted by the Administrator to discuss a possible job transfer.
 - C. All internal recruitment efforts are to be conducted in accordance with our internal employee transfer policies and procedures.

VI. EMPLOYMENT OF FOREIGN APPLICANTS

1. It is the policy of this Center to follow requirements listed below in regards to foreign applicants for employment. In order to be considered for employment, a foreign applicant must first submit the following:
 - A. Application for Employment provided by the Center.
 - B. Certified copy of applicant's I-9 form (back and front).
 - C. Copy of passport, if no passport is available a copy of immigration documents or work VISA and social security card. (per federal I-9 instructions)
 - D. Copy of educational records from the country where training or education was received.
 - E. Current License, Registration or Certification, if applicable.
2. In addition, the following requirements are made:
 - A. Working visa (H-1) must be valid for at least six (6) months from date of employment.
 - B. A contract must be signed for the time which each visa or extension is requested.
3. In the event a foreign employee with a working visa should submit his or her resignation,

the Immigration Department will be notified unless prior arrangements have been made for release of sponsorship of the H-1 visa.

4. It is the responsibility of the employee to maintain current H-1 visa status and notification of the Administrator. It is imperative in order to conduct prior and timely renewal.

VII. EMPLOYMENT OF THE HANDICAPPED

1. This Center will make every attempt to employ physically and/or mentally handicapped individuals in jobs which they are capable of performing. In employing the handicapped, the Center will provide these workers with training as needed, making every effort to comply with requirements as spelled out in the statutes and regulations for "reasonable accommodation."
2. Those employees with documented histories of substance abuse will be considered individually with appropriate medical recommendation.

VIII. BECOMING RELATED AFTER EMPLOYMENT

1. It is the policy of the Center to consider relatives of current employees for employment only when a specific need arises, with approval from the Medical Director and Administrator. When employees become related by marriage after they have been employed, they may continue their employment except as restricted in the provisions above. If both employees are in the same department or unit of a department, the employee with the least seniority will be transferred from the department at the earliest possible date. If this is not feasible or possible, the matter will be resolved by Administration.

IX. REFERENCE CHECKING

1. It is the policy of this Center to verify and validate background factors on applicants for employment. These factors may include, but are not limited to the following:
 - A. Education pertinent to the job applied for.
 - B. Formal or informal training received related to the job applied for.
 - C. Past work record, including dates of previous employment in a similar position.
 - D. Past work record indicating patterns of attendance and/or reliability from previous employment.
 - E. Verification of licensure and/or registration.
 - F. Criminal background check, as indicated by history on application, and as required by position applied for per Nevada state regulations.
2. Reference Release: It is the policy of this Center to release past employment information as requested and only upon written authorization of the employee concerned. Only that information which has been duly verified and documented in the personnel file will be released to outside parties, upon receipt of proper authorization.
3. Without written authorization, the only information which will be released are the dates of employment and job title or position held during employment.

4. Employment information will be released by this Center only through the Administrator.
5. Reference Checking – External
 - A. Once an applicant has been deemed acceptable for employment by the Administrator, Clinical Director or Medical Director, the reference request will be initiated.
 - B. During the interview, the interviewer will have the applicant sign the Reference Request to authorize release of the desired information from the proper source.
 - C. References will be checked at the discretion of the Administrator or Medical Director based on the position applied for and state regulations.
 - D. A telephone request will be made only at the discretion of the Administrator in order to verify dates of employment, position, etc.
 - E. When the information is received, the interviewer may review the completed form upon request. The form will be filed with the application, or in the personnel file if that person is employed.

XI. SELECTION AND HIRING

1. Upon completion of the recruitment and screening process, the applicants, along with all pertinent information, will be referred to the appropriate department supervisor for final selection and hiring. The selection and hiring process will be documented with the use of an appropriate notation on the bottom of the employment application. On meeting the candidate, the department manager/supervisor will:
 - A. Interview the candidate.
 - B. Complete the application form.
 - C. Refer the candidate, application and referral form back to the Administrator.
 - D. Upon final decision, it will be the responsibility of the Administrator to notify the interviewed applicants.

XII. REEMPLOYMENT

1. Consideration will be given to the application of former employees who left employment of the Center in good standing after having completed the probationary period.
2. Reemployment is based on the same needs and qualifications as are needed in the employment of any other applicant.
3. For the purpose of establishing beginning wage or salary, a rehired employee is one who returns within one (1) year of termination. All rehired employees are regarded as new employees and must serve a new probationary period of 90 days.

- A. Any rehire of an employee must first receive the required authorization in the same manner as a new employee.
 - B. Any employee rehired in the same or related position and assigned to the same pay grade will have the salary determined in the same manner as the new employee.
 - C. An employee rehired into a position unrelated to any position formerly held, even though in the same pay grade, will have the salary determined in the same amount as a new employee.
4. Those reemployed will qualify for employee benefits in the same way that other new employees qualify except:
- A. Employees who leave their jobs to perform training or service in the Armed Forces will be reemployed in accordance with the Reemployment Rights Act according to federal guidelines.
 - B. Employees rehired as a non-benefited employee; i.e. staffing pool/per diem.

XIII. TRANSFER/PROMOTION OF EMPLOYEES

1. It is the policy of this Center that our employees will be entitled to the privilege of requesting transfer to another job within their department or a job within another department.
2. Transfer requests will be considered on the basis of qualifications and experience of the employee in relation to those requirements of the specific job sought, based on the job description.
3. Promotion of employees will be recommended by the supervisor and considerations given under the same measures as stated in "2" above.
4. Employee Promotions
 - A. An employee promotion is considered to be that activity which places an employee in a position upwards from the present job being performed. This action may result in an increase in salary, upon the approval of the Administrator.
 - B. Promotions are recommended by the Clinical Director and are approved by the Administrator.

XIV. USE OF TEMPORARY EMPLOYEES

1. Policy

- A. From time to time it may be necessary to employ temporary personnel to meet manpower requirements to resolve special workload demands. Such needs will be reviewed and considered on an individual basis by the Administrator.

2. Procedure

- A. When the Clinical Director sees a need for temporary personnel, it will be discussed with the Administrator and Medical Director directly. Approval is needed for all temporary personnel hiring/use.
- B. It should be explained the personnel needed and the amount of hours per week the help is being requested and the reasons why. (i.e. vacation coverage, ect)
- C. Payment of temporary personnel will be determined by what source is used.
- D. It is the responsibility of the Administrator to request temporary help through the use of a temporary agency.

PRECISION SURGERY CENTER

VII. HUMAN RESOURCES

1. General Principles

C. Personnel Records

I. PERMANENT RECORD:

A permanent record is maintained on each employee in the administration office. Since it is important to the employee and to the Center that records be kept accurate and up to date, employees are required to be sure that all records are kept current. The employee should report the following changes to administration, including but not limited to the following;

1. Change of marital status – i.e. marriage, divorce, etc.
2. Change of home address
3. Change of telephone number
4. Change of person to be notified in an emergency
5. Change in number of dependents for income tax deductions
6. Change of beneficiary(s)
7. Military or draft status
8. Legal change of name
9. Exemptions on W-4 Tax Form
10. Notice of any regular, special training or education courses completed since completion of original application.

II. PERSONNEL FILES: CONTENTS AND ORIGINATION

1. Policy
 - A. It is the policy of this Center to initiate a personnel file on all individuals employed. The origination of the file will be made by the Administrator at such time when employment commences. Accurate maintenance of the contents of this file will be carried out.
 - B. It is appropriate for the Administrator to originate and maintain personnel files according to that information which is required by Federal, state or local regulations or that information otherwise required by this Center to commence employment.
 - C. Three employee files will be kept in the administration office per regulations One for general documents, (application, diploma, ect.), a separate file for I-9 identification documents (copies of passport, social security card, ect.) and another separate file for all documents pertaining to employee health/medical records (vaccinations, physicals, health forms ect).

2. Procedure

- A. The personnel files will be originated by the Administrator and will contain the documents listed below, but not limited to those documents solely. The documents will be separated into the 3 employee files as described above. Other information placed in the personnel file will be included at the discretion of the Administrator and in accordance with other related policies.
- B. Application for Employment, previously completed by the employee, including:
 - ◆ Employee's full name and address
 - ◆ Employment classification
 - ◆ Hire date and, if applicable, termination date
- C. Documentation of reference requests made or the documents themselves.
- D. Photocopy of license/registration as required, also identification documents necessary for the federal I-9 form completion.
- E. Documents required for setup on payroll with pertinent information as contained on the form itself, with required signatures.
- F. Employee's Withholding Allowance Certificate" (W-4) completed with Social Security number and signed by employee.
- G. Enrollment form for benefit plans as required.
- H. Authorization of the employee, in writing, for any payroll deductions to be made which are extraneous to those required by law.
- I. Other documents, or photocopies thereof, as deemed useful and necessary by the Administrator (may include resume, special awards or certificates, etc.)
- J. Employee medical records shall be considered confidential and will be maintained in a file separate from the employee's personnel records. Employee medical files are maintained and kept by the Nursing Administrator.

III. PERSONNEL FILES: RETENTION, ACCESS, CONFIDENTIALITY, OWNERSHIP

1. Policy

- A. Retention of Personnel Files. It is the policy of this Center to retain current personnel files for the duration of employment. When the employment status is terminated, the file will be retained in the "terminated" files on the premises for a period of time no less than three (3) years. When removed from the "terminated" file, they will be removed to the storage area where they will remain for a period of seven (7) years. The Administrator will authorize appropriate destruction of employee records still in storage after seven years. A log will be maintained in the

administration office of any records destroyed.

B. Access to Personnel Files

- ◆ Employee: Employees will be allowed to review the contents of their personnel file at a time convenient to the Administrator. No document will be removed from the file without the approval of the Administrator. The employee may request, in writing, photocopies of documents contained in the personnel file. Such a written request must contain the reason for the request, specific documents requested, date of the request and employee's signature. If the request is granted by the Administrator or CEO, the photocopied documents will be mailed to the employee's home address within ten (10) working days of the date the request was received.
- ◆ Supervisor: When it becomes necessary for review of certain documents in the personnel file, these individuals will be allowed limited access to the employee's personnel file. Such access will be limited to that information necessary to the reason for the request; such review will be done in the Administrator's offices.
- ◆ Outside Parties: No information or document from any personnel file will be released to any outside party without the written authorization and consent of the employee, unless required by law and requested in a lawful manner. In such cases, the employee will be notified.

C. Confidentiality of Personnel Files. This Center ensures the total confidentiality of personnel files maintained. Strict adherence to rules of access as outlined in Section B of this policy is required. Deviations or alterations of these rules will occur only at the direction of the Administrator.

D. Ownership of Personnel Files. Ownership of all personnel files maintained by the Administrator is that of the Center. No personnel file will be removed from the premises unless approved by the Medical Director.

PRECISION SURGERY CENTER

VII. HUMAN RESOURCES

1. General Principles

D. Classification of Employees

I. POLICY

1. It is the policy of the Center to abide by all regulations and interpretations of requirements for qualifying an employee as an exempt or non-exempt from Wage and Hour overtime regulations and for the administration of payroll procedures for hourly paid employees, in accordance with the Fair Labor Standards Act as amended and in conformance to the Code of Federal Regulations. Furthermore, it is the policy of this Center to maintain an internal classification of employees for the purposes of benefits administration and payroll record keeping.
2. All employees will be informed of their classification status at the time of employment and/or at the time of change of status when he or she changes from non-exempt to exempt status, or from exempt to non-exempt status, or change from internal classification status.
3. Classification definitions and current regulations are maintained in the office of the Administrator and are further outlined in the procedure corresponding to this policy.

II. DEFINITIONS – INTERNAL CLASSIFICATION OF EMPLOYEES

1. Regular Full-Time Employees: A regular full-time employee is one who is regularly scheduled to work a minimum of 32 hours per week on a routine basis. This employee is entitled to all non-legislated employee benefits.
2. Regular Part-Time Employee: All employees who work part-time (less than 32 hours per week but at least 20 hours per week) will receive some non-legislated employee benefits. At the Center's convenience, an employee may be asked to adjust their hours, but this will not affect their non-legislated employee benefits.
3. Temporary Employees: Any employee who is hired for a limited period of time to fill a temporary position. This employee is not entitled to any non-legislated benefits, regardless of the number of hours worked each pay period.
4. "On Call," Per Diem or Relief Employee: Any employee who is hired on an on-call, per diem or relief basis works only at the discretion of the Center and is not entitled to non-legislated employee benefits. When hired under this agreement, no work is guaranteed and the employee reports to duty at the direction of the supervisory staff.
5. Probationary Employee: Any employee who is within the first three months (90 calendar days) of employment. An employee in this status is not entitled to vacation, sick time, or bereavement leave and will not receive health insurance benefits until the "effective date" has been met and an acceptable probationary review has been submitted by the Supervisor.

III. PROCEDURE FOR TRANSFER OR CHANGE IN CLASSIFICATION

1. A transfer in the classification of employment may be available, depending upon needs. Recommendations for change in status are made by the supervisor and must be approved in all cases by the Administrator/Medical Director.
2. The employee whose status change results in downward or reduced classification will be notified by the appropriate persons of any change in benefits or pay status.

IV. DEFINITIONS – FEDERAL CLASSIFICATION OF EMPLOYEES

1. Definitions

- A. **Non-exempt employees:** Non exempt employees are those who do not meet the requirements for exempt status as outlined by the Federal Wage and Hour requirements, or those who are not considered to be exempt employees by mutual agreement with the Center.
- B. **Exempt Employees:** An exempt employee is considered to be "salaried" and qualifies for exempt status as an executive, professional or administrative employee. Employees are placed in this classification by mutual agreement with the Center.

2. Benefits and Compensation – Exempt Employees and Non Exempt full time Employees

- A. **Overtime:** No compensation for overtime will be paid to administrative or executive employees. Compensation for overtime will be paid to professional exempt employees only if it is necessary due to the request of the Center and approved by the Governing Body.
- B. **Sick Leave:** It is our policy to allow every full-time employee to accumulate a reserve of sick leave which can be used for time off with pay when necessitated. Falsification of sick leave may be grounds for dismissal. Time off reimbursed by Workers' Compensation is not considered sick leave.

Payment for sick leave will commence on the first day of an excused absence due to illness. Sick days are accumulated at a rate of 5 days per year or 40 hours per year up to a maximum of 30 days or 240 hours. Probationary employees are not eligible for sick leave pay, however, hours will be accrued.

- C. **Educational Leave:** Paid educational leave may be granted upon the approval of the Administrator and Medical Director for attending approved seminars. These days will be noted on the employee's time record and paid at the regular rate of pay and, under no circumstances, may not create overtime.
- D. **Personal Leave of Absence:** Personal leaves of absence are discouraged. However, if the Administrator determines there are justifiable reasons, a personal leave of up to 30 days may be granted.
- E. **Vacation Benefits and Paid Holidays**

-The official Precision Surgery Center Employee Handbook has detailed information regarding vacation benefits, paid holidays, personal leave and other matters. Employees are given a copy upon hire and it is available at all times in the administrative office.

- Health Insurance: Comprehensive health insurance is available to all employees as well as their family, who are working full time both as exempt or non-exempt. This is effective following completion of 90-day introductory period. At that time, employee may choose to accept the insurance coverage, or not. Additional compensation will not be made to those employees choosing not to accept the insurance in whole or in part. The Center will pay a portion of the premiums for the employee's insurance coverage. The Center reserves the right to change the terms and conditions of this policy at any time.
- ◆ 401K: This is a voluntary benefit offered by the Center to qualified employees. The plan meets all the federal regulations governing retirement plans.
- ◆ Workers' Compensation: The Center maintains workers compensation insurance for all employees.
- ◆ Liability Insurance – The Center provides professional liability insurance to all regular full-time and regular part-time employees.
- ◆ Maternity Leave: Available up to twelve weeks without pay.

3. Compensation – Non-exempt Employees (40 hour work week)

- A. Overtime: All employees who are considered to be hourly paid employees will be paid at the rate of one and one-half times their regular rate of pay for hours worked over 40 hours in work week following prior approval for overtime. It is the policy of this Center to incur "no overtime"
 - ◆ Overtime must have the approval in advance from the Human Resources Director or Administrator. Documentation of overtime justification must be provided to the Administrator when requested.

- Record of Time: Non-exempt employees must record their time worked each day by use of the time clock. The time clock shall reflect an accurate account of time in and time out each day, with an entry made for lunch or meal time. Incorrect recordings of hours worked on a time card may be grounds for termination.

For the purposes of clarification, the following are interpretations of this Center in regards to meal time, and leaving the Center.

- ◆ Meal Time: The Center provides sixty (60) minutes to each employee for each workday to be considered "meal time" without pay.
- Breaks: Two ten (10) minute breaks with pay, one in the morning and one in the afternoon, are provided to each employee.
- Leaving the building for personal reasons: An employee is considered to have "left the building" if he or she has exited the building property, and would not readily be available for work if needed. For this reason, an employee who takes a meal break or otherwise leaves the building during normal work hours must clock out on the time clock. The parking garage, although it is Center property, is not considered to be part of the building and an employee spending work time in the parking lot (when not engaged in services directed or required by the Center) is considered to have "left the building."
- Employees must notify their supervisor in all cases requiring them to leave the building (other than the routine and approved lunch period) and appropriate approval is required.

4. Part-Time Regular Employees

All employees who work less than 32 hours, however, work more than 20 hours, are considered to be in this category and these employees are qualified for some of the benefits provided to employees in other categories: The official Precision Surgery Center Employee Handbook has details regarding all benefits for Part-time employees, including vacation, leave and other matters.

5. Part time, Temporary, Relief Employee Classifications

All employees whose internal classification places them in one of the above categories are considered to be non-exempt employees, and are subject to benefits and compensation related to their status. Details of this information are found in the Precision Surgery Center Employee Handbook.

V. JOB DESCRIPTION

A job description is a detailed written presentation of the duties and responsibility of an employee's job. Each job description defines and delineates functional responsibilities and authority of a position within the organization. These are given to each employee prior to the orientation period and signed upon acceptance of the position applied for.

1. All jobs have been classified into categories or job grades having similar or equal performance requirements.
2. Specific job descriptions are listed in the policy and procedure manual.
3. Each employee's job will be reviewed and a job description is issued and signed at the time of hiring.
4. Departmental supervisor may request an employee to perform duties that are not covered in the job description or the position.
5. It is the philosophy of the Center that all jobs and everything an employee does is important.
6. When an employee repeatedly performs responsibilities that are not assigned to the job description, it shall be reviewed and re-evaluated.

PRECISION SURGERY CENTER

VII. HUMAN RESOURCES

1. General Principles

E. Performance Assessment

I. POLICY

The Center assesses the competency and ability of each staff member to fulfill expectations of their job descriptions. Competence or performance assessment is conducted and documented for each staff member. In addition, periodic review of employee compensation will also take place.

II. PROCEDURE

1. Performance assessments are conducted and documented for each staff member, along with reviews of employee compensation.
2. Performance assessment focuses on special needs and behaviors of specific age groups in defining the qualifications, duties, and responsibilities of the staff members with regular clinical contact with patients, but not clinical privileges. During the assessment, an individual is assessed with regards to his or her abilities to meet the specific needs of their patients and produce expected results of clinical interventions.
3. Evaluation of job performance is given initially after the first three months of employment. The first three months of employment is considered as a probationary period. Each employee is then evaluated on an annual basis.
4. Intermittent or progressive evaluations may be performed as deemed necessary by the supervisor, administrator, or Medical Director.
5. Proper documentation of each employee's job performance and compensation review will be maintained and recorded on the appropriate form. This document will become a permanent portion of each employee's personnel file.

PRECISION SURGERY CENTER

VII. HUMAN RESOURCES

1. General Principles

F. Verification and Control Systems

I. PREAMBLE

The Administrator shall have full responsibility for developing procedures to record and verify all required personnel licenses, certifications, and credentials, as well as procedures for identifying expiration dates, obtaining and verifying license or certification renewals, and for suspension of employees from work functions prohibited by policy or law without current licenses, certifications or credentials.

II. PURPOSE

1. To maintain current status of all personnel employed by this Center in jobs requiring licensure, certification or registration, as called for by regulation.

III. POLICY

1. It is the policy of this Center to employ only those individuals who have proper licensure, certification or registration by the appropriate agency in those jobs requiring such status.
 - A. Furthermore, it is the policy of this Center that this status be maintained current by those employees. The employee will furnish proof of this status before employment begins and will provide a photocopy of the document which will be placed on permanent record in the personnel file. At each time the status requires updating and/or renewal, the employee will provide further photocopies to the Human Resources Director as proof of update and/or renewal.
 - B. Prior and current licensure, certification or registration will also be maintained by administrative staff. Evidence of current status will be posted as required in each department for those employees who are considered to be "certified" or "registered." Licensure documents will not be posted unless required by regulation or statute.
 - C. Failure on the part of the employee to provide such documentation or proof of current status will result in one or more of the following actions:
 - ◆ Demotion to an available position closest to that normally held which does not require licensure, certification or registration.
 - ◆ Suspension without pay until such documentation is received.
 - ◆ Disciplinary action as deemed appropriate by the Supervisor.

IV. PROCEDURE

1. At time of employment: All new employees whose job requires licensure by the State or other proof of registry or certification, will provide a photocopy of such document to the Administration. The proof is due upon demand before the employee may assume duties associated with such a license. Failure on the part of the employee to provide this document will relieve the Center of any obligations. The employee will be considered unable to perform duties of the job requiring the document, or the date of hire will be adjusted to reflect the date the document is received.
2. Periodic renewal: It is again the responsibility of the employee to provide a photocopy of the required document at each date or time of renewal.
 - A. The following procedure will be followed to ensure current status:
 - ◆ At the date of hire, a photocopy of the document is received by the Administrator and secured in the employee's file.
 - ◆ License monitoring will be done within the department where the employee works.
 - ◆ The employee will be notified by the Administrator of impending expiration before the first day of the month in which the expiration will occur.
 - ◆ If a photocopy of the document is not received by the last day of the month of expiration, the employee's status is considered to have changed. At this time, one or more of the following actions may be implemented.
 - ◆ Demotion to an available position closest to that normally held which does not require licensure; termination if no position is available.
 - Suspension without pay until such documentation is received.
 - Disciplinary action as deemed appropriate by the Supervisor and/or Medical Director.
 - A telephone call from the Administrator to the state licensing agency may confirm the renewal of said license. The hard copy of the license will be presented to the personnel office within a reasonable period of time.
 - In case of clerical or procedural error on the part of the licensing agency, documentation from that agency must be provided in lieu of the actual license.

PRECISION SURGERY CENTER

VII. HUMAN RESOURCES

1. General Principles

G. Confidentiality

1. It is the policy of the Precision Surgery Center to ensure that the patient's personal and informational data be kept confidential. This will include visual and auditory privacy during examination or treatments, interviews, consultation or discussion involving his/her case, and all communications, reports, and the medical record. There can be no exceptions to this policy.
2. Therefore, employees should, when talking with a patient about any matter, try to do it in such a way that other patients cannot overhear conversations. Employees shall not give advice to patients on personal matters, even if they ask for it. If patients have questions about their own case, employees shall refer them to their physician.
3. Employees shall be kind, sympathetic, and understanding to all patients, no matter how adverse the circumstances may be. Employees shall always keep in mind that our patients have come here to have their health problems treated, not to listen to the problems of the employees.
4. Information about patients, their illnesses, or their personal lives will be kept completely confidential. There are no exceptions to this policy.
5. Since medical information obtained by a physician is confidential, it cannot be released to an insurance company or attorney without written permission of the patient. The only exception to this rule is provision of information to the Bureau of Workers' Compensation. The Center has the right to release information concerning a specific patient who has filed a claim with the Bureau.

PRECISION SURGERY CENTER

VII. HUMAN RESOURCES

1. General Principles

H. Dress Regulations

I. PURPOSE

1. To ensure standards of dress regulations by employees that present a professional appearance to our visitors, coworkers and others who may enter our Center.

II. POLICY STATEMENT

1. Uniforms: Those departments which require specific types of uniforms to be worn by employees will be notified by the Administrator. Each employee will be notified upon hire regarding uniform requirements.
 - A. Uniforms must be appropriate as determined by the Administrator, must be neat, clean and appropriate for professional work and the image that the Center must project to others.
2. General Dress code: All clothing worn by employees must be neat, clean and appropriate for professional work. Additional details regarding employee dress code are in the Precision Surgery Center Employee Handbook.
3. Name Tags: The Center will provide a name tag for each employee upon employment. When received, the name tag is considered as part of the uniform and is to be worn at all times by the employee when on duty. The name tag is to be worn on the outside of the clothing and in plain and obvious view.
4. Penalty for Improper Attire: Due to our contact with patients and the public, it is imperative that the work attire of all employees be appropriate and identify them as our employees. For this reason, the employee may be sent home by the Supervisor or Administrator for reporting to duty in a substandard uniform, or otherwise subject to disciplinary action.
5. Reasonable Period of Time for Obtaining Proper Uniform: It is expected of each employee that they will obtain a proper uniform before beginning employment. The employee will be informed of uniform requirements before beginning work and will be allowed ample time in which to acquire the proper attire, which is considered to be a part of the requirements for employment.
6. Personal Hygiene and Perfume: Good personal hygiene must be maintained and perfume/makeup, if worn, should be done in moderation avoiding a strong and/or powerful smell.

PRECISION SURGERY CENTER

VII. HUMAN RESOURCES

1. General Principles

I. Attendance

I. POLICY

1. Prompt attendance at scheduled work is expected and is essential for providing timely service to patients. Excessive absenteeism and/or tardiness may result in disciplinary action up to and including termination and may have an adverse effect on a staff member's future salary increase, transfer request, promotion or continued employment.

II. PROCEDURE

1. Each staff member is responsible for reporting any absence or tardiness to his/her immediate supervisor in a timely manner to allow the supervisor to plan for staff coverage.
2. At the time of notification of absence or tardiness, the Supervisor shall determine and discuss with the employee the appropriate use of or denial of paid leave or extended illness time.
3. Administration may at its discretion request an employee to submit proof of illness, to include the request of the employee to obtain a physician's statement. Administration may also request the attending physician to examine an employee who has been ill for more than three (3) days.
4. If an employee is absent one (1) day without notification of the Supervisor, he/she is considered to have "quit without notice" and termination measures may be undertaken.
5. Absences or tardiness records are available to each Supervisor and shall be properly maintained and placed in the personnel file upon termination of employment.
6. Accurate documentation of all absences and tardiness on the employee's time records shall also be maintained by the Administrator.

PRECISION SURGERY CENTER

VII. HUMAN RESOURCES

1. General Principles

J. Employee Communications

I. PURPOSE

To provide an atmosphere of open communication between employees and Administration.

II. POLICY

1. It is the policy of this Center to provide a method by which our employees may offer constructive suggestions and ideas, convey information of interest, and express their opinions to Administration.
2. Employees are invited to attend periodic informal meetings held by Administration.

PRECISION SURGERY CENTER

VII. HUMAN RESOURCES

1. General Principles

K. Work/Salary

I. DAYS OF OPERATION:

1. Regular Days of Operations: Monday – Friday

II. HOURS OF OPERATION:

Employees are expected to be at their station and at work by each department's schedule. They are allowed 1 (one) hour for lunch and the time allocated will be determined by supervisor. There should be one-third of employees in the office at lunch on any given day to cover phones, walk-ins, etc.

Employees are allowed two (2), ten (10) minute breaks – one in the morning and one in the afternoon. Employees must clock in and out for their breaks. The Center recommends that employees take care of personal matters and all phone calls during their break periods.

Overtime is permitted only under unusual circumstances, with prior approval by the Administrator.

III. PAYROLL INFORMATION

The payroll is twice a month. Employees are responsible for clocking in and out. All compensation paid will be subject to withholding, Social Security, federal, city and state taxes, based on exemption information supplied by the employee.

IV. SALARY AND WAGES

Individual information concerning each employee's salary and performance will be provided to the employee by the Administrator. Changes in salary will be based upon merit and market conditions. Most of the full and part-time employees are reviewed for merit increases at established intervals. Employee benefits are considered extra and apart from these schedules of pay and these benefits apply in most instances to all employees regardless of employment skills or category.

V. GARNISHMENT OF WAGES

1. Policy

- A. It is the policy of this Center to comply with the requests for garnishment of wages when properly executed and delivered by a lawful federal, state, or local government or their authorized agents upon presentation of valid identification.
- B. Compliance with such lawful garnishment requests will be carried out by the Administrator, and proper notification will be given to the employee involved in the advance of the action in all cases.

VI. PROCEDURE

- 1. Upon receipt of the Summons of Garnishment (or other lawfully executed document), the Administrator will note on the document the following information:
 - A. Date received
 - B. Amount or estimate of garnishment
 - C. Signature
- 2. The employee's personnel file is retrieved with the request for garnishment noted, and the employee is immediately contacted.
- 3. In such cases which may require consultation with the legal counsel, the Administrator is notified immediately.
- 4. If the employee is unable to obtain a proper release from garnishment in written form, instructions will be given to the Payroll Department for execution. Withdrawal of those instructions will be made upon receipt of proper release.
- 5. In such cases requiring consultation of legal counsel, such advice received will be considered to supersede this policy.

PRECISION SURGERY CENTER

VII. HUMAN RESOURCES

1. General Principles

L. New Employee Orientation

I. POLICY

1. It is the policy of this Center that each new employee will be employed on an initial three months (90 day calendar days) "probationary period." During this period of time, the employee is not considered to be on permanent status.
2. In order to ensure successful completion of the probationary period, each employee will be oriented to all facets of his or her job, as well as working conditions, policies and procedures and all employee benefits. This will be completed within 30 days of commencement of employment, and provided annually thereafter and when there is an identified need.
3. Initial orientation to employee benefits and orientation to policies and specific aspects of the job will be conducted by the Human Resources Department. Orientation to the employee's department will be conducted by the Department Supervisor. All privileges and responsibilities will be explained during the initial orientation period, including compliance with an adverse incident reporting system.
4. Orientation to working conditions and specific aspects of the job will be conducted by that individual appointed by the Department Supervisor on an "on-the-job" basis.
5. Orientation to other related areas will be determined and conducted by the administrative staff or Clinical Director involved.

II. PROCEDURE FOR ORIENTATION OF NEW EMPLOYEES

1. Orientation will begin for the employee when all pre-employment requirements have been satisfied; i.e., references checks, verification of job qualifications, etc.
 - Verification of eligibility for employment will also be completed prior to the orientation period, in compliance with federal and state laws and regulations. (I-9 documentation)
2. The employee will meet with the Administrator for initial orientation paperwork and enrollment in the employee benefit programs, if desired.
3. During this orientation phase, the employee will be given a copy of the most recent Employee Handbook and sign acknowledging its receipt. This handbook describes all personnel policies and describes all benefits and incentives for employment

PRECISION SURGERY CENTER

VII. HUMAN RESOURCES

1. General Principles

M. Employee Requests for Time Off

I. POLICY

1. It is the policy of the Center to consider all properly submitted requests for time off, with or without pay, from all employees.
2. When such requests are made in connection with earned or accrued benefit time, proper considerations will be given to the employee, with the welfare of our patients foremost in mind. Initial approval of all such requests is required by supervisory personnel in the employee's department, but are always subject to Administrative approval.
3. When requests for time off are made by the employee who has not earned or accrued proper benefit time off, such requests, when granted, will be without pay and subject to Supervisory and Administrative approval.

II. PROPERLY SUBMITTED REQUESTS FOR TIME OFF

1. For all purposes and uses of this policy, a request for time off will only be considered when it meets the following conditions:
 - A. The request is made in writing by use of the proper form provided by the Administration and contains an accurate account of all regularly scheduled working days off desired by the employee.
 - B. In cases of extreme and expected emergency, the request is made in writing on a sheet of paper other than forms provided, containing accurate information as to the reason for the request, as well as the regularly scheduled working days off desired.
 - C. In case of an unexpected situation and/or semi-emergency, the request is made verbally to the supervisor and/or Administrator and is made at least 24 hours before the regularly scheduled working day off desired.
 - D. In cases of extreme and unexpected emergency, the request is made via telephone (only when the employee is unable to appear in person) to the supervisor and/or Administrator and is made sufficiently early so that adequate staffing may be arranged for.
2. Requests for time off which do not meet one or more of the following conditions will be considered improper and may lead to disciplinary action.

III. PROCEDURE: REQUEST FOR EARNED BENEFIT TIME OFF

1. Vacation Time
 - A. The employee shall obtain a "Vacation/Time Off Form" from his/her supervisor or Administrator. The form shall be completely filled out by the employee and returned to the supervisor or administrator as soon as possible.
 - B. Administrator will consult the employee file in regards to earned time off to make sure the employee has the proper amount accrued and has fulfilled length of service requirements and then either approve or deny the request.
 - C. If approved, a request is sent to Human Resources/Payroll for processing. The original is placed in the employee's personnel file.
 - D. If the request is denied, further discussion with the employee will occur to agree on a more suitable time off.
 - E. Employees must take all vacation in the calendar year which it accrued. Employees may carry out 3 months of the accrued time. Vacations are not accrued unless a written approval is obtained by the Administrator.
2. Sick Leave: Proper notification to the supervisor and/or department manager must be made according to the following conditions:
 - A. If the employee has advance knowledge of physical incapacity to perform work, written request may be made for "Request for Leave of Absence" or by another written method chosen by the employee. Written documentation from a physician may be required before approval is given for time off.
 - B. If injury or illness occurs without advance knowledge or warning, verbal notification is sufficient, if made directly to the supervisor and/or Administrator and with notification made as soon as possible. Only in severe intractable illness will notification made by someone other than the employee be sufficient.
 - C. In all cases, employees are expected to provide notification with a proper period of time allowed to arrange for adequate staffing in their absence. Only in extreme instances will notification later than two (2) hours before the regularly scheduled working shift be acceptable.
 - D. Written documentation from a physician may be necessary before time off is approved due to illness. In all absences of more than 72 hours (beginning with employee's regularly scheduled time for reporting to duty) a written release from a physician may be required before the employee will be allowed to return to duty.
 - E. Sick leave is available for legitimate, documented employee sickness only.
3. Leave of Absence Without Pay: Requests for leave of absence must be made in accordance

with categories outlined and are subject to benefit rules and regulations as stated.

- A. The employee desiring a leave of absence shall obtain a "Request for Leave of Absence" from the Administrator as far in advance as possible.
 - B. All requests for leave of absence are subject to Administrative approval.
 - C. If the employee will experience any change in employment status or benefit levels as a result of the leave of absence, an appointment with the Administrator and/or Human Resources Coordinator shall be made to discuss these changes as well as eligibility for reassignment at the end of approved leave.
 - D. Any leave of absence over 30 days will require an appropriate adjustment in the anniversary date, and benefits due on this date.
4. Family Care Leave
- A. Employees with at least one year of continuous service are entitled to family care leave in connection with the birth or adoption of a child or the serious illness of a child, parent, spouse, brother, sister, or grandparent.
 - B. The employee must exhaust any other leave (other than sick leave) to which the employee is entitled before receiving additional family care leave upon approval from the Administrator.
 - C. During an employee's family care or medical leave, the company shall continue to pay for the participation on the company's group health plans and employee is responsible for their portion of premium. The Center follows all Federal standards of the Family Medical Leave Act.
5. Jury Duty, Bereavement Leave, Time off to Vote: The current employee handbook details all additional time off and leaves of absence for Precision Surgery Center.

PRECISION SURGERY CENTER

VII. HUMAN RESOURCES

1. General Principles

N. In-service Education Program

I. POLICY

It is the policy of the Center to provide ongoing programs that will educate or enhance our employees in the day-to-day performance of their job duties.

II. IN-SERVICE RESPONSIBILITIES

1. The Administrator is responsible for providing current and factual information to his or her employees regarding performance of their job duties. New methods, procedures, or policies governing such duties shall be conveyed to the employees in a manner that is understandable and reasonable to all involved. Proper documentation is required of all such programs.
2. The Administrator will provide up-to-date and factual information to all employees regarding policies, procedures, and benefits. Information regarding benefits will be distributed to the employees as deemed proper and reasonable by the Administrator.
3. In-service information shall be posted to inform employees of upcoming in-services at the Center and in the community.

III. PROCEDURE – IN-SERVICE ATTENDANCE WITHIN THE CENTER

1. Mandatory In-service Meetings: Those meetings which have been determined necessary for employees within a particular department or group of common interest are considered to be mandatory. Mandatory attendance is at the discretion of the Administrator.
 - A. Mandatory meetings are generally those which will provide vital and necessary information to the employees involved, and attendance will be requested with prior notice to all those required to attend. Employees will receive their regular rate of pay for attendance at mandatory meetings, unless their attendance is not specifically requested. If attendance at a mandatory meeting will involve overtime for an employee during that work week, specific approval from the Administrator is required if an alternate attendance time cannot be arranged.
2. Voluntary Service Meetings: Those meetings for which attendance is not deemed necessary and vital to a particular department or group of common interest are considered to be voluntary. Attendance at voluntary meetings is at the discretion of the employee, based on his or her interest in the subject being presented.
3. Credit for Attendance at In-service Programs
 - A. In order to receive proper credit for attendance, the employee shall sign his or her

name on the sign-in sheet provided at each meeting.

- B. The employee must attend at least three-fourths (3/4) of the program in order to receive credit for attendance.

4. Internal Scheduling of In-service Programs

- A. Equipment and Supplies – All audiovisual and other in-service equipment is maintained by the Administrator. Those who desire use of this equipment shall request the item needed as early in advance as possible for purposes of reservation.

- ◆ Supplies necessary for in-service programs are the responsibility of the individual conducting the program. Prior Administrative approval is required for expenditures made for in-service program supplies.

5. Record keeping for In-service Programs

- A. Record keeping for in-service programs is to be maintained by each department supervisor. Proper record keeping will contain the following information:

- ◆ Signature list of all employees who attended the program.
- ◆ Title of the program, name of the individual conducting the program, dates and times the program was conducted, location of the program.
- ◆ A description of the content of the program, its relation to the department and/or employees, voluntary/mandatory status of the program.
- ◆ The reason the program was conducted; i.e., documentation of statement of events or situation leading to the program.

- B. In-service records for the individual employees will be considered valid on either on a form showing dates and subjects of programs attended placed in the employee's personnel file.

- C. Copies of sign-in sheets from in-services should be turned in to Administrator.

PRECISION SURGERY CENTER

VII. HUMAN RESOURCES

1. General Principles

O. Sexual Harassment

I. POLICY

The Center will not tolerate any form of sexual harassment. It is the responsibility of all employees to report such occurrences according to procedure. This includes inappropriate remarks, gestures, innuendos, and uninvited touching. Documented occurrences will result in actions being taken by the Administrator.

II. PROCEDURE

1. Any employee who feels this has happened to them or is made to feel uncomfortable will immediately notify their supervisor. Confidentiality must be maintained.
2. Once notified, the department head will notify the Administrator.
3. If it is impossible to notify that individual, the Administrator will be notified directly by the employee.
4. Further investigation will be conducted under the direction of the Administrator.
5. The offended employee will be notified of any actions taken and will not be persecuted for reporting such occurrences.
6. Administration retains final responsibility for the resolution of all sexual harassment complaints.
7. Employees making such charges without just cause will be disciplined and may be responsible for any legal fees incurred.

PRECISION SURGERY CENTER

VII. HUMAN RESOURCES

1. General Principles

P. Personal Telephone Calls

1. It is the policy of the Center to strongly discourage personal calls made or received by our employees, except in true emergency situations.
2. Employees are not to receive or make personal telephone calls at their work area. Employees may use their personal cellular phones or public telephones if it is necessary to make an emergency call.
3. Use of telephones in the work area may disrupt incoming calls pertaining to patient care. Only with the authorization of the supervisor may an employee use these telephones for personal reasons which are not considered immediate emergency situations.
4. When incoming personal telephone calls are received by the receptionist, the following guidelines will apply:
 - A. The receptionist will determine from the caller the Department in which the employee works and if the call is an emergency.
 - B. If the caller indicates an emergency situation, the receptionist will connect the call to the supervisor of the employee.
5. Excessive amounts of employee telephone calls for personal, non-emergency reasons will subject the employee to disciplinary action, possibly including termination.
6. It is understood that employees may have bona fide reasons for making personal telephone calls, such as obtaining transportation to and from work, checking on the status of unattended children at home, receiving calls from public schools or child care services, etc. Although calls of this type are normally acceptable, the employee shall not tie up business telephones for these calls and make sure that the calls are not excessive in length or frequency.

PRECISION SURGERY CENTER

VII. HUMAN RESOURCES

1. General Principles

Q. Disciplinary Procedure

I. POLICY

1. It is the policy of the Center to administer fair and reasonable methods of disciplinary action for those employees whose job performance or behavior does not meet the standards of the Center as outlined elsewhere in this policy.

When (based on the judgment of the Supervisor and/or Administrator) the employee's job performance or work behavior does not meet those standards for continued employment, it is the policy of this Center to initiate disciplinary action for corrective purposes in the following manner:

- A. Verbal reprimand: Considered to be a notice to the employee that the job performance or work behavior does not meet standards of employment. This will be documented by the supervisor or Administrator on the appropriate form and placed in the employee file.
 - B. Written reprimand: Considered to be further notice to the employee of undesirable work behavior or unacceptable job performance, submitted in writing, and placed in the personnel file for permanent record.
 - C. Final Reprimand: Suspension without pay, considered to be the final notice to the employee that undesirable work behavior or unacceptable job performance must be corrected at once or termination will result.
 - D. Discharge: Considered to be the most extreme form of disciplinary action and final step in this process. This will occur when all previous steps have been followed or in the event that immediate discharge is considered to be justifiable by the Supervisor and Administrator.
2. Furthermore, it is the policy of the Center that all employees shall have the right to initiate our internal grievance procedure in connection with any aspect of this policy.

II. STANDARDS OF CONDUCT

1. The following standards of conduct are prescribed to ensure continuation of employment. Employees as at all times are expected to:
 - A. Give primary consideration to the welfare of patients, employees, and visitors.
 - B. Respect established authority.
 - C. Use equipment and supplies judiciously and with extreme care.
 - D. Perform all duties and responsibilities in an acceptable manner.
 - E. Be honest; seek help in resolving problems.
 - F. Use care in their personal appearance and confidence in their ability.

- G. Comply with departmental rules/regulations.
- H. Conduct themselves as responsible members of the staff and as good citizens.

III. GENERAL GROUNDS FOR DISCIPLINARY ACTION

The understanding of the Standards of Conduct and rules and regulations of the Center must be considered an important issue. Although not intended to limit the rights of the staff, it is a clarification of these rules and regulations which is meant to assist the employee. When an employee violates any one (1) or more of the following categories, it will be considered sufficient grounds for disciplinary action.

1. Falsification of personnel records
2. Falsification of any portion of a patient's medical record or test.
3. Absence without justifiable cause.
4. Reporting late for scheduled work.
5. Leaving the office premises without prior approval.
6. Creating or contributing to unsanitary conditions.
7. Refusal to obey directives of the Center.
8. Refusal or failure to perform assignments.
9. Threatening, intimidating, coercing, or interfering with fellow employees, Department supervisors, Administrator, and Physician(s).
10. Unauthorized soliciting or collecting of contributions.
11. Unauthorized distribution of literature.
12. Intentional misuse or removal of property, patient records, equipment, supplies, or confidential material of the Center.
13. Gambling, lottery, or other games of chance on the premises.
14. Substance abuse of any nature or scope.
15. Acceptance of gratuities from past, current or potential suppliers.
16. Non-compliance with the regulations of The Occupational Health, and Safety Administration (OSHA)

IV. PROCEDURE

1. Initiation of disciplinary action: When an employee's job performance or work behavior ceases to meet acceptable standards for continued employment, disciplinary action procedures are initiated by persons in authority. Those persons having this authority are as follows:
 - A. The Clinical Director.
 - B. The Administrator.
 - C. Administrative Assistants, as appropriate
 - D. Medical Director/CEO
2. Verbal reprimand: The first step in the process is the verbal reprimand issued to the employee as an initial warning. It is documented and maintained by the Supervisor, or Administrator for future reference and placed in the employee file.
3. Written reprimand: The next step in the process is the written reprimand issued to the employee as the second warning. This reprimand is presented to the employee in writing

and is documented on a "Disciplinary Action Form" requiring the signature of the counselor and the employee.

- A. The employee is asked to sign this document not as an admission of guilt, but to acknowledge that the counseling did occur.
 - B. The document is placed in the employee's personnel file as a part of the permanent employment record regardless of signature. Failure to sign the form must be documented on the Disciplinary Action form.
4. Final Reprimand: Suspension without pay. The next step in the process is suspension without pay issued to the employee as the third and final warning. This action is presented to the employee in writing and is documented on a "Disciplinary Action Form" requiring the signature of the counselor and the employee.
- A. The employee is asked to sign this document not as an admission of guilt, but to acknowledge that the event did occur.
 - B. This document is placed in the employee's personnel file as a part of the permanent employment record.
 - C. The employee will not be allowed to return to work until the suspension period has expired.
5. Discharge: The final step in the process is discharge. At this time, the employment status is terminated and termination documents are processed.
- A. When the decision is made to enter into this step of the process, it has been fully determined through previous steps that the employee does not intend to correct the undesirable work behavior or unacceptable job performance and thus fails to meet those standards required for continued employment.
 - B. This action is documented on the "Disciplinary Action Form" requiring the signature of the Administrator and the employee.
 - C. The employee is asked to sign the document not as a direct admission of guilt, but to acknowledge that the event did occur.
6. Immediate Suspension: Automatic suspension occurs when it is determined by those persons having authority that the employee has:
- A. Violated Center and/or department policy to the extent that damage done, or the results and consequences of the action will be severely detrimental to the Center and/or department.
 - B. Exhibited extremely undesirable work behavior and/or job performance or neglect of job performance.
 - C. Substantially violated those standards of conduct set forth in the Disciplinary

Action policy to the extent that damage done, or the results and consequences of the violation will be severely detrimental to the Center and/or the department.

D. Other undesirable actions as deemed sufficient to justify automatic and immediate discharge.

7. Those persons having the authority to execute immediate suspension are as follows:

A. The employee's immediate Supervisor, upon the direction and approval of the Administrator and/or Medical Director.

B. The Administrator.

C. The Medical Director/CEO.

V. GENERAL PROCEDURES INVOLVING DISCIPLINARY ACTION

1. The employee, at all times, shall have the right to initiate the internal grievance procedure for matters related to the disciplinary action process. The employee may obtain information regarding the grievance from the Administrator.

2. The disciplinary action process is to be administered fairly and consistently to all employees at all times and in a manner consistent with policy, rules and regulations to ensure equal treatment to all employees.

3. Employees shall be informed of their status throughout the disciplinary action process of the following items:

A. What he/she can expect to occur next if the problem is not corrected.

B. What actions he/she can take to correct the problem.

C. What specifically lead to the disciplinary action.

D. Specifically, what is necessary for the employee to meet standards for continued employment.

E. What is a reasonable period of time in which corrective action is to occur.

VI. PROCEDURE – EMPLOYEE GRIEVANCE REPORTING METHODS

1. Problems arise in any group of people working together. It is important to all of us that these problems be solved as quickly and as fairly as possible so that small problems do not grow out of proportion. Occasionally, however, it may be necessary to investigate certain problems in greater detail. The grievance procedure enables employees to have a fair review of any work-related controversy, dispute or misunderstanding.

2. If any employee feels that they have a valid grievance, the following procedure used:

A. Step One: An employee may submit, in writing or orally, the problem to his/her immediate supervisor/department head within three (3) days after the problem becomes known to the employee. The supervisor/department head will attempt to resolve the employee's grievance during the initial meeting. If unable to reach a

mutually agreed upon settlement, the supervisor/department head will investigate the situation further and within three (3) working days, meet with the employee with a proposed solution to the grievance. If the employee is still not satisfied, then he/she may request a Step Two meeting.

- B. Step Two: If the employee is not satisfied in Step One, he/she must submit in writing within five (5) working days the problem or grievance. The Administrator will investigate the problem with all involved parties and schedule a meeting with the employee and the supervisor/department head. The employee may elect to have a fellow employee accompany him/her to this meeting to assist in the presentation of the problem. A concerted effort will be made at this meeting to resolve the problem. The Administrator will be responsible for preparing a written report of this meeting. If the employee does not believe the solution presented is satisfactory, a Step Three procedure may be requested.
 - C. Step Three: The employee may request, within thirty (30) working days, a review of the proceedings by the Medical Director. The Medical Director will within five (5) working days after receipt of the grievance thoroughly investigate the problem and considering every aspect of the employee's and the supervisor/department head's position, as well as information described in Steps One and Two, make a final and binding determination on the grievance.
 - D. Grievance against Supervisors: The employee may request within thirty (30) working days, a hearing by the Medical Director. The Medical Director will within five (5) working days after receipt of the grievance thoroughly investigate the problem and considering every aspect of the employee's and the supervisor/department head's position, make a final and binding determination on the grievance.
3. Employees who are discharged for cause may appeal that decision by using the grievance procedure. However, the discharged employees shall appeal the Human Resources Department as Step One and the appeal must be in writing. Any discharge appeal must be received by the Administrator within seven (7) working days of the discharge to be considered.

PRECISION SURGERY CENTER

VII. HUMAN RESOURCES

1. General Principles

R. Termination of Employment

I. POLICY

1. It is the policy of the Center to provide all employees with the means of terminating their employment relationships, at their discretion. Upon receipt of the documents explained in the policy governing employment status, the Center will recognize that employee's intent to cease employment, and proper procedures will be initiated by the Administrator or Medical Director.
2. Furthermore, it is the policy of the Center to initiate termination of the employer/employee relationship, at its discretion, and when justified. Methods utilized by the Center for this purpose will be executed in a manner which is deemed fair and equitable to all parties involved. Proper termination procedures will be carried out by the Administrator or Medical Director.

II. PROCEDURE FOR TERMINATION OF EMPLOYMENT

1. The employee will submit, in writing, a letter of resignation to his or her immediate supervisor. The letter will contain the following information.
 - A. Name, department and position of the departing employee.
 - B. Date the letter of resignation is written.
 - C. Effective date of the resignation (the employee's last day of work).
 - D. Specific reasons for the resignation, forwarding address information.
2. The letter of resignation will be forwarded to the Administrator, immediately upon receipt.
3. The Administrator will begin closure of the employee's personnel file in the following manner:
 - A. The personnel file and is removed from the current employee files, and the termination date is noted appropriately and included in the file.
 - B. The employee's insurance records are removed from the files, and the termination date is noted appropriately.

- C. The Administrator will indicate termination pay or benefits in the Personnel/Payroll Action form, and distribute parts of the form to the payroll department, and maintain the original in the personnel file.
- D. All other activities associated with termination (withdrawal from other benefit plans, etc.) will be carried out by the Human Resources Director.

III. PROCEDURE FOR TERMINATION OF EMPLOYEE – CENTER REQUEST

- 1. When deemed necessary, and after completion of the Center's disciplinary action policy and procedure, termination information will be forwarded to the Administrator.
- 2. When all documentation is deemed adequate for termination activities by the Administrator, the procedure outlined in "PROCEDURE FOR TERMINATION OF EMPLOYMENT – EMPLOYEE REQUEST" will be initiated by the Administrator.
- 3. When termination is by the Center's request and if termination becomes effective immediately, the employee's final paycheck will be available to the employee at the time of dismissal, if possible.

IV. EXIT INTERVIEWS

- 1. It is the policy of this Center to encourage terminated staff members to make an appointment with the Administrator for an exit interview.
- 2. The interview will be summarized, and if appropriate, information will be shared with the employee's supervisor.
- 3. Information gathered at exit interviews, if applicable, will be considered in revising policies, procedures or working conditions.

PRECISION SURGERY CENTER

SECTION VII

HUMAN RESOURCES

2. Employee Health

PRECISION SURGERY CENTER

VII. HUMAN RESOURCES

2. Employee Health

A. Objectives

I. PURPOSE

To promote health and protect patients and personnel from infectious diseases, injuries, and exposure to hazardous and bio-hazardous materials. The Employee Infection Control Program is maintained in conjunction with Compliance Alliance, LLC (also known as Infection Control Solutions, LLC). Details of the program are inside the employee Infection Control Program Manual, and also in the employee Injury and Illness Prevention Program Manual.

II. GOALS

1. To hire employees physically able to work in the positions for which they were hired, free of active communicable diseases.
2. To provide a safe and healthy environment for the employee.
3. To annually review the health and physical status of all employees.
4. To have medical-administrative control and follow-up of injuries and illnesses of employees that occur both on the job and off the job.
5. To prevent transmission of infection between patients and employees.
6. To reduce the incidence of illness among personnel and thereby reduce absence.

III. RESPONSIBILITIES

1. Administrator
 - A. Ensure adequacy of policy through regular review and revision of the Employee Health Program. Incorporate state and local health regulations into the Program.
 - B. Maintain current health records of all employees, including health examinations, disease exposure, industrial injuries, immunizations, as required.
 - C. Maintain list of related infection: Purified protein derivative (PPD) converters, communicable disease contacts, and needle puncture wounds.
2. Physician
 - A. Evaluate and treat personnel involved in on the job injury, accidental exposure to communicable diseases, etc.
3. Infection Control Program Coordinator – will work in conjunction with Compliance Alliance, LLC, (also known as Infection Control Solutions, LLC), to update and revise the Employee Infection Control Program and the Injury and Illness Prevention Program.
 - A. Review and approve infection Prevention and control policies for employee health.
 - B. Review summary of job-related infections and recommend follow-up action as appropriate.
 - C. Provide input into Employee Health Program.

IV. HEALTH MAINTENANCE PRACTICES

1. Personnel Health Management

A. Physical Examinations

- ◆ All employees shall have a pre-employment tubercular skin test at Precision Surgery Center.
- ◆ In requirement with OSHA updated guidelines, a 2 step PPD testing is required for all new employees. The compliance directive applies to any facility where an employee has had or is expected to have possible occupational exposure to tuberculosis. Under this directive, coverage of "non-hospital health care facilities such as doctors offices and clinics includes only personnel present during performance of high hazard procedures on suspect or active tuberculosis patients". CDC guidelines include that physicians, as well as other health care workers, undergo routine, periodic PPD testing for latent tuberculosis infection.
- ◆ Skin tests should be given to employees at initial hire unless they have documentation of a negative PPD test within the past three months. The initial tests should consist of the two-step test unless employees have had negative skin tests within the past 12 months. Following the initial test, employees who test negative are to be tested periodically under the following circumstances:
 - ◆ At least every 12 months for all exposed employees,
 - Immediately following an exposure incident and three months later a forced exposure skin test is negative
 - Students from affiliated education programs shall comply with employee health policies. In the event of accidental exposure to disease, the Infection Prevention Control Program Director shall notify the educational institution.

B. Disease Exposure

- ◆ Defined as having significant contact with blood or body secretions during direct patient care, by accidental skin puncture by a contaminated needle, or by significant exposure to a patient with a communicable disease without appropriate barrier precautions.
 - ◆ Exposure procedure:
 - Report incident to Infection Prevention and Control Program Director
 - ◆ Document the incident by filling out appropriate forms in the packet inside the Illness and Injury Prevention Program Manual. Reports should be documented within twenty-four (24) hours of incident if possible. Concentra Medical Center (address and directions in employee injury packet) may be consulted for testing and prophylactic treatment if indicated

2. Protection of the Patient/Employee

- A. The Infection Control Program Coordinator sets guidelines to limit or prohibit personnel contact with patients when certain conditions exist as follows:
- Skin infections, (open lesions or draining wounds of any kind).
 - ◆ Respiratory tract infections including group A streptococci, pneumonia, active pulmonary tuberculosis, influenza, mumps, fever, sore throat and/or rhinitis.
 - ◆ Active exanthemas (rubella, measles, chicken pox, herpes zoster) in exposed areas during communicable phase.
 - ◆ Enteric infections (hepatitis, salmonellosis, shigellosis, amebiasis, giardiasis), vomiting or diarrhea.
 - ◆ Personnel with herpes simplex (fever blister/cold sore) must not care for immunosuppressed patients, pregnant patients or infants.
 - ◆ The Infection Control Program Coordinator guidelines to protect employees from patients with certain conditions are as follows.
 - ◆ Pregnant employees shall not care for patients with known or suspected rubella, cytomegalovirus infections, and/or radiation therapy patients.
 - Personnel with known immunity, active or passive, to infectious diseases such as measles, mumps, chicken pox or influenza shall be assigned to care for patients who may be infected.

V. PROPHYLAXIS FOR EXPOSURE TO COMMUNICABLE DISEASE

1. Prophylaxis for exposure to communicable disease shall be provided under the direction of the physician, and/or using the CDC GUIDELINES, and when appropriate telephone consultation and recommendations from the Department of Health Services.
2. The decision for prophylaxes shall be made on the basis of the following:
 - A. The potential infectiousness of the patient.
 - B. The type and duration of the contact.
 - C. Results of laboratory examinations.
 - D. Employee susceptibility.
3. In-service Education
 - A. In-service Education relative to infection prevention and control is a requirement for all newly hired employees. Compliance Alliance, LLC assists with all new employee education via on site training or webinar. In addition, all departments supervisors are to inform new employees about the Infection Control Program Coordinator, Exposure Control Plan, the Infection Prevention and Control Program, and the employees' responsibility to the program. This includes personal hygiene, hand washing, reporting of infectious conditions, or infectious hazards to the Infection Control Program Coordinator, and the Employee Health Program. This program is presented as part of the General Orientation program, and is

documented.

- B. Education relating to infection prevention and control is provided by the department managers, in conjunction with Compliance Alliance, LLC (also known as Infection Control Solutions, LLC) and /or may be coordinated through the Infection Control Program Coordinator.

4. Controls of the System

- A. Records of employee infections/sick calls shall be reviewed monthly to detect trends or outbreaks, and shall be reported to the Infection Control Officer.
- B. All personnel shall be required to attend an annual update in-service which consists of the following: Infection Prevention and Control, Exposure Control Plan, and Fire/Safety/Emergency Preparedness.

PRECISION SURGERY CENTER

VII. HUMAN RESOURCES

2. Employee Health

B. Employee Health Program

I. PURPOSE

To promote and safeguard the health of all employees and to ensure that all employees are physically able to perform their jobs, as well as to ensure the well-being of our patients.

II. POLICY

It is the policy of the Center to assess the physical ability of each and every employee to perform his/her job.

III. PROCEDURES

1. Employees Returning to Work after Illness
 - A. All employees who are absent from work for more than three (3) scheduled working days due to illness will be required to submit evidence of physical ability to return to duty, from a physician.
 - B. An employee will not be allowed to return to duty until satisfactory evidence of physical ability is provided to the supervisor or Administrator.
2. Ongoing Employee Health Services
 - A. Employees with upper respiratory infections, diarrhea, or skin lesions shall report their condition to their supervisor.
 - B. Flu vaccine may be offered to employees periodically and upon the order of the staff physician.
3. Exposure to Communicable Diseases
 - A. The employee shall report to their supervisor for completion of an incident report immediately or as soon as possible after having learned of possible exposure to a communicable disease. The Medical Director will be contacted in regards to prophylaxis, as well as the Infection Prevention Control Program Director.
 - B. The employee is to contact their supervisor for completion of an employee injury packet immediately in case of needle puncture or other exposure to blood or body fluids and report to the physician in charge. Concentra Medical Center is available for post exposure testing and treatment.
 - C. A written report of the post-exposure medical examination shall be available to the employee within 15 days.
 - D. Exposure to HIV/HBV policies shall be followed. (section G)
4. Accidents or Injuries While on the Job
 - A. Employees shall report to their supervisor immediately in such cases, and adhere to policy regulating incident reporting and on-the-job injuries. Details of these policies are also located in the Employee Injury and Illness Prevention Program Manual.

5. Prevention of Injuries and Illnesses

- A. All safety and infection control policies and procedures including both employee manuals from Infection Control Solutions, LLC, will be reviewed with each employee during orientation and annually.
- B. Ergonomic training will be provided for each employee during orientation to prevent work injuries associated with improper body alignment during normal work activities.

PRECISION SURGERY CENTER

VII. HUMAN RESOURCES

2. Employee Health

C. Exposure Control Plan

I. POLICY

The purpose of the Exposure Control Plan is to identify workers who are at risk or are potentially at risk for occupational exposure to blood or other potentially infectious materials and therefore are at risk for exposure to HIV and other communicable diseases.

II. EXPOSURE DETERMINATION

1. Job Classifications in which all employees have occupational exposure.
 - A. Nursing Personnel
 - B. Physicians
 - C. Radiology Personnel
 - F. Certified Surgical Technician
 - G. Operating Room Technician
 - H. Medical Assistant

2. Job Classifications in which there is little chance of exposure.
 - A. Admitting Personnel
 - B. Medical Records Personnel
 - C. Administrative Personnel

3. Tasks and Procedures in which occupational exposure may occur
 - A. Handling of blood, blood products or body fluids or objects contaminated thereof
 - B. Pre/Post pain management procedures
 - C. Phlebotomy or vascular access procedures and the care thereof
 - D. Contact with laboratory or pathological specimens
 - E. Wound care, suctioning/sputum induction
 - F. Contact with mucous membranes or non-intact skin
 - G. Handling/disposal of medical waste
 - H. Cleaning/processing of contaminated equipment
 - I. Handling of soiled linen
 - J. Cleaning/decontamination of environmental surfaces.
 - K. Emergency procedures, CPR and intubation
 - L. Injections

III. METHOD OF COMPLIANCE

1. Methods of compliance include but are not limited to:
 - A. Universal Precautions
 - B. Environmental and Work Practice Control (including personal protective equipment)
 - C. Isolation Practices
 - D. Medical Waste Policies and Procedures

IV. POST EXPOSURE FOLLOW-UP

1. Following an exposure incident, all employees shall receive a confidential medical evaluation and follow-up with the following elements: This is performed at Concentra Medical Center (address and directions in the Employee Injury Packet)
 - A. Documentation of the route(s) of exposure and the circumstances under which the exposure occurred.
 - B. A description of the employee's duties as they relate to the incident.
 - C. Identification and documentation of the source individual when known.
 - D. The employee's relevant medical records and vaccination dates shall be made available to the health care professional evaluating the employee.
2. Results of the source individual's testing shall be made available to the exposed employee and the employee shall be informed of applicable laws and regulations concerning disclosure of the identity and infectious status of the source individual.
3. A written report of this medical evaluation shall be available to the employee within 15 days of exposure. This report shall be limited to:
 - A. That the employee has been informed of the results of the evaluation;
 - B. That the employee has been told of any medical conditions resulting from exposure to blood or other potentially infectious materials which require further evaluation or treatment;
 - C. All other findings or diagnoses shall remain confidential and shall not be included in the written report.
4. If the employee consents to a baseline blood draw but not to HIV testing, the specimen shall be stored for 90 days. Should the employee change his/her mind, testing will be done as soon as feasible.

V. COMMUNICATION OF HAZARDS

1. All blood or potentially infectious materials shall have a bio-hazard label affixed to the container (blood and blood products for clinical use are exempt) or shall be stored in red bags or red containers.

PRECISION SURGERY CENTER

VII. HUMAN RESOURCES

2. Employee Health

D. Tuberculosis Screening

I. POLICY

It is the policy of the Center to properly screen all employees for the presence of inactive or active Tuberculosis at the time of employment and at least annually thereafter.

II. PROCEDURE

1. Pre-employment Screening

- A. Skin tests should be given at the employee's initial hire unless they have documentation of a negative PPD test within the past 3 months.
- B. One step tuberculin testing – Applicant with a negative tuberculin skin test within the past 12 months, no known history of Tuberculosis and no previous significant Mantoux (PPD) Tuberculin skin test. Testing method will include:
- C. Two step skin test – The initial test should consist of a two-step test unless employees have had:
 - Negative skin tests within the past 12 months.
- D. A tuberculin reaction of 5 mm or more is classified as positive in the following groups:
 - ◆ People who have had close recent contact with a patient within infectious tuberculosis,
 - ◆ People who have chest radiographs with fibrotic lesions likely to represent old healed tuberculosis,
 - ◆ People with known or suspected HIV infection.

2. A tuberculin reaction of 10 mm or more is classified as positive in people who do not meet the above criteria but who have other risk factors for tuberculosis. This would include:

- A. People with other medical risk factors known to substantially increase the risk of tuberculosis once infection has occurred,
- B. Foreign-born people from high-prevalence countries (example those from Asia, Africa, and Latin America),
- C. Medically underserved, low income populations, including high risk minorities,
- D. Intravenous drug users,

3. A reaction of 15 mm or more is classified as positive in all other people.
4. An absence of a reaction to the tuberculin test does not exclude the diagnosis of tuberculosis or tuberculosis infection. Self-medicated responses such as tuberculin reactions may decrease or disappear during any severe or febrile illness, measles or other exanthemas, HIV infection, live virus vaccination, Hodgkin's disease, sarcoidosis, overwhelming miliary or pulmonary tuberculosis, and after administration of corticosteroids or immunosuppressive drugs. Up to 30% of patients with HIV infection and 60% of patients with AIDS may have skin test reactions less than 5 mm even though they are infected with tubercle bacilli. In addition, people who have been very recently infected may not have a reaction to the tuberculin skin test.
5. Tuberculin Testing
 - A. Annual Tuberculin Testing
 - ◆ All employees in clinical departments who have exposure to patients potentially suffering with tuberculosis should have the tuberculin tests repeated at least every 12 months.
 - ◆ All personnel immediately following an exposure incident and three months later if post exposure skin test is negative.
 - B. Positive Tuberculin Test
 - ◆ If a person is tested positive, which is determined by measuring the amount of induration or swelling (not redness):
 - ◆ A chest x-ray is obtained to determine if this person has passive or active tuberculosis infection.
 - ◆ If a chest x-ray is negative and the physician determines this person has passive tuberculosis, this person is evaluated as a candidate for drugs that will prevent the tuberculosis from becoming active.
 - ◆ This person either will be referred to their personal physician or to the health department.
6. Active Tuberculosis
 - A. No new employee will be hired with active tuberculosis.
 - B. If an employee who has been working at the Center becomes exposed and presents with active tuberculosis, further testing will be done including a sample of sputum followed by referral to a personal physician or health department along with multi-drug treatment.
 - C. Active tuberculosis is contagious; hence an employee who is suffering with active

tuberculosis is taken off duty to prevent transmission to patients and to other workers. The Center will also look at various other employees potentially who could have active tuberculosis.

- D. Passive tuberculosis is not contagious, however it is important that this employee monitor oneself for signs and symptoms of active tuberculosis, especially if this employee cannot or chooses not to take prophylactic drug therapy
 - E. A person who is suffering with active tuberculosis can only return to work after three consecutive negative sputum smears and shows improvement in symptoms as determined by the health department or private physician.
7. Response to screening:
- A. If chest x-ray shows no activity, applicant will be hired.
 - B. Yearly Tuberculosis counseling will be done, following education concerning signs and symptoms of active Tuberculosis infection.
 - C. If chest films suggest recent activity, the applicant will be referred to their personal physician and will not be allowed to work until after 4 weeks of treatment on appropriate anti-tuberculin medication has passed.
8. If an applicant has had a significant Mantoux (PPD) in the past and has been adequately treated with anti-tuberculin medication:
- A. He/she will require a pre-employment chest x-ray.
 - B. He/she will be required to answer a Tuberculosis questionnaire annually.
9. If an applicant has had active tuberculosis in the past:
- A. Documented proof of adequate treatment with anti-tuberculin medication from employee's personal physician will be required before the employee begins work.
 - B. A pre-employment chest-ray will be necessary.
 - C. Yearly tuberculosis counseling will be required.

III. SUBSEQUENT ANNUAL SCREENING

- 1. Those employees who have a previous negative PPD skin test will be retested on an annual basis. All employees who previously had a significant PPD reaction will have one chest x-ray done and fill out an annual tuberculosis questionnaire.
 - A. If an employee's PPD. becomes significant or if any questions on the questionnaire are answered affirmatively, the employee will be referred to a physician for follow-up whether or not a documented situation of exposure to an infected patient or fellow employee occurred during the last year interval.

2. Unprotected Employee Exposure

- A. Screening: An employee who is exposed to a patient with a bacteriologically positive case of Tuberculosis, and who has:
- Never had a significant PPD or who received a Bacille Calmette Guérin (BCG) vaccination longer than three years ago will receive a PPD skin test approximately three months after the exposure.
 - ◆ A previously significant PPD will not be screened. If the employee becomes symptomatic, a chest x-ray will be done.
- B. Response to Screening: The employee who converts to significant PPD will receive:
- ◆ Chest x-ray
 - ◆ Treatment under Workman's Compensation as recommended by the Medical Director

PRECISION SURGERY CENTER

VII. HUMAN RESOURCES

2. Employee Health

E. Immunization

I. POLICY

The Center recommends that all health care workers who perform invasive procedures should know their HIV and Hepatitis B antigen (HBAg) status. It is recommended that all health care professionals in these areas be immunized against Hepatitis B.

II. PROCEDURE

1. Hepatitis B Vaccine – Available at no cost to all personnel who handle patient blood and body secretions. This includes, but is not limited to: Physician staff, nursing staff and laboratory staff.

A. Before receiving vaccine, employee will:

- ◆ Be instructed of risks and benefits of vaccine either by the Infection Control Program Coordinator, or the physician.
- ◆ Be instructed that there is a series of three doses: the initial dose, a second dose in one month, and a third dose six (6) months following the initial dose.

PRECISION SURGERY CENTER

VII. HUMAN RESOURCES

2. Employee Health

F. Post-Exposure Prophylaxis of Hepatitis

I. POLICY

All employees in cases of exposure to Hepatitis will be referred for evaluation to receive prophylactic therapy.

II. DEFINITION

An important exposure is defined as follows:

1. Hepatitis A – Person to Person contact, generally through fecal contamination or sexual contact.
2. Hepatitis B and C – Accidental percutaneous, ocular, or mucous membrane exposure to blood known to be HBAg positive and/or human bite that penetrates the skin from HBAg carriers.

III. LABORATORY STUDIES

1. Employee – hepatitis diagnostic panel will be performed with consent. If not, blood will be stored for 90 days.
2. Patient – hepatitis diagnostic panel will be performed with written consent which is obtained with all invasive procedures.

IV. PROPHYLAXIS

1. Hepatitis A – Routine IG prophylaxis for Center personnel is not indicated.
2. Hepatitis B – In the event of important exposure to known HBAg positive blood, vaccine can be administered.
3. Hepatitis C – In the event of an important exposure, a single dose of IM of IG 0.02 ml/kg may be recommended.

PRECISION SURGERY CENTER

VII. HUMAN RESOURCES

2. Employee Health

G. Exposure to HIV

I. POLICY

Employee cases of important exposure to a patient with possible or confirmed HIV positive will be referred for evaluation and follow-up. Employees are referred to Concentra Medical Center for testing and treatment, as per the Employee Injury and Illness Prevention Program.

II. DEFINITION

An important exposure is defined as exposure to blood and/or other body fluids via parenteral (e.g., needle stick, cut or bite) or mucous membrane exposure (e.g., splash to the eye or mouth).

III. LABORATORY STUDIES

1. Employee

- A. A baseline study for HIV antibody shall be performed as soon as possible after exposure, if status is unknown or negative in the past. Written consent is needed for testing. If the employee consents to blood drawing but not to HIV testing, the blood will be held for 90 days should the employee change their mind and request HIV testing.
- B. If baseline HIV antibody study is negative, employee is to be retested after 6 weeks, then 3, 6, and 12 months following exposure.
- C. If employee is seropositive for HIV antibody, no further testing is necessary.

2. Patient

- A. HIV antibody shall also be performed, if status unknown, with the patient's written consent which is obtained for all invasive procedures.

IV. REFERRALS

- 1. Refer employee to Infection Control Program Coordinator for follow-up and appropriate counseling as necessary.

PRECISION SURGERY CENTER

VII. HUMAN RESOURCES

2. Employee Health

H. Exposure to Meningococcal Meningitis

I. POLICY

Employee cases of important exposure to Meningococcal Meningitis will be referred for evaluation to receive prophylactic therapy. Employees are referred to Concentra Medical Center for testing and treatment, as per the Employee Injury and Illness Prevention Program.

II. DEFINITION

An important exposure in this case is defined as intimate contact (mouth to mouth resuscitation) to a patient highly suspected of or diagnosed as having meningococcal meningitis before definitive treatment of the patient was established.

III. EMPLOYEE INSTRUCTIONS

1. Instruct the employee in the following:
 - A. Incubation period varies from 2-10 days, commonly 3-4.
 - B. If any of the following symptoms occur report to the on-duty physician immediately for further evaluation.
 - ◆ SYMPTOMS: sudden onset of fever, intense headache, nausea, often vomiting, stiff neck, petechial rash.

IV. RECOMMENDED PROPHYLACTIC THERAPY (to be used as a guideline only)

1. Rifampin BID for 2 days (600 mg/adults).

PRECISION SURGERY CENTER

VII. HUMAN RESOURCES

2. Employee Health

I. General Safety for All Employees

1. Be physically fit for your work through good health habits, proper diet, sufficient rest, and cleanliness.
2. Prevent the spread of infectious or contagious diseases; when you are ill, call in, but remain at home.
3. Personal hygiene is paramount: wash your hands often, in particular after arriving at and before leaving work, before meals, after use of the restroom, and after patient contact.
4. Wear proper clothing for your particular job with appropriate uniforms as required.
5. Heed all warning signs cautioning you about a hazard or a condition detrimental to your safety.
6. Use caution with swinging doors. If there is a window panel, check clearance before opening the door.
7. Always use a suitable ladder; do not climb on chairs or boxes to reach overhead items.
8. Pick up any foreign matter found on floors and put them into the proper receptacles.
9. Assist new or inexperienced personnel in your department to become familiar with proper safe practices.
10. Know the location of fire extinguishers in your area.
11. Look for tripping and slipping hazards and have such hazards removed immediately.
12. Keep traffic areas clear of obstructions such as chairs, supplies, etc.
13. Use handrails when descending stairs and watch your step.

PRECISION SURGERY CENTER

VII. HUMAN RESOURCES

2. Employee Health

J. Reporting Injury on the Job

I. POLICY

The intent of this policy is to ensure a safe environment for our employees at all times and provide a method by which reporting, investigation, and review are conducted on an on-going basis for all incidents as defined below.

II. DEFINITION

Definition of an "incident": An incident is broadly defined as any happening (occurrence) which is not consistent with the routine operation of the Center. Included in this broad spectrum are accidents (with or without injury) involving employees.

III. PROCEDURE

1. After injury, the employee shall:
 - A. Be given first aid on location if indicated;
 - B. Be taken to the emergency room, Concentra Medical Center, or
 - C. See physician at the Center for evaluation and treatment as soon as possible.
2. The Nurse will:
 - A. Have the physician evaluate and treat employee.
 - B. Submit related doctor's notes, test results etc to the employee
 - C. Notify the Medical Director and Administrator of the injury as soon as possible.
3. Follow-up will be coordinated by the Clinical Director or Administrator based on the recommendations of the physician.
4. The Infection Control Program Coordinator will be notified by the Administrator, if the injury is a result of a communicable disease exposure.

IV. REPORTING RESPONSIBILITIES

1. Employees: It is the responsibility of each and every employee to report any and all employee incidents/injuries which may occur at this Center. Initial reporting by the employee shall be made verbally and in writing via the employee injury report packet and given to the supervisor or Administrator. All reports shall be reported promptly, legibly, and accurately.
2. Department Supervisor: It is the responsibility of these individuals to assist the employee with the incident reporting process.
3. Compensation Injuries – If required, an "Employees First Report of Injury" (WC Claim

Form) shall be completed by the Administrator.

4. An accurate and current file of all employee incident/injury reports is maintained by the Administrator.
5. The log and summary of occupational injuries and illnesses (OSHA No. 200) and any supplementary record of occupational injuries and illnesses (OSHA No. 101) are kept in the Employee Injury and Illness Prevention Manual.

V. INTERNAL REVIEW

1. Ongoing internal review is conducted of all incident reports which have been filed with the Administrator by the Safety and Maintenance Coordinator.

VI. EDUCATIONAL RESPONSIBILITIES

1. It is the responsibility of each employee to seek assistance and advice about matters of concern regarding safety. Any unsafe or possibly hazardous condition must be promptly reported to the supervisor.
2. It is the responsibility of the Safety and Maintenance Coordinator to advise and assist their employees in matters of concern regarding safety. Prompt attention to unsafe conditions, education of employees regarding proper use of equipment and safety devices provided by the Center are considered to be ongoing responsibilities of our supervisory and managerial personnel.

PRECISION SURGERY CENTER

VII. HUMAN RESOURCES

2. Employee Health

K. Workers Compensation

I. REPORTING PROCEDURES

1. First Aid Cases: Those injuries requiring minor medical attention or only first aid, generally are not "recordable" under OSHA. However, a location record of all injuries must be kept in the administration office.
2. Physicians' Cases: If the employee sees a physician and the injury is considered reportable, an Employee Claim Form for Workers' Compensation Injury must be prepared and copies forwarded immediately to the Administrator. This report must be submitted immediately. Benefits cannot be paid until paperwork has been completed.
3. Serious Medical Claims: In serious injuries or fatalities, the Administrator and Medical Director shall be notified immediately. OSHA notification shall be the responsibility of the Administrator in conjunction with the Safety Coordinator.
4. Investigations and Questionable Claims: Every claim involving lost time shall be investigated immediately; to include interviewing witnesses, the injured employee (as soon as health permits), examination of the injury scene and photographs, if appropriate. Any physical evidence (broken machine parts) shall be retained. Should there be any information uncovered that would cause a question as to the validity of the claim, this information shall be communicated immediately and fully to the Administrator. This shall be by phone call initially and then followed by a letter, either attached to the Injury Report, or sent later.
5. Medical Care: For any injury, the employee is to receive prompt and appropriate medical treatment. Concentra Medical Center is authorized to provide medical care per for employees per the Injury and Illness Prevention Program Manual. If referred to a doctor, the employee shall take with him/her a "doctor's referral slip" which authorizes the doctor to treat the person as a work-related injury.
6. Treatment of Pre-existing Conditions:
 - A. Departments shall direct their personnel accordingly and consideration given when assigning a prospective or current employee with a known preexisting injury which could be aggravated while doing the work assigned.
 - B. Documentation of prior injuries shall be placed in the employee's medical files. Documentation may be in the form of group insurance information, pre-employment physical, or as a result of a claim examination or prior W/C claim. The claim service can better direct the investigation and administration of an injury when documented information is available

- C. Contact with Injured Employees: It is very important to maintain close contact and open communications with an injured employee, but particularly if he/she is away from work more than a week. This shall include phone calls and home visits by the employee's immediate supervisor and other members of management as deemed necessary.
- D. Rehabilitative Work: It is recommended that every effort be made to accommodate an employee who may return to work on a restricted activity basis. This can be accomplished by discussion with the Unit Manager, the treating physician and the employee. Rehabilitation is most effective when initiated as soon as medical conditions stabilize (usually within six weeks).

7. Return to Work

- A. Authorization for the employee to return to work must be in writing by the attending physician.
- B. Even though the physician returns the employee to "full work" status, caution shall be exercised for all employees returning after a prolonged disability period.
- C. If an employee does not report to work on the day he/she is designated, the supervisor shall attempt to reach the employee to see if the disability period was extended. If the disability period has not been extended, disciplinary action shall be taken in accordance with standard procedures for non-reporting to work.
- D. If there are any restrictions noted by the physician on the return to work authorization, advise the supervisor of such and determine if the employee can return to work with the restrictions noted.

8. OSHA Reporting Responsibilities

- A. Reports of fatalities or hospitalization of five or more employees from a single cause must be made to the local OSHA office within 24-hours of the injury; contact Personnel and Administration for specific instructions.
- B. Maintenance of the OSHA Log and supplemental report is the responsibility of the Administrator with the assistance of the Human Resources Coordinator.

PRECISION SURGERY CENTER

SECTION VII

HUMAN RESOURCES

3. Nursing Services

PRECISION SURGERY CENTER

VII. HUMAN RESOURCES

3. Nursing Services

A. General Policies

I. POLICY

The nursing services of the Center are directed and staffed to ensure that the nursing needs of all patients are met. The nursing service is directed under the leadership of a nurse who is designated as Clinical Director.

II. PROCESS

1. Sufficient nursing staff is provided at the Center with the appropriate qualifications to ensure the nursing needs of all Center patients are met, with ongoing assessment of patients' needs for nursing care and addressing the identified needs based on the volume and types of surgery.
2. Patient care responsibilities are delineated for all nursing service personnel. Nursing services are provided in accordance with recognized standards of practice. There is always a registered nurse available for emergency treatment whenever there is a patient in the Center.
3. The Center's nursing services are consistent with recognized standards of practice. Every nurse in the Center has clearly delineated assigned responsibilities for providing nursing care to patients.

III. NURSES

All nurses must have a degree and be a Registered Nurse or Licensed Practical Nurse and licensed in the State of Nevada. All professional licensed staff members will have primary source verification of their credentials by the Administrator.

IV. SURGICAL TECHNOLOGISTS

All surgical technologists employed by the Center must be a graduate of a certified technologist program.

VI. STAFFING POLICY

1. Members of the staff will be assigned for daily patient care responsibilities and auxiliary tasks by the Clinical Director or Administrator.
2. This is to provide adequate nursing personnel necessary to meet the individual needs of the patient undergoing procedures. The number of nurses staffed each day will correspond with the number of procedures scheduled and the number of patients expected to be admitted.
3. The Clinical Director shall assign personnel to nursing care in the Center, as needed, keeping in mind the number of personnel available, as well as ancillary tasks to be performed, to allow for smooth and safe functioning of the Center.

PRECISION SURGERY CENTER

VII. HUMAN RESOURCES

3. Nursing Services

B. Clinical Director

JOB DESCRIPTIONS

I. BASIC FUNCTION

Responsible for the supervision of all clinical operations of the Center, as well as directing, staffing, planning, organizing, delegating, controlling, and marketing of all services provided in the Center.

II. RESPONSIBILITIES

1. Adheres to mission, vision, values, goals, philosophy, objectives, policies and procedures of the Center.
2. Communicates effectively to promote relationships, within the department, the Center and community.
3. Participates in overall long-range planning for the Center regarding financial, personnel, human relations, external relations and quality control.

III. ORGANIZATIONAL PERFORMANCE

1. Develop, review and/or revise policies and procedures in all aspects of the Center's operation.
2. Inform staff regarding important issues pertaining to the Center's regulatory performance standards.

IV. FINANCIAL MANAGEMENT

1. Direct day to day operations of the Center, including staffing
2. Develop procedures to maximize productivity
3. Establish need to replace existing or purchase of additional medical equipment

V. PERSONNEL/HUMAN RELATIONS

1. Recruit nurses, medical assistants and technicians to fill vacancies and/or meet demand
2. Orient and train new employees, assist with annual competencies review/training
3. Direct and monitor workloads according to schedule
4. Assist in evaluation of staff job performance
5. Mediate interpersonal conflict resolution among staff
6. Ensures stock inventories are maintained
7. Resolves patient complaints or direct to appropriate authority
8. Performs as staff nurse when necessary

VI. QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT

1. Develop, review, and revise standard operating policies and procedures for delivering patient care.
2. Collect information, process, and evaluate information and/or make recommendations relative to factors that affect patient demand.
3. Conduct monthly staff meetings, ensuring that minutes of meetings are recorded and made available to those staff members not in attendance.
4. Assist in development and maintenance of quality assurance studies and data collection for clinical/non-clinical activities.
5. Assist in development of infection prevention and control system for clinical operations.
6. Ensure material safety data sheet (MSDS) book/CD is up to date and available to all employees.
7. Ensures adequate in-servicing on new equipment/procedures to staff.
8. Enforces adherence to standard operating procedures by all employees.
9. Maintains education record for continuing education and required in-services.

VII. QUALIFICATIONS

1. Registered Nurse with management experience preferred.

V. WORK RELATIONSHIPS

1. Reports to Administrator and Medical Director.
2. Communicates with admission staff, medical records staff, and billing staff.
3. Coordinates care with admissions, nursing and administrative staff.
4. Maintains skills to monitor patient scheduling, evaluation and progress.

PRECISION SURGERY CENTER

VII. HUMAN RESOURCES

3. Nursing Services

C. Staff Nurse

I. BASIC FUNCTION

To provide and coordinate patient care in the preoperative, intraoperative and postoperative setting. Specific nursing assignments will be assigned by the Clinical Director, but nurses are trained in all areas of patient care for versatility throughout the Center with nursing staff.

II. RESPONSIBILITIES

1. Prepares the all patient care areas including preoperative, postoperative and the operating room for the patient
 - A. Assembles supplies, instruments, and equipment
 - B. Checks all equipment for proper functioning
 - C. Monitors cleanliness of all areas including operating room
2. Provides individualized care to patients
 - A. Assesses patient condition upon arrival/admission and provides physical or emotional support as needed.
 - B. Checks patient's chart while admitting noting accuracy of consents, allergies, history and physical present, verifying lab work, and medication ordered and given.
 - C. Starts IV per policy and procedures and assists through patient anesthetic changes
 - D. Provides for constant evaluation, observation, and treatment of patients under local anesthesia
 - E. Administers IV conscious sedation per policy and physician orders
 - F. Assists in safe transportation and positioning of patient
 - G. Provides for preparation of the operative site when necessary
 - H. Oversees maintenance of sterile technique according to policy
 - I. Anticipates surgeon's needs during the operation or procedure, maintains constant awareness of the operative situation and provides extra supplies as needed
 - J. Maintains a constant awareness of a safe environment during surgery for the patient and for the personnel regarding electrical or anesthetic hazards
 - K. Has knowledge of cardiac monitors and cardiac arrhythmias.
 - L. Responsible for proper documentation of information prior to discharge
 - M. Ensures discharged patients and their responsible party understand all post-operative instructions
 - N. Counts and records controlled substances at beginning and end of shift
 - O. Restocks medications and supplies as needed
 - P. Is knowledgeable of MSDS sheets and the location of the MSDS manual

3. Formulates and maintains a positive working relationship with patients, families, peers, and other medical personnel.
 - A. Interacts with patients, families, and/or significant others in a supportive manner
 - B. Communicates effectively and professionally with co-workers, medical staff, and ancillary departments for continuity of patient care.
 - C. Acts as a liaison between departments, co-workers, supervisors, and physicians
 - D. Promotes positive public relations for the nursing division and the Center
 - E. Investigates and attempts to resolve complaints of patients, visitors and physicians through personal actions or referral to higher authority, serves as patient advocate
 - F. Understands chain of command and follows proper lines of communications promoting positive working relationships
 - G. Respects at all times the confidentiality of patient, Center, and physician related information
 - H. Discourages gossip and professionally approaches co-workers to resolve issues of concern
 - I. Adapts to change in a positive, professional manner.
4. Monitors the operative schedule and ensures patients will have a timely and safe course of treatment.
 - A. Communicates with patient's families as necessary relating status cooperatively and post-operatively
 - B. Documents and cares for any surgical specimens as needed
 - C. Maintains accurate and complete records of patient's surgical course
 - D. Assists with providing an expedient, smooth turnover between cases
 - E. Assists with emergencies in all patient care areas per policy
 - F. Submits accurate records of occurrences/incidents
5. Assumes responsibility for continuing education through formal and informal education programs and/or workshops or conferences.
 - A. Attends required in-services yearly
 - B. Attends at least one educational seminar or workshop yearly pertaining to relevant areas of clinical skill development
 - C. Attends 75% of staff meetings. Reads and signs minutes of meetings not attended.
 - D. Maintains education record for continuing education and required in-services
6. Demonstrates an awareness and participation in the Quality Assurance and Improvement Program
 - A. Is alert of potential Quality Assurance problems and actively participates in the resolution of problems.
 - B. Responds with improved performances to results obtained from QA studies
 - C. Assists with QA studies and data collection when necessary.
 - C. Is knowledgeable of and follows the nursing and Center standards, policies, and procedures.

III. PHYSICAL DEMANDS AND WORKING CONDITIONS:

1. Visual acuity for chart review and equipment operation.
2. Heavy lifting of up to 100 pounds with assistance and 50 pounds without assistance.
3. Considerable stooping, pushing, and pulling

IV. QUALIFICATIONS

1. Registered Nurse with current license to practice in Nevada
2. Current BLS Certification (Basic Life Support)

PRECISION SURGERY CENTER

VII. HUMAN RESOURCES

3. Nursing Services

D. Surgical Technologist

I. BASIC FUNCTION:

Provides surgical assistance and participates during procedures of surgical intervention.

1. Is knowledgeable of equipment and instrumentation and supplies required to perform specific procedures.
2. Is knowledgeable of asepsis and maintaining sterile technique during each procedure.
3. Assists the surgeon as necessary by position of the surgical team.

II. RESPONSIBILITIES

1. Adheres to and supports the mission and goals, philosophy, objectives, policies and procedures of the Center.
2. Cleans and maintains care of equipment in operating order according to departmental procedures and infection prevention and control policies.
 - A. Transports used instrument sets for reprocessing and sterilization daily.
 - B. Ensures that instrument sets are properly identified and contain accurate count of each instrument..
 - C. Wraps and labels instruments as needed.
 - D. Changes sterilizer graphs and files appropriately daily.
 - E. Fills instrument orders in a timely manner as requested.
 - F. Pulls and rewraps out-dated supplies as needed biweekly.
 - G. Initiates requisitions for repair of equipment and transports to appropriate department.
 - H. Assists maintaining cleanliness of the clean and soiled workrooms.
 - I. Assists with maintenance of sterilizers and updates logs
3. Expedites room turnover
 - A. Removes linen and trash to appropriate disposal area.
 - B. Cleans bed, tables, soiled areas, and mops floor between cases.
 - C. Prepares room for next scheduled case (opens supplies, replaces suction equipment, process instruments).
 - D. Anticipates needs of team members in OR.
4. Assists in care and handling of supplies, equipment and instruments.
 - A. Helps prepare OR suites by gathering supplies, equipment and instruments as needed.
 - B. Places sterile supplies in proper places, uses sterile technique to open supplies.
5. Promotes cooperation and communication utilizing proper channels with OR staff, the entire health care team and patients.

- A. Relays appropriate information to co-workers within promptly
 - B. Maintains close communication with the registered nurses daily.
 - C. Facilitates and promotes effective interdepartmental and medical staff relationships on a daily basis.
 - D. Always ensures a supportive and caring attitude in delivery of patient care.
 - E. Always provides reassurance and support to patients.
 - F. Respects at all times the confidentiality of patient, Center and physician related information.
 - G. Assists with orientation of new personnel to the department as assigned.
 - H. Understands chain of command; always follows proper line of communication.
 - J. Handles personal and professional frustrations without disrupting the department.
 - K. Always promotes good public relations for the department, nursing division and the Center.
 - L. Demonstrates flexibility in responding to changes in patient assignments.
6. Inspects, cleans, and lubricates surgical instruments as per individual instrument and equipment instruction.
- A. Uses supplies and equipment economically on every procedure.
 - B. Assists in transporting patients to and from the operating room.
 - C. Ensures surgical room set-up with proper equipment and linens.
 - D. Assists in maintaining file of procedural information of physician's preference cards and appropriate instrumentation daily.
 - E. Performs other tasks as assigned.
7. Is knowledgeable of the Center's policies and procedures
- A. Demonstrates awareness of infection prevention and control by always following established procedures.
 - B. Attends required in-services annually and assumes personal responsibility for professional development.
 - C. Demonstrates understanding of the Center's fire and safety procedures outlined in the safety manual.
 - E. Attends staff meetings; reads and signs minutes of meetings not attended.
 - F. Attends in-service classes pertinent to clinical area, remains informed of clinic communications.
 - H. Sets goals with Clinical Director for own performance based on self-evaluation.

III. PHYSICAL DEMANDS AND WORKING CONDITIONS

- 1. Visual acuity for chart review and equipment operation.
- 2. Heavy lifting of up to 100 pounds with assistance and 50 pounds without assistance.
- 3. Considerable stooping, pushing and pulling.

IV. QUALIFICATIONS

- 1. Graduate of a certified surgical technology program.
- 2. Current CPR Certification

PRECISION SURGERY CENTER

VII. HUMAN RESOURCES

3. Nursing Services

E. Licensed Practical Nurse

I. BASIC FUNCTION

Assists in performing nursing tasks in all areas of patient care.

II. RESPONSIBILITIES

1. Adheres to mission, vision, values, goals, philosophy, objectives, policies, and procedures of the Center.
2. Exhibits interpersonal and interdepartmental relationships.
 - A. Demonstrates reassurance and support to patient and family; explains actions, provides information regarding waiting areas and communication of patient status to family members.
 - B. Is courteous and respectful of interdepartmental staffs; avoids conflicts and communicates effectively utilizing the proper channels.
 - C. Is cognizant of proper lines of communication.
3. Is skillful, accurate and organized in performing assignments
 - A. Initiates pre-op nursing assessment and administers ordered medication.
 - B. Prepares surgical shave preps as assigned (patient room, holding area, operating room).
 - C. Transports and positions patients utilizing techniques of proper body mechanics and patient safety.
 - D. Assists nurse with surgical skin prep as needed.
 - E. Acts as runner between OR and other departments as needed.
 - F. Starts IVs as needed.
 - G. Assesses patient in post-op stage making note of operative site, and discharge per physician's orders.
4. Is knowledgeable of checking, ordering, and restocking supplies in all areas of the Center.
5. Cooperates willingly and communicates effectively utilizing proper channels with team members.
 - A. Demonstrates awareness and is committed to patient, physician, and Center confidentially.
6. Attends in-service classes and staff meetings regularly.

III. PHYSICAL DEMANDS AND WORKING CONDITIONS

- A. Visual acuity for chart review and equipment operation.
- B. Heavy lifting of up to 100 pounds with assistance and 50 pounds without assistance.
- C. Considerable stooping, pushing, and pulling

IV. QUALIFICATIONS

1. Licensed Practical Nurse with current license to practice in Nevada
2. Current BLS Certification (Basic Life Support)

PRECISION SURGERY CENTER

VII. HUMAN RESOURCES

3. Nursing Services

F. Medical Assistant/Nursing Assistant

I. BASIC FUNCTION

Assist the physician and nursing staff and clinical coordinator by performing various administrative and clinical functions.

II. RESPONSIBILITIES

1. Adheres to mission, vision, values, goals, philosophy, objectives, policies, and procedures of the Center.
2. Exhibits interpersonal and interdepartmental relations:
 - A. Demonstrates reassurance and support to patient and family; explains actions, provides information regarding waiting area and communication procedure to family members
 - B. Is courteous and respectful of interdepartmental staffs; avoids conflicts and communicates effectively utilizing the proper channels
 - C. Is cognizant of proper lines of communication
3. Is skillful, accurate and organized in performing assignments
 - A. Phone duties to include but not limited to: appointment scheduling, incoming and outgoing messages, keyboarding and computer operations.
 - B. Medical records management, retrieval and filing of charts, incoming and outgoing records.
 - C. Coordinate care between the physician, nursing staff and patient as needed.
 - E. Acts as runner between OR and other departments as needed.
 - F. Functions as a resource person for staff and patient.
 - G. Attends all required meetings and in-services.
 - H. Performs any and all duties assigned.
4. Expedites room turnover
 - A. Removes linen and trash to appropriate disposal area when necessary.
 - B. Cleans bed, tables, and soiled areas.
 - C. Prepares room for next scheduled case.

5. Is knowledgeable of checking, ordering and restocking supplies in all patient care areas
6. Cooperates willingly and communicates effectively utilizing proper channels with team members
 - A. Reports appropriate information to holding area nurse.
 - B. Demonstrates awareness and is committed to patient and department confidentiality.
7. Remains informed of nursing staff and Center communication
 - A. Reads and initials posted memos
 - B. Attends required staff meetings.
8. Attends in-service classes and staff meetings regularly.

III. CLINICAL DUTIES

1. Assists in checking the vital signs, height, and weight if needed, documents as appropriate in the medical record.
2. Assists with physical examination if needed.
3. Assists with transporting patients to and from the OR when appropriate.
4. Assists with laboratory specimens and CLIA waived testing as ordered.
5. Assists with fluoroscopy positioning before/during and after procedure

IV. LABORATORY DUTIES

1. CLIA compliant in waived laboratory testing: Dip stick urinalysis, hematology including, PT, glucometer operation, and pregnancy testing.
2. Maintains a clean, neat, and safe environment for patients.
3. Performs any and all duties assigned.

V. WORKING RELATIONSHIPS

1. Reports to the physician, clinic coordinator, and Clinical Director.

VII. QUALIFICATIONS

1. High school graduate.
2. Current CPR Certification
3. Medical/Nursing Assistant Certification preferred but not required.
3. Previous Medical/Nursing Assistant experience preferred but not required.

PRECISION SURGERY CENTER

VII. HUMAN RESOURCES

3. Nursing Services

G. Departmental Safety: Nursing Department

1. All work areas and equipment shall be periodically checked and problems noted. Any repairs needed shall be referred to the Safety and Maintenance Coordinator.

2. Position of Beds/Stretchers

All beds/stretchers must be kept in low position except during the time nursing care is being given to the patient.

3. Side Rails

Side rails are to be kept in a raised position at all times except during nursing care for all patients. The nurse should remain immediately at the patients bed side if the rail is down.

4. Wheelchair and Stretchers

Wheelchairs and stretchers shall be kept in a locked position except when a patient is being transported.

5. Electrical Safety

- A. Nursing responsibilities for providing a safe electrical environment include:

- ◆ Reading the operating instructions for each piece of electrical equipment prior to use.
- ◆ Keeping fluids away from electrical equipment, e.g. computers, automated external defibrillator (AED), suction equipment, to avoid shock damage of equipment and prevent electrical shock.
- ◆ Keeping electrical cords away from beds, furniture and cabinets.
- ◆ Avoid touching electrical equipment and the patient at the same time to prevent current flowing through to the patient.
- ◆ Extension cords must be approved and obtained from the Safety and Maintenance Coordinator.
- ◆ Only approved three prong plug equipment should be used in the Center.
- ◆ Avoiding the use of fuel burning and electrical space heaters in any location of this Center including office and lounge areas.
- ◆ Remove power plugs from wall outlets by grasping the plug, not by pulling the cord.
- ◆ Keeping mobile equipment cases, e.g., suction machines, from contacting the metal bed frames.

- B. Malfunctioning clinical patient care equipment e.g., AED, monitors, or malfunctioning non-clinical equipment, e.g., electrical beds are to be put out of service and reported immediately to the Safety and Maintenance Coordinator.

Report the any of the following immediately to the Safety Coordinator:

- ◆ If electrical equipment has been dropped or otherwise physically abused, or if liquid has been spilled on it.
- ◆ If patient, nurse or visitor has received a tingling sensation or a shock from electrical equipment.
- ◆ If electrical plugs are broken, bent, loose or only have two prongs.
- ◆ If power cords are worn, frayed, or burned or any insulation has been cut.
- ◆ If there is overheating or electrical equipment seems overheated by smell or touch.
- ◆ If cables, cords or knobs are not attached to machinery securely.
- ◆ If alarm systems are not functioning properly.

6. General Safety Principles

A. The following safety principles are to be observed by the nursing staff:

- ◆ Storage of equipment and/or supplies in any corridor or aisle way is prohibited.
- ◆ Blocking fire exit doors is prohibited.
- ◆ Storing or stacking supplies, etc., within 18" of the ceiling is prohibited
- ◆ Storing equipment, supplies, etc. in such a fashion as to block access to fire alarms or extinguishers is prohibited.

B. Employees shall remedy and/or report hazards, such as spills, immediately.

- ◆ Take immediate action to make the environment safe by cleaning up spills and/or call Safety and Maintenance Coordinator. MSDS information on all potentially hazardous chemicals in the Center are on CD inside the Injury and Illness Prevention Program Manual.
- ◆ Report safety hazards to Clinical Director or Clinical Coordinator.
- ◆ Notify Safety and Maintenance Coordinator to correct problems that require immediate attention, e.g., electrical outlet broken.

C. Practice good body mechanics and safety principles associated with turning and positioning of patients.

PRECISION SURGERY CENTER

SECTION VII

HUMAN RESOURCES

4. Policies of Administrative Personnel

PRECISION SURGERY CENTER

VII. HUMAN RESOURCES

4. Policies of Administrative Personnel

B. Human Resources Coordinator

I. BASIC FUNCTIONS

To manage all issues related to employee relations and community involvement.

II. RESPONSIBILITIES

1. To adhere to and support the mission, vision, values, goals, philosophy, objectives, policies, and procedures of the Center.
2. Manage professional responsibilities on various assignments.
 - A. Develop a good working relationship with all employees in order to better understand any internal conflicts that may arise.
 - B. Be familiar with the policies and procedures to better serve human resources functions.
 - C. Conduct training seminars as needed to promote better communications and understanding in the work place.
3. Monitor and maintain
 - A. Benefits of professional and administrative staff.
 - B. Maintain personnel files (professional and administrative), and payrolls, etc.
 - C. Function as ombudsman among various departments and disciplines.
4. Maintain all assigned equipment.
5. Order all the necessary publication materials for ongoing communications.
6. Attend all required meetings and in-services for continuing education.
7. Perform other duties as assigned.

III. MACHINES, TOOLS, EQUIPMENT AND WORK AIDS

A working knowledge of all equipment used in the operations. This includes but is not limited to the computer systems, equipment technology used, corporate updates, and awareness of policy and benefit changes as relates to specific job classification.

IV. WORKER TRAITS: APTITUDES, INTERESTS, AND TEMPERAMENTS

1. Aptitudes

- A. Effective communication skills with customers, staff, physicians, and others.
- B. Necessary computer skills required to enable effective performance of the job.

2. Interests

- A. An interest in continual self development and professional growth.
- B. Improved employee relations and awareness of the standards to which we are all driven to achieve as employees of the Center.

3. Temperament

- A. Ability to perform in situations requiring limited supervision for successful execution of daily functions to meet deadlines.
- B. Ability to deal with the public in a manner projecting a positive image.
- C. Exhibit confidentiality and good judgment when aware of information requiring discretion.

V. PHYSICAL DEMANDS AND WORKING CONDITIONS

- A. Ability to be flexible enough to meet the demands and conditions of situations as they arise.

REPORTS TO: Administrator and Medical Director

PRECISION SURGERY CENTER

VII. HUMAN RESOURCES

4. Policies of Administrative Personnel

E. Front Office Clerk/Receptionist

I. BASIC FUNCTION

The admissions clerk is responsible for scheduling of patients and secretarial duties.

II. RESPONSIBILITIES

1. To adhere to and support the mission, vision, values, goals, philosophy, objectives, policies, and procedures of the Center.
2. Manage secretarial duties assigned by professional staff:
 - A. Receive and report on assignments from professional staff.
 - B. Receive incoming phone calls and direct to appropriate personnel.
 - C. Maintain records of all patients.
 - D. Prepare medical charts for patient treatment days which includes pulling the charts and properly marking the face sheets that should accompany each.
 - E. Document dates attended, cancellations, and no-shows by patients.
 - F. Assist in mailing copies of dictation to referring doctors as supplied by transcriptionist.
 - G. Mail new patient forms to referrals for completion prior to first appointment.
 - H. Retrieve copies of all possible medical records for evaluation of new patient. Make said copies available to physical therapy secretary prior to evaluation appointment.
3. Serve as initial contact point for all patients:
 - A. Direct to appropriate location.
 - B. Notify appropriate staff of client's arrival.
4. Coordinate schedules for services:
 - A. Coordinate patient's scheduled appointments between physicians, physical therapy, and others as necessary.
 - B. Schedule all new and follow-up patients for treatments and/or evaluations.
 - C. Communicate changes in schedule to appropriate staff member(s).
5. Maintain secretarial equipment:
 - A. Assist in inventory of supplies.
 - B. Order secretarial supplies as needed.
6. Attend required meetings and in-services.
7. Perform any and all duties as assigned.

III. MACHINES, TOOLS, EQUIPMENT, AND WORK AIDS

A working knowledge of all office machines including telephone system, intercom system, copy machine, postage machine, calculator, facsimile machine, and word processing software.

IV. WORKER TRAITS: APTITUDES, INTERESTS, AND TEMPERAMENTS

1. Aptitudes

- A. Effective communication skills with patients, staff and physicians.
- B. Good mathematical skills necessary.

2. Interests

- A. An interest in developing continual self development and professional growth.
- B. A preference for seeking time-saving techniques in job performance with relation to the professional staff's needs.

3. Temperament

- A. Ability to perform in situations requiring direction, control, planning, and execution of the daily schedule.
- B. Ability to work with people in a polite and tactful manner.
- C. Exhibit confidentiality and good judgment when aware of such information requiring discretion.

V. PHYSICAL DEMANDS AND WORKING CONDITIONS

Visual acuity for chart review and equipment operation. Heavy lifting of up to 100 pounds with assistance and 50 pounds without assistance. Considerable stooping, pushing, and pulling.

VI. WORK RELATIONSHIPS

- 1. Reports to the Administrator
- 2. Is supervised by the Admissions Coordinator
- 3. Communicates and coordinates with nursing staff and Nursing Administrator

VII. QUALIFICATIONS

- 1. High school graduate
- 2. Medical office training and/or experience is preferred
- 3. Good communications skills and computer skills are preferred.

PRECISION SURGERY CENTER

VII. HUMAN RESOURCES

4. Policies of Administrative Personnel

F. Administrative Assistant

I. BASIC FUNCTION

Provide assistance to Medical Director, Administrator and physician staff.

II. RESPONSIBILITIES

1. To adhere to and support the mission, vision, values, goals, philosophy, objectives, policies, and procedures of the Center.
2. Manage secretarial duties assigned by professional staff:
 - A. Check, sort, and distribute all mail.
 - B. Function as a courier between the Center and accounting firm, bank, and other facilities as required.
 - C. Make appropriate deposits, and assist appropriate posting of payment.
 - D. Perform all other duties as assigned.

III. MACHINES, TOOLS, EQUIPMENT, AND WORK AIDS

A working knowledge of all office machines including telephone system, intercom system, copy machine, postage machine, calculator, facsimile machine, and word processing software.

IV. WORKER TRAITS: APTITUDES, INTERESTS, AND TEMPERAMENTS

1. Aptitudes
 - A. Effective communication skills with patients, staff, and physicians.
 - B. Good working attitude
2. Interests
 - A. An interest in developing continual self development and professional growth.
 - B. A preference for seeking time-saving techniques in job performance with relation to the professional staff's needs.
3. Temperament
 - A. Ability to perform in situations requiring direction, control, planning, and execution of the daily schedule.
 - B. Ability to work with people in polite and tactful manner.
 - C. Exhibit confidentiality and good judgment when aware of such information requiring discretion.

V. PHYSICAL DEMANDS AND WORKING CONDITIONS

Visual acuity for equipment operation. Heavy lifting of up to 50 pounds with assistance and 25 pounds without assistance. Considerable stooping, pushing, and pulling.

VI. WORK RELATIONSHIPS

1. Reports to Medical Director and Administrator

PRECISION SURGERY CENTER

SECTION VII

HUMAN RESOURCES

6. Education and Training

PRECISION SURGERY CENTER

VII. HUMAN RESOURCES

6. Education and Training

A. General Policies

I. POLICY

Personnel will be prepared for their responsibilities in the provision of care through appropriate education, training programs and in-services.

II. PROCEDURE

1. Personnel participate in relevant in-service programs.
2. The administration encourages participation in relevant education programs outside of the Center.
3. Education will be based in part on findings which result from the monitoring and evaluation of the quality of care provided and address safety and infection prevention and control.
4. The extent of participation in education and training will be documented.
5. CPR or BLS and ACLS certification will be kept up-to-date by all appropriate professional personnel who work in the patient care departments. Personnel are required to attend annual updates in electrical safety, emergency preparedness, fire safety, and infection prevention and control, etc.
6. Annual evaluations will be done to determine that individuals who provide patient care services are, and continue to be, competent to do so.

PRECISION SURGERY CENTER

VII. HUMAN RESOURCES

6. Education and Training

B. Educational Profiles

All educational records are maintained by the Administrator, who advises employees to make copies of attendance, certificates and/or licenses for verification, and places them in his/her file. The educational activities can include, but are not limited to:

1. Attendance at Center in-services, seminars, and/or mandatory classes.
2. Participation and attendance of an external seminar and/or educational program relevant to work and/or professional activities and career.
3. Continuing education classes for maintaining licensure.
4. Participation and attendance of a recertification program for maintaining certificate status according to professional standards.

PRECISION SURGERY CENTER

VII. HUMAN RESOURCES

6. Education and Training

C. CPR, BLS and ACLS Certification

I. POLICY

All personnel who have direct patient contact will maintain current CPR (Cardiopulmonary Resuscitation) or BLS (Basic Life Support) with or without ACLS (Advanced Cardiac Life Support) certification as evidenced by an annual update review or recertification class. All new health care personnel who have direct patient care are required to present current certification upon hire.

II. NEW PERSONNEL

1. Will present a current CPR, BLS or ACLS card for photocopying.
2. A copy of the card will be kept in the employee's file and will be updated according to policy and procedure.

III. EMPLOYEES

1. It is the responsibility of the employee to maintain a current certification card and provide evidence of recertification according to policy and procedure.
2. A copy of the card will be kept in each employee's current file and updated according to policy and procedure.

IV. PROCEDURE

1. Initial Certification – obtained prior to employee's start date. The following are required certifications for each position;

Front Office/Clerk – CPR Certifications
Administrative Personnel – CPR Certification
Medical Assistants – CPR Certification
Surgical Technician – CPR Certification
Licensed Practical Nurses – BLS Certification
Registered Nurse – BLS Certification
Certified Registered Nurse Anesthetist – ACLS Certification
Nurse Practitioners/Physicians Assistants – ACLS Certification
Physician Staff – ACLS Certification

Any employee having direct patient contact is required to be certified as indicated above.

2. Recertification

Each employee will recertify his/her certification card annually prior to the expiration date printed on the card..

PRECISION SURGERY CENTER

VII. HUMAN RESOURCES

6. Education and Training

D. Continuing Education

I. PURPOSE

To establish a mechanism for ensuring continuing education of personnel.

II. POLICY

1. Continuing education and in-service programs shall be provided to personnel.
2. Attendance at in-services and education programs shall be documented and a copy of the activity shall be kept in the employee's records in the administration office.
3. Educational programs shall be based on the needs of personnel, findings from monitoring of care and quality assurance studies, new technology, safety, new equipment, and/or infection prevention and control.

PRECISION SURGERY CENTER

SECTION VIII

MEDICAL RECORDS

PRECISION SURGERY CENTER

SECTION VIII

MEDICAL RECORDS

1. Purposes

PRECISION SURGERY CENTER

VIII. MEDICAL RECORDS

1. Purposes

A. Functions

I. PREAMBLE

Precision Surgery Center maintains complete, comprehensive, and accurate medical records to ensure adequate patient care. The Center has developed and maintains a system for the proper collection, processing, storage, use and distribution of patient records. Each record is completed accurately, legibly, promptly, and is readily accessible to health care practitioners. The Center currently uses an Electronic Medical Record for all charting and scheduling purposes. Paper charting is only done when necessary (i.e., in case of EMR system down, internet outage, ect). The following guidelines may apply to paper charts, electronic medical records, or both.

II. FUNCTIONS

1. The Center maintains a comprehensive system for medical record management which includes collection of records, processing, maintenance, storage, retrieval, and distribution.
2. The Center provides adequate storage space. The Center's medical record filing system includes safety, security, accountability, and retrievability. There is a medical record room available for paper charts which are locked behind a door and protected from fire. The majority of medical records are completed using an Electronic Medical Record and are stored securely within the systems' database.
3. Each medical record is maintained in such a way that clinical information relevant to a patient is readily available to health care practitioners and staff.
4. Patient records are separately identified as ambulatory surgery records. An existence of departmental records from another department or entity is clearly documented on the chart.
5. The Center maintains strict confidentiality and privacy of medical information and records that contain clinical, social, financial or other data on a particular patient except as required by the law. These records are reasonably protected from loss, tampering, alteration, destruction, and unauthorized or inadvertent disclosure of the information.
6. The Center has appointed medical records coordinators who are in charge of the medical records of the Center. The functions and responsibilities of these individuals include maintaining the confidentiality, security, and physical safety of the patient's medical records. In addition, the medical records coordinators are responsible for maintaining the unique identification of each patient's medical record, supervising the collection processing, maintenance, storage, timely retrieval, appropriate access, usage and distribution of medical records and maintaining a predetermined organized medical record format. Security of medical records is achieved by a method of tracking who accesses the records and a method of identifying designated locations of paper records throughout the center in order to avoid unauthorized access.
7. It is the policy of the Center to retain all active medical records indefinitely either on a hard copy or in electronic format. It is also the policy of the Center to store inactive medical records for at least ten years in a safe environment. In case of a death, records will be stored two more years from date of death or ten years, whichever comes first.

PRECISION SURGERY CENTER

VIII. MEDICAL RECORDS

1. Purposes

B. Protection, Availability & Destruction

I. PROTECTION & AVAILABILITY

1. Records shall be kept on all patients accepted for treatment.
2. The medical record is the property of the Center, and is maintained for the benefit of the patient, the medical staff, and other health care workers.
3. All required records, either as originals or accurate reproductions of the contents of such originals, shall be maintained in such form as to be legible and readily available upon request of: the attending physician; a facility or its medical staff, or any authorized officer, agent, or employee of either; authorized representatives of the Department of Health, or any other person authorized by law to make such a request.
4. Access to medical records is restricted to authorized personnel and medical staff. All entries to medical records will be dated, verified and authenticated by the health care provider making the entry to ensure accountability for editing, deleting and access of clinical record content.
5. The Center shall safeguard the information in the medical record against loss, defacement, tampering, or use by unauthorized persons.
6. Controlled locked access to the inactive medical record storage files is maintained.
7. The Medical Records Storage area shall remain locked at all times when Medical Records personnel are not present. During such times, the Administrator shall control access.
8. The Center shall provide adequate measures and maintenance to physically safeguard the medical record from loss by fire, water, and foreseeable sources of potential damage.
9. Medical records shall be filed in an easily accessible manner in the Center.
10. Records will be removed from the Center's premises only by court order, statute, or subpoena.
11. Written consent of the patient or his legal qualified representative is required for release of information from the medical record, except when release is required by law. These records will be released by hard copy and/or by CD-ROM upon request. At a minimum, a photo ID and signature needs to be provided for identification. If a designated person is assigned to pick up records, it is required that the patient write a letter stating this person is allowed to pick up the records. Before records are released, a photo ID and signature are required to confirm the identity of the designated person along with the patient's signature and date and the designated person's signature.

12. Records needed for reasons other than patient care (i.e., case studies, peer review) must be returned to the Medical Records Storage area if charts are in paper format..
13. Records shall be readily accessible at all times in the Electronic Medical Record database or in the Medical Records Storage area in the case of paper charts.
Exception: Designated legal cases will be maintained in a locked file cabinet.
14. Health care information may be restricted upon request from the patient to withhold information from their health plan concerning a healthcare item or service for which they have paid out of pocket in full as long as that disclosure is not needed for treatment.
15. The Center ensures the continuity of care for its patients by requesting medical records from outside practitioners in a timely manner and incorporating them into the clinical record. Medical records that are properly requested and consented for release by the patient are sent to outside health care professionals in a timely manner as appropriate so future care can be provided.

II. DESTRUCTION OF RECORDS

1. All documents may be destroyed only if the exact reproduction of the document is visually screened and confirmed in the electronic medical record (EMR) system. All documents may be destroyed after 10 years of retention as stated in policy and procedure.
2. All documents that are destroyed after the 10 year retention will be recorded as follows:
 - A. Date of destruction
 - B. Type of charts
 - C. Destruction method
 - D. Title of records (Department)
 - E. Date span (oldest to most recent) dates of records destroyed
3. Documents that have been confirmed in the EMR system can be destroyed by the Center's industrial shredder and destroyed by designated staff members who will provide a signature for the testimonial documenting the date the materials were destroyed. The designated employee will abide by HIPAA standards and confidentiality agreement.

PRECISION SURGERY CENTER

SECTION VIII

MEDICAL RECORDS

2. Medical Record Management

PRECISION SURGERY CENTER

VIII. MEDICAL RECORDS

2. Medical Record Management

A. Authentication

I. POLICY

All entries in medical records are dated and authenticated, and the Center has established a method to identify the authors of entries.

II. PROCEDURE

1. Authentication may be written signatures or initials, or electronic signatures in the electronic medical record.
2. The appropriate practitioner or assigned individual whose name is listed on the authentication form, authenticates the parts of the medical record for which he or she is responsible.
3. Orders given orally for drugs and biologicals must be followed by a written order, signed by the prescribing physician or practitioner.
4. Entries made in a chart by personnel other than the physician or nurse is restricted to the lined sheet for appointment changes or other pertinent information; the physician order sheet contains documentation for prescriptions per a nurse; the sheet labeled chart notes is for entries which all are dated and signed.
5. The medical records coordinator may make entries on letters requesting for medical records, which include date sent, data sent and their initials. All medical records sent out will be recorded in a log book, with the request and date sent legibly documented.
6. The administrator keeps all official authentication forms including employee names and initials to identify the authors of entries for reference.

PRECISION SURGERY CENTER

VIII. MEDICAL RECORDS

2. Medical Record Management

B. Form and Content

1. The Center follows uniform content and format for medical records with departmental variations. These medical records contain reports of history and physical (H&P) examination, progress notes, and other materials such as laboratory reports, radiology reports, and consultations which are incorporated into each patient's medical record in a timely manner. The date of all entries in the clinical record are documented.
2. The Center maintains on a patient's record two front sheets as appropriate (for paper charts):
 - A. One with demographic information, emergency telephone number, information of referral physician, and insurance information.
 - B. If a patient has had three or more admissions, or the clinical record is complex and lengthy, the second sheet (Summary Sheet) includes identifying information, a summary of past and current diagnoses or problems, including past procedures, is documented in the patients record to facilitate the continuity of care. Also documented are known allergic reactions to drugs, medications known to be prescribed and/or used by the patient and previous illnesses. This summary is updated on subsequent visits with additional information pertaining to the above items.
 - C. No summary sheets are maintained for charts with a single visit.
3. It is the express policy of the Center to enter into the medical record:
 - A. Precision Surgery Center maintains a medical record for each patient with each record which is accurate, legible, and promptly completed.
 - B. Medical records of Precision Surgery Center must include at least the following:
 - ◆ Patient identification including name, date of birth, gender, identification number (if appropriate) demographic information and responsible party (if applicable).
 - ◆ Significant medical history and results of physical examination including chief complaint or purpose of the visit. A surgical History and Physical will be completed by the physician within 30 days of the patient's scheduled surgery or procedure.
 - C. Date of visit/procedure, care rendered and therapies administered.
 - E. Preoperative diagnostic study results entered before surgery, if performed, such as laboratory or radiology reports.
 - F. Any changes in prescription and non-prescription medication with name and dosage, when available.
 - G. An operative report or dictation which details findings and techniques of the operation or procedure.

- H. The presence or absence of allergies and untoward reaction to medication and materials is recorded in prominent and consistently defined location in all clinical records. This is verified at each patient encounter and updated whenever new allergies or sensitivities are identified.
 - I. Entries, including incidents and abnormal reactions related to anesthesia administration.
 - J. Documentation of properly executed informed patient consent. Discussions with the patient concerning the necessity, appropriateness, and risks of the proposed care, surgery or procedure, as well as discussions of treatment alternatives are incorporated into the patient's clinical record.
 - L. Discharge diagnosis or impression.
 - M. Disposition, follow up recommendations and instructions given to the patient.
 - N. Verification of all contents by health care professionals.
 - O. Signature of, or authentication by the health care professional(s) of all clinical record entries.
 - P. Significant medical advice given by text, email or telephone, including medical advice provided after hours is entered in the clinical record and signed appropriately.
 - Q. Any notation in a patient's clinical record indicating diagnostic or therapeutic intervention as part of clinical research is clearly defined in contrast to other care provided.
4. History and Physical
- A. A comprehensive medical H&P assessment is completed and entered into the medical record, along with the results of pre-surgical assessments.
 - B. All the preoperative diagnostic studies performed are also reviewed and entered into the medical record prior to the start of surgery.
 - C. The patient's history of allergies or abnormal drug reactions is always entered into the record.
5. Operative Report
- An operative report describes the surgical techniques and findings. It also includes a pathologist's report on all tissues removed during surgery except when it is exempted by the Governing Body by adopting a written policy for certain types of tissues removed. The medical record of the Precision Surgery Center describes the following for all procedures and operations.
- A. Preoperative
 - ◆ Informed Consent, including discussion and plan
 - ◆ Preoperative preparation and orders
 - B. Intraoperative
 - ◆ Monitoring

- ◆ Preparation
 - ◆ Sedation
 - ◆ Position
 - ◆ Description
- C. Postoperative
- ◆ Monitoring
 - ◆ Complications
 - Postoperative orders
- D. Discharge/Disposition
- ◆ Status
 - ◆ Instructions
 - ◆ Return appointment
- E. Any allergies or abnormal drug reactions are documented. Information about anesthesia pre-assessment, administration, and adverse medication reactions also will be documented.
6. Informed Consent
- The Precision Surgery Center provides a well designed informed consent which includes discussion of all aspects and elements.
- A. A description of the proposed surgery, including anesthesia to be used.
- B. The indications for the proposed surgery.
- C. Material risks and benefits for the patient related to the surgery and anesthesia, including the likelihood of each, based on the available clinical evidence, as informed by the responsible practitioner's clinical judgment. The consent includes material risks including risks with a high degree of likelihood, but a low degree of severity, as well as those with a very low degree of likelihood, but a high degree of severity.
- D. Treatment alternatives, including the attendant material risks and benefits, and the name of the individuals conducting the surgical intervention. The names of the other practitioners performing important tasks related to the surgery such as opening and closing, dissecting and/or removing tissue (if applicable).
- E. Consent for anesthesia services are included on the surgical consent form. The anesthesia is administered by an anesthesiologist or certified registered nurse anesthetists (CRNAs). Certified Nurse Anesthetists work independently without supervision in Precision Surgery Center, in accordance with Nevada State Regulations.
8. Documentation of the Patient's Discharge Diagnosis
- The record also includes the patient's disposition whether the patient was discharged home or transferred to another healthcare facility, including emergent transfers to a hospital.
9. The Center's designee physically secures all the documents within a patient's record.
10. Patient's record includes missed and canceled appointments along with follow-up documentation.

11. Personnel

- A Multiple personnel are involved in managing the medical records. These include receptionists, administrative assistants, nurses, and physicians. The major functions are carried out by physicians and nurses in an Electronic Medical Record format.
- B. Management of the records is carried out by the administrative assistant(s) for the surgery center, and overseen by the Clinical Director, Administrator and/or Medical Director.

PRECISION SURGERY CENTER

SECTION IX

ANCILLARY SERVICES

PRECISION SURGERY CENTER

SECTION IX

ANCILLARY SERVICES

1. Pharmaceutical Services

PRECISION SURGERY CENTER

IX. ANCILLARY SERVICES

1. Pharmaceutical Services

A. Principles

I. PREAMBLE

1. Precision Surgery Center provides drugs and biologicals in a safe and effective manner, in accordance with the accepted professional practice, and under the direction of the Medical Director, designated responsible for pharmaceutical services, with assistance of a consultant pharmacist.
2. Pharmaceutical services are provide in accordance with ethical and professional practice and applicable federal and state laws. Drugs are prepared and administered according to established policies and acceptable standards of practice. Records and security are maintained to ensure the control and safe dispensing of all medication.
3. Adverse reactions are reported to the physician responsible for the patient and are documented in the record. Staff informs patients concerning safe and effective use of medication, when applicable and consistent with legal requirements.
4. Precision Surgery Center's policy is that blood and blood products are not administered in the Surgical Center.
5. Precision Surgery Center policy is that orders given orally for drugs and biologicals must be followed by a written order and signed by the prescribing physician.

II. FUNCTIONS

1. The Center maintains written policies and procedures with regards to how drugs and biologicals are stored, secured, prepared, dispensed, administered, and discarded.
 - A. Policies and procedures address maintenance of all staff medications, sample medications, and emergency drugs supplied.
 - B. Policies and procedures also address issues involving storage, security, disposal and sample medications.
 - C. All policies and procedures are implemented appropriately.
2. The Center also provides a written policy specifying the method for maintaining the integrity of emergency drug supplies and policies showing that the Center dispenses drugs safely and complies with applicable federal, state, and local laws.
 - A. Pharmaceutical services of the Center are available through a contractual agreement in accordance with the same professional practices and legal requirements that would be required if such a service were provided directly by the Center.
 - B. The Pharmacy is supervised by a licensed pharmacist on a part-time/consulting basis. The Medical Director assumes all professional and administrative responsibility for the quality of pharmaceutical services rendered.
 - C. A current pharmacy license with Nevada State Board of Pharmacy will be maintained by the Center.

PRECISION SURGERY CENTER

IX. ANCILLARY SERVICES

1. Pharmaceutical Services

B. Expired Medication Policy

I. PURPOSE: To provide guidelines for outdated or expired medications

II. POLICY:

It is the policy of the surgery center to remove all outdated drugs on a monthly basis. Medications are considered outdated when they have reached their manufacture's listed outdate on the package or have been opened and have reached the maximum period of use allowed in the guidelines listed below. The medications will be pulled from stock in the month that they outdate and segregated for appropriate pharmacy disposal. All drugs and supplies in emergency carts will be checked monthly or checked and replaced if a cart is used. The Clinical Director is ultimately responsible but may delegate other staff to check the medication expirations.

III. PROCEDURE:

1. The following guidelines will be used for determining the date at which a medication is considered outdated and/or unusable when a vial is opened and has not reached its manufacturer's outdate on the package; if a container is multi-dose and available for use by more than one patient. All vials marked "single dose" or preservative free vials shall be discarded at the end of the procedure and used on a single patient only.
 - Opened vials which contain a preservative will be considered out of date 28 days from the date of opening. The physician or nurse opening the vial will mark it with the date of opening. Appropriate storage conditions will be maintained (i.e:refrigeration)
 - Opened insulin will be considered out of date for medication use in 28 days from the date of opening. The physician or nurse opening the vial will mark it with the date of opening.
 - Opened ophthalmic drops will be considered out of date in 90 days from the date of opening. The physician or nurse opening the container will mark it with the date of opening.
 - Opened tuberculin test vials will be considered out of date for use in 28 days from the date of opening. The physician or nurse opening the vial will mark it with the date of opening.
 - Single dose and unpreserved vials will be discarded at the end of the day or within 24 hours of opening.
 - Reconstituted vials of antibiotics will expire according to the manufacturer's guidelines found in the package insert.

- Unopened medications dated with a month and year will be considered out of date on the last day of the month as stated on the package (i.e.: 01/13 will expire on the 31st of January, 2013.) Unopened medications dated with any specific date will be considered outdated at the end of that day. (i.e.: 01/01/2013 will expire on 1st of January, 2013.)
2. Medications expiring in a given month will be identified and segregated in an area for the pharmacist consultant to dispose of on their next scheduled visit.
 - A bin labeled “expired medications” will be placed in the medication room and outdated medications will be placed there for pharmacist consultant pick-up.
 - The pharmacist will determine medication is to be wasted at the center.
 - All controlled substances that have passed their expiration date will be removed from stock and from the perpetual inventory by licensed personnel. Expired medications should be stored in a designated marked area secured and separate from medications available for administration. Wasted at the center and the narcotic waste will be recorded on the controlled substance sign out record by 2 licensed persons, one of whom should be the pharmacist consultant. In the case that the medication is a schedule II drug, the pharmacist will complete the appropriate paper work leaving copy in the facility narcotic records and mailing the original copy to the DEA. Waste of a scheduled drug will be witnessed by the pharmacist consultant and a member of the nursing staff. Both will sign out on the controlled substance record. The outdated medication may also be saved for processing by a DEA approved reverse distributor if a contract for services has been signed and agreed upon by the surgery center and an approved independent company.
 3. A log of expired medications will be kept including the name of the drug, strength, dosage form, amount or number of expired units, expiration date, NDC number and lot number from the vial. Records will be maintained for 6 years in accordance with the Drug Supply Chain Security Act.
 4. Medications that are outdated, contaminated, deteriorated and those with the contents of containers without intact labels shall be disposed of according to state and federal regulations. – refer to Medication Destruction/Disposition Policy.

PRECISION SURGERY CENTER
IX. ANCILLARY SERVICES
1. Pharmaceutical Services
C. Medication Destruction/Disposition Policy

I: PURPOSE: To provide guidelines for the appropriate and safe destruction and disposal of medications in the center.

II: POLICY:

To ensure safe handling and destruction/disposition of medications and hazardous materials that are expired, contaminated, deteriorated or that do not have intact/clear labels, in compliance with state and federal regulations.

III: PROCEDURE:

1. With state authorities, the consultant pharmacist shall verify the appropriate method of medication disposition as well as which titled professionals need to be present to witness destruction. Destruction methods that render tablets/capsules, injectables and controlled substances unusable may include the following:
 - Transfer to a container for release to a pharmaceutical waste contractor or reverse distributor
 - Transfer to a sharps container after emptying vial or dissolving a solid dosage form
 - Transfer to a hazardous waste container
2. The Clinical Director and the consultant pharmacist shall be responsible for the center's compliance with laws and regulations in the handling and disposal of medications and hazardous materials.
3. Medications and hazardous materials shall be segregated for special waste management and shall not be put into the sewer or landfill.
4. Controlled substances are subject to special handling, storage, disposal, and recordkeeping in the center. Controlled substances listed in Schedules II, III, IV and V shall be retained in the center in a securely double-locked area with restricted access until destroyed or properly disposed.
5. A Medication Disposition Log shall be used for documentation. The log shall contain the following information:
 - Medication name and strength
 - Quantity / amount
 - Date of disposition
 - Method of disposition
 - Lot number and expiration date
 - Signatures of the witnesses

PRECISION SURGERY CENTER

IX. ANCILLARY SERVICES

1. Pharmaceutical Services

D. Controlled Substance Policy

- I. PURPOSE:** To maintain accurate records regarding controlled substances and ensure all controlled substances in the facility are kept secure and accounted for.

INFORMATIONAL NOTES:

- The Federal Comprehensive Drug Abuse Prevention and Control Act of 1970, commonly referred to as the Controlled Drug Act, created the following five medication schedules (or classes) based upon potential for abuse :
 - I. Schedule I (CI) contains medications with no accepted medical purpose (e.g., heroin).
 - II. Schedule II (CII) contains medications with an extremely high abuse potential such as amphetamines, cocaine, fentanyl, hydromorphone, meperidine, methadone, and morphine.
 - III. Schedule III (CIII) contains medications with a very high abuse potential, such as acetaminophen with codeine, acetaminophen with hydrocodone, ketamine, and paregoric.
 - IV. Schedule IV (CIV) contains medications with less abuse potential than Schedule III and includes chloral hydrate, diazepam, midazolam, and thiopental sodium.
 - V. Schedule V (CV) contains seldom abused medications, such as codeine-containing cough syrups and diphenoxylate.
- Note that there may be medications not federally deemed controlled substances that may be considered controlled substances per state Board of Pharmacy statute or code. With governmental regulations, the stricter law always prevails. In some situation, state regulations may dictate that a particular medication is scheduled higher than the federal regulation. Such medications may include muscle relaxants, ephedrine and others. Ensure that these items are properly accounted for and secured.

II: POLICY:

- Medications listed in Schedules II, III, IV and V of the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970 are subject to special handling, storage, disposal, and record keeping. Controlled substances shall be accessible only to authorized nursing and pharmacy personnel. Medications listed in Schedules II, III, IV and V of the Act shall be stored in a designated double-locked cabinet.

- Separate and detailed records of receipt and use shall be maintained for all controlled substances. Records of use shall be reconciled at the beginning and end of each day by two (2) licensed nurses authorized to administer controlled substances and shall be retained on file in the center for three (3) years. The center does not have change of shifts in their scheduling.
- Schedule II, III, IV and V medications shall be destroyed or disposed of in accordance with state and federal regulations.

III: PROCEDURE:

1. Controlled substances shall be accessible to authorized licensed nursing and pharmacy personnel. The Clinical Director, the Drug Enforcement Agency (DEA) registrant, and/or the consultant pharmacist shall be responsible for the control of these medications.
2. Medications listed in Schedules II-V shall be stored separate from all other medications. The key to the controlled substance cabinet shall remain under the supervision of a registered nurse during hours of operation. After hours the key shall be secured in a locked key box available only to authorized nursing personnel.
3. Medications listed in Schedules II, III, IV and V shall be provided in easily accountable quantities and containers designed for easy counting of contents. Controlled substances, when ordered for injection, shall be provided in ampules or in the smallest available dosage unit.
4. The registered nurse (RN) ordering the medication(s) listed in schedules II, III, IV and V shall prepare a controlled substance audit record for the medications. The RN responsible for placing medications in controlled substance cabinets and inserting appropriate sheets in the controlled substance log shall receive the controlled medication(s). The RN shall sign for the medication(s) with the delivery personnel. The RN shall complete a physical inventory of that medication at the time of delivery against the packing slip. If there is no packing slip present, the RN shall contact the distributor to have a packing slip faxed immediately. Controlled substances shall NOT be added to inventory until they have been verified against the packing slip.
5. The RN shall be responsible for adding the controlled substances to inventory by co-signing with a second RN and documenting on the controlled substance log. If only one RN is available for adding the medication(s), the items shall be locked in the cabinet in original packing until a second RN is available.
6. Controlled Substances Security Measures/Narcotic Key Security:
 - Controlled substances shall be housed in a double locked controlled substance cabinet/door at all times.
 - The controlled substance cabinet key shall be kept “on the person” of an RN at all times during hours of operation

- The controlled substance cabinet key shall be locked in a separate lockbox that is located in another location after the controlled substance count is verified at the end of each day.

7. Controlled Substance Counting:

- For PACU/Pre-op/OR: two licensed staff shall conduct counting at the beginning and end of each day when patients are present in the center.
- The two licensed nurses counting must sign the controlled substance count log and initial the perpetual inventory sheet.
- Licensed Nurses shall be required to report any discrepancies as outlined in the policy.

8. An RN designee shall review the controlled substance log on a regular basis to ensure the record is accurate and complete.

9. Any discrepancy in the count of a controlled substance shall be reported to the clinical director, administrator and medical director as soon as possible. The Clinical Director and/or administrator shall be responsible for investigating and making a reasonable effort to reconcile all reported discrepancies.

10. If a discrepancy is irreconcilable, an incident report is required to document the details including: a copy of the controlled substance log, the possible persons responsible for the discrepancy, and the efforts made to reconcile it. If any discrepancy cannot be reconciled or a pattern of discrepancies occurs, or there is obvious criminal activity, the clinical director shall notify the administrator, medical director and the consultant pharmacist immediately.

11. Should any person(s) enter the center for the purpose of stealing controlled substances, the staffs' first concern shall be for his/her own safety and the safety of the patients and other staff members. Under no circumstances shall staff refuse to provide the controlled substances, for which they are responsible, to persons who are threatening to do bodily harm. After the person(s) leave the center, the nurse shall immediately notify the following persons and inform of the incident: immediate supervisor, clinical director, and administrator. The clinical director or administrator shall notify the police department, medical director and consultant pharmacist.

12. Upon a discrepancy or theft, a controlled substance inventory shall be conducted immediately by any two licensed personnel available, signed by both and least one additional staff member as witness, with time and date notations. This list shall be made available only by bona fide request to:

- Local police unit or sheriff
- DEA
- State Board of Pharmacy
- State Board of Nursing

- State Department of Investigations
13. The consultant pharmacist shall review the controlled substances logs monthly. The following items shall be inspected and verified: ordering, invoicing, security, dispensing, labeling, administration, disposal and documentation.
14. Biennial Inventory
- a. Inventory count of all controlled substances on hand shall be completed at least every two years.
 - b. Biennial Inventory may be taken on any date that is within two years of the previous biennial inventory date on or around the 1st of May of the odd year.
 - c. The clinical director, consultant pharmacist or licensee nurse designated by the clinical director shall complete the biennial inventory.
 - d. Biennial Inventory shall include:
 - Name of controlled substance
 - Each finished form or medication strength (e.g., 10mg tablet, 50mg/1mL vial)
 - Number of units or volume of each finished form in each commercial container or package size (e.g., 5mL vial)
 - Number of commercial containers of each finished form (e.g., ten 5mL vials)
 - Center name and address
 - Date and time of inventory
 - Signatures of individuals completing the inventory
15. Recalled controlled substances shall be collected for disposal or return by the clinical director. Instructions shall be followed as directed by the recall notice.
16. Expired controlled substances shall be removed from stock and the perpetual inventory log. Expired items shall be stored in a designated / marked locked cabinet separate from medications available for administration.
17. Destruction and disposition of unused and/or expired controlled substances may occur in either of these methods, depending on state regulations:
- The center may return the controlled substance to the pharmaceutical manufacturer who, as a service to its customers, accepts returns of expired and/or damaged controlled substances.
 - The center DEA registrant may dispose of controlled substances without the benefit of a DEA or state witness. The DEA Form 41 must be completed and filed with the DEA completed 222 forms. DEA requires that the registrant provide two designated responsible individuals to destroy and witness the controlled substance the destruction so they are non-recoverable.
 - The center may distribute the controlled substances to a reverse distributor vendor to take control of the controlled substances for the purpose of returning them to the manufacturer or, if necessary, disposing of them. This transfers ownership of the controlled substance to a DEA-approved pharmaceutical returns processor for re-use, re-sale, or destruction. This process involves the completion of various forms which

may include the DEA Form 222 (for Schedule II items) or DEA Form 41 (for Schedule III-V items). These forms should be maintained by the center for six years. Information necessary for documentation includes:

- Controlled substance medication name and form
- Manufacturer
- Actual amount
- Container size
- Lot number
- NDC number

PRECISION SURGERY CENTER

IX. ANCILLARY SERVICES

1. Pharmaceutical Services

E. Single and Multi-Dose Medication Vial Use

I: PURPOSE/INFORMATIONAL NOTES:

- Aseptic technique is a method of clinical practice with the goal of protecting patients from infection and preventing the spread of pathogenic organisms.
- United States Pharmacopeia (USP) Chapter <797> (“USP<797>”) provides guidelines, recognized as national practice standards, regarding sterile product compounding. Nurses, operating room technicians, and physicians who may be compounding sterile products and preparing injectable medications, shall have a working knowledge of the principles of aseptic technique as well as the USP<797> guidelines available for reference. Due to an absence of a clean room with a laminar flow hood, the center’s USP risk category is considered for “immediate use” (or emergency use) for the compounding of sterile preparations.

II: POLICY: To provide injectable medications in a safe manner that shall prevent contamination and risk to patients. Clinical staff shall use aseptic technique whenever handling single- and multi-dose medication vials. At all times staff will perform their duties with a safety of culture in mind and practice.

III: PROCEDURE:

1. All clinical staff shall complete an annual educational inservice in aseptic technique provided by the center or by a program approved by the Quality Assurance / Performance Improvement (QA/PI) Committee.
2. Newly hired clinical staff shall complete a written educational inservice in aseptic technique approved by the QA/PI Committee.
3. Each clinical staff member shall complete an annual competency evaluation regarding parenteral medication preparation assessment. A copy of the assessment shall be retained in the employee’s file.
4. Medications for injection shall be stored according to manufacturer guidelines and appropriate temperatures to preserve product integrity.
5. Medications for injection shall be inspected for particles or discoloration before entering or removing medication.
6. Aseptic technique including proper hand washing before drawing up single and multi-dose vials shall be used to avoid contamination of sterile injection equipment and medications in accordance with the guidelines of USP<797>.

7. A sterile, single-use, disposable needle and syringe (or needleless system) shall be used for each injection and discarded intact in an appropriate sharps container after use.
8. Single-dose medication containers are meant for single patient use only. Single-dose vials (SDV), pre-filled syringes or ampules shall be used when possible.
 - When dividing doses from a SDV, a sterile unused needle and syringe shall be used for each divided dose withdrawn.
 - The syringe shall be used within one hour of opening and shall be appropriately labeled with medication name, strength, beyond use date and time and nurse's initials according to USP<797> guidelines for aseptic technique if not immediately used.
 - All partially used syringes and SDVs shall be discarded at the end of the procedure and shall be used on only one patient.
9. Multi-dose vials (MDV) shall be restricted to a centralized medication preparation area that has been appropriately cleaned and prepared prior to the manipulation of the MDV.
 - Each time the vial is to be entered; the opening shall be inspected, swabbed with 70% isopropyl alcohol and allowed to dry before entering.
 - A single use disposable needle and syringe shall be used to withdraw each dose.
 - Opened vials shall be dated and initialed upon first entry, also labeled with the 28 day expiration date and disposed of within 28 days unless manufacturing guidelines recommend a shorter storage.
 - No spikes or needles shall be left in a MDV.
 - A multi-dose vial used at the patient bedside will be considered for single patient use only.
10. When removing medication from an ampule, a filter needle shall be used for removal and new needle attached for injection.
11. Bags or bottles of intravenous solutions shall not be utilized as a common source of supply for multiple patients.
12. Policy and procedure for aseptic technique shall be reviewed on an annual basis with the consultant pharmacist to ensure compliance with any newly instituted state and/or federal regulations.

PRECISION SURGERY CENTER

IX. ANCILLARY SERVICES

1. Pharmaceutical Services

F. Temperatures for Medication Storage

I: PURPOSE: To properly store and document appropriate storage temperatures for medications to maintain patient safety.

INFORMATIONAL NOTES: Common temperature ranges include:

- Room 68°F to 77°F (20°C to 25°C)
- Refrigerator 36°F to 46°F (2°C to 8°C)
- Freezer -13°F to 14°F (-25°C to -10°C)

II: POLICY: To maintain appropriate temperature ranges and documentation for the proper storage for medications.

III: PROCEDURE:

1. Temperatures will be within the appropriate range in all medication areas, including rooms, refrigerators and freezers.
2. Medication refrigerators and freezers will be plugged into a generator-backed electrical outlet when possible.
3. An alarmed memory-equipped thermometer will be in place for monitoring both minimum and maximum temperatures for all medication storage areas and to aid in determining any period of power outage and subsequent temperature fluctuation. The thermometer will be certified if vaccines are stored in the refrigerator.
4. Each working day nursing personnel will inspect the medication storage areas, documenting on a Temperature Log for Medication Storage Areas the observed temperatures registered on the thermometers. This will include readings from the memory for days the center is not open, including weekends and holidays. Each daily line entry, including noting of “in range” temperature will be initialed by the recording nurse. (Refer to sample Appendices and Forms – Temperature Log for Medication Storage Areas.)
5. If a medication storage area temperature falls outside of the acceptable range, the observing nurse will document the steps taken to review and ensure the medications are considered safe to use or whether they should be segregated for return or disposal. Stability of medications will be determined by the consultant pharmacist and/or the medication manufacturer instructions. Actions to correct the out of range reading will be documented. When adjusted to the acceptable range, the alarm will be reset to “on”.
6. The center’s maintenance or engineering manager will be notified to promptly correct any temperature issues.
7. Refrigerators and freezers will be cleaned on a regular basis with freezers free of frost.

PRECISION SURGERY CENTER

IX. ANCILLARY SERVICES

1. Pharmaceutical Services

G. Formulary Management

I: PURPOSE: To maintain a designated formulary of all medications available for immediate use within the center.

II: POLICY: The center will create and maintain a designated formulary of medications available for immediate use within the center. It shall be reviewed on at least an annual basis by the consultant pharmacist and approved by the Governing Body.

III: PROCEDURE:

1. A designated medication formulary shall be developed from criteria specific to indications for use, effectiveness, and safety and risks. The formulary shall be available for all individuals involved in medication management.
2. All medications on the formulary shall be reviewed at least annually and submitted for approval to the Governing Body.
3. The formulary shall include the brand and generic medication name, dosage forms and strengths to be kept in inventory in the center. Package (or vial) size may or may not be included due to manufacturer availability of a certain vial, bottle or package size.
4. The formulary process shall include limiting the number of medication concentrations available so as to reduce possibilities of medication errors.
5. The formulary shall be posted in the medication storage areas and accessible to all staff.
6. The medications should be available at all times unless slated for removal from the formulary and awaiting approval.
7. Any new medication made available before the approval process has been completed shall be monitored for patient response to the medication.
8. A formulary request or deletion form shall be completed for each request and presented to the Governing Body for approval.
 - Generic and brand name of medication
 - Dosage form and strength
 - Indications for use and therapeutic classification
 - Pharmacokinetics including absorption, distribution, metabolism (including duration of action), and excretion methods
 - Risks, side effects, black box warnings, interactions and potential for errors

- Any known incidence of medication-associated error or sentinel event
- Requirements necessary to reduce risk of potential error
- Similar products already on the formulary
- Reasons for formulary inclusion
- Cost effectiveness evaluation
- References
- Name of requesting physician or staff member

9. Formulary items designated as look alike/sound alike, high alert medications or those carrying a black box warning will be designated on the formulary.

PRECISION SURGERY CENTER

IX. ANCILLARY SERVICES

1. Pharmaceutical Services

H. Medication Recalls

I: POLICY: To take immediate action upon notice of a medication recall issued by the Food and Drug Administration (FDA), any manufacturer, vendor or other source.

II: PROCEDURE:

1. Receipt of all recall notices by the FDA, manufacturers, distributors, or other vendors shall be handled by the clinical director or administrator.
2. Upon receipt, all areas where the recalled medication might be stored shall be searched and any matching products immediately removed and segregated. Recall notices received that provide direction for return or destruction shall be followed.
3. A record of all medication recalls shall be kept in a designated file and action on each recall noted (including note that the product was not in the inventory), dated and initialed by the staff involved. Records will be maintained for 6 years in accordance with FD & C Act.
4. Appropriate replacement medication shall be sought by the appointed purchasing staff with the input of the consultant pharmacist or clinical staff if an equivalent product is not available.
5. Any changes in medication shall be presented as a formulary addition and the appropriate procedure for addition/deletion followed.
6. When possible, the disposition of potential stock that may have been used under recall shall be traced and physician notification shall be made to address patient safety concerns. Patients will be notified if patient safety has been compromised.
7. The Governing Body shall be notified of recalled products for their review and any needed follow-up.

PRECISION SURGERY CENTER

IX. ANCILLARY SERVICES

1. Pharmaceutical Services

I. Medications Brought into the Center (Patient's Own Medications)

I: POLICY: To establish guidelines for the proper storage, control and distribution of medications brought into the center with the patient.

II: PROCEDURE:

1. At the request of the surgeon or anesthesia provider, a patient may bring personal medications for use at the center.
2. Personal medications are generally limited to respiratory inhalers and insulin and shall not include controlled substances.
3. All medications brought into the center and that were not provided by the center are subject to proper procedures regarding storage, distribution, control, safety and verification.
4. Identification or verification of the patient's own medication shall be performed by utilizing current medication references and resources. The local poison control center shall be contacted for any variances or medications not easily identifiable. Verification of the medication as labeled shall be documented in the patient's record.
5. If the medication is not properly labeled or in the appropriate container, it shall not be used at the center and shall be returned to the patient's responsible party.
6. The medication shall be within the expiration date as labeled.
7. Upon the physician's order, the nurse shall administer the medication to the patient.
8. The physician shall enter the order for appropriate documentation.
9. The nurse administering the medication shall document the medication given and that it belongs to the patient.

PRECISION SURGERY CENTER

IX. ANCILLARY SERVICES

1. Pharmaceutical Services

J. Departmental Safety: Pharmacy

I. GENERAL

1. All personnel handling drugs are trained in safety procedures. Personnel shall be trained in the handling, care and use of supplies and materials both during orientation and annually. Where mechanical, chemicals and other hazards are potential, personnel shall be warned of the dangers, instructed in how to prevent and avoid accidents, and emergency measures to take should an accident occur. Further details of these policies are in the Injury and Illness Prevention Program Manual.
2. All incidents must be reported in writing to the Administrator and Medical Director. Employee Injury forms are located in the Injury and Illness Prevention Program Manual. Treatment is provided or referred as needed.

II. MEDICATION ADMINISTRATION SAFETY

1. All injectable medications drawn into syringes and any oral medications removed from the packaging identified by the original manufacturer must be appropriately labeled with the date, time and dose/strength of the medication, if not administered immediately.
2. ALL needles and syringes used in Precision Surgery Center are considered single use devices and will be used for one patient and one administration only. Safe injection practices further described in the employee Injury and Illness Prevention Manual and Infection Control Manual will be followed by all employees.
3. All health care professionals who prescribe, administer or provide patient education on medications have access to current drug information via multiple online resources and drug handbooks as needed for decision support.
4. All look-alike, sound-alike medications are kept separate from each other and clearly labeled with appropriate warning signs posted on the cabinets they are stored in. The Clinical Director maintains a current list of all look-alike, sound-alike medications in stock.

III. FLAMMABLE LIQUIDS

1. Flammable liquids are not stored in the refrigerator.
2. Disposal of residual contents of flammable liquid containers may not be open to avoid evaporation in the Center.
3. Flammable liquids may not be used or positioned near an open flame. Flammable liquids are kept in suitable containers.

IV. STORAGE PROCEDURES

1. Large bulk items shall be stored on lower shelves in storage areas. Acids or alkali solutions must be stored on lower shelves and in separate designated identified areas. Poisonous substances must be stored separately from non-poisonous substances.
2. All containers in storage or in a work area must be clearly labeled as to contents and manufacturer's instructions for use and disposal, if applicable. Containers without labels shall be disposed of with contents.

V. PERSONAL AND ENVIRONMENTAL

1. Any working condition or equipment that is hazardous or potentially unsafe are reported to the Administrator and/or Safety Coordinator. Examples include inadequacies in ventilation, lighting, temperature, plumbing, heating, cooling, communications and other service items.
2. Employees are instructed to always keep to the right in corridors and approach intersections carefully, making sure traffic on the other side is clear when opening swinging doors. Doors are not to be opened with equipment, only push panels or door knobs. The door on the right is to be used if there are two.
3. Proper procedures for lifting materials and equipment should be used at all times. Examples: Knees bent, back straight, with good hold on the object to be lifted. Feet should be on firm surface. Lift with the legs and thigh muscles and the lifted object can be held against the body for additional support.
4. Glass ampules should be broken away from the body and fingertips covered with gauze for protection.
5. Dispose of all metal or items with sharp edges in puncture-proof containers.
6. Only approved step stools or stepladders for climbing should be used.
7. Drawers and doors should be kept closed on cupboards, desks, closets, etc. Use handles and knobs to close.
8. Floors are kept clean and clear of any foreign material. Pick up broken glass immediately with damp paper towel or broom and dustpan and dispose them in a metal container.
9. Spills are cleaned up immediately. Floors are kept dry at all times. Chemical spills are cleaned with caution according to MSDS guidelines and manufacturer's instructions. MSDS documentation is kept on CD located in the Injury and Illness Prevention Manual.

PRECISION SURGERY CENTER

SECTION IX

ANCILLARY SERVICES

2. Pathology and Clinical Laboratory Services

PRECISION SURGERY CENTER

IX. ANCILLARY SERVICES

2. Pathology and Clinical Laboratory Services

A. Principles

1. The Center has made provisions to provide routine and emergency laboratory services which are performed promptly with adequate examinations in the areas of anatomic pathology, hematology, chemistry, microbiology, clinical microscopy, and urology, as it relates to pathology and clinical laboratory services.
2. All services are subcontracted except for Clinical Laboratory Improvement Amendment (CLIA) waived testing which is performed on the premises. Waived testing performed includes urine toxicology, pregnancy (HCG) testing, and finger stick blood glucose testing.
2. Testing methods utilized for all waived tests performed meet all regulations and requirements under federal law. The Center will maintain a current CLIA certificate for waived testing and a current Laboratory license from the State of Nevada, Department of Public and Behavioral Health. The Medical Director of the facility will function as the laboratory director and will oversee all testing performed in the lab.
3. The Center has written policies and procedures which are readily available to address specimen collection, specimen preservation, quality care and remedial action, equipment performance and evaluation and test performance.

PRECISION SURGERY CENTER
IX. ANCILLARY SERVICES
2. Clinical Laboratory Services
B. Blood and Urine Specimen Collection

I. POLICY:

For the waived laboratory testing performed at Precision Surgery Center, small blood samples and urine samples will need proper collection.

Blood samples will be taken pre-operatively at the Center for blood glucose testing for all diabetic patients, and as deemed necessary per physician order.

Urine samples will be collected to test for pregnancy (HCG) in all women of child bearing age. Child bearing age is defined as any woman prior to menopause who has not had a hysterectomy. Women unable or refusing to take a pregnancy test will sign a waiver of pregnancy form.

Urine toxicology testing will be performed on patients as deemed necessary per physician order.

All test results are documented in the patient's medical record and any abnormal results are reported to the physician immediately.

II. PROCEDURE:

1. Urine specimens will be collected in a specimen container with correct patient identification, the patient's name, date and time collected.
2. HCG testing will be performed according to the test manufacturer's instructions and a log will be maintained of all tests completed with the patient's name and test result.
3. Blood glucose testing will be performed aseptically with single use disposable lancets for finger stick blood glucose testing and the according to the glucometer and test strip manufacturer's instructions.
4. A laboratory log will be maintained by qualified staff members that records the date, patient's name, type of test performed and the test result.
6. All staff will receive training upon initial orientation and annually on all laboratory testing performed and equipment use and maintenance.
7. All specimens and supplies will be discarded in the appropriate trash receptacle or sharps bin after the test has been completed and recorded.
8. Quality controls will be performed and documented in a log for all testing equipment per manufacturer's instructions.

PRECISION SURGERY CENTER

IX. ANCILLARY SERVICES

2. Pathology and Clinical Laboratory Services

C. Departmental Safety: Laboratory

I. GENERAL

1. Laboratory equipment must be checked daily prior to use for electrical, electronic, and mechanical safety. Any equipment found defective must be removed from service, repaired, and rechecked. Equipment shall be calibrated as often as required to maintain quality control per manufacturer's instructions.
2. All laboratory personnel must be well trained in the handling, care and operation of the equipment and use of supplies and materials. Manufacturers' safety instructions must be on the equipment in view of the operator. Manuals and texts and other instructional literature are on file and accessible to personnel. Where electronic, electrical, mechanical, chemical and other hazards are present, personnel must be warned of all dangers and possible consequences; must be instructed in how to prevent and avoid accidents, and emergency measures to take should an accident occur.
3. In case of an accident, the incident must be reported in writing using the forms provided in the employee Injury and Illness Prevention Program Manual. The injured person must be sent or taken to the appropriate facility for treatment as directed by the Medical Director.

II. PERSONAL AND ENVIRONMENTAL SAFETY

1. Be sure that safety devices on equipment are functioning.
2. Use only approved step ladders or step stools for climbing.
3. Never lift anything that cannot be carried safely alone and use proper lifting techniques.
4. Wipe spills immediately according to appropriate procedure.
5. Pick up foreign objects, broken glass, etc. immediately from floor, using disposable paper towels or broom and dust pan, and discard in appropriate container.
8. Eating is not permitted in the laboratory area.
9. All hazardous areas shall have appropriate signage.
11. Report any unsafe or unsanitary conditions to the Clinical Director or Administrator.
12. Environment shall be well-ventilated, well-lighted and temperature and humidity shall be kept within normal range.

III. EQUIPMENT-ELECTRICAL AND MECHANICAL SAFETY

1. All electrical equipment must be properly grounded and have a facility grade plug. Cheater plugs are prohibited. Equipment must be inspected at least weekly to be sure there is proper grounding of equipment, and that there are no defects in cords, switches, sockets, receptacles, and other electrical equipment. If defects are found, equipment must be removed from use until repaired or adjusted. Only approved extension cords of the 3-wire type may be used.
2. Do not make yourself a link between two power sources.

3. Never operate electrical equipment with wet hands or while standing in water.
4. Always have equipment in "off" position before plugging it in.

IV. CHEMICAL SPILLS

1. Chemical spills must be wiped up immediately. Spillage over a large area of floor or equipment must be reported to the Administrator or Safety Coordinator and the chemical must be properly neutralized and disposed of per MSDS guidelines. MSDS information is located on CD in the Injury and Illness Prevention Program Binder.

V. GLASSWARE

1. Glassware with cracks, chips, or sharp edges, or broken glass, shall be discarded in puncture-proof containers. Glass ampules shall be broken at the neck, wrapped in gauze, and snapped apart in a direction away from others.

VI. GLUCOMETER CARE AND MAINTENANCE

1. Use of the Glucometer in a safe and efficient way will be according to the manufacturer's written instructions, with calibrations and logging of usage.
2. The Glucometer(s) will undergo quality control daily to ensure proper functions. This must also be done when the instrument is new, after each battery change, when a control test result is out of range, and each time a new or different bottle of reagent strips is used.
3. Glucose test:
 - a. Switch on the Glucometer
 - b. When indicated, apply a drop of blood to the test strip pad. Entire test strip must be covered. Too little blood on the reagent pad may give inaccurate results.
 - c. Wait for the equipment to display results. Read promptly, dispose supplies appropriately, and perform proper hand washing techniques.
 - d. Document results in the medical record and in the glucose test log.
4. The equipment is cleaned and wiped in between patient use and on a daily basis using water and soap or mild detergent as appropriate based on manufacturer's recommendations.
5. Preserve batteries- turn Glucometer off when not in use.

PRECISION SURGERY CENTER

SECTION IX

ANCILLARY SERVICES

3. Radiologic Services

PRECISION SURGERY CENTER

IX. ANCILLARY SERVICES

3. Radiologic Services

A. Principles

I. PREAMBLE

1. Precision Surgery Center provides fluoroscopy for needle guidance during interventional pain procedures at the Center under the direction of a physician.
 - A. Precision Surgery Center has subcontracted any additional orders for radiological testing performed for patient diagnosis and treatment will be obtained from Apex Medical Center.
 - B. If a patient has had radiological testing done at another facility, those reports will be obtained by having the patient sign a medical records release form, which will be sent to the facility to obtain copies of the official reports.
 - C. The only radiologic equipment used in Precision Surgery Center are mobile C-arm units, which are handled only by staff trained in how to properly and safely operate the equipment, under direction of a physician.

II. SERVICES

1. The Center provides radiology services in the form of fluoroscopic needle guidance for interventional pain management procedures, which are provided by a C-arm.
2. The Center assigns the responsibility of interpretation and subsequent action of fluoroscopic examinations to the physician, who is granted privileges to do so by the Governing Body.
3. Radiological services provided at the Center are directed by the Medical Director who ensures professional, organizational, and administrative responsibilities of the quality of services rendered.
4. Competent and appropriately trained and educated personnel are available to conduct the radiology services at the Center.
5. It is the policy of the Center to perform radiological services only by the order of a physician. Appropriate records or reports of radiological services are maintained in the electronic medical record at the request of the physician.
6. The Center has designated adequate space and equipment for performing the volume of work with optimal accuracy, precision, efficiency, and safety. These include an appropriate space meeting state and federal requirements, precaution against electrical, mechanical, and radiation hazards. Proper shielding where radiation sources are used, monitoring devices are to be worn by all personnel in any area with a potential radiation hazard. Appropriate records will be maintained on personnel exposed to radiation, in addition to instructions to personnel concerning safety precautions and handling of emergency radiation hazards, periodic evaluation by qualified personnel of the radiation sources and of all safety measures followed, including calibration of equipment, in compliance with federal, state, and local laws and regulations.

PRECISION SURGERY CENTER
IX. ANCILLARY SERVICES
3. Radiologic Services
B. Radiation Exposure Monitoring

I. PURPOSE

To monitor radiation exposure of the Center's personnel on a monthly basis through participation in the Dosimetry program. To provide protective guidelines for Precision Surgery Center personnel during any procedure that requires the use of x-ray.

II. POLICY

1. The Center's nursing and surgical staff will participate in the dosimetry (film badge) program.
2. The Center will verify at a minimum yearly all protective gear for any damages that might expose employees unnecessarily to radiation exposure.
3. All personnel are to follow procedural guidelines for radiation safety in the operating room.
4. Any employee who becomes pregnant will follow procedural guidelines to limit the total radiation dose to the fetus with an exposure limited to 500 MREM during the period of that pregnancy.

III. PROCEDURE

1. All personnel will wear protective lead and a film badge whenever x-ray/fluoroscopy is used for patient procedures.
 - A. Provide the supervisor with the information necessary to participate in the dosimetry program with date of birth and social security number.
 - B. On a monthly basis, obtain new film badge and return exposed film badge to supervisor.
 - C. Film badges are to be worn outside of any protective wear.
 - D. Badges are to be kept in a safe, non-radiation area when not in use.
 - E. Badges will be read monthly by a radiation detection company and reviewed by a designee of the Center's radiation detection company. Reports of exposure to all employees are reviewed monthly by the Clinical Director or Administrator and kept in the Administrative office.
 - F. Individuals who receive a radiation dose in excess of the program limits will be

contacted by the Safety and Maintenance Coordinator. Established dose levels are:

1,250 MREM to the whole body in any calendar quarter or

5,000 MREM to the whole body in any year.

- H. If an employee terminates employment at the Center they may request in writing documentation of exposure and must sign a release.
- 2. Procedure for the use of C-arm in the operating room.
 - A. All the Precision Surgery Center personnel will wear lead aprons for any planned x-ray exposure done during the surgical procedure.
 - B. Personnel shall stand at least six (6) feet away from x-ray source when possible.
 - 3. The following guidelines are for use by pregnant personnel working in the Precision Surgery Center.
 - A. Female employees shall report their confirmed pregnancy in writing as soon as possible to the Administrator.
 - B. If possible, the supervisor will adjust or revise the workload of the employee so as to reduce the expected radiation dose to her abdomen to below 500 MREM during the entire term of pregnancy. If this is not possible, the employee will be placed on leave.
 - C. An additional badge will be ordered by the supervisor and will be worn at the waist and under any protective apparel.
 - D. The pregnant employee will be directed to the Administrator to receive a copy of the appendix of United States Nuclear Regulatory Commission Guide, Number 8.13 "Possible Health Risk to Children of Women Who are Exposed to Radiation During Pregnancy" (Form 307) and to ask any questions they might have.
 - F. A review of the monthly film badge readings for the fetus will be reviewed by the Administrator and given in writing to the employee if requested to verify that the 500 MREM limit will not be exceeded during the pregnancy.

PRECISION SURGERY CENTER

IX. ANCILLARY SERVICES

3. Radiologic Services

C. Contrast Reactions

I. High Allergic/Idiosyncratic Risk:

1. Previous Reactions to Contrast Media
 - A. Diffuse urticaria
 - B. Clinically apparent bronchospasm
 - C. Upper airway reaction: stridor, hoarseness
 - D. Hypotension requiring intervention
2. Significant Allergic History
 - A. Perennial allergic rhinitis ("hay fever")
 - B. Atopic asthma
 - C. Drug allergies, ASA or penicillin sensitivity
 - D. History of severe allergic reaction to foods.
3. Any type of asthma history

II. Cardiac Risk Factors:

1. Hypotension present or anticipated at time of exam
2. Poor left ventricular function
3. Congestive heart failure
4. Three vessel coronary disease
5. Severe valvular heart disease
6. Patients on calcium entry blockers

III. Severe Renal Disease

1. Renal Failure
2. Patients on Dialysis

All patient allergies are documented on the patients chart and communicated effectively to the physician and all staff members involved in the patient's care. Any of the above listed conditions or possible allergies to contrast media will be discussed with the physician prior to the procedure, and further orders are written by the physician if necessary.

PRECISION SURGERY CENTER

IX. ANCILLARY SERVICES

3. Radiologic Services

D. Departmental Safety: Radiology

I. GENERAL

1. There shall be radiation monitoring of personnel with appropriate radiation dosimeters, and the Administrator shall be responsible for maintenance of personnel monitoring records. Cumulative radiation exposure of each individual shall also be kept in the administrative office as reported by the dosimetry company.
2. There shall be annual inspection for safety defects of all leaded gloves and aprons. Any cracks or damage in the lead will be reported to the Administrator or Safety Coordinator who will remove the lead from use and order new aprons for staff use.
3. The C-arm equipment will be visually inspected each day prior to use and the Administrator or Safety Coordinator notified if any equipment appears to be damaged or not working properly.

II. RADIATION SAFETY REGULATIONS – PATIENTS

1. Pregnant women shall not be subjected to abdominal radiation unless clinically necessary and in emergency situations. A sign instructing the patient to inform the technician if she may be pregnant is posted in each exam room.

III. ELECTRICAL SAFETY

1. Check daily: wall receptacles, cords, plugs, switches, knobs for frays, breaks, weak areas, burned spots and obvious damage. Report defects and request repairs to the Administrator or Safety Coordinator.
3. All power cords must be of facility grade.
4. Extension cords are not to be used in the facility unless approved by the Safety Coordinator.
5. Do not drape power cords over any metal or across traffic lanes.
6. Do not make yourself a link between two power sources. Do not turn on equipment with one hand while the other hand is on equipment housing or other metal, or in contact with patient.
7. Be sure hands and floor are dry when operating electrical equipment.
8. Do not overload circuits.
10. Equipment shall be checked for electrical, electronic, mechanical and radiation safety prior to use on a routine basis. Any equipment found to be defective must be removed

from use, and the Administrator or Safety Coordinator notified to schedule repair. Defective equipment shall be tagged prior to repair to prevent usage until repaired.

IV. PERSONAL AND ENVIRONMENTAL SAFETY

1. Any working conditions or equipment that are hazardous or potentially unsafe should be reported to the Administrator or Safety Coordinator.
2. Proper lifting technique should be followed at all times to prevent injury. Example: Knees bent, with good hold on object, back straight, lift using leg and thigh muscles. The object may be held against the body for additional support. Feet should be firmly on the floor.
3. Know where fire extinguishing equipment and alarms are located and know how to use the equipment as well as evacuation routes and procedures for removing patients.
4. Observe all electrical safety regulations as instructed, additional safety tips are listed in the employee Injury and Illness Prevention Program manual.

V. RADIATION SAFETY – PERSONNEL

1. Personnel shall wear lead aprons and dosimeter badges at all times when working in fluoroscopic rooms.
2. Disposable gloves shall be worn when handling potentially contaminated items.
3. Dosimeter badges may not be taken out of the Center or left on a uniform to be laundered. They shall be stored in a designated area near the lead aprons.

VI. RADIATION SAFETY – EQUIPMENT

1. Radiation Safety services are provided by in-house and outside contractors. All C-arms will be calibrated annually by a physicist and the reports are kept in the Administrative office. Each C-arm will maintain a current certificate for the radiation producing machine obtained by the Nevada State
2. All diagnostic equipment in the Center shall be calibrated according to federal, state, and local requirements. When radiological equipment is initially installed, altered significantly or relocated, a radiation protection survey shall be made, including calibration. All diagnostic radiologic equipment in surgical departments shall be calibrated annually or at not less than one year intervals.

PRECISION SURGERY CENTER

SECTION X

INFECTION PREVENTION AND CONTROL PROGRAM

PRECISION SURGERY CENTER

SECTION X

INFECTION PREVENTION AND CONTROL PROGRAM

1. General Principles

PRECISION SURGERY CENTER
X. INFECTION PREVENTION AND CONTROL PROGRAM
1. General Principles
A. Principles and Overview

I. GOALS

The goals of the Infection Prevention and Control Program are to:

1. Decrease the risk of infection by maintaining a functional, sanitary environment for the provision of surgical services for patients and personnel.
2. Monitor for occurrence of infection and implement appropriate control measures to prevent infections.
3. Identify and correct problems relating to infection control practices, including direct intervention to prevent infection, as needed.
4. Maintain compliance with state and federal regulations, including infection control reporting requirements.

II. SCOPE OF THE INFECTION PREVENTION AND CONTROL PROGRAM

The Infection Control Program is comprehensive and ongoing in that it addresses detection, prevention and control of infections among patients and personnel, throughout the Center including waiting rooms, patient rooms, pre and post-operative areas. It provides a plan of action for immediate implementation of corrective and preventive measures for managing infections and communicable diseases that result in improvement. The program is developed by Infection Control Solutions, LLC, approved by the Governing Body and implemented and maintained by the Infection Control Program Coordinator.

III. ACTIVITIES OF THE INFECTION PREVENTION AND CONTROL PROGRAM

1. Surveillance of infections with implementation of control measures and prevention of infections. The following activities are overseen by the Infection Control Program Coordinator in conjunction with Infection Control Solutions, LLC. Documentation is found in the Infection Control Program Binder, kept in the administrative office.
 - A. There is an on-going monitoring for infections among patients and personnel and subsequent documentation of infections that occur.
 - B. Prevention of the spread of infections is accomplished by use of Standard Precautions and other barriers, appropriate treatment and follow-up, and employee work restrictions for illness.
 - C. Staff and patient education focuses on risk of infection and practices to decrease risk. Policies, procedures, and aseptic practices are followed by personnel in performing procedures and in disinfection of equipment. Immunizations are offered as appropriate to personnel to decrease the incidence of preventable infectious diseases.

2. Outbreak Investigation
 - A. Systems are in place to facilitate recognition of increases in infections as well as clusters and outbreaks.
3. Policy and Procedure Review and Revision

Policies and procedures for infection prevention and control are reviewed and updated on an annual basis by the Governing Body. Program implementation and maintenance is overseen by the Infection Control Program Coordinator in conjunction with Infection Control Solutions, LLC.
4. Staff Education
 - A. Training of staff in infection prevention begins with orientation of new hires and occurs at least annually.
 - B. Infection Control Solutions, LLC provides on-site and webinar training to all new staff members and meets or exceeds current OSHA and CDC requirements.
5. Quality Assessment and Performance Improvement (QAPI)
 - A. Infection prevention and control is a component of the Center's QAPI program and infection prevention and control reports are made to the Governing Body. In addition, infection prevention and control rounds are made to assess the level of quality provided and actions for improvement are taken as needed.
6. Consultation
 - A. The Infection Control Program Coordinator serves as a resource for all staff and all departments relating to prevention and control of infections.

IV. DIVISION OF RESPONSIBILITIES FOR INFECTION PREVENTION AND CONTROL ACTIVITIES

The Governing Body is ultimately responsible for the Infection Prevention and Control Program.

1. Infection Control Program Coordinator – Michelle Edwards, CRNA

The Infection Control Program Coordinator will assist in carrying out the daily functions of the Infection Prevention and Control Program. The Infection Control Program Coordinator has knowledge and interest in Infection Prevention and Control and has completed required additional training specific to Infection Control in the ambulatory healthcare setting.
2. Role of the Governing Body

The Governing Body meets quarterly to manage aspects of the Infection Prevention and Control Program and provides input, direction and evaluation of the Program. Policies and procedures relating to Infection Prevention and Control are approved by the Governing Body, and reports of infections are presented meetings where recommended actions and control measures are initiated when necessary.

V. REPORTING MECHANISMS FOR INFECTION PREVENTION AND CONTROL

1. Patient infection cases are monitored by the Infection Control Program Coordinator and nursing staff. The ICPC completes the line listing of infections and the monthly report forms and:
 - A. Reports to the Governing Body at quarterly meetings
 - B. Provides feedback to staff as needed.

2. Employee infections are reported by the employee to the employee's supervisor, then to the Infection Control Program Coordinator. The ICPC completes the employee infection report form and reports:
 - A. To the Administrator and/or Medical Director
 - B. The Governing Body at quarterly meetings

3. Compliance with infection prevention and control practices is monitored and documented by:
 - A. Staff evaluation
 - B. Observation of Practices

The Infection Control Program Coordinator, in conjunction with representatives from Infection Control Solutions, LLC perform and review the compliance monitoring and initiate appropriate actions as deemed necessary by the Governing Body.

VI. UPDATING THE INFECTION PREVENTION PLAN

The Infection Prevention and Control Program will be reviewed and updated annually by the Governing Body.

PRECISION SURGERY CENTER
X. INFECTION PREVENTION AND CONTROL PROGRAM
1. General Principles
B. Infection Prevention and Control Plan

I. PURPOSE:

To develop and maintain a written plan for infection prevention and control including an assessment of risk, services provided, the population served, strategies to decrease risk, and an active surveillance plan, in order to reduce the risk of health care associated infections.

II. POLICY:

1. A current written infection prevention and control plan will be implemented, this will be developed and approved by the Governing Body in conjunction with Infection Control Solutions, LLC. The plan will follow CDC nationally recognized guidelines for hand hygiene and safe injection practices.

2. The written plan will include:

- A. Assessment of risk
- B. Assessment of services provided
- C. Assessment of the population served
- D. Prioritized strategies to decrease risk
- E. Evaluation of effectiveness of strategies
- F. Surveillance plan based on analysis of previous data.

3. The written infection prevention plan will guide the activities of the Infection Control Program Coordinator.

4. The plan will be updated at least annually and more often as needed (e.g., changes in services provided, risks, etc.).

5. The written plan with the evaluation of effectiveness of the strategies may facilitate development of an annual summary of the infection prevention and control program.

6. All medical staff members, allied health practitioners and employees of the Center will receive infection prevention education and training and comply with all requirements of the program.

PRECISION SURGERY CENTER
X. INFECTION PREVENTION AND CONTROL PROGRAM

1. General Principles

C. Infection Control Program Coordinator (ICPC)

I. BASIC FUNCTION

Evaluates quality of patient care and patient outcomes as they relate to healthcare-associated infections; collects, prepares and analyzes healthcare-associated infection data; presents infection data and makes recommendations for actions; monitors employee compliance in use of barriers and infection prevention measures; prepares and presents educational opportunities for the staff; serves as a resource to all departments and personnel.

II. RESPONSIBILITIES:

1. Does on-going monitoring of healthcare-associated infections.
2. Identifies infection prevention problems and makes recommendations for corrective action, in conjunction with representatives from Infection Control Solutions, LLC.
3. Prepares reports and discussion as needed for the Infection Control section of the Governing Body quarterly meetings..
4. Monitors infection prevention practices and employee compliance with the Infection Prevention and Control Program.
5. Serves as a resource for all departments and personnel.
6. Initiates, reviews, and revises infection prevention and control policies and procedures.
7. Conducts outbreak investigation and initiates control measures.
8. Reports communicable diseases to the local health department as required by law.
9. Provides educational offerings for orientation and on-going in-services.
10. Consults with department heads and physicians as needed to improve care.
11. Initiates follow-up on employee/patient exposures to communicable diseases.
12. Participates in quality improvement activities.
13. Performs other duties as directed.

III. PHYSICAL DEMANDS AND WORKING CONDITIONS

(With or without the aid of mechanical devices)

1. Must be able to move intermittently throughout the work day.
2. Must be able to speak and write the English language in an understandable manner.
3. Must be able to cope with the mental and emotional stress of the position.
4. Must possess sight/hearing senses or use prosthetics that will enable these senses to function adequately so that the requirements of the position can be fully met.
5. Must function independently, have flexibility, personal integrity, and the ability to work effectively with patients, personnel, and support agencies.
6. Must meet the general health requirements set by the policies of this Center, which may include a physical assessment.
7. Must be able to push, pull, move and/or lift a minimum of 25 pounds to a minimum height of 6 feet and able to push, pull, move, and/or carry such weight a minimum

distance of 10 feet.

8. Must be able to assist in the evacuation of patients during emergency situations.

IV. QUALIFICATIONS:

1. Holds a current state license as a registered nurse or physician.
2. Ability to develop policies and procedures.
3. Ability to teach and evaluate clinical performance.

V. WORK RELATIONSHIPS

1. Supervised by the Medical Director.
2. Communication with the Clinical Director, Nursing Staff, Medical Director, and Governing Body.
3. Maintains skills and education to manage the position of Infection Control Program Coordinator..
4. Reports to the Medical Director and Administrator.

PRECISION SURGERY CENTER

SECTION X

INFECTION PREVENTION AND CONTROL PROGRAM

3. Surveillance

PRECISION SURGERY CENTER
X. INFECTION PREVENTION AND CONTROL PROGRAM
3. Surveillance
A. Infection Prevention and Control Surveillance

I. PURPOSE:

To have knowledge of patient and employee infections to guide prevention activities so appropriate actions/follow-up may be done.

II. POLICY:

1. The Infection Control Program Coordinator does surveillance of infections among patients and employees, in conjunction with representatives from Infection Control Solutions, LLC.
2. Healthcare-associated infections in ambulatory care are those associated temporally with an ambulatory care visit or with the care provided during the visit.
3. Targeted surveillance may be done in the ambulatory setting with a focus on high-risk areas and those with a potential to reduce risks (i.e., catheter-related bloodstream infection or surgical procedure-related infections).
4. Precision Surgery Center shall develop a system for post-discharge surveillance. This system shall consist of both a follow up phone call to the patient where signs and symptoms of infection are discussed and documented in a log. The patient will be contacted within 24-48 hours of their procedure by a qualified employee of the Center. A follow up appointment is also made for the patient with the surgeon and any evidence of infection will be reported to the Center.
 - A. Surveillance of healthcare-associated infections is performed by Infection Control Program Coordinator or his/her designee as follows:
 - ◆ Review of culture reports and other pertinent lab data
 - ◆ Nurse consultation and referral
 - ◆ Medical record review
 - ◆ Patient examination
 - ◆ Personal consultation by employees
 - ◆ Follow-up on communicable disease exposure
 - ◆ Review of employee's physical assessments
 - ◆ Maintenance of the employee infection record
 - ◆ Physician consultation
 - B. Specific definitions of healthcare-associated infections are used consistently. (See Infection Control Manual) Healthcare-associated infections are reported quarterly to the Governing Body.

- C. Surveillance documentation is maintained on the:
- ◆ Line listing of patient infections
 - ◆ Log of employee infections
- D. Outcome measures shall be monitored:
- ◆ Focus on the results of an activity, e.g., surgical procedure.
 - ◆ Healthcare-associated infections are outcome measures.
- E. Process measures shall be monitored:
- ◆ Involves monitoring of practices that directly or indirectly contribute to a health outcome.
 - ◆ Focuses on observations and analysis of practices and environmental conditions.
 - ◆ May include:
 - ◆ Immunization rates
 - Use of surgical antibiotic prophylaxis
 - Antibiotic timing
- F. Reporting of infections to the public health department authorities is done as required by law.
- A list of these diseases and the report forms from the health department are maintained in the Infection Control Manual and reporting is done as required. An exception to reporting is if there is knowledge that the disease has already been reported by the laboratory or other provider.
- G. An outbreak is defined as two (2) or more cases over the usual (endemic) number of cases of healthcare-associated infections, usually produced by the same organism. The time period will vary according to the infection.

A final written report of the investigation, outlining findings and recommendations, is prepared by the Infection Control Program Coordinator and issued to the Governing Body, others participating in the investigation, attending physician(s), Clinical Director, and others as needed.

PRECISION SURGERY CENTER
X. INFECTION PREVENTION AND CONTROL PROGRAM
3. Surveillance
C. Healthcare-Associated Infections and Sentinel Events

I. PURPOSE:

To manage as sentinel events all identified cases of death and major permanent loss of function attributed to a healthcare-associated infection (i.e., except for the infection, the patient would not have died or suffered loss of function).

II. PROCEDURAL GUIDELINE:

1. Identification of cases to be reviewed:

- A. During infection surveillance activities and following identification of healthcare-associated infections, the Infection Control Program Coordinator will be alert to cases of death and/or major permanent loss of function among patients having been identified as having a healthcare-associated infection.
- B. The Infection Control Program Coordinator, in reviewing for sentinel events, will be alert to cases of death and/or major permanent loss of function among patients that may also have a healthcare-associated infection.
- C. All unexpected deaths occurring in a hospital following transfer from the Center will be reviewed by the Infection Control Program Coordinator for the presence of healthcare-associated infection and the potential for a sentinel event.

2. Review and follow-up of potential cases

- A. Once alerted to the potential of a healthcare-associated infection as a sentinel event, the Infection Control Program Coordinator will conduct a review of the patient's records to determine if the case meets the definition of a healthcare-associated infection related sentinel event. If the case clearly is not a sentinel event (e.g. the patient was terminally ill prior to the infection, other life threatening events/illnesses were present, etc.), no further review will be needed. If the ICPC cannot make the determination, the case will be reviewed with the Governing Body and with the attending physician if needed to make a determination.

If it is determined to be a sentinel event, the Center's procedural guideline for sentinel events will be followed, including completion of a root cause analysis.

PRECISION SURGERY CENTER
X. INFECTION PREVENTION AND CONTROL
3. Surveillance
D. Infection Prevention and Control Education

I. PREVENTION AND CONTROL ORIENTATION AND IN-SERVICES

1. Orientation and in-services are provided to ensure instruction of personnel regarding the importance of infection prevention and the use of infection prevention policies and procedures.
2. All new personnel will attend an orientation program that addresses infection prevention and control including basic principles and the infection control policies and procedures of the Center. OSHA bloodborne pathogens regulations and tuberculosis education will be included. This will be done either in person or via webinar by representatives from the contracted organization Infection Control Solutions, LLC.
3. All personnel will attend at least one mandatory infection prevention and control update per year. OSHA bloodborne pathogens regulations and tuberculosis education will be included as well as other infection prevention issues of importance to the Center.
4. The Infection Control Program Coordinator will conduct one-on-one training with personnel as practices are observed and corrections or changes in practice are needed.
5. Records will be maintained documenting:
 - A. Date and time of training
 - B. Instructor and qualifications
 - C. Content outline
 - D. Participants and department

II. INFECTION PREVENTION AND CONTROL ORIENTATION OUTLINE

1. General Infection Prevention Principles
 - A. Hand washing and Hand Hygiene
 - ◆ Washing with soap and water
 - ◆ Avagard D Instant Hand Antiseptic (Ethyl Alcohol 61%) or substitute
 - ◆ Use of alcohol hand rubs
 - B. Employee Health
 - ◆ Work restrictions for communicable diseases
 - ◆ Reporting of exposures to infectious diseases
 - ◆ Vaccines
 - ◆ TB skin tests
 - C. Patient Infections
 - ◆ Prevention of infections
 - ◆ Recognition and reporting
 - ◆ Definitions of infection
 - Infection communication form
 - Verbal reports to Infection Control Program Coordinator

- Documentation of signs and symptoms of infection
2. Standard Precautions and other barrier precautions
- A. Reasons for Standard Precautions
- Employee protection against bloodborne diseases
 - ◆ OSHA regulations
 - ◆ CDC guidelines
- B. Standard Precautions Policy
- C. Components of Standard Precautions
- ◆ Barriers for protection
 - ◆ Gowns
 - Gloves
 - Masks
 - Eye protection
 - Ambu bags or CPR devices
 - Safer sharps devices
 - ◆ Biomedical waste
 - ◆ Linen handling
- D. Transmission-Based Precautions
- ◆ Airborne
 - ◆ Droplet
 - ◆ Contact
- E. Additional Infection Concepts:
- ◆ Standard precautions/transmission-based precautions protect employees from acquiring transmissible diseases from the patient.
 - ◆ Principles of asepsis are designed to protect the patient from microorganisms from the equipment/environment/caregiver.
 - ◆ Clean technique – refers to practices that reduce the numbers of microorganisms to prevent or reduce transmission.
 - Sterile technique – refers to practices designed to render and maintain areas and equipment maximally free from microorganisms.
 - Patients who are immunocompromised require diligent protection from microorganisms due to increased risk and susceptibility.
 - ◆ Separation of clean and dirty procedures is paramount to the prevention and spread of microorganisms.
- F. Compliance Monitoring – will be documented monthly via Infection Control Rounds Form completed by Infection Control Program Coordinator or delegated staff member.
- ◆ Staff self-evaluations
 - ◆ Observation of practices

PRECISION SURGERY CENTER
X. INFECTION PREVENTION AND CONTROL
3. Surveillance
E. Isolation

I. STANDARD PRECAUTIONS

It is the intent of the Center that: 1) all patient blood, body fluids, excretions and secretions will be considered potentially infectious; 2) standard precautions will be used for all patients.

1. Gloves – gloves should be worn whenever exposure to the following is planned or anticipated:
 - A. Blood/blood products/body fluids with visible blood, excretions, and secretions
 - B. Urine
 - C. Feces
 - D. Saliva
 - E. Mucous membranes
 - F. Wound drainage
 - G. Drainage tubes
 - H. Non-intact skin
 - I. Amniotic, cerebral spinal, pericardial, pleural, peritoneal, synovial fluids
 - J. Performing venipuncture or invasive procedures
2. Masks and eyewear (or face shields) - should be worn during procedures that are likely to generate droplets/splashing of blood/body fluids.
3. Gowns/Aprons (fluid resistant) - should be worn when there is potential for soiling clothing with blood/body fluids.
4. Private Exam or Treatment Room – consider when patient hygiene is poor or in cases where blood/body fluids cannot be contained.
5. Hand washing/hand hygiene – refer to procedure on hand washing/hand hygiene.
6. Resuscitation Equipment – disposable mouthpieces or other ventilation devices should be available as alternatives for mouth-to-mouth resuscitation.
7. Sharps Precautions – safety engineered sharps should be used and used sharps should be placed in an appropriately labeled puncture resistant container.
8. Lab Specimens – should be placed in a container which prevents leakage during collection, handling, processing, storage, transport, or shipping. If outside contamination of the primary container occurs, it should be placed within a second container.
9. Blood Spills – spills of blood or other body fluids should be removed and the area decontaminated using the Center-approved blood spill kit. Gloves should be worn during cleaning and decontamination. The manufacturer’s directions will be followed for use of the product in cleaning and decontaminating spills. The disinfectant should be EPA registered and have kill data against Hepatitis B and human immunodeficiency virus (HIV) or should be tuberculocidal.
10. Linen – soiled linen should be handled as little as possible. Gloves should be worn to handle linen wet with blood or body fluids. Linen will be bagged in an impervious bag or placed

in a container lined with an impervious lining.

11. Waste – waste should be bagged in impervious bags.

II. PERSONAL PROTECTIVE EQUIPMENT (PPE)

1. PPE is provided to all employees. Each employee is responsible for knowing where the equipment is kept in the department.
2. The type of protective barrier(s) should be appropriate for the procedure being performed and the type of exposure anticipated.
3. PPE available includes gloves, gowns or aprons, masks and eye protection (or face shields), and resuscitation devices.

III. RESPIRATORY HYGIENE/COUGH ETIQUETTE

1. Purpose

To prevent the transmission of all respiratory infections, including influenza, the following infection prevention measures should be implemented at the first point of contact with a potentially infected person. They are incorporated into infection prevention practices as one component of Standard Precautions.

A. Visual Alerts

Visual alerts are posted at the entrance to the Center instructing patients and persons who accompany them (e.g., family, friends) how to practice respiratory hygiene and cough etiquette. Patients should also inform health care personnel of symptoms of a respiratory infection when they enter the building or first register for care.

- ◆ Notice to Patients to Report Flu Symptoms
Emphasizes covering coughs and sneezes and the cleaning of hands
- ◆ Cover Your Cough
Tips to prevent the spread of germs from coughing: Posted in waiting areas and patient rooms
- ◆ Information about Personal Protective Equipment
Demonstrates the sequences for donning and removing personal protective equipment

B. Respiratory Hygiene/Cough Etiquette

The following measures to contain respiratory secretions are recommended for all individuals with signs and symptoms of a respiratory infection.

- ◆ Cover the nose/mouth when coughing or sneezing;
- ◆ Use tissues to contain respiratory secretions and dispose of them in the nearest waste receptacle after use;
- ◆ Perform hand hygiene (e.g., hand washing with non-antimicrobial soap and water, alcohol-based hand rub, or antiseptic hand wash) after having contact with respiratory secretions and contaminated objects/materials.

- ◆ Healthcare facilities should ensure the availability of materials for adhering to Respiratory Hygiene/Cough Etiquette in waiting areas for patients and visitors.
 - ◆ Provide tissues and no-touch receptacles for used tissue disposal.
 - Provide conveniently located dispensers of alcohol-based hand rub; where sinks are available, ensure that supplies for hand washing (i.e., soap, disposable towels) are consistently available.

III. MASKING AND SEPARATION OF PERSONS WITH RESPIRATORY SYMPTOMS

During any periods of respiratory infection in the community (e.g., when there is increased absenteeism in schools and work settings and increased medical office visits by persons complaining of respiratory illness), the Center offers masks to persons who are coughing. Either procedure masks (i.e., with ear loops) or surgical masks (i.e., with ties) may be used to contain respiratory secretions (respirators such as N-95 or above are not necessary for this purpose). When space and chair availability permit, the Center encourages coughing persons to sit at least three feet away from others in common waiting areas. This recommendation is instituted year-round.

IV. DROPLET PRECAUTIONS

Advise healthcare personnel to observe Droplet Precautions (i.e., wearing a surgical or procedure mask for close contact), in addition to Standard Precautions, when examining a patient with symptoms of a respiratory infection, particularly if fever is present. These precautions should be maintained until it is determined that the cause of symptoms is not an infectious agent that requires Droplet Precautions http://www.cdc.gov/ncidod/dhqp/gl_isolation.html.

V. ISOLATION PRECAUTIONS

1. Purpose

To address isolation precautions in areas specific to an ambulatory surgery setting.

2. Policy

To implement practices to minimize the risk of transmission of infections.

A. Waiting rooms

- Efforts will be taken to minimize crowding in waiting rooms.
- ◆ Efforts will be taken to assess patients as quickly as possible and place them into an exam room.

B. Patient Scheduling

- ◆ Patients known to have fever over 101° or rash will be rescheduled for procedures when symptoms resolve.

C. Triage of patients

- ◆ Reception staff will be educated to triage as well as possible by telephone

and to be alert to patients presenting with symptoms of infection.

- ◆ Reception staff will notify clinical staff of their observations to enable rapid placement into an exam room and determination of rescheduling a patient.
- ◆ Patients with known diseases or suspected of having any of the following diseases will not be seen until symptoms resolve, and the disease is no longer transmittable.
 - ◆ Tuberculosis
 - Chickenpox
 - Measles
 - Mumps
 - Rubella
 - Meningitis
 - Influenza
 - Pneumonia

I. DROPLET PRECAUTIONS

1. Purpose

The purpose of droplet precautions is to use them in addition to Standard Precautions for patients with infections that can be transmitted by droplets. Droplet transmission involves contact of the conjunctiva or mucous membranes of the nose or mouth of a susceptible person with large-particle droplets containing microorganisms generated from a person who has a clinical disease or who is a carrier of the microorganism. Droplets may be generated by the patient's coughing, sneezing, talking, or during the performance of procedures, e.g. suctioning. These precautions may be considered for influenza and pneumonia infections.

1. Patient's requiring droplet precautions will not be admitted to the surgical center. The procedure will be rescheduled until symptoms have resolved and the disease is no longer transmissible.
3. In the rare case a patient is admitted the Center who has an infection necessitating droplet precautions the patient is required to wear a mask while in the center. The procedure will be rescheduled and transportation arranged if needed to a hospital setting for acute care.

VII. MULTIDRUG-RESISTANT ORGANISMS (MDROS)

Patients with multidrug-resistant organisms (MDROs) will not undergo any surgical procedures.

PRECISION SURGERY CENTER
X. INFECTION PREVENTION AND CONTROL

3. Surveillance

F. Compliance Monitoring

I. PURPOSE:

To provide a system of monitoring to ensure that employees are following established policies regarding infection control practices.

II. POLICY:

To establish the methods for compliance monitoring for infection control. The following is used to evaluate compliance.

III. STAFF SELF-EVALUATION:

Each employee providing direct patient care may be given self-evaluation forms to complete. The forms will be reviewed by the Infection Control Program Coordinator and any problems will be discussed with the individual employee.

IV. OBSERVATION:

Each employee providing direct patient care will be observed during orientation, and periodically during Infection Control Rounds, documented each month by the Infection Control Program Coordinator or delegated staff member. Specific items related to compliance with infection prevention policies will be included on the evaluation form. Specific compliance issues will be discussed with the employee involved. Any problems will be evaluated by the ICPC and reported to the Governing Body during the quarterly meeting.

V. HANDLING AND/OR DISPOSING OF USED NEEDLES

1. The purpose is to provide guidelines for the safe handling and disposal of used needles.

A. Equipment and Supplies

- ◆ Safer sharps devices;
- ◆ Sharps container;
- ◆ Gloves;
- ◆ Other as necessary or appropriate supplies

B. SAFETY PRECAUTIONS

- ◆ After use, discard the needle after activating the safety feature and without recapping by hand, into the sharps container.
- ◆ Used needles and syringes must be placed in the sharps container. Do not bend,

break, or cut needles. When the sharps container is $\frac{3}{4}$ filled, the container must be closed, locked and stored until picked up by a licensed vendor for proper disposal.

- ◆ Recapping of needles is acceptable only for sterile needles.
- ◆ Needles, used or unused, may not be discarded into trash receptacles.
- ◆ In the event of a needle stick injury, the employee should:
 - Immediately wash the wound with soap and running water;
 - If desired, apply alcohol or hydrogen peroxide to the wound; and
 - Notify the Infection Control Program Coordinator of the incident as soon as possible and fill out appropriate Employee Injury documents inside the Employee Injury and Illness Prevention Manual.

2. Using Gloves

- A. Guidelines are provided for the use of gloves for patient and employee protection.
- B. When gloves are indicated, disposable single-use gloves should be worn.
- C. Used gloves should be discarded into the nearest waste receptacle.
- D. Sterile gloves are indicated only in performing sterile procedures.
- E. Non-sterile gloves should be used primarily to prevent the contamination of the employee's hands when providing treatment or services to the patient and when cleaning contaminated surfaces.
- F. Perform hand hygiene before donning gloves and after removing gloves.
- G. Disposable (single-use) gloves must be replaced as soon as practical when contaminated, torn, punctured, they exhibit signs of deterioration, or when their ability to function as a barrier is compromised.
- H. Indications for glove use and procedural guidelines are described in the Infection Control Program Manual.

PRECISION SURGERY CENTER
X. INFECTION PREVENTION AND CONTROL
3. Surveillance
G. Employee Health

I. HEALTH ASSESSMENT

1. Health assessments are required for all patient care staff to ensure that staff are physically fit to perform the essential functions of the job and to determine that they are free of communicable diseases. Ergonomic training will be provided for each employee during orientation to prevent work injuries associated with improper body alignment during normal work activities.
2. New employees are required to complete a health assessment prior to beginning work. As part of the assessment, the infectious disease and immunization history form will be completed.
 - A. Employees with positive tuberculin skin tests (TSTs) will have an annual assessment for symptoms of tuberculosis (TB). Employees with negative TSTs will be retested annually based on the Center's TB risk assessment.
 - B. If at any time during employment a physician indicates that an employee is unable to perform the essential functions of the job, or if there is reason to suspect the employee is putting others at risk due to a communicable disease, the employee will not be permitted to work in that position until further evaluation and determination has been made.

II. TUBERCULOSIS SCREENING FOR EMPLOYEES

1. Purpose
To promote patient and employee safety and well-being by screening employees for tuberculosis and initiating appropriate follow-up.
 - A. Tuberculin skin testing
 - New employees
 - ◆ New employees who have been made a conditional offer of employment shall be screened for the presence of infection with *M. tuberculosis* using the Mantoux TST. Skin testing will employ the two-step procedure. (If the reaction to the first test is less than 10 mm induration, a second test will be given 1-3 weeks later). A positive second test is indicative of a boosted reaction and NOT a new infection. If the second test remains negative, the person is classified as uninfected.

- Individuals with a documented history of a positive TST will not undergo skin testing. They will, however, be asked to bring documentation from their private physician or the local health department of their work-up following conversion. If documentation is unavailable, the employee will have a chest x-ray to determine TB status. In addition, an assessment for signs and symptoms of TB will be completed by the Center.
- Individuals who are found to be TST positive upon initial screening will be referred as in "2" above.
- Individuals with documented history of a negative TST performed within the last 12 months need to receive only one (1) intradermal injection of TST tuberculin. (Note: In this instance, the prior skin test serves as the 1st step of a two-step procedure). If the 2nd test remains negative, the person is classified as uninfected and no further action is necessary. If the second test is positive, the individual will be referred as in "2" above.
- Individuals with no documented history of a TST within the last 12 months will undergo the two-step procedure. If the 2nd test remains negative, no further action is necessary.

B. Annual employee screening

- Employees with a negative skin test history will have, at a minimum, an annual TST and, depending on the test results, will be followed as above. The two-step procedure need not be used. The frequency of repeat skin testing will depend on the Center's annual TB risk assessment.
- ◆ Skin test converters will be sent to their private physician or to the local health department for follow-up. If the employee is symptomatic, return to work will be contingent upon the receipt of documentation attesting to lack of infectivity.
- ◆ Positive reactors who are unable or unwilling to take preventive treatment do not require periodic chest x-rays. Such individuals shall be informed of symptoms suggestive of tuberculosis and to report the occurrence of such symptoms to the Administrator.

C. Exposure incidents

- ◆ Exposure may result from contact with a patient, caregiver, family member or co-workers. In the event of documented occupational exposure to a diagnosed case of infectious pulmonary tuberculosis, all employees having occupational exposure will undergo the following:

- ◆ TST, if previously TST negative
- Follow-up TST in 10-12 weeks. If employee develops a positive skin test, a chest x-ray will be obtained.
- All TST converters, regardless of chest x-ray results, will be referred to a physician or the local health department for follow-up.
- If symptomatic, employment may be resumed contingent upon the receipt of documentation attesting to the lack of infectivity.

2. Administration of the Tuberculin Test

- A. Tuberculin skin testing is the standard method of identifying persons infected with *M. tuberculosis*. The intradermal Mantoux test, not a multiple puncture test, should be used to determine if tuberculosis infection has occurred. As an alternative, a blood assay for *M. tuberculosis* (BAMT) may be used.
 - B. The Mantoux test is performed by the intradermal injection of 0.1 ml of TST tuberculin containing 5 TU (tuberculin units) into either the volar or dorsal surface of the forearm. The injection should be made with a disposable tuberculin syringe. The injection should be made just beneath the surface of the skin, with the needle bevel facing upward to produce a discrete, pale elevation of the skin (a wheal) 6mm to 10mm in diameter.
 - C. To prevent needle stick injuries, safety engineered sharps should be used or needles should not be recapped, purposely bent or broken by hand, removed from disposable syringes, or otherwise manipulated by hand. After they are used, disposable needles and syringes should be placed in puncture-resistant containers for disposal.
 - D. The Mantoux test should be read 48 to 72 hours after the injection. If the employee fails to show up for the scheduled reading, a positive reaction may still be measurable up to one week after testing. However, if an employee who fails to return after 72 hours has a negative test, skin testing should be repeated. The reading should be based on measurement of induration, not erythema. The diameter of induration should be measured transversely to the long axis of the forearm and recorded in millimeters.
2. Classification of the Tuberculin Reactions are detailed in the Infection Control Program Manual.
 4. Interpretation of the Tuberculin Test in Persons with a History of Bacillus Calmette-Guérin (BCG) Vaccination
 - A. Many foreign countries still use BCG as part of their tuberculosis control programs, especially for infants. TST sensitivity and immunity to tuberculosis infection after BCG vaccination is highly variable, depending upon the strain of BCG used and the population vaccinated. Thus, the size of a tuberculin skin test reaction in a BCG vaccinated person is not a factor in determining whether a reaction is caused by *M. tuberculosis* infection or the prior BCG vaccination.
 - B. Tuberculin skin testing will be performed on new employees who have been vaccinated with BCG. If previous positive results already documented a chest x-ray will be obtained (if not already done) and annual signs and symptoms evaluation will occur.

III. INFLUENZA VACCINE TO PATIENTS OR HEALTHCARE PERSONNEL

Influenza vaccines will be offered at the discretion of the Medical Director and/or the availability of the vaccine itself.

IV. BLOOD AND BODY FLUID EXPOSURE REPORT

1. Purpose: To document the type and circumstances of a blood and body fluid exposure.

2. Policy:

To define that the employee will provide detailed information to the Clinical Director or other designee on the blood and body fluid exposure.

A. As soon as possible following an exposure, the employee shall report the exposure to the supervisor.

B. The employee will see the Clinical Director or other designee to complete the appropriate forms in the employee injury packet located in the Infection Control Program Manual.

C. The form will be used to assist in evaluating the cause of the injury and for prevention of future similar injuries.

V. POST-EXPOSURE EVALUATION AND FOLLOW-UP OF BLOODBORNE PATHOGENS

1. First aid:

At the time of a suspected exposure, the following basic first aid measures should be taken to thoroughly irrigate and disinfect the affected body part to prevent infection/illness:

A. For skin exposure, puncture, or laceration: Wash with bactericidal soap and water.

B. For exposure of eyes, mouth, or other mucous membranes: Rinse with running water, normal saline, or other suitable sterile eye wash for at least 10 minutes.

2. Healthcare workers exposed to HIV, hepatitis B virus (HBV), or hepatitis C virus (HCV) being evaluated for exposure or needle stick should be evaluated within hours (rather than days) of their exposure, as HIV post-exposure prophylaxis (PEP), Hepatitis B vaccine, and hepatitis B immune globulin (HBIG) are most effective administered as soon as possible after exposure.

A. Rapid screening tests are now available to allow for HIV testing results within hours. This screening test may be followed up with an HIV antibody test as confirmation.

B. Post-exposure prophylaxis (PEP) is now available and recommended for use after different types of exposures, based on risk of HIV infection.

- Risk of type of exposure should be weighed against potential toxicity of PEP.

- ◆ The Center has access to Concentra Medical Center (address with directions located in the Injury and Illness Prevention Binder) which as laboratory

capabilities for post exposure testing and access to medication for the initial PEP treatment for immediate use.

- ◆ Employee should be evaluated as soon as possible by a practitioner skilled in use of anti-retro viral drugs as well as HIV.
- ◆ Healthcare worker should receive post-exposure counseling, testing and evaluation whether or not PEP is given.
 - ◆ Exposed healthcare personnel (HCP) should be advised to use precautions (e.g., avoid blood or tissue donations, breastfeeding, or pregnancy) to prevent secondary transmission, especially during the first 6-12 weeks post-exposure.
 - For exposures for which PEP is prescribed, HCP should be informed regarding:
 - Possible drug toxicities and the need for monitoring
 - Possible drug interactions
 - The need for adherence to PEP regimens
 - Consider reevaluation of exposed HCP 72 hours post-exposure, especially after additional information about the exposure or source becomes available.

3. Hepatitis B management:

- A. Source patient testing for Hepatitis B, PEP if indicated.

4. Hepatitis C management:

- A. Source patient testing for anti-HCV.
- B. Exposed person must do the following:
 - Have baseline testing for anti-HCV and alanine aminotransferase (ALT) activity.
 - ◆ Have follow-up testing (e.g., four to six months) for anti-HCV and ALT activity. Testing for HCV RNA may be substituted for earlier diagnosis.
 - ◆ Confirm all anti-HCV results reported positive by enzyme immunoassay using supplemental anti-HCV testing.

PRECISION SURGERY CENTER
X. INFECTION PREVENTION AND CONTROL
3. Surveillance
H. Cleaning, Disinfection and Sterilization

I. PURPOSE:

To provide instruments, supplies and equipment that are adequately cleaned, disinfected or sterilized, in accordance with manufacturer's recommendations and state and federal guidelines. This policy is related to reprocessing of supplies and equipment approved for multiple uses only. Single use items are disposed of immediately after one use and not reprocessed in Precision Surgery Center.

II. POLICY:

The policy is as follows:

1. Cleaning

A. Definition: The removal of all soil from surfaces. This can be accomplished by using water with detergents. Thorough cleaning is necessary before proceeding to high-level disinfection and sterilization.

B. Guidelines

- ◆ Cleaning of patient care items must occur prior to beginning high level disinfection or sterilization, should remove all visible soil and should occur as soon as practical after use.
- ◆ Proper protective equipment must be used when cleaning an item if a risk of aerosolization exists (spraying of particles into air) and for protection against exposure to the chemicals used (as directed by the material data safety sheet (MSDS)).

2. Disinfection/Sterilization

A. Definitions:

- ◆ Disinfection: A process that kills or destroys many or all disease-producing microorganisms on the inanimate object. It usually does not kill spores.
- ◆ Sterilization: The complete elimination/destruction of all forms of microbial life.

3. General Guidelines:

- A. The Food and Drug Administration (FDA) label claim for high-level disinfection should be used unless scientific studies can show an alternate effective exposure time.

- B. Routine testing of liquid sterilants and high-level disinfectants should be performed to ensure effective concentration of the active ingredient.
- C. Personnel must have proper training on processing instruments with competency testing.
- D. Semi-critical devices such as probes and can be cleaned with high-level disinfection with a non-toxic product. Use of probe covers over the instrument is encouraged but still requires the above cleaning procedures.
 - ◆ Steam is the preferred method for sterilization for critical instruments not damaged by heat.
 - ◆ Low-level sterilization methods may be used (ethylene oxide, hydrogen peroxide, gas plasma) for heat or moisture-sensitive equipment.
 - ◆ Mechanical, chemical, and biological monitors must be used to ensure that the sterilization process has been effective.
 - ◆ A quality control program is important to ensure appropriate disinfection and sterilization, this is documented in the Infection Control Program Manual.
 - ◆ Training of staff is comprehensive and complete and performed during new hire orientation and annually by Infection Control Solutions, LLC.

III. CLASSIFICATION OF DEVICES, PROCESSES, AND GERMICIDAL PRODUCTS

Device classification	Devices (examples)	Spaulding process classification	EPA product classification
<i>Critical</i> (enters sterile tissue or vascular system)	Implants, scalpels, needles, other surgical instruments, etc.	Sterilization – sporicidal chemical; prolonged contact	Sterilant/disinfectant
<i>Semi-critical</i> (touches mucous membranes - except dental)	Flexible endoscopes, laryngoscopes, endotracheal tubes, and other similar instruments	High-level disinfection – sporicidal chemical; short contact	Sterilant/disinfectant
	Thermometers, hydrotherapy tanks	Intermediate-level disinfection	Hospital disinfectant with label claim for tuberculocidal activity
<i>Noncritical</i> (touches intact skin)	Stethoscopes, tabletops, bedpans, etc.	Low-level disinfection	Hospital disinfectant without label claim for tuberculocidal activity

Modified from Favero MS, Bond WW. Chemical disinfection of medical and surgical materials. In: Block SS. Ed. Disinfection, sterilization and preservation. 4th ed. Philadelphia: Lea & Febiger 1991:627

NOTE: The Center purchases pre-packaged sterile items for single use and does high-level disinfection in the facility for multiple use items. Many reusable patient care objects can be disinfected or sterilized by the methods found in the above table.

IV. SUPPLY AND EQUIPMENT MANAGEMENT

1. The integrity of clean and sterile equipment and supplies is assessed prior to use.
2. All non-disposable patient care equipment shall be cleaned the same regardless of the patient's infectious status. It will be cleaned after each use and at the end of the day with an appropriate disinfectant.

V. MONITORING OF STERILIZING EQUIPMENT

To enhance patient safety, policy has been established for monitoring of sterilizers. The policy and various steps to be taken when biological indicators are positive is described in detail in Infection Prevention and Control Manual.

VI. HAND HYGIENE

The purpose of hand hygiene is to decrease the risk of transmission of infection by appropriate hand hygiene. Listed below are guidelines followed in the facility regarding hand hygiene. Complete and detailed hand hygiene policy is located in the Infection Control Program Manual.

1. Hand washing/hand hygiene is generally considered the most important single procedure for preventing healthcare-associated infections. Antiseptics control or kill microorganisms contaminating skin and other superficial tissues and are sometimes composed of the same chemicals that are used for disinfection of inanimate objects. Although antiseptics and other hand washing/hand hygiene agents do not sterilize the skin, they can reduce microbial contamination depending on the type and the amount of contamination, the agent used, the presence of residual activity and the hand washing/hand hygiene technique followed.
 - A. Hand washing

When hands are visibly soiled or contaminated with with blood or other body fluids, and in case of a patient with a spore-forming organism (e.g., *C. difficile*), after going to the restroom, and before eating, perform hand hygiene with either a non-antimicrobial soap and water or an antimicrobial soap and water.
2. Waterless Hand washing Products
 - A. If hands are not visibly soiled, use an alcohol-based hand rub for routinely decontaminating hands in all clinical situations other than those listed under "Hand washing" above.
 - ◆ When decontaminating hands with an alcohol-based hand rub, apply product to palm of one hand and rub hands together, covering all surfaces of hands and fingers, until hands are dry.
 - ◆ Follow the manufacturer's recommendations regarding the volume of product to use.

PRECISION SURGERY CENTER
X. INFECTION PREVENTION AND CONTROL
3. Surveillance
I. Infectious Waste Management

I. PURPOSE:

To decrease the potential of exposure to hazardous waste by appropriate management and disposal.

II. POLICY:

1. Definition of Infectious (Biomedical/Regulated) Waste

- ◆ OSHA has defined regulated waste to include:
 - ◆ Blood and blood products
 - Pathological waste
 - Microbiological waste
 - Contaminated sharps (e.g. needles, lancets, scalpel blades)

2. Needles and Sharps – all new employees will be educated during initial orientation regarding sharp safety and applicable policies and procedures. Regular staff training and education will occur annually or more often as needed. All training is documented in the Infection Control and/or Injury and Illness Prevention Program Manual.

- A. Sharps will be placed directly into impervious, rigid, leak-proof and puncture-resistant containers to eliminate the hazard of physical injury. The containers will be appropriately marked with the bio-hazard symbol and secure from tampering, in accordance with current state and federal guidelines. Sharps receptacles should be placed at eye-level to personnel or at a locale allowing for easy access and visualization near all patient care areas.
- B. Sharps containers will not be overfilled. They should be replaced when $\frac{3}{4}$ full. When full, the Clinical Director or designated staff member will be responsible to see that the $\frac{3}{4}$ full containers are locked, removed from the use area and placed in the bio-hazard waste (soiled utility) room. The containers will be picked up for proper disposal weekly by the contracted bio-hazard waste disposal company.
- C. Used needles will not be recapped, purposely bent or broken by hand, removed from disposable syringes or otherwise manipulated by hand. Safer sharps devices will be used whenever commercially available as a substitute for a specific non-safety-engineered device.

3. Blood and Blood Products

- A. If blood is collected in a tube and then needs to be discarded, it may be placed in the tube in the needle disposal container to be disposed of with infectious waste.
- B. Bloody fluids, e.g. bloody urine, may be discarded by carefully pouring it into the

sanitary sewer. Appropriate personal protective equipment must be worn to prevent exposure to splashing/aerosolized liquids. When possible it is preferable to close the container and place in an appropriate area for pick-up, decontamination and disposal. Solidifying products may be another way to decrease risk of contamination and exposure of employees.

4. Labeling (Biomedical/Regulated) Waste
 - A. All containers must have a fixed a universal bio-hazard label. The outside contractor must also affix the address and registration number to the outside of containers.
5. Storage Of Infectious (Biomedical/Regulated) Waste
 - A. Biomedical waste will be stored in the labeled soiled utility room. This location affords protection from animals, insects, and weather conditions; and minimizes exposure to patients, staff and the public.
6. Other Wastes (Non-Regulated)
 - A. Fluid filled containers, e.g. Foley bags, will be emptied into the sewer prior to disposal of the container in the trash in the soiled utility room.
 - B. Dressings will be bagged at the bedside and discarded in the soiled utility room trash can. Dressings are not considered infectious waste unless they are soaked and dripping wet with blood. Otherwise they can be contained in a regular, impervious trash bag and discarded with regular trash.
 - C. Final disposal of waste will be in accordance with local, state, and federal regulations. The contracted waste disposal company will pick up Biomedical hazardous waste every week or more often as needed.

PRECISION SURGERY CENTER
X. INFECTION PREVENTION AND CONTROL
3. Surveillance
J. Safe Injection Practices

I. PURPOSE:

The purpose is to provide safety in administering medications by injection.

II. GENERAL GUIDELINES

The following recommendations will apply in the Center to the use of needles, cannula that replace needles, and, where applicable, intravenous delivery systems. This policy is intended as a general guideline and the complete and detailed policy is located in the Infection Control Program Manual.

1. Aseptic technique will be used to avoid contamination of sterile injection equipment.
2. Medications will not be administered from a syringe to multiple patients, even if the needle or cannula on the syringe is changed.
 - A. Needles, cannulas and syringes are sterile, single-use items; they will not be reused for another patient nor to access a medication or solution that might be used for a subsequent patient.
3. Fluid infusion and administration sets (i.e., intravenous bags, tubing and connectors) will be used for one patient only and disposed appropriately after use.
 - A. The Center will consider a syringe or needle/cannula contaminated once it has been used to enter or connect to a patient's intravenous infusion bag or administration set.
4. Single-dose vials for parenteral medications will be used whenever possible.
5. Medications will not be administered from single-dose vials or ampules to multiple patients or combine leftover contents for later use.
 - A. If multi-dose vials must be used, both the needle or cannula and syringe used to access the multi-dose vial will be sterile.
6. Multi-dose vials will not be kept in the immediate patient treatment area and will be stored in accordance with the manufacturer's recommendations; they will be discarded if sterility is compromised or questionable. Multi-dose vials will be used for a single patient whenever possible.
7. Bags or bottles of intravenous solution will not be used as a common source of supply for multiple patients.

II. INTRAVENOUS THERAPY

1. Purpose:

The purpose of this policy is to provide guidelines for intravenous therapy

2. Policy:

A. Intravenous catheters less than 3 inches may be inserted by physician, certified registered nurse anesthetist (CRNA), certified registered nurse (RN), licensed practical nurse LPN. Medical Assistants may insert an intravenous saline lock after appropriate competency testing has been completed and signed off by the Clinical Director.

- Use of intravenous catheters of 3 inches or less is for peripheral vein administration of intravenous fluids and medications.

III. MANAGEMENT OF CLEAN EQUIPMENT

1. Purpose

The purpose is to ensure appropriate technique in maintaining clean equipment.

2. Policy

This policy below is a general guideline as complete detailed policies are located in the Infection Control Program Manual.

- A. Clean equipment and supplies are stored in the labeled clean utility room. Items stored off the floor. Clean equipment is always separated from soiled equipment.
- B. Items marked disposable should not be re-used. If covers are used over equipment, the soiled cover should be discarded and the item disinfected before a new cover is placed.
- C. Ideally, individual equipment should be provided for each patient. When equipment is shared, disinfection of equipment should take place prior to the next patient use.
- D. Non-critical equipment such as beds, stethoscopes, and bedside tables should be wiped down in between patients with approved disinfectant.
- E. Semi-critical equipment, those touching mucous membranes, such as laryngoscopes, endoscopes, respiratory care and anesthesia equipment require high level disinfection, with exposure time of ≥ 20 minutes.
- F. Use of disposable or one time patient-use products are preferred whenever possible.

IV. PREVENTION OF SURGICAL SITE INFECTION

1. Purpose:

The purpose is to promote best practices for Surgical Site Infection (SSI) prevention. A complete and detailed policy is located in the Infection Control Program Manual.

A. Precision Surgery Center will work toward preventing SSIs by implementing the following components of care:

- ◆ Appropriate Use of Prophylactic Antibiotics
 - ◆ The antibiotic process measures for prevention of SSIs are these:
 - Prophylactic antibiotic received within 1 hour prior to surgical incision when indicated and required.
 - Prophylactic antibiotic selection for surgical patients consistent with national guidelines.
 - Appropriate Hair Removal
 - ◆ The use of razors prior to surgery increases the incidence of wound infection when compared to clipping, depilatory use, or no hair removal at all. When hair must be removed to safely perform the procedure, it should never occur with a razor. Clippers are used to remove hair.

PRECISION SURGERY CENTER
X. INFECTION PREVENTION AND CONTROL
3. Surveillance
K. Central Sterile Processing

I. PURPOSE

The policy is to promote best practices in the sterile processing work room. The Infection Control Program Manual has additional policies detailed.

II. POLICY

1. Personnel Apparel

Personnel shall wear proper clean OR scrub attire, hair cover, shoe covers, and masks when necessary, and use frequent hand washing. Occupational health department policies for work restrictions will be followed.

2. Housekeeping

Daily cleaning and disinfecting of floors, walls, overhead lighting, and trash removal is performed by a qualified contracted cleaning company.

3. Processing of Items

A. Disposable items should be discarded immediately after use in the nearest appropriate waste receptacle.

B. Reusable items

1. Prior to use items are checked on receipt and sterilized according to manufacturer's instructions..

2. Contaminated instruments are presoaked for decontamination and the sterilized according to manufacturer's instructions. All employees receive training on how to properly sterilize equipment and reusable supplies. Details of this training are in the Infection Control Program Manual.

IV. CONTAINERS AND WRAPPERS

1. The outside wrapper/container constitutes a bacterial barrier which ensures sterility of the contents.

A. Acceptable containers/wrappers for sterilization are:

- Commercially prepared sterilizer bags, not reusable.
- ◆ Commercially made disposable paper wrap.

V. PACKAGING AND STORAGE OF SUPPLIES

1. Glass, delicate instruments and sharp points must be adequately protected with padding before final wrap.
2. A wrap within a wrap of some items is recommended for ease in dispensing onto a sterile field.
3. Placement of equipment on trays should be in order of use.
4. Articles which have surfaces in close contact must be separated for steam penetration.
5. Indicator tape must be used on all items to be sterilized. Tapes are checked after sterilization; white to black indicates sterilization, or read manufacturer's instructions.
6. Commercially sterilized products may be stored indefinitely unless otherwise stated by the manufacturer. The wrapper must be clean, intact, sealed and dust free.
7. Sterilized items and equipment are stored in the labeled clean utility/storage room on appropriate shelving. Shelf life of a packaged item is event related. Items sterilized in the central sterile department are considered sterile when the packaging is not compromised.
 - A. Sterile items are to be CAREFULLY INSPECTED for integrity of packaging prior to use. If intact, they are considered sterile.
 - B. Packaging will be considered non-sterile (compromised) when certain events occur:
 - ◆ Holes/tears
 - ◆ Broken or no seal
 - ◆ Dropped
 - ◆ Moisture
 - ◆ Unsealed dust cover
 - ◆ Broken tape
 - ◆ Lids improperly applied
 - ◆ Absence of external or internal indicators
 - C. If inspection of items reveals compromised packaging or there is any question of sterility or possible contamination, the item is reprocessed prior to use.

VI. LOADING OF STERILIZER

1. Arrange on rack or carriage so as to present least possible resistance to the passage of steam.
2. Do not overload sterilizer.
3. When possible, sterilize like materials together. Example: Linen packs with soft goods, all hard goods with other hard goods.

4. Basins, trays, test tubes, etc., must be set on edge or upside down so air will flow out freely as steam flows in.

VII. STERILIZATION CYCLE

1. For safety reasons, only an adequately instructed person may operate sterilizer.
2. Instructions must be available at all times for reference.
3. Proper temperature and exposure time must be known. Chart and temperature gauge must be checked to see that these are achieved.
4. Appropriate log will be maintained.

VIII. REMOVING LOAD FROM STERILIZER

1. Load should be dry and cool when removed.
2. Care must be taken to keep sterile items separated from non-sterile items.

IX. MONITORING OF STERILIZERS

1. The following CDC recommendations will be followed for monitoring sterilizers:
 - A. Use mechanical, chemical, and biologic monitors to ensure the effectiveness of the sterilization process.
 - B. Monitor each load with mechanical (e.g., time, temperature, pressure) and chemical (internal and external) indicators. If the internal chemical indicator is visible, then the external indicator is not needed.
 - C. Processed items are not used if the mechanical (e.g., time, temperature, pressure) or chemical (internal and/or external) indicators suggest inadequate processing.
 - D. Use biologic indicators to monitor the effectiveness of sterilizers at least weekly with an FDA-cleared commercial preparation of spores intended specifically for the type and cycle parameters of the sterilizer.
 - E. Detailed policies regarding positive biological indicators are in the Infection Control Program Manual.
 - G. Use biologic indicators for every load containing implantable items and quarantine items, whenever possible, until the biologic indicator is negative.

PRECISION SURGERY CENTER

SECTION X

INFECTION PREVENTION AND CONTROL PROGRAM

4. Environmental Services

PRECISION SURGERY CENTER
X. INFECTION PREVENTION AND CONTROL
4. Environmental Services
A. Physical Plant

I. PURPOSE:

The purpose is to promote a sanitary environment for patients and staff members.

II. POLICY:

These policies reflect general guidelines, additional detailed policies are in the Infection Control Program Manual.

1. Frictional Cleaning

A. Thorough scrubbing will be used for all environmental surfaces that are being cleaned in patient care areas.

- ◆ Mop heads, cleaning cloths and cleaning solutions will be changed when obviously soiled.
- ◆ Cleaning methods and machines that resuspend dust from surfaces will be avoided, especially in patient care areas. Damp mopping or use of a chemically treated mop for reduction of airborne dust is generally recommended in patient care areas. **NOTE:** The microfiber mop system has demonstrated superior microbial removal compared with cotton string mops when used with a detergent cleaner.
- ◆ Hooding of floor buffers and other machinery is recommended to prevent aerosolization of dust in patient care areas.
- ◆ HEPA-filtered vacuums shall be used in patient care areas.

2. Disinfectant Fogging

Disinfectant fogging is ineffective, time consuming and potentially toxic. It is not used.

3. Routine Cleaning of Horizontal Surfaces

In patient care areas, cleaning of non-carpeted floors and other horizontal surfaces will be done daily and more frequently if spillage or visible soiling occurs.

4. Choice of Cleaning Agents for Use in Patient Care Areas
 - A. A hospital-grade disinfectant/detergent registered by the federal EPA will be used.
 - ◆ Except for alcohol (70 to 90%), antiseptic agents intended for use on skin will not be used for surface cleaning.
5. Cleaning Blood Spills
 - A. Blood spills will be cleaned using an approved blood spill kit. This kit has an EPA registered disinfectant effective against Hepatitis and HIV. The spill kit manufacturer's recommendations for cleaning and decontaminating the spill will be followed. As an alternative, a fresh 1:10 dilution of bleach may be used. Gloves and other appropriate personal protective equipment (based on the specific situation) will be worn.

III. INFECTION PREVENTION

1. The Center staff play a large role in maintaining a clean healthcare environment as well as working in partnership with the infection prevention program of the Center.
 - A. Personnel will be oriented and trained in proper technique. This training takes place during new employee orientation, annually and more often if needed. It is performed by a representative from Infection Control Solutions, LLC. Documentation of all training is kept in the Infection Control Program Manual.
 - ◆ Employees will be encouraged to report infectious diseases to the Clinical Director or Administrator.
 - ◆ If disease is thought to be communicable, employee will not return to work until cleared by medical doctor and have documentation of treatment.
 - B. Routine environmental cultures are not recommended.
 - C. Disinfectants and cleaners used by Center staff and Janitorial Services will be reviewed by the Infection Control Program Coordinator.

IV. CARPETING IN PATIENT CARE AREAS

1. Carpeting will be vacuumed regularly, cleaned promptly if spills occur and shampooed every 3 to 6 months or when indicated by appearance. Deep soil extraction will be provided on an as-scheduled basis.
 - A. Carpeting will not be used in heavy soiling and spillage areas.
 - B. Vacuum cleaners should be designed to filter discharged air and not resuspend dust from the floor.

V. TRASH

1. Trash will be removed from all areas on a specific schedule to prevent spillage and odors.
 - A. Trash cans will be covered in patient care areas.

PRECISION SURGERY CENTER
X. INFECTION PREVENTION AND CONTROL
4. Environmental Services
B. Maintenance Program

I. PURPOSE:

The purpose of the maintenance program is to ensure proper maintenance of the physical Center and its equipment.

II. POLICY:

The policies include:

1. Preventive Maintenance

A. The Safety and Maintenance Coordinator is responsible for maintaining the Center's ventilation systems and temperature control, along with cleaning and/or changing filters on a routine basis. The Center has a contracted company in charge of maintaining the HVAC system per regulations.

2. Contaminated Wastes

A. Contaminated wastes, needles, and blood are disposed of by contracted waste management company.

3. Barrier Precautions

A. If maintenance personnel must enter patient care areas or operating suites, they must observe the same precautions observed by nursing personnel. They should avoid direct contact with patients and personal supplies. When at all possible maintenance personnel will be scheduled when the center is not admitting patients. (i.e. before/after business hours or on weekends)

B. Any equipment/tools that become contaminated with body secretions will be cleaned upon removal from the patient care areas. Standard precautions with use of PPE (Personal Protective Equipment) will be emphasized for all outside personnel similar to that of staff members.

4. General Center Maintenance

The department will do on-going monitoring of the Center for areas needing repair and, if needed, will report to the Administrator for approval of the repairs needed.

5. Preventive Maintenance of Filters of Ice machines

A. Filters and maintenance on ice machines will be performed quarterly, or per manufacturer's instructions

6. Miscellaneous

- A. Aerators will be removed from sinks in all high-risk areas to prevent bacterial build-up of organisms.
- B. Patients should stay in their areas with their curtains closed if maintenance is being performed in hallways. Every effort will be made to schedule maintenance work outside of normal business hours.
- C. Whenever possible, this work should be contained using a dust-mist portable unit which isolates work and HEPA-filters air. When this is not possible, a temporary plastic barrier should be used with HEPA-filter inside. This area shall be sealed with masking tape to floor and ceiling. After maintenance work is complete within the enclosure, plastic and areas with dust shall be wiped off with germicide and a HEPA-filter portable vacuum may be used to remove dust. Then the enclosure can be safely dismantled. If work is performed in an operating room, the room shall be unoccupied and the door shall be closed. The room shall be thoroughly cleaned prior to reopening.
- D. Leaks and areas of moisture should be fixed promptly and drywall, ceiling tiles and other materials should be replaced, using guidelines as above. (C.)

PRECISION SURGERY CENTER
X. INFECTION PREVENTION AND CONTROL
4. Environmental Services
C. Laundry Services

I. PURPOSE:

The purpose of laundry services is to ensure a clean supply of medical linen and to protect employees who handle and process the laundry.

II. POLICY:

1. Routine Handling of Soiled Linen

- A. Soiled linen should be handled as little as possible and with a minimum of agitation to prevent gross microbial contamination of the air and of persons handling the linen. Standard precautions will be used by clinical and laundry staff handling the linen.
- B. All soiled linen should be bagged or put into carts at the location where used; it should NOT be sorted or pre-rinsed in patient-care areas. Linen that is saturated with blood or body fluids should be deposited and transported in impervious bags. All staff use standard precautions in handling linen, therefore all linen is handled in the same manner.
- C. Soiled linen should be removed from patient-care areas at least daily and may need to be removed more frequently depending on the amount of soiled linen that is generated.

2. Transportation of Linen

- A. All clean linens should be stored and transported in carts used exclusively for this purpose or in linen carts that have been decontaminated after being used for soiled laundry. Clean linen is NOT to come in contact with dirty linen.
- B. Laundry hampers are used solely for the transport of soiled linen. Clean linen is delivered separately and they are stored in separate rooms to prevent contamination.
- C. Staff members are only responsible for getting the soiled linen bags from the hampers to the soiled utility room, all transportation of linen is done by an outside contracted company who is responsible for washing and transportation of medical grade linen for the facility.

PRECISION SURGERY CENTER
X. INFECTION PREVENTION AND CONTROL
4. Environmental Services
D. Surgical Services

I. PURPOSE

To promote effective infection prevention procedures in the surgical suite. Listed below are guidelines and complete detailed policies are in the Infection Control Program Manual.

III. GENERAL GUIDELINES

1. Remote infections will be treated prior to elective surgeries and procedures. No patient will be admitted to the center with a known or sign and symptoms of an active infection. Procedures will be postponed until after medical treatment.
2. Antimicrobial prophylaxis, if indicated, will be given with an appropriate antimicrobial agent via IV route. In most instances, a single antibiotic dose should be completed within 30-60 minutes of skin incision.

IV. PERSONNEL

1. Personnel will follow all occupational health policies, detailed in the Infection Control Program Manual

V. ATTIRE FOR RESTRICTED AREAS

1. Purpose

To decrease the source of bacterial-causing wound infection; to reduce the risk of contamination to the surgical suite, and to promote effective infection prevention.

2. Policy

A. Those entering the restricted area (designated by signage) shall wear scrub clothes. Freshly laundered scrub attire is donned in the designated staff changing area prior to entry into restricted areas. Scrub clothes will be changed when they become visibly soiled, wet with blood, sweat, etc.

B. All personnel entering the restricted area of the surgical suite are to wear closed-toed shoes donned with shoe covers and/or designated surgery shoes.

◆. Designation of Surgical Procedures

◆ The purpose is to decrease the source of bacteria causing wound infections; to reduce the risk of contamination to the surgical suite, and to promote effective infection prevention.

- The policy is that the surgical procedures performed at Precision Surgery Center are either sterile or clean.

- All personnel entering restricted areas of the surgical suite shall be in operating room attire. Operating room attire at minimum consists of scrub uniform, shoe covers, and/or designated surgery shoes. Head cover and mask are required for a majority surgical procedures and for certain pain management procedures without incision. Each has an appropriate purpose to combat external sources of contamination.. Sterile gown and gloves are added to this basic attire for scrubbed team members. Proper attire is one facet of environmental control. It also protects personnel against exposure to communicable diseases and hazardous materials.
- Patient clothing is either removed or covered prior to the patient's entry into a surgical area, as needed and per physician request to minimize contamination of the surgical environment.

VI. ATTIRE FOR SEMI-RESTRICTED AREAS

1. Those entering the semi-restricted areas (outside the operating and procedure rooms) shall wear at a minimum, scrub uniform.

VII. PERSONNEL TRAFFIC

1. Only authorized personnel are allowed within the surgical suites.
 - A. Proper attire is worn by all persons entering the restricted area. Signage on operating room doors indicates restricted areas.
 - B. During a surgical procedure, traffic should be controlled in and out of the room to minimize air turbulence. The door should be kept closed except for passage of necessary personnel, equipment, etc.

VI. SURGICAL SCRUB

1. Surgical scrub is done before gowning and gloving for sterile procedures. Time is from two to five minutes with an appropriate antiseptic. Alternate scrubless products may be employed using the manufacturer's recommendations.
 - A. Adjust mask over mouth and nose.
 - B. Adjust water to a comfortable temperature.
 - C. Wet hands under running water.
 - D. Put several drops of scrub solution into palm of hand. Wash hands.
 - E. Clean fingernails, under running water, with a disposable nail cleaner.
 - F. Open a disposable scrub sponge and wet it thoroughly.
 - G. Scrub each hand for one and one-half minutes. Be sure to scrub between fingers and around nails.
 - H. Scrub each arm, starting at the wrist up to the elbow, for one-half minute.
 - I. Rinse hands and arms. Begin with the hand and rinse back to the elbow.
 - J. Keep the hands higher than the elbows, so that water will not run down the lower

- arms to the hands.
 - K. Cut the water off with the knee.
2. Masks
- A. Disposable masks are worn at all times when in the operating room during sterile procedures and should cover nose and mouth completely.
 - Masks are changed between each case and as they become moist.
3. Jewelry/Nails
- ◆ Rings, watches, and bracelets will be removed.
 - ◆ Non-scrubbed personnel may wear a wedding band and watch.

VII. PREOPERATIVE PATIENT SKIN PREP

1. It is the option of the physician to order the patient to shower or bathe with an antiseptic agent the night before surgery.
2. Do not remove hair unless it will interfere with the surgery. If removed, electric clippers will be used.
3. The surgical prep allows for patients' skin and surrounding site to be as free of exogenous microorganisms as possible.
 - A. Antimicrobial agent may be chosen by facilities or physician preference considering a patient's skin requirements/allergies. All gross soil and debris should be removed before prep and pre solutions and devices should be used according to the manufacturer's requirements.
 - B. Use absorbent barrier towels under the prep site to absorb drips. Do not allow solutions to pool.

VIII. LATEX ALLERGY (PERSONNEL AND PATIENTS)

1. Non latex products may be used to reduce exposure to latex and to prevent latex allergy. Products should be evaluated for their effectiveness as barriers for blood borne pathogens. Employees with latex allergy should receive appropriate counseling, education and equipment.
2. Peri-operative assessment for latex should be done on all surgical patients.
3. Latex-free equipment may be gathered together for ease-of-use in a patient with latex allergy.
4. Excellent documentation/communication should be done in surgical services when a patient is identified as having a latex allergy.

IX. RESPONSIBILITIES OF NURSES AND OTHER STAFF

1. Sterile items are examined for expiration date, if applicable, prior to use. Sterilized items have indefinite shelf life, when properly processed, unless the package is damaged or opened.

2. When items are outdated, contents are re-sterilized when required by manufacturer.
3. Exterior of sterile items should be examined for contamination.
 - A. Broken seal
 - B. Moisture
 - C. Discoloration
4. Sterile supply storage
 - A. Cabinet doors are kept closed.
 - B. Items are kept clean and dry.
 - C. Shelves are cleaned monthly.
 - D. Items should be stored off the floor and no higher than 18 inches from ceiling.

X. CLEANING RESTRICTED AREA

1. Prior to case
 - A. Flat surfaces, overhead lights and equipment are wiped with a germicide.
 - B. Damp dust any equipment entering operating room from outside the area.
2. Between case cleaning for restricted areas:
 - A. Prior to leaving the operating room, personnel should place gown and gloves in proper receptacles.
 - B. All linen, whether clean or soiled, is deposited in linen hamper inside room.
 - C. Waste articles and soiled sponges are disposed of in plastic lined containers. Plastic bags are disposed of directly into trash collectors.
 - D. Wet linen and drapes are placed in the center of the laundry in the hamper to avoid contaminating the bag.
 - E. Disposable suction tubing is disposed of with waste articles.
 - F. Suction contents are disposed of in the soiled utility room using appropriate personal protective equipment. The disposable suction canister is disposed of with waste articles. Solidifier may be used to dispose of suction canisters.
 - G. A gloved scrub nurse places all instruments in a contamination bag. Instruments are then carried to the instrument room for reprocessing.
 - H. Lensed or fiber optic instruments are cleaned and chemically disinfected according to the manufacturer's instructions.
 - I. All flat surfaces, OR table and equipment are wiped with a germicide. This includes lights and visibly soiled areas of room.
 - J. Mop with germicide if floor is visibly soiled.

3. Semi-restricted Cleaning:
 - A. All flat surfaces, medical devices and equipment used for multiple patients are wiped with germicidal disinfectant before use, in between patients and if visibly soiled or deemed necessary. All manufacturer's guidelines are followed for appropriate cleaning solutions.
 - B. Mop with germicide if floor is visibly soiled.
4. Terminal cleaning
 - A. Terminal cleaning will be performed daily by qualified contracted cleaning company. These areas include surgical suites, sterilizer rooms, utility rooms, work rooms, scrub sinks.
 - B. Clean areas as above, adding these additional areas:
 - ◆ Clean all furniture, including casters, kick buckets.
 - ◆ Fixed and ceiling-mounted equipment and tracks.
 - ◆ Wall-mounted boxes and equipment.
 - ◆ Cabinet handles, light switches.
 - ◆ Walls and ceilings.
 - ◆ Anesthesia gas lines, etc.
 - ◆ Ventilation air returns (vacuumed and cleaned).
 - ◆ All additional areas, not included above.

XI. SAFETY PROCEDURES

1. Engineering controls such as needleless systems in the surgical environment should be evaluated and a system should be in place to routinely review new safety products and equipment and implement if appropriate.
2. All needles, blades and sharps shall be disposed of in appropriate rigid containers, placed for ease of use to employee (e.g., eye-level). Containers shall not be overfilled and should be changed frequently. Sterile needle counter containers may be used for disposing of sharps during a surgical case. Whenever possible, needleless systems will be used.
3. Needles will never be broken, capped, or resheathed.
4. A “no-touch” or hands-free safety zone technique will be employed as a safe method of transferring sharps from one person to the other. This replaces hand-to-hand passing of sharps from one member of the surgical team to another. Modifications may need to be made in special circumstances with the end result being safety for all involved in the procedure.

XII. HOUSEKEEPING IN THE OPERATING ROOM

1. Environmental cleaning guidelines will be the same for all cases and surgical procedures. All cases are considered contaminated.
2. Standard precautions (mask, gown, gloves, etc.) will be used for technicians cleaning the operating rooms.

3. Housekeeping will provide terminal cleaning and all other cleaning as outlined in the policy per the qualified contracted cleaning company.

XIII. BACTERIOLOGICAL MONITORING

1. Culturing is done as deemed necessary by the Infection Control Program Coordinator. Reports are reviewed by the Governing Body at quarterly meetings when necessary.

XIV. PRESSURE DIFFERENTIAL AND AIR EXCHANGE

1. The operating room maintains:
 - A. Adequate air exchanges per hour to remove microorganisms in the room.
 - ◆ At least 15 inside air changes per hour and
 - ◆ Three outside air changes per hour.
 - B. Temperature range of 68°–73°F (20°–23°C).
 - C. Humidity control of 30%–60%.
 - D. Humidity and temperature should be checked by designated surgical staff each morning prior to surgery. Each operating suite has it's own humidifier with a digital read and control.

XV. STERILIZERS

1. Steam
 - A. The preferred method for sterilizing critical surgical instruments, not damaged by heat, moisture, steam, or pressure.
 - ◆ Conventional—250°F or 121°C for 30 minutes.
 - ◆ Pre-vacuum sterilizer—270°–275°F (132°C) for four minutes.
2. “Flash” steam sterilization
 - A. Rapid steam penetration is accomplished by items placed in tray or container. Lack of biological indicators and unwrapped status of instruments raises some concerns for safety. Equipment for flash steam sterilization may be placed at point-of-use for sterilizing clean equipment that cannot be sterilized, packaged, or stored prior to use. Time: Four minutes at 270°F.
 - B. Flash sterilization of implanted surgical devices is performed only when it is unavoidable. Flash sterilization is not utilized for convenience or as an alternative to purchasing additional instruction sets or to save time.
3. ETO (Ethylene Oxide)
 - A. Low-temperature sterilant. Used for moisture-sensitive medical devices. Acceptable for penetrating device lumens.
 - B. 1.5 stages: preconditioning and humidification, gas introduction, evacuation, air washes. Two-and-a-half hours' aeration—eight to 12 hours at 50°-60°C.
4. Other low temperature sterilization systems

- A. Peracetic acid sterilization
- B. Monitoring (Mechanical, chemical, and biological indicators)
 - ◆ Mechanical—cycle time and pressure charts to be kept.
 - ◆ Chemical—indicates that temperature has been met. Color change noted.
 - ◆ Biological—spores used to monitor efficacy.
 - ◆ B. stearothermophilus spores (105) are used to monitor steam sterilization, liquid peracetic acid sterilizer.
 - B. subtilis spores (106) are used to monitor ETO, hydrogen peroxide gas plasma and dry heat.

5. Cleaning and maintenance

- A. Sterilizers will be cleaned each morning prior to first load being run by wiping interior surfaces with a mild detergent solution. After cleaning the surfaces will be rinsed thoroughly with water.
- D. Follow manufacturer's directions for specific cleaning requirements of equipment.