



State of Nevada Sentinel Events Registry

[https://dphh.nv.gov/Programs/SER/Sentinel_Events_Registry_\(SER\)-Home/](https://dphh.nv.gov/Programs/SER/Sentinel_Events_Registry_(SER)-Home/)

Patient Safety Plans 2020

Facility ID	Healthcare Facility Public Name	City	Zip	County	Facility License Type
7783	215 SURGERY CENTER	LAS VEGAS	89148	CL	SURGICAL CENTER FOR AMBULATORY PATIENTS
7871	AFFINITY SURGERY CENTER LLC	LAS VEGAS	89147	CL	SURGICAL CENTER FOR AMBULATORY PATIENTS
5334	AMBULATORY SURGICAL CENTER OF SOUTHERN NEVADA	LAS VEGAS	89113	CL	SURGICAL CENTER FOR AMBULATORY PATIENTS
633	BOULDER CITY HOSPITAL	BOULDER CITY	89005	CL	RURAL HOSPITAL
517	CARING NURSES INC	LAS VEGAS	89120	CL	AGENCY TO PROVIDE NURSING IN THE HOME
5368	CARSON ENDOSCOPY CENTER	CARSON CITY	89703	CC	SURGICAL CENTER FOR AMBULATORY PATIENTS
5213	CARSON TAHOE CONTINUING CARE HOSPITAL	CARSON CITY	89703	CC	HOSPITAL
3986	CARSON VALLEY MEDICAL CENTER	GARDNERVILLE	89410	DO	RURAL HOSPITAL
5086	CENTENNIAL HILLS HOSPITAL MEDICAL CENTER	LAS VEGAS	89149	CL	HOSPITAL
5381	CORONADO SURGERY CENTER	HENDERSON	89052	CL	SURGICAL CENTER FOR AMBULATORY PATIENTS
9330	Cure 4 The Kids Foundation	LAS VEGAS	89135	CL	Outpatient Facility
7579	DESERT PARKWAY BEHAVIORAL HEALTHCARE HOSPITAL LLC	LAS VEGAS	89109	CL	HOSPITAL
641	DESERT SPRINGS HOSPITAL MEDICAL CENTER	LAS VEGAS	89119	CL	HOSPITAL
8696	DESERT VIEW HOSPITAL	PAHRUMP	89048	NY	RURAL HOSPITAL
2128	DESERT WILLOW TREATMENT CENTER	LAS VEGAS	89146	CL	HOSPITAL

652	DINI-TOWNSEND HOSPITAL AT NORTHERN NEVADA ADULT ME	SPARKS	89431	WA	HOSPITAL
4784	DURANGO OUTPATIENT SURGERY CENTER	LAS VEGAS	89113	CL	SURGICAL CENTER FOR AMBULATORY PATIENTS
3275	EVERGREEN RESIDENCE	RENO	89503	WA	RESIDENTIAL FACILITY FOR GROUPS
6389	GOLDEN MANOR	RENO	89521	WA	RESIDENTIAL FACILITY FOR GROUPS
9061	GOLDEN MANOR SERENITY	RENO	89521	WA	HOME FOR INDIVIDUAL RESIDENTIAL CARE
7914	GRACEFUL LIVING	RENO	89521	WA	RESIDENTIAL FACILITY FOR GROUPS
647	HARMON HOSPITAL	LAS VEGAS	89119	CL	HOSPITAL
8436	HENDERSON HOSPITAL	HENDERSON	89011	CL	HOSPITAL
3879	HOLY CHILD RESIDENTIAL CARE HOME	RENO	89503	WA	RESIDENTIAL FACILITY FOR GROUPS
4582	HOLY CHILD RESIDENTIAL CARE IV	RENO	89523	WA	RESIDENTIAL FACILITY FOR GROUPS
645	HUMBOLDT GENERAL HOSPITAL	WINNEMUCCA	89445	HU	RURAL HOSPITAL
9443	Kidney Specialist of Southern Nevada	LAS VEGAS	89129	CL	SURGICAL CENTER FOR AMBULATORY PATIENTS
639	KID'S CO-OP	LAS VEGAS	89130	CL	CENTER
3368	KINDRED HOSPITAL - LAS VEGAS (FLAMINGO CAMPUS)	LAS VEGAS	89119	CL	HOSPITAL
664	KINDRED HOSPITAL - LAS VEGAS (SAHARA CAMPUS)	LAS VEGAS	89146	CL	HOSPITAL
1888	LAKE TAHOE SURGERY CENTER	ZEPHYR COVE	89448	DO	SURGICAL CENTER FOR AMBULATORY PATIENTS
462	LAS VEGAS SURGERY CENTER	LAS VEGAS	89106	CL	SURGICAL CENTER FOR AMBULATORY PATIENTS
682	LIGHTHOUSE ACADEMY	HENDERSON	89052	CL	CENTER
651	MOUNT GRANT GENERAL HOSPITAL	HAWTHORNE	89415	MI	RURAL HOSPITAL
5575	NATHAN ADELSON HOSPICE - HENDERSON	HENDERSON	89015	CL	HOSPICE CARE - PROGRAM OF CARE
2128	NCA LEARNING CENTER	LAS VEGAS	89146	CL	CENTER
653	NORTHERN NEVADA MEDICAL CENTER	SPARKS	89434	WA	HOSPITAL
3082	PAM SPECIALTY HOSPITAL OF LAS VEGAS				HOSPITAL-CLOSED 2020

333	PARK PLACE	RENO	89503	WA	RESIDENTIAL FACILITY FOR GROUPS
5647	PARKWAY SURGERY CENTER AT HORIZON RIDGE	HENDERSON	89052	CL	SURGICAL CENTER FOR AMBULATORY PATIENTS
2147	PARKWAY SURGERY CENTER, LLC	HENDERSON	89074	CL	SURGICAL CENTER FOR AMBULATORY PATIENTS
655	PERSHING GENERAL HOSPITAL	LOVELOCK	89419	PE	RURAL HOSPITAL
655	PERSHING GENERAL HOSPITAL	LOVELOCK	89419	PE	RURAL HOSPITAL
484	RENO ENDOSCOPY CENTER	RENO	89502	WA	SURGICAL CENTER FOR AMBULATORY PATIENTS
466	SAHARA SURGERY CENTER	LAS VEGAS	89102	CL	SURGICAL CENTER FOR AMBULATORY PATIENTS
466	SAHARA SURGERY CENTER	LAS VEGAS	89102	CL	SURGICAL CENTER FOR AMBULATORY PATIENTS
658	SAINT MARY'S REGIONAL MEDICAL CENTER	RENO	89503	WA	HOSPITAL
659	SAINT ROSE DOMINICAN HOSPITALS - ROSE DE LIMA CAMPUS	HENDERSON	89015	CL	HOSPITAL
4576	SAINT ROSE DOMINICAN HOSPITALS - SAN MARTIN CAMPUS	LAS VEGAS	89113	CL	HOSPITAL
2969	SAINT ROSE DOMINICAN HOSPITALS - SIENA CAMPUS	HENDERSON	89052	CL	HOSPITAL
7414	SIERRA MANOR CARE HOME	RENO	89523	WA	RESIDENTIAL FACILITY FOR GROUPS
660	SOUTH LYON MEDICAL CENTER	YERINGTON	89447	LY	RURAL HOSPITAL
4914	SOUTH MEADOWS ENDOSCOPY CENTER	RENO	89521	WA	SURGICAL CENTER FOR AMBULATORY PATIENTS
3641	SOUTHERN HILLS HOSPITAL AND MEDICAL CENTER	LAS VEGAS	89148	CL	HOSPITAL
661	SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES	LAS VEGAS	89146	CL	HOSPITAL
3351	SPECIALTY SURGERY CENTER	LAS VEGAS	89128	CL	SURGICAL CENTER FOR AMBULATORY PATIENTS
3420	SPRING VALLEY HOSPITAL MEDICAL CENTER	LAS VEGAS	89118	CL	HOSPITAL
5309	STONECREEK SURGERY CENTER	LAS VEGAS	89118	CL	SURGICAL CENTER FOR AMBULATORY PATIENTS
662	SUMMERLIN HOSPITAL MEDICAL CENTER	LAS VEGAS	89144	CL	HOSPITAL

7591	SUN VALLEY SURGERY CENTER	NORTH LAS VEGAS	89032	CL	SURGICAL CENTER FOR AMBULATORY PATIENTS
639	SUNRISE HOSPITAL AND MEDICAL CENTER	LAS VEGAS	89109	CL	HOSPITAL
9677	SUNSET PAIN SURGERY CENTER	LAS VEGAS	89148	CL	SURGICAL CENTER FOR AMBULATORY PATIENTS
461	SURGERY CENTER OF RENO	RENO	89503	WA	SURGICAL CENTER FOR AMBULATORY PATIENTS
8065	TAHOE PACIFIC HOSPITALS - NORTH				HOSPITAL-CLOSED 2020
666	UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA	LAS VEGAS	89102	CL	HOSPITAL
667	VALLEY HOSPITAL MEDICAL CENTER	LAS VEGAS	89106	CL	HOSPITAL
1830	WILDCREEK SURGERY CENTER	SPARKS	89431	WA	SURGICAL CENTER FOR AMBULATORY PATIENTS
670	WILLIAM BEE RIRIE HOSPITAL	ELY	89301	WP	RURAL HOSPITAL

PARK PLACE
SAFETY POLICY

POLICY

It is the intent of management to have a safe work environment for all employee's. We expect all staff members to be educated in working safely, and to practice what they have learned.

We as management will see to it that;

- All employees who sustain injuries will be treated with dignity and respect.
- All employees will be given the best practical medical care in order to speed recovery and return to work.
- The rapid and efficient return of the worker is the goal of the recovery effort.
- All injuries will be treated as legitimate unless investigation reveals otherwise.
- Safety training will be a part of new and continuing employee orientation and will be conducted on site by the Supervisor of each facility. Training must be documented for the employee file. If turnover or work rotation is high, it is important to maintain training records on site. These records will be retained for three years.
- Each employee has the responsibility for their own safety, and the safety of their fellow employees and the residents of the facility as well. It is only by each employee becoming familiar with the hazards of their job and doing what is necessary to insure their safety, that our company can achieve the safe working conditions deserved by all its members.

Policy/Procedure

Section: Wellness Services

Subject: Incident Reporting

Policy Number: 8D

POLICY:

It is the policy of this facility to ensure all incidents/accidents occurring on our premises are investigated and reported to the administrator.

PROCEDURE:

1. Reporting of Incidents/Accidents:

- A. Regardless of how minor an accident or incident may be, including injuries of an unknown source, it must be reported to the Administrator or designee, and an Incident Report Form must be completed on the shift that the accident or incident occurred;
- B. Employees witnessing an accident or incident involving a resident, employee, or visitor, must report such occurrence to his or her immediate supervisor as soon as practical. Do not leave an accident victim unattended unless it is absolutely necessary to summon assistance; and
- C. The Wellness Director must be informed of all accidents or incidents.

2. Assisting Incident/Accident Victim

Should you witness an accident, or find it necessary to aid an accident victim, the following steps are to be initiated where appropriate:

- A. Render immediate assistance. Do not move the victim until he/she has been examined for possible injuries;
- B. If possible, move the injured to the a private area, or, if it is a resident in his/her room, move the resident to his or her bed; and
- C. If assistance is needed, summon help. If you cannot leave the victim, ask someone to call for help.
- D. If deemed necessary, call 9-1-1.

3. Investigation and Follow up

- A. The Administrator or Wellness Director will follow up with any investigation needing to occur to enable completion of the incident report.
- B. Should the incident/accident meet the requirements of reporting to the State Department of Health, the Administrator or Wellness Director will follow regulations.

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SURGERY CENTER OF RENO

Section Appendix Medication Management

Policy: Medication Management

Subject: Adverse Drug Reaction

Effective Date: 2-06

Review / Revision: 2-07, 2-08, 4-09, 3-10, 3-11, 3-12,
3-13, 3-14, 3-15, 3-16, 3-17, 3-18, 3-19, 3-20

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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 Medication Management

Policy: Medication Management Plan

Subject: Medication Management Plan

Effective Date: 2-06

Review / Revision: 2-07, 2-08, 4-09, 3-10, 3-11, 3-12, 3-13,
3-14, 3-15, 3-16, 3-17, 3-18, 3-19, 3-20

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POLICY:

The SCOR has a Medication Management Plan to promote patient safety, implement the federal and state regulations for medication procurement, distribution, prescribing, administering, storage of medications, and documentation. The SCOR has an agreement with a licensed registered pharmacist for his/her consulting services.

PROCEDURE:

- A. The Consulting pharmacist will perform and include but not limited to the following:
1. Monthly audit visits to include medications use and documentation, narcotic audit fallouts with chart audit, record tracking of all medication transactions so receipt and disposition of any drug may be readily traced, inspection of medication as noted on inspection form, outdated medication, inventory and all matters pertaining to the use of drugs in SCOR. These visits must be documented.
 2. Monthly evaluation of the effectiveness of the Plan from audits.
 3. Biennial (every two years) inventory audit of DEA controlled substances.
 4. Help establish and review policies and procedures which are consistent with the federal and State policies and procedures for storage and dispensing of drugs to patients in SCOR and for the destruction of expired or contaminated drugs at SCOR.
 5. Monitor completeness of annual competencies on IVCS with verification of aseptic technique, on Malignant Hyperthermia, and other pertinent drug topics.
 6. At minimum, annually reviews the drug formulary of SCOR.
 7. Present and assist with the development and implementation of patient safety activities such National Patient Safety Goals for Medication Management.
 8. Assist to secure medication resources as needed and recommends needed reference sources.
- B. The MEC and GB will identify in writing the Medication Management Nurse. The Medication Management Nurse is responsible for the control of dangerous drugs and controlled substances in the absence of a full time pharmacist at SCOR. The Medication Management Nurse is also responsible to report to the MEC and GB any recommendations or needed implementation the pharmacist makes in relation to the results of audits or the standards of safety for any matter pertaining to the use of drugs.
- C. The licensed nursing staff will abide by SCOR policies and procedure for the safe management of medications and report any adverse reaction(s) a patient experiences.

Who Should Know This Policy

- | | | |
|---|---|--|
| <input checked="" type="checkbox"/> All Licensed Nurses | <input checked="" type="checkbox"/> Clinical Managers | <input checked="" type="checkbox"/> Medical Director |
| <input checked="" type="checkbox"/> Administrator | <input checked="" type="checkbox"/> 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: Medication Management Plan

SURGERY CENTER OF RENO

Section: Appendix OSHA

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

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

Effective Date: 2-06

**Review / Revision: 2-07, 2-08, 2-09, 3-10, 3-11, 3-12, 3-13,
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Attachment A Methods of Compliance

A. Universal Blood and Body Fluid Precautions:

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

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

B. Engineering and Work Practice Controls:

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

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

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

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

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

SURGERY CENTER OF RENO

Section: Appendix OSHA

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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

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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

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

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

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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

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.

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- 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.
 - 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.

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- 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. 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.

SURGERY CENTER OF RENO

Section: Appendix OSHA

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

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

Effective Date: 2-06 Review / Revision: 2-07, 2-08, 2-09, 3-10, 3-11, 3-12, 3-13, 3-14, 3-15, 3-16, 3-17, 3-18, 8-18, 3-19, 3-20

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4. Surgical caps or hood and/or shoe covers will be worn in instances when gross contamination with blood or body fluids can reasonably 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.

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 compromised.

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..

SURGERY CENTER OF RENO

Section: Appendix OSHA

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

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

Effective Date: 2-06

Review / Revision: 2-07, 2-08, 2-09, 3-10, 3-11, 3-12, 3-13,
3-14, 3-15, 3-16, 3-17, 3-18, 8-18, 3-19,
3-20

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

2. Workers compensation steps:

a) Depending on severity of injury:

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

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

c) Provide injured worker with information on carrier

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

Party handling workers' compensation claims	ZURICH CLAIMS SERVICES
Business Address	P.O. Box 49547 Colorado Springs, CO 80949-9537
Business Phone	800-987-3373
Effective Date	11/17/2018
Termination Date	11/17/2019
Policy Number	WC 005473353-07
Employer's FEIN	770615561

d) Contact MedHQ to file First Report of Injury

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

Who Should Know This Policy

☒ All Employees ☒ Clinical Managers ☒ Administrator ☒ Medical Director

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

☒ Governing Board ☒ Administrator ☒ Medical Director ☒ Clinical Managers

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

SURGERY CENTER OF RENO

Section: Appendix OSHA

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

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

Effective Date: 2-06

**Review / Revision: 2-07, 2-08, 2-09, 3-10, 3-11, 3-12, 3-13,
3-14, 3-15, 3-16, 3-17, 3-18, 8-18, 3-19,
3-20**

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Date: _____ Employee Signature: _____

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

SURGERY CENTER OF RENO

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

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

Effective Date: 2-06

Review / Revision: 2-07, 2-08, 2-09, 3-10, 3-11, 3-12, 3-13, 3-14, 3-15, 3-16, 3-17, 3-18, 3-19, 3-20

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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, 3-18, 3-19, 3-20

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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, 3-18, 3-19, 3-20

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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, 3-18, 3-19, 3-20**

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

Name of employee (Print), Job Title

Date

Signature of employee

Date

Signature of Director, Clinical Manager or Administrator

Date

SURGERY CENTER OF RENO

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

Subject: Bloodborne Pathogens Exposure Plan, Attachment D:

Sharps Injury Log

Effective Date: 2-06

Review / Revision: 2-07, 2-08, 2-09, 3-10, 3-11, 3-12, 3-13, 3-14, 3-15, 3-16, 3-17, 3-18, 3-19, 3-20

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Exposure to Blood/Body Fluids

Employee:

Name, Last: _____

First: _____

Middle: _____

Gender: ☐ F ☐ M ☐ Other

Date of Birth: ____/____/____

Work Location: _____

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

Section I – General Exposure Information

1. Date of exposure: ____/____/____

2. Number of hours on duty: _____

3. Time of exposure: _____ ☐ AM ☐ PM

6. Location where exposure occurred: _____

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

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

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

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

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

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

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

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

☐ Blood/blood products

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

☐ Visibly bloody

☐ Not visibly bloody

☐ Tissue

☐ Other (specify): _____

☐ Unknown

☐ Body fluids: (Check one)

☐ Visibly bloody

☐ Not visibly bloody

If body fluid, indicate one body fluid type:

☐ Amniotic

☐ Saliva

☐ CSF

☐ Sputum

☐ Pericardial

☐ Tears

☐ Peritoneal

☐ Urine

☐ Pleural

☐ Feces/stool

☐ Semen

☐ Other (Specify): _____

☐ Synovial

☐ Vaginal fluid

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

☐ Hand/finger

☐ Eye

☐ Arm

☐ Leg

☐ Foot

☐ Mouth

☐ Nose

☐ Other (specify): _____

Section II – Percutaneous Injury

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

2. Depth of the injury: (Check one)

- | | |
|---|---|
| <input type="checkbox"/> Superficial, surface scratch | <input type="checkbox"/> Deep puncture or wound |
| <input type="checkbox"/> Moderate, penetrated skin | <input type="checkbox"/> Unknown |

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

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

Hollow-bore needle

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

Suture needle

☐ Suture needle

Other solid sharps

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

Glass

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

Plastic

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

Non-sharp safety device

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

4. Manufacturer and Model: _____

Exposure to Blood/Body Fluids

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

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

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

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

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

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

Obtaining a blood specimen percutaneously

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

Giving a percutaneous injection

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

Performing a line related procedure

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

Performing surgery/autopsy/other invasive procedure

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

Performing a dental procedure

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

Handling a specimen

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

Other

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

Exposure to Blood/Body Fluids

Page 4 of 7

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

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

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

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

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

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

Exposure to Blood/Body Fluids

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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)

☐ End-stage AIDS
☐ AIDS
☐ Acute HIV illness

☐ Other symptomatic HIV, not AIDS
☐ HIV infection, no symptoms
☐ 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? ☐ Y ☐ N ☐ U

Taken: ☐ Y ☐ N ☐ U (If Yes, complete PEP form)
2. HBIG given? ☐ Y ☐ N ☐ U Date administered: ____ / ____ / ____
3. Hepatitis B vaccine given: ☐ Y ☐ N ☐ U Date 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, 3-18, 3-19, 3-20

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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:

1st Dose

2nd Dose

3rd 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, 3-18, 3-19, 3-20**

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

E. INFECTION SURGERY CENTER

☐ Infection/Nosocomial confirmed

F. EQUIPMENT/PRODUCT-RELATED INCIDENT

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

LOT # _____

EQUIPMENT TYPE: _____ MODEL #: _____

MANUFACTURER: _____ SERIAL #: _____

G. MISCELLANEOUS

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

H. MEDICAL TREATMENT

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

Physician Name: _____

☐ Notified Date: _____ Time: _____

Address: _____

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

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

J. RELATED FACTORS (check all that apply)

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

K SEVERITY LEVEL

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

WITNESSES

Name: _____ Name: _____

EMPLOYEE PREPARING REPORT

Name: _____ Date/Time: _____ Title: _____

L. HOW COULD THIS EVENT HAVE BEEN PREVENTED?

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

Signature: _____ Title: _____

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

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

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

Administrator Signature: _____ Date/Time: _____

Medical Director: _____ Date/Time: _____

Governing Board: _____ Date/Time: _____

SURGERY CENTER OF RENO

Section 5.2

Policy: Quality Management and Improvement

Subject: Incident reports

Effective Date: 2-06

Revised: 2-08, 10-17

Page 1 of 5

**Reviewed: 2-07, 2-09, 3-10, 3-11, 3-12, 3-13, 3-14, 3-15,
3-16, 3-17, 3-18, 3-19, 3-2020, 11-20**

POLICY:

The SCOR uses the Occurrence Reports, also referred to Incident reports throughout this Manual, as a method to record an adverse occurrence, and to relay this information to the immediate Supervisor, Administrator, or to Risk Management for action as needed. This allows early intervention and the potential to eliminate, reduce, and manage any subsequent claims or lawsuit. This policy establishes procedures for reporting and documenting unexpected occurrences or unusual events on the Occurrence Report.

The definition of an incident includes any clinical or non-clinical occurrence that is not consistent with the routine care or operation of the organization. Incidents may involve patients, visitors, employees, and medical or dental staff members.

The definition of an adverse incident includes:

- a) 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.
- b) Any process variation for which a recurrence carries a significant chance of a serious adverse outcome.
- c) 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 of acceptable risks associated with the provision of care and service for a patient.
- d) All events involving reactions to drugs and materials.
- e) Circumstances or events that could have resulted in an adverse event (i.d., near-miss events)

The Occurrence Report is meant to be used not as a punitive process but rather to improve the quality of services provided at SCOR:

- 1. Improve patient, visitor, and employee safety.
- 2. Identify potential losses and claims.
- 3. Documents the facts on a timely basis.
- 4. Provides early intervention if corrective action is needed.
- 5. Collects data for detecting trends, patterns, and needed system or process changes.
- 6. Review and identify potential causes of such occurrences and instituting corrective actions as deemed necessary in order to minimize and/or eliminate the potential for injury to patients, visitors, and employees.

PROCEDURES:

SURGERY CENTER OF RENO

Section 5.2

Policy: Quality Management and Improvement

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3-16, 3-17, 3-18, 3-19, 3-2020, 11-20**

- A. Responsibility: Occurrence Reporting is the responsibility of all employees, in all areas, in order to promote patient safety, prevent employee injury, and to improve patient care and staff performance.
- B. Reportable occurrences are contained in the definition of an adverse occurrence. Examples: include but are not limited to the following:
1. Safety related incidents, where patient, visitor, or staff, such as slips and falls- any time a person falls to the ground whether it is an assisted (controlled) descent or unexpected (uncontrolled) event.
 2. Diagnosis or treatment, procedure variance, communication related occurrences:
 - a. Procedure performed without informed consent
 - b. A procedure was performed other than the procedure that was consented.
 - c. Incorrect handling of specimen according to SCOR's policies and procedures.
 - d. Surgery/anesthesia related errors of wrong patient, wrong surgery site.
 - e. Unscheduled return to the OR.
 3. Medication variance, drugs and intravenous related incidents:
 - a. Medication error resulting from wrong drug, wrong dose, wrong patient, wrong route, or wrong time to ordered medication. This includes "near misses".
 - b. If medication is given and patient is documented as having an allergy to that medication.
 4. Equipment/Product Related Incident:
 - a. Malfunction in equipment or product that causes or has the potential to cause patient/staff injury.
 - b. Improper product or equipment procedure (i.e. not following policy for proper sterilization).
 5. Exposures:
 - a. Stick from contaminated sharps to any employee, patient, or physician.
 - b. Eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious material to any employee, patient, or physician.
 6. A dissatisfied patient or family member.
 7. Infection
 8. Fire or thermal injury
 9. Refusal of medical treatment
 10. Referral to ER or back to surgeon on post-op call
 11. Cancellation on date of service
 12. Transfer to higher level of care
 13. Miscellaneous:
 - a. Incidents involving lost, damaged, or stolen property of visitors, patients, staff, or SCOR.
 - b. Any allegation of patient abuse by patient, employee, family, or visitor.

SURGERY CENTER OF RENO

Section 5.2

Policy: Quality Management and Improvement

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3-16, 3-17, 3-18, 3-19, 3-2020, 11-20**

- c. Being struck by an object such as doors, thrown objects, or scraping against another object.
- d. Non-compliance of procedure by co-worker, physician, patient, or visitor.
- e. Any allegation of discrimination, sexual misconduct, or workplace violence by co-worker, physician, patient, or visitor.
- f. AMA or elopement
- g. Any variant from normal patient care or business operations.

C. Elements of Occurrence Report:

- 1. Name of person affected.
- 2. Date, time, location.
- 3. Type of occurrence as listed in the specific headings.
- 4. Comments about the occurrence with factual descriptions that may include statements from the potentially injured or injured person.
- 5. MD notified and response if applicable.
- 6. List of witness.
- 7. Name of employee completing report.
- 8. Name of the supervisor receiving the report.
- 9. Classification of Priority of action by the supervisor.

D. Completion of Occurrence Report, Actions to take

- 1. Notify immediate Supervisor or Administrator of occurrence.
- 2. Obtain Occurrence Report form from designated area. Accurately document the facts as soon as possible. If time constraints are present, immediate notification of occurrence may be verbal with written completed Occurrence Report as the final approved documentation. The Supervisor will receive the report and submit the report to the Administrator as soon as possible.
The Administrator will prioritize the occurrence and take immediate actions as necessary. The Occurrence Report is submitted to the QI Committee for review and further action as necessary.
- 4. If the incident involves exposure to hazardous chemicals, utilize the associated SDS for clean up and use hazardous chemical spill kit.
- 5. If the incident involves exposure to biohazardous fluids, follow the policy and procedure for this exposure and use biohazardous fluid clean up kit as needed.
- 6. Notify MD of occurrence if applicable and note MD's remarks if any.
- 7. Document pertinent details regarding patient occurrence/treatment in the patient's medical record.
 - a. Document only the facts of the occurrence and the actions taken if any. Do not make reference in the patient's medical record that an Occurrence Report was completed as the Occurrence Report is not part of the medical record.

SURGERY CENTER OF RENO

Section 5.2

Policy: Quality Management and Improvement

Subject: Incident reports

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3-16, 3-17, 3-18, 3-19, 3-2020, 11-20

E. Treatment of Occurrence Report:

1. Secure the Occurrence Report in the appropriate folder, separate from the patient's medical record.
2. Information contained in the Occurrence Report is confidential and distribution will be on a need-to-know basis.
3. The Occurrence Report will include the statement, "This form is confidential and is not a part of the patient's record. The Report is not subject to subpoena or discovery and not subject to inspection by the general public."

F. Actions after occurrence take place:

1. Assess the person and provide first aid care needed.
2. Notify the physician, immediate Supervisor or Administrator responsible for Risk Management activities.
3. Document the clinical assessment, any physician's orders, and treatment in the patient's medical record.
4. Record the comments from person(s) or witnesses involved.
5. Impound any equipment or supplies involved in the event; do not return to manufacturer. If needed, an independent third party will perform the testing.
6. If a patient or family member reports an occurrence after the date of the occurrence, document the time of the notification and the reason for the delay.
7. Do not discuss the event with the media or any other outsider.
8. Limit documentation of the response to the occurrence to:
 - a. Who assisted the person involved in the occurrence.
 - b. Name of the Supervisor, Administrator, or Risk Management notified.
 - c. Name, date, and time physician's notified,
 - d. Extent of any injury; if applicable, completion of transfer packet if patient transferred to hospital.
 - e. Parties included in the disclosure conversation as well as the content of the conversation.

REFERENCE: AAAHC Standards, *Quality Management and Improvement*, Section 5.2.

Who Should Know This Policy

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

SURGERY CENTER OF RENO

Section 5.2

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3-16, 3-17, 3-18, 3-19, 3-2020, 11-20**

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

- ☒ Board of Directors
- ☒ Administrator
- ☒ Medical Director
- ☒ Clinical Managers
- ☒ Director of Nursing

Effective as of: _____

Quality Improvement Plan

SURGERY CENTER OF RENO, LLC

Approved by the Medical Staff

By: _____ Dated: _____

Medical Director

Adopted by the Governing Board of Directors

By: _____ Dated: _____

President of the Board

Surgery Center of Reno

Quality Improvement Plan

Purpose:

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

QI Indicators to be monitored will include:

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

Quality Improvement Issues:

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

Routine monitoring will also include:

Emergency Cart / Defibrillator checks

Refrigerator and Fluid warmer temperature checks.

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

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, such as other Regent 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 Regent 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. Infection Control and Safety Officers will report directly to Quality Improvement Coordinator. 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:

Administrator:

QI Coordinator

Business Office Manager:

OR Manager:

Clinical Manager:

Ad HOC members:

Pharmacy Consultant:

Laboratory Consultant:

Environmental Consultant:

Housekeeping Services:
Medical Executive Committee:
Radiology Consultant:
Safety Officer:
Infection Control Nurse:

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 affect 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

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 annually

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 Regent Administration.

2. OPPORTUNITIES ENCOUNTERED ON PATIENT FOLLOW-UP

Tool:

Post-Operative Nursing Follow-up Call

All patients will be called by an R.N. within two working days after surgery. If the patient is unable to be reached, a postcard will be sent by the third working day. Anytime a patient is referred to their physician for

a post-operative complication an incident report will be given to the Administrator. Post-op follow up (unable to reach card) will be mailed to each patient that was unable to be reached for their follow up call.

Post-operative Complication Log

Per incident 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: Incident Report

A. Incident report

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. An incident report will be completed for any unanticipated returns to the OR, and injury/deaths.

B. Transfers

An incident report will be created to monitor transfers to a hospital. The person caring for the patient will enter the information on the incident report. The QI Committee will monitor and review all incident reports.

Percentage Monitored:

1. Incident reports – 100%.
2. Transfer Log – 100%.

Frequency:

1. Incident reports – monthly
2. Transfer Log – monthly

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 meetings 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.

Reported quarterly to Regent QI indicators by Administrator.

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. Incident Report
All incidents involving medication administration will be submitted to the Q.I. team for review.
- D. Medication Error
All medication incidents will be recorded according to type for monitoring, education and risk management purposes.
- E. Adverse Reaction
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. Incident Report – as needed.
- D. Medication Error – as needed
- E. Adverse Reaction – 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. Reported quarterly to Regent QI indicators by Administrator.

5. **CANCELLATION ON THE DAY OF SURGERY**

Tool:

A. Same Day Cancellation

This will be documented on an incident 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

A summary report with the reason for cancellation is available through HST and ASC webQI. 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. Reported quarterly to Regent QI indicators by Administrator.

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 identify chart components.

B. Incomplete Health Record Report

This report is available through HST. It is reviewed monthly. Any critical issues will be taken to MEC and the Board.

Percentage Monitored:

1. Daily Chart Review – 100% - all patients
2. Incomplete Health Record Report – 100% of all delinquent charts.

Frequency:

1. Daily Chart Review – monthly
2. 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. Incident 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. Incident 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 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. Reported quarterly to Regent QI indicators by Administrator.

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 & Urine Hcg Monitoring Form
Monitoring of the form will be done by the Q.I. team quarterly.
- 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 & Urine Hcg Monitoring results- quarterly
- B. Pathology Review Checklist - quarterly
- C. 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. Incident 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
 - i. Employee Exposure
 - ii. Patient consent

Percentage Monitored:

100% of all employee exposures

Frequency:

- A. Incident report ongoing
- B. BBP exposure report ongoing
- C. Reported quarterly to Regent QI indicator by Administrator.
- D. 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	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	

QUALITY IMPROVEMENT, RISK MANAGEMENT, AND PATIENT SAFETY PLAN

LAS VEGAS SURGERY CENTER 2021

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

- Improving patient safety and reducing risk to patients which includes, but not limited to medication and radiation safety, safe quality care and reducing risk of injury to patients and staff. This will be accomplished through true learning from errors.
- 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 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 agencies, accrediting bodies (state, CMS, (AAAHC, TJC) and collaboration with nationally recognized quality organizations (ASCQC, AHRQ) through the identification of opportunities to improve patient care, demonstration of appropriate action taken, and follow up on the effectiveness of action taken.

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

- Performance Improvement Processes
- Quality studies
- Risk Management Strategies
- Patient Safety Initiatives

- Infection Control Strategies
- Medication Safety Strategies
- Radiation Safety Initiatives

Goals

- Achieve a culture of patient safety that is a common, consistent practice as evidenced by maintenance of complications at or below the benchmark.
- Instill a sense of ownership at all levels of the organization through quarterly comparison of center performance with other HCA ambulatory surgery centers
- Commit to zero patient harm with emphasis on zero wrong site procedures, zero retained surgical items and zero patient burns
- Identification of Quality Improvement opportunities with completion of a formal quality study that results in sustained process improvement
- Improve identification of opportunities for improvement by increasing the reporting of medication errors and close calls. Analyze these reports for trends and take action which may include the performance of a quality study.

HCA Patient Safety Organization (PSO), LLC

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

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

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

patient safety and quality care. All information submitted will remain confidential within the PSO.

Quality Improvement Plan

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

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

Risk Management and Patient Safety

Definitions of Potential Risk Issues

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

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

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

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

Adverse Event:

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

Any injury caused by medical care. Examples:

- pneumothorax from central venous catheter placement;

- anaphylaxis to penicillin;
- postoperative healthcare acquired wound infection;

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

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

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

Serious Safety Event

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

- Death
- Permanent harm
- Severe temporary harm (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).

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

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

to lapses in verification of patient identification, but caught prior to the procedure (Source: VA Patient Safety Program).

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

Risk Management

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

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

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

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

- The Quality Committee will serve as the oversight committee for Patient Safety, Risk Management, and Infection Control. Medication Safety and Radiation Safety fall within a subsection of the Quality Committee and will be addressed as indicated.

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

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

Medication Safety

A designated regional 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 medication safety practices.
- Adhering to strict processes for ordering, administration and tracking of controlled substances.
- Collaborating with the Center on choice of pharmaceutical vendors and formularies
- Collaborating with the Center on policy review and development
- Participating in review of any medication error or diversion
- Assuring controlled substance ordering and monitoring is in accordance with state and federal regulations

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

Radiation Safety

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

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

- Educate staff on radiation safety practices

Infection Control

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

Peer Review Peer Review is overseen by the medical staff and occurs in accordance with requirements outlined by AAAHC, CMS, and other regulatory agencies. The Ambulatory Surgery Center assists in the identification of and tracking of quality improvement and peer review on medical staff members and allied health professionals. Peer review activities including the review of medical staff related variances, trends and other data are reported up through the MEC and Governing Board as outlined in the Medical Staff Bylaws, or equivalent. A summary of a provider's peer review activity is reviewed at the time of rec-credentialing or more frequently if needed.

Confidentiality

All quality improvement, peer review activities and data are considered confidential. Requests by outside sources for QI, Risk management, Peer Review or credentialing informational 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/Radiation Safety/Infection Control designees and Clinical Managers. Leaders foster quality improvement through planning, educating, setting priorities, providing support such as time and resources, and empowering staff as appropriate.

Governing Board/Medical Executive Committee

The Board has the ultimate authority and accountability for the quality and risk programs to ensure that the quality of patient care is provided in an efficient, safe, timely and cost-effective manner. The Governing Body provides support for the improvement strategies and delegates to the Medical Executive Committee and leadership 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 are 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 Governing Board is ultimately responsible for all quality, risk and patient safety activities. The Governing Board has delegated the Administrator, in collaboration with the V.P. of Operations to oversee all activities and provide reports to the Governing Board. Delegated qualified personnel are assigned to support the proper functioning of quality improvement and risk management activities. Administration will participate in performance improvement activities, rounding, and in the assignment of priorities to the functions identified by performance improvement activities.

Key Priorities:

- 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 review and current with regulatory standards (CMS,CDC, state and AAAHC)

Key Activities:

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

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

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

Key activities:

- Establish and oversee ongoing measurement, periodic review, and improvement of key processes, including the review of identified Quality Indicators. Oversee actions for improvement of Quality Indicators as needed

- Assist in identifying opportunities for improvement and participate in QI studies.
- Participate in Ambulatory Surgery Division quality, risk and patient safety initiatives including Best Practices
- Communicate relevant activities, as necessary, to the staff.
- Support a system that builds and reinforces a non-punitive culture for reporting and reducing errors
- Serve as a resource for patient safety/regulatory issues and for the regulatory component of accrediting agencies.
- Provide periodic reports on quality improvement activities to Medical Executive Committee and Governing Board.
- Educate staff on quality, risk and patient safety activities

Quality Studies

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

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

Staff Education

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

Ongoing Measurement

The Quality/Risk Manager in collaboration with the Facility Administrator and Medical Director oversees ongoing measurement.

Design of New Processes

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

- The organization's mission, vision and strategic plans;
- Patient and community needs;

- Information about performance and outcomes of the process (including information from reference data bases).
- Current evidence based practice and research
- Current regulatory standards

Periodic Assessment and Improvement

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

Assessment may be triggered for any of the following:

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

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

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

REFERENCED ORGANIZATIONS

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

AHRQ – Agency for Healthcare Research and Quality, <https://www.ahrq.gov/>

AHRQ – Agency for Healthcare Research and Quality, <https://www.ahrq.gov/>

ASC QC- Ambulatory Surgery Center Quality Collaboration,

<https://www.ascquality.org/home>

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

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

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

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

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

SMDA-Safe Medical Device Act,

<https://www.fda.gov/MedicalDevices/Safety/ReportaProblem/default.htm>

VA Patient Safety PROGRAM, VA National Center for Patient Safety,

<https://www.patientsafety.va.gov/>

WHO- World Health Organization, WHO.Int

ONGOING QUALITY AND RISK MANAGEMENT PERFORMANCE MEASUREMENTS (as applicable)

Performance Measure	Data Source	How Calculated	Frequency
**Patient Satisfaction	Press Ganey/Postop Call	Percent	Quarterly
OMP Completion	OMP	Percent	Quarterly
**Patient Grievances	Grievance Process	Raw Number	Quarterly
Complications			
**Retained Foreign Body	Variance Reports	Raw number	Quarterly
**Wrong site, patient, procedure	Variance Reports	Raw number	Quarterly
**Direct Admits	Variance Reports	Rate	Quarterly
**Indirect Admits	Variance Reports	Rate	Quarterly
**Post Op DVT/PE	Variance Reports	Raw number	Quarterly
**Mortality within 7 days r/t procedure	Variance Reports	Rate	Quarterly
**Falls	Variance Reports	Rate	Quarterly
**Burns	Variance Reports	Raw number	Quarterly

Performance Measure	Data Source	How Calculated	Frequency
**Unplanned Vitrectomy	Variance Reports	Rate	Quarterly
**Loss of Vision	Variance Reports	Raw number	Quarterly
**TASS	Variance Reports	Raw number	Quarterly
**Medication Errors	Variance Reports	Rate	Quarterly
**Normothermia			
Variations in expected performance	Variance Reports	Raw number	Quarterly
Infection Control			
**Surgical Site Infection	Variance Reports, Post op letters	Rate	Quarterly
Physician Response	Survey	Percentage	Quarterly
**Hand Hygiene Compliance	Visual Observations	Percentage	Quarterly
**Antibiotic Administration	Chart Review, SQI	Percentage	Quarterly
**IUSS use	CSP Data Tracking	Percentage	Quarterly
**Additional Indicators as identified via the ICRA	ICRA	Variable	quarterly
Medical Record Review			
Medical Record Delinquency	Chart Review	Percentage	Quarterly
**Medical Chart Audit Results – components TBD based on variances	Chart review	Percentage	Quarterly
Radiation Safety			
**Dosimetry Badge w/in Range	Radiation tracking system	Raw number	Quarterly
Radiation Time – average	Radiation tracking system	Raw number	Quarterly
Training completion per policy	Radiation tracking system	Percentage	quarterly
High Volume / High Risk Indicators			
Incomplete / Aborted colonoscopy	Chart review / Variance reports	Rate	Quarterly
Withdrawal Rate	Provation report	Time	Quarterly
Storage, Administration, Inventory, Diversion	Pharmacy Audit, Administration Record Review	Raw Data	Quarterly
Patient Flow			
On time start and flow of surgical cases	Manual data collection	Average time	Quarterly
Turn around time	Manual data collection	Average time	Quarterly
Case Cancellations – same day	Manual data collection	Raw number	Quarterly
Pre-op Care			
Pre op instructions	Manual data collection	percentage	Quarterly
DVT assessment – including use of	OMP and Manual Chart	Percentage	Quarterly

Performance Measure	Data Source	How Calculated	Frequency
SCE when indicated	Review		
Fall Assessment – completion and implementation of prevention activities	OMP and Manual Chart Review	Percentage	Quarterly
Intra-Op Care and Processes			
Time Out/Correct Site Verification process	Visual observations and chart review	Percentage	Quarterly
Blood Utilization	Chart Review, Lab data	Raw number	Quarterly
Resuscitation			
Code Blue – occurrence and results	Code Forms and Variance reports	Raw number	Quarterly
Malignant Hyperthermia – occurrence and results	Code Forms and Variance reports	Raw number	Quarterly
Diagnostic Results			
Pre and Post Op diagnosis agreement	Chart review	Percentage	Quarterly
Specimen results received	Lab reports, manual logs	Percentage	Quarterly
Medication Usage			
Medication Reconciliation – completion per policy	Chart review	Percentage	Quarterly
Performance of independent double checks – per policy	Visual observations	Percentage	Quarterly
Controlled substance audit results	Manual data collection	Percentage	Quarterly
Antimicrobial Stewardship			
Life Safety			
**Surveillance Rounds – results	Monthly Surveillance Rounds	Percentage / raw number	Quarterly
Recalls – compliance with process	Monthly data collection	Raw number	Quarterly
**Drill – completion / results (fire, infant, provider, MH etc.)	Drill completion forms	Raw number	Quarterly

**** indicates that the Quality Indicator is required data collection. Quality Indicators without an asterisk are optional based on center need**

QI/RISK GOALS for 2021

Market Goals:

Risk Assessment for Infection Surveillance, Prevention and Control Programs in the ASD.

CENTER SPECIFIC GOALS:

-Culture of Safety—Conduct daily huddles to review quality, risk and operational issues. Utilize a facility designed huddle board. On a weekly basis conduct safety rounds throughout the ASC to confirm established expectations are being met.

-Medical Director Engagement—Must attend 6 virtual Medical Director Forums. If the Medical Director is unable to attend a live forum, the recorded session must be viewed within 30 days. These must be shared with ASC employees and medical staff in a timely manner.

-Promote a Learning Organization-Administrator and relevant staff attendance on 3 learning calls with lessons learned shared with staff within 45 days of call.

-Continue to decrease radiation exposure in Pain cases.

Sahara Surgery Center

SAFETY MANAGEMENT PROGRAM 2020

POLICY AND PROCEDURE

Policy:

It is the policy of the Sahara Surgery Center to provide a physical environment free of physical hazards for the patients, employees and visitors. In addition, monitor those activities that have the potential to minimize the possibility or risk associated with those physical hazards. The Governing Board has final oversight of the safety program/plan

PURPOSE:

The purpose of the safety management program is to establish, organize, implement, monitor, and evaluate an effective program designed to provide a physical environment free of hazards and to manage staff activities to reduce the risk of human injury. Safety is an ongoing process and each employee and medical staff provider should be constantly aware of providing a safe environment for themselves, patients and visitors.

GOALS AND OBJECTIVES

The objectives and goals of the safety management program are to reduce and eliminate unnecessary hazards within the facility by:

1. Identification of individuals who will be responsible for the overall coordination, direction, and monitoring of safety activities within the Sahara Surgery Center.
2. Establishing a procedure whereby any Sahara Surgery Center employee or medical staff member will be encouraged to identify and present problems, deficiencies, and ideas for review and analysis in an effort to improve overall safety at Sahara Surgery Center.
3. Assuring the various problems and opportunities to improve safety are objectively assessed and that performance indicators designed to achieve an optimum level of safety are monitored.
4. Assuring that the safety activities are properly documented to indicate findings, conclusion, actions, recommendations, and evaluation of the effectiveness of the action that was taken.
5. Providing for a method of communication that allows for effective collection and dissemination of information relating to safety activities.
6. Establishing and maintaining an ongoing mechanism for monitoring the resources necessary to ensure the safety of the patients, staff, visitors, building, grounds, and internal physical systems

AUTHORITY AND RESPONSIBILITY

The Governing Body shall maintain ultimate responsibility for the oversight and effectiveness of the safety management program and shall strive to assure a safe environment for patients, staff and visitors. The Governing Body, through Administration, Risk Manager, and managers

shall provide whatever administrative assistance that is reasonably necessary to support and facilitate the implementation of ongoing operation of this effort.

The Governing Body has appointed the Safety Officer. His/her role includes:

1. Oversight of the implementation and maintenance of safety practices at Sahara Surgery Center.
2. Proactive with ergonomics in the workplace - .Employee Health Nurse and Safety Officer work together to evaluate employee ergonomic needs and make appropriate referrals when indicated.
3. Integration of safety as part of Sahara Surgery Center wide Quality and Risk Plans.
4. Assures investigation and follow through of any unsafe practices identified.
5. Work with managers to ensure ongoing education of employees through staff inservice, emergency (mock) drills, online training, and new employee orientation.
6. Surveillance and audits to identify areas of opportunity.

Sahara Surgery Center, in conjunction with contracted Facilities Manager, will maintain a safe building and grounds.

1. Routine maintenance is provided by the contracted Facilities Manager.
2. Utilities and emergency backup systems are checked routinely.
3. Sahara Surgery Center should report any unsafe conditions in the building or grounds immediately to the management.
4. Sahara Surgery Center will conduct periodic safety rounds to check for potential hazardous risks. Risks are corrected as soon as possible.

SCOPE OF SAFETY MANAGEMENT PROGRAM

The safety activities for the Center are a function of all employees, medical staff, the Medical Executive Committee (MEC), and Governing Body. The following delineates the scope of service of the safety management program.

1. All areas of the Center. This includes:
 - a) Clinical areas
 - b) Public access areas
 - c) Employee areas
 - d) Outside sidewalks and grounds
 - e) Mechanical equipment areas
2. Maintenance of a safe environment
3. Life Safety
4. Equipment management
5. Utilities management
6. Hazardous Materials management
7. Emergency preparedness
8. Security management
9. Training and Education
10. Quality Improvement activities

COMPONENTS OF THE PROGRAM/PLAN

The safety management program shall contain the following components and related policies:

1. **Safety Management**, which includes:
 - a) General safety policies
 - b) Fall Risk assessment
 - c) Appointment of a Safety Officer
 - d) Staff Education and training
 - e) QI/Risk/Safety/Infection Control Committee
2. **Life Safety Management**, which includes:
 - a) Buildings
 - b) Grounds
 - c) Fire warning and safety systems
3. **Equipment Management**, which includes:
 - a) Patient care equipment
 - b) User errors/equipment failures
 - c) Product/equipment alerts/recall
 - d) Electrically powered equipment
4. **Utilities Management**, which includes:
 - a) Life support systems
 - b) Infection control systems
 - c) Communications systems
 - d) Equipment support systems
 - e) Utilities outage/failure
5. **Hazardous Materials**:
 - a) Selection
 - b) Training
 - c) Inventory
 - d) SDS
6. **Emergency preparedness**:
 - a) Management of disasters, internal and external
 - b) Involvement of the Center in community disaster (drills and actual)
7. **Security Management**
 - a) Variance reporting
 - b) Security risk assessment
8. **Radiation Management**
 - a. Dosimetry monitoring
 - b. Radiation audits
 - c. C-arm logs to assure < 20 individual exposure time

MONITORING AND EVALUATION

There is ongoing monitoring of the safety program to ensure compliance with all regulatory agencies and Center policies. Results of the monitoring activities are reported to Administration, QI Committee, MEC and the Governing Body. The staff are informed through departmental meetings and staff in-services.

1. Data Resources Used for Monitoring

- a) Quality/Risk Monitors
- b) Variance reports
- c) Outside regulating agencies reports (AAAHC,TJC, QRS, CMS, State, Fire Marshall, OSHA etc)
- d) Preventive maintenance reports (from engineering and biomed)
- e) Surveillance rounds (IFC, Safety, Radiation etc.)
- f) Fire drill critiques
- g) Disaster drill critiques
- h) Claims data/Probable Claims Reports

2. Areas of Improvement

Data information will be evaluated to determine if there are any problems or opportunities for improvements in the service. The source of the problem will be analyzed to determine if the problem occurred because of:

- a) Insufficient knowledge
- b) Problems in the system
- c) Poor performance due to lack of conformity to policy
- d) Other

3. Corrective Action

Appropriate actions will be implemented to eliminate or alleviate the identified problems. Actions may be taken by the manager, Risk Manager, Administrator, or QI Committee. Actions may include, but are not limited to:

- a) Education/training
- b) Revision of policies and procedures or implementation of new policies
- c) Staffing adjustments
- d) Change in equipment, vendors, repair services, etc.
- e) Counseling/guidance

4. Follow-up and Evaluation

- a) Follow-up and evaluation of the corrective actions will be done through the Quality Improvement/Risk Management Committee.
- c) Based on the evaluation by the Quality Improvement/Risk Management Committee, the need for further monitoring or additional corrective action will be determined.
- d) All evaluations of monitoring will be reflected in the Quality Improvement Committee, MEC, and Governing Body minutes.

5. Safety Monitoring and Evaluation Reporting

Results of monitoring, evaluation, corrective actions and evaluation of same shall be communicated to:

- a) Center Quality Improvement/Risk Management Committee (Quarterly)
- b) Medical Executive Committee (Quarterly)
- c) Governing Body (Quarterly)
- d) Managers (monthly or as appropriate for dissemination to Center employees)

Findings and change in policies and processes are communicated to the staff through staff meetings or other desired method of communication.

POLICIES

Sahara Surgery Center has policies and procedures that promote safety as a priority. These policies and procedures are developed in accordance with regulatory standards and current trends in healthcare. These policies include, but are not limited to...

1. Fall Risk Assessment
2. Product Recalls
3. Medication Administration and Control policies
4. USP 800 policies and guidelines
5. Exposure Control Plan
6. Sharps Prevention
7. Infection Control Plan
8. Equipment inventory and maintenance policies
9. Variance Reporting
10. Employee response grids to systems failure
11. Emergency Preparedness Plans- Bioterrorism, Weather, Evacuation, Fire Safety, Bomb Threats, etc.
12. Emergency Procedures- Respiratory Arrest, Malignant Hyperthermia. Child Abduction, Chemical Spills etc.
13. Procedures for Incapacitated and/or Impaired Healthcare provider

SAFETY MANAGEMENT PROGRAM APPRAISAL

The program is reviewed at least annually or as indicated by other activities or survey findings.

References: AAAHC, JCAH, CMS, OSHA standards. HCA Life Safety program

**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: 6/2020

Purpose: Gastroenterology Consultants, Ltd (GIC) and affiliated Endoscopy Centers are committed to ensuring the ongoing safety of our patients. To ensure the ongoing safety and care of our patients we follow specific guidelines and policies which, at a minimum, include:

I. Infection Control (IC): Refer also to the Infection Control (IC) Policy

1. Guidelines followed include:

- a. American Society for Gastrointestinal Endoscopy (ASGE) Multisociety Guideline on Reprocessing Flexible Gastrointestinal Endoscopes 2016
- b. Society of Gastroenterology Nurses and Associates, Inc. (SGNA) Standards of Infection Prevention in Reprocessing Flexible Gastrointestinal Endoscopes 2018
- c. Society of Gastroenterology Nurses and Associates, Inc. (SGNA) Standards 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 2017
- e. American Society for Gastrointestinal Endoscopy (ASGE) Infection Control during GI Endoscopy 2018
- 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 2016
- h. Association for Professionals in Infection Control and Epidemiology (APIC) Guide to the Elimination of Clostridium difficile in Healthcare Settings 2013
- i. CDC Safe Injection Practices

2. The IC Policy includes, at a minimum, processes or guidelines for:

- a. Patient selection and placement within the facility
- b. Infection Control Monitoring and Surveillance, Reporting
- c. Standard and Transmission Precautions, Hand Hygiene, Personal Protective Equipment, Respiratory Hygiene / Cough Etiquette and General Infection Control Practices in Healthcare Facilities as developed by the CDC and APIC
- d. Environmental and Terminal Cleaning
- e. Infection Control Officer
- f. Equipment Processing: Cleaning, Disinfection, High Level Disinfection and Sterilization

Approved Board of Managers REC/SEC/ CEC 10/11/11; Revised 8/9/12, Approved Board of Managers REC/SEC 1-31-16; CEC 1-25-16; Approved Medical Directors 4/2016, minor changes approved by Director of Center Operations 6/2020

The proceedings and records of a patient safety committee are subject to the same privilege and protection from discovery as the proceedings and records described in NRS 49.117 - 49.123 and NRS 49.265.

- II. Patient Selection and Screening:** Refer also to the Criteria for Scheduling Patients at ASC Policy.
1. To ensure patients are appropriate for the planned procedure in the planned setting patients undergo:
 - a. Pre-procedure scheduling evaluation with referral for office visit or consultation as appropriate
 - b. Pre-procedure assessment which includes at a minimum:
 - i. Review of past medical & surgical history
 - ii. Medication reconciliation, review
 - iii. Allergy and reaction, review of
 - iv. Physical assessment; assessment for communicable diseases
 - v. Vital signs
- III. Patient Identification:** Refer to Patient Identification Policy. Patient identity is verified with at minimum two (2) identifiers at check-in and at multiple points throughout care.
- IV. Safe Surgery Checklist:** Refer to Safe Surgery Checklist Policy. Patient and procedure are verified immediately prior to procedures.
- V. Discharge Teaching:** Patients are provided with written discharge instructions which are reviewed with patient and driver, as applicable, prior to discharge. Medications are reconciled prior to discharge if any new medications are ordered. Information specific to diagnosis, as best as known, is given to the patient. Patients are educated about signs and symptoms to report and given a twenty-four (24) hour telephone number to call in event of questions or concerns.
- VI. Post Procedure Callbacks:** Patients are contacted one (1) to two (2) business days post-procedure for follow up of any concerns and questions regarding discharge instructions.
- VII. Pathology follow up:** Patients are notified of pathology results and given information and follow up orders as applicable within two (2) weeks.
- VIII. Pharmaceutical Services:** Refer to Pharmaceutical Services Policy. Safe injection practices are strictly followed. Pharmaceutical services are overseen by a contracting pharmacist on a monthly basis.
- IX. Quality Assurance and Benchmarking:** Refer to the Quality Management Plan. More than one hundred (100) quality assurance checkpoints are monitored on per patient, per case, per day, per week or per month basis as applicable. Benchmarking of multiple facility and nursing care factors are completed on an ongoing basis. In addition, multiple procedure-related factors are tracked and trended in aggregate and specific to individual physicians on an ongoing basis. Incidents, procedure complications/events, adverse and sentinel events are investigated tracked and trended by facility, staff and physician. All data is reported to the Quality Management Committee.

X. Staff Training: Extensive staff training is done at time of hire. Annual staff retraining is mandatory; ongoing training is provided as applicable. Staff are evaluated for customer service and performance on an ongoing basis.

1. New Hire and Annual training for employees and credentialed providers (including anesthesia and endoscopists) includes:

- a. Infection control training
- b. Safe injection practices
- c. PPE
- d. Bloodborne pathogens
- e. Emergency Preparedness Plan (completed every two (2) years).
- f. Fire safety
- g. HIPAA
- h. Hazard communication

XI. Checklists: All items above are monitored via specific checklists, logs and / or chart documentation.

Refer to:

- Infection Control Policy
- Criteria for Scheduling Patients at ASC Policy
- Identification of Patient Policy
- Pharmaceutical Services Policy
- Quality Management Plan
- Safe Surgery Checklist Policy
- Incident Reports Policy
- Emergency Preparedness Plan
- Complications: Procedure Event, Adverse and Sentinel Events Policy
- Staff Training Competencies and Logs
- NRS 439.865; 439.877
- CMS §416.54 (Appendix Z)



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HOME SAFETY

- 1) Keep telephone and emergency numbers in reach, especially when alone. Keep necessary items close by to avoid reaching and stooping.
- 2) If you use a wheelchair, be sure to lock the brakes before getting up and sitting down. If you tend to forget, use a lap belt. If your balance is not steady, have someone with you when transferring.
- 3) Keep walker / cane within reach. Do not attempt to walk without it and do not walk alone if your balance is not steady.
- 4) Use the devices and instructions for moving as given by your therapist(s) or nurse.
- 5) Remove throw rugs – they can trip you.
- 6) Secure electrical cords behind furniture.
- 7) Fire Safety: Do not run electrical cords under carpeting. Do not overload outlets. Smoke detectors should be located on each level of the home, in each living area, and outside of bedrooms. Test smoke detectors monthly. Keep bedroom doors closed at night in case of fire. Make and practice an emergency exit plan. If you are bed or chair bound, notify your emergency service. Obtain a multipurpose (ABC) type fire extinguisher for each living area, furnace area, garage, and storage area.
- 8) Use adequate lighting. Use nightlights for pathways to and from bathroom.
- 9) Have flashlight and battery operated radio in the home in case of power failure.
- 10) If you live alone, consider arranging for someone to call or stop by daily to make sure you are okay. This person should have your emergency number.



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MEDICATION SAFETY

- 1) Never share or borrow medicine.
- 2) Take medicine as close to scheduled times as possible according to your medications schedule sheet. If you miss a dose, consult your doctor.
- 3) Do not skip, double up, or stop taking your medicine. If you feel a medicine is causing side effects, call your doctor. Do not stop taking the medicine suddenly on your own.
- 4) Do not save old medicines for future use as they can weaken or change. If the dose of your current medicine is changed, ask your doctor or pharmacist to re-label it for you.
- 5) Turn on the lights and read the bottle before taking your medicine. If you have trouble with small print, ask your pharmacist to re-label the bottle.
- 6) Non-prescription medicines (drug store remedies) can affect the way your usual medicines work. Ask your doctor before using any non-prescription medicine, including cold/flu, cough, and pain relievers.
- 7) Keep your medicines in a safe, dry place, out of the reach of children. Be especially careful when children visit or you visit a home with children – be aware of medicine kept in your purse, pocket, or pillbox.
- 8) If you cannot open a childproof container, notify your pharmacist of this problem.
- 9) If you have trouble remembering to take your medicine, ask your nurse for help. A calendar box may be helpful.
- 10) Keep a list of your medicines with you at all times. If you are allergic to any medicines, you should have a medical alert tag or card.
- 11) Take your medication schedule sheet with you to medical appointments. Your doctor can assist you in keeping it up to date.



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Patient Emergency Preparedness Planning

Emergency Contact Information		
Contact	Phone	Address
Police		
Fire		
EMS		
Local Red Cross		
Local Emergency Management Office		
Physician		
Pharmacy		
Neighbor		
Relatives		

Make a list

- Medications
- Medical Information
- Allergies and sensitivities
- Copies of health insurance cards

Have on hand

- A seven-day supply of essential medications
- Consult your physician and/or health plan to determine if you are able to obtain additional medication.
- Cell phone
- Standard Telephone
- That does not need to be plugged into an electric outlet
- Flashlights and extra batteries
- Assorted sizes of re-sealable plastic bags for storing food, waste, etc.
- Small battery-operated radio and extra batteries
- Assemble a first-aid kit (See Appendix A-1)



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Evacuation Plans:

- Know where the shelter is located that can meet your special needs.
- Plan for alternate locations
- Plan for transportation to a shelter or other location.
- “Have a “grab bag” prepared (See Appendix B)
- Arrange for assistance if you are unable to evacuate by yourself.

Shelter-in-Place

- Maintain a supply of non-perishable foods for seven days.
- Maintain a supply of bottled water; one gallon per person.
- Be prepared to close, lock and board/seal windows and doors if necessary.
- Have an emergency supply kit prepared (See Appendix B)

Pets

- Have a care plan for your pet.
- Locate a shelter for your pet (hotel, local animal shelter, etc.) Emergency shelters will not accept animals.
- Extra food and/or medications, leashes, carriers, bowls, ID tags, etc.

Special Needs Considerations

Speech or communication Issues

- If you use a laptop computer or communication, consider getting a power converter that plugs into the cigarette lighter.

Hearing Issues

- Have a pre-printed copy of key phrase messages handy, such as “I use American Sign Language (ASL), “I do not write or read English well, “if you make announcements, I will need to have them written simply or signed”
- Consider getting a weather radio, with a visual/text display that warns of weather emergencies.

Vision Issues

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- Mark your disaster supplies with fluorescent tape, large print, or braille.
- Have high-powered flashlights with wide beams and extra batteries
- Place security lights in each room to light paths of travel.

Assistive Device Users

- Label the equipment with simple instruction cards on how to operate it (for example how to “free wheel” or “disengage the gears” of your power wheelchair) Attach the cards to your equipment.
- If you use a cane, keep extras in strategic, consistent and secured locations to help you maneuver around obstacles and hazards.
- Keep a spare cane in your emergency kit.
- Know what your options are if you are not able to evacuate with your assistive device.

Infection prevention and control practices, including considerations for family member exposure, when evaluating and caring for clients with known or suspected COVID-19

The CDC advises the client stay home except to get medical care, separate yourself from other people and animals in the home as much as possible (in a separate room with the door closed) with separate bathroom if possible, call ahead before visiting your doctor, and wear a facemask in the presence of others when out of the client room.

For everyone in the home, CDC advises covering coughs and sneezes followed by hand washing or using an alcohol-based hand rub, not sharing personal items (dishes, eating utensils, bedding) with individuals with known or suspected COVID-19, cleaning all “high-touch” surfaces daily, and monitoring for symptoms. Agency staff may share additional information with families. Please see

<https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-preventspread.html>
<https://www.cdc.gov/coronavirus/2019-ncov/community/home/index.html>

- Visitors should not be allowed in the home until the person has completely recovered, shows no signs or symptoms of COVID-19 and has been released from isolation.
- Visitors should perform hand hygiene according to the CDC guidelines. Hand hygiene should also be performed before and after preparing food, before eating, after using the toilet, and whenever hands look dirty. If hands are not visibly soiled, an alcohol-based hand rub can be used. For visibly soiled hands, always use soap and water.
- Client should wear a mask when agency staff are in the same room. Individuals who cannot wear mask should practice rigorous respiratory hygiene; that is, coughing or sneezing into a bent elbow or tissue and then immediately disposing of the tissue followed by hand hygiene.
 - o Note: mask should not be worn or placed on anyone who has trouble breathing, or anyone who is unconscious, incapacitated, or otherwise unable to remove the mask without assistance. Additionally, they should not be placed on children under age 2.
 - o Materials used to cover the mouth and nose should be discarded or cleaned appropriately after use (e.g. wash handkerchiefs, using regular soap or detergent and water).
- Family caregivers should wear a mask that covers their mouth and nose when they are in the same room as the client. Masks should not be touched or handled during use. If the mask gets wet or dirty from secretions, it must be replaced immediately with a new clean, dry mask. Remove the mask using the appropriate technique, which is to untie it or hold the elastic straps, rather than touching the front of the mask, to discard it immediately after use and then to perform hand hygiene.
- Staff should encourage clients to follow CDC guidelines as part of their daily routine when going out in public (wear a mask, keep social distancing, limit exposure risk).

- Wear gloves when you touch or have contact with the sick person's blood, stool, or body fluids, such as saliva, mucus, vomit, and urine. Throw out gloves into a lined trash can and wash your hands right away.
- Clean and disinfect surfaces that are frequently touched in the room where the client is being cared for, such as bedside tables, bedframes, and other bedroom furniture.

Eat in separate rooms or areas:

- Stay separated: The person who is sick should eat (or be fed) in their room, if possible.
- Wash dishes and utensils using gloves and hot water: Handle any dishes, cups/glasses, or silverware used by the person who is sick with gloves. Wash them with soap and hot water or in a dishwasher.
- Perform hand hygiene after taking off gloves or handling used items. Avoid sharing personal items
- Do not share dishes, cups/glasses, silverware, towels, bedding, or electronics (like a cell phone) with the person who is sick.

Bedroom and bathroom

- If you are using a separate bedroom and bathroom: Only clean the area around the person who is sick when needed, such as when the area is soiled. This will help limit your contact with the sick person. o If they feel up to it, the person who is sick can clean their own space. Give the person who is sick personal cleaning supplies such as tissues, paper towels, cleaners, and EPA-registered disinfectants.
- *If sharing a bathroom:* The person who is sick should clean and then disinfect after each use. If this is not possible, wear a mask and wait as long as possible after the sick person has used the bathroom before coming in to clean and use the bathroom.

Wash and dry laundry

- Do not shake dirty laundry.
- Wear disposable gloves while handling dirty laundry.
- Dirty laundry from a person who is sick can be washed with other people's items.
- Wash items according to the label instructions. Use the warmest water setting you can.
- Remove gloves, and wash hands right away.
- Dry laundry, on hot if possible, completely.
- Wash hands after putting clothes in the dryer.
- Clean and disinfect clothes hampers. Wash hands afterwards.

Use lined trash can

- Use gloves when handling trash
- Place used disposable gloves and other contaminated items in a lined trash can.

- Use gloves when removing garbage bags, and handling and disposing of trash. Wash hands afterwards.
- Place all used disposable gloves, masks, and other contaminated items in a lined trash can.
- If possible, dedicate a lined trash can for the person who is sick.
- Avoid other types of exposure to contaminated items from the client's immediate environment (e.g. do not share toothbrushes, cigarettes, cutlery, crockery, towels, washcloths or bed linen)

Further information for caring for someone Sick at Home can be found in below link:


<https://www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/care-for-someone.html>

Monitor for worsening symptoms regularly: Advise the COVID-19 clients and their caregivers about the signs and symptoms of complications or how to recognize a deterioration in their health status that require medical attention. Monitor these regularly, ideally once a day. For example, if a client's symptoms become much worse (such as light headedness, difficulty breathing, chest pain, dehydration, etc.) from the initial clinical assessment, he or she should be directed to seek urgent care. Caregivers of children with COVID-19 should also monitor their clients for any signs and symptoms of clinical deterioration requiring an urgent re-evaluation. These include difficulty breathing/fast or shallow breathing, blue lips or face, chest pain or pressure, new confusion as well as an inability to wake up, interact when awake, drink or keep liquids down. For infants these include grunting and an inability to breastfeed. If any of these conditions exist, the agency staff should call 911. Clients should be educated to watch for these symptoms and to call 911 if they occur.

Screening Clients for COVID-19 When making a home visit, agency staff should identify clients at risk for having COVID-19 infection before or immediately upon arrival to the home. They should ask clients about the following: • International travel within the last 14 days to countries with sustained community transmission. For updated information on affected countries visit: <https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html> 2.

- In the last 14 days, has had contact with someone with or under investigation for COVID19, or are ill with respiratory illness.
- Residing in a community where community-based spread of COVID-19 is occurring.
- Screen for signs and symptoms of a respiratory infection with COVID-19, such as:
 - Cough
 - Shortness of breath or difficulty breathing
 - Fever
 - Chills
 - Repeated shaking with chills
 - Muscle pain
 - Headache
 - Sore throat
 - New loss of taste or smell
 - Persistent pain or pressure in the chest
 - New confusion or inability to wake up
 - Bluish lips or face

Note: Older people with COVID-19 may not show typical symptoms such as fever or respiratory symptoms. Atypical symptoms may include new or worsening malaise, new dizziness, or diarrhea. Identification of these symptoms should prompt isolation and further evaluation for COVID-19 by the client's physician. For ill clients, implement source control measures (i.e., placing a facemask over the client's nose and mouth if that has not already been done, if client can tolerate). Inform the agency's administrator and/or clinical lead, as applicable, and local and state public health authorities about the presence of a person under investigation (PUI) for COVID-19. Agencies should ensure the availability of resources for their care agency staff according to the types of services, supplies and equipment required by the individualized plan of care and CDC Guidelines, including COVID-19 confirmed or suspected cases.

		Patient/Resident Safety Plan	
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PURPOSE:

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


POLICY:

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

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

PROCEDURE:

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


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

III. Scope of Program

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

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

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c. Assures:

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

IV. Methodology

a. Responsibility

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

b. Membership will include but not be limited to:

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


c. Communication

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


V. Review of Internal and External Reports

a. To include, but not be limited to:


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

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

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


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vii. Sentinel Event



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

VIII. Organizational Response

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

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

 	ORG.2404 Performance Improvement and Patient Safety Plan
Last Reviewed: (04/2007); 04/2014; 01/2015; 02/2016; 02/2017; 01/2018; 01/2019	Replaces Policy Dated: 04/2007; 04/2014; 01/2015; 02/2016; 02/2017
HCA Effective Date: N/A	Approved by BOT: 04/2014; 01/2015; 08/2016; 03/2017; 02/2019
Submitted by: Risk Management	Page 1 of 14

PURPOSE

Sunrise Hospital and Medical Center and Sunrise Children's Hospital (SHMC|SCH) develops, implements, and maintains an effective, ongoing, facility-wide, data-driven quality and patient safety assessment, and performance improvement program.

SCOPE

Housewide

POLICY/STRUCTURE

- A. SHMC|SCH has a leadership structure to support operations and the provision of care.
- B. Structure is formed by three (3) leadership groups:
 1. Board of Trustees (BOT), the organized medical staff which is represented by the Medical Executive Committee (MEC), and Senior Leadership.

BOT

- A. BOT serves as the governing body legally responsible for the conduct of SHMC|SCH as an institution.
- B. BOT has ultimate responsibility for safety and quality which is derived from their legal responsibility and operational authority for SHMC|SCH performance.
- C. In this context, the BOT provides for internal structures and resources, including staff that supports safety and quality.
- D. Working with the MEC and Senior Leaders, the BOT establishes a mission, vision, and goals of the organization to support safety, quality of care, treatment, and services.
- E. Roles and responsibilities of the BOT in ensuring performance improvement (PI) and patient safety activities include:
 1. Reflects the complexity of SHMC|SCH organization and services; involves all SHMC|SCH departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors.
 2. Identifies those responsible for planning, management, and operational activities.
 3. Identifies those responsible for the provision of care, treatment, and services.
 4. Defines in writing its responsibilities.
 5. Approves SHMC|SCH written scope of services.
 6. Selects and approves the Chief Executive Officer (CEO) responsible for managing SHMC|SCH.
 7. Works with the Senior Leaders and the MEC to annually evaluate SHMC|SCH performance in relation to its mission, vision, and goals.
 8. Ensures the ongoing program for quality improvement and patient safety is defined, implemented, and maintained.
 9. Establishes clear expectations for safety.

10. Provides the organized medical staff, represented by the MEC with the opportunity to participate in governance and the opportunity to be represented at BOT meetings.
11. Assumes full legal authority and responsibility for operations of SHMC|SCH and medical staff.
13. Establishes a process for making decisions when a leadership group fails to fulfill its responsibilities and/or accountabilities.
14. Provides for the resources needed to maintain safe, quality care, treatment, and services.
15. Provides a system for resolving conflict among individuals working within the organization.
16. Receives and reviews reports summarizing the data, analysis, findings, and recommendations related to facility-wide organizational PI Projects and Clinical Safety Improvement Program (CSIP).
17. Reviews the annual PI and CSIP Appraisal.
18. Approves the annual PI and Patient Safety Plan.

Medical Staff and MEC

- A. SHMC|SCH has an organized medical staff that is accountable to the BOT.
- B. Medical staff is represented by the MEC.
- C. Role and responsibilities of the MEC in ensuring PI and patient safety activities include:
 1. Organized and accountable to the BOT for the quality and safety of the medical care provided to the patients.
 2. Operates under Medical Staff Bylaws and Rules and Regulations approved by the BOT.
 3. Oversees the quality of care, treatment and services provided by those individuals with clinical privileges.
 4. Approves the PI and Patient Safety Plan (PSP) including the design of the PI and patient safety activities.
 5. Requires the Medical Staff departments to continuously assess and improve the quality of care and services provided, continue to evaluate the competence of individuals with or without clinical privileges (i.e., allied health providers) and provide information for the re-credentialing process.
 6. Requires the Medical Staff to maintain quality control programs, as appropriate.
 7. Systematically evaluates SHMC|SCH performance activities of departments, committees and functional teams by the review of minutes, reports, and inquiries directed to/from the departments or committees by the MEC.

Senior Leaders

- A. SHMC|SCH identifies the responsibilities of its Senior Leaders.
- B. Role and responsibilities of Senior Leaders in ensuring PI and patient safety activities include:
 1. CEO manages SHMC|SCH and leads the Senior Leadership group.
 2. Senior Leaders work with the organized medical staff and the governing body to define their shared and unique responsibilities and accountabilities.
 3. CEO, MEC, the Chief Nurse Officer (CNO), and the Vice-President (VP) of Quality Management (QM) work together to make certain that the facility-wide PI and CSIP along with training programs address identified problems.
 4. Discuss issues that affect SHMC|SCH and the population(s) it serves, including the following:
 - a. PI and Clinical Safety Improvement activities.

- b. Reported safety and quality issues.
 - c. Proposed solutions and their impact on SHMC|SCH resources.
 - d. Reports on key quality measures and safety indicators.
 - e. Safety and quality issues specific to the population served.
 - f. Input from the population(s) served.
- 5. Ensures the scope of the safety program includes the full range of safety issues, from potential to no-harm errors (e.g., near misses).
- 6. Provides and encourages the use of systems for blame-free internal reporting of a system or process failure.
- 7. Defines sentinel events and ensures the performance of credible serious event analysis in response to sentinel events.
See: [SUNR.PSO.003 Patient Safety Serious Event Analysis Policy](#)
- 8. Selects one (1) high-risk process and conducts a proactive risk assessment at least every 18 months.
- C. Creates and maintains a culture of safety and quality throughout the organization.
- D. Organization regularly evaluates the internal culture of safety and quality using the Agency for Healthcare Research & Quality (AHRQ) Hospital Survey on Patient Safety Culture.
- E. Survey allows Leaders to:
 - 1. Prioritize and implement changes identified by the survey.
 - 2. Provide opportunities for all individuals who work in SHMC|SCH to participate in safety and quality initiatives.
 - 3. Develop a code of conduct that defines acceptable behavior and behaviors that undermine a culture of safety.
 - 4. Create and implement a process for managing behaviors that undermine a culture of safety.
 - 5. Provide education that focuses on safety and quality for all individuals.

Patient Safety Officer (Nevada Revised Statutes [NRS] 439.870)

- A. Organization has designated the Risk Manager as the Patient Safety Officer for the organization.
- B. Patient Safety Officer:
 - 1. Serves on the Quality Care and Patient Safety Committees (PSC).
 - 2. Promotes a culture of safety and the elimination of avoidable harm.
 - 3. Supervises the reporting of all sentinel events.
See: [SUNR.PSO.003 Patient Safety Serious Event Analysis Policy](#)
 - 4. Reports all sentinel events and the actions taken to ensure the event does not reoccur.
 - 5. Takes action as deemed to be necessary to ensure the safety of patients as a result of an investigation of the event.

Department Directors

- A. Department Directors of each ancillary/nursing service area is responsible for all PI and Patient Safety activities as they relate to their specific areas.
- B. Directors are responsible for the continuous assessment and improvement of their department's performance, promotion of patient safety, and the maintenance of appropriate quality control programs.
- C. Directors are responsible for evaluating the effectiveness of care delivered in their departments and the clinical performance of their staff.
- D. Although it is recognized that process issues or deficiencies account for most variances in performance, when PI activities lead to a determination that an individual is unable or

unwilling to improve, modification of the individual's job assignment will occur or other appropriate action will be taken.

- E. Significant findings of PI or Patient Safety activities will be reported through the appropriate channels.

PSC and Quality Care Committee (QCC)

- A. PSC and the QCC are responsible to the BOT, MEC, and Senior Leaders for the overall operation of the PI and PSP.
- B. These interdisciplinary committees include but are not limited to, representatives from the BOT, Senior Leaders, Medical Staff, QM, Pharmacy, Nursing Leadership, Infection Control, Ancillary Services Directors, Patient Safety Officer, and Facility Safety Officer.
- C. On an annual basis the PSC and QCC performs an annual PI appraisal of the PI activities.
- D. At this meeting, current PI priorities, patient safety priorities, and associated activities are reviewed and evaluated.
- E. General functions of the PSC and QCC include:
1. Collects data to monitor its performance.
 2. The BOT, MEC, and Senior Leaders set priorities for and determine the frequency of data collection.
 3. Measures, analyzes, and tracks quality indicators, including adverse patient events, and other aspects of performance that assess processes of care, SHMC|SCH services, and operations.
- F. Collects data and reports to the MEC, and BOT.
- G. Types of data collected includes but is not limited to:
1. Operative or other procedures that place patients at risk of disability or death.
 2. All significant discrepancies between preoperative and postoperative diagnoses, including pathologic diagnoses.
 3. Adverse events related to using moderate or deep sedation or anesthesia.
 4. Use of blood and blood components.
 5. All reported and confirmed transfusion reactions.
 6. Results of resuscitation.
 7. Behavior management and treatment.
 8. Significant medication errors.
 9. Significant adverse drug reactions.
- H. SHMC|SCH considers collecting data on the following:
1. Staff opinions and needs
 2. Staff perceptions of risk to individuals
 3. Staff suggestions for improving patient safety
 4. Staff willingness to report adverse events
- I. Patient perception of the safety and quality of care, treatment, and services.
- J. Evaluates the effectiveness of all fall reduction activities including assessment, interventions, and education.
- K. Effectiveness of its response to change or deterioration in a patient's condition.
1. Note: Measures may include length of stay, response time for responding to changes in vital signs, cardiopulmonary arrest, respiratory arrest, and mortality rates before and after implementation of an early intervention plan.
- L. PSC shall have oversight of the SHMC|SCH Patient Safety Program, which includes but is not limited to:
1. Review the annual PSP and Strategies.
 2. Collect data to monitor PSP performance.
 - a. Measure, analyze, and track safety indicators, including adverse patient

- events, and other aspects of performance that assess processes of care, SHMC|SCH services, and operations.
3. Types of data collected includes but is not limited to:
 - a. Patient safety related to the use of at least two (2) patient identifiers when giving medication, blood products, or before a procedure.
 - b. Infection Prevention as it relates to the use of proven guidelines such as hand cleaning to prevent infections of Catheter Associated Urinary Tract Infections (CAUTI), Central Line Associated Bloodstream Infections (CLABSI), Surgical Site Infections (SSI), and other SHMC|SCH acquired infections.
 - c. Safe surgical practices by prevention of mistakes made in surgery such as wrong patient, wrong site, and wrong procedure with use of standardized *Time Out* practices before any treatments or procedures.
 - d. Use of medication safety as it relates to the prevention of significant medication errors.
 - e. Evaluate the effectiveness of all fall reduction activities including assessment, interventions, and education.
 - f. Evaluate the effectiveness of the reduction of all SHMC|SCH acquired conditions (HAC) to improve health outcomes and reduce length of stay.
 4. Receive reports from the patient safety officer pursuant to NRS. 439.870
 5. Review and evaluate the quality of measures carried out by the medical facility to reduce the number of severity of sentinel events and infections that occur at the medical facility.
 6. Ensures all Patient Safety policies/checklists follow protocols to improve the health outcomes of patients at the medical facility and will include, without limitation:
 - a. Checklists related to specific types of treatment must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of health care.
 - b. Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of health care follow protocols to ensure that the room and environment of the patient is sanitary.
 7. Checklists to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - a. Proper instructions concerning prescription medications;
 - b. Instructions concerning aftercare; and
 - c. Any other instructions concerning his or her care upon discharge.
 - M. Ensure that a policy for appropriately identifying a patient before providing treatment the policy will require the patient to be identified with at least two (2) personal identifiers before each interaction with a provider of healthcare.
 1. The personal identifiers may include without limitation, the name, and date of birth of the patient.
 - N. Ensure that a policy regarding the nationally recognized standard precautionary protocols to be observed by providers of health care at the facility including, without limitation, protocols relating to hand hygiene.
 - O. Monitor and document the effectiveness of the patient identification (ID) policy.
 - P. At least annually, review and revise the patient safety checklists and patient safety

- policies adopted and consider any additional patient safety checklists and patient safety policies that may be appropriate for adoption for use at the medical facility as necessary to ensure that the checklist or policy, as applicable, reflects the most current standards in patient safety protocols.
- Q. Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred at the medical facility.
- R. Ensure that on or before July 1 of each year, the Patient Safety officer will submit a report to the Director of Legislation Counsel Bureau for transmittal to the Legislative Committee on Health Care.
1. The report must include information regarding the development, revision, and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to paragraph (II).
- S. Evaluate the recommendations provided to the executive or governing body of the medical facility regarding:
1. The number of sentinel events that occurred at the medical facility during the preceding calendar quarter;
 2. The number and severity of infections that occurred at the medical facility during the preceding calendar quarter; and
 3. Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
- T. Evaluate the role of the Patient Safety Officer in the adoption of patient safety checklists and patient safety policies as required by NRS 439.877, including the review of the checklist and policies annually and revision of the checklists and policies as the patient safety committee determines necessary.
- U. QCC compiles and analyzes data
- V. Program includes, but is not limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will improve health outcomes and patient safety, including:
1. Sets expectations for using data and information to improve the safety and quality of care, treatment, and services.
 2. Responsible for the implementation of successful corrective action plans in affected problem areas.
 3. Measures, analyzes, and tracks quality indicators, including adverse patient events, and other aspects of performance that assess processes of care, SHMC|SCH service and operations.
 4. Develops, implements, and maintains an effective, ongoing, facility-wide, data-driven quality assessment and performance improvement program.
 5. Compiles data in usable formats.
 6. Uses statistical tools and techniques to analyze and display data.
 7. Analyzes and compares internal data over time to identify levels of performance, patterns, trends, and variations.
 8. Compares data with external sources, when available.
 9. Analyzes its Organ Procurement conversion rate data as provided by the Organ Procurement Organization (OPO).
 10. Uses the results of data analysis to identify improvement opportunities.
- W. In regard to staffing:
1. When SHMC|SCH identifies undesirable patterns, trends, or variations in its performance related to the safety or quality of care (for example, as identified in the analysis of data or a single undesirable event), it includes the adequacy of

- staffing, including nurse staffing, in its analysis of possible causes.
- 2. When analysis reveals a problem with the adequacy of staffing, the Senior Leaders responsible for the facility-wide patient safety program are informed, of the results of this analysis and actions are taken to resolve the identified problem(s).
- 3. At least once a year, the leaders responsible for the facility-wide patient safety program review a written report on the results of any analyses related to the adequacy of staffing and any actions taken to resolve identified problems.
- X. QCC considers participation in Quality Improvement Organization (QIO) cooperative projects.
- Y. Trauma Program manages an intensive Performance Improvement and Patient Safety (PIPS) program regarding its practice.
 - 1. Minutes of the program's reviews are submitted to the MEC and the BOT through the Department of Surgery.
 - 2. In addition, members of the SHMC|SCH Quality Assurance Program attend the Trauma Peer Review Committee meetings.
- Z. PSC and QCC ensures the organization improves performance on an ongoing basis, including:
 - 1. Prioritizes the identified improvement.
 - 2. Takes action on improvement priorities.
 - 3. Evaluates actions to confirm that they resulted in improvements.
 - 4. Takes action when it does not achieve or sustain planned improvements.
- AA. PSC and QCC drafts priorities for the organization's PI activities, which are recommended for adoption through the MEC and the BOT.
- BB. QCC considers factors such as:
 - 1. Focus on high-risk, high-volume, or problem-prone areas,
 - 2. Consider the incidence, prevalence, and severity of problems in those areas.
 - 3. Affect health outcomes, patient safety, and quality of care.

Patient Safety Organization (PSO)

- A. SHMC|SCH is committed to an organizational environment aimed at improving patient safety and the quality of healthcare provided.
- B. To further this objective, SHMC|SCH contracted with Hospital Corporation of America (HCA) PSO, LLC (HCA|PSO|LLC), a federally certified PSO, to receive assistance in conducting a wide variety of patient safety activities intended to reduce medical errors in a legally protected environment.
- C. Generally speaking, patient safety work product (PSWP) is not subject to subpoena or discovery in State or Federal court, in administrative proceedings, or pursuant to the Freedom of Information Act (FOIA), and cannot be disclosed except as permitted under the Patient Safety and Quality Improvement Act (PSQIA) and its associated regulations. *(See 42 Code of Federal Regulations [CFR] § 3.204, Privilege of patient safety work product; and 42 CFR § 3.206, Confidentiality of patient safety work product.)*
- D. SHMC|SCH will be receiving and exchanging patient safety information with the PSO, including event or incident reports and investigations, analytic tools such as root cause analyses (RCA), patient safety communications, quality reviews, and other documents aimed at improving patient safety.
- E. Documents will be submitted in a standardized format to allow for comparison with like Providers.
- F. As part of this effort, SHMC|SCH will operate a Patient Safety Evaluation System (PSES) designed to encourage internal reporting of adverse events, near misses, and unsafe conditions for purposes of reporting to HCA PSO, LLC.

- G. PSES will be the vehicle for collecting, managing, and analyzing information for patient safety purposes.
- H. Designated SHMC|SCH personnel will collect patient safety information and report it to HCA PSO, LLC on an ongoing basis for analysis and feedback.

Methodology

- A. FOCUS-Plan-Do-Check-Act (PDCA) is the methodology used for PI projects.
- B. Using this methodology data is systematically aggregated and analyzed on an ongoing basis.
- C. Statistical tools used are displayed in diagram II below.

FOCUS**Find an Improvement Opportunity:**

- A. Review results of measurement activities and input from staff, patients, medical staff, and other customers.
- B. How are we doing compared to ourselves/external benchmarks over time?
- C. What situation yields an opportunity for improvement?
- D. What processes should be addressed first?

Organize a Team that Knows the Process:

- A. Is there representation from those who work in the process
- B. Educate the team on the PI process.
- C. Establish the team purpose, process and measures of team progress.

Clarify Current Knowledge of the Process:

- A. Is the process well defined, including the customers, their needs and expectations?
- B. Do our perceptions of the process relate to the actual process?
- C. “Flow chart” the process to determine the actual flow or sequence of events that the process follows.
- D. What is the baseline data on the current process?
- E. Review recent scientific literature for up to date information regarding the process.

Uncover Root Cause of the Process Variation:

- A. “Fishbone” a cause and effect diagram to allow the team to identify, explore and graphically display, in increasing detail, all of the possible causes related to a problem.
- B. Are the causes the root cause or just symptoms of the problem?
- C. What are the causes that have the greatest impact in priority order?

Start the Improvement Cycle:

- A. What new knowledge have you acquired about the process?
- B. What changes need to be made to improve the process?

PDCA**Plan Improvement**

- A. Who, what, when and how are we going to change the process
- B. Data collection-who, what, where, when and how are we going to track the process change?
- C. Identify those forces that assist or prevent change-force field analysis.

Do Improvement:

- A. Implement change

Check Results:

- A. Do results match the expectations?
- B. What was learned?
- C. What does the team want to continue to do?

- D. What would the team do differently?

Act

(To sustain improvement and continue to improve or abandon change and start cycle again)

- A. What part of the process needs to be standardized?
B. What policies/procedures need to be revised?
C. Who needs to be trained?
D. Determine method for ongoing measurement.

Serious Event Analysis

- A. Is the primary PI methodology used for analysis of significant unanticipated outcomes and/or Sentinel Events.

See: [SUNR.PSO.003 Patient Safety Serious Event Analysis Policy](#)

EXTERNAL DATA SOURCES

- A. Data is also collected as indicated for participation in the following external databases or for participation with the following organizations:

Lavanta

- A. Centers for Medicare & Medicaid (CMS) contracted Quality Improvement Organization (QIO) has developed Healthcare QI Initiatives that examine patterns of practice.
B. Areas for study are suggested by practitioners in the community, university, hospital settings, nationally recognized patient safety and quality improvement organizations and CMS.
C. Studies enable hospitals and medical staff to compare their performance with what may be optimal levels of practice.

Comprehensive Health Outcomes Information System (CHOIS) Reports

- A. CHOIS is designed to identify opportunities for improvement, identify best practices, and manage resources appropriately, effectively, and efficiently.
B. Clinical Outcome Summary Reports are distributed on a quarterly basis.
C. Data captured in this report reflects numerous clinical indicators.
D. These indicators were developed through medical staff focus groups.
E. Data is risk and severity adjusted using CMS's Refined diagnosis-related group (DRG)s and economic cycle research institute (ECRI), a risk index used to adjust complication rates, Risk Adjusted Mortality Index (RAMI) and the Risk Adjustment Specialty Algorithm (RASPEC) as appropriate.
F. Each hospital is provided with actual and risk adjusted mortality and complication rates.
G. Rates are compared to the company overall and national statistics.
H. Patient and Provider level details are provided to facilitate a detailed analysis of the cases reflected in the data.

The Joint Commission (TJC) Measurement System (ORYX)

- A. This is TJC initiative to integrate performance measures into the accreditation process.
B. It involves a collection of service, process and outcome indicators related to specific patient populations.
C. Data for this initiative is collected through the Comprehensive Outcomes Measurement Evaluation and Transmission (COMET) database.
D. Information is collected at the facility level and transmitted directly to TJC from HCA, as the chosen vendor for this project.
E. Data abstracted through the COMET system are also submitted to CMS for public reporting through the Hospital Compare website.
F. Hospital Compare website was created through the efforts of the CMS, an agency of the United States Department of Health and Human Services (DHHS), along with the

- Hospital Quality Alliance (HQA).
- G. HQA is a public-private collaboration established to promote reporting on hospital quality of care.
 - H. HQA consists of organizations that represent consumers, hospitals, Providers and nurses, employers, accrediting organizations, and Federal agencies.
 - I. Information on this website can be used by any adult needing hospital care.

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

- A. HCAHPS is a national, standardized, publicly reported survey of patients' perspectives of hospital care.

Vermont Oxford Neonatal Database

- A. Oxford Neonatal Database is a comprehensive database of 600 plus neonatal intensive care (NICU) centers which compares morbidity, mortality, and length of stay data on the very low birth weight infants (501 to 1500 grams).
- B. As part of this network, the neonatal intensive care quality benchmarking project applies a team approach to health care benchmarking with the goal of improving the effectiveness and efficiency of neonatal intensive care.

Cancer Registry

- A. Cancer Registry submits cancer data on select neoplasms to the State of Nevada Administrative Code (NAC) 457.010 to 457.040.
- B. Data is generally requested annually.
- C. Cancer Registry department manages the cancer program and the American College of Surgeon's Commission on Cancer accreditation.
- D. Accreditation program maintains a robust set of metrics pertaining to 37 standards for the diagnosis, treatment and follow-up of cancers.
- E. As part of the accreditation, the Cancer Registry collects data adhering to the Commission of Cancer (COC)s strict criteria and submits data to the National Cancer Data Base (NCDB).
- F. Data is submitted to the NCDB at schedule intervals.
- G. NCDB data is used nationally to identify areas for quality improvement as well as direct other important activities.
- H. NCDB database is available at a facility level providing tools such as hospital comparison benchmarks, survival reports, Cancer Program Practice Profile Reports, Rapid Quality Reporting System, and the Cancer QI Program data reports.
- I. COC used NCDB data to direct participating organizations to perform special studies throughout the year.

Trauma Registry

- A. Trauma Registry at Sunrise is a State of Nevada database.
- B. Nevada Trauma Registry (NTR) data is collected from all licensed acute care hospitals and trauma centers in Nevada.
- C. NTR can provide information on the incidence, and prevalence, morbidity, and mortality of injuries in Nevada.
- D. Data can be broken down to a specific county, specific hospital, specific race, or specific age group, for example.
- E. Data are available for state, private or federal entities, grant applicants to measure the impact of trauma on Nevada and initiate health education programs that address traumatic injuries.

Society of Thoracic Surgeons (STS)

- A. Offers outcome programs in the areas of Adult Cardiac, General Thoracic, and Congenital surgery.

- B. By committing to collecting outcomes data to the STS National Database, surgeons are committing to improving the quality of care that their cardiothoracic surgery patients receive.
- C. SHMC|SCH participates in the STS database, using the national comparisons and benchmarking as an integral part of the PI program for Cardiovascular Services.

American College of Cardiology (ACC)/National Cardiovascular Data Registry (NCDR)

- A. NCDR is the recognized resource for measuring and quantifying outcomes and identifying gaps in the delivery of quality cardiovascular patient care in the United States.
- B. Its mission is to improve the quality of cardiovascular patient care by providing information, knowledge and tools, implementing quality initiatives, and supporting research that improves patient care and outcomes.

Perinatal Services Quality Initiative

- A. Perinatal Services Program is an HCA Corporate Initiative to improve perinatal services and reduce the risk associated with the delivery of maternal and infant care.

Emergency Management Risk Initiative

- A. Emergency Management Risk Initiative audit is one of the fundamental elements in the creation of the risk managed Emergency Department (ED).
- B. This is the most powerful audit tool available in emergency medicine.
- C. It is clinically oriented and provides an unprecedented look at the individual practitioner, the emergency practitioners as a group, and ED systems.
- D. Audit is accomplished through the Sullivan Group via an agreement with HCA hospitals.
- E. SHMC|SCH participates on a semi-annual basis.

Get with the Guidelines GWTG™

- A. Stroke Management Tool (Outcome Sciences) is a comprehensive quality management measurement tool that captures critical information regarding the care and treatment of patients with an acute stroke, with an emphasis of secondary prevention.
- B. Database is used to assess and measure internal compliance of treatment standards, and the ability to provide concurrent comparison to external entities and provides national benchmarks.

ACTION Registry®-GWTG™

- A. ACTION Registry is a risk-adjusted, outcomes-based quality improvement program that focuses exclusively on high-risk ST Elevation Myocardial Infarction (STEMI)/non-ST (NSTEMI) patients.
- B. It helps hospitals apply American College of Cardiology (ACC)/American Heart Association (AHA) clinical guideline recommendations in their facilities and provides invaluable tools to measure care and achieve quality improvement goals.

Leapfrog

- A. Leapfrog Hospital Survey is the public reporting initiative launched in 2001 by the Leapfrog Group.
- B. Leapfrog Group is an independent, not-for-profit organization aimed at mobilizing employer purchasing power to alert America's health industry that big leaps in health care safety, quality and customer value will be recognized and rewarded.
- C. Leapfrog strives to make giant "leaps" forward in safety, quality, and affordability of healthcare by promoting transparency.
- D. Leapfrog Group Survey assesses hospital performance based on 28 different metrics.
- E. Leapfrog algorithm computes a letter grade reflecting the hospital's performance based on these metrics.
- F. Currently nine (9) different Safe Practices are assessed.

- G. These safe practices, created by the National Quality Forum (NQF), have been found to reduce preventable medical mistakes.
- H. Leapfrog works to continually assess safe practices and new practices are added or removed accordingly.
- I. Leapfrog algorithm also analyzes 18 data points from the publically reported data as required by the CMS.

National Healthcare Safety Network (NHSN) Database

- A. NHSN is a secure, internet-based surveillance system that integrates former Center for Disease Control (CDC) surveillance systems, including the National Nosocomial Infections Surveillance System (NNIS), National Surveillance System for Healthcare Workers (NaSH), and the Dialysis Surveillance Network (DSN).
- B. NHSN enables healthcare facilities to collect and use data about HAC infections, adherence to clinical practices known to prevent HAC infections, the incidence or prevalence of multidrug-resistant organisms within their organizations, trends and coverage of healthcare personnel safety and vaccination, and adverse events related to the transfusion of blood and blood products.

REFERENCES

§482.21 Condition of Participation: Quality Assessment and Performance Improvement Program
NAC 449.3152 Quality Improvement Program
NRS 439.865 Patient Safety Plan
NRS 439.870 Patient Safety Officer
NRS 439.875 Patient Safety Committee
Joint Commission Requirements for Performance - Performance Improvement Chapter

PERFORMANCE IMPROVEMENT REPORTING STRUCTURE

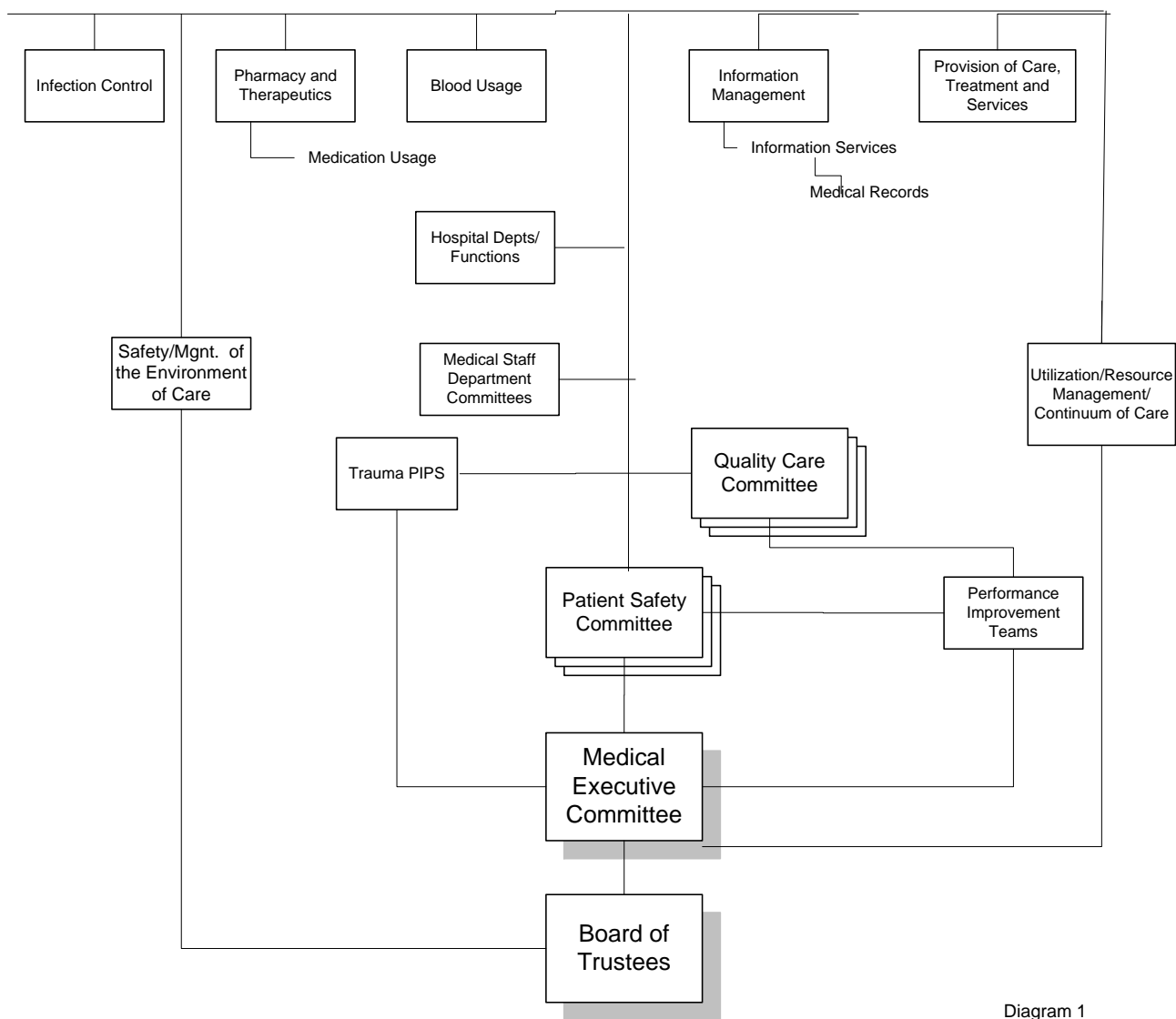
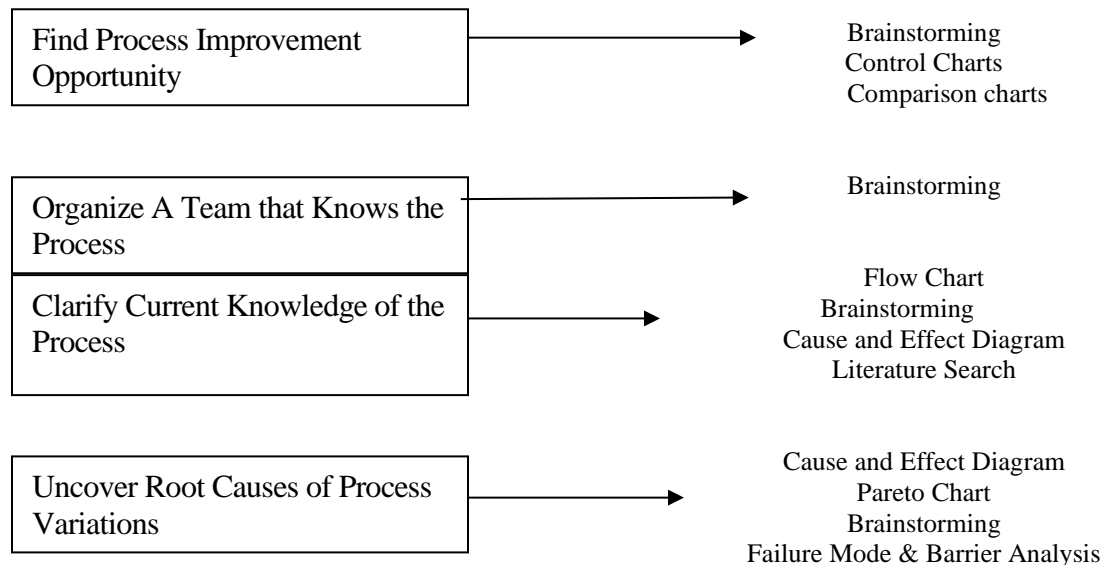
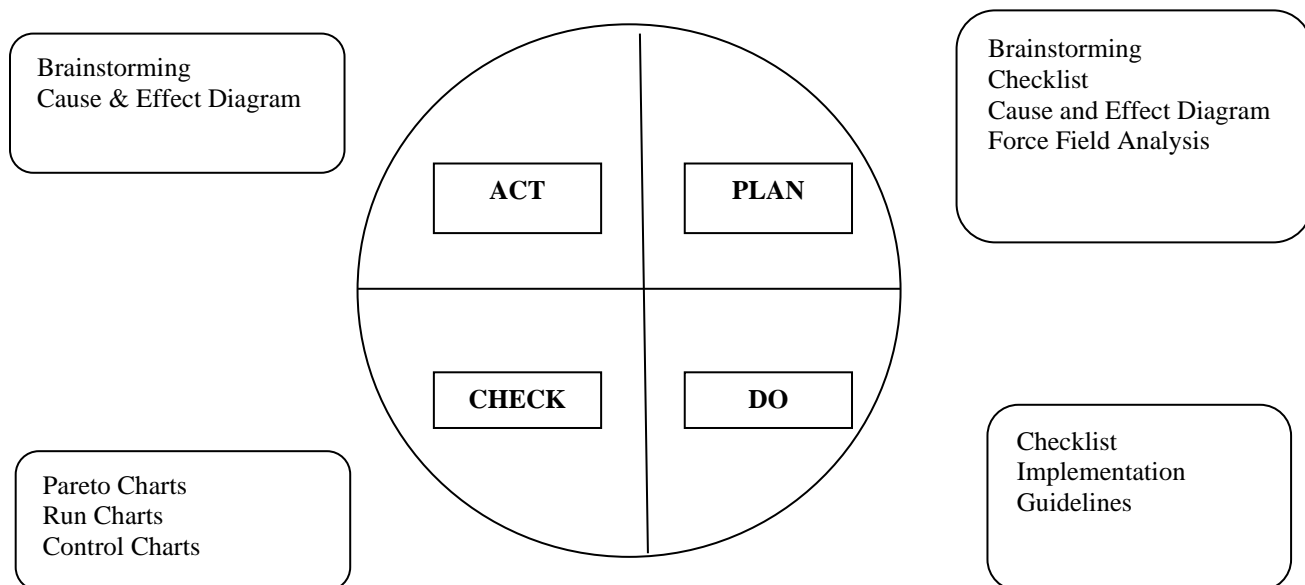


Diagram 1

FOCUS - PDCA**1. Start**

PDCA Improvement



Desert Springs Hospital Medical Center

Risk Management/ Patient Safety Plan

Nevada Acute Care Division

Revised 1/2021

I. Overview

Desert Springs 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 Springs Hospital** operates as a Patient Safety Organization to further its commitment in promoting patient safety and assuring that **Desert Springs 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 Springs Hospital** to track safety information, generate Patient Safety Work Product (PSWP) analysis of safety and clinical performance, and promote best practices. This Acute Care Division Risk Management/Patient Safety Plan ("Plan") provides the general framework to identify, manage, reduce, and eliminate patient safety risks.

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

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

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

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

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

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

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

B. Infection Control Officer

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

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

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

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

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

C. Patient Safety

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

I. Facility Patient Safety Committee

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

Membership:

In accordance with [NRS 439.875](#), the committee core membership consists of the following Key Members: (CEO{member of the Executive or Governing Body}, CNO, Physician, Risk Management and others designated as Patient Safety Officer, Quality Designee, Infection Control Officer, , and Pharmacy). 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 (CFO) of the medical facility. A Patient Safety Committee established pursuant to this section must meet at least once every calendar year.

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'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 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.
- Monitor and document the effectiveness of the hand hygiene protocol or policy.
- Review policy to ensure compliance with the Patient Safety Checklists pursuant to NRS 439.877.
- **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\(4\)\(d\)](#).
- Receive reports from the Patient Safety Officer pursuant to [NRS 439.870](#).

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

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

II. Patient Safety Advisories

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

Desert Springs Hospital is required to address the Safety Watch newsletters, Clinical Risk Alerts and Medication Safety Alerts via their Patient Safety Committee and this is

evidenced in their monthly minutes. Responses to the Safety Watch are reviewed for the opportunity to generate a best practice to implement.

C. TERM Program

The facility has utilized its formalized risk management program identified as TERM: the Technical Elements of Risk Management. Each element focuses on a separate organizational function and details specific strategies for managing risk in these areas. In addition to the delineated elements, the TERM program also includes an evaluation of clinical practices that have or are likely to result in liability or patient harm. The TERM elements are summarized as follows:

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

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

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

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

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

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

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

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

D. MIDAS

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

E. RiskConnect (STARS)

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

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

Trending of claim information is performed on a scheduled basis to operations leadership metrics to form strategies on facilitating risk reduction efforts. Previous examples of this function include the formation of an OB HRU and Perioperative

concepts. Quarterly reports should be provided by **Desert Springs Hospital's** RM to the Governing Board of all claims activities.

F. Event Notification Site

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

G. Root Cause Analysis (RCA)

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

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

The Joint Commission's root cause analysis framework and action plan table should be used as a reference. 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, NRS 439.877, for use by:

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

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

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

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

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

I. Patient Safety Policies

The Patient Safety Policies must include, without limitation:

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

J. MEMBER PATIENT SAFETY EVALUATION SYSTEM (PSES)

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

K. Training and Education

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

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

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

IV. Acute Care Division Patient Safety Priorities, Goals and Objectives for 2021

- **Surgical and Procedural Safety**
 - **Wrong Site Surgery (WSS)**

- **Goal:** A 50% reduction in WSS events for 2021. Ultimately, the goal is zero (0).
 - Monitor through Midas event reporting and the Patient Safety Dashboard. Report monthly with oversight by CPSC.
 - **Retained Procedural items (RPIs)**
 - **Goal:** Prevent RPIs- a 50% reduction in RPIs with harm for 2021. Ultimately, the goal for RPIs is 0.
 - Monitor through Midas event reporting and the Patient Safety Dashboard. Report monthly with oversight by CPSC.
- **CLABSI Initiative**
 - **Goal:** CLABSI will be reduced to less than the national CMS mean Standardized Infection Ratio (SIR: CLABSI 0.736) in 2021.
 - Monitor through CDC's National Healthcare Safety Network (NHSN) and the Patient Safety Dashboard. Report quarterly with oversight by CPSC.
- **Safe Medication Use**
 - **Reduce the preventable occurrences of Opioid Induced Respiratory Events (OIRD) in 2021.**
 - **Goal:** Decrease the number of preventable OIRD events by 10%.
 - **Goal:** Each facility will track and trend naloxone administrations and will identify a performance improvement project related to safe use of opioids by March 1, 2021.
 - **Goal:** 100% of Acute Care facilities will have a medication safety committee that utilizes a standardized charter and agenda by June 1, 2021
 - Monitor through MIDAS reports, Cerner ICD-10 codes and other intervention data and the Patient Safety Dashboard. Report quarterly with oversight by CPSC.
- **Reduce Falls and Falls with Injury**
 - **Goal:** 10 % reduction in the number of falls by end of 2021.
 - **Goal:** 10% reduction in the rate of falls by the end of 2021.
 - **Goal:** 10% reduction in the rate of falls with injury by the end of 2021.
 - **Goal:** A debrief will be completed within 72 hours for 100% of falls with injury.
 - Monitor through MIDAS event reporting and the Patient Safety Dashboard. Report quarterly with oversight by CPSC.
- **Decreasing Hospital Acquired Pressure Injuries**
 - **Goal:** 10% reduction of NPOA rate for all HAPI stages in the Acute Care Division by the end of 2021.
 - Monitor through Midas event reporting and the Patient Safety Dashboard. Report quarterly with oversight by CPSC.

- **Culture of Safety**
 - **Goal:** reduce the number of GHI events (serious safety event rate) for the Acute Care Division by the end of 2021. Ultimately, the goal is 0.
 - Monitor through MIDAS event reporting and the Corporate Patient Safety Dashboard. Report monthly with oversight by CPSC.
 - **Goal:** 100% of 2021 Patient Safety Plan Priorities will be implemented within the hospitals.

V. Monitoring and Accountability

A. Evaluation of TERM Program

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

B. Patient Safety Committee

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

C. Dashboards

The Risk Management/Patient Safety Dashboard and the Environment of Care includes multiple indicators to demonstrate the facility's performance as to patient safety markers. These include event reporting statistics, overall harmful event rate, fall rate including harmful event rate, medication event rate including harmful medication events or adverse drug events, serious harm OB events, pressure injury rates, infection variances, and procedural events.

VI. Evaluation/Review:

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

- The culture supports the identification and reporting of "Near Miss" events
- The framework advances a "Just Culture" approach to patient safety

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

VII. Confidentiality

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

VIII. Approval of Patient Safety Plan

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

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

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

Appendix A: Checklist Example: Injuries from Falls and Immobility

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

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

**Developed by: Quality Services Director
Revised by: Quality Services director
Department: All Departments
Page 1 of 1 Page**

POLICY: PATIENT SAFETY PLAN

POLICY STATEMENT: It is the policy of Humboldt General Hospital to establish measurable objectives for improving patient safety and reducing medical errors. The focus of the plan is on improving patient safety processes and reducing system and process failures, not punitive measures against staff that commit errors. Areas of emphasis in the safety program will include but are not limited to:

1. Informed Consent
2. Patient Identification
3. Surgical site verification
4. Preventive maintenance
5. Restraint compliance
6. Medication administration
7. Drug Recalls
8. Med reconciliation on admission/discharge
9. Blood product administration
10. Staff competency
11. Hand washing
12. Unsafe medical device reporting process
13. Feedback from Patient Satisfaction Survey process
14. Product Recalls
15. Core measures reporting
16. Compliance with National Patient Safety Goals

I. DEFINITIONS:

- A. No Harm Occurrence** – those unintentional acts, either of omission or commission, or acts that do not achieve their intended outcome – that do not result in a physical or psychological negative outcome, or the potential for a negative outcome, for the patient.
- B. Mild-Moderate Adverse Outcome Occurrence** – those unintentional 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.
- C. Any Medication Error, Adverse Drug Reaction or Transfusion Reaction.**

- D. Sentinel Event** – An event included in Appendix A of “Serious Reportable Events in Healthcare – 2011 Update: A Consensus Report,” published by the National Quality forum; or any death that occurs in a health facility. (NRS 439.830)
- E. Near Miss** – any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome.
- F. Hazardous Condition** – any set of circumstances (exclusive of the disease or condition for which the patient is being treated) which significantly increases the likelihood of serious adverse outcome.
- G. Hospital Acquired Conditions (HACS)** – object left in surgery, air embolism, vascular catheter-associated infection, surgical site infections, patient falls, manifestation of poor control of blood sugar levels, such as diabetic ketoacidosis, hypoglycemic coma.

II. CORE PRINCIPLES:

- A.** Humboldt General Hospital recognizes that a patient has the right to a safe environment, therefore the organization is committed to undertaking a proactive program to identify processes which may adversely affect patient safety or be associated with medical errors.
- B.** All departments within the organization (patient care and non-patient care) are responsible to report patient safety occurrences and potential occurrences per department, occurrence impact on the patient, remedial actions taken and the patient outcome. The Patient Safety Committee will analyze the report information and determine future patient safety activities as appropriate.
- C.** Our environment will encourage:
 - 1. “Blame Free” culture where there is a minimization of individual blame or retribution for involvement in a medical error.
 - 2. Recognition and acknowledgement of risks to patient safety.
 - 3. Internal reporting of what has been found and the actions taken

Weekly patient safety “huddle” to include executive member, chief nursing officer or designee, patient safety officer, pharmacist, infection control officer, medical staff representative, case manager, social services and maintenance representative.

The Patient Safety Committee will meet monthly and will include the following members:

 - 1. Executive Member
 - 2. Chief Nursing Officer
 - 3. Patient Safety Officer
 - 4. Pharmacist
 - 5. Infection Control Officer
 - 6. Medical Staff Representative

III. PROGRAM COMPONENTS

- A.** Upon identification of a process or system failure and/or medical/health care error:
 - 1. The patient care provider will immediately perform any necessary healthcare interventions to protect and support the care of the affected patient.
 - 2. Contain the risk to others (example, immediate removal of contaminated IV fluids from floor stock should it be discovered a contaminated lot of fluid solutions was delivered and stocked).
 - 3. Preservation of physical information related to the error for subsequent analysis (example, removal and preservation of IV tubing, fluid bag and/or pumps for a patient with a

severe drug reaction form IV medication; preservation of medication label for medications administered to the incorrect patient; preservation of equipment and disposables for injuries during therapy).

4. The employee/staff member who discovers, or witnesses the event is responsible for documentation and reporting the event. A Quality Review Report will be completed and the staff member completing this documentation will state only the facts.
- B.** The Quality Services Director, as the designated Patient Safety Officer, is responsible for conducting a root cause analysis for the most critical events.
 - C.** Departments involved in the process or system failure and/or medical care error will review information related to the event and identify and implement measures or process redesign to minimize the recurrence of identified events.
 - D.** Department Supervisors will include departmental program and will ensure staff within their department practice safe processes.
 - E.** The Patient Safety Officer will provide quarterly reports of all patient safety activities to the Medical Staff and to the governing board. Information in the report shall include: system and process failures, number and type of sentinel events, actions taken to improve safety, both proactively and in response to actual occurrences and actions taken to resolve identified problems.

Harmon Hospital

**Patient Safety
Plan**

Patient Safety Plan

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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.
- ✚ Promote systems thinking.
- ✚ Employ well-trained and competent staff maintaining high healthcare quality.

Roles and Responsibilities

Patient Safety Plan

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

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.

Patient Safety Plan

- ✚ 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

- ✚ 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.

[illegible]

Patient Safety Plan

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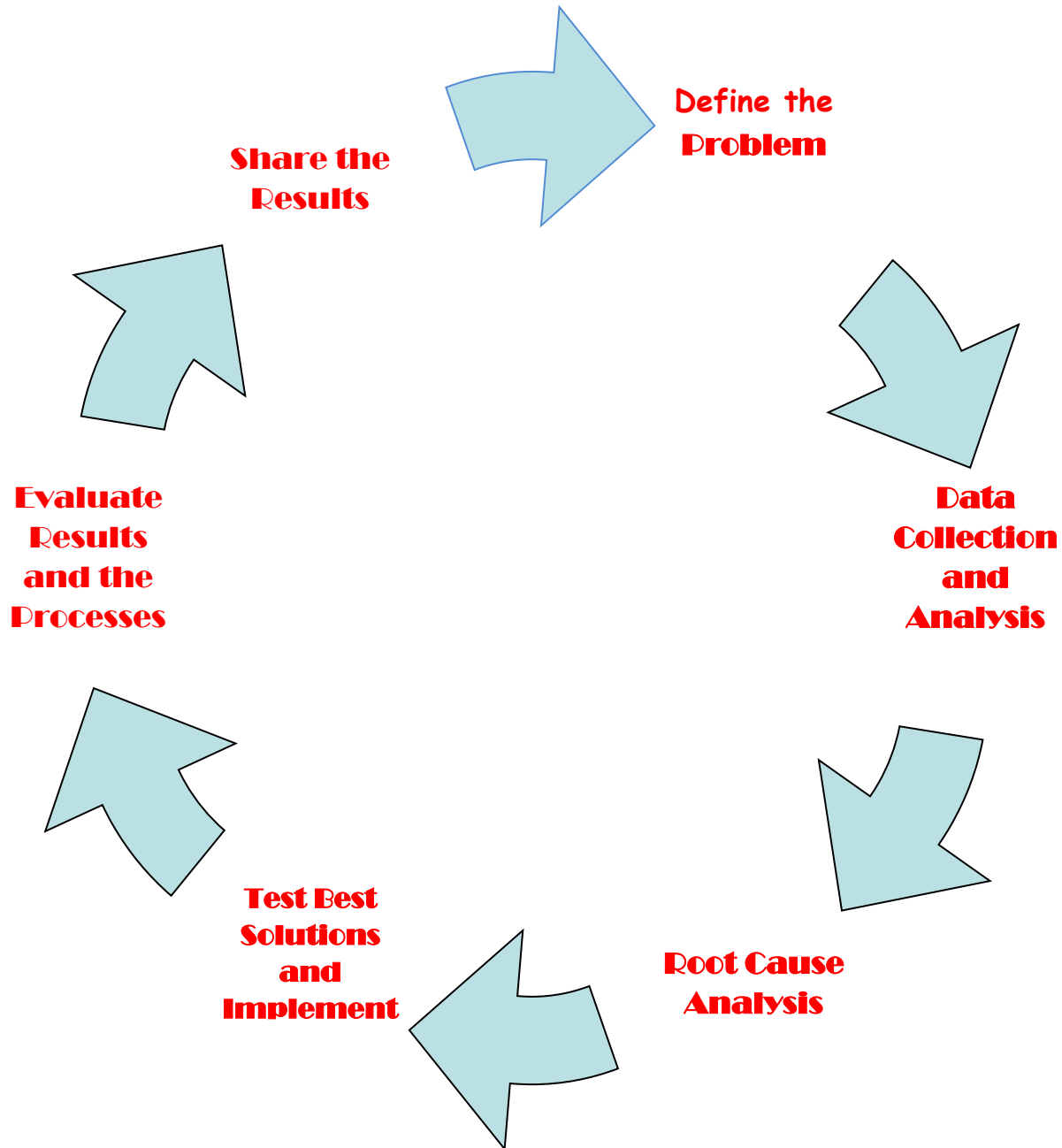
Components and Methods

- + 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.

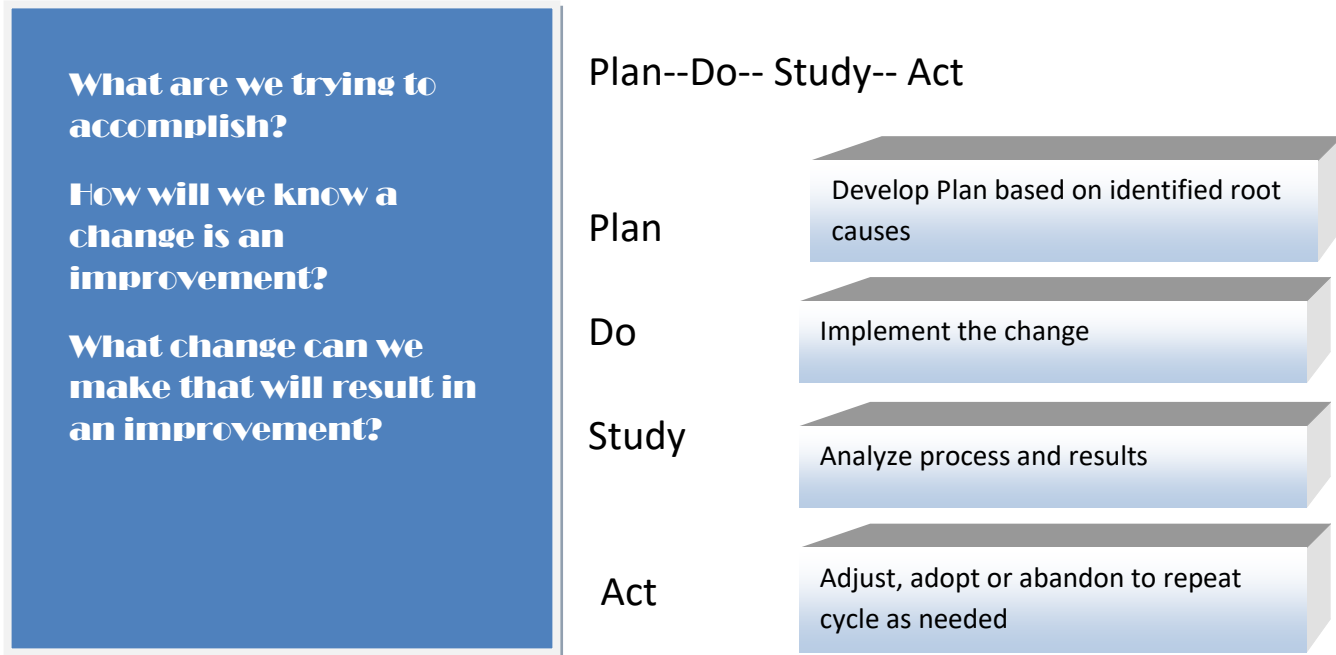
RCA team members will brainstorm and ask multiple times, “why did this happen?” for each cause until all ideas are exhausted. The highest priority root causes will be chosen for PDSA topics. Once all the categories are established on the fishbone diagram, 5 Why’s technique also can be used to drill down 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;

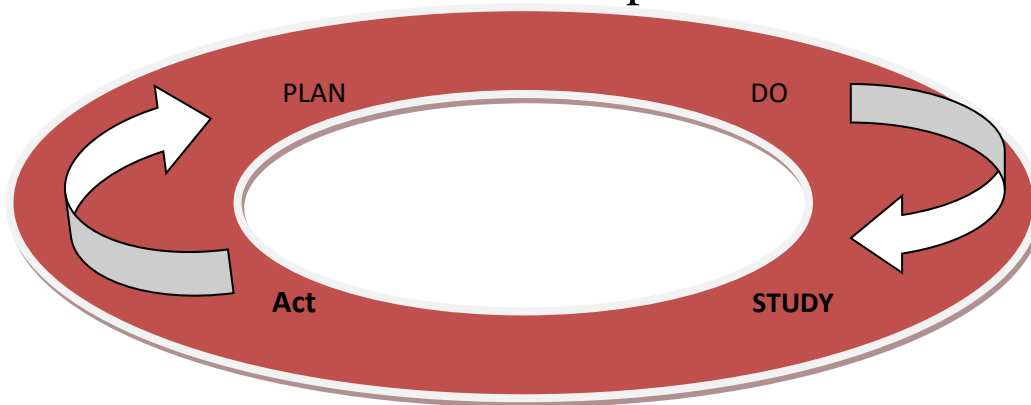
- ✓ if the change is an improvement.
- ✓ Adjust, adopt, or abandon
- ✓ Study process and results
- ✓ Implement the change
- ✓ Develop plan based on the identified root causes

Patient Safety Plan



□

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;

Patient Safety Plan

- + Other personnel of the facility who provide treatment or assistance to patients;
- + Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; 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.
 - ✓ 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.

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:

- ✚ 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.)


Patient Safety Plan


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.)

 **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_PatientSafetyProtocolCURRENT_b.pdf.)

 **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_PatientSafetyProtocolCURRENT_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

Plan-Do-Study-Act

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

LEADERSHIP POLICY ON 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.

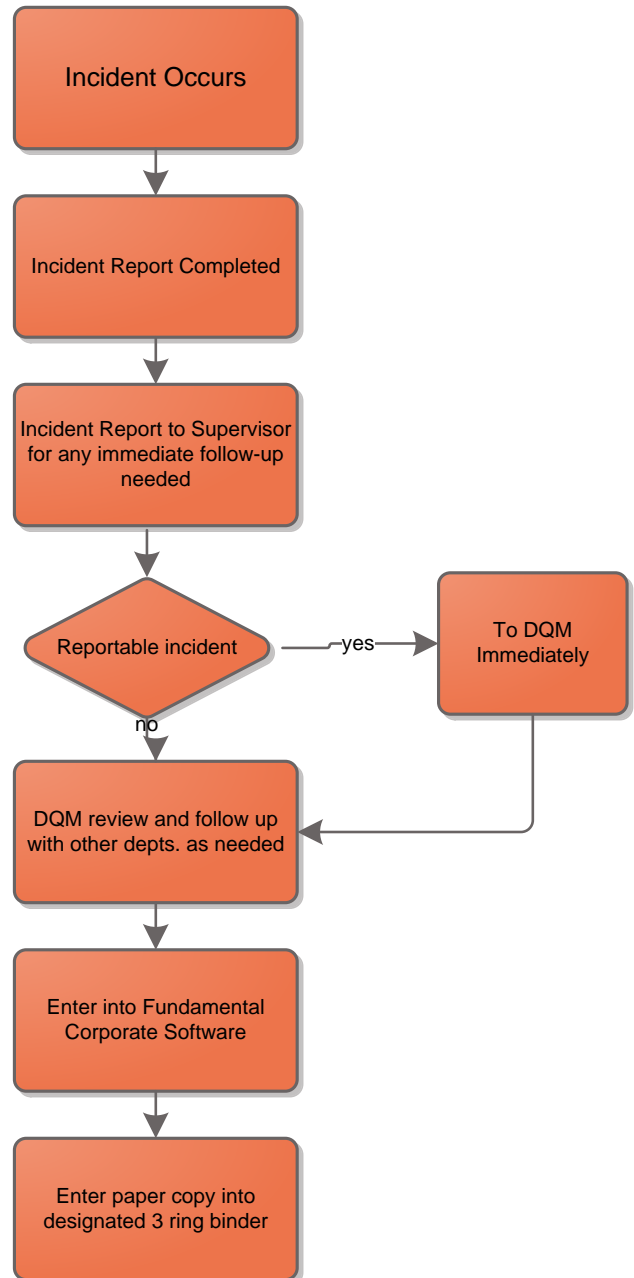
APPENDIX E

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.

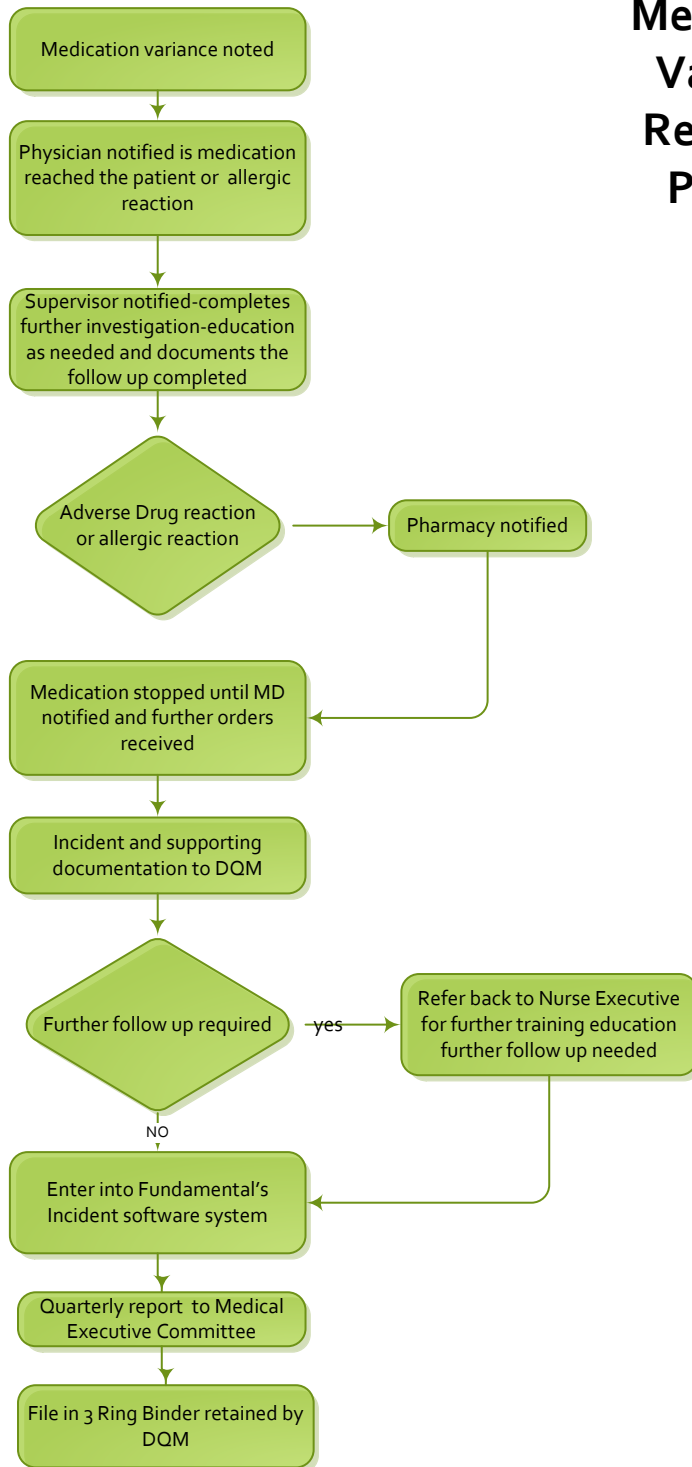
Incident Process Flow Chart



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	Nursing Services Jan 1 2020
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 June 01 2020
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 On-going
Multidiscipline input for falls	✓			On-going
Prevention measures from PT, OT, MD, RN, Pharm D	✓			Patient Safety Committee Review On-going
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	Information is communicated but forms would increase quality and accuracy of reports. Patient specific visual cues in place Huddles are not consistently conducted immediately post fall-no form utilized for consistent review. Analysis forms but are not conducted by team.	<ol style="list-style-type: none"> 1. Fall investigation documentation reviewed by Nursing Management and Administration 2. Cues for staff on fall safety 	Nursing Services July 1, 2020
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 	
Develop daily routine of activities out of bed, sensory stimulation, strengthening, and restorative services in highly monitored environment for high fall risk patients.	DayHab program	<ol style="list-style-type: none"> 1. Re-start dayhab program for inpatient services for high fall risk patients. 2. Maintain social distancing and infection control procedures in program 	Nursing Services 06/01/2020

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]

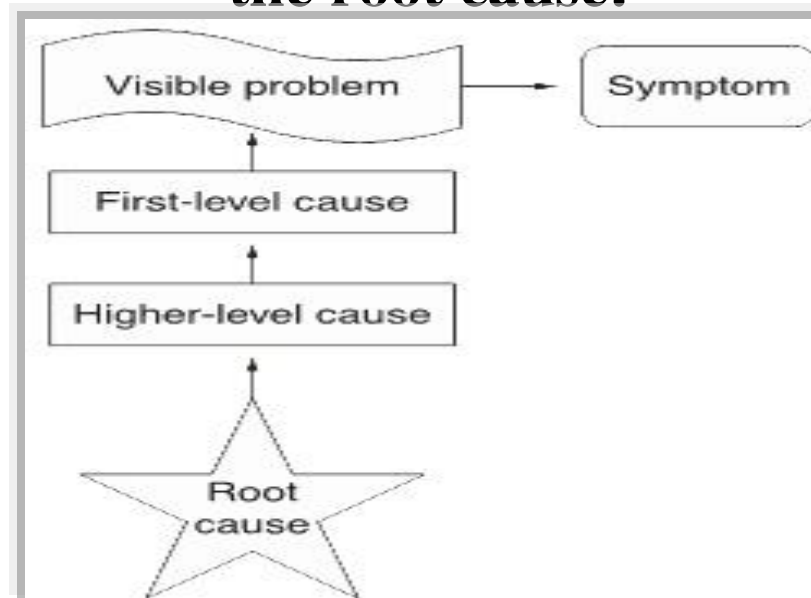
✓ **N/A**

- ☐ ☐ Home medication record completed
- ☐ ☐ Administration database completed
- ☐ ☐ TO/VO/critical value documentation completed

Appendix F

ROOT CAUSE ANALYSIS

The highest-level cause of a problem is called the root cause:



The root cause is “the evil at the bottom” that sets in motion the entire cause-and-effect chain causing the problem(s) and or adverse outcome.

Some root cause analysis approaches are geared more toward identifying true root causes than others; some are more general problem-solving techniques, while others simply offer support for the core activity of root cause

At the start of your fact finding team meeting list the sequence of events (flowchart) as they happened that lead to the problem, issues, or Sentinel Event.

If there is a defined procedure for the process that resulted in an adverse outcome list the sequence of steps in the approved procedure.

Compare the actual sequence of events to the steps outlined in the procedure. Identify any areas in the event sequence where approved procedure was not followed.

These areas may become the basis to develop a Cause and Effect Diagram to identify Root Cause.

Root causes analysis using the Cause and Effect methods.

What's the Problem?



Define the issue by its impact to overall goals. People often disagree over how to define the problem. You can get alignment when the problem is defined by the impact to the goals.

Why did it happen?



Break the problem down into a visual map. Using a Cause and Effect Diagram to provide a thorough explanation revealing all of the causes required to produce the problem.

What will be done?



Prevent or mitigate any negative impact to the goals by selecting the best solutions. Effective solutions should make a change to how people execute work process.

Better Communication, Better Analysis



The Sequence of Events identifies areas needing more investigation.

The Cause and Effect Diagram creates a visual dialogue, making it easier to communicate what's known and what needs a little more digging.

People can see how all of the pieces fit together to produce a particular incident.

The better an organization gets at explaining its problems, the better it becomes at finding smart solutions.

How to Use the Cause and Effect (Fishbone) Tool for Root Cause Analysis

Overview:

Root cause analysis is a structured team process that assists in identifying underlying factors or causes of an adverse event or near-miss. Understanding the contributing factors or causes of a system failure can help develop actions that sustain the correction.

A cause and effect diagram, often called a “fishbone” diagram, can help in brainstorming to identify possible causes of a problem and in sorting ideas into useful categories. A fishbone diagram is a visual way to look at cause and effect. It is a more structured approach than some other tools available for brainstorming causes of a problem (e.g., the Five Whys tool). The problem or effect is displayed at the head or mouth of the fish. Possible contributing causes are listed on the smaller “bones” under various cause categories. A fishbone diagram can be helpful in identifying possible causes for a problem that might not otherwise be considered by directing the team to look at the categories and think of alternative causes. Include team members who have personal knowledge of the processes and systems involved in the problem or event to be investigated.

Directions:

The team using the fishbone diagram tool should carry out the steps listed below.

- Agree on the problem statement (also referred to as the effect). This is written at the mouth of the “fish.” Be as clear and specific as you can about the problem. Beware of defining the problem in terms of a solution (e.g., we need more of something).
- Agree on the major categories of causes of the problem (written as branches from the main arrow). Major categories often include: equipment or supply factors, environmental factors, rules/policy/procedure factors, and people/staff factors.
- Brainstorm all the possible causes of the problem. Ask “Why does this happen?” As each idea is given, the facilitator writes the causal factor as a branch from the appropriate category (places it on the fishbone diagram). Causes can be written in several places if they relate to several categories.
- Again asks “Why does this happen?” about each cause. Write sub-causes branching off the cause branches.
- Continues to ask “Why?” and generate deeper levels of causes and continue organizing them under related causes or categories. This will help you to identify and then address root causes to prevent future problems.

Tips:

- Use the fishbone diagram tool to keep the team focused on the causes of the problem, rather than the symptoms.
- Consider drawing your fish on a flip chart or large dry erase board.
- Make sure to leave enough space between the major categories on the diagram so that you can add minor detailed causes later.
- When you are brainstorming causes, consider having team members write each cause on sticky notes, going around the group asking each person for one cause. Continue going through the rounds, getting more causes, until all ideas are exhausted.

- Encourage each person to participate in the brainstorming activity and to voice their own opinions.
- Note that the “five-whys” technique is often used in conjunction with the fishbone diagram – keep asking why until you get to the root cause.
- To help identify the root causes from all the ideas generated, consider a multi-voting technique such as having each team member identify the top three root causes. Ask each team member to place three tally marks or colored sticky dots on the fishbone next to what they believe are the root causes that could potentially be addressed.

Examples:

Here is an example of the start of a fishbone diagram that shows sample categories to consider, along with some sample causes.

Here is an example of a completed fishbone diagram, showing information entered for each of the four categories agreed upon by this team. Note, as each category is explored, teams may not always identify problems in each of the categories.

Facts gathered during preliminary investigation:

- Time of fall: change of shift from days to evenings
- Location of fall: resident’s bathroom
- Witnesses: resident and aide
- Background: the plan of care stipulated that the resident was to be transferred with two staff members, or with one staff member using a sit-to-stand lift.
- Information from interviews: the resident was anxious and needing to use the bathroom urgently. The aide was helping the resident transfer from her wheelchair to the toilet, without using a lift, and the resident fell, sustaining an injury. The aide stated she did not use the lift because the battery was being recharged, and there was no extra battery available. The aide stated she understood that the resident could be transferred with assist of one.

With this information, the team proceeded to use the fishbone diagram to better understand the causes of the event.

The value of using the fishbone diagram is to dig deeper, to go beyond the initial incident report, to better understand what in the organization’s systems and processes are causing the problem, so they can be addressed.

In this example, the root causes of the fall are:

- There is no process in place to ensure that every lift in the building always has a working battery. (One battery for the lift on this unit is no longer working, and the other battery was being recharged.)
- There is no process in place to ensure timely communication of new care information to the aides. (New transfer information had not yet been conveyed to the aide. The aide’s “care card” still indicated transfer with assist of one for this resident.)

The root causes of the event are the underlying process and system problems that allowed the contributing factors to culminate in a harmful event. As this example illustrates, there can be more than one root cause. Once you have identified root causes and contributing factors, you will then need to address each root cause and contributing factor as appropriate.

➤ **Root Causes are Identified**

➤ **Develop Action Plan for each Root Cause.**

➤ **Identify a Goal for each Root Cause.**

➤ **List the Steps needed to accomplish the Goal.**

➤ **What Resources are needed to complete the action steps?**

➤ **Who is Responsible for the Goal's steps?**

➤ **What is the anticipated Timeframe for completion?**

➤ **How will you Measure the effectiveness of the action steps?**

Planning is preparatory to action. Analytically at least, planning must be separated from implementation so that the major policy decisions can be taken and their implications understood prior to action

8 Steps to Develop a Plan for Action

1 Express your solution as a series of goals

Having agreed on a root cause to a particular problem within your organization, you first need to define that solution in terms of a goal. For example, each goal could be expressed as follows: "For us to, we would need to" Record each goal at the top of a whiteboard or sheet of paper

2 Generate a list of Actions for each goal

Use brainstorming to compile a list of actions to achieve a particular goal and record these below the goal. Arrange this list of suggested actions in sequential order. Include training and education, P&P changes, approvals.

3 Prepare a timeline

Beginning with a time point labeled "now" and ending with a point labeled "goal achieved", build a timeline on which you allocate dates by which you intend to complete each of the sequential actions listed under a particular goal. It is important that you get both sequence and timing right if you are to reach "goal achieved" effectively.

4 Allocate resources

Financial, physical and human resources must be allocated to each action step. If resources are limited, or fall short of requirements at any stage, it may be necessary to return to an earlier step and revise the action plan.

5 Identify possible problems

Consider all of the things that could go wrong in the process of achieving a particular goal. List these problems and identify causes and suitable actions to resolve them. If necessary, these actions might need to be added to appropriate slots in the timeline

6 Develop strategies for monitoring progress

List ways in which progress of the action plan can be monitored. These monitoring stages should also be included on the timeline.

7 Assign tasks

Take each point on the timeline in turn and ask : "Who will do what, by the date set, to bring about the specified action? Allocate these tasks to appropriate individuals or teams.

8 Implement the plan

Translate all your information to a clean copy, listing the actions required, the person responsible for a particular task, and when that task is to be completed. Having now finalized the plan for action in specific terms, this information can now be made available to all involved.

Corrective Action Plan			
Root Cause:			
Goal:			
Potential Obstacles:			
Action Steps	Required Resources	Projected timeframes	Responsible
1.			
2.			
3.			
4.			
5.			
6.			
7.			
Corrective Action Plan			
Root Cause:			
Goal:			
Potential Obstacles:			
Action Steps	Required Resources	Projected timeframes	
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Executive Summary Report

Brief incident description: Incident date: Incident type: Actual effect on patient and/or service: Actual severity of incident:
Level of investigation conducted
Involvement and support of the patient and/or relatives
Detection of the incident
Care and service delivery problems
Contributory factors
Root causes
Lessons learned
Recommendations

Arrangements for sharing learning
Outcome of Measurement

Name

Title

Date

Root Cause Analysis Investigation Report

Incident Investigation Title:	
Incident Date:	
Incident Number:	
Author(s) and Job Titles	
Investigation Report Date:	

Executive Summary Report

Brief incident description: Incident date: Incident type: Actual effect on patient and/or service: Actual severity of incident:
Level of investigation conducted
Involvement and support of the patient and/or relatives
Detection of the incident
Care and service delivery problems
Contributory factors

Root causes
Lessons learned
Recommendations
Arrangements for sharing learning
Outcome of Measurement

Name

Title

Date

Complete Report Below (include action plan and data collection tools)

FINDINGS:

Chronology of events

Chronology (timeline) of events	
Date & Time	Event

Detection of incident

Notable practice

Care and service delivery problems

Contributory factors

Root causes

Lessons learned

CONCLUSIONS:

Recommendations

Arrangements for Shared Learning

Distribution List

Appendices

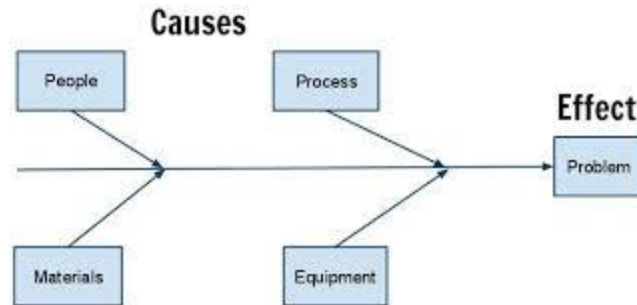
Data Collection

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APPENDIX G

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 H

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](#)

Policy:

It is the policy of MGGH to develop and implement, in consultation with the providers of health care, an internal Patient Safety Program to improve the health and safety of patients/residents who are treated at our facility.

Procedure:

1. The Patient Safety Plan at MGGH encompasses Acute care, Emergency room, surgical services, clinic and Home Maker Services and compliance with the Patient Safety Plan is mandatory.
2. Following approval of the safety plan by the Governing Body, the Medical Staff shall be notified as to the existence and requirements of the plan.
3. The Patient Safety Committee is comprised of a physician, a nurse from SNF, pharmacist, governing board member, risk manager, Infection Control Officer, Patient Safety Officer, and the Administrator

The Committee shall:

- Function under the authority of the Medical Staff
- Submit its patient safety plan to the Governing Board
- Meet monthly
- Investigate, report and formulate corrective actions related to alleged sentinel events
- Review Medical Equipment/devices safety and maintenance inspections
- Review and recommend actions related to medications events
- Review and investigate patient care related incident reports
- Additional tasks as assigned by the Medical Staff
- Annually review patient safety checklists and policies and consider any additional checklists and policies for appropriate adoption
- Revise check lists and policies to ensure they reflect the most current standards in patient safety protocols
- On or before July 1st of each year, submit a report to the Director of the Legislative Bureau for transmittal to the Legislative Committee on Health Care that includes information regarding the development, revision, and usage of the patient safety checklists and policies and a summary of the annual review conducted by the facility.

3. The Administrator shall appoint a Patient Safety Officer with the following responsibilities:

- Serve on the Patient Safety Committee
- Supervise the reporting of all sentinel events alleged to have occurred in the medical facility.
- Shall within 13 days of being notified of a Sentinel event or within 14 days of becoming aware without notification, report the date, time and brief description of the sentinel event to the health division, The Bureau of Licensure, Administrator and the Patient Safety Committee
- Take such actions as he/she determine necessary to ensure the safety of the patients as a result of an investigation of any sentinel event alleged to have occurred at the medical facility
- Report to the Patient Safety Committee regarding any actions taken
- The Patient Safety Officer may designate alternates to act in his/her absence. Kathy The Risk Manager will act as Patient Safety Officer in the absence of the Patient Safety Officer
- The Patient Safety Officer is responsible to review, investigate and act upon patient safety issues other than sentinel events at this facility, including medication errors, environmental issues and equipment and supply malfunction

4. Jan Kollodge RN DON has been appointed by the Administrator as Patient Safety Officer

POLICY: The Patient Safety Committee functions to enhance patient safety through data collection, reporting, investigation and evaluation of patient safety issues prior to an event and when an event occurs. All patient safety information will be confidential and reported through the Medical Staff Quality Assurance process.

PROCEDURE: The Patient Safety Committee shall:

- Receive reports from the Patient Safety Officer (PSO)
- Evaluate actions of the PSO in connection with all reports of sentinel events alleged to have occurred at MGGH
- Review and evaluate the quality of measures carried out to improve the safety of patients who receive treatment at MGGH
- Review and evaluate the quality of measures carried out by MGGH to prevent and control infections
- Make recommendations to the Governing Board of MGGH to reduce the number and severity of sentinel events and infections that occur at MGGH
- Monitor and document the effectiveness of the patient identification policy
- At least annually, review the patient safety checklists and patient safety policies appropriate for adoption for use by MGGH
- Revise a patient safety checklist and patient safety policy as necessary to ensure that the checklist or policy reflects the most current standards in patient safety protocols
- On or before July 1 of each year, submit a report to the Director of the Legislative Counsel Bureau for transmittal to the Legislative Committee on Health Care with information regarding the development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted in #3 above
- Forward Patient Safety Committee minutes/reports to the Medical Staff quarterly. Minutes will summarize MGGH patient safety activities.
- Report on a quarterly basis to the Governing Body of MGGH regarding:
 1. The number of sentinel events that occurred at MGGH during the preceding calendar quarter
 2. The number and severity of infections that occurred at MGGH during the preceding calendar quarter
 3. Any recommendations to reduce the number and severity of sentinel events and infections that occur at MGGH

PATIENT SAFETY DATA COLLECTION:

Patient safety data collection, review and reporting of the following patient safety events is a means of providing the safest patient care possible. Data collection will begin with the completion of a Quality Review Report.

- Sentinel events
- Adverse events
- Near Misses
- Medication errors and falls
- Equipment malfunctions
- Preventive corrective interventions

SUBJECT: MEETING AGENDA

DEPARTMENT: HOSPITAL WIDE

REFERENCE 4002

PAGE: 1 of 1

APPROVED BY: _____ EFFECTIVE: 11/03 REVISED:

Patient Safety Committee Meeting Agenda

The Patient Safety Committee meets on the fourth Tuesday of each month.

Patient Safety officer: Jan Kollodge RN

Date:

Members Present:

Standard Agenda Items:

- 1. Sentinel Event**
- 2. Other Events**
- 3. Adverse Drug Events and medication errors**
- 4. Incident Reports**
- 5. Equipment/ Supply issues**
- 6. Root Cause Analyses Evaluation**

Old business:

New business:

Other:

SUBJECT: EMPLOYEE TRAINING/EDUCATION

REFERENCE 4003

DEPARTMENT: HOSPITAL WIDE

PAGE: 1 of 1

APPROVED BY: _____ EFFECTIVE: 11/03 REVISED: 6/21/16

POLICY:

It is the policy of MGGH that all employees and individuals contracted for patient care receive Patient Safety Training and are familiar with the job related aspects of patient safety and staff specific roles and responsibilities to actively support patient safety

PROCEDURE:

All staff will receive patient safety education and training during their new employee orientation and on an annual and as needed basis. Contracted individuals will be monitored for compliance with patients safety policies by the supervisor of the department the contracted individual is assigned to.

SUBJECT: INTERNAL EVENT REPORTING

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

APPROVED BY: _____ **EFFECTIVE:** 11/03 **REVISED:****POLICY:**

It is the policy of MGGH to investigate all patient safety events that occur (actual event) or almost occurred (near miss) that caused or had the potential to cause harm to a patient.

PROCEDURE:

1. Upon notification of a patient safety event the Patient Safety Officer will review all pertinent data related to the event i.e. diagnostic testing, medication orders, medical records and interviews of the parties involved etc
2. Take any action deemed necessary at the time of the investigation
3. Form a plan to prevent recurrence of a similar event
4. In the event of a sentinel event, begin investigation immediately and take such actions necessary to ensure the safety of the patient.
5. Report the event and the results of the review, action taken, and the prevention plan to the Patient Safety Committee for their recommendations
6. The Patient Safety Officer will inform the appropriate supervisor of actions taken and the determinations of the Patient Safety Committee

SUBJECT: PATIENT SAFETY 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

APPROVED BY: _____ EFFECTIVE: 01/01/2010 REVISED: _____

POLICY:

Health Care Workers at MGGH are required to recognize and follow established nationally recognized standards of care.

PROCEDURE:

Nationally recognized standards of care are to be followed by all Health Care Workers relevant to their departments and to standards related to all departments involved in patient care. Established standards of care include, but are not limited to, the following:

1. Implementation of evidence based practice to prevent health care associated infections:
 - A. Hand hygiene based on CDC guidelines
 - B. CAUTI
 - C. Infections caused by multi-drug resistant organisms
 - D. Central line infections
 - E. Surgical site infections
 - F. Blood stream infections
2. Improve the accuracy of patient identification prior to any treatment, care, or services, using 2 patient identifiers
3. Report critical results of tests and diagnostics on a timely basis
4. Prevent pressure ulcers
5. Identify safety risks and prevent falls
6. Prevent wrong site, wrong patient, and wrong surgery
 - A. Mark the site
 - B. Time out before procedures
 - C. Surgical checklists
7. Improve the safety of medications
 - A. Label all IV medications accurately and completely
 - B. Use approved protocols for the initiation and maintenance of anticoagulation therapy
 - C. Maintain and communicate accurate patient medication records
 - E. 2 nurses to verify certain high risk medications before administration i.e. insulin, cardiac drips, heparin, etc.

SUBJECT: INFECTION CONTROL OFFICER

REFERENCE # 4013

DEPARTMENT: HOSPITAL WIDE

PAGE: 1 of 1

APPROVED BY: _____ EFFECTIVE: 10/1/11 REVISED:

POLICY:

MGGH has designated the DON as the Infections Control Officer for the facility which includes ER, OR, acute care, SNF, and the medical clinic. The Infection Control Officer also serves as the Patient Safety Officer at MGGH

RESPONSIBILITIES:

- Serves on the Patient Safety Committee
- Monitors the occurrences of infections to determine the number and severity of infections at the facility
- Reports to the patient safety committee concerning the number and severity of infections at the facility
- Shall take such action as he or she determines is necessary to prevent and control infections alleged to have occurred at MGGH
- Shall carry out the provisions of the infection control program adopted by NRS 439.865 and ensure compliance with the program
- Shall consult with the Health Division for education and technical assistance relating to infection control in medical facilities when indicated
- The Risk Manager will service as the Infection Control Officer in the absence of the Infection Control Officer. If neither one is available, the charge nurse is responsible.

POSITION REQUIREMENTS:

- Must be a Registered Nurse
- Must successfully complete a nationally recognized basic training program in infection control
- Must complete at least 4 hours of continuing education each year on topics relating to current practices in infection control and prevention
- MGGH shall maintain records concerning the required training

POLICY:

It is the policy of MGGH that when a patient at our facility has an infection, the provider of health care or the designee of the provider of health care shall, as soon as practicable, but not later than 5 days after the diagnosis is confirmed, inform the patient or legal guardian or other person authorized by the patient to receive such information that the patient has an infection. Notification of the patient may be delayed only if the patient does not have a legal guardian, has not authorized any other person to receive such information and:

1. Is not capable of understanding the information
2. Is not conscious or
3. In the judgment of the provider of health care, is likely to harm himself or herself if informed about the infection

If the provider of health care or the designee of the provider of health care delays providing information about an infection, such information must be provided as soon as practicable after:

1. The patient is capable of understanding the information
2. The patient regains consciousness
3. In the judgment of the provider of health care the patient is not likely to harm himself or herself if informed about the infection or
4. A legal guardian or other person authorized to receive such information is available

PROCEDURE:

1. At admission, all patients or their legal guardian sign a Release of Protected Health Information that lists who may be given information about their health condition
2. The provider of health care will consult this list when someone other than the patient must be given information about an infection
3. The provider of health care may authorize the Infection Control Officer, Risk Manager or other RN to inform the patient, legal guardian, or another person authorized by the patient of an infection
4. Notification will be verbal and will be documented in the medical record
5. If an infection is known or determined while the patient remains at MGGH, the patient or person authorized by the patient or the legal guardian will be notified whether the infection was acquired at the facility and of the apparent source of the infection

PATIENT LABEL

FOLEY CATHETER INSERTION AND MAINTENANCE CHECK LIST

	Patient identified using 2 identifiers?
	Is it necessary for patient care?
	Is there a doctor's order?
	Hand hygiene performed prior to procedure?
	Sterility of catheter kit verified?
	Sterile gloves applied?
	Area cleansed per protocol?
	Sterile drapes applied?
	Asceptic technique insured? May need assistance for some patients
	Foley bag hung on bed frame below patient's bladder?
	Leg strap on to prevent movement and urethral traction?
	UA obtained?
	Hand hygiene performed after procedure?
	Care Plan on chart?
	Daily catheter care performed?
	Foley to be removed as soon as possible? Assess for need every 24 HOURS
	Closed system maintained and additional UAs taken from sampling port

NURSE SIGNATURE _____ DATE _____

PATIENT LABEL

LIVER BIOPSY CHECKLIST

	Patient identified by name and date of birth
	Procedure verified with patient
	Anticoagulants held by patient as ordered by doctor
	Consent signed
	All equipment available
	Hand hygiene prior to procedure
	Sterile technique throughout procedure
	Specimens labeled correctly and delivered to the lab
	Post liver biopsy orders on chart and followed
	Patient given discharge instructions

NURSE SIGNATURE_____DATE____

SUBJECT: COMPLIANCE WITH PATIENT SAFETY POLICY/CHECKLISTS

REFERENCE # 4011

DEPARTMENT: HOSPITAL WIDE

PAGE: 1 of 1

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

QUALITY AND PATIENT SAFETY PLAN 2021

DATE: 01/27/2021



This plan was created and revised by the Dini-Townsend Hospital 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
Dini-Townsend Hospital**

480 Galletti Way

Sparks, NV 89431

Leah Lewis, Patient Safety Officer

llewis@health.nv.gov

775-688-2018

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Commitment to Patient Safety

Dini-Townsend 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, Dini-Townsend Hospital'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 Dini-Townsend 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, Dini-Townsend 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

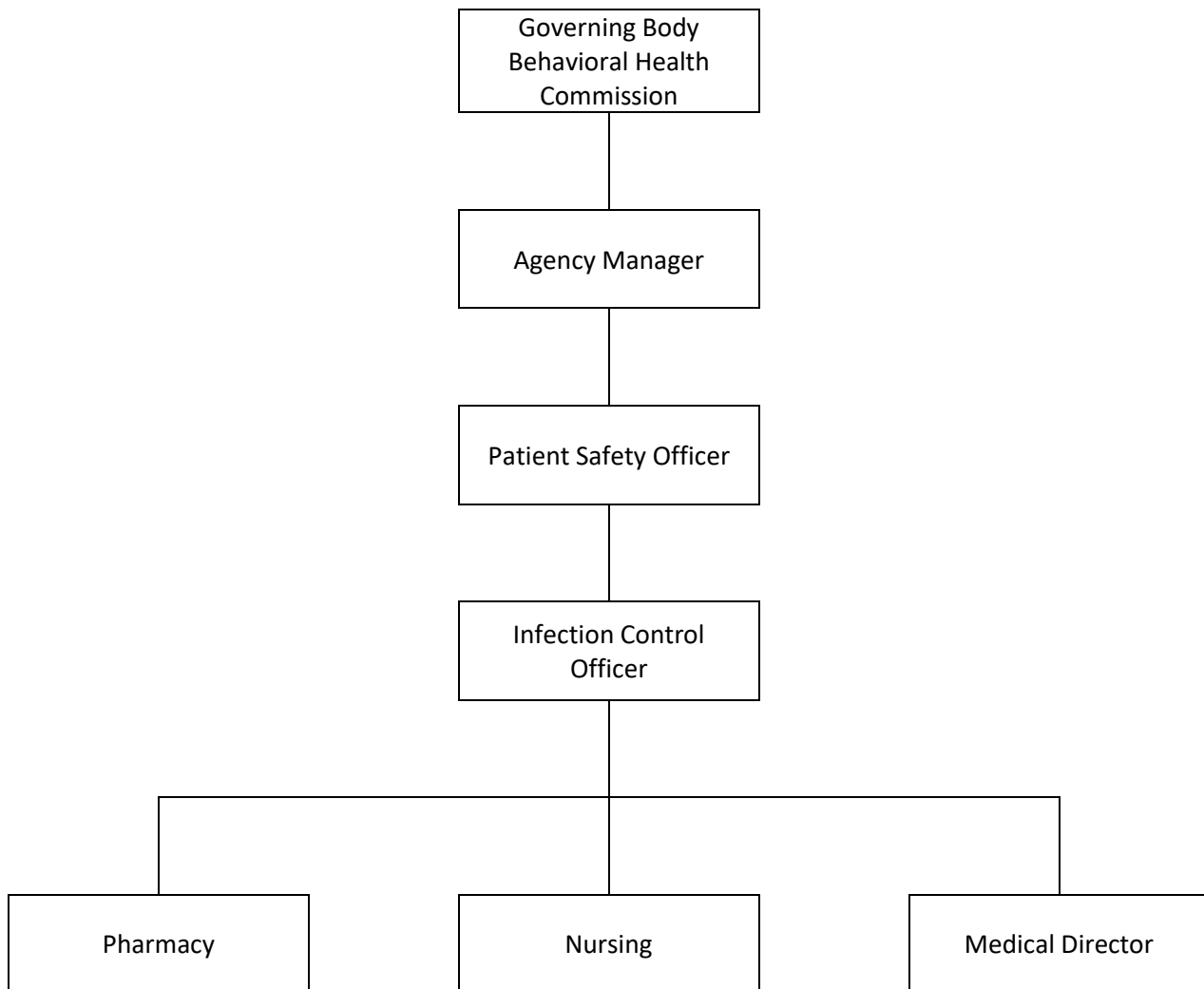
core principles of this plan include:

- 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.
- 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.
- 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

(Additional responsibilities here if needed)

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

(Please provide additional responsibilities here if needed)

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.

Patient Safety and Quality Improvement Plan

Objectives and Goals of the Quality and Patient Safety Plan

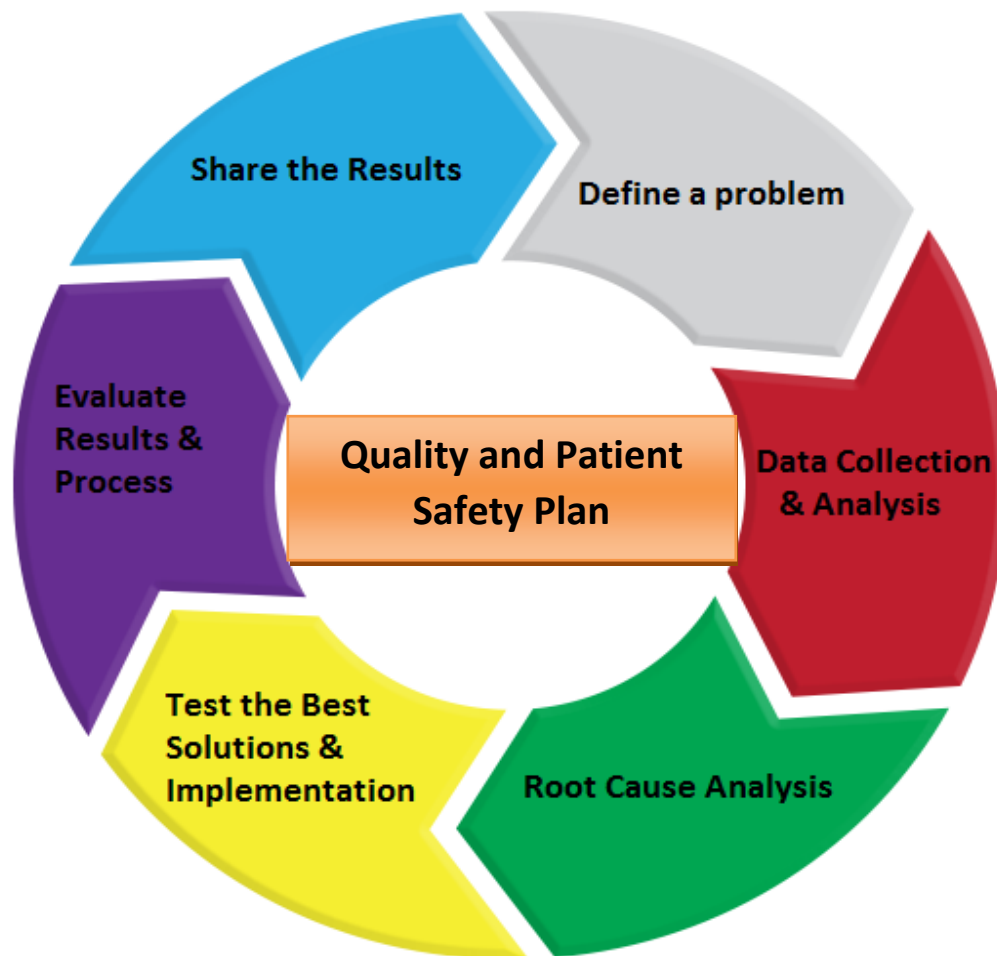
Objective	Goals	Plan	Planned Completion Date	Responsible Party
To reduce falls by 10%	Implement a fall prevention program	Monitor compliance to the program through audits Monitor and evaluate all falls and revise if indicated	12/31/2021	Nursing
Reduce seclusion and or restraints by 10 %	Increase the training period for De-escalation (CPI)	<ul style="list-style-type: none"> • Monitor compliance with training. • Audit charts for proper documentation of the de-escalation techniques used prior to all seclusion and restraints. • Monitor compliance and training of De-Escalation Techniques as part of the debriefing procedure after each incident. • Revise the seclusion and restraint policy/procedure as needed • Implement mock codes to evaluate techniques 	12/31/2021	Nursing
Monitor staff hand hygiene	100% compliance monthly	Revise Hand hygiene policy as needed and educate staff.	Ongoing	Infection Control Committee

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.”

Dini-Townsend Hospital 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 (check)-Act

(PDSA or PDCA) is the model, which was developed by the Institute of Health Care Improvement, which we will use to test the changes.



Root Cause Analysis

A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals.

Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

Root cause analysis and action plan framework table, which was introduced by the Joint Commission. It contains 24 analysis questions. It guides the organization to the steps in a root cause analysis. Not all the questions apply to all the events or cases. This table can be used individually or with the fishbone diagram.

5 Whys technique will be used in Rawson-Neal to explore the cause and effect relationship underlay a problem. One can find the root causes by asking “why” no less than five times. This technique can be used individually or as a part of the fishbone diagram.

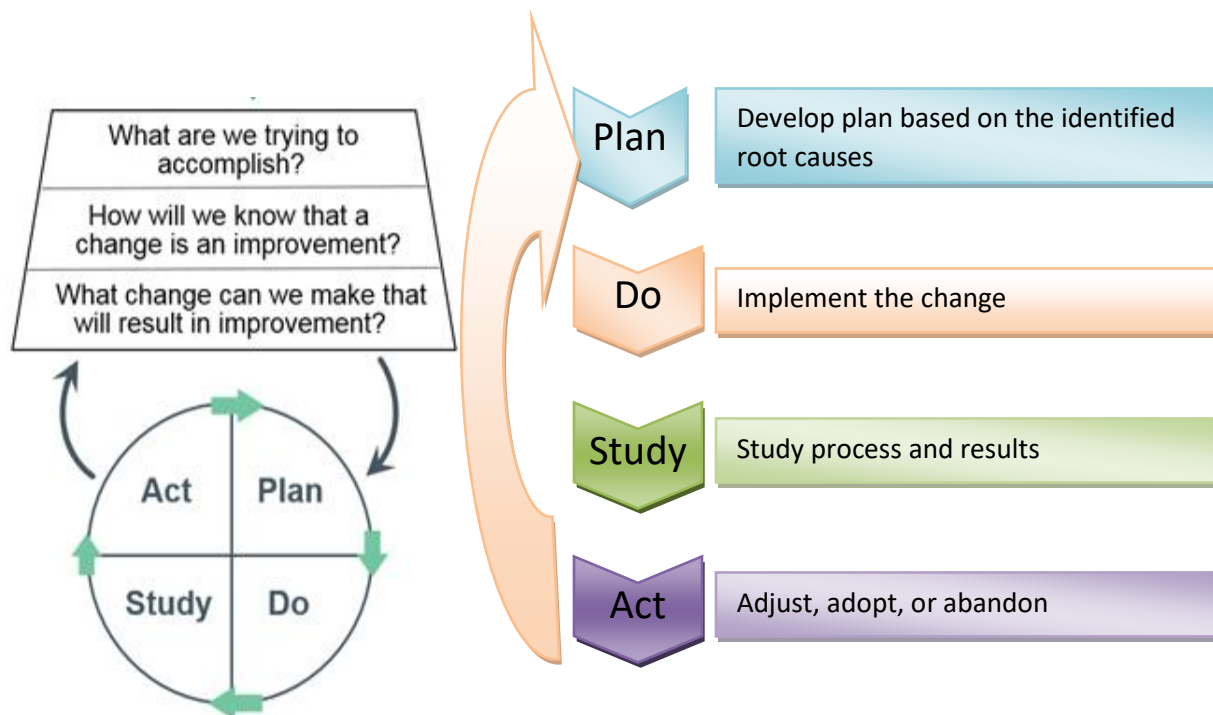
Fishbone Diagram

Once the problems are identified, a Fishbone Diagram (Appendix C) will be used for analyzing the problems. You can use the fishbone diagram individually to analyze the root causes, or use it with the root cause analysis and action plan framework table.

A Fishbone Diagram, also called a Cause-and-Effect diagram, is a useful tool for a team to structurally brainstorm by discovering possible underlying factors or root causes from different major categories for the chosen problems. General categories used include: people, methods, materials, measurements, education, procedures, process, location, environment, etc. RCA team members will brainstorm and ask multiple times, “why did this happen?” for each cause until all ideas are exhausted. The highest priority root causes will be chosen for PDSA topics. Once all the categories are established on the fishbone diagram, 5 Why’s technique also can be used to drill down the problem and find the root causes.

Model for Improvement

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



The cycle is defined as follows:

- Plan--collect data and establish appropriate goals. Identify the problem and the possible root causes, and answer the following questions.

- What is the objective of the test?
- What are the steps for the test - who, what, when?
- How will you measure the impact of the test?
- What is your plan to collect the data needed?
- What do you predict will happen?
- Do--make changes designed to correct or improve the situation. Use the following questions for the guidance.
 - What were the results of the test?
 - Was the cycle carried out as designed or planned?
 - What did you observe that was unplanned or expected?
- Study -- Study the effect of the changes on the situation. Data should be collected on the new process and compared to the baseline or expected results. Results should be evaluated and by using the following questions as guidance.
 - Did the results match your prediction?
 - What did you learn?
 - What do you need to do next?
- Act--If the result is successful or desirable, standardize the changes and then work on the next prioritized problem or the further improvements. If the outcome is not yet successful, look for different ways to identify the causes or change the testing process.

PDSA worksheet will be used to map the potential change strategies and to establish a course of action. The PDSA worksheet and the PDSA progress report are attached in Appendix D-1.

Data Collection and Reporting

Data should drive any quality and patient safety effort. (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.)

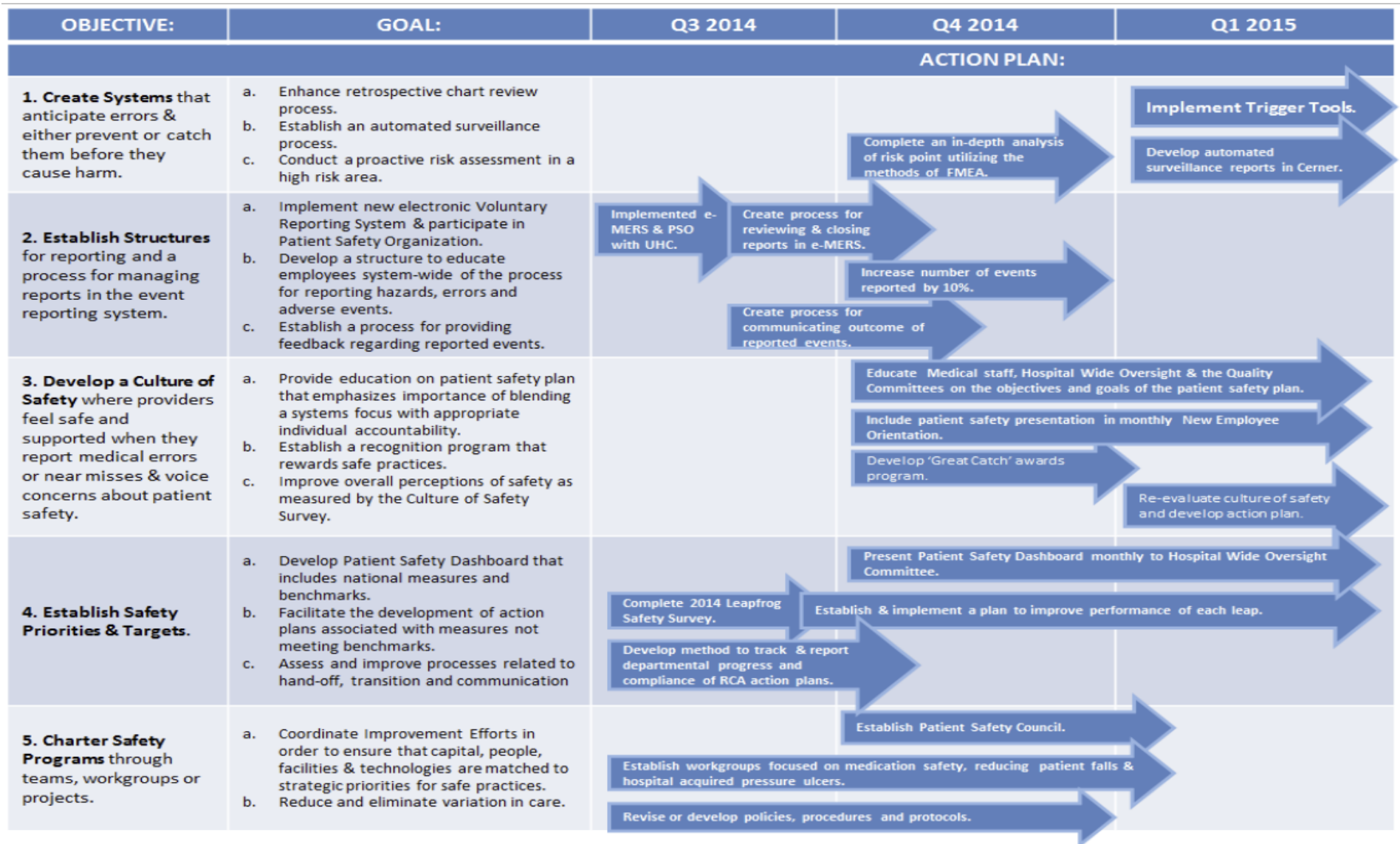
Risk: Possibility of loss or injury. (Merriam-Webster’s Online Dictionary, Risk, Available at <http://www.merriamwebster.com/dictionary/risk>. Last Accessed August 2009.)

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_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



Reference: Patient Safety Plan and Its Applicable Goals. 2014. Cook County Health and Hospitals System.

Appendix C: Fishbone Diagram

Patient Safety and Quality Improvement Plan

Communication

Doctor and patient

Training/documentation

People

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

[Reference: Hospital Policies. MERCY Hospital. <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>]

 MERCY HOSPITAL	HOSPITAL POLICY AND INFORMATION MANUAL	
PERSONAL PROTECTIVE EQUIPMENT POLICY Page 1 of 2	Date Issued: Date Last Revised: Next Review Date: Approved By:	07/01 08/14 08/17 Policy Committee

Key Words: 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



Northern Nevada Medical Center

Risk Management/ Patient Safety Plan

Nevada Acute Care Division

Revised 1/2021

I. Overview

Northern Nevada Medical Center endorses an integrated, system-wide patient safety program designed to improve patient safety and reduce risk to patients.

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

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

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

GENERAL STATEMENTS ON GOALS AND OBJECTIVES

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

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

- Evaluation and documentation of the effectiveness of actions implemented.
- Aggregation of data/information collected for integration in information management systems and use in managerial decisions and operations.

II. Mission and Vision

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

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

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

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

III. ROLES AND RESPONSIBILITIES

A. Risk Management/Patient Safety Officer

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

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

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

B. Infection Control Officer

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

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

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

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

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

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

C. Patient Safety

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

I. Facility Patient Safety Committee

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

Membership:

In accordance with [NRS 439.875](#), the committee core membership consists of the following Key Members: (CEO{member of the Executive or Governing Body}, CNO, Physician, Risk Management and others designated as Patient Safety Officer, Quality Designee, Infection Control Officer, , and Pharmacy). 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 (CFO) of the medical facility. A Patient Safety Committee established pursuant to this section must meet at least once every calendar year.

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'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 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.
- Monitor and document the effectiveness of the hand hygiene protocol or policy.
- Review policy to ensure compliance with the Patient Safety Checklists pursuant to NRS 439.877.
- **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\(4\)\(d\)](#).

- Receive reports from the Patient Safety Officer pursuant to [NRS 439.870](#).
- Evaluate actions of the Patient Safety Officer in connection with all reports of sentinel events alleged to have occurred.
- The Quality member of the PSC will review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- The Quality member in conjunction with the Infection Control Officer will review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- Make recommendations to the Board of Directors of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the Board of Directors of the facility regarding:
 - (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);
 - (2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and
 - (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
- Adopt Patient Safety Checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

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

II. Patient Safety Advisories

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

Medication Safety Alerts are also formulated to apprise the facilities of a specific safety issue that needs to be assessed to prevent reoccurrence.

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

C. TERM Program

The facility has utilized its formalized risk management program identified as TERM: the Technical Elements of Risk Management. Each element focuses on a separate organizational function and details specific strategies for managing risk in these areas. In addition to the delineated elements, the TERM program also includes an evaluation of clinical practices that have or are likely to result in liability or patient harm. The TERM elements are summarized as follows:

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

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

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

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

Element V. Patient Safety Priority: Root Cause Analysis (RCA): The cornerstones of an effective Patient Safety and Risk Management Program are (i) the performance of a

thorough and credible RCA when a serious, sentinel, never event or a significant near miss event occurs; and (ii) implementation of systemic improvements to enhance patient safety and improve healthcare outcomes going forward.

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

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

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

D. MIDAS

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

E. Riskonnect (STARS)

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

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

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

F. Event Notification Site

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

G. Root Cause Analysis (RCA)

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

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

The Joint Commission's root cause analysis framework and action plan table should be used as a reference. 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, NRS 439.877, for use by:

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

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

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

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

I. Patient Safety Policies

The Patient Safety Policies must include, without limitation:

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

J. MEMBER PATIENT SAFETY EVALUATION SYSTEM (PSES)

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

K. Training and Education

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

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

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

IV. Acute Care Division Patient Safety Priorities, Goals and Objectives for 2021

- **Surgical and Procedural Safety**
 - **Wrong Site Surgery (WSS)**
 - **Goal:** A 50% reduction in WSS events for 2021. Ultimately, the goal is zero (0).

- Monitor through Midas event reporting and the Patient Safety Dashboard. Report monthly with oversight by CPSC.
- **Retained Procedural items (RPIs)**
 - **Goal:** Prevent RPIs- a 50% reduction in RPIs with harm for 2021. Ultimately, the goal for RPIs is 0.
 - Monitor through Midas event reporting and the Patient Safety Dashboard. Report monthly with oversight by CPSC.
- **CLABSI Initiative**
 - **Goal:** CLABSI will be reduced to less than the national CMS mean Standardized Infection Ratio (SIR: CLABSI 0.736) in 2021.
 - Monitor through CDC's National Healthcare Safety Network (NHSN) and the Patient Safety Dashboard. Report quarterly with oversight by CPSC.
- **Safe Medication Use**
 - **Reduce the preventable occurrences of Opioid Induced Respiratory Events (OIRD) in 2021.**
 - **Goal:** Decrease the number of preventable OIRD events by 10%.
 - **Goal:** Each facility will track and trend naloxone administrations and will identify a performance improvement project related to safe use of opioids by March 1, 2021.
 - **Goal:** 100% of Acute Care facilities will have a medication safety committee that utilizes a standardized charter and agenda by June 1, 2021
 - Monitor through MIDAS reports, Cerner ICD-10 codes and other intervention data and the Patient Safety Dashboard. Report quarterly with oversight by CPSC.
- **Reduce Falls and Falls with Injury**
 - **Goal:** 10 % reduction in the number of falls by end of 2021.
 - **Goal:** 10% reduction in the rate of falls by the end of 2021.
 - **Goal:** 10% reduction in the rate of falls with injury by the end of 2021.
 - **Goal:** A debrief will be completed within 72 hours for 100% of falls with injury.
 - Monitor through MIDAS event reporting and the Patient Safety Dashboard. Report quarterly with oversight by CPSC.
- **Decreasing Hospital Acquired Pressure Injuries**
 - **Goal:** 10% reduction of NPOA rate for all HAPI stages in the Acute Care Division by the end of 2021.
 - Monitor through Midas event reporting and the Patient Safety Dashboard. Report quarterly with oversight by CPSC.
- **Culture of Safety**

- **Goal:** reduce the number of GHI events (serious safety event rate) for the Acute Care Division by the end of 2021. Ultimately, the goal is 0.
 - Monitor through MIDAS event reporting and the Corporate Patient Safety Dashboard. Report monthly with oversight by CPSC.
- **Goal:** 100% of 2021 Patient Safety Plan Priorities will be implemented within the hospitals.
- **Increase Hospital Midas Event Reporting**
 - **Goal:** 10% increase of events reported through Midas
 - **Goal:** Each department will have goals and specific event types to focus on.
 - Monitor through Midas event reporting and the Patient Safety Dashboard.

V. Monitoring and Accountability

A. Evaluation of TERM Program

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

B. Patient Safety Committee

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

C. Dashboards

The Risk Management/Patient Safety Dashboard and the Environment of Care includes multiple indicators to demonstrate the facility's performance as to patient safety markers. These include event reporting statistics, overall harmful event rate, fall rate including harmful event rate, medication event rate including harmful medication events or adverse drug events, serious harm OB events, pressure injury rates, infection variances, and procedural events.

VI. Evaluation/Review:

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

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

VII. Confidentiality

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

VIII. Approval of Patient Safety Plan

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


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

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

Appendix A: Checklist Example: Injuries from Falls and Immobility

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

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

	Policy Name: Patient Safety Plan
	Department(s) Affected Facility Wide
Approved by: CEO, Risk Manager, Safety Officer, Board of Director	
This P&P complies with the following regulation(s): NRS 439.865, NRS 539.830, NRS 439.877, NRS 439.843	

PERSHING GENERAL HOSPITAL & NURSING HOME, LOVELOCK, NV

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.

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 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 a Quality Review Report (QRR), 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 QRR 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 a QRR. The QRR 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 a QRR 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 a QRR – 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 a QRR – 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 a QRR. The QRR 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 a QRR 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. Infection Control Officer
3. At least three providers of healthcare who treat patients at the medical facility including one member of the medical, nursing, and pharmaceutical staff.
4. One member of the executive or governing board of the medical facility

The patient Safety Committee will meet monthly.

Saint Mary's Regional Medical Center:

PATIENT SAFETY PLAN

DATE: 01/21/2021
VERSION: 01
KRYSTAL FLANIKEN
RN,MSN



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 Reginal 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".

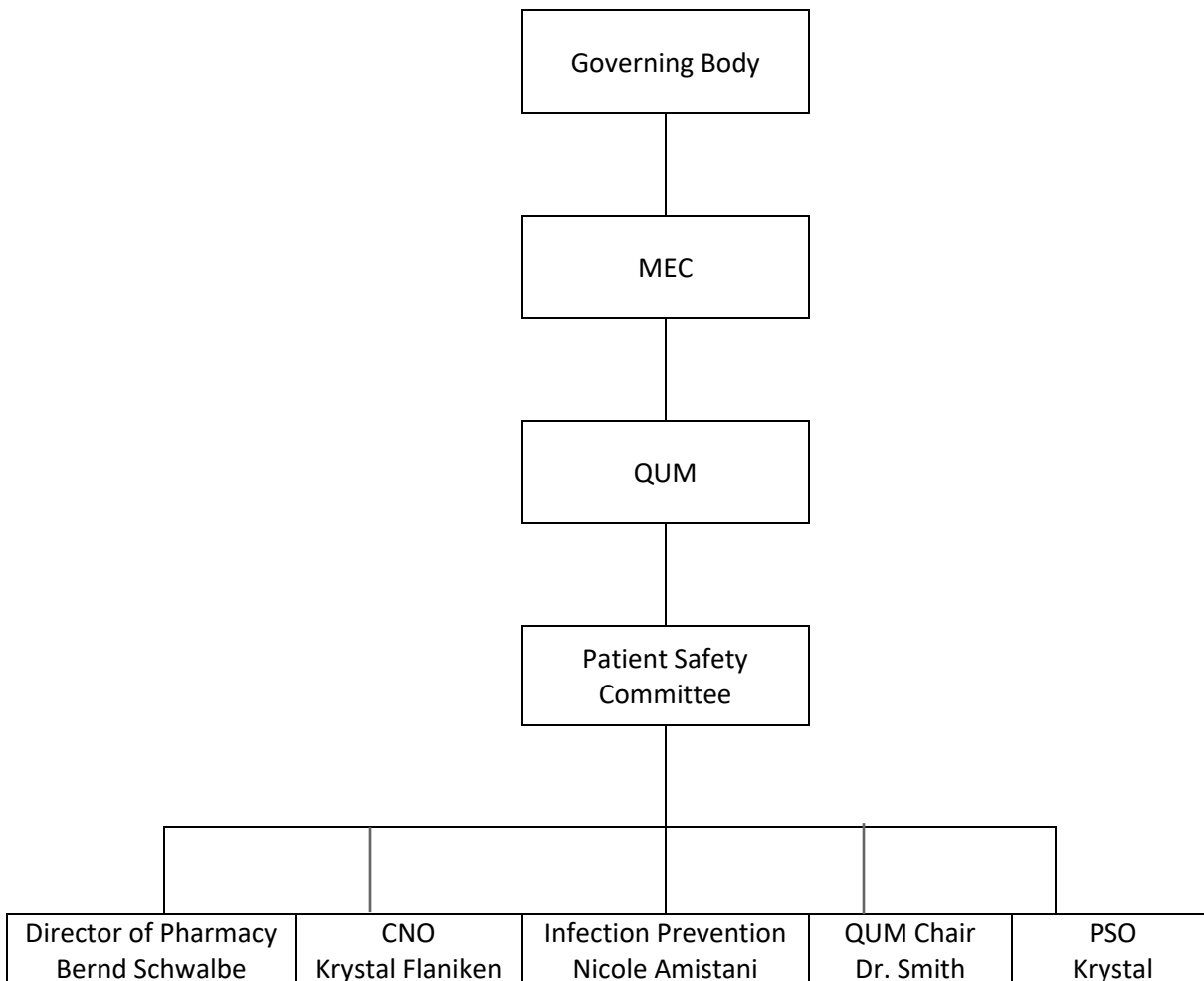
These reports will be reported to appropriate hospital and Medical Staff committees and to the Governing Board at regular intervals. The aggregate data will be used to prioritize organization-wide patient safety efforts.

- 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



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Roles and Responsibilities

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

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 Medication Reconciliation	Use PDSA tools to create a way to make medication reconciliation timely (within 24hrs) and accurate (dosage, frequency, rout) for home medication information of every patient admission by June of 2021.	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 medication reconciliation. We will have a bias toward action implementing small tests of change utilizing the PDSA model.	July 1, 2021	AH
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, 2021	CS
Improve response rate of AHRQ Safety Attitude Survey	Maintain respondents of 80%	Focus on patient care areas by removing non-clinical departments from denominator	May 30, 2020	EM

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.

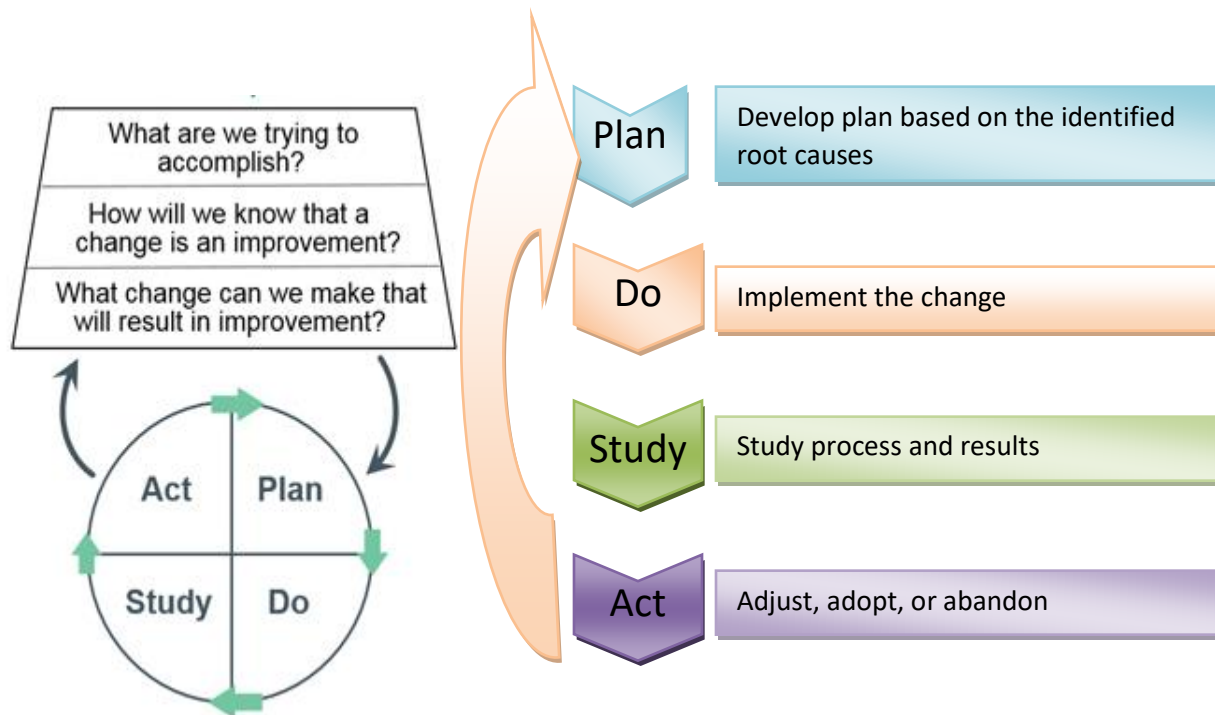
Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

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

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 2011 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.

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 does not apply to routine situation in which short-term prophylactic anticoagulation is used for preventing venous thromboembolism (for example, related to procedures or hospitalizations)

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.

Goal 15 -The hospital identifies safety risks inherent in its patient population.

NPSG.15.01.01

Reduce the risk for suicide.

Note: Eps 2-7 apply to patients in psychiatric hospitals or patients being evaluated or treated for behavioral health conditions as their primary reason for care. In addition, Eps 3-7 apply to all patients who express suicidal ideation during the course of care.

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

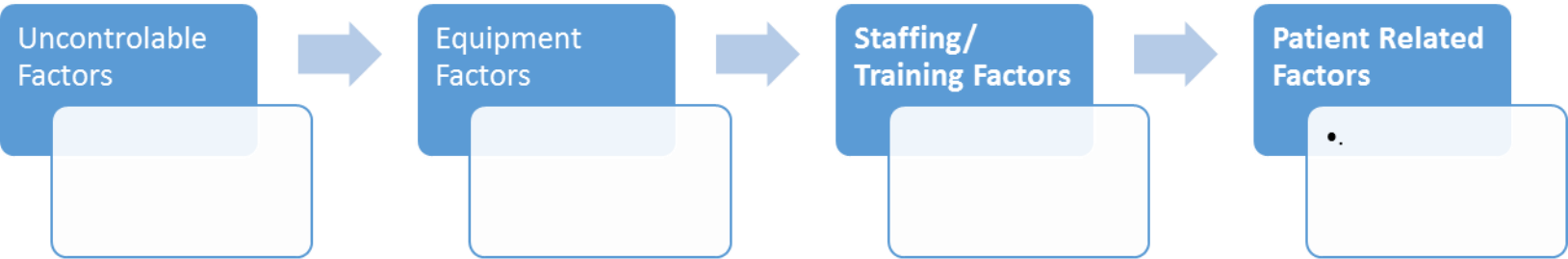
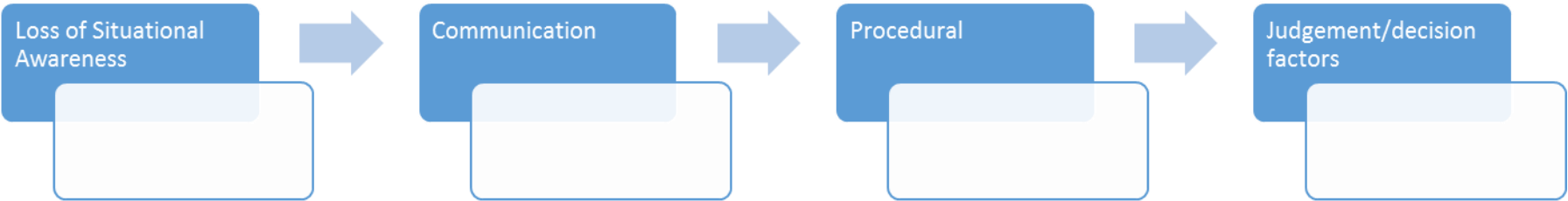
Narrative:

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.

☐ 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: Code Neuro


Code Neuro - New Item


EDIT


 Save


 Cancel

 Paste

 Cut

 Copy

 Attach File

 ABC Spelling


Commit

Clipboard

Actions

Spelling

Last Known Well Time

 12 AM 00

Events prior to Code Neuro Call

Total NIHSS Score

Was head CT done

☐

Were Labs ordered

☐

Was Primary MD called

☐

Was Stroke Program Coordinator notified

☐

Name of recorder

Name of primary MD

Name of Primary RN

Name of Code Neuro Team RN

Supervisor

Was Patient transferred


☐

Save

Cancel

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

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 into 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, 2021 National Patient Safety Goals.

The Joint Commission FAQ's 2009 Universal Protocol; November, 2008 Sentinel Event Alert-Wrong Site Surgery

Physician Insurer's Association of America (PIAA). Claims Data
American Academy of Orthopedic Surgeons: Report on Wrong-Site Surgery Feb 1998

Bulletin of the American College of Surgeons, Vol. 87, No. 12, December 2002.

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APPROVAL:

Committee Approvals	Date
Surgical Services Executive Committee	12/13
Procedural Safety Team	12/13
Committee Approvals	Date
Policy Committee	6/16
QUM	6/16
MEC	8/16
BOARD	

Origination date: 09/01

Reviewed/Revised: 10/02, 12/02, 02/03, 06/03, 08/03, 10/03, 05/04, 04/05, 11/05, 08/06, 07/07, 05/08, 12/08, 02/09, 04/09, 04/10, 10/12, 12/13, 6/16, 2/21

**Dignity Health – St. Rose Dominican
Rose de Lima Campus
PATIENT SAFETY/RISK MANAGEMENT PLAN**

DATE: 01/2020



This plan was created and revised by the Dignity Health – St. Rose Dominican Patient Safety Officer with review and input from the Patient Safety Committee. Implementation of this plan is intended to optimize the healthcare quality and patient safety outcomes, encourage recognition, reporting, and acknowledgment of risks to patient, visitor, and employee safety, as well as reduce the medical/healthcare errors and /or preventable events.

Patient Safety Committee/Program
St. Rose Dominican – Rose de Lima Campus
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Commitment to Patient Safety

Dignity Health St. Rose Dominican Hospital – Rose de Lima Campus is committed to a comprehensive approach to improving healthcare quality and patient safety by aligning with our Mission, Vision, and Values, creating an environment that supports a dynamic, proactive, and safe culture for patients, family members, visitors, and employees, through continuous learning and improving patient safety policies, systems, and processes.

Mission, Vision, and Values

In support of our mission, vision, and values, Dignity Health – St. Rose Dominican, Rose de Lima Campus' Patient Safety/Risk Management program promotes:

- Honest, open collaboration and partnership of hospital leadership, medical staff, patients and their families, the community and other healthcare providers to deliver compassionate, high-quality, affordable healthcare.
- Promote justice and respect for those we serve.
- Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.
- Responsibility and accountability for every healthcare related decision and action.
- A focus on excellence, teamwork and innovation through continuous learning, improvement in system design, and the management of choices and changes, bringing the best possible outcomes or performances to the facility.
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare.
- Education of staff and physicians to assure participation of healthcare providers.

Scope and Purpose

The Patient Safety/Risk Management Program at St. Rose Dominican is an organization-wide/campus specific strategy that includes not only facility staff and medical staff, but is inclusive of patients, family and visitors. The Patient Safety/Risk Management Program at Rose de Lima Campus supports and encourages the active participation of each person in order to be an effective program. When processes, functions or services are designed or redesigned, information internal and external to the campus and/or organization regarding potential risks to patient safety will be considered and where appropriate, utilized to minimize the risk to patients affected by the new or redesigned process, function or services.

The purpose of this plan is to establish system-wide guidelines and processes supporting a comprehensive, effective, organization-wide Patient Safety/Risk Management Program Plan designed to promote and improve patient safety at Dignity Health – St. Rose Dominican, Rose de Lima Campus, by working to prevent medical/healthcare adverse events and reducing risk to patients and visitors.

Undesirable facility specific and system patterns or trends in performance and sentinel events will be intensively analyzed to determine where best to focus changes for improvement. Intensive analysis will be initiated when:

- Levels of performance, patterns or trends vary significantly and undesirably from those expected including significant near misses;
- Performance varies significantly and undesirable from that of other campuses/organizations;
- Performance varies significantly and undesirably from recognized standards; and/or
- A reportable event has occurred at that campus.

Minimally, data from the following areas will be gathered at each facility and presented at that facility for analysis with action plans developed reflective of the findings:

- Initial and on-going proactive risk assessments utilizing internal and external resources;
- Campus aggregate event reports reflective of all medical/healthcare events, with and without adverse outcomes, including but not limited to:
 - Hospital acquired infections
 - Medication events, to include delays in administration
 - Adverse drug events
 - Transfusion reactions
 - Patient falls
- Actual and near misses
- Hazardous conditions
- Restraint issues
- Medical record legibility issues
- Patient/family/staff opinions, needs, perceptions of risks to patients, and suggestions for improving patient safety;
- Identified data trends and analysis reports from sister facilities, Dignity Health Shared Learnings, etc.
- Others as defined by various campus committees, Leadership and/or Quality Council and Advisory Committee of the Board (QCAC).

Roles and Responsibilities

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

The Patient Safety Committee Organization

Roles and Responsibilities

- In accordance with [NRS 439.875](#), a patient safety committee must be comprised of:
- The infection control officer of the medical facility;

- The patient safety officer of the medical facility, if he or she is not designated as the infection control officer;
- At least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility; and
- One member of the executive or governing body of the medical facility.

The roles and responsibilities are defined below.

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

The Patient Safety Committee convenes monthly in accordance with NRS 439.875. In collaboration with the Patient Safety Officer, the committee represents the Rose de Lima Campus and includes multidisciplinary team members which has oversight responsibility to ensure that the responsibilities and functions outlined in this program are carried forward throughout the organization. The following are responsibilities assigned:

- Serve as champions of the Patient Safety/Risk Management Program within the facility/organization.
- Establish and evaluate data to identify patient safety performance indicators.
- Evaluate other sources of patient safety data utilizing internal and external resources including but not limited to adopted patient safety checklists, risk assessments, sentinel event report/alert information and event reporting information from a variety of available resources including the event reporting system, APIC, CHPSO, etc.;
- Selection of a high-risk patient safety process for proactive risk assessment and improvement annually;
- Collaborates with each facility's Quality Council to identify, address and conduct follow-up on patient safety related trends, analysis results, changes in processes, and policies.
- Annual review of the Patient Safety Program to ensure its appropriateness of focus and effectiveness of efforts for each campus.
- Monitor and document the effectiveness of the patient identification policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the patient safety officer pursuant to [NRS 439.870](#).
- Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred.
- Review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- Review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur.

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

Root Cause Analysis (RCA) Team Responsibilities

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

Patient Safety Officer Responsibilities (based on [NRS 439.870](#))

The Manager of Patient Safety/Risk Management 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 2021.	May 2021
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
Quality/Patient Safety staff orientation	Quality/Patient Safety Services will review/update Manager orientation.	March 31, 2020
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, and 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 Privilege (PSWP Privilege) 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

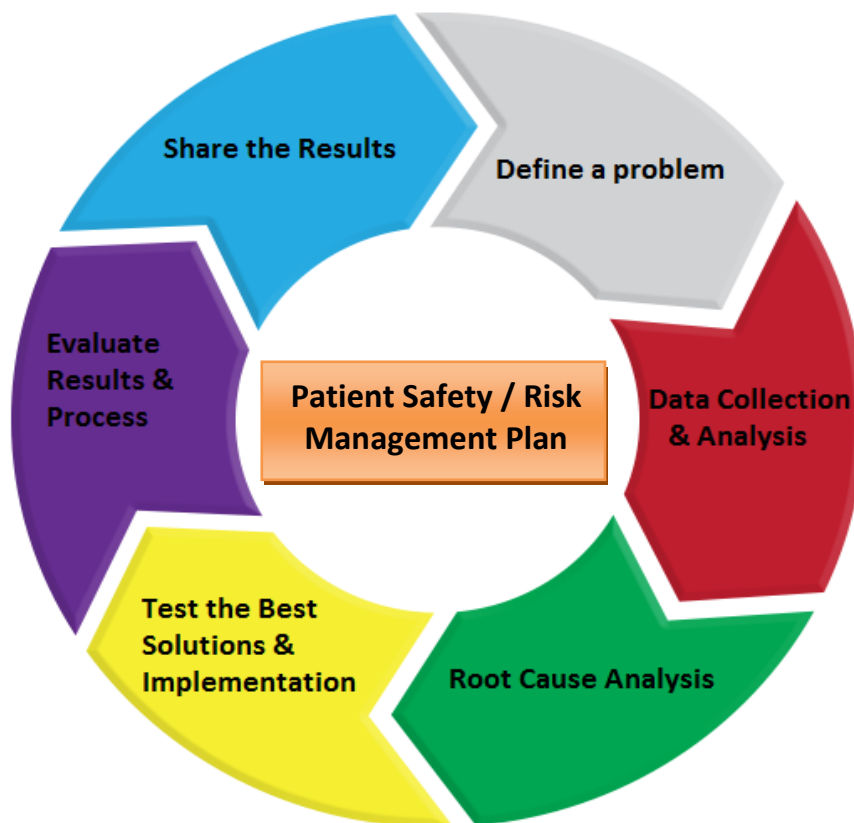
- ii. Significant adverse drug reactions
- iii. Significant medication events and hazardous conditions
- iv. Manor discrepancies, or patterns of discrepancies, between preoperative and postoperative (including pathologic) diagnoses, including those identified during the pathologic review of specimens 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 measure to prevent and control infections	1) Quality and Patient Safety Plan update 2) Checklists and Policies reviewing and revising

Assessment of the Quality and Patient Safety Plan

Please see the Patient Safety Assessment Tool (PSAT) from the VA National Center for Patient Safety for your reference.

Patient Safety Checklists and Patient Safety Policies

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

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

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

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

The patient safety policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include the name and date of birth of the patient.
- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.

- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

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

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

http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf

The following link provides you some patient safety policies for your reference

<https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies-and-guidelines>

Approval of Patient Safety Plan

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

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

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

Patient Safety Program Reporting and Review

All patient safety work product privilege (PSWP Privilege) 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 <https://www.health.state.mn.us/facilities/patientsafety/adverseevents/toolkit/>
- Quality and Service Improvement Tools <https://improvement.nhs.uk/resources/pdsa.cycles/>
- CQI 101 An Introduction to Continuous Quality Improvement: <https://www.coursehero.com/file/13827355/CQI-Overviewppt/>
- Quality Improvement <http://www.hrsa.gov/quality/toolbox/>
- Root Cause Analysis <http://www.patientsafety.va.gov/professionals/onthejob/rca.asp>
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2 https://www.jointcommission.org/sentinel_event.aspx
- Hospital Policies <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies-and-guidelines>
- Checklists to Improve Patient Safety http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf
- Minutes of the Meeting of the Quality and Patient Safety Committee <https://cookcountyhealth.org/wp-content/uploads/12-13-19-QPS-scan-Minutes.pdf>
- Title 40 – Public Health and Safety <https://www.leg.state.nv.us/NRS/NRS-439.html>

Reviewed/Approved:

Patient Safety Committee, January 2020

Quality Care Advisory Committee of the Board, January 2020

Community Board, January 2020

SOUTH LYON MEDICAL CENTER
213 S. Whitacre St
Yerington, NV 89447

PATIENT SAFETY COMMITTEE

SUBJECT: Patient Safety Plan

CROSS: Medical Staff

POLICY NO:

PAGE NO: 1 of 8

EFFECTIVE: 11/2002

REVISED: 1/2021

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 works in conjunction with the Civil Rights Coordinator and helps to assure that SLMC is up to date with all ADA requirements.
- c. 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.
- d. All patient safety related reports require that an investigation be conducted to determine the cause(s) of the adverse event.
- e. 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.
- f. 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.
- g. The vast majority of errors are unintentional. No disciplinary action will be initiated against the individual(s) involved in an unintentional error. However, certain events, such as noted below, do warrant administrative, disciplinary or legal action. Should any of the following be discovered in the course of a patient safety event investigation, the Administrator and

Medical Staff will be immediately informed of the circumstance and action taken beyond the scope of the Patient Safety Program:

- 1) Criminal activity (e.g. assault and battery, etc)
- 2) Intentional unsafe acts due to gross negligence or reckless behavior
- 3) Alleged patient abuse of any kind
- 4) Impairment due to medical and psychological conditions including alcohol or other drug abuse.

III. South Lyon Medical Center Patient Safety Function.

- a. Integration of all patient safety related issues and processes under the auspices of a single committee/ functional team. This reduces duplication of effort and enhances program efficiency.
- b. Patient Safety Committee.
 - 1) Membership. Membership is outlined in NRS 439.875; 1) The infection control officer, 2) The patient safety officer, 3) At least three providers of health care who treat patients at the medical facility, including, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility. And 4) One member of the executive or governing body of the medical facility.
 - 2) Chairperson. The chairperson shall be a nurse or physician.
 - 3) Committee minutes/reports. The committee minutes/reports will summarize the organizations patient safety activities to include, as a minimum:
 - a. Analysis of all clinical and non-clinical reported events, trends and lessons learned.
 - b. Actions necessary for organizational process/systems improvements as appropriate.
 - c. Proactive patient safety error reduction activities.
 - d. Progress related to risk assessments, prospective analysis and root cause analysis action plan implementation and effectiveness, according to established time-lines.
 - e. Patient Safety Committee minutes/reports will be forwarded to the Medical Staff Committee and the Governing Board quarterly. Recommendations associated to patient safety will be forwarded to the Medical Staff for implementation as appropriate.
- c. Management of Patient Safety Information.
 - a. The focus of patient safety data collection and reporting is to improve organizational systems and to provide the safest care possible. The information and data amassed through reporting, investigation and evaluation will be confidential and reported through the Medical Staff Quality Assurance process.
 - b. Data trend analysis will include, but not be limited to, the following:
 - 1) Sentinel Events or actual or alleged.
 - 2) Medication errors and fall.
 - 3) Equipment malfunctions.
 - 4) Preventive/corrective interventions
 - c. Ad hoc committees may be assigned by the Medical Staff regarding competency investigations related to a patient safety related event to insure

that peer status is maintained throughout any investigation. All information obtained will remain confidential under the auspices of Medical Staff Quality Assurance.

IV. Patient Safety Event Management.

- a. Event identification. A patient safety event is any incident that occurred (actual event) or almost occurred (near miss) that caused or had the potential to cause harm to a patient. Identification and reporting of near misses and adverse events, including those that result from practitioner/professional error, should be encouraged as an expectation of everyday practice. The three types of patient safety events include near miss, adverse events and sentinel events.
- b. Near Miss. A near miss is an event or situation that could have resulted in harm to a patient, but did not, either by chance or through timely intervention. The event was identified and resolved before reaching the patient. Because near misses generally occur more frequently than actual adverse events, proactive analyses of near misses provide a tangible opportunity to improve the system without having to experience an actual adverse event. Staff should be encouraged to report near miss events for the purpose of analysis and identification of methods improvement.
- c. Adverse Event. An adverse event is an occurrence associated with the provision of health care or services that may or may not result in harm to the patient. Adverse events may be due to acts of commission or omission. Incidents such as patient falls or improper administration of medications are also considered adverse events even if there is no harm or permanent effect to the patient.
- d. Sentinel Event. A sentinel event is an unexpected occurrence involving death, serious physical or psychological injury, or the risk thereof. **Serious injury** specifically includes loss of limb or function. The phrase “or risk thereof” includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called “sentinel” because they signal the need for immediate investigation and proactive response on the part of the organization.

V. Event Documentation and Reporting.

1. Prevention of harm to patients is everyone’s responsibility and reporting all potential and/or actual patient safety events is a performance expectation of all organizational staff. Anyone with knowledge of a patient safety event not only may, but should, report it.
 - a. Immediate actions.
 - 1) Upon identification of a actual patient safety event, the staff member will immediately perform necessary health care interventions to protect and support the patient’s clinical condition. The patient’s attending physician and other physicians, as appropriate, will be contacted as soon as possible to report the incident and provide an update on the patient’s current clinical status.
 - 2) As appropriate to the event, the staff will initiate all physician directed orders and take other necessary health care interventions to contain the risk to others, and to preserve event-related materials that may require further investigation. Examples of physical information preservation include: removal and preservation of a blood unit for a

suspected transfusion reaction; preservation of IV tubing, fluid bag, and/or IV pump for a patient with a severe drug reaction from a IV medication. Preservation of information also includes documenting the facts regarding the event in the patient's medical record according to organizational policy and procedure.

- 3) If the patient safety event involves serious physical or psychological injury, unexpected death, or qualifies as a sentinel event, the appropriate department director will be notified immediately. If such events occur after hours, the administrative on-call staff will be notified immediately. Individuals notified will ensure proper notification of senior management is accomplished in a timely fashion.

b. Documentation and Internal Reporting.

- 1) Any individual in any department who identifies a potential (e.g. near-miss) or actual patient safety event will immediately notify their immediate supervisor and will initiate a Incident Report. This report will contain concise, factual, objective and complete details about the event.
- 2) Incident Reports or in the case of medication errors, a Adverse Drug Event Report will be forwarded to the department director within 24 hours of the discovery of the event or the first duty day following a weekend or holiday. The department director will review the report, add any additional relevant information, and forward it to the Patient Safety Officer, or designee, within 24 hours of receipt.
- 3) The Patient Safety Officer (PSO), or designee, will review all incident reports and ADE reports. In addition, the PSO will determine what specific actions are necessary to further evaluate the event. If the event is a sentinel event, the PSO will immediately notify the Administrator and Risk Manager and activate a Root Cause Analysis Team from the Patient Safety Committee and others as deemed appropriate to investigate the event.
- 4) If the patient safety event is an intentional unsafe act that results from gross negligence or possible criminal activity, the event shall be reported to the appropriate authorities for investigation.
- 5) Some events fall within the definition of both an adverse event and an intentional unsafe act. For example, infant abduction would be both a crime and a reportable Sentinel Event that require Root Cause Analysis. In cases that appear to be both a adverse event and an intentional unsafe act, primary authority and responsibility for dealing with the event belongs to the Administrator and Risk Manager. This is beyond the scope of the Patient Safety Program. The PSO will coordinate a review of the systems and processes implicated in the actual or potential unsafe act, to include conducting a root cause analysis, if applicable, but will defer to a separate investigation with respect to the culpability of any persons involved in the event.
- 6) External reporting requirements. All incidents meeting the definition of a Sentinel Event must be reported to the State Health Department

and Bureau of Licensure. Reports must be completed within the time frame as outlined in policy and procedure.

VI. Patient Safety Event Analysis.

Event analysis assists in the discovery of the root causes and/or contributing factors associated with the patient safety event. Tracking and trending of data allows the Patient Safety Committee and Medical Staff to identify familiar trends or circumstances so that system or process issues can be identified and improved.

- a. Aggregate review analyses. Aggregate review consists of examining data elements for common trends or patterns within the group. The use of aggregated review serves two purposes. It allows for wider applicability of the analyses (i.e., trends or patterns that were not noticeable in an individual case analysis become more obvious as the number of cases increases). In addition, it more clearly defines specific data elements in a recurring problem and encourages prudent use of the time and expertise of the organization staff associated with evaluation and corrective action.
- b. Root Cause Analysis. A root cause analysis must be conducted and an action plan completed for all actual sentinel events. The Patient Safety Committee will formally designate a root cause analysis team to conduct a thorough and credible root cause analysis on all sentinel events. A Root Cause Analysis (RCA) is the process for identifying the basic and/or contributing casual factor(s) associated with patient safety events. The review is interdisciplinary and includes those who are closest to the process, but typically not those directly involved in the specific event. Those directly involved may be consulted for event-related information if appropriate. The RCA focuses on systems and processes, not individual performance. It identifies changes that could be made in the systems and processes to improve performance and to reduce the risk of adverse events, or the recurrence of near misses, with the ultimate goal of reducing and/or eliminating patient harm.
- c. Root Cause Analysis Action Plan. Once the RCA has been completed, a detailed action plan must be developed to enumerate the risk reduction strategies that the organization intends to implement to prevent the recurrence of similar events. The action plan should address responsibility for implementation, oversight, pilot testing (if appropriate), timeliness, and the specific metrics to be employed in evaluating the effectiveness of the actions taken.
- d. The RCA action plan will be submitted to the Medical Staff for approval.
- e. Follow-up review. All RCA action plans will be reviewed at a minimum of 6 months following implementation to address the effectiveness of the improvements implemented by the organization. These findings will be reported to the Medical Staff and Governing Board.

VII. Patient Safety Event Communication.

Administration and all staff are reminded that all data compiled as part of the Patient Safety Program are QA information and protected from disclosure and must be marked as Quality Assurance Document.

- a. Staff involved in a patient safety event. Any staff member reporting and/or directly involved in a patient safety event that caused patient harm will receive

support and assistance from their supervisor to facilitate the staff member's professional and emotional needs related to the patient safety event. Management efforts and activities will focus on improving the systems and processes that may have contributed to the event rather than disciplining those involved.

- b. Reporting a patient safety event. Staff members and supervisors who submit patient safety event reports will receive timely feedback on the actions being taken as a result of their report.
- c. Patient/family affected by a patient safety event. In cases involving an unanticipated outcome of care, a qualified health care provider will inform the patient and/or his/her family member(s) within seven (7) days of discovery of the event. This information is provided as a matter of policy and does not affect any rights or obligations in legal or administrative proceedings. Under no circumstances will QA-protected information be released or provided to the patient/family member.
- d. The Patient Safety Officer, or designee, is responsible to ensure that the provider and patient/family member communication takes place. The designated primary communicator will document in the patient's medical record what was communicated to the patient/family member, the patient/family member's response, and any other pertinent information. It shall be the responsibility of the affected patient's primary care physician or Chief of the Medical Staff or Vice Chief of the Medical Staff to make the initial and subsequent notification.
- e. In most cases, facts surrounding the patient safety event that affect the patient can and should be disclosed to the patient/family member by the provider.
- f. Any specific questions relative to disclosure of information associated with unanticipated adverse outcomes should be referred to the organization's legal representatives.

VIII Patient safety Education and Training

- a. All staff shall receive patient safety education and training during their initial new employee orientation and on an annual and as-needed basis, regarding job-related aspects of patient safety and staff specific roles and responsibilities to actively support patient safety policy.
- b. Community education. Patients and potential patients/family members shall be educated concerning their role in helping to facilitate the safe delivery of care. Methods include but are not limited to; public forums, newspaper articles, addressing specific community groups and organizations.
- c. **Checklists have been developed and implemented in several different formats that range from facility policies, department checklists and medical record audits. These checklists and policies include but are not limited to; correct patient identification and verification, foley catheter criteria, informing patients of Healthcare Acquired Infections (HAI's) or Facility Acquired Infections (FAI's), hospital inpatient information sheets related to HAI's and hand hygiene and respiratory etiquette and patient information regarding discharge planning, medication reconciliation and request that providers indicate the use or reason for each prescription that is issued.**
 - a. **On or before July 1 of each year a report will be submitted to the Director of the Legislative Counsel Bureau which includes the development, revision and usage of patient safety checklists and policies.**

IX Confidentiality of Medical Quality Assurance Information.

As with other medical QA documents, any information, records, reports, minutes, and other documents directly associated with patient safety activities are protected under 10 USC 1102. In discussing medical information with family members, staff shall also comply with other applicable restrictions on nonconsensual disclosures, including those under the Privacy Act, 5 USC 552a. As a general rule under the Privacy Act, information regarding a patient's condition shall not be provided to others without the patient's consent.

SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES

QUALITY AND PATIENT SAFETY PLAN 2021

Rawson Neal Hospital at Southern Nevada Adult Mental Health Services

DATE: 01/1/2021
VERSION: 01



DPBH Mission Statement

It is the mission of the Division of Public and Behavioral Health to protect, promote and improve the physical and behavioral health of the people of Nevada.

This plan was created and revised by the Rawson Neal Hospital at Southern Nevada Adult Mental Health Services 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 occurrence of medical and healthcare errors and preventable events.

**Patient Safety Committee
Rawson Neal Psychiatric Hospital
Southern Nevada Adult Mental Health Services**
1650 Community College Dr.
Las Vegas, NV 89146
ME, RN Hospital Patient Safety Officer
SNAMHS Patient Safety Committee Chair
702-486-5387

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Commitment to Patient Safety

Rawson Neal Hospital at Southern Nevada Adult Mental Health Services is committed to a comprehensive approach to improving healthcare quality and patient safety by aligning with our Mission, Vision, and Values. The agency aims to create 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, Rawson Neal Hospital at 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 and challenges and to revise programs to better serve patients and their

families. To achieve this, Rawson Neal Hospital at SNAMHS has developed this Patient Safety plan.

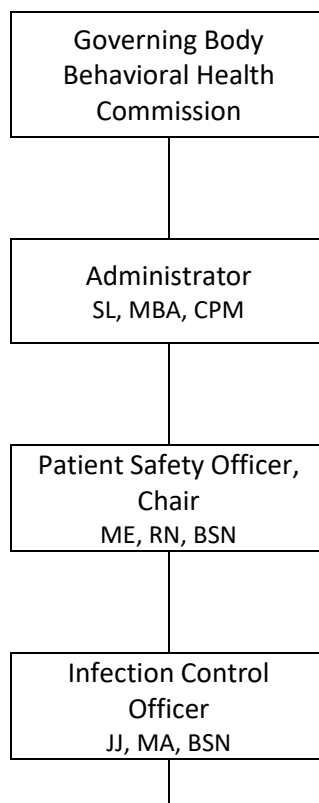
The plan focuses on the process rather than the individual and recognizes both internal and external customers. It facilitates the need for analyzing and improving processes. The core principles of this plan include:

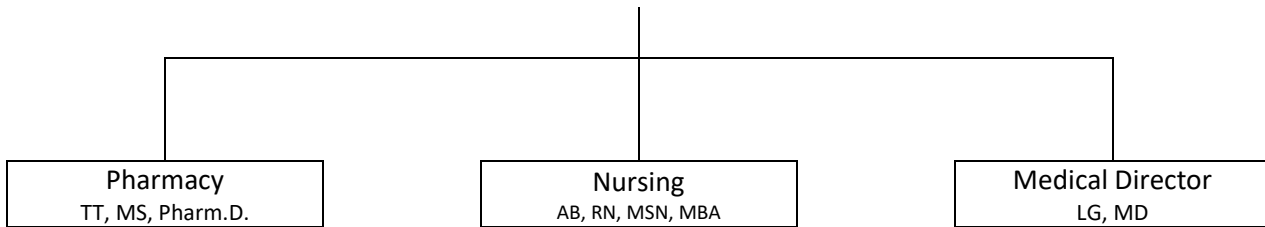
- All staff have the same goal and contribute their knowledge, vision, skills, and insight to improve the process of the Patient Safety Plan.
- Decisions will be based on data and facts, and staff will be encouraged to learn from their experiences.
- Customer based including patients, families, and visitors.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

The Patient Safety Committee will meet monthly to accomplish the following:

- Report and discuss sentinel events which include:
 - Number of sentinel events from the 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.

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 in Root Cause Analysis Committees
- Communicate the progress of the investigation, institutional barriers, and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of 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

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

Root Cause Analysis (RCA) Facilitator Responsibilities

- Organize, coordinate and facilitate the RCA process.
- Ensure the collection of all necessary materials, i.e. medical records, police reports, policies and equipment
- Identify committee members and alert their supervisors and the staffing department to ensure unit coverage.
- Assemble and encourage a supportive and proactive team. Assign committee members to conduct any necessary interview and data collection
- Conduct and be actively involved in the investigation and corrective action plan implementation process.

Root Cause Analysis (RCA) Team Responsibilities

- Conduct root cause interviews, analysis and investigation
- Participate in the RCA meetings and discussions and corrective action plan implementation.
- Communicate honestly and openly about data and facts to the team members and their supervisors and leaders.

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

- Identify systems and processes that may have led to the event
- Analyze the data and identify contributing factors
- Review the RCA process and quality improvement related activities and timelines
- Recommend a Corrective Action Plan
 - Identify topics for Plan-Do-Study-Act (PDSA)
 - Discuss possible changes in policies and procedure to improve areas indicated
 - Identify process strengths and areas that need improvement.
- 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
Incident Report tracking and review	1)Identify safety incident trends. 2)Conduct thorough review of each patient safety incident and complete follow up activities.	The Patient Safety Officer, The Patient Safety Committee, and Hospital Administration will track and monitor all safety incidents and identify any trends that need to be addressed. Incident report statistics and follow up activities for any trends identified are reported monthly to the Executive Committee of the Medical Staff and Executive Leadership Committee	Ongoing	Patient Safety Officer Patient Safety Committee Hospital Administration Executive Committee of the Medical Staff Executive Leadership Committee
Sentinel Event Tracking and Review	1)To have an established process for the management, investigation and reporting of sentinel events. 2)To identify opportunities for improvement.	1)Review all safety incidents and identify those that meet sentinel event criteria. 2)Complete all reporting requirements per Nevada Revised Statutes and as required by regulatory and licensing bodies. 3)Complete the RCA process to determine the Root Cause of sentinel events and identify, implement and monitor action plans developed to prevent future incidents.	Ongoing	Patient Safety Officer RCA Committees Executive Committee of the Medical Staff Hospital Administration
Risk Assessments	1)To identify individual risk factors,	1) All patients admitted to the facility undergo suicide, elopement, fall and	Ongoing	QAPI Department Patient Safety

9 Southern Nevada Adult Mental Health Services

	<p>environmental hazards and vulnerabilities in current day to day processes and operations.</p> <p>2) To develop and implement individualized treatment plans, mitigation plans and control measures to decrease level of risk and maintain the safety of patients, visitors and employees</p>	<p>anger/aggression risk assessments.</p> <p>2) Environmental Risk assessments are completed, at a minimum, monthly by the environmental rounds committee</p> <p>3) Trends identified through incident reports and seclusion and restraint reports trigger the completion of risk assessments and follow up inquiries to determine and address their root cause.</p>		<p>Committee</p> <p>Executive Leadership</p> <p>All SNAMHS Employees</p>
Performance Improvement Program	<p>1)To monitor, and assist the Governing body, Leadership and the agency as whole in meeting its client's quality care, safety, treatment and service responsibilities</p> <p>2)To continuously evaluate and improve patient care outcomes and services provided to individuals served</p>	<p>1)Data collection, analysis and reporting of pertinent information for review by Leadership</p> <p>2)Performance improvement project activities designed to improve the quality of services</p>	Ongoing	All SNAMHS staff are involved in ongoing performance improvement efforts and initiatives.

Components and Methods

Pursuant to [NRS 439.837](#) and [NAC 439.917](#), 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.

Southern Nevada Adult Mental Health Services will use the 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 will be used 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 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 Southern Nevada Adult Mental Health Services 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.

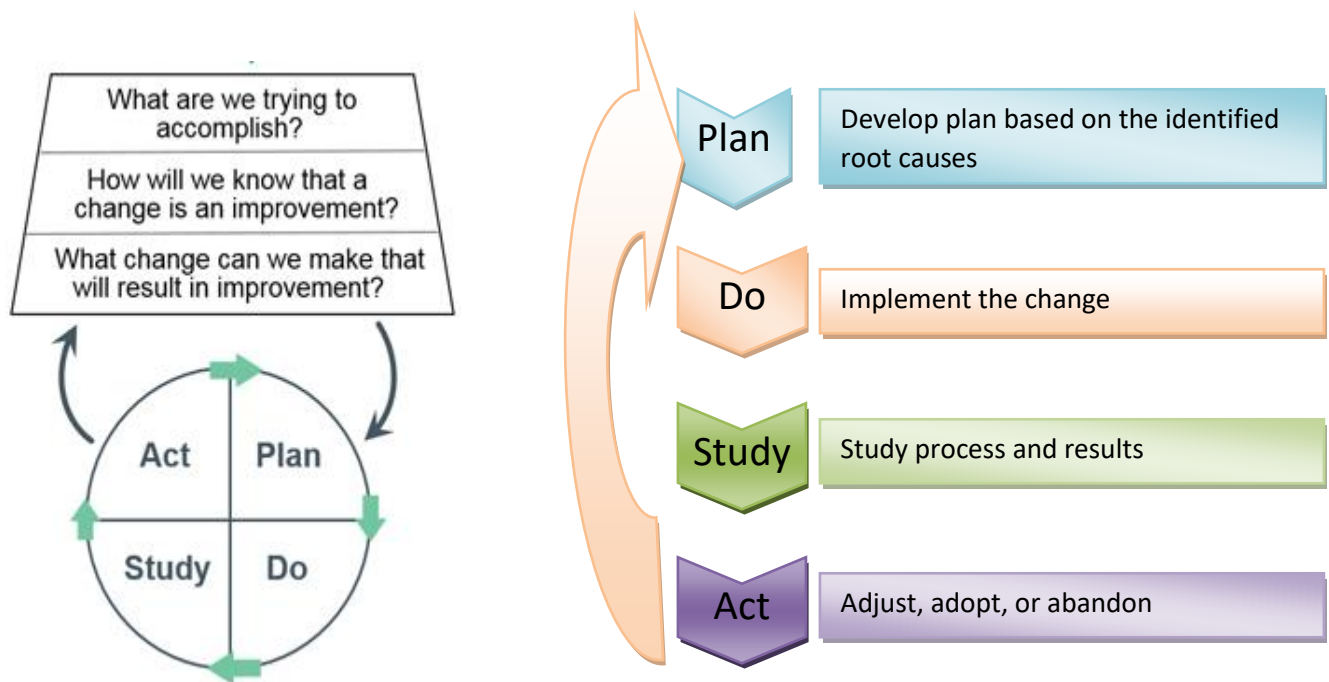
Fishbone Diagram

When problems are identified, a Fishbone Diagram (Appendix C) can 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. Rawson Neal Hospital at 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 5) Patient Safety Incidents 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 trends in seclusion and restraint episodes 5) Review and evaluate data trends in Patient Safety Incidents	1) Yearly Quality and Patient Safety Plan update, due March 1, 2021 2) Yearly Sentinel Event Report, due March 1, 2021 2) Yearly AB280 report (Checklists and Policies reviewing and revising) due July 1, 2021

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, 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.

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: 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_CURRb.pdf.)

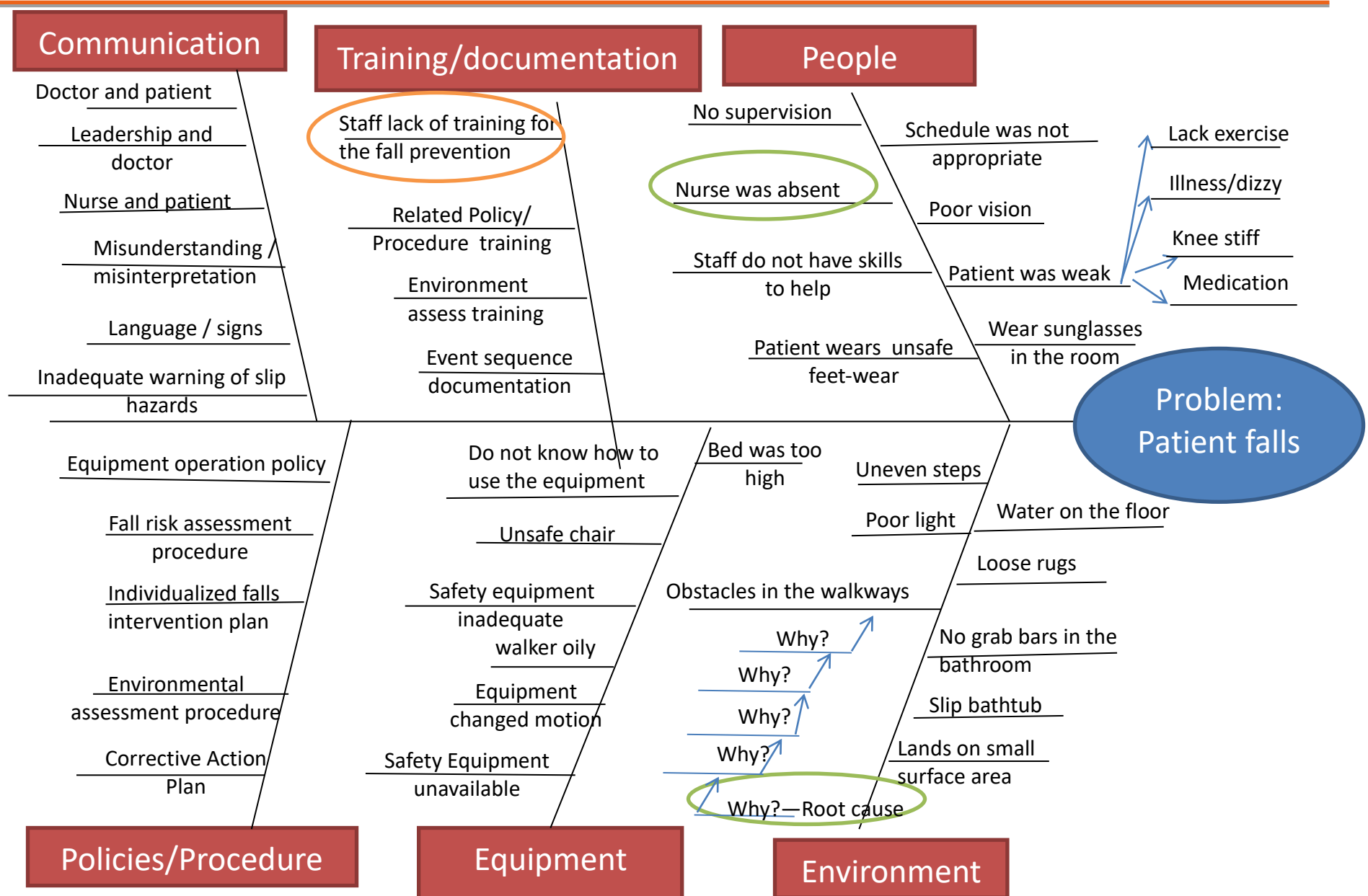
Central Line Associated Bloodstream Infections (CLABSI): Primary bloodstream infections that are associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection.

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.	<ul style="list-style-type: none"> a. Enhance retrospective chart review process. b. Establish an automated surveillance process. c. Conduct a proactive risk assessment in a high risk area. 		<ul style="list-style-type: none"> Complete an in-depth analysis of risk point utilizing the methods of FMEA. 	<ul style="list-style-type: none"> Implement Trigger Tools. Develop automated surveillance reports in Cerner.
2. Establish Structures for reporting and a process for managing reports in the event reporting system.	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> Implemented e-MERS & PSO with UHC. Create process for reviewing & closing reports in e-MERS. Create process for communicating outcome of reported events. 	<ul style="list-style-type: none"> Increase number of events reported by 10%. 	
3. Develop a Culture of Safety where providers feel safe and supported when they report medical errors or near misses & voice concerns about patient safety.	<ul style="list-style-type: none"> 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. 		<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> Re-evaluate culture of safety and develop action plan.
4. Establish Safety Priorities & Targets.	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> Complete 2014 Leapfrog Safety Survey. Develop method to track & report departmental progress and compliance of RCA action plans. 	<ul style="list-style-type: none"> Present Patient Safety Dashboard monthly to Hospital Wide Oversight Committee. Establish & implement a plan to improve performance of each leap. 	
5. Charter Safety Programs through teams, workgroups or projects.	<ul style="list-style-type: none"> 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. 		<ul style="list-style-type: none"> Establish Patient Safety Council. Establish workgroups focused on medication safety, reducing patient falls & hospital acquired pressure ulcers. Revise or develop policies, procedures and protocols. 	

Reference: Patient Safety Plan and Its Applicable Goals. 2014. Cook County Health and Hospitals System.

Appendix C: Fishbone Diagram



Appendix D-1: PDSA Worksheet

PDSA Worksheet

Topic:			
Person Completing Worksheet:		Date:	
Telephone/ Email:		Cycle:	
Patient Safety Committee Members			
CEOs/CFOs			
Patient Safety Officer			
Infection Control Officer			
Other Medical Staff			
Other team members			
Aim: (Describe the overall SMART goal that your team wishes to achieve.)			
Plan:			
1. List the tasks needed to set up this test of change.			
2. Predict what will happen when the test is carried out.			

3. List the steps to develop the test-who, what, and when.

Steps	By Whom	By When	Desired Outcome

Do: (Describe what actually happened when you ran your test, including any problems and unexpected findings.)

Study: (Describe what you learned and did you meet your measurement goal?)

Did you meet your measurement goal? Explain.

Summarize what was learned: success, failure, unintended consequences, etc.

Act: (Describe what you concluded from this cycle.)

Based on what was learned, please indicate what action will be considered.

Describe what modifications to the plan will be made for the next cycle based on what you learned.

☐ 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

[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: 07/01 08/14 Date Last Revised: 08/17 Next Review Date: Policy Committee Approved By:

Key Words: personal protective equipment, PPE, safety equipment,

Policy Applies to:

- All staff employed by Mercy Hospital;
- Credentialed Specialists, Allied Health Professionals, patients, visitors and contractors will be supported in meeting policy requirements.

Related Standards:

- Infection and Prevention and Control Standards NZS 8134.3:2008
- Health and Safety in Employment Act 1992
- EQuIP5 - 1.5.1 and 1.5.2 Infection Control
- EQuIP5 - Standard 3.2 Criterion 3.2.1 Health and Safety

Rationale:

Mercy Hospital will provide suitable personal protective equipment (PPE) when the risk to health and safety cannot be eliminated or adequately controlled by other means.


Definitions:

Personal protective equipment (PPE) means all equipment which is intended to be worn or held by a person to protect them from risk to health and safety while at work.

Examples of PPE include: protective footwear, gloves, hard hats/helmets, clothing affording protection from the weather, visibility clothing, eye and face protection.

Objectives:

- To ensure appropriate PPE is identified to minimize hazards not able to be controlled by elimination or isolation;
- To ensure fit for purpose PPE is provided at Mercy Hospital for use by staff;
- To ensure adequate training in the use of PPE is provided;
- To monitor the use of PPE and evaluate effectiveness.

	HOSPITAL POLICY AND INFORMATION MANUAL		
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

**Summerlin Hospital Medical Center
Las Vegas, Nevada**

Risk Management/ Patient Safety Plan

Nevada Acute Care Division

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](#) include:

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

B. Infection Control Officer

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

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

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

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

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

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

C. Patient Safety

Summerlin Hospital Medical Center has an established Patient Safety Council (PSC) to support patient safety activities. The PSC should ensure that its Patient Safety Plan is promoted and executed successfully. 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 Riskonnect (STARS) and Midas) to maintain and manage PSWP.

1. Facility Patient Safety Committee

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

2. Membership:

In accordance with [NRS 439.875](#), the committee core membership consists of the following Key Members: (CEO{member of the Executive or Governing Body}, CNO, Physician, Risk Management and others designated as Patient Safety Officer, Quality Designee, Infection Control Officer, , and Pharmacy). 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 (CFO) of the medical facility. A Patient Safety Committee established pursuant to this section must meet at least once every calendar year.

3. 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.

4. Duties and Responsibilities:

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

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

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

- Monitor and document the effectiveness of the patient identification policy 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.
- Monitor and document the effectiveness of the hand hygiene protocol or policy.
- Review policy to ensure compliance with the Patient Safety Checklists pursuant to NRS 439.877.

- **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\(4\)\(d\)](#).
- 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.

D. Patient Safety Advisories

When an untoward event occurs at the facility or in the industry, it is important that we respond in a positive manner. Systems that lead to failure at one facility can be assessed at other facilities to avoid the same or similar occurrence. To this end, Safety

Watch newsletters are distributed. These alerts detail the circumstances that lead to a negative outcome and the facility is charged with assessment and improvement of their own processes to prevent similar occurrences. In addition, Clinical Risk Alerts and Medication Safety Alerts are also formulated to apprise the facilities of a specific safety issue that needs to be assessed to prevent reoccurrence.

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

E. 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. In addition to the delineated elements, the TERM program also includes an evaluation of clinical practices that have or are likely to result in liability or patient harm. The TERM elements are summarized as follows:

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

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

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

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

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

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

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

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

F. 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.

G. Riskonnect (STARS)

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

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

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

H. Event Notification Site

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

I. 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.

The Joint Commission's root cause analysis framework and action plan table should be used as a reference. 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.



J. Patient Safety Checklists

By [NRS 439.865](#), the Patient Safety Plan must include the Patient Safety Checklists and Patient Safety Policies, NRS 439.877, for use by:

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

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

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

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

K. 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.

L. 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.

M. Training and Education

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

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

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

IV. Acute Care Division Patient Safety Priorities, Goals and Objectives for 2021

- **Surgical and Procedural Safety**
 - **Wrong Site Surgery (WSS)**
 - **Goal:** A 50% reduction in WSS events for 2021. Ultimately, the goal is zero (0).
 - Monitor through Midas event reporting and the Patient Safety Dashboard. Report monthly with oversight by CPSC.

- **Retained Procedural items (RPIs)**
 - **Goal:** Prevent RPIs- a 50% reduction in RPIs with harm for 2021. Ultimately, the goal for RPIs is 0.
 - Monitor through Midas event reporting and the Patient Safety Dashboard. Report monthly with oversight by CPSC.
- **OBHRU**
 - **Reduction/Elimination of serious harm by reducing the response time to excessive obstetrical bleeding initiative.** As evidenced by:
 - **Goal:** Quantification of blood loss will occur at 95% of all deliveries as evidenced by facility results in a Healthy Intent / Analytics dashboard.
 - **Goal:** A debrief will be completed on 100% of hemorrhages >1500ml.
 - Monitor through Healthy Intent/ Analytics dashboard, Midas/ENS/Claims data, facility education reports, and the Patient Safety Dashboard. Report monthly with oversight by CPSC.
 - **Reduction / elimination of serious harm by increasing the intervention rate for uterine tachysystole and fetal heart rate category II algorithm compliance.**
 - **Goal:** To be developed in 2Q 2021.
- **CLABSI Initiative**
 - **Goal:** CLABSI will be reduced to less than the national CMS mean Standardized Infection Ratio (SIR: CLABSI 0.736) in 2021.
 - Monitor through CDC's National Healthcare Safety Network (NHSN) and the Patient Safety Dashboard. Report quarterly with oversight by CPSC.
- **Safe Medication Use**
 - **Reduce the preventable occurrences of Opioid Induced Respiratory Events (OIRD) in 2021.**
 - **Goal:** Decrease the number of preventable OIRD events by 10%.
 - **Goal:** Each facility will track and trend naloxone administrations and will identify a performance improvement project related to safe use of opioids by March 1, 2021.
 - **Goal:** 100% of Acute Care facilities will have a medication safety committee that utilizes a standardized charter and agenda by June 1, 2021
 - Monitor through MIDAS reports, Cerner ICD-10 codes and other intervention data and the Patient Safety Dashboard. Report quarterly with oversight by CPSC.

- **Reduce Falls and Falls with Injury**
 - **Goal:** 10 % reduction in the number of falls by end of 2021.
 - **Goal:** 10% reduction in the rate of falls by the end of 2021.
 - **Goal:** 10% reduction in the rate of falls with injury by the end of 2021.
 - **Goal:** A debrief will be completed within 72 hours for 100% of falls with injury.
 - Monitor through MIDAS event reporting and the Patient Safety Dashboard. Report quarterly with oversight by CPSC.
- **Decreasing Hospital Acquired Pressure Injuries**
 - **Goal:** 10% reduction of NPOA rate for all HAPI stages in the Acute Care Division by the end of 2021.
 - Monitor through Midas event reporting and the Patient Safety Dashboard. Report quarterly with oversight by CPSC.
- **Culture of Safety**
 - **Goal:** reduce the number of GHI events (serious safety event rate) for the Acute Care Division by the end of 2021. Ultimately, the goal is 0.
 - Monitor through MIDAS event reporting and the Corporate Patient Safety Dashboard. Report monthly with oversight by CPSC.
 - **Goal:** 100% of 2021 Patient Safety Plan Priorities will be implemented within the hospitals.
- **Workplace Violence**
 - **Goal:** 10% reduction in Workplace Violence events by the end of 2021.

V. Monitoring and Accountability

A. Evaluation of TERM Program

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

B. Patient Safety Committee

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

C. Dashboards

The Risk Management/Patient Safety Dashboard and the Environment of Care includes multiple indicators to demonstrate the facility's performance as to patient safety markers. These include event reporting statistics, overall harmful event rate, fall rate including harmful event rate, medication event rate including harmful medication events or adverse drug events, serious harm OB events, pressure injury rates, infection variances, and procedural events.

VI. Evaluation/Review:

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

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

VII. Confidentiality

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

VIII. Approval of Patient Safety Plan

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

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

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

Appendix A: Checklist Example: Injuries from Falls and Immobility

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

Review medications (by pharmacist); avoid unnecessary hypnotics, sedatives				
Incorporate multidisciplinary input for falls				
Prevention from PT, OT, MD, RN and Phar.D.				
Include patients, families and caregivers in efforts to prevent falls. Educate regarding fall prevention measures; stay with patient				
Hold post-fall huddles immediately after event; analyze how and why; implement change to prevent other falls				

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

Kindred Hospital Las Vegas Sahara Campus

PATIENT SAFETY PLAN

DATE: 02/10/21



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

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Las Vegas, Nevada 89146

TA
Director of Quality Management
702-790-0827

HS
Chief Executive Officer
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ES
Chief Clinical Officer
702-790-0801

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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

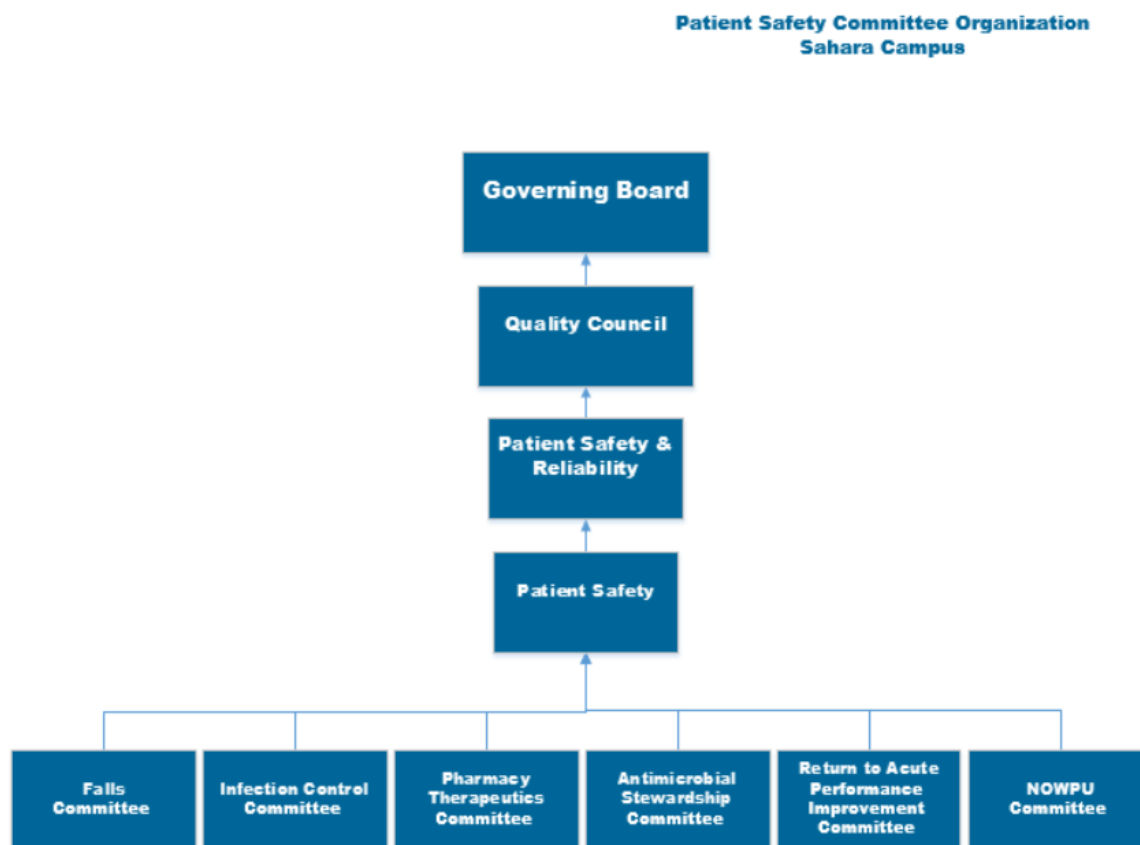
core principles of this plan include:

- 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	GOAL: Reduce CLABSI by 10% 2020 CLABSI Rate 1.05	<ol style="list-style-type: none"> 1) Dedicated licensed personnel assigned for weekly dressing changes with compliance to identifications. (e.g. Initial and date) 2) Educate and enforce appropriate use of blood culture collection process by end of second quarter to reduce contamination rate. Educate staff on blood collection from peripheral and central line sites. 3) Re-educate and reinforce to staff the importance of patient bathing with CHG. 4) Central line maintenance audits will be conducted daily by nurse manager and Infection Preventionist 	12/31/21	ICP/CCO

<p>CAUTI Prevention</p>	<p>GOAL: Reduce CAUTI by 10% 2020 CAUTI Rate 1.22</p>	<ol style="list-style-type: none"> 1) Educate and enforce staff compliance to the Urinary Catheter protocol approved by MEC/GB policy 2) Patients admitted with a urinary catheter in place will be assessed upon admission by a Registered Nurse for removal following the indwelling urinary catheter discontinuation protocol. 3) Urinary catheter maintenance audits will be conducted daily by nurse manager/ICP 4) Enforce use of appropriate urine collection kits 	<p>12/31/21</p>	<p>ICP/CCO</p>
<p>NOWPU Prevention</p>	<p>Reduce NOWPU by 10% 2020 Rate – 2.99%</p>	<ol style="list-style-type: none"> 1) Wound assessment by admitting nurse and verified by the Wound Nurse with wound measurement within 48 hours. 2) Weekly re-assessment by the wound team 3) Braden Scale, Repositioning, Assessment and Wound Education to Patient Family Score 4) Place patient on the appropriate 	<p>12/31/21</p>	<p>Wound Care Coordinator/ Chief Clinical Officer</p>

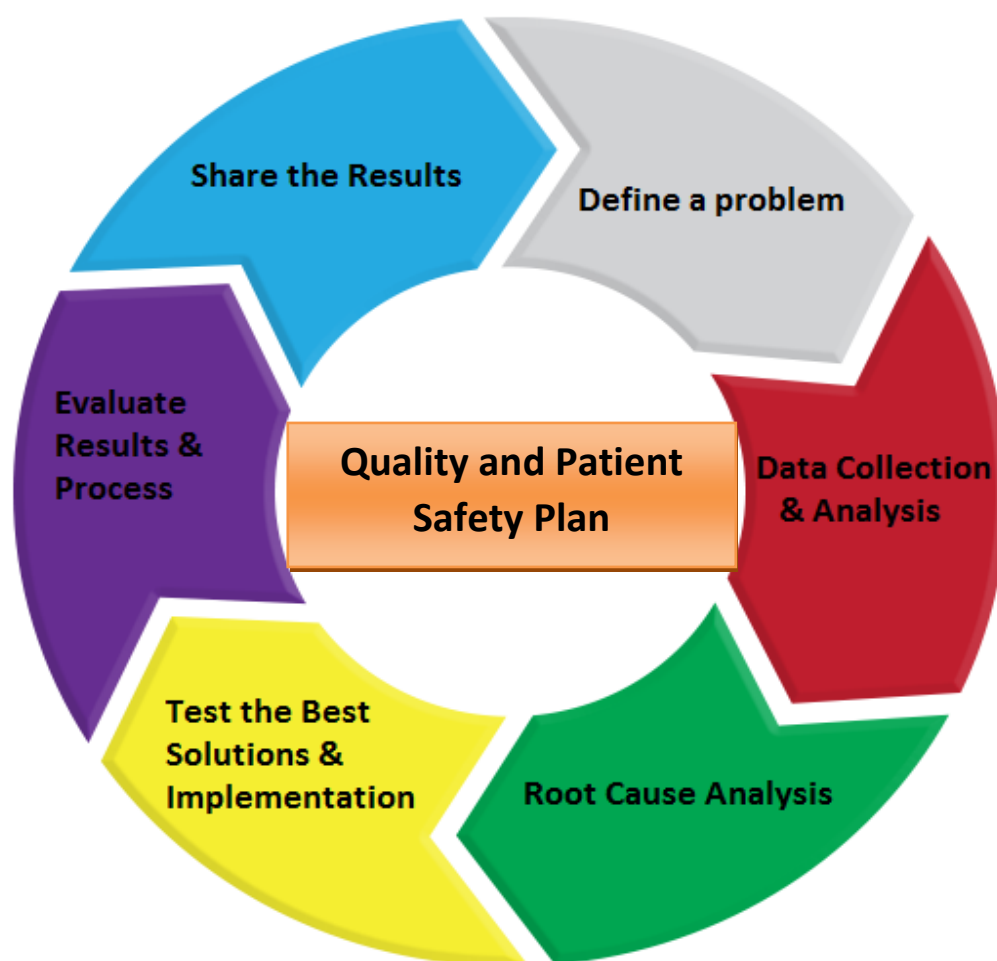
		bed surface as well as treatment plan 5) Repositioning Q 2hours 6) RCA done for each event		
Employee Health	Improve flu vaccine by 5% 2019-2020 season = 96% 2020-2021 season = 98%	1) Vaccine Education at time of hire to include required vaccines, influenza, and other mandated vaccines i.e COVID 2) Provide CDC, state health department, and other regulatory education to staff and patients/families 3) Monitor use of face masks, PPE, and hand hygiene by all personnel in patient care areas (TST audits) 4) Provide staff and patients/families with Just in-Time education for pandemic and other situations requiring vaccines i.e. COVID-19 vaccinations	12/31/21	Employee Health Nurse/ Chief Clinical Officer
Antimicrobial Stewardship	Reduce Antibiotic usage to ≤ 35% of total drug cost	1) Antibiotic Stewardship Meetings Qmonth 2) Pharmacist/ICP/ Infectious Disease MD rounding 3) Staff, physician and Leadership Education on antimicrobials	12/31/21	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 upon admission, every 7 days and with any change of condition or change in medication that increase tendency for falls. 2) Continue with Fall Reduction rounding 3) Staff education regarding Fall Prevention on hire and annually thereafter 4) Post-fall assessment completed and a re-assessment of the Fall screening and complete/update Nursing Care Plan after each event 	12/31/21	DQM/CCO
Unplanned Return to Acute Care within 30 days Performance Improvement Team (Market and Medical Staff)	2020-2021 Decrease current RTA rate of 13.99 to meet est. goal of 6.59.	<ol style="list-style-type: none"> 1.) RTA Performance Improvement Team formed with physician participation 2.) All RTA's are reviewed by clinical and medical staff 	12/31/21	DQM

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.

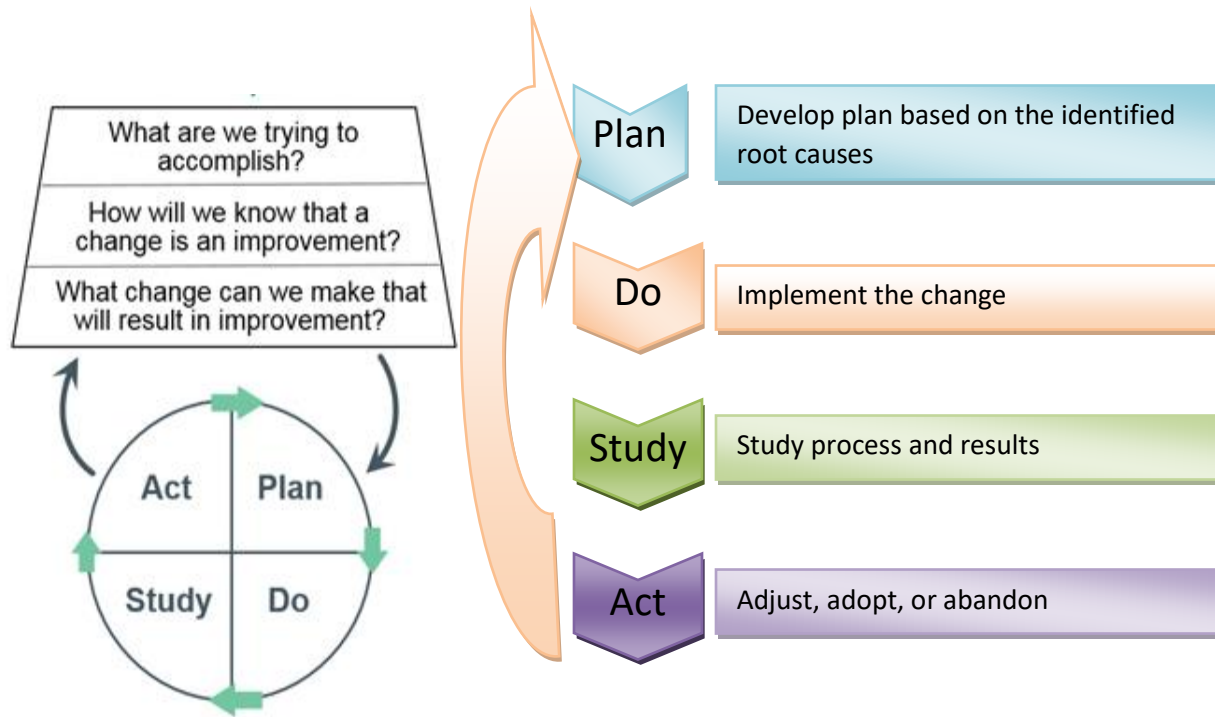
Fishbone Diagram

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.hpo.e.org/Reports-HPOE/CkLists_PatientSafety.pdf

<http://www.who.int/patientsafety/implementation/checklists/en/>

The patient safety policies are listed in Appendix F. (The following link provides you some patient safety policies for your reference—a policy example is shown in **Appendix F.**)

<https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>

Approval of Patient Safety Plan

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

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

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

Reference

- Root Cause Analysis Toolkit <http://www.health.state.mn.us/patientsafety/toolkit/>
- Quality and Service Improvement Tools
http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html
- CQI 101 An Introduction to Continuous Quality Improvement:
<https://www.coursehero.com/file/13827355/CQI-Overviewppt/>
- Quality Improvement <http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/>
- Root Cause Analysis <http://www.patientsafety.va.gov/professionals/onthejob/rca.asp>
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2
https://www.jointcommission.org/sentinel_event.aspx
- Hospital Policies <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>
- Checklists to Improve Patient Safety http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf
- Patient Safety Checklists <http://www.who.int/patientsafety/implementation/checklists/en/>
- Minutes of the Meeting of the Quality and Patient Safety Committee
<http://www.cookcountyhhs.org/wp-content/uploads/2013/12/09-23-14-QPS-scan-Minutes.pdf>
- Title 40 – Public Health and Safety <https://www.leg.state.nv.us/NRS/NRS-439.html>

Appendix A: Terms and Definitions

Patient Safety: The Agency for Healthcare Research Quality (AHRQ) defines patient safety as “a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.”
http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

Sentinel event ([NRS 439.830](#))

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

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

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

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

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

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

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

Facility-Associated Infection: ([NRS 439.802](#))

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

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

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

Medical Facility ([NRS 439.805](#))

“Medical facility” means:

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

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

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

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

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

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

Catheter Associated Urinary Tract Infection (CAUTI): A urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CUR_RENT_b.pdf.)

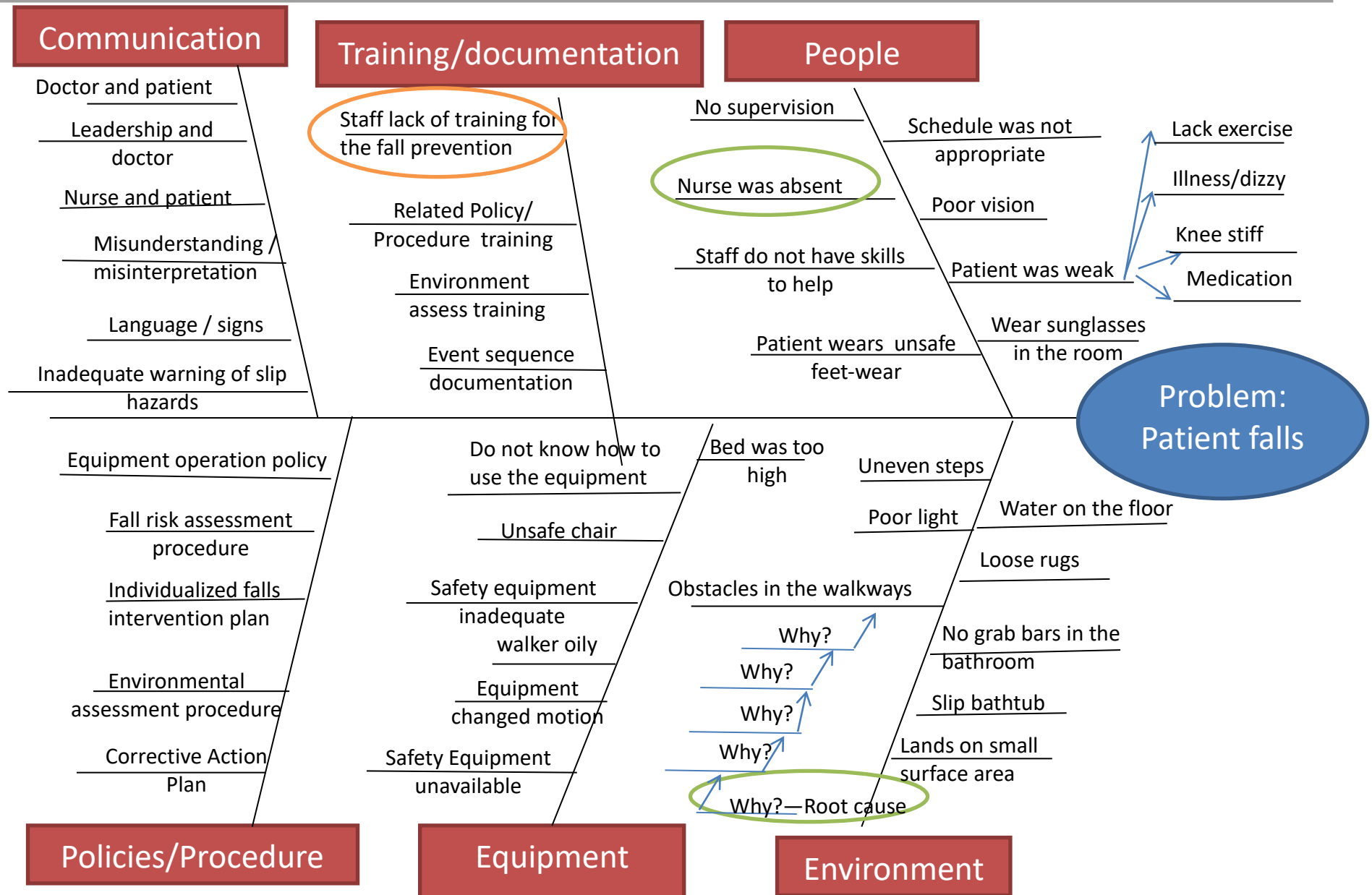
Central Line Associated Bloodstream Infections (CLABSI): Primary bloodstream infections that are associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection.

Appendix B: Patient Safety Goals

OBJECTIVE:	GOAL:	Q3 2014	Q4 2014	Q1 2015
ACTION PLAN:				
1. Create Systems that anticipate errors & either prevent or catch them before they cause harm.	a. Enhance retrospective chart review process. b. Establish an automated surveillance process. c. Conduct a proactive risk assessment in a high risk area.		Complete an in-depth analysis of risk point utilizing the methods of FMEA.	Implement Trigger Tools. Develop automated surveillance reports in Cerner.
2. Establish Structures for reporting and a process for managing reports in the event reporting system.	a. Implement new electronic Voluntary Reporting System & participate in Patient Safety Organization. b. Develop a structure to educate employees system-wide of the process for reporting hazards, errors and adverse events. c. Establish a process for providing feedback regarding reported events.	Implemented e-MERS & PSO with UHC. Create process for reviewing & closing reports in e-MERS. Create process for communicating outcome of reported events.	Increase number of events reported by 10%.	
3. Develop a Culture of Safety where providers feel safe and supported when they report medical errors or near misses & voice concerns about patient safety.	a. Provide education on patient safety plan that emphasizes importance of blending a systems focus with appropriate individual accountability. b. Establish a recognition program that rewards safe practices. c. Improve overall perceptions of safety as measured by the Culture of Safety Survey.		Educate Medical staff, Hospital Wide Oversight & the Quality Committees on the objectives and goals of the patient safety plan. Include patient safety presentation in monthly New Employee Orientation. Develop 'Great Catch' awards program.	Re-evaluate culture of safety and develop action plan.
4. Establish Safety Priorities & Targets.	a. Develop Patient Safety Dashboard that includes national measures and benchmarks. b. Facilitate the development of action plans associated with measures not meeting benchmarks. c. Assess and improve processes related to hand-off, transition and communication	Complete 2014 Leapfrog Safety Survey. Develop method to track & report departmental progress and compliance of RCA action plans.	Present Patient Safety Dashboard monthly to Hospital Wide Oversight Committee. Establish & implement a plan to improve performance of each leap.	
5. Charter Safety Programs through teams, workgroups or projects.	a. Coordinate Improvement Efforts in order to ensure that capital, people, facilities & technologies are matched to strategic priorities for safe practices. b. Reduce and eliminate variation in care.		Establish Patient Safety Council. Establish workgroups focused on medication safety, reducing patient falls & hospital acquired pressure ulcers. Revise or develop policies, procedures and protocols.	

Reference: Patient Safety Plan and Its Applicable Goals. 2014. Cook County Health and Hospitals System.

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

[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:	07/01 08/14	
	Date Last Revised:	08/17	
	Next Review Date:	Policy Committee	
	Approved By:		

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 2021**

I. PURPOSE

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

This is achieved through:

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

II. SCOPE OF ACTIVITIES

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

- Patient safety
- Visitor safety
- Employee safety

All staff in University Medical Center of Southern Nevada is able to fully support and participate in this plan, and devote their expertise to the patient safety and healthcare quality improvement process.

The purpose of this plan is to address patient safety related concerns, challenges and revise the program to better serve the patients and their families. To this end, UMC has developed this Patient Safety Plan.

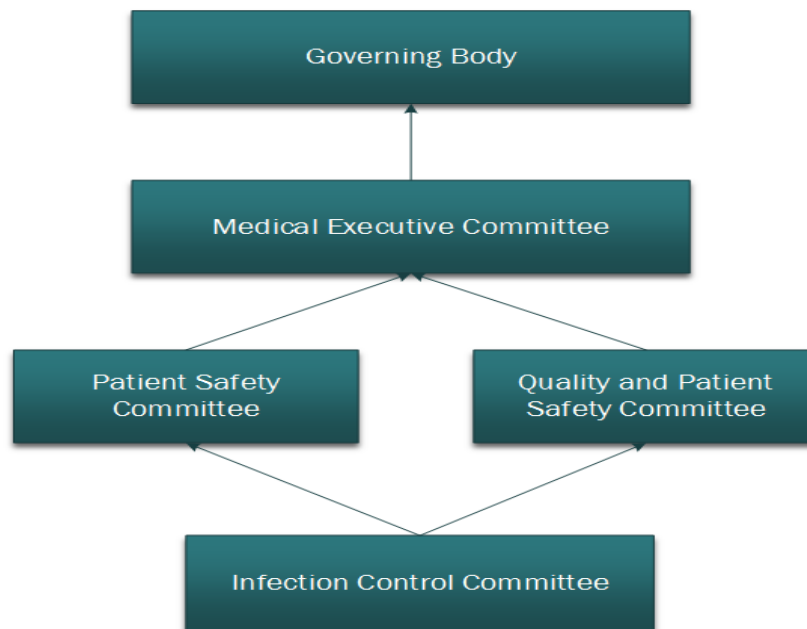
The plan focuses on the process and systems rather than the individual, and recognizes both internal and external customers, as well as facilitates the need for analyzing and improving processes. The core principles of this plan include:

- All staff are encouraged to contribute their knowledge, vision, skill, and insight to improve the process of the Patient Safety Plan.
- Decisions will be based on data and facts, and staff will be encouraged to learn from the experiences.
- Customer based including patients, families, and visitors.
- Promote systems thinking.
- Employ well-trained and competent staff maintaining high healthcare quality.
- Failure Mode Effect Analysis (FMEA)
- Culture of Safety Survey

III. ROLES AND RESPONSIBILITIES

In accordance with [NRS 439.875](#), UMC has established a Patient Safety Committee (PSC). The PSC is responsible to oversee UMC's Patient Safety Program. As directed by the Board of Governors, the Patient Safety Committee will act as the hospital's Grievance Committee.

Patient Safety Committee Organization



Roles and Responsibilities

- In accordance with [NRS 439.875](#), a patient safety committee must be comprised of:
- The infection control officer of the medical facility
- The patient safety officer of the medical facility
- At least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility
- One member of the executive or governing body of the medical facility.

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

- The Patient Safety Committee will meet at least monthly.
- Receive reports from the patient safety officer pursuant to [NRS 439.870](#).
- Review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment, including the effectiveness of patient identification policy.
- Review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least once each calendar quarter, report to the executive or governing body of the facility regarding:
 - (1) The number of sentinel events that occurred at the medical facility during the previous calendar quarter;
 - (2) The number and severity of infections that occurred at the facility during the preceding calendar quarter; and
 - (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.
- The Patient Safety Committee shall be responsible for generating, evaluating and reviewing proactive risk assessments for the use of such documents and records in its proceedings. All risk assessments and associated documentation and records shall be subject to the applicable privileges under NRS 49.265 and NRS 439.875 provided that it is generated or produced during the Patient Safety Committee's review process.

Patient Safety Officer Responsibilities ([NRS 439.870](#))

At UMC the Patient Safety Director is designated as the Patient Safety Officer. The Patient Safety Officer shall perform all duties and responsibilities required under Nevada law, including, without limitation:

- Serve on the Patient Safety Committee;
- Supervise the reporting of all sentinel events alleged to have occurred at UMCSN, including without limitation, performing the duties required pursuant to [NRS 439.835](#) ;
- Investigating the occurrence of sentinel events and implementing developed action plans;
- Report to the Patient Safety Committee on actions taken to ensure patient safety.

IV. COMPONENTS AND METHODS

Reporting of patient safety events:

All medical, nursing and support clinical staff should report any event, situation or circumstance that is significant or potentially significant to patient safety. These events will be reviewed and investigated as needed

This is accomplished by:

- Completing an event report in accordance with UMCSN policy
- Area manager/designee review and completion of the manager's section of the event report
- Quality review by the Center for Quality and Patient Safety
- Review of significant/potentially significant events by the Patient Safety Officer
- Unit review of actual or potential patient safety events with action plans reported through the Patient Safety Committee

Mandatory Reporting of Sentinel Events:

Pursuant to [NRS 439.835](#):

- A person who is employed by UMC shall, within 24 hours after becoming aware of a sentinel event, notify the Patient Safety Officer of the event.
- Within 13 days after receiving notification, the patient safety officer shall report the event to the Nevada Division of Public and Behavioral Health (DPBH).
- If the Patient Safety Officer personally discovers or becomes aware of a sentinel event, in the absence of notification by another employee, the patient safety officer shall report the event to DPBH within 14 days of discovering or becoming aware of the sentinel event.

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 or grievances
- Risk Management findings
- Morbidity/Mortality reviews
- Infection Control information
- Compliance findings
- Operative/procedural data
- Staff verbal reporting

External sources include but are not exclusive:

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

V. Patient Safety Checklists and Patient Safety Policies:

Patient Safety Checklists must follow protocols, are utilized to improve the health outcomes of patients at UMCSN and include, without limitation:

- Checklists related to specific types of treatment, which include documentation that the treatment provided was properly ordered by the provider of healthcare.
- Checklists to ensuring
- that the patient's room and overall environment is sanitary.

- Checklist for patient discharge that must include: proper instructions concerning prescription medications, aftercare instructions, and any individualized patient instructions.

Patient Safety Policies include, without limitation:

- Appropriate identification of patient prior to providing treatment requiring at least two personal patient identifiers
- Nationally recognized standard precaution protocols, including protocols relating to hand hygiene
- Compliance with the patient safety checklists and patient safety policies

Pursuant to [NRS 439.865](#), Patient Safety Checklists and 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](#))

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(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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References

- IHI RCA2
- Framework for Conducting a Root Cause Analysis and Action Plan
- NRS Title 40 – Public Health and Safety
- UMC policy, Patient Safety Checklist and Policies
- UMC Patient Safety
- UMC Infection Prevention/Control Risk Assessment, Plan and Authority Statement
- UMC policy, Safety Intelligence (SI) Event Reporting
- UMC policy, Patient compliant, grievance and insurance inquiry process
- UMC policy, Just Culture- Response to Safety Events

Valley Hospital Medical Center

**Risk Management/
Patient Safety Plan**

Nevada Acute Care Division

Revised 1/2021

I. Overview

Valley Hospital Medical Center endorses an integrated, system-wide patient safety program designed to improve patient safety and reduce risk to patients.

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

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

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

GENERAL STATEMENTS ON GOALS AND OBJECTIVES

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

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

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

II. Mission and Vision

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

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

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

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

III. ROLES AND RESPONSIBILITIES

A. Risk Management/Patient Safety Officer

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

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

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

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

B. Infection Control Officer

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

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

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

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

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

C. Patient Safety

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

I. Facility Patient Safety Committee

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

Membership:

In accordance with [NRS 439.875](#), the committee core membership consists of the following Key Members: (CEO{member of the Executive or Governing Body}, CNO, Physician, Risk Management and others designated as Patient Safety Officer, Quality Designee, Infection Control Officer, , and Pharmacy). 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 (CFO) of the medical facility. A Patient Safety Committee established pursuant to this section must meet at least once every calendar year.

Meetings:

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

Duties and Responsibilities:

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

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

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

- Monitor and document the effectiveness of the patient identification policy 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.
- Monitor and document the effectiveness of the hand hygiene protocol or policy.
- Review policy to ensure compliance with the Patient Safety Checklists pursuant to NRS 439.877.
- **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\(4\)\(d\)](#).
- Receive reports from the Patient Safety Officer pursuant to [NRS 439.870](#).

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

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

II. Patient Safety Advisories

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

Valley Hospital Medical Center is required to address the Safety Watch newsletters, Clinical Risk Alerts and Medication Safety Alerts via their Patient Safety Committee and

this is evidenced in their monthly minutes. Responses to the Safety Watch are reviewed for the opportunity to generate a best practice to implement.

C. TERM Program

The facility has utilized its formalized risk management program identified as TERM: the Technical Elements of Risk Management. Each element focuses on a separate organizational function and details specific strategies for managing risk in these areas. In addition to the delineated elements, the TERM program also includes an evaluation of clinical practices that have or are likely to result in liability or patient harm. The TERM elements are summarized as follows:

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

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

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

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

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

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

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

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

D. MIDAS

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

E. Riskonnect (STARS)

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

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

Trending of claim information is performed on a scheduled basis to operations leadership metrics to form strategies on facilitating risk reduction efforts. Previous examples of this function include the formation of an OB HRU and Perioperative

concepts. Quarterly reports should be provided by **Valley Hospital Medical Center's** RM to the Governing Board of all claims activities.

F. Event Notification Site

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

G. Root Cause Analysis (RCA)

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

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

The Joint Commission's root cause analysis framework and action plan table should be used as a reference. 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, NRS 439.877, for use by:

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

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

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

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

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

I. Patient Safety Policies

The Patient Safety Policies must include, without limitation:

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

J. MEMBER PATIENT SAFETY EVALUATION SYSTEM (PSES)

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

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

K. Training and Education

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

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

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

IV. Acute Care Division Patient Safety Priorities, Goals and Objectives for 2021

- **Surgical and Procedural Safety**
 - **Wrong Site Surgery (WSS)**
 - **Goal:** A 50% reduction in WSS events for 2021. Ultimately, the goal is zero (0).
 - Monitor through Midas event reporting and the Patient Safety Dashboard. Report monthly with oversight by CPSC.
 - **Retained Procedural items (RPIs)**

- **Goal:** Prevent RPIs- a 50% reduction in RPIs with harm for 2021. Ultimately, the goal for RPIs is 0.
 - Monitor through Midas event reporting and the Patient Safety Dashboard. Report monthly with oversight by CPSC.
- **OBHRU**
 - **Reduction/Elimination of serious harm by reducing the response time to excessive obstetrical bleeding initiative.** As evidenced by:
 - **Goal:** Quantification of blood loss will occur at 95% of all deliveries as evidenced by facility results in a Healthy Intent / Analytics dashboard.
 - **Goal:** A debrief will be completed on 100% of hemorrhages >1500ml.
 - Monitor through Healthy Intent/ Analytics dashboard, Midas/ENS/Claims data, facility education reports, and the Patient Safety Dashboard. Report monthly with oversight by CPSC.
 - **Reduction / elimination of serious harm by increasing the intervention rate for uterine tachysystole and fetal heart rate category II algorithm compliance.**
 - **Goal:** To be developed in 2Q 2021.
- **CLABSI Initiative**
 - **Goal:** CLABSI will be reduced to less than the national CMS mean Standardized Infection Ratio (SIR: CLABSI 0.736) in 2021.
 - Monitor through CDC's National Healthcare Safety Network (NHSN) and the Patient Safety Dashboard. Report quarterly with oversight by CPSC.
- **Safe Medication Use**
 - **Reduce the preventable occurrences of Opioid Induced Respiratory Events (OIRD) in 2021.**
 - **Goal:** Decrease the number of preventable OIRD events by 10%.
 - **Goal:** Each facility will track and trend naloxone administrations and will identify a performance improvement project related to safe use of opioids by March 1, 2021.
 - **Goal:** 100% of Acute Care facilities will have a medication safety committee that utilizes a standardized charter and agenda by June 1, 2021
 - Monitor through MIDAS reports, Cerner ICD-10 codes and other intervention data and the Patient Safety Dashboard. Report quarterly with oversight by CPSC.
- **Reduce Falls and Falls with Injury**
 - **Goal:** 10 % reduction in the number of falls by end of 2021.
 - **Goal:** 10% reduction in the rate of falls by the end of 2021.
 - **Goal:** 10% reduction in the rate of falls with injury by the end of 2021.
 - **Goal:** A debrief will be completed within 72 hours for 100% of falls with injury.

- Monitor through MIDAS event reporting and the Patient Safety Dashboard. Report quarterly with oversight by CPSC.
- **Decreasing Hospital Acquired Pressure Injuries**
 - **Goal:** 10% reduction of NPOA rate for all HAPI stages in the Acute Care Division by the end of 2021.
 - Monitor through Midas event reporting and the Patient Safety Dashboard. Report quarterly with oversight by CPSC.
- **Culture of Safety**
 - **Goal:** reduce the number of GHI events (serious safety event rate) for the Acute Care Division by the end of 2021. Ultimately, the goal is 0.
 - Monitor through MIDAS event reporting and the Corporate Patient Safety Dashboard. Report monthly with oversight by CPSC.
 - **Goal:** 100% of 2021 Patient Safety Plan Priorities will be implemented within the hospitals.

Valley Hospital Medical Center's 2021 Goals

- **Reduce Falls and Falls with Injury**
 - 10% Reduction in number of inpatient falls.
 - 10% Reduction in the rate of inpatient falls.
 - 10% Reduction in falls with harm with a goal of 0.
 - Reduce G,H,I events for 2021 with a goal of 0.
- **Reduce Occurrences of Pressure Ulcers**
 - 15% Reduction of all stages of pressure ulcers.
- **Medication Safety**
 - 10% Reduction in occurrences with no more than 5 for the year
- **Infection Prevention**
 - Goal of reduction in CLABSIs to maintain a SIR rate below 0.783.
- **Surgical Safety**
 - Reduce Wrong Site Surgery by 50% with a goal of 0.
 - Reduce Retained Procedural Items by 50% with a goal of 0.

V. Monitoring and Accountability

A. Evaluation of TERM Program

These evaluations consist of both a core risk and clinical risk review. The facility is required to submit a written corrective action plan for noted deficiencies determined

during the TERM evaluation. All information is shared with senior staff and monitored through the facility PSC.

B. Patient Safety Committee

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

C. Dashboards

The Risk Management/Patient Safety Dashboard and the Environment of Care includes multiple indicators to demonstrate the facility's performance as to patient safety markers. These include event reporting statistics, overall harmful event rate, fall rate including harmful event rate, medication event rate including harmful medication events or adverse drug events, serious harm OB events, pressure injury rates, infection variances, and procedural events.

VI. Evaluation/Review:

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

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

VII. Confidentiality

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

VIII. Approval of Patient Safety Plan

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

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

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

Appendix A: Checklist Example: Injuries from Falls and Immobility

Process Change	In Place	Not Done	Will Adopt	Notes (Responsible & By When?)
Conduct fall and injury risk assessment upon admission				
Reassess risk daily and with changes in patient condition				
Implement patient-specific intervention to prevent falls and injury				
Communicate risk across the team; use handoff forms, visual cues, huddles				

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

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

**WILLIAM BEE RIRIE CRITICAL ACCESS HOSPITAL/RURAL HEALTH CLINIC
ELY, NV**

ADMINISTRATION POLICY & PROCEDURES

Department: Risk Management

Program/Manual: Patient Safety

Policy Subject: Patient Safety Plan

Section Number: P

Effective Date: 11-5-2007

Revision Date: 12-3-2013, 2-11-2015, 02-2019

Review Date: 11-2020

I. INTRODUCTION

The Patient Safety Program supports and promotes the mission, vision and values of William Bee Ririe Hospital and Rural Health Clinic through organizational prioritization of patient, visitor and employee safety.

The patient safety program is implemented through the Enterprise Safety Committee and is supported by leadership's promotion of a safety culture that:

- Encourages recognition, reporting, and acknowledgment of risks to patient/visitor and employee safety and medical/healthcare errors
- Initiates/monitors actions to reduce risks/errors
- Internally report's findings and actions taken
- Promotes a blame-free culture facilitating the reporting and follow-up on safety concerns, errors and adverse events
- Educates staff and physicians to assure participation in the program

II. PURPOSE

The Patient Safety Program is designed to enhance patient care delivery and prevent adverse outcomes of care by utilizing a systematic, coordinated and continuous approach to the improvement of patient safety. This approach focuses on actual and potential occurrences; ongoing proactive risk management; and integration of patient safety priorities in the development and revision of processes, functions and services.

III. MISSION, VISION AND VALUES

In support of the mission, vision and values of this organization the Patient Safety Program promotes;

- Collaboration among staff members, physicians and other providers to deliver comprehensive, integrated and quality health care.

- A focus on comprehensive, integrated quality service
- Open and honest communication to foster trust relationships among staff members, physicians, other providers and patients.

IV. OBJECTIVES

The objectives of the Patient Safety Program are to:

- Encourage organizational learning about adverse or potential adverse events
- Incorporate recognition of patient safety as an integral job responsibility
- Provide patient safety education
- Involve patients in decisions about health care and promote open communication
- Collect and analyze data, evaluate care processes for opportunities to reduce risk and initiate proactive measures
- Report internally any findings and actions taken to reduce risk
- Support sharing of knowledge to effect change
- Supplying support systems to health care workers who are involved in sentinel events.
- Have a sufficient number and mix of individuals to support safe, quality care, treatment, and services.

V. RESPONSIBILITIES/DUTIES

It is William Bee Ririe Hospital and Rural Health Clinic's responsibility to designate an officer or employee of the facility to serve as the patient safety officer of the medical facility.

The duties of the designated patient safety officer are:

- To serve as the patient safety officer of WBRH and RHC
- Serve on the Enterprise Safety Committee
- Supervise the reporting of all incident reports and/or sentinel events alleged entered in CCD Health Systems (Electronic QRR) to have occurred at the WBRH and RHC, including, without limitation, performing required pursuant to NRS 439.835
- Duties pursuant to 439.835 are
 - a) A person who is employed by WBRH and RHC shall, within 24 hours after becoming aware of a sentinel event that occurred at WBRH and RHC, notify the patient safety officer of the sentinel event.
 - b) The patient safety officer shall, within 13 days after receiving notification, report the date, the time and a brief description of the sentinel event to The Health Division and facility representative if that person is different from the patient safety officer.

- c) If the patient safety officer of WBRH and RHC personally discovers or becomes aware, in the absence of notification by another employee, of a sentinel event that occurred at WBRH and RHC, the patient safety officer shall, within 14 days after discovering or becoming aware of the sentinel event report the date, time and brief description event to those listed in b) above.
- Take such action as he or she determine to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at WBRH and RHC
- Report to the Enterprise safety committee regarding any action taken in accordance to the above paragraph.

The Enterprise Safety Committee shall meet monthly.

The Patient Safety Plan and any changes thereafter shall be presented to the governing board of WBRH and RHC for approval.

The Patient Safety Plan must include, without limitation, the patient safety checklists and patient safety policies most recently adopted in regards to the patient safety plan.

After the WBRH and RHC's patient safety plan is approved, WBRH and RHC shall notify all providers of health care who provide treatment to patients at WBRH and RHC of the existence of the plan and of the requirements of the plan. WBRH and RHC shall require compliance with the patient safety plan.

The Enterprise safety Committee shall

- Receive reports from the Patient Safety Officer
- Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred at the facility
- Review and evaluate the quality of measures carried out by WBRH and RHC to improve the safety of patients who receive treatment at WBRH and RHC
- Make recommendations to the governing body of WBRH and RHC to reduce the number and severity of sentinel events that occur at WBRH and RHC.

The Enterprise Safety Committee provides a multidisciplinary forum for the collection and analysis of risk to patient safety and the dissemination of information on identified risk for the purpose of improving patient care. It shall review reports on occurrences including near misses to sentinel events. It shall identify those individuals or groups best situated to perform a root cause analysis and develop and implement an action plan for identified issues. It shall review, analyze and disseminate the information it receives, as appropriate, to the designated individuals and/or committees. Is shall provide recommendations

concerning identified risks, approve plans for corrective actions and evaluate the implantation of corrective actions taken.

Membership may include representatives from administration, providers, clinical and support staff. Membership shall have at least 3 providers of healthcare who treat patients at WBRH and RHC, including without limitation, at least 1 member of the medical, 1 member of nursing and 1 pharmaceutical staff, member and 1 member of the governing body.

VI. SCOPE

The types of occurrences to be addressed include, but are not limited to, sentinel events, near misses, and actual events related to:

- a) Patient safety
- b) Adverse drug events (medication errors and adverse drug reactions)
- c) Health acquired infections
- d) Patient Falls
- e) Other patient incidents/unexpected clinical/medical events
- f) Unsafe conditions
- g) Visitor safety
 - Visitor incidents
- h) Employee safety
 - Blood/body fluid exposures
 - Occupational diseases
 - Communicable disease exposures
 - Musculoskeletal injuries
 - Immunization programs
 - Other employee incidents
- i) Environmental safety
 - Product recalls
 - Drug recalls
 - Product/equipment malfunction
 - Construction
 - Infection Control Risk Assessment
 - Water Quality
 - Air Quality
 - Disaster Planning
 - Security incidents
 - Workplace violence

Data from external sources, including but not limited to:

- Centers for Disease Control and Prevention (CDC)
- Joint Commission
- Institute for Healthcare Improvement (IHI)
- Institute for Safe Medication Practices (ISMP)
- Occupational Safety and Health Administration (OSHA)
- Nevada State Health Division
- Published literature

VII. DEFINITIONS

Serious Reportable (Sentinel) Event is defined by NRS 439.830 and means an event included in Appendix A of “Serious Reportable Events in Healthcare”. The seven (7) Serious Reportable Events along with their subsets are as follows:

Specifications of the Serious Reportable Events in Healthcare

1. Surgical or Invasive Procedure Events

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

2. Product or Device Events

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

3. Patient Protection Events

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

4. Care Management Events

- A. Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration).

- B. Patient death or serious injury associated with unsafe administration of blood products
- C. Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting.
- D. Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy.
- E. Patient death or serious injury associated with a fall while being cared for in a healthcare setting.
- F. Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting.
- G. Artificial insemination with the wrong donor sperm or wrong egg.
- H. Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen.
- I. Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results.

5. Environmental Events

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

6. Radiologic Events

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

7. Potential Criminal Events

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

VIII. STRUCTURE

The authority for the Patient Safety Plan rests with the CEO, CNO, Quality Improvement Coordinator, Patient Safety Officer, and Chief of Medical Staff and has delegate the authority to implement and maintain activities described in this plan to the Enterprise safety committee.

IX. QUALITY REVIEW INFORMATION

To the extent possible, and in the manner consistent with the protection of confidentiality of quality assurance and patient safety data, pertinent information will be shared between the Quality Improvement Program and the Enterprise Safety Program.

In an attempt to protect quality review information from discovery, all quality review documents must be labeled as a Quality Review document. Documents should be in a formal format, handled by a limited number of individuals and secured in the Quality or Risk Managers Office accessible only to designated individuals. Nevada Revised Statute that protects quality documents is NRS49.265.

X. EDUCATION

Annual Staff and physician/provider education includes but is not limited to the following topics:

- Fire Drills
- Emergency and Disaster Drills
- Workplace violence
- Customer Service
- Creating, implementing, achieving, and maintaining a culture of Enterprise safety
- Risk management and error prevention
- Teamwork

XI. SAFETY IMPROVEMENT ACTIVITIES

Specify Measures Selected for an annual focus; (Examples are listed below)

- Patient satisfaction surveys
- Medical Record review; legible documentation, clear, complete, signed
- Complaints and resolution; to improve care and satisfaction (trends)
- Confidentiality; insure patient and employee information is secure
- Appointments/scheduling process; accessibility to physician
- Informed Consent Policy and Procedure
- Medication management and reconciliation i.e. current allergy information
- Telephone response time to callers
- Occurrence review

Give consideration to measures that facilitate safe practices; (Examples are listed below)

- Involve patients in their health care; consider literacy issues and cultural values, partner with patients in developing and planning their care plan.

- Use a team approach to safety; hold focused safety meetings
- Endorse open, effective communication; identify shared values and attitudes among all members. Interview and/or survey staff for attitudes, perceptions and communication barriers.
- Encourage error reporting to include near miss events. Institute a non-punitive reporting that is confidential and timely.
- Ensure employee and patient information or event reports shared with staff for educational purposes do not identify individuals.
- Facilitate communication skills learning (teamwork)
- Examine physical premises to identify and correct potential hazardous conditions.
- Orient physicians and new employees to risk management and patient safety concepts
- Conduct patient safety rounds
- Provide education and training on high risk processes.

XII. METHODOLOGY

A. Structure

- Proactive risk prevention strategies
- Identification of High Risk Areas
- General Incidences (Patient Injuries)
- Potential or actual adverse events (medication errors)

B. Method – Establish a process for;

- Identification, Selection, Prioritization
- Data Collection and Analyses
- Development of Actions
- Implementation
- Reporting
- Follow-up

C. Process Improvement – Establish teams/individual staff members to implement processes and to monitor for effectiveness.

Utilize applicable tools to facilitate improvement; for example

- PDCA: Plan, Do Check Act with focus on process improvement
- FMEA: Failure Mode Effect Analysis a systematic process for identifying potential process failures before they occur with the intent to eliminate or minimize risk.
- RCA: Root Cause Analysis is a retrospective approach to error analysis that identifies what and how the event occurred and why it happened. The focus is on the process and systems not individuals.

XIII. PROGRAM EVALUATION

The Patient Safety Officer will submit monthly a report the Enterprise Safety Committee, Medical Staff and the Board of Directors

1. Definition of the scope of occurrence including sentinel events, near misses and serious occurrences that occurred at WBRH and RHC during the preceding month including;
 - Employee injuries
 - Potential lawsuits
 - Resolutions
 - Recommendations to the decrease of the number and severity of Sentinel Events

Yearly the Patient Safety Officer will submit to the Enterprise Safety Committee, Medical Staff and the Governing Board the following;

- a. Detail of activities that demonstrate the enterprise safety program has a proactive component by identifying the high-risk process selected.
- b. Results of the high-risk or error-prone processes selected for ongoing measurement and analysis.
- c. A description of how the function of process design that incorporates patient safety has been carried out using specific examples of process design or redesign that include patient safety principles.
- d. The results of how input is solicited and participation from patients and families in improving patient safety is obtained.
- e. The results of the program that assesses and improves staff willingness to report errors.
- f. A description of the examples of ongoing education and training programs that are maintaining and improving staff competence and supporting an interdisciplinary approach to patient care.

Yearly the Enterprise Safety Committee shall;

1. Monitor and document the effectiveness of the patient identification policy.
2. Review the patient safety checklists and patient safety policies adopted and consider any additional patient safety checklists and patient safety policies that may be appropriate for adoption for use at the medical facility.
3. Revise a patient safety checklist and patient safety policy adopted as necessary to ensure that the checklist or policy reflects the most current standards in patient safety protocols.
4. On or before July 1 of each year, submit a report to the Director of the Legislative Counsel Bureau for transmittal to the Legislative Committee on Health Care. This report must contain;

- Information regarding the development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted.

XIV.NO CRIMAL PENALTY OR CIVIL LIABILITY

No person is subject to any criminal penalty or civil liability for libel, slander or any similar cause of action in tort if the person, without malice;

- Reports sentinel event to a governmental entity with jurisdiction or another appropriate authority.
- Notifies a governmental entity with jurisdiction or another appropriate authority of a sentinel event.
- Transmits information regarding a sentinel event to a governmental entity with jurisdiction or another appropriate authority
- Compiles, prepares or disseminates information regarding a sentinel event to a governmental entity with jurisdiction or another appropriate authority; or
- Performs any other act authorized pursuant to NRS 439.800 to 439.890.

NRS439.860 ANY REPORT, DOCUMENT AND ANY OTHER INFORMATION COMPILED OR DISSEMINATED PURSUANT TO THE PROVISIONS OF NRS 439.800 TO 439.890, INCLUSIVE AND SECTION I OF AB 280 IS NOT ADMISSIBLE AS EVIDENCE IN ANY ADMINISTRATIVE OR LEGAL PROCEEDING CONDUCTED IN THE STATE OF NEVADA.



Las Vegas, Nevada

Excerpts from Policy and Procedure Manual

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

<u>Section Title:</u> Facilities And Environment	<u>Section:</u> 8
<u>Subject :</u> ADA Compliance Policy	<u>Policy:</u> 8.10

POLICY

Our facility is committed to providing accommodations for individuals with disabilities as defined by federal, state, and local law in the most timely and effective manner possible. Our intent is to ensure that anyone who makes a request for accommodation under the Americans with Disabilities Act (ADA) or Rehabilitation Act is promptly and properly advised of the accommodation process. We are committed to following the requirements of the ADA and all appropriate federal and/or state laws, rules and regulations.

PROCEDURE

Provisions have been made by Affinity Surgery Center, LLC to reasonably accommodate disabled individuals.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

SECTION: N SAFETY

DATE: 8/11

REVIEWED: 3/12, 2/13, 1/21

POLICY: N-10 PATIENT SAFETY CHECKLIST

PROCEDURE:

1. A PATIENT SAFETY LIST WILL BE CONSTRUCTED BY THE MEMBERS OF THE SAFETY COMMITTEE. AND APPROVED BY MEMBERS OF THE MEDICAL EXECUTIVE COMMITTEE.
2. THE LIST WILL BE REVIEWED ANNULLY AND REVISED BY THE SAFETY COMMITTEE WHEN DEEMED NECESSARY TO ENSURE THE CHECKLISTS REFLECT THE MOST CURRENT STANDARDS IN PATIENT SAFETY PROTOCOLS.
3. A PATIENT SAFETY LIST WILL BE COMPLETED FOR EACH PATIENT AND FOR EACH ADMISSION TO THE CENTER.
4. THE PATIENT SAFETY LIST WILL BE COMPLETED BY ALL EMPLOYEES INIATING TREATMENT AT THE CENTER.
5. MONTORING AND EVALUTION OF THE PATIENT SAFETY LISTS AND PATIENT SAFETY POLICIES WILL BE DONE BY THE QAPI (QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT) COMMITTEE AND REPORTED TO THE SAFETY COMMITTEE, FACITITY OPERATIONS COMMITTEE, AND THE MEDICAL EXCUTIVE COMMITTEE.
6. THE SAFETY COMMITTEE WILL SUBMIT AN ANNUAL REPORT ON OR BEFORE JULY 1 OF EACH YEAR TO THE DIRECTOR OF THE LEGISLATIVE COUNSEL BUREAU FOR THE TRANSMITTAL TO THE LEGISLATIVE COMMITTEE ON HEALTH CARE. THE REPORT MUST INCLUDE INFORMATION REGARDING THE DEVELOPMENT, REVISION, AND USAGE OF PATIENT SAFETY CHECKLISTS AND PATIENT SAFETY POLICIES AND SUMMARY OF THE ANNUAL REVIEW CONDUCTED BY THE FACILITY.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

SECTION: N SAFETY DATE: 11/97, 3/09, 11/11, 1/13, 5/16, 4/17 6/18,

4/19, 12/20, 1/21

TITLE: N-20 CRASH CART CONTENTS

TOP

- Zoll pacemaker/Defibrillator
- Portable Suction
- Crash Cart Manual
 - Crash Cart Check Sheet
 - Algorithms
 - Code Blue Record
 - Transfer Summary
 - Crash Cart Contents
 - Critical Care Drugs
 - Malignant Hyperthermia references

BACK

- Back Board

LEFT SIDE

- Pacer Magnet
- Oxygen tank with regulator

RIGHT SIDE

- IV Pole
- Ambu Bag With Mask

DRAWER 1

- 30 cc Syringes (2)
- 12 cc Syringes (4)
- 5 cc Syringes (4)
- 3cc Syringes (4)
- 18g Needles
- Recording Paper
- ECG Cable with Electrodes
- Electrode Gel
- Alcohol Preps
- Pacer Cable with Pads
- Micro-Shield Disposable Barrier

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

SECTION: N SAFETY

DATE: 11/97, 3/09, 11/11, 1/13, 5/16, 4/17,
4/19, 12/20, 1/21

6/18,

TITLE: N-20 CRASH CART CONTENTS

DRAWER 2

- Sodium Bicarbonate 7.5% (2)
- Dextrose 50% (2)
- Calcium Chloride 10% (2)
- Atropine 1mg (6)
- Lidocaine 2% (2)
- Epinephrine 1mg (4)
- Adenosine 6mg (3)
- Amiodarone 450mg (2)
- Narcan 0.4mg (2)
- Metoprolol 5mg (2)
- Dilantin 100mg (2)
- Benadryl 50mg (2)
- Ativan 2mg-----in med frig

DRAWER 3

- Lactated Ringers 1000ml (1)
- 0.9% sodium chloride 1000ml (1)
- 0.9% Sodium Chloride 250ml (2)
- Primary IV Set (2)
- Secondary IV Set (2)
- 3-way Stop Cocks (2)
- Disposable Pressure Infuser
- Dopamine 400mg (1)
- IV Start Kit (4)
 - Razor
 - Tape
 - Gauze 2x2
 - 19g Butterfly
 - 14g Jelco (2)
 - 16g Jelco (2)
 - 18g Jelco (2)
 - 20g Jelco (2)

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

SECTION: N SAFETY

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

5/16, 4/17, 6/18, 4/19, 12/20, 1/21

TITLE: N-20 CRASH CART CONTENTS

DRAWER 4

- McIntosh #3 & #4 Disposable Laryngoscopes
- Welch-Allyn Illuminator for Laryngoscopes
- Lubricating Jelly+
- 14 fr. Intubating Stylet (2)
- Cuffed (Endotracheal) tubes
 - 6.5 (3)
 - 7.0 (3)
 - 7.5 (3)
 - 8.0 (3)
- Suction tubing (2)
- 5 in 1 Adapters (2)
- Yankauer Suction Tip (2)
- 8 fr. Suction Catheter (1)
- 10 fr. Suction Catheter (2)
- 12 fr. Suction Catheter (2)
- 16 fr. Naso Gastric Tube
- Oral Pharyngeal airways
 - 80mm 100mm
 - 90mm 120mm
- Sterile Gloves size 6.5, 7, 7.5, and 8 (1 ea.)
- Oxygen Cannula (1)
- Oxygen Mask (1)
- Thoracotomy/Tracheotomy set
 - Shiley 6 Uncuffed Trach Tube
 - 22 fr. Foley
 - 15 Blades (2)
 - 2-0 Nylon Suture
 - Senn Retractors
 - Knife handle
 - Needle Holder
 - Suture Scissor
 - Kelly Clamp
 - Betadine
 - Gauze 4x4
 - Lubricant

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

SECTION: N SAFETY

DATE: 11/97, 3/09, 11/11, 1/13,
1/13, 5/16, 4/17, 6/18, 4/19, 12/20,
1/21

TITLE: N-20 CRASH CART CONTENTS

DRAWER 5

- MALIGNANT HYPERTHERMIA
 - Dantrium Intravenous 20mg (36)
 - Sterile Water for Reconstitution (1000 cc X 4)
 - 3-way Stop Cocks (2)
 - 60 cc Luer Lock Syringe (4)
 - 60 cc Cath Tip Syringe (2)
 - Foley Catheter Kit
 - Zip Locks for Ice
 - Sterile Med Cup (2)

MALIGNANT HYPERTHERMIA SUPPLIES – NOT IN CRASH CART

ITEM

Cubed Ice
Freeze Packs
NACL Pour Bottles (1000 cc X 2)
Normal Saline I.V. (1000 cc X 3)
Insulin Humulin R (1)

LOCATION

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

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

TITLE: N-30 CRASH CART AND DEFIBRILLATOR CHECK

POLICY: WILDCREEK SURGERY CENTER WILL MAINTAIN A CRASH CART AND DEFIBRILLATOR IN GOOD WORKING ORDER AT ALL TIMES. THE CRASH CART WILL BE FULLY STOCKED AND AVAILABLE FOR ALL CARDIO-PULMONARY EMERGENCIES IN THE FACILITY. ITEMS FROM THE CRASH CART WILL NOT BE USED IN ROUTINE PATIENT CARE IN ORDER TO ENSURE AVAILABILITY DURING AN EMERGENCY.

PROCEDURE:

- 1) THE CRASH CART WILL BE KEPT LOCKED DURING HOURS THE CENTER IS NOT IN OPERATION AND UNLOCKED DURING OPERATIONAL HOURS.
- 2) A CHECK LIST WILL BE KEPT ON TOP OF THE CRASH CART WHICH WILL BE SIGNED DAILY BY THE PERSON WHO CHECKS THE CART AND DEFIBRILLATOR.
- 3) THE PROCEDURE FOR CHECKING THE DEFIBRILLATOR IS AS FOLLOWS:
 - A) UNPLUG THE DEFIBRILLATOR
 - B) TURN THE DIAL TO DEFIB.
 - C) ADJUST THE JOULES TO 30J.
 - D) PRESS THE CHARGE BUTTON. THE BUTTON WILL LIGHT UP AND BEEP INDICATING THE UNIT IS CHARGED.
 - E) WHEN CHARGED, PRESS THE SHOCK BUTTON
 - F) THE PANEL WILL DISPLAY "TEST OK".
 - G) TURN THE DIAL TO THE OFF POSITION
 - H) PLUG THE UNIT BACK IN.
- 4) CHECK TO MAKE SURE THERE IS PAPER IN THE STRIP RECORDER.
- 5) CHECK THE DEFIB PADS LOCATED ON THE TOP OF THE CART
- 6) MAKE SURE THE OXYGEN TANK IS FULL AND SUCTION IS FUNCTIONING.
- 7) ASSURE THAT CODE BLUE AND TRANSFERS RECORDS ARE AVAILABLE.
- 8) CHECK THAT THE EYE WASH STATION IS FUNCTIONING.
- 9) CHECK THE DRUGS FOR EXPIRATION.
- 10) SIGN THE CHECKLIST.
- 11) REPORT ANY VARIANCES TO NURSE MANAGER.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

SECTION: N SAFETY

DATE 11/97, 7/03, 9/14, 3/19

REVIEWED: 3/12, 5/16, 1/21

TITLE: N-30 CRASH CART AND DEFIBRILLATOR CHECK

- 12) IF THE CART WAS LEFT UNLOCKED, THE ENTIRE CART MUST BE GONE THROUGH TO ASSURE THAT IS IT FULLY STOCKED, AND THAT ALL EQUIPMENT IS IN WORKING ORDER (I.E.; LARYNGOSCOPE BATTERIES AND BULB)
- 13) NOTHING IS TO BE PLACED IN OR ON THE CRASH CART THAT IS NOT ON THE APPROVED CONTENTS LIST.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

DATE: 11/97, 9/99, 7/03, 5/16, 1/17

REVIEWED: 3/13, 4/19, 1/21

TITLE: N-40 MALIGNANT HYPERTHERMIA

PROCEDURE:

1. MALIGNANT HYPERTHERMIA SUPPLIES ARE STORED IN THE BOTTOM DRAWER OF THE CRASH CART AND CHECKED DAILY AS PART OF THE CRASH CART PROCEDURE. MHAUS POSTERS WILL BE MAINTAINED AT THE CRASH CART AND IN BOTH SURGICAL SUITES.
2. SUPPLIES REQUIRING REFRIGERATION ARE STORED IN THE MEDICATION REFRIGERATOR AT THE NURSES STATION AND IN THE BREAK ROOM FREEZER
3. PATIENTS RECEIVING **MH** TRIGGERING AGENTS (SUCCINYLCHOLINE/INHALATION AGENTS) WILL BE OBSERVED FOR THE SIGNS AND SYMPTOMS OF **MH** BY ANESTHESIOLOGIST, OR AND PACU NURSING STAFF.
4. PATIENTS RECEIVING GENERAL ANESTHESIA WILL BE SCREENED FOR HISTORY OF **MH** BOTH SELF AND FAMILY. IN THE PRESENCE OF A POSITIVE HISTORY THE PROCEDURE WILL BE CANCELLED AND RESCHEDULE AT AN INPATIENT FACILITY.

SYMPTOMS TO OBSERVE FOR MALIGNANT HYPERTHERMIA

- **INTENSE MUSCLE RIGIDITY (USUALLY MASSETER MUSCLE FIRST)
CAN INVOLVE ENTIRE BODY.
- **RAPID INCREASE IN END TIDAL CO₂
- **RAPID DECREASE IN OXYGEN SATURATION
- **SUDDEN UNEXPLAINED TACHYCARDIA.
- **TACHYPNEA
- **UNSTABLE BLOOD PRESSURE
- **ARRHYTHMIAS
- **DARK BLOOD IN SURGERY FIELD, DESPITE ADEQUATE VENTILATION
- **CYANOTIC MOTTLING OF SKIN
- **PROFUSE SWEATING
- **FEVER, RAPID RISE OF 1 DEGREE/15 MIN, CAN RISE TO 108 DEGREES (42C) OR MORE
- **CENTRAL VENOUS DESATURATION
- **CENTRAL VENOUS AND ARTERIAL HYPERCARBIA
- **METABOLIC ACIDOSIS
- **RESPIRATORY ACIDOSIS
- **HYPERKALEMIA
- **MYOGLOBINEMIA
- **ELEVATED CPK

4. FOLLOWING THE SUSPECTED DIAGNOSIS OF MALIGNANT HYPERTHERMIA, THE ANESTHESIOLOGIST WILL STOP ANESTHESIA. (**MHAUS GUIDELINES WILL BE FOLLOWED**)

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

SECTION: N SAFETY

DATE: 11/97, 9/99, 7/03, 5/16, 1/17

REVIEWED: 3/12, 4/19, 1/21

TITLE: **N-40 MALIGNANT HYPERTHERMIA**

5. A 911 CALL WILL BE PLACED FOR AMBULANCE SERVICE RELAYING A PATIENT PICK-UP WITH POSSIBLE **MH**.

6. THE ANESTHESIA MACHINE WILL BE PURGED WITH HIGH FLOW O2 AND NEW HOSES ATTACHED PER REQUEST OF ANESTHESIOLOGIST.

7. THE CIRCULATING NURSE WILL INITIATE A CODE BLUE DESIGNATING THE AREA AND BRING CRASH CART/HYPERTHERMIA CART TO ARE.

8. PACU WILL RESPOND WITH INSULIN, MANNITOL AND ICE.

9. THE ANESTHESIOLOGIST WILL HYPERVENTILATE THE PATIENT WITH 100% O2 AT A FLOW OF 8-10 LITERS/MIN

10. DANTROLENE SODIUM (DANTRIUM) WILL BE ADMINISTERED I.V. ASAP AT A STARTING DOSE OF 2MG/KG TO A TOTAL OF 10MG/KG VIA RAPID INFUSION. NEARBY SURGERY CENTERS WILL BE ALERTED TO BE ON STAND-BY FOR ADDITIONAL DANTRIUM.

11. COOLING OF THE PATIENT WILL BE INITIATED:

- A. IV ICED NORMAL SALINE ADMINISTERED 15CC/KG/15 MIN X 3 DOSES
- B. SURFACE COOLING WITH ICE PACKS (AND CRUSHED ICE IN ZIPLOCK BAGS)
- C. LAVAGE OF STOMACH, BLADDER, RECTUM, PERITONEAL AND THORACIC CAVITIES AS APPLICABLE WITH ICED SALINE TO A TOTAL OF 3-6 LITERS

13. THE CIRCULATING NURSE WILL NOTIFY THE O.R. NURSE MANAGER TO SECURE ARRANGEMENTS FOR:

- A. TRANSFER ARRANGEMENTS TO HOSPITAL OF THE PHYSICIAN'S CHOICE.
- B. AMBULANCE ARRANGEMENTS

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

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REVIEWED: 3/12, 4/19, 1/21

TITLE: N-40 MALIGNANT HYPERTHERMIA

14. THE O.R. SCRUB TECHNICIAN WILL ASSIST THE SURGEON TO SECURE THE SURGERY SITE TO PREVENT CONTAMINATION AND ATTAIN HEMOSTASIS

15. THE CIRCULATING NURSE AND/OR ASSIGNED STAFF MEMBER WILL ASSIST THE ANESTHESIOLOGIST IN INSERTING AND SECURING MONITORING LINES: NG, FOLEY, RECTAL TUBES ETC.

16. THE SURGEON, ANESTHESIOLOGIST, AND CIRCULATING NURSE WILL ACCOMPANY THE PATIENT TO THE ADMITTING HOSPITAL, SPACE PERMITTING.

17. DOCUMENTATION WILL BE MADE ON:

A. THE PATIENT CHART

B. THE CODE RECORD

18. THE O.R. NURSE MANAGER WILL:

A. ARRANGE TRANSPORTATION OF TRANSPORT TEAM BACK TO CENTER

B. NOTIFY THE ADMINISTRATOR AND MEDICAL DIRECTOR

C. COMMUNICATE THE INCIDENT TO THE QI/RM COMMITTEE AND OBTAIN APPROPRIATE PEER REVIEW

MALIGNANT HYPERTHERMIA PROTOCOL

1) ANESTHESIOLOGIST/ CIRCULATOR:

A) STOPS ANESTHESIA / SURGERY

B) CALL A CODE BLUE AND DESIGNATE AREA

C) CHANGING OF CIRCUITS AND BARALYME AT ANESTHESIOLOGISTS REQUESTS

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

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REVIEWED: 3/12, 4/19, 1/21

TITLE: N-40 MALIGNANT HYPERTHERMIA

2) AVAILABLE STAFF:

- A) BRINGS CRASH CART/M.H. CART TO DESIGNATED AREA
- B) PACU STAFF WILL BRING INSULIN TO AREA
- C) ICED SALINE AND FREEZE PACKS WILL BE OBTAINED FROM EMPLOYEE LOUNGE FREEZER AND BROUGHT TO AREA.
- D) CRUSHED ICE WILL BE OBTAINED FROM FREEZER IN EMPLOYEE LOUNGE AND BROUGHT TO AREA.

3) R.N./CIRCULATOR WILL ASSIGN STAFF TO:

- A) MIX DANTRIUM
- B) INSERT FOLEY CATHETER-----REMEMBERING TO SAVE FIRST RETURN FOR STAT LAB
- C) RECORD EVENTS ON CODE BLUE RECORD
- D) ASSIST ANESTHESIOLOGIST INTUBATION, STARTING LINES, AND/OR LAVAGE.

MALIGNANT HYPERTHERMIA CART SUPPLIES

- Dantrium Intravenous 20mg (36)
- Sterile Water for Reconstitution (1000 cc X 3)
- IV Administration Set (2)
- Oxygen Mask, Adult, Disposable with 7 Foot Tubing
- Malignant Hyperthermia Emergency Protocol
- Foley Catheter, 16Fr
- Foley Catheter, 22Fr
- Zip Lock Bags for Cubed Ice
- 2 oz Catheter Tip Syringe (2)
- Urinary Drainage Bag
- Nasogastric Tube, 16 Fr
- Sterile Lubricant Packets (6)

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

SECTION: N SAFETY

DATE: 11/97, 9/99, 7/03, 5/16, 1/17

REVIEWED: 3/12, 4/19, 1/21

TITLE: **N-40 MALIGNANT HYPERTHERMIA**

MALIGNANT HYPERTHERMIA SUPPLIES – NOT IN CRASH CART

ITEM

LOCATION

Cubed Ice

Staff Lounge Freezer

Freeze Packs (10)

Staff lounge freezer, Patient freezer

NACL Pour Bottles

Medication Refrigerator, Recovery Room

(1000 cc X 2)

Lactated Ringer's I.V.

Medication Refrigerator, Recovery Room

(1000 cc X 2)

Insulin (Humulin R)

Medication Refrigerator, Recovery ROOM

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

SECTION: N SAFETY

DATE: 11/97, 7/03, 3/10
8/12, 11/13, 5/16, 4/19, 1/21

TITLE: N-50 MANAGEMENT OF A LATEX ALLERGY

POLICY: WILDCREEK SURGERY CENTER SHALL MAINTAIN OR HAVE PROMPT ACCESS TO NECESSARY EQUIPMENT, SUPPLIES, DRUGS, AND PERSONNEL TO EFFICIENTLY MEET THE DEMANDS OF A PERSON WHO HAS A LATEX ALLERGY.

PROCEDURE:

1. SCREENING:

UPON ADMISSION, PATIENTS WILL BE ASKED ABOUT ANY LATEX ALLERGIES. IN PATIENTS WITH SUCH ALLERGIES, IT NEEDS TO BE DETERMINED TO WHAT EXTENT THE ALLERGY INVOLVES.

2. RECOGNITION:

A. TYPE I HYPERSENSITIVITY (PROTEIN ALLERGY). THIS IS DEFINED AS AN ALLERGY TO SOME OF THE PROTEINS FOUND IN NATURAL RUBBER LATEX. TYPE I ALLERGIES MAY PRODUCE URTICARIA, SWOLLEN EYELIDS OR LIPS, RESPIRATORY DISTRESS, RHINITIS, AND CAN RESULT IN SYSTEMIC ANAPHYLAXIS. INDIVIDUALS WITH A TYPE I HYPERSENSITIVITY TO NATURAL RUBBER LATEX SHOULD ONLY USE A SYNTHETIC GLOVE OR ALTERNATIVELY A VINYL GLOVE BENEATH LATEX.

B. TYPE IV HYPERSENSITIVITY (CHEMICAL ALLERGY). TYPE IV HYPERSENSITIVITY IS A CHEMICAL ALLERGY TO THE ACCELERATORS, STABILIZERS, PRESERVATIVES, OR OTHER CHEMICALS. THIS REACTION PRESENTS ITSELF AS DRY THICKENED SKIN WITH POSSIBLE BUMPS OR SORES, BUT DOES NOT DEVELOP INTO SYSTEMIC REACTIONS.

3. MANAGEMENT:

A. IN THE CASE THAT A LATEX ALLERGY BECOMES EVIDENT DURING A PROCEDURE, ADAPT THE ENVIRONMENT ACCORDING TO THE SEVERITY OF THE ALLERGY. THE FOLLOWING EQUIPMENT MAY NEED TO BE TAKEN INTO CONSIDERATION:

WILDCREEK SURGERY CENTER

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TITLE: N-50 MANAGEMENT OF A LATEX ALLERGY

- GLOVES-WEAR VINYL GLOVES. WEARING VINYL GLOVES MAY BE ALL THAT IS REQUIRED FOR SOME ALLERGIC REACTIONS.
- MONITORS AND OTHER EQUIPMENT-SOME EQUIPMENT, SUCH AS BLOOD PRESSURE CUFFS AND TUBING AND STETHOSCOPE TUBING MAY CONTAIN LATEX.

B. THE PATIENT SHOULD BE GIVEN AN ALLERGY BAND STATING HIS/HER ALLERGY TO LATEX.

C. A MASTER LIST OF COMMONLY USED LATEX ITEMS WILL BE AVAILABLE TO PERSONNEL RESPONSIBLE FOR THE CARE OF THE LATEX ALLERGY PATIENT.

D. ALL O.R. PERSONNEL CARING FOR THE LATEX ALLERGIC PATIENT PERI-OPERATIVELY WILL ADHERE TO THE GUIDELINES SPECIFIC FOR THE CARE OF THESE PATIENTS.

NURSING CARE FOR THE PATIENT WITH LATEX ALLERGY NURSING CHECK-OFF LIST

PRE-OP:

1. IDENTIFY IF PATIENT HAS A LATEX ALLERGY.
2. ASSURE THAT CHART IS CLEARLY DOCUMENTED STATING THAT A LATEX ALLERGY IS PRESENT.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

SECTION: N SAFETY

**DATE: 11/97, 7/03, 3/10
8/12, 11/13, 5/16, 4/19, 1/21**

TITLE: N-50 MANAGEMENT OF A LATEX ALLERGY

3. LATEX FREE GLOVES SHOULD BE WORN FOR ANY PATIENT CARE/CONTACT.
4. ASSURE THAT ALL MEMBERS OF THE HEALTH CARE TEAM ARE AWARE OF THE LATEX ALLERGY (O.R. CHARGE NURSE, ANESTHESIOLOGISTS, ETC.)
5. REFER TO THE LIST OF LATEX FREE ITEMS AND HAVE ALTERNATIVES AVAILABLE. POSTED IN PRE-OP MEDICATION CABINET AND SUBSTERLE SUTURE CABINET.

INTRA-OP:

1. LATEX WILL BE LISTED ON PATIENT ALLERGY BRACELET AND DOCUMENTED IN RED ON ALL CHART RECORDS.
2. HANG SIGN ON O.R. DOOR TO IDENTIFY LATEX ALLERGY.
3. USE NON- LATEX ITEMS TO SUBSTITUTE FOR LATEX PRODUCTS
4. WRAP WEBRIL AROUND ARM AND OR LEG TO PREVENT BLOOD PRESSURE CUFF TUBING COMING INTO CONTACT WITH PATIENT'S ARM.
5. ASSESS THE STERILE FIELD WITH THE SCRUB NURSE TO ASSURE A LATEX FREE SETUP
7. COMMUNICATE WITH THE PACU NURSE PRIOR TO PATIENT'S ARRIVAL REGARDING THE PATIENT'S LATEX ALLERGY.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

SECTION: N SAFETY

**DATE: 11/97, 7/03, 3/10
8/12, 11/13, 5/16, 4/19, 1/21**

TITLE: N-50 MANAGEMENT OF A LATEX ALLERGY

LATEX ITEMS:

- 1. BLADDER AND TUBING IN BLOOD PRESSURE CUFF**
- 2. STETHOSCOPES**
- 3. STERILE SURGICAL GLOVES**

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WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

SECTION: N SAFETY

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

REVIEWED: 5/16, 1/21

TITLE: N-55 CODE BLUE ANNOUNCEMENT

POLICY:

WILDCREEK SURGERY CENTER WILL ENSURE THAT THE RESPONSE TO A CARDIO-PULMONARY ARREST IS CONDUCTED IN A TIMELY MANNER AND WITH ADEQUATE PERSONNEL TO PERFORM RESUSCITATION.

PROCEDURE:

1. THE PERSON IDENTIFYING THAT A CONDITION OF EMERGENCY EXISTS WILL CALL A CODE BLUE, OR IF ATTENDING TO THE PERSON IN DISTRESS, WILL DIRECT ANOTHER EMPLOYEE TO CALL THE CODE BLUE. IMMEDIATELY FOLLOWING THE CODE BLUE ANNOUNCEMENT, THE EMPLOYEE WILL CALL 911 AND REQUEST AMBULANCE SUPPORT AND TRANSFER.
2. A CODE BLUE IS CALLED BY; PICKING THE RECIEVER ON ANY PHONE, DIALING 8888 AND ANNOUNCING THE CODE BLUE ALONG WITH THE LOCATION OF CODE BLUE PATIENT.
3. THE CODE BLUE TEAM AND ALL AVAILABLE EMPLOYEES AND PHYSICIANS WILL RESPOND.
4. THE CODE BLUE TEAM WILL CONSIST OF:
 - AN ANESTHESIOLOGIST AND/OR SURGEON.
 - A RN TO DIRECT TRAFFIC.
 - A PACU NURSE TO BRING AND MANAGE THE CRASH CART.
 - 2 CERTIFIED ACLS PERSONNEL.
 - A RN DOING DOCUMENTATION.
5. PERSONNEL ON THE CODE BLUE TEAM:
 - THE ANESTHESIOLOGIST IN ATTENDANCE WILL RESPOND TO THE CODE BLUE
 - PACU NURSE MANAGER OR NURSE MANAGER AND/OR QA NURSE WILL RESPOND IF DEEMED NECESSARY.
 - ALL AVAILABLE PACU NURSES WILL RESPOND BRINGING THE CRASH CART WITH DEFIBRILLATOR.
 - ALL AVAILABLE EMPLOYEES AND PHYSICIANS WILL RESPOND AND REMAIN UNTIL IT IS EVIDENT THAT ADEQUATE COVERAGE IS AVAILABLE.
 - ALL INVOLVED PERSONNEL ARE TO RETURN OR REMAIN WITH OTHER PATIENTS OR FAMILIES
 - A WRITTEN DEBRIEFING WILL BE COMPLETED FOLLOWING THE CODE BLUE AND PRESENTED TO THE QAPI AND SAFETY MEETINGS.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

SECTION: N SAFETY

DATE: 11/97, 7/03, 9/09, 5/16

REVIEWED: 3/12, 1/21

TITLE: N-60 DEVICE TRACKING

POLICY: WILDCREEK SURGERY CENTER WILL SUPPORT AND COMPLY WITH THE PROVISIONS SET FORTH BY THE SAFE MEDICAL DEVICES ACT IN REGARD TO TRACKING SPECIFIED IMPLANTABLE DEVICES. IMPLEMENTED ON AUGUST 29, 1993, THIS ACT DIRECTS ITS ATTENTION TO THE ABILITY TO CONTACT RECIPIENTS OF THE IMPLANTABLE DEVICE IN THE EVENT OF A RECALL.

PROCEDURE:

1. ALL PERMANENTLY IMPLANTABLE DEVICES WILL BE TRACKED. THESE INCLUDE THE FOLLOWING:
 - BREAST PROSTHESIS
 - EAR PROSTHESIS (DOES NOT INCLUDE MYRINGOTOMY TUBES)
 - FINGER IMPLANTS
 - HOMOGRAFTS (CORNEA, TYMPANIC MEMBRANE, FASCIA, ETC.)
 - HUNTER RODS
 - INFUSION PUMPS
 - INTRAOCULAR LENS
 - AMNIO GRAFTS
 - MESH (MARLEX, PROLENE, SURGIPRO, GORETEX, ETC.)
 - MOLTENO IMPLANTS
 - PLATES
 - SPINAL CORD STIMULATORS (PERMANENT)
 - TOE IMPLANTS
2. WHEN AN IMPLANT, OTHER THAN AN INTRAOCULAR LENS, IS USED, THE CIRCULATOR WILL PUT IMPLANT INFORMATION (CATALOG #, TYPE AND SERIAL OR LOT NUMBER), AND A REGISTRATION FORM, IF AVAILABLE, IN THE IMPLANT BOOK. IMPLANT INFORMATION IS MARKED RIGHT OR LEFT FOR MAMMARY PROSTHESIS. THE CIRCULATING NURSE WILL SEND THE APPROPRIATE REGISTRATION FORMS TO THE MANUFACTURER.
3. WHEN AN INTRAOCULAR LENS IS USED, THE CIRCULATOR WILL USE THE IOL LOGBOOK FOR PATIENT AND IMPLANT INFORMATION. AN IMPLANT STICKER IS ALSO PLACED ON THE INTRA-OPERATIVE RECORD WHICH IS A PERMANENT PART OF THE PATIENT RECORD. THE IMPLANT BOX CONTAINING THE IMPLANT STICKERS AND PATIENT INFORMATION CARD ARE GIVEN TO THE DISCHARGE PERSONNEL WHO COMPLETES THE PATIENT INFORMATION CARD AND GIVES TO THE PATIENT UPON DISCHARGE.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

SECTION: N SAFETY

DATE: 11/97, 8/98, 7/03

REVIEWED: 3/12, 5/16, 1/21

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

POLICY: WILDCREEK SURGERY CENTER WILL PROVIDE A SAFE AND HEALTHFUL ENVIRONMENT THROUGHOUT ITS FACILITIES. THE CENTER WILL PROVIDE EXPLICIT GUIDELINES FOR THE PROTECTION OF ALL EMPLOYEES WHO MAY BECOME EXPOSED OR HAVE CONTACT WITH HUMAN BLOOD OR BODY FLUIDS. THE CENTER WILL COMPLY WITH ALL RULES, LAWS, REGULATIONS, AND GUIDELINES PERTAINING TO THE SAFETY AND HEALTH OF ITS EMPLOYEES.

PROCEDURE: RESPONSIBILITIES OF ALL EMPLOYEES AND MEMBERS OF THE MANAGEMENT STAFF ARE AS FOLLOWS:

DEPARTMENT MANAGERS' RESPONSIBILITIES:

- 1) EACH DEPARTMENT MANAGER WILL EVALUATE AND CLASSIFY EVERY POSITION UNDER THEIR JURISDICTION IN ACCORDANCE WITH THE EXPOSURE CATEGORIES THAT FOLLOW.
- 2) THE APPROPRIATE EXPOSURE CATEGORY WILL THEN BE INCORPORATED INTO THE INDIVIDUAL POSITION DESCRIPTION.
- 3) ONCE EACH POSITION HAS BEEN PROPERLY CLASSIFIED, THE INDIVIDUALS OCCUPYING THAT POSITION WILL BE ADVISED IN WRITING OF THE EXPOSURE CATEGORY WHICH BEST FITS THE POSITION, AND THE PROTECTIVE MEASURES TO BE IMPLEMENTED FOR THAT CATEGORY.
- 4) EACH MANAGER WILL DEVELOP AND MAKE AVAILABLE WRITTE STANDARD OPERATION PROCEDURES FOR ALL EXPOSURE CATEGORY I AND II TASKS. THESE STANDARD OPERATING PROCEDURES SHOULD BE READILY AVAILABLE FOR ALL EMPLOYEES WHO PERFORM CATEGORY I AND II TASKS. WORK PRACTICES SHOULD BE DEVELOPED ON THE ASSUMPTION THAT ALL BODY FLUIDS AND TISSUES ARE INFECTIOUS.
- 5) PROCEDURES WILL BE DEVELOPED OR REVISED FOR THE CONTROL OF SPILLS AND PROPER HANDLING AND DISPOSAL METHODS FOR CONTAMINATED CLOTHING AND EQUIPMENT.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

SECTION: N SAFETY

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

- 6) EACH MANAGER WILL DEVELOP AND ESTABLISH AN INITIAL AND PERIODIC TRAINING FOR ALL EMPLOYEES WHO PERFORM EXPOSURE CATEGORY I AND II TASKS. NO WORKERS SHOULD ENGAGE IN ANY EXPOSURE I AND II TASKS BEFORE RECEIVING TRAINING PERTAINING TO THE WORK PRACTICES AND PROTECTIVE EQUIPMENT REQUIRED FOR THOSE TASKS
- 7) A POLICY OR SURVEILLANCE WILL BE ESTABLISHED BY THE MANAGER OR APPROPRIATE SUPERVISOR TO ENSURE THAT REQUIRED WORK PRACTICES ARE OBSERVED, AND THAT PROTECTIVE CLOTHING AND EQUIPMENT ARE PROPERLY PROVIDED AND USED.
- 8) ALL KNOWN OR SUSPECTED PENETRATING CONTACTS WILL BE INVESTIGATED TO ESTABLISH THE CONDITIONS SURROUNDING THE EXPOSURE AND TO IMPROVE TRAINING AND WORK PRACTICES OR PROTECTIVE EQUIPMENT TO PREVEN A REOCCURRENCE.
- 9) EACH MANAGER WILL ENSURE THAT ANY NEW POSITION DESCRIPTION INCLUDE THE APPROPRIATE EXPOSURE CATEGORY.

EXPOSURE CATEGORIES:

CATEGORY I: TASKS THAT INVOLVE EXPOSURE TO BLOOD, BODY FLUIDS, OR TISSUES. ALL PROCEDURES OR OTHER JOBRELATED TASKS THAT INVOLVE AN INHERENT POTENTIAL FOR MUCOUS MEMBRANE OR SKIN CONTACT WITH BLOOD, BODY FLUIDS, OR TISSUES, OR POTENTIAL FOR SPILLS OR SPLASHES OF THE SAME, ARE CATEGORY I.

CATEGORY I PROTECTIVE MEASURES:

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

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

SECTION: N SAFETY

DATE: 11/97, 8/98, 7/03

REVIEWED: 3/12, 5/16, 1/21

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

CATEGORY II: TASKS THAT INVOLVE NO EXPOSURE TO BLOOD, BODY FLUIDS, OR TISSUES, BUT EMPLOYMENT MAY REQUIRE UNPLANNED CATEGORY I TASKS. THE NORMAL WORK ROUTINE INVOLVES NO EXPOSURE TO BLOOD, BODY FLUIDS, OR TISSUES, BUT THE EXPOSURE OR POTENTIAL EXPOSURE MAY BE REQUIRED AS A CONDITION OF EMPLOYMENT.

CATEGORY II PROTECTIVE MEASURES:

THERE WILL BE READY ACCESS TO APPROPRIATE PROTECTIVE CLOTHING AND EQUIPMENT, (I.E. GLOVES, MASKS, GOWNS, AND EYE SHIELDS) BUT THE CATEGORY II WORKERS NEED NOT WEAR THESE AT ALL TIMES. THEY MUST, HOWEVER, BE PREPARED TO PUT ON PROTECTIVE EQUIPMENT AT ANY TIME AND ON SHORT NOTICE.

CATEGORY III: TASKS THAT INVOLVE NO EXPOSURE TO BLOOD, BODY FLUIDS, OR TISSUES. THE TASKS PERFORMED IN CATEGORY I ARE NOT A CONDITION OF EMPLOYMENT. THE NORMAL WORK ROUTINE INVOLVES NO EXPOSURE TO BLOOD, BODY FLUIDS, OR TISSUES. EMPLOYEES WHO PERFORM CATEGORY III TASKS ARE NOT CALLED UPON AS PART OF THEIR JOB TO PERFORM OR ASSIST IN CATEGORY I OR II TASKS. TASKS THAT INVOLVE CASUAL CONTACT (SHAKING HANDS, USING PUBLIC OR SHARED BATHROOMS, OR HANDLING OF PENS AND PENCILS) ARE CATEGORY III TASKS.

PERSONNEL EXPOSURE CATEGORIES:

CATEGORY I:

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

CATEGORY II:

LAUNDRY PERSONNEL
HOUSEKEEPING

CATEGORY III:

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

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

SECTION: N SAFETY

DATE: 11/97, 8/98, 7/03

REVIEWED: 3/12, 5/16, 1/21

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

STANDARD OPERATING PROCEDURES:

CATEGORY I:

ALL PERSONNEL PERFORMING CATEGORY I TASKS WILL WEAR THE APPROPRIATE PROTECTIVE CLOTHING AND EQUIPMENT. THIS INCLUDES MASKS, GOWNS, GLOVES, AND EYE SHIELDS. PROTECTIVE GARB WILL BE WORN DURING ALL CONTACTS WITH HUMAN BLOOD, BODY FLUIDS, OR TISSUES. THIS

INCLUDES SKIN PREPARATION OF THE OPERATIVE SITE, ASSISTING WITH OR STANDING NEAR THE OPERATIVE SITE, AND CLEANING OF THE OPERATING ROOM AND EQUIPMENT AFTER THE CASE IS FINISHED. PROTECTIVE GARB WILL ALSO BE USED DURING TRANSFER OF THE PATIENT TO AND FROM THE OPERATING TABLE, AND HOOK-UP OF MONITORING EQUIPMENT AND ANESTHETIC INDUCTION.

CATEGORY II:

ALL PERSONNEL PERFORMING CATEGORY II TASKS WILL HAVE PROTECTIVE CLOTHING AND EQUIPMENT READILY AVAILABLE FOR USE. THIS INCLUDES MASKS, GLOVES, GOWNS, AND EYE SHIELDS. THIS GARB NEED NOT BE WORN AT ALL TIMES BUT MUST BE DONNED WHEN PERFORMING TASKS THAT INVOLVE ANY CONTACT WITH OR POTENTIAL SPLASHING OF BLOOD, BODY FLUIDS, OR TISSUES. THIS INCLUDES ORAL, NASAL AND ET TUBE SUCTIONING, STARTING/DISCONNECTING IV'S, CHANGING/REINFORCING IV'S, CHANGING/REINFORCING DRESSINGS, HANDLING OF SOILED LINENS, FINGER-STICK BLOOD SAMPLING, AND CLEANING SOILED/CONTAMINATED EQUIPMENT. CASUAL CONDUCT SUCH AS ASSISTING THE PATIENT TO DRESS DOES NOT REQUIRE PROTECTIVE CLOTHING AND EQUIPMENT.

CATEGORY III:

NO SPECIAL PROTECTIVE CLOTHING OR EQUIPMENT IS REQUIRED FOR CATEGORY III TASKS. IF A TASK REQUIRES CATEGORY I OR II EXPOSURE, THE APPROPRIATE PERSONNEL WILL BE CALLED TO PERFORM THE TASK.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

SECTION: N SAFETY

DATE: 11/97, 7/03, 9/04
REVIEWED: 3/12, 5/16, 1/21

TITLE: N-80 PATIENT OR VISITOR INCIDENT OR INJURY

POLICY: WILDCREEK SURGERY CENTER WILL OUTLINE PROCEDURES FOR REPORTING UNUSUAL INCIDENTS THAT OCCUR IN OR AROUND THE CENTER AND/OR ANY OF ITS FACILITIES OR PROPERTIES REGARDLESS OF THE DEGREE OF SERIOUSNESS AT THE TIME OF THE OCCURRENCE AS FOLLOWS:

PROCEDURES:

- 1) THE CENTER SHALL DOCUMENT ALL UNUSUAL OCCURRENCES.
- 2) EMPLOYEES AND STAFF WILL BE CAUTIONED AGAINST COMMITTING TO THE CENTER'S LIABILITY THROUGH THEIR ACTIONS OR STATEMENTS IN THE PRESENCE OF PATIENTS, VISITORS, OR OTHERS AT ANY TIME.
- 3) ALL VARIANCE INVOLVING PATIENTS WILL BE REPORTED TO THE RISK MANAGEMENT NURSE.
- 4) NO EMPLOYEE SHALL BE TERMINATED FOR AN UNINTENTIONAL NONMALICIOUS OCCURRENCE IF IT IS REPORTED PROVIDED THAT SAID EMPLOYEE IS NOT VIOLATING ANY POLICIES THAT ARE CURRENTLY IN EFFECT. HOWEVER, FAILURE TO REPORT AN INCIDENT WILL BE GROUNDS FOR DISCIPLINARY ACTION.
- 5) IN THE CASE OF PERSONAL INJURY TO A VISITOR ON THE CENTER'S PREMISES, THE DEPARTMENT MANAGER SHALL BE IMMEDIATELY NOTIFIED, AND A VARIANCE REPORT FILLED OUT.
- 6) IN THE CASE OF THEFT, DISTURBANCE, OR UNAUTHORIZED SOLICITATION, THE DEPARTMENT MANAGER MUST BE NOTIFIED, AND THE MANAGER WILL INVESTIGATE AND COMPLETE A VARIANCE REPORT.
- 7) WHEN CENTER OWNED ITEMS OR MATERIALS ARE INVOLVED IN AN OCCURRENCE, THE VARIANCE REPORT IS TO BE COMPLETED BY THE STAFF MEMBER WORKING IN THE AREA WHERE THE EVENT OCCURRED.

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SECTION: N SAFETY

DATE: 11/97, 7/03, 9/04
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WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

TITLE: N-80 PATIENT OR VISITOR INCIDENT OR INJURY

8) EQUIPMENT MALFUNCTION OR EQUIPMENT USER ERROR DURING TREATMENT OR DIAGNOSIS OF A PATIENT THAT DID OR COULD HAVE ADVERSELY AFFECTED THE PATIENT OR PERSONNEL INVOLVED MUST BE REPORTED. VARIANCES THAT REQUIRE REPORTING IN THIS CATEGORY INVOLVE POTENTIAL HARM TO PATIENTS, ACTUAL HARM TO PATIENTS, OR FAILURE TO PROVIDE NEEDED SERVICES ON A TIMELY BASIS TO PATIENTS DUE TO EQUIPMENT MALFUNCTION OR EQUIPMENT USER ERROR.

9) A VARIANCE REPORT MUST BE COMPLETED FOR THE UNSCHEDULED TERMINATION OF ANY SERVICE VITAL TO THE CONTINUED SAFE OPERATION OF THE FACILITY, OR TO THE HEALTH AND SAFETY OF THE STAFF AND PATIENTS. THIS INCLUDES, BUT IS NOT LIMITED TO: TERMINATION OF THE TELEPHONE, ELECTRICITY, GAS, WATER, HEAT, AIR CONDITIONING SERVICES OR SUPPLIES.

10) ANY EMPLOYEE INVOLVED IN, OBSERVING, OR DISCOVERING AN UNUSUAL OCCURRENCE IS RESPONSIBLE FOR INITIATING A VARIANCE REPORT. THE DEPARTMENT MANAGER WILL ASSIST IN THE COMPLETION OF THE REPORT IF NECESSARY.

11) THE MANAGER OF THE DEPARTMENT INVOLVED IN THE OCCURRENCE HAS THE RESPONSIBILITY OF FORWARDING ALL VARIANCE REPORTS TO THE RISK MANAGER WITHIN 24 HOURS.

12) THE RISK MANAGER WILL REVIEW ALL VARIANCE REPORTS. ALL NON-PATIENT OCCURRENCES WILL BE REVIEWED BY THE ADMINISTRATOR. FOLLOW-UP RESPONSES, WHEN NECESSARY, WILL BE KEPT IN THE RISK MANAGEMENT FILES.

13) PATIENT RELATED VARIANCE REPORTS WILL BE MAINTAINED IN THE RISK MANAGEMENT FILES.

14) THE RISK MANAGER WILL FOLLOW UP WITH PATIENTS, VISITORS, EMPLOYEES, OR MEDICAL STAFF AS THE SITUATION MANDATES.

15) THE RISK MANAGER WILL FOLLOW UP ON ALL MISCELLANEOUS EMPLOYEES, OR VISITOR SAFETY VARIANCES. THIS MAY INVOLVE WORKING WITH EACH DEPARTMENT TO DETERMINE THE SPECIFIC CAUSE OF THE VARIANCE REPORTED.

16) IN ALL CASES OF MEDICATION LOSS, THE DIRECTOR OF PHARMACY SERVICES WILL BE NOTIFIED.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

SECTION: N SAFETY

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

REVIEWED: 3/12, 5/16, 1/21

TITLE: N-80 PATIENT OR VISITOR INCIDENT OR INJURY

SURGICAL CENTER OWNED ITEMS OR MATERIALS:

1. NOTIFICATION: WHEN COMPLETING A VARIANCE REPORT OF THIS NATURE THE FOLLOWING INFORMATION SHOULD BE PROVIDED.

A. DESCRIPTION OF ITEM(S) OR MATERIAL(S) INVOLVED

1. MANUFACTURER, OR MANUFACTURER'S SERIAL #
2. ANY OTHER RELATED IDENTIFICATION

B. THE PERSON COMPLETING THE VARIANCE REPORT SHOULD ALSO STATE THE FACTS THAT LET THEM TO BELIEVE IT WAS A POSSIBLE CENTER-OWNED ITEM(S) OR MATERIAL(S) INVOLVED IN THE OCCURRENCE.

C. THE ITEM(S) INVOLVED ARE TO BE IMMEDIATELY REMOVED FROM SERVICE, AND THE DEPARTMENT MANAGER IS TO TAG THE ITEM(S) AS SOON AS POSSIBLE. THE MANAGER OF THE DEPARTMENT INVOLVED IS TO CONTACT THE RISK MANAGEMENT COORDINATOR TO REPORT SUCH OCCURRENCES. THE RISK MANAGER WILL THEN CONTACT THE CENTER'S ADMINISTRATOR FOR FURTHER DIRECTION OR INVOLVEMENT OF THE CENTER'S ATTORNEY IF NECESSARY. FURTHER INVESTIGATION INTO THE MATTER MAY BE ADVISED OR REQUIRED.

D. IF A MEDICAL DEVICE HAS BEEN DETERMINED TO BE A CONTRIBUTING FACTOR IN THE HARMING OF A PATIENT, A REPORT WILL BE FILED IN COMPLIANCE WITH THE "SAFE MEDICAL DEVICE ACT". (REFER TO POLICY **N-160**)

2. TAGGING:

A. AS SOON AS THE ITEM(S) OR MATERIAL(S) INVOLVED ARE TAKEN OUT OF SERVICE, THE ITEM(S) ARE TO BE TAGGED. THE TAG SHOULD SPECIFY THE FOLLOWING:

1. NAME AND I.D. NUMBER OF PATIENT INVOLVED.
2. DATE OF OCCURRENCE.
3. A LISTING OF ALL PERSONS WHO HAVE HANDLED THE ITEM(S) AFTER THE OCCURRENCE AND THE DATES OF HANDLING.

3. OUTSIDE EXPERTS:

THE ADMINISTRATOR WILL, AT THE DISCRETION OF THE CENTER'S ATTORNEY, DECIDE IF THE ITEM(S) OR MATERIAL(S) SHOULD BE INSPECTED BY OUTSIDE EXPERTS. THE ADMINISTRATOR WILL ARRANGE FOR THE OUTSIDE EXPERT TO CHECK THE ITEM(S) OR MATERIAL(S) IN QUESTION.

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SECTION: N SAFETY

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

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WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

TITLE: N-80 PATIENT OR VISITOR INCIDENT OR INJURY

IF THE ITEM(S) NEED TO BE TRANSPORTED TO THE OUTSIDE EXPERT, THE ADMINISTRATOR WILL BE RESPONSIBLE FOR TRANSPORTATION. THE REPORT OF THIS INVESTIGATION WILL BE FORWARDED TO THE ADMINISTRATOR AND THE CENTER'S ATTORNEY.

4. PREVENTIVE MAINTENANCE RECORDS AND POLICIES AND PROCEDURES REGARDING THE USE OF ITEMS AND MATERIALS:

THE ADMINISTRATOR OR DEPARTMENT MANAGER SHOULD SECURE ALL PREVENTIVE MAINTENANCE AND SERVICE RECORDS AS WELL AS SERVICE CONTRACTS ON ALL ITEMS/MATERIALS. A COPY OF THIS INFORMATION WILL BE KEPT ON FILE AND ANY POLICIES AND PROCEDURES REGARDING THE USE OF THESE ITEMS/MATERIALS SHOULD ALSO BE KEPT ON FILE IN THE DEPARTMENT MANAGER'S OFFICE.

5. ITEMS OR MATERIALS NOT OWNED BY THE CENTER:

A. WHEN ANY ITEM(S) OR MATERIAL(S) THAT ARE NO OWNED BY THE CENTER ARE INVOLVED IN AN OCCURRENCE, APPROVAL NEEDS TO BE OBTAINED FROM THE OWNER OF THE ITEM(S)/ MATERIAL(S) BEFORE THEY CAN BE SENT OUT OR TESTED.

B. IF THERE IS A DISAGREEMENT BETWEEN OWNER OF THE ITEM(S)/MATERIAL(S) AS TO THE TESTING OR PROCEDURE TO BE FOLLOWED, THE ADMINISTRATOR WILL BE CONTACTED.

6. FOREIGN BODIES:

WHEN A FOREIGN BODY IS REMOVED FROM A PATIENT AND IT APPEARS THAT IT MAY HAVE BEEN INVOLVED IN AN INJURY TO THE PATIENT, THE SPECIMEN SHOULD BE SENT TO PATHOLOGY ACCORDING TO STANDARD PROCEDURES. A VARIANCE REPORT SHOULD BE WRITTEN ON WHICH IT IS SPECIFIED THAT THE SPECIMEN WAS SENT TO PATHOLOGY AND THE DATE IT WAS SENT. IF NECESSARY, THE NURSING DEPARTMENT MANAGER WILL THEN CONTACT PATHOLOGY SO THAT THE SPECIMEN CAN BE RETAINED.

FOREIGN BODIES WHICH ARE MATERIAL TO CRIMINAL INVESTIGATION WILL BE DIRECTLY TURNED OVER TO THE APPROPRIATE LAW ENFORCEMENT AGENT.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

SECTION: N SAFETY

DATE: 11/97, 7/03

REVIEWED: 3/12, 5/16, 1/21

TITLE: N-90 ON-THE-JOB INJURIES OF EMPLOYEES

POLICY: WILDCREEK SURGERY CENTER WILL ASSURE APPROPRIATE TREATMENT AND COMPENSATION, THROUGH THE SIIS PROGRAM, FOR EMPLOYEES WHO INCURE JOB-RELATED INJURY OR ILLNESS, AND WILL ESTABLISH THE TIME WHEN THE EMPLOYEE MAY SAFELY RESUME THEIR JOB.

PROCEDURE:

1. ACCIDENT REPORT: EMPLOYEE'S RESPONSIBILITIES:

- A. REPORT EVERY ACCIDENT INCURED TO THE SUPERVISOR IN CHARGE, REGARDLESS OF HOW MINOR IN NATURE.
- B. COMPLETE A VARIANCE REPORT AND A STATE INDUSTRIAL INSURANCE REPORT.
- C. IF TREATMENT IS NEEDED OR DESIRED, EMPLOYEE SHOULD INFORM THEIR SUPERVISOR, AND WILL SEE THE MEDICAL DIRECTOR OR HOUSE PHYSICIAN.
- D. REPORT BACK TO THE SUPERVISOR FOLLOWING TREATMENT AND INFORM THE DEPARTMENT MANAGER OF ANY DAYS' WORK LOST OR TO BE LOST.

2. DEPARTMENT MANAGER'S RESPONSIBILITIES:

- A. UPON RECEIVING REPORT OF AN ACCIDENT BY AN EMPLOYEE, GIVE THE EMPLOYEE A VARIANCE REPORT AND INSTRUCT THE EMPLOYEE TO COMPLETE THE REPORT, UNLESS IMMEDIATE TREATMENT IS INDICATED.
- B. THE EMPLOYEE SHOULD BE SENT TO THE MEDICAL DIRECTOR OR HOUSE PHYSICIAN FOR TREATMENT. IF IMMEDIATE TREATMENT IS NECESSARY, THE EMPLOYEE SHOULD COMPLETE THE VARIANCE REPORT UPON THEIR RETURN FROM TREATMENT. IF THE EMPLOYEE IS ADVISED NOT TO RETURN TO WORK, THE MANAGER SHOULD COMPLETE THE VARIANCE REPORT TO THE GREATEST EXTENT POSSIBLE. THE FORM MUST BE SIGNED BY THE EMPLOYEE, AS WELL AS THE SIIS FORM.

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POLICIES AND PROCEDURES

SECTION: N SAFETY

DATE: 11/97, 7/03

REVIEWED: 3/12, 5/16, 1/21

TITLE: N-90 ON-THE-JOB INJURIES OF EMPLOYEES

FOLLOWING EXAMINATION BY THE MEDICAL DIRECTOR OR HOUSE PHYSICIAN, IF A LIMITED WORK STATUS IS INDICATED, DETERMINE IF SUCH WORK IS AVAILABLE FOR THE EMPLOYEE. IF LIMITED WORK IS NOT AVAILABLE, CHECK WITH OTHER DEPARTMENT MANAGERS FOR SUCH WORK AND OBTAIN THEIR APPROVAL BEFORE OFFERING THE LIMITED WORK TO THE EMPLOYEE.

D. REVIEW THE FORMS AND REPORTS FROM CARE GIVEN TO ENSURE APPROPRIATE MEDICAL FOLLOW-UP CARE IS PROVIDED TO THE EMPLOYEE.

E. COORDINATE WITH OTHER DEPARTMENT MANAGERS THE RETURN-TO-WORK STATUS OF INJURED OR ILL EMPLOYEES.

F. REVIEW ALL PAYMENTS, FEES, AND CHARGES FROM LICENSED PRACTITIONERS AND OTHER MEDICAL PROVIDERS, AND ASSURE THAT THERE ARE MEDICAL REPORTS. SIGN AND SUBMIT RECEIPTS TO THE ACCOUNTS PAYABLE DEPARTMENT, AS WELL AS ANY CLAIMS PAID BY THE SIIS.

3. MEDICAL DIRECTOR'S RESPONSIBILITIES:

A. EXAMINE AND TREAT OR REFER FOR TREATMENT ALL ON-THE-JOB INJURIES INCURRED BY EMPLOYEES. IF THE MEDICAL DIRECTOR IS NOT AVAILABLE, THEN THE DESIGNATED HOUSE PHYSICIAN WILL ASSUME THESE RESPONSIBILITIES.

B. CONSULT WITH THE DEPARTMENT MANAGER TO DETERMINE "FULL WORK" OR "LIMITED WORK" STATUS.

C. IF THE EMPLOYEE'S CONDITION REQUIRES ADDITIONAL TREATMENT, THE MEDICAL DIRECTOR WILL PROVIDE THE EMPLOYEE WITH A LIST OF PHYSICIAN SPECIALISTS BEST QUALIFIED TO TREAT THE CONDITION. THE EMPLOYEE CAN SELECT ONE OF THESE PHYSICIANS OR ANY OTHER PHYSICIAN OF THEIR CHOICE FOR THE ADDITIONAL TREATMENT.

D. CONTACT OR ARRANGE FOR AN APPOINTMENT WITH THE SELECTED PHYSICIAN AND FORWARD ALL PERTINENT REPORTS TO THAT PHYSICIAN VIA THE EMPLOYEE OR OTHER MEANS, IF INDICATED.

4. RISK MANAGEMENT COORDINATOR'S RESPONSIBILITIES:

A. IMMEDIATELY EVALUATE THE VARIANCE REPORT TO DETERMINE IF AND TO WHAT EXTENT A SAFETY INVESTIGATION IS NEEDED.

B. COMPLETE THE APPROPRIATE ITEM FOR CORRECTIVE ACTION INDICATED. CONSULT WITH THE APPROPRIATE DEPARTMENT MANAGER TO DETERMINE ESTIMATED DATE CORRECTIVE ACTION WILL BE COMPLETED, IF IMMEDIATE CORRECTIVE ACTION IS NOT POSSIBLE.

C. OBTAIN THE NUMBER OF PREVIOUS ACCIDENTS INCURRED BY THIS EMPLOYEE. IF THE NUMBER OF PREVIOUS ACCIDENTS SEEMS TO BE EXCESSIVE, CONSIDER MEDICAL EVALUATION SUCH AS AN EYE EXAMINATION, HEARING TEST, OR A COMPLETE PHYSICAL EXAM, OR EDUCATIONAL COUNSELING TO ELIMINATE FUTURE ACCIDENTS.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

SECTION: N SAFETY

DATE: 11/97, 7/03

REVIEWED: 3/12, 5/16, 1/21

TITLE: N-90 ON-THE-JOB INJURIES OF EMPLOYEES

D. IF THIS TYPE OF ACCIDENT SEEMS TO BE PREVALENT THROUGHOUT THE CENTER, REFER THIS TO THE QA COMMITTEE FOR REVIEW AND RECOMMEND ACTION.

E. IF IMMEDIATE CORRECTIVE ACTION IS NOT POSSIBLE, FOLLOW-UP CORRECTIVE ACTION AT A LATER SPECIFIED DATE.

F. RECORD ALL INJURIES/ILLNESSES ACCORDING TO GUIDELINES OF OSHA, REPORTABLE ON A MASTER LOG.

5. CHANGE OF PHYSICIAN:

A. IF THE EMPLOYEE IS NOT SATISFIED WITH THE FIRST PHYSICIAN CHOSEN, THEY MAY MAKE AN ALTERNATIVE CHOICE OF PHYSICIANS IF THE CHOICE IS MADE WITHIN 90 DAYS AFTER THE INJURY. ANY FURTHER CHANGE IS SUBJECT TO THE APPROVAL OF THE INSURER.

6. COMPLICATIONS AND TRANSPORTATION:

A. AN EMPLOYEE WHO HAS REPORTED TO THE MEDICAL DIRECTOR OR HOUSE PHYSICIAN FOR TREATMENT OF AN INJURY OR ILLNESS WHICH IS JOB RELATED AND FINDS THEIR CONDITION TO WORSEN OR BECOME COMPLICATED OUTSIDE OF WORKING HOURS, IS AUTHORIZED TO REPORT TO AN EMERGENCY ROOM OR URGENT CARE CENTER FOR FURTHER CONSULTATION AND/OR TREATMENT.

B. IF AMBULANCE TRANSPORTATION IS NECESSARY, THE EMPLOYEE IS TO NOTIFY THEIR DEPARTMENT MANAGER IF POSSIBLE AND OBTAIN APPROVAL FOR SUCH TRANSPORTATION.

7. RETURN TO WORK:

A. BEFORE RETURNING TO WORK, AN EMPLOYEE WHO HAS BEEN ABSENT FROM THEIR DUTIES DUE TO AN OCCUPATIONAL DISABILITY OR INJURY FOR FIVE (5) OR MORE WORKING DAYS, MUST HAVE A MEDICAL RELEASE FROM THE MEDICAL DIRECTOR, HOUSE PHYSICIAN, OR PERSONAL PHYSICIAN.

B. EMPLOYEES RETURNING TO WORK FOLLOWING AN OCCUPATIONAL INJURY/ ILLNESS MUST REPORT TO THEIR DEPARTMENT MANAGER PRIOR TO PERFORMING ANY DUTIES WITH WILDCREEK SURGERY CENTER UNDER ANY CIRCUMSTANCES.

C. COPIES OF PHYSICIAN OR ANY OTHER RELATED MEDICAL RELEASES PROVIDED BY AN EMPLOYEE MUST BE PLACED IN THE WORKMAN'S COMPENSATION FILE.

D. EMPLOYEES GRANTED UNPAID LEAVE TIME ARE RESPONSIBLE FOR ARRANGING TO CONTINUE THEIR GROUP LIFE BENEFITS AND THEIR HEALTH OR DEPENDENT COVERAGE IF THE UNPAID LEAVE OF ABSENCE PERIOD EXCEEDS THIRTY (30) DAYS.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

SECTION: N SAFETY

DATE: 10/10, 8/13

REVIEWED: 7/14, 5/16, 6/19, 1/21

TITLE: N-100 EMERGENCY MANAGEMENT PLAN-DISASTER PREPAREDNESS

POLICY:

THE SURGERY CENTER ACCEPTS THE RESPONSIBILITY TO ESTABLISH A PLAN TO ENSURE THE PROMPT AND EFFECTIVE ACTIONS NECESSARY TO PROTECT PATIENTS, VISITORS, AND STAFF IN THE EVENT OF AN INTERNAL AND/OR EXTERNAL DISASTER. THIS PROTECTION WILL BE PROVIDED BY EMPLOYEES, THE ADT MOTION DETECTOR ALARM, AND LOCAL OFFICIALS. ALL EMPLOYEES WILL ABIDE BY THE FOLLOWING PROCEDURES TO ENSURE THE SAFETY OF ALL PERSONS AT THE CENTER.

PROCEDURES:

THE FACILITY WILL NOT BE A DIRECT PARTICIPANT IN THE COMMUNITY DISASTER PLAN. THE FACILITY WILL NOT BE OPEN 24 HOURS PER DAY AND 7 DAYS PER WEEK. THE FACILITY WILL PROVIDE ASSISTANCE, AS REQUESTED, IN THE FORM OF HEALTHCARE SUPPLIES, EQUIPMENT, AND/OR PERSONNEL TO OTHER HEALTHCARE FACILITIES IN THE COMMUNITY IN THE EVENT OF AN EXTERNAL DISASTER.

AN **INTERNAL DISASTER** IS A SITUATION THAT OCCURS WITHIN THE SURGERY CENTER INTERFERING WITH THE NORMAL OPERATIONS, PRODUCING ACTUAL OR POTENTIAL CASUALTIES AND REQUIRING EMERGENCY ACTION FROM WITHIN OR FROM OUTSIDE TO MINIMIZE DAMAGE.

AN **EXTERNAL DISASTER** IS DEFINED AS ANY INCIDENT OCCURRING IN THE GEOGRAPHICAL AREA SURROUNDING THE SURGERY CENTER, PRODUCING ACTUAL OR POTENTIAL MULTIPLE CASUALTIES, AND/OR CAUSING DAMAGE OR DANGER TO THE CENTER ITSELF.

NOTIFICATION:

THE FACILITY PROVIDES ELECTIVE OUTPATIENT SURGERY ON A PART TIME BASIS. THE FACILITY WILL BE CLOSED IN THE EVENT OF AN IMPENDING DISASTER THAT HAS THE POTENTIAL TO HARM THE CENTER AND ITS OCCUPANTS. SHOULD THE CENTER BE IN OPERATION DURING A DISASTER CURRENT SURGERIES WOULD CONCLUDE, PATIENTS STABILIZED AND EVACUATE PER POLICY. THE FACILITY WILL REMAIN CLOSED UNTIL SUCH A TIME THAT NORMAL OPERATIONS CAN BE SAFELY RESUMED.

THE FACILITY WILL CONTINUALLY MONITOR RADIO AND TELEVISION BROADCASTS IN ADDITION TO NOTIFICATIONS FROM THE COUNTY AND/OR CITY DEPARTMENT OF EMERGENCY MANAGEMENT.

THE ADMINISTRATOR AND/OR DESIGNEE WILL CONTACT ALL KEY PERSONNEL BY PHONE.

WHEN IT IS DETERMINED THAT THE FACILITY WILL REMAIN OPERATIONAL, ALL KEY STAFF WILL BE NOTIFIED BY PHONE AND INSTRUCTED TO ASSEMBLE, VIA THE SAFEST DIRECT ROUTE.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

EMERGENCY POWER:

THE EMERGENCY POWER SUPPLY FOR THE FACILITY IS PROVIDED BY AN EMERGENCY GENERATOR THAT WILL PROVIDE CONSISTENT ELECTRICAL POWER AND LIGHT TO ALL NECESSARY EQUIPMENT IN THE EVENT OF ELECTRICAL FAILURE.

EMERGENCY CONTACT INFORMATION:

THE FIRST LINE OF AUTHORITY WILL BE THE ADMINISTRATOR. IF THE ADMINISTRATOR IS UNABLE TO PERFORM THIS DUTY, THE DESIGNEE IS THE NURSE MANAGER. TO ENSURE CONTINUOUS LEADERSHIP AND AUTHORITY DURING AN EMERGENCY, THE FOLLOWING IS THE CHAIN OF COMMAND: ADMINISTRATOR, NURSE MANAGER, STAFF REGISTERED NURSES, SURGICAL TECHNICIANS AND BUSINESS STAFF.

ADMINISTRATOR AND/OR NURSE MANAGER:

IN THE EVENT OF A DISASTER THE ADMINISTRATOR OR DESIGNEE WILL CONTACT THE LOCAL AUTHORITIES AND AWAIT FURTHER INSTRUCTION.

NURSE MANAGER:

THE NURSE MANAGER IS RESPONSIBLE TO CONDUCT A YEARLY DISASTER PREPAREDNESS DRILL IN ACCORDANCE WITH THE **STATE OF NEVADA** AND **CMS** REQUIREMENTS. IN ACCORDANCE WITH **AAAH**C THE CENTER WILL CONDUCT AT LEAST ONE (1) DRILL EACH CALENDAR QUARTER AND ONE OF THOSE DRILLS MUST BE A CPR TECHNIQUE DRILL A WRITTEN EVALUATION WILL BE COMPLETED FOR EACH DRILL AND FORWARDED TO THE APPROPRIATE COMMITTEES AT WHICH TIME THE ORGANIZATION WILL PROMPTLY IMPLEMENT ANY MODIFICATIONS TO THE PLAN.

EMPLOYEES RESPONSIBILITIES:

TEAMWORK IS ESSENTIAL WHEN A DISASTER OCCURS; THEREFORE, EACH EMPLOYEE NEEDS TO BE FAMILIAR WITH THE TASKS AND RESPONSIBILITIES THAT WILL BE IMPLEMENTED IN THE EVENT OF A DISASTER. DURING THEIR INITIAL ORIENTATION TO THE FACILITY, EACH NEW EMPLOYEE WILL BE INTRODUCED TO THE PLAN, AND SUBSEQUENTLY REQUIRED TO UNDERSTAND THEIR DUTIES IN THE EVENT OF A DISASTER.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

PATIENT TRANSPORT/ TRANSFER LOG

Date: _____ **Transfer Facility:** _____

[illegible]

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

SECTION: N SAFETY
8/19
1/21

DATE: 11/97, 7/03, 4/06,
REVIEWED: 7/14, 5/16,

TITLE: N-110 BOMB THREATS, WORKPLACE VIOLENCE

POLICY: WILDCREEK SURGERY CENTER WILL PROTECT PATIENTS, VISITORS, AND STAFF MEMBERS FROM POSSIBLE HARM INFLICTED BY HOSTILE INDIVIDUALS, ROBBERY ATTEMPTS, OR BOMB THREATS. THIS PROTECTION WILL BE PROVIDED BY EMPLOYEES AND THE ADT MOTION DETECTOR ALARM. ALL EMPLOYEES WILL ABIDE BY THE FOLLOWING PROCEDURES TO ENSURE THE SAFETY OF ALL PERSONS AT THE CENTER.

PROCEDURE:

BOMB THREAT:

A BOMB THREAT AGAINST THE CENTER MAY BE RECEIVED BY TELEPHONE, MAIL, OR MESSAGE AT ANY TIME AND IN ANY LOCATION. ALL THREATS SHOULD BE CONSIDERED AS A REAL AND SERIOUS DANGER TO THE LIVES OF PATIENTS, STAFF, AND VISITORS, AND DESTRUCTION OF THE CENTER'S FACILITIES.

NOTIFICATION OF A BOMB THREAT:

- 1) **BY TELEPHONE:** THE PERSON RECEIVING THE CALL SHOULD ATTEMPT TO OBTAIN AS MUCH INFORMATION AS POSSIBLE:
 - EXACT LOCATION OF THE BOMB.
 - TIME SET FOR DETONATION.
 - DESCRIPTION OF EXPLOSIVE CONTAINERS.
 - TYPE OF EXPLOSIVE.
 - REASON FOR CALL OR THREAT.

DURING THE COURSE OF THE CONVERSATION, THE PERSON RECEIVING THE CALL SHOULD WRITE DOWN ALL AVAILABLE INFORMATION. IN ADDITION, THE RECEIVER SHOULD NOTE AS MUCH OF THE FOLLOWING INFORMATION AS POSSIBLE:

- DATE AND TIME CALLED.
- EXACT LANGUAGE USED.
- SEX OF CALLER.
- ESTIMATED AGE OF CALLER.
- PECULIAR OR IDENTIFIABLE ACCENT OF CALLER.
- APPARENT KNOWLEDGE OF THE CENTER BY DESCRIPTION OF LOCATIONS WITHIN THE CENTER.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

TITLE: N-110 BOMB THREATS, WORKPLACE VIOLENCE

- 2) BY MAIL OR MESSAGE: ONCE THE PERSON RECEIVING THE BOMB THREAT RECOGNIZES IT AS SUCH, THIS PERSON WILL NOTIFY THEIR DEPARTMENT MANAGER AND ADMINISTRATOR IMMEDIATELY. DO NOT LEAVE THE LOCATION OF THE RECEIVED THREAT; THE DEPARTMENT MANAGER AND ADMINISTRATOR WILL COME TO THE SITE. NO OTHER PERSONS WILL HANDLE THE PIECE OF MAIL OR MESSAGE, INCLUDING ANY ENVELOPE OR CONTAINER IT MAY HAVE COME IN.

SEARCH PROCEDURE:

- 1) THE ADMINISTRATOR WILL NOTIFY THE LOCAL POLICE OF THE THREAT RECEIVED BY DIALING 911.
- 2) THE ADMINISTRATOR WILL MAKE THE DECISION OF WHETHER TO:
 - SEARCH THE BUILDING
 - EVACUATE THE PREMISES
- 3) IF A SEARCH IS DECIDED ON, THE DEPARTMENT MANAGER WILL INITIATE THE SEARCH AND ASSIGN MEMBERS TO ASSIST.
- 4) ALL EMPLOYEES SHOULD ACT CALMLY AND QUIETLY DURING THE SEARCH. DO NOT ANNOUNCE OR OTHERWISE ALARM PATIENTS AND VISITORS.
- 5) ALL EMPLOYEES SHOULD MAINTAIN A FAMILIARITY WITH ALL EQUIPMENT, MATERIALS, AND SUPPLIES NORMALLY UTILIZED AT THE CENTER. THIS ALLOWS FOR EASY DETERMINATION OF ITEMS THAT DO NOT BELONG IN THE CENTER WHICH MAY POSSIBLY BE AN EXPLOSIVE DEVICE.
- 6) DURING THE SEARCH, EMPLOYEES SHOULD DIRECT CLOSE ATTENTION TO: STRANGE OR UNFAMILIAR PACKAGES OR SMALL ARTICLES; DOORS TO CABINETS OR CLOSETS WHICH ARE NOT IN THEIR NORMAL POSITION, SUCH AS PARTIALLY OPENED WHEN THEY ARE NORMALLY CLOSED; OR A PIECE OF FURNITURE OR EQUIPMENT NOT IN ITS NORMAL LOCATION.
- 7) UPON DISCOVERY OF ANY OF THE ABOVE SITUATIONS, WILDCREEK SURGERY CENTER PERSONNEL MUST NOT ATTEMPT TO MOVE OR DISTURB ANY ITEM OR ABNORMAL CONDITION FOUND. THEY SHOULD IMMEDIATELY NOTIFY THE ADMINISTRATOR OF THE SITUATION SO THAT QUALIFIED INDIVIDUALS CAN INVESTIGATE THE MATTER.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

TITLE: N-110 BOMB THREATS, WORKPLACE VIOLENCE

8) IF AN EVACUATION OF THE BUILDING IS DECIDED ON, ALL CENTER EMPLOYEES SHOULD FOLLOW THE SAME PLAN AS FOR A FIRE EVACUATION.

RESPONSIBILITIES OF DEPARTMENT MANAGERS:

- 1) POLICIES OF THEIR RESPECTIVE AREAS AT ALL TIMES. THE IMPORTANCE OF GOOD HOUSEKEEPING AND ORDERLY ARRANGEMENT OF MATERIALS AND SUPPLIES CANNOT BE OVEREMPHASIZED. THIS WILL FACILITATE A THOROUGH AND SPEEDY SEARCH OF THE ENTIRE CENTER.
- 2) ENSURING THAT ALL PERSONNEL WITHIN THEIR RESPECTIVE AREAS ARE FAMILIAR WITH THIS PLAN AND THE IMPORTANCE OF REMAINING CALM WHEN A THREAT IS RECEIVED. THIS IS PARTICULARLY IMPORTANT IN THE PATIENT CARE AREAS.
- 3) UPON NOTIFICATION OF A THREAT, INSTRUCT EACH EMPLOYEE TO SEARCH THEIR IMMEDIATE AREA FOR STRANGE OR UNFAMILIAR OBJECTS OR CONTAINERS.
- 4) EMPLOYEES SHOULD BE INSTRUCTED NOT TO HANDLE OR MOVE ANY SUSPICIOUS OBJECTS OR SITUATIONS.
- 5) PROPER SECURITY OF THEIR AREAS, PARTICULARLY EXTERIOR ACCESSES TO THEIR WORK AREAS.
- 6) CONDUCT PERIODIC DEPARTMENTAL INSERVICE TRAINING PROGRAMS ON BOMB THREAT AND SEARCH PROCEDURES.

HOSTILE PATIENTS, VISITORS, EMPLOYEES, OR INTRUDER

ANY THREAT, VERBAL OR PHYSICAL, SHALL BE CONSIDERED REAL. ALL FACILITY STAFF MEMBERS SHOULD REMAIN CALM AND WILL COOPERATE WITH THE HOSTILE PERSON AND OFFER NO CHALLENGES. IF A PATIENT, VISITOR, OR EMPLOYEE BECOMES AGITATED OR HOSTILE, THE STAFF WILL DO THEIR BEST TO CALM THE PATIENT VERBALLY. THIS CAN USUALLY BE ACCOMPLISHED WITH A QUIET MANNER, REASSURANCE, AND/OR NEGOTIATION. IF THE INITIAL STAFF ATTEMPT IS UNSUCCESSFUL, THE FOLLOWING STEPS SHOULD BE TAKEN:

- 1) DO NOT PUT YOURSELF IN A COMPROMISING POSITION, EITHER VERBALLY OR PHYSICALLY.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

TITLE: N-110 BOMB THREATS, WORKPLACE VIOLENCE

- 2) ENLIST THE HELP OF YOUR CO-WORKERS. OFTEN, A CHANGE OF PERSONALITY WILL DEFUSE THE SITUATION.
- 3) IF UNSUCCESSFUL, NOTIFY YOUR DEPARTMENT MANAGER IMMEDIATELY. CONTACT THE ADMINISTRATOR IF NECESSARY
- 4) DO NOT ARGUE WITH THE PERSON. REMAIN CALM AND TRY NOT TO AGITATE THE PERSON FURTHER.
- 5) NEVER ATTEMPT TO DEAL WITH A PHYSICALLY AGGRESSIVE PATIENT OR INTRUDER.
- 6) DON'T IGNORE THREATS.
- 7) CALL 911 IF THE THREAT ESCALATES, FOR UNTHREATENING AGITATED PERSONNEL CALL THE SPARKS POLICE DEPARTMENT NON-EMERGENCY DISPATCH AT **775-353-2231**.
- 8) IF THE PERSON IS ARMED, COMPLY WITH THEIR DEMANDS AS MUCH AS POSSIBLE. DO NOT PUT YOURSELF IN A DANGEROUS POSITION BY RESISTING. MATERIAL ITEMS CAN BE REPLACED.
- 9) WHEN THE POLICE OFFICERS ARRIVE, DIRECT THEM TO THE LOCATION OF THE SITUATION. DO NOT ATTEMPT TO ASSIST THEM IN THEIR DUTIES, BUT AVAILABLE TO GIVE THEM INFORMATION.
- 10) ASSIST YOUR DEPARTMENT MANAGER/THE ADMINISTRATOR TO COMPLETE ANY POLICE REPORTS, VARIANCE REPORTS, OR INSURANCE CLAIMS IF NECESSARY.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

SECTION: N SAFETY

DATE: 11/97, 7/03, 11/10, 5/16
REVIEWED: 3/12, 1/21

TITLE: N-120 SMOKING POLICY

POLICY: TO MINIMIZE FIRE DANGER AND TO PROMOTE A HEALTHY LIFESTYLE AND ENVIRONMENT WILDCREEK SUREGERY CENTER HAS CREATED A SMOKE FREE CAMPUS. THIS POLICY APPLIES TO ALL EMPLOYEES, VISITORS, PHYSICIANS, AND PATIENTS. SMOKERS WILL BE ASKED TO REFRAIN FROM SMOKING UNTIL THEY HAVE LEFT THE PREMISES.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

SECTION: N SAFETY

DATE: 11/97

REVIEWED: 7/14, 5/16, 1/21

TITLE: N-130 FIRE SAFETY RULES AND REGULATIONS

POLICY: WILDCREEK SURGERY CENTER WILL ENSURE THE SAFETY OF THE PATIENTS, STAFF, AND VISITORS THROUGH THE ENFORCEMENT OF FIRE SAFETY RULES AND REGULATIONS. THE LOCAL, STATE, AND FEDERAL LAWS AND ORDINANCES WILL BE INCLUDED IN THESE RULES.

A) **FIRE REGULATIONS:**

- 1) SMOKING IS PROHIBITED AT WILDCREEK SURGERY CENTER.
- 2) NO OPEN FLAMES ARE PERMITTED IN OR AROUND COMBUSTIBLE GASES OR ROOMS CONTAINING SUCH.
- 3) WHEN THE FIRE ALARM SOUNDS, ALL EMPLOYEES ARE TO RETURN TO THEIR ASSIGNED AREAS IMMEDIATELY.

B) **FIRE ALARM PROCEDURE:**

- 1) THE PERSON DISCOVERING THE FIRE IS RESPONSIBLE FOR ACTIVATING THE FIRE ALARM SIGNAL BY PULLING DOWN ON THE FIRE ALARM HANDLE. THESE ALARMS ARE CLEARLY MARKED AND LOCATED THROUGHOUT THE CENTER. THE ALARM HANDLE IS LOCATED IN THE FRONT ENTRY VESTIBULE.
- 2) THE PERSON DISCOVERING THE FIRE WILL THEN REMOVE ALL PERSONS FROM THE IMMEDIATE DANGER AREA OF THE FIRE AND WILL CLOSE THE FIRE DOORS TO THE AREA.
- 3) THE PERSON DISCOVERING THE FIRE WILL THEN NOTIFY THE FRONT DESK RECEPTIONIST OF THE CENTER OF THE LOCATION, TYPE, AND SIZE OF THE FIRE. THIS IS ACCOMPLISHED BY DIALING "0" ON THE NEAREST PHONE.
- 4) WHEN THE FIRE ALARM SOUNDS, EMPLOYEES IN THEIR DESIGNATED AREAS WILL PROCEED WITH THE FOLLOWING:
 - A) REMOVE ALL PATIENTS, VISITORS, AND OTHER STAFF MEMBERS FROM IMMEDIATE DANGER.
 - B) CONTAIN THE FIRE BY CLOSING ALL FIRE DOORS IN THE AREA.
 - C) IF POSSIBLE, USE THE FIRE EXTINGUISHER TO FIGHT THE FIRE **ONLY** IF IT IS A SMALL FIRE THAT DOES NOT INVOLVE TOXIC CHEMICALS MATERIALS. IF THERE IS ANY DOUBT AS TO YOUR ABILITY TO EXTINGUISH THE FIRE, EVACUATE THE AREA.
- 5) THE FIRE ALARM SYSTEM IS CONNECTED TO THE ADT ALERT. THE CENTER'S RECEPTIONIST WILL ASSURE DOUBLING COVERAGE BY DIALING 911 AND REPORTING THE FIRE.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

C) DESIGNATED AREA PROCEDURE:

1) BUSINESS OFFICE PERSONNEL:

- A) CALL 911 AND REPORT THE FIRE SIZE, TYPE, AND LOCATION.
- B) DIRECT FIREMEN UPON ARRIVAL.
- C) RESPONSIBLE FOR EVACUATION OF PATIENTS AND VISITORS FROM THE FRONT WAITING AREA WHEN INDICATED.

2) PRE-OP/ADMITTING PERSONNEL:

- A) HAVE THE PARENTS OF PEDIATRIC VISITORS WALK WITH OR CARRY THEIR CHILDREN OUT THE NEAREST **SAFE** EXIT WHEN INDICATED.
- B) USE WHEELCHAIRS OR STRETCHERS FOR UNSTEADY OR IMPAIRED PATIENTS.
- C) REMAIN WITH THE PATIENTS AT A SAFE DISTANCE FROM THE BUILDING, AWAY FROM THE ENTRANCES WHEN EVACUATION IS INDICATED.

3) OPERATING ROOM PERSONNEL:

- A) TURN OFF THE GAS VALVES OF ALL GAS TANKS NOT IN USE.
- B) IF SURGERY IS IN PROGRESS, ASSIST THE PHYSICIANS TO SECURE THE SURGERY SITE. OBTAIN, EQUIPMENT AND SUPPLIES FOR TRANSPORT IF THERE IS AN IMMEDIATE DANGER OF FIRE OR SMOKE ENTERING THE OPERATING ROOM.
- C) IF THE FIRE IS IN ANOTHER PART OF THE BUILDING AND SAFELY SEPARATED FROM THE OPERATING AREA BY FIRE DOORS, CLOSE THE DOORS AND REMAIN WITH THE PHYSICIANS AND PATIENT.
- D) IF MOVING OF THE PATIENT IS REQUIRED, ASSIST THE PHYSICIANS TO DO SO THROUGH THE NEAREST **SAFE** EXIT, OR TO ANOTHER SAFE PART OF THE BUILDING.
- E) ENLIST ADDITIONAL HELP AS NEEDED FOR MOVING OF THE PATIENT AND ANESTHESIA MACHINE/EQUIPMENT.
- F) IF YOUR ROOM WAS NOT IN USE AT THE TIME OF THE ALARM, REPORT TO THE NURSING MANAGER FOR DIRECTIONS ON WHERE ASSISTANCE IS NEEDED.
- G) ASSIST AS NEEDED TO EVACUATE PATIENTS, VISITORS, AND OTHER STAFF MEMBERS.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

H) EVACUATION OF ALL PATIENTS AND VISITORS SHOULD BE VIA THE FRONT ENTRANCE AND/OR THE WEST EMERGENCY EXIT IN THE SURGERY CENTER.

4) RECOVERY ROOM PERSONNEL:

A) CLOSE ALL FIRE DOORS.

B) USE PORTABLE OXYGEN TANKS ON PATIENTS THAT STILL REQUIRE OXYGEN ADMINISTRATION.

C) TURN OFF ALL GAS VALVES LOCATED NEAR RECOVERY ROOM.

D) IF THE FIRE IS LOCATED IN ANOTHER PART OF THE BUILDING AND IS SAFELY SEPARATED BY CLOSED FIRE DOORS, **AND** IF THERE IS NO SMOKE ENTERING THE PACU AREA, REMAIN WITH THE PATIENTS WHILE PREPARING AS MUCH AS POSSIBLE FOR EVACUATION.

E) IF THERE IS SMOKE ENTERING THE PACU AREA, OR IF THE DANGER OF THE FIRE IS IMMEDIATE, EVACUATE PATIENTS THROUGH THE NEAREST **SAFE** EXIT. MOVE AWAY FROM THE BUILDING AND REMAIN WITH THE PATIENTS AT ALL TIMES.

F) WHEN EVACUATING PATIENTS, USE STRETCHERS WHEN POSSIBLE. WHEELCHAIRS AND AMBULATION MAY ALSO BE USED AS EACH PATIENTS CONDITION PERMITS

G) PRE-OPERATIVE PATIENTS WHO HAVE NOT RECEIVED SEDATION MAY BE AMBULATED OUT OF THE BUILDING IF THEIR CONDITION PERMITS.

5) ADMINISTRATOR/NURSE MANAGER

A) RESPOND TO AREA OF FIRE IMMEDIATELY AND DETERMINE IF EVACUATION OF AREA IS NECESSARY.

B) ADVISE RECEPTIONIST OF PLAN OF ACTION SO THAT SHE/HE CAN NOTIFY APPROPRIATE PERSONNEL.

C) ASSIST WITH CARE OF PATIENTS/STAFF IN IMMEDIATE DANGER.

D) ASSURE THAT ALL PERSONS IN THE BUILDING HAVE SAFELY BEEN EVACUATED.

E) ASSIST FIRE DEPARTMENT REPRESENTATIVE WITH ANY PERTINENT INFORMATION.

F) ASSURE THAT STAFF IS RESPONSIVE TO PHYSICAL AND EMOTIONAL NEEDS OF PATIENTS AND VISITORS.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

G) CONDUCTS POST FIRE DE-BRIEFING OF STAFF, PERFORMS AN EVALUATION OF CAUSE OF FIRE AND RESPONSE OF STAFF AND EMERGENCY PERSONNEL.

H) NOTIFICATION OF MANAGEMENT PERSONNEL, SAFETY AND RISK MANAGEMENT COMMITTEES AND OUTSIDE AGENCIES AS APPROPRIATE.

D) IMPORTANT POINTS FOR ALL STAFF MEMBERS:

1) PREVENT FIRES:

GOOD HOUSEKEEPING AND OBSERVING RULES ARE THE BEST DETERRENT FOR FIRES. MAKE IT A HABIT TO WATCH FOR FIRE HAZARDS AND REPORT ANY POSSIBLE DANGERS TO YOUR DEPARTMENT MANAGER.

2) KNOW THE LOCATION OF ALARMS, EXITS, AND EXTINGUISHERS:

BE AWARE OF YOUR NEAREST ALARMS, EXITS, AND EXTINGUISHERS IN YOUR ASSIGNED WORKPLACE. REVIEW THE ESCAPE ROUTE WITH YOUR DEPARTMENT MANAGER IF YOU ARE UNSURE OF THE EXIT LOCATIONS. PARTICIPATE IN PRACTICES AND DRILLS AND KNOW HOW TO USE THE EQUIPMENT.

3) AVOID PANIC:

THE GREATEST DANGER IN MOST FIRES IS **PANIC**. IF YOU REMAIN CALM, SO WILL YOUR CO-WORKERS. A QUIET, ASSURING MANNER WILL KEEP PATIENTS AND VISITORS CALM. THE PUBLIC WILL LOOK TO YOU FOR GUIDANCE AND WILL **PANIC** IF YOU DO. **NEVER** SHOUT "**FIRE**", AS THIS IS A SURE INVITATION FOR CHAOS.

4) KNOW YOUR ASSIGNED DUTIES IN A FIRE ALARM:

DON'T SCOFF AT FIRE DRILLS OR REHEARSALS, PEOPLE'S LIVES ARE AT STAKE AND MAY DEPEND ON YOUR ACTIONS TO SAVE THEM. REVIEW THE FIRE PLAN FOR YOUR AREA AND LEARN HOW TO USE THE FIRE EXTINGUISHERS. ATTEND ALL IN-SERVICES AND ASK FOR YOUR DEPARTMENT MANAGER'S ASSISTANCE IF YOU ARE UNSURE OF ANY PART OF THE PLAN. **BE PREPARED!!**

5) BE ALERT FOR SIGNS OF FIRE:

IF YOU SEE OR SMELL SMOKE INVESTIGATE AND REPORT IT AT ONCE. EVERY SECOND COUNTS IN A FIRE, AND THE FASTER IT IS CONTAINED, THE LESS DAMAGE AND LOSS IT IS LIKELY TO CAUSE.

6) FIRE DRILLS WILL BE CONDUCTED QUARTERLY:

PER NEVADA STATE DEPARTMENT OF HEALTH AND HUMAN SERVICES FIRE DRILLS WILL BE CONDUCTED AND DOCUMENTED ON A QUARTERLY BASIS.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

SECTION: N SAFETY

DATE: 11/97, 7/03

REVIEWED: 3/12, 5/16, 1/21

TITLE: N-140 SAFETY RULES AND REGULATIONS (GENERAL)

POLICY:

IT IS THE POLICY OF WILDCREEK SURGERY CENTER TO PROVIDE A SAFE, HEALTHFUL, AND SANITARY WORKING ENVIRONMENT FOR PATIENTS, STAFF, AND VISITORS. STANDARDS SHALL BE SET AND MAINTAINED ACCORDING TO LOCAL, STATE AND FEDERAL RULES, LAWS, AND REGULATIONS. IT IS ONE OF THE OBJECTIVES OF THE CENTER TO COMPLY WITH ALL RULES, MANDATES, LAWS, AND REGULATIONS PERTAINING TO THE SAFETY AND HEALTH OF ITS EMPLOYEES.

PROCEDURE:

EACH DEPARTMENT MANAGER IS RESPONSIBLE FOR DEVELOPING SPECIFIC WRITTEN SAFETY RULES AND REGULATIONS. THESE RULES AND REGULATIONS MUST BE A PART OF THE INTRODUCTION AND ORIENTATION OF EACH NEW EMPLOYEE BROUGHT INTO THE DEPARTMENT. SAFETY SYSTEMS WILL BE DEVELOPED AND MAINTAINED THROUGH POLICIES AND PROCEDURES TO MINIMIZE HAZARDS TO PATIENTS, STAFF, AND VISITORS. GUIDELINES FOR ALL EMPLOYEES INCLUDE THE FOLLOWING:

- 1) KNOW THE SAFETY RULES AND REGULATIONS FOR BOTH DEPARTMENT AND THOSE APPLICABLE TO THE OPERATION OF THE CENTER.
- 2) KNOW THE LOCATION AND OPERATION OF THE CENTER'S TELEPHONES, FIRE EXTINGUISHERS, EXITS, AND YOUR INDIVIDUAL RESPONSIBILITIES IN CASE OF FIRE, BOMB THREAT OR DISASTER.
- 3) REPORT IMMEDIATELY TO YOUR SUPERVISOR HAZARDS OR VIOLATIONS OF SAFETY STANDARDS, SUCH AS IN THE FOLLOWING EXAMPLES:
 - A) DEFECTIVE EQUIPMENT.
 - B) CARELESS USE OF EQUIPMENT.
 - C) OBSTRUCTION TO EXIT DOORS, CORRIDORS, ENTRY WAYS OR ENTRY DOORS TO PATIENT ROOMS, OFFICES, OR DEPARTMENTS.
 - D) SMOKING ANYWHERE ON THE CAMPUS.
 - 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.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

SECTION: N SAFETY

DATE: 11/97, 7/03

REVIEWED: 3/12, 5/16/21

TITLE: N-140 SAFETY RULES AND REGULATIONS (GENERAL)

5) OBSERVE THE BASIC RULES FOR LIFTING PATIENTS. PROPER BODY MECHANICS SHOULD BE USED WHEN LIFTING OR MOVING PATIENTS. REQUEST ASSISTANCE, AS NECESSARY.

6) USE CARE WHEN APPROACHING SWINGING DOORS, CONGESTED AREAS, OR TURNING CORNERS. "NEVER RUN".

7) REPORT UNAUTHORIZED INDIVIDUALS NEAR OR IN THE FACILITY

8) DO NOT OPERATE EQUIPMENT UNLESS YOU HAVE BEEN PROPERLY INSTRUCTED.

9) UNPROFESSIONAL CONDUCT WILL NOT BE ALLOWED

10) FOLLOW SAFETY PRECAUTIONS IN DISPOSING OF ALL TYPES OF NEEDLES OR OTHER SHARP ITEMS IN THE APPROPRIATE SHARPS PUNCTURE RESISTANT CONTAINERS.

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.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

SECTION: N SAFETY

DATE: 11/97, 7/03

REVIEWED: 3/12, 5/16, 1/21

TITLE: N-140 SAFETY RULES AND REGULATIONS (GENERAL)

18) MALFUNCTIONING OR BROKEN EQUIPMENT SHOULD BE IMMEDIATELY REMOVED FROM USE, APPROPRIATELY LABELED, REPORTED TO THE SUPERVISOR AND SUBMITTED FOR REPAIR WITH A LOCK-OUT TAG.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

SECTION: N SAFETY

DATE: 11/97, 7/03

REVIEWED: 3/12, 5/16, 1/21

TITLE: N-150 SAFETY FOR OFFICE AREAS

WILDCREEK SURGERY CENTER WILL ENSURE THAT THE CENTER IS MAINTAINED IN A SAFE AND ORDERLY MANNER.

PROCEDURE:

THE INDIVIDUALS WORKING IN THE OFFICE AREAS OF THE CENTER WILL MAINTAIN AN ENVIRONMENT FREE OF SAFETY HAZARDS. THESE PERSONS WILL BE COGNIZANT OF SAFETY ISSUES THAT ARE PRESENTED ON A DAY-TO-DAY BASIS WITHIN THEIR WORKING AREAS. ALL OFFICE WORKERS WILL BE RESPONSIBLE FOR THE FOLLOWING:

- 1) DESK AND COMPUTER TOPS SHOULD BE FREE OF SHARP CORNERS.
- 2) MATERIALS SHOULD BE EVENLY DISTRIBUTED IN FILE CABINETS SO THAT THE UPPER DRAWERS DO NOT UNBALANCE THE FILE AND CAUSE THE FILE TO FALL OVER.
- 3) ONLY ONE FILE DRAWER SHOULD BE OPEN AT A TIME, AND EACH DRAWER WILL BE CLOSED AFTER USE.
- 4) PAPERS AND OTHER MATERIALS SHOULD BE KEPT OFF THE FLOORS AND OUT OF PATHWAYS.
- 5) ALL ELECTRICAL EQUIPMENT WILL BE PROPERLY GROUNDED.
- 6) HEAVY MATERIALS WILL BE STORED CLOSE TO THE GROUND, NEVER ON HIGH SHELVES OR ABOVE PATHWAYS.
- 7) ANY DEFICIENCIES OF THE ABOVE WILL BE REPORTED IMMEDIATELY TO THE APPROPRIATE DEPARTMENT MANAGER.
- 8) IN THE EVENT OF A FACILITY EMERGENCY, SUCH AS FIRE, IT WILL BE THE RESPONSIBILITY OF THE BUSINESS OFFICE MANAGER TO TRANSFER ALL PATIENT MEDICAL RECORDS TO A DESIGNATED AREA FOR SAFE KEEPING. IN THE ABSENCE OF THE BUSINESS OFFICE MANAGER, THE MEDICAL RECORDS COORDINATOR WILL ASSUME THIS RESPONSIBILITY.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

SECTION: N SAFETY

DATE: 11/97, 7/03

REVIEWED: 3/12, 5/16, 1/21

TITLE: N-160 SAFE MEDICAL DEVICES ACT (SMDA)

WILDCREEK SURGERY CENTER WILL SUPPORT AND COMPLY WITH THE SAFE MEDICAL DEVICES ACT (SMDA) WHICH BECAME EFFECTIVE ON NOVEMBER 28, 1991. THIS ACT REQUIRES THAT HEALTHCARE FACILITIES UTILIZING MEDICAL DEVICES WHICH HAVE CAUSED PATIENT CERTAIN ADVERSE OUTCOMES, TO REPORT SUCH EVENTS TO THE FDA AND/OR MANUFACTURER

PROCEDURE:

- 1) A MEDICAL DEVICE IS DEFINED AS AN INSTRUMENT, IMPLEMENT, MACHINE, APPARATUS, IMPLANT, OR OTHER SIMILAR OR RELATED ARTICLE INTENDED FOR USE IN DIAGNOSIS, CURE, TREATMENT, OR PREVENTION OF DISEASE. (PHARMACEUTICALS ARE NOT INCLUDED). EXAMPLES: ANESTHESIA MACHINES, DEFIBRILLATORS, CATHETERS, INTRAOCULAR LENSES, BLOOD GLUCOSE MONITORS, BREAST IMPLANTS, X-RAY MACHINES, AND LASERS TO NAME A FEW.
- 2) A REPORT WILL BE FILED WHEN INFORMATION EXISTS THAT REASONABLY SUGGESTS THERE IS A PROBABILITY THAT A DEVICE HAS CAUSED OR CONTRIBUTED TO THE DEATH, SERIOUS INJURY, OR SERIOUS ILLNESS OF A PATIENT.
- 3) THE REPORT WILL BE MADE WITHIN 10 WORKING DAYS AFTER BECOMING AWARE OF A REPORTABLE EVENT.
- 4) A SEMI-ANNUAL SUMMARY WILL BE MADE EVERY JANUARY AND JULY IF THE CENTER HAS EXPERIENCED A REPORTABLE EVENT.
- 5) THE REPORT WILL BE MADE TO THE FDA IN THE CASE OF A DEATH. THE REPORT WILL BE MADE TO THE MANUFACTURER IN THE CASE OF SERIOUS INJURY OR ILLNESS. IF THE MANUFACTURER IS UNKNOWN, THEN THE REPORT WILL BE MADE TO THE FDA.
- 6) SEMI-ANNUAL REPORTS WILL BE MADE TO THE FDA:

FOOD AND DRUG ADMINISTRATION
CENTER FOR DEVICES AND RADIOLOGICAL HEALTH
FDA USER REPORT
P.O. BOX 3002
ROCKVILLE, MD. 20847-3002

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

SECTION: N SAFETY

DATE: 11/97, 7/03

REVIEWED: 3/12, 5/16, 1/21

TITLE: N-160 SAFE MEDICAL DEVICES ACT (SMDA)

REPORT TO INCLUDE:
FACILITY NAME AND ADDRESS
PRODUCT, SERIAL NUMBER, MODEL NUMBER
MANUFACTURER AND ADDRESS
BRIEF DESCRIPTION OF EVENT

- 7) FDA REPORTING FORM WILL BE KEPT IN THE QA/RM OFFICE.
- 8) THE RISK MANAGEMENT NURSE, NURSE MANAGER, ADMINISTRATOR, AND MEDICAL DIRECTOR WILL WORK TOGETHER TO PROPERLY COMPLETE THE REPORTING FORM.
- 9) ANY DEVICE REPORTABLE WILL BE REMOVED FROM THE PATIENT CARE AREA AND LABELED "DEFECTIVE". THE DEVICE WILL NOT BE USED AGAIN UNTIL SERVICING HAS BEEN COMPLETED. THE DEVICE WILL BE EVALUATED BY AN INDEPENDENT BIOMEDICAL CONSULTANT BEFORE REPAIR AND WRITTEN EVALUATION SUBMITTED TO THE CENTER. THIS EVALUATION WILL BE ATTACHED TO THE FDA REPORTING FORM AND TO THE VARIANCE REPORT.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

SECTION: N SAFETY

DATE: 7/03

REVIEWED: 3/12, 5/16, 1/21

TITLE: N-170 EXTENSION CORD USE

POLICY:

WILDCREEK SURGERY CENTER WILL COMPLY WITH FIRE AND SAFETY REGULATIONS TO ENSURE A SAFE WORKING ENVIRONMENT.

PROCEDURE:

1. EXTENSION CORD USE WILL BE LIMITED TO ONLY NECESSARY SITUATIONS.
2. ONLY GROUNDED (THREE PRONG) EXTENSION CORDS WILL BE UTILIZED.
3. EXTENSION CORDS WILL BE RATED WITH AS GREAT OR GREAT ELECTRICAL CAPACITY AS THE UNIT IT IS BEING CONNECTED WITH.
4. CARE WILL BE TAKEN THAT THE EXTENSION CORD IS NOT EXPOSED TO SPILL OR POOLING OF FLUIDS.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

SECTION: N SAFETY

DATE: 11/97, 12/10, 8/12

REVIEWED: 3/12, 5/16, 1/21

TITLE: N-180 EYE WASH STATIONS

POLICY: WILDCREEK SURGERY CENTER WILL PROVIDE AND MAINTAIN A MEANS TO FLUSH THE EYES IN A SITUATION WHERE THE EYES HAVE BEEN SUBJECTED TO GASSES, SOLUTIONS, OR DEBRIS CAPABLE OF PRODUCING INJURY.

PROCEDURE:

- 1) EYE WASH STATIONS WILL BE ESTABLISHED AND MAINTAINED IN THE CENTER (CURRENTLY ONE STATION IS ESTABLISHED).
- 2) SIGNS WILL BE POSTED DESIGNATING THE EYE WASH STATION.
- 3) OPERATION OF EYEWASH STATION:
 - TURN WATER FAUCET ON
 - PUSH BUTTON ON FAUCET OUTWARD
 - LEAN OVER SINK AND ALLOW STREAM OF WATER TO FLUSH EYES
 - 15 MINUTE FLUSH IS RECOMMENDED
- 4) MAINTENANCE
 - THE STATION WILL BE CHECK DAILY AND DOCUMENTED ON THE CRASH CRASHCART CHECK LIST
 - PLASTIC PROTECTIVE COVERS WILL BE REPLACED WHEN LOST OR DAMAGED.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

SECTION: N SAFETY

DATE: 11/97, 7/03, 3/11, 12/16

REVIEWED: 3/12, 5/16, 1/21

TITLE: N-190 HAZARDS, RECALLS AND ALERTS

POLICY: THE NURSING MANAGER OF WILDCREEK SURGERY CENTER WILL BE RESPONSIBLE FOR ALL HAZARDS, RECALLS, AND ALERTS. THIS PERSON WILL COLLECT AND REVIEW ALL DATA CONCERNING DEFECTIVE EQUIPMENT, SUPPLIES, MEDICATIONS AND FOOD PRODUCTS WHICH MAY AFFECT THE GENERAL SAFETY OR PRESENT A RISK TO PATIENT CARE, VISITORS, OR CENTER STAFF.

PROCEDURE: THE NURSE MANAGER WILL:

- REVIEW ALL DATA COLLECTED FROM ALL SOURCES CONCERNING RECALLS OR ALERTS OF DEFECTIVE OR HAZARDOUS EQUIPMENT, SUPPLIES, MEDICATIONS AND FOOD PRODUCTS.
- TAKE IMMEDIATE ACTION AS NECESSARY TO PROVIDE THE PROPER PROTECION OF ALL PATIENTS, VISITORS, AND STAFF MEMBERS. REMOVE RECALLED EQUIPMENT, SUPPLIES, MEDICATION, OR FOOD PRODUCT FROM PATIENT USE AREA IMMEDIATELY.
- FOLLOW MANUFACTURER OR DISTRIBUTERS INSTRUCTION AS TO DISPOSITION OF RECALLED PRODUCT.
- INFORM THE CENTER'S ADMINISTRATOR AND MEDICAL DIRECTOR.
- DISSEMINATE HAZARDOUS RECALL OR ALERT INFORMATION TO APPROPRIATE STAFF MEMBERS INVOLVED IN THE UTILIZATION OF THE POTENTIAL HAZARDOUS EQUIPMENT, SUPPLIES, MEDICATIONS AND FOOD PRODUCTS.
- COLLECT, COORDINATE, AND EVALUATE INFORMATION RETURNED FROM THE INVOLVED AREAS TO ASSURE THAT ANY ACTION REQUIRED HAS BEEN ADDRESSED AND HANDLED TO MINIMIZE RISK ASSOCIATED WITH THE ITEM IN QUESTION.
- MONITOR ALL OUTSTANDING RECALLS TO ASSURE THAT ALL ISSUES OR POTENTIAL PRODUCT LIABILITIES HAVE BEEN RESOLVED TO COMPLETION.
- MAINTAIN SUPPORTING DOCUMENTATION WITHIN THE CENTER.
- REPORT RESULTS INCLUDING ANY ACTIONS TAKEN TO THE QAPI COMMITTEE.
- CALL IN OTHER PERSONNEL AS NEEDED TO ASSIST IN FINDING RESOLUTIONS TO IDENTIFIED ISSUES AS NECESSARY THIS PERSON WILL COLLECT AND REVIEW CONCERNING DEFECTIVE EQUIPMENT SUPPLIES, MEDICATIONS AND FOOD PRODUCTS WHICH MAY EFFECT PATIENTS, VISITORS, OR CENTER STAFF.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

SECTION: N SAFETY

DATE: 11/97, 7/03, 8/12

REVIEWED: 3/12, 5/16, 1/21

TITLE: N-200 MEDICAL WASTE MANAGEMENT

POLICY:

WILDCREEK SURGERY CENTER WILL COMPLY WITH ALL LOCAL, STATE, AND FEDERAL LAWS, RULES, AND REGULATIONS GOVERNING THE HANDLING AND DISPOSAL OF CONTAMINATED MEDICAL WASTE. THE CENTER WILL PROTECT ALL EMPLOYEES, VISITORS, AND STAFF MEMBERS FROM POSSIBLE EXPOSURE TO INFECTIOUS DISEASES THROUGH A WASTE MANAGEMENT PROGRAM. IN ADDITION, THE CENTER WILL PROTECT THE PUBLIC AND THE ENVIRONMENT IN GENERAL BY CONTAINING ALL CONTAMINATED WASTES PRIOR TO THEIR DISPOSAL SO AS NOT TO CAUSE INFECTIOUS DISEASE TO BE SPREAD. THESE CONTAMINATED WASTES WILL BE CONTAINED AND DISPOSED OF IN A SAFE AND APPROVED MANNER.

PROCEDURE:

DEFINITION-INFECTIOUS MEDICAL WASTE:

BIOHAZARDOUS WASTE IS ANY SOLID OR LIQUID WASTE WHICH MAY PRESENT A THREAT OF INFECTION TO HUMANS. THE REQUIREMENTS FOR INDUCTION OF DISEASE IS THE PRESENCE OF A PATHOGEN WITH SUFFICIENT VIRULENCE AND IN A QUANTITY SUBSTANTIAL ENOUGH SO THAT EXPOSURE TO THE WASTE BY A SUSCEPTIBLE HOST OR ORGANISM COULD RESULT IN AN INFECTIOUS DISEASE.

IDENTIFICATION OF MEDICAL WASTE:

ISOLATION WASTE FROM PATIENTS WITH INFECTIOUS DISEASE CULTURES AND STOCKS OF INFECTIOUS AGENTS AND ASSOCIATED BIOLOGICALS HUMAN BLOOD AND BLOOD PRODUCTS; USED, ABSORBENT MATERIALS SUCH AS BANDAGES, SPONGES, AND GAUZE SUPERSATURATED WITH BLOOD OR BODY FLUIDS HAVING THE POTENTIAL TO DRIP OR SPLASH

PATHOLOGICAL WASTE; TISSUES, ORGANS, OR BODY PARTS

CONTAMINATED SHARPS; HYPODERMIC NEEDLES, SYRINGES, PIPETTES, BROKEN GLASS, SCALPEL BLADES, SUTURING NEEDLES, TROCARS, ETC.

- 1) THE NURSE MANAGER WILL BE RESPONSIBLE FOR THE DEVELOPMENT AND MAINTENANCE OF A MEDICAL WASTE MANAGEMENT PROGRAM.
- 2) THE WASTE MANAGEMENT PROGRAM WILL INCLUDE:
 - A) EMPLOYEE TRAINING IN MEDICAL WASTE HANDLING
 - B) MONITORING OF PROPER PACKAGING AND LABELING
 - C) FOLLOW-THROUGH ON TRACKING PROCEDURES
 - D) CONTINGENCY/EMERGENCY PLAN

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

SECTION: N SAFETY

DATE: 11/97, 7/03, 8/12

REVIEWED: 3/12, 3/15, 5/16, 1/21

TITLE: N-200 MEDICAL WASTE MANAGEMENT

- 3) ALL POTENTIALLY INFECTIOUS MEDICAL WASTE WILL BE SEPARATED FROM GENERAL FACILITY GARBAGE AT ITS POINT OF ORIGIN.
- 4) ALL POTENTIALLY INFECTIOUS MEDICAL WASTE WILL BE PLACED IN BOXES LABELED "BIOHAZARD WASTE" THAT CONSPICUOUSLY DISPLAYED THE BIOHAZARD SYMBOL. THESE BOXES WILL BE LINED WITH TWO (2) RED PLASTIC BAGS THAT ARE IMPERVIOUS TEAR RESISTANT, AND WITH SEAMS THAT ARE OF EQUAL RESISTANCE TO TEARING AND LEAKING.
- 5) EACH HAZARDOUS WASTE BOX WILL NOT EXCEED A FIFTY (50) POUND MAXIMUM WEIGHT LIMIT.
- 6) ALL FLUIDS PLACED IN THE HAZARDOUS WASTE BOX WILL BE CONTAINED; CAPS WILL BE PLACED SECURELY ON ALL PORTS OF SUCTION CONTAINERS. BULK BLOOD, SUCTIONED FLUIDS EXCRETIONS, AND SECRETIONS MAY BE CAREFULLY POURED DOWN A DRAIN CONNECTED TO SANITARY SEWER.
- 7) NEEDLES WILL NOT BE BENT BROKEN OR RECAPPED AND WILL BE PLACED IN APPROVED SHARPS CONTAINERS IMMEDIATELY AFTER USE. ALL SHARPS WILL FIRST BE PLACED IN A PUNCTURE PROOF SHARPS CONTAINER. WHEN **TWO THIRDS**, THE SHARPS CONTAINER WILL BE SECURELY CLOSED AND LOCED IN THE BIOHAZARD CABINET UNTIL PICK-UP
- 8) FILLED HAZARDOUS WASTE BOXES WILL BE SECURED BY FOLDING THE INNER RED BAG OVER THE CONTENTS, THEN TWISTING THE OUTER RED BAG CLOSED AND SECURELY WITH A TIE. THE LID MUST BE ABLE TO FIT SNUGLY ON TO THE BOX, BOXES WILL NOT BE OVERFILLED.
- 9) SECURED HAZARDOUS WASTE BOXES WILL BE LOCKED IN THE BIO-HAZARD CABINET UNTIL PICK-UP. THIS AREA HAS BEEN DESIGNATED FOR CONTAMINATED WASTE CONTAINERS AND HAS RESTRICTED ACCESS BY UNAUTHORIZED PERSONS.
- 10) PICK-UP WILL BE ARRANGED ON AN AS NEEDED BASIS.

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SECTION: N SAFETY

DATE: 11/97, 7/03, 8/12

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POLICIES AND PROCEDURES

REVIEWED: 3/12, 5/16, 1/21

TITLE: N-200 MEDICAL WASTE MANAGEMENT

- 11) IN THE EVENT OF LEAKAGE OR ACCIDENTAL SPILL OF A HAZARDOUS WASTE BOX, PROTECTIVE ATTIRE WILL BE WORN, AND THE CONTENTS WILL BE PLACED IN AN INTACT BIO-HAZARDOUS WASTE BOX. SPILLS WILL BE CLEANED UP USING A GERMICIDAL AGENT AND DISPOSABLE TOWELS. ALL MATERIALS USED IN CLEANING THE SPILL WILL THEN BE DISPOSED OF IN A HAZARDOUS WASTE BOX; SATURATED OR DRIPPING MATERIALS WILL FIRST BE PLACED IN A PLASTIC BAG.
- 12) TRANSPORTATION OF THE FILLED HAZARDOUS WASTE BOXES OFF THE PREMISES WILL BE BY ENCLOSED, LEAK PROOF TRUCKS.
- 13) DOCUMENTATION OF PICK-UP WILL BE MAINTAINED BY THE CENTER; DOCUMENTATION OF APPROPRIATE DISPOSAL WILL BE MAINTAINED BY THE RECEIVING SERVICE AS WELL AS TRACKING OF CENTER VOLUME.
- 14) WASTE MANAGEMENT IS A STATE APPROVED BIO-HAZARDOUS WASTE DISPOSAL SERVICE AND WILL BE UTILIZED FOR THE COLLECTION OF WILDCREEK SURGERY CENTER BIO-HAZARDOUS WASTE.
- 15) POLICIES AND PROCEDURES RELATING TO THE OPERATION OF THE HAZARDOUS MATERIALS AND WASTE MANAGEMENT SYSTEM WILL BE REVIEWED ANNUALLY.
- 16) THE QUALITY IMPROVEMENT/RISK MANAGEMENT COMMITTEE WILL BE RESPONSIBLE FOR TRACKING THE MANAGEMENT OF BIO-HAZARDOUS WASTE, SECURING REGULATIONS, AND MAINTAINING COMMUNICATION FOR OPERATION OF SERVICE WITH B & L DISPOSAL.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

SECTION: N SAFETY

DATE: 11/97, 7/03

REVIEWED: 3/12, 5/16, 1/21

REVISED: 7/19

TITLE: N-210 HAZARDOUS MATERIALS COMMUNICATION PROGRAM

POLICY: WILDCREEK SURGERY CENTER WILL MAINTAIN AN UP-TO-DATE PROGRAM FOR THE PURPOSE OF COMMUNICATING TO EMPLOYEES ON HAZARDOUS CHEMICALS IN THE WORKPLACE.

PROCEDURE:

RECORD KEEPING:

- 1) **SAFETY DATA SHEETS:**
THESE WILL BE KEPT UP TO DATE WITH ALL CURRENT AND ANY NEW CHEMICALS IN THE CENTER.
- 2) **EMPLOYEE SIGN OFF SHEETS:**
WHEN EMPLOYEES ATTEND THE HAZARDOUS COMMUNICATIONS PROGRAM AS PART OF THEIR ORIENTATION, THEY WILL SIGN AND DATE A FORM ACKNOWLEDGING THIS. THESE COMPLETED FORMS WILL BE KEPT IN PERSONNEL FILES.
- 3) **RESPONSIBILITIES:**
THE CENTER'S NURSING MANAGER WILL BE RESPONSIBLE FOR ASSURING THAT ALL EMPLOYEES RECEIVE THE HAZARDOUS MATERIAL INFORMATION.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

SECTION: N SAFETY

DATE: 11/97, 7/03, 9/09
REVIEWED: 3/12, 5/16, 1/21
REVISED: 7/19

TITLE: N-220 HAZARDOUS MATERIALS EDUCATION, ORIENTATION, AND TRAINING

POLICY: WILDCREEK SURGERY CENTER WILL PROVIDE THE EMPLOYEES WITH INFORMATION AND TRAINING ON HAZARDOUS MATERIALS IN THE WORK AREA AT THE TIME OF EMPLOYMENT AND WHEN NEW HAZARDOUS MATERIALS ARE INTRODUCED INTO HIS/HER WORK AREAS.

ACTION: THE EMPLOYEE WILL BE ABLE TO IDENTIFY AND VERBALIZE:

1. THE LOCATION AND STORAGE OF POTENTIALLY HAZARDOUS MATERIALS IN THE WORK AREA.
2. THE PHYSICAL AND HEALTH HAZARDS OF MATERIALS IN THE WORK AREA.
3. THE LABELING INFORMATION REQUIRED ON ALL POTENTIALLY HAZARDOUS MATERIALS.
4. THE MEASURES TO BE TAKEN TO PROTECT HIM/HER FROM EXPOSURE TO HAZARDOUS MATERIALS, SUCH AS APPROPRIATE WORK PRACTICES, EMERGENCY PROCEDURES AND THE PERSONAL PROTECTIVE EQUIPMENT TO BE USED.
5. LOCATION OF SAFETY AIDS SUCH AS SHOWERS, EYE WASH STATIONS, FIRE EXTINGUISHERS, ETC.
6. LOCATION AND CONTENT OF THE SAFETY DATA SHEET (SDS).
7. THE REQUIREMENT OF COMPLETION OF THE HAZARDOUS COMMUNICATION PROGRAM AT THE TIME OF EMPLOYMENT AND ANNUALLY.

DATE _____ SIGNED _____

DATE _____ SIGNED _____

DATE _____ SIGNED _____

DATE _____ SIGNED _____

DATE _____ SIGNED _____

DATE _____ SIGNED _____

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

SECTION: N SAFETY

DATE: 11/97, 7/03, 5/16

REVIEWED: 3/12, 1/21

REVISED: 7/19

TITLE: N-230 HAZARDOUS MATERIALS SPILL OR ACCIDENT

POLICY: WILDCREEK SURGERY CENTER WILL PROTECT ALL PATIENTS, VISITORS, AND STAFF MEMBERS FROM THE POTENTIAL DANGERS OF A HAZARDOUS MATERIAL SPILL BY FOLLOWING THE PROCEDURE LISTED BELOW.

PROCEDURE: 1) REGULAR INSPECTIONS WILL BE MADE OF THE STORAGE SITES FOR ALL HAZARDOUS MATERIALS. THESE INSPECTIONS WILL BE MADE FOR THE PURPOSE OF DETECTING ANY LEAKING OR SPILLED CONTAINERS. IF ANY LEAKS OR SPILLS ARE FOUND, THE FOLLOWING STEPS WILL BE TAKEN:

2) BEFORE ATTEMPTING TO CLEAN UP ANY HAZARDOUS CHEMICAL SPILL, KNOW WHAT THE CHEMICAL IS!

3) OBTAIN THE SAFETY DATA SHEET (SDS) FOR THAT PARTICULAR PRODUCT. THE SAFETY DATA SHEETS ARE KEPT CLEARLY MARKED BINDERS IN THE ANESTHESIA WORK ROOM.

4) FOLLOW THE DIRECTIONS ON THE SDS FOR THAT PRODUCT TO ACQUIRE THE PROPER PROTECTIVE CLOTHING/EQUIPMENT AND TO CLEAN UP THE LEAK OR SPILL.

5) ENSURE ADEQUATE VENTILATION FOR THE TASK.

6) IF NECESSARY, EVACUATE ALL PERSONS FROM THE AREA BEFORE DOING THE CLEAN UP.

7) IF A FIRE OCCURS, PROCEED WITH THE FIRE ALARM PROCEDURE (SEE "FIRE SAFETY RULES AND REGULATION").

8) AVOID TRACKING THROUGH THE SPILL DURING THE CLEAN UP.

9) COMPLETE A VARIANCE REPORT ON THE LEAK OR SPILL.

10) NOTIFY THE NURSING MANAGER OF ALL LEAKS/SPILLS.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

SECTION: N SAFETY

DATE: 11/97, 7/03

REVIEWED: 3/12, 5/16, 1/21

REVISED: 7/19

TITLE: **N-240 HAZARDOUS MATERIALS**

POLICY:

WILDCREEK SURGERY CENTER WILL COMPLY WITH ALL LOCAL, STATE, AND FEDERAL RULES AND REGULATIONS GOVERNING THE USE, HANDLING, AND STORAGE OF ALL HAZARDOUS MATERIALS. THE CENTER'S RISK MANAGEMENT COMMITTEE IS RESPONSIBLE FOR DEVELOPING AND IMPLEMENTING A CENTER-WIDE HAZARDOUS MATERIAL SAFETY PROGRAM WHICH WILL INCLUDE:

- 1) IDENTIFICATION OF HAZARDOUS MATERIALS USED WITHIN THE CENTER.
- 2) MAINTAIN AND MONITOR APPROPRIATE SAFETY DATA SHEETS ON ALL MATERIAL THAT IS CONSIDERED HAZARDOUS.
- 3) TRAINING OF EMPLOYEES WHO HANDLE OR ARE EXPOSED TO THE HAZARDOUS MATERIALS WITH EMPHASIS ON SAFETY ASPECTS ASSOCIATED WITH THE HAZARDOUS MATERIALS.
- 4) IMPLEMENTATION AND ON-GOING MONITORING OF THE HAZARDOUS MATERIAL POLICY.

PROCEDURE: EMPLOYEE INFORMATION AND TRAINING:

THE CENTER'S DEPARTMENT MANAGERS WILL PROVIDE THEIR EMPLOYEES WITH INFORMATION AND TRAINING ON HAZARDOUS CHEMICALS IN THEIR WORK AREA AT THE TIME OF THEIR INITIAL ASSIGNMENT, AND WHENEVER A NEW HAZARD IS INTRODUCED INTO THEIR WORK AREA. INFORMATION AND TRAINING WILL CONSIST OF THE FOLLOWING:

- A) THE REQUIREMENTS OF THIS POLICY.
- B) ANY OPERATIONS IN THEIR WORK AREA WHERE HAZARDOUS MATERIALS ARE PRESENT.
- C) THE LOCATION AND AVAILABILITY OF WRITTEN HAZARD COMMUNICATIONS, INCLUDING THE REQUIRED LIST OF HAZARDOUS MATERIALS AND SAFETY DATA SHEETS REQUIRED BY THIS POLICY.
- D) METHODS AND OBSERVATIONS THAT MAY BE USED TO DETECT THE PRESENCE OR RELEASE OF A HAZARDOUS MATERIAL INTO THEIR WORK AREA.
- E) THE PHYSICAL AND HEALTH HAZARDS OF THE MATERIALS IN THE WORK AREA.

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POLICIES AND PROCEDURES

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TITLE: N-240 HAZARDOUS MATERIALS

- F) THE MEASURES EMPLOYEES CAN TAKE TO PROTECT THEMSELVES FROM THESE HAZARDS, INCLUDING SPECIFIC PROCEDURES THE EMPLOYER HAS IMPLEMENTED TO PROTECT EMPLOYEES FROM EXPOSURE TO HAZARDOUS MATERIALS, SUCH AS APPROPRIATE WORK PRACTICES, EMERGENCY PROCEDURES, AND PERSONAL PROTECTIVE EQUIPMENT TO BE USED.
- G) THE DETAILS OF THE HAZARD COMMUNICATIONS PROGRAM DEVELOPED BY THE EMPLOYER, INCLUDING AN EXPLANATION OF THE LABELING SYSTEM AND THE SAFETY DATA SHEET, AND HOW EMPLOYEES CAN OBTAIN AND USE THE APPROPRIATE HAZARD INFORMATION.
- H) DOCUMENTATION IN EACH EMPLOYEE'S FILE THAT THE ABOVE MATERIAL HAS BEEN DISCUSSED AT LEAST ON AN ANNUAL BASIS.

2) DEFINITION AND RESPONSIBILITIES:

- A) A HAZARDOUS MATERIAL IS DEFINED AS ANY CHEMICAL THAT IS TOXIC, FLAMMABLE, CORROSIVE, REACTIVE, OR CAPABLE OF CAUSING HARM OR SERIOUS INJURY TO HUMANS, ANIMALS, OR THE ENVIRONMENT.
- B) THE ADMINISTRATOR AND DEPARTMENT MANAGERS HAVE THE AUTHORITY TO INSTITUTE THE EMERGENCY PLAN IN THE EVENT OF A MAJOR CHEMICAL WASTE ACCIDENT OR SPILL OF A HAZARDOUS MATERIAL.
- C) A SAFETY DATA SHEET (SDS) IS REQUIRED AND COMPLETED BY ALL VENDORS. MSDS'S ARE MAINTAINED WITHIN EACH DEPARTMENT ON EVERY CHEMICAL USED WITHIN THEIR AREA.
- D) A MASTER FILE OF ALL THE SDS'S IS TO BE MAINTAINED BY THE RISK MANAGEMENT NURSE AND THE SPARKS FIRE DEPARTMENT FOR USE IN THE EVENT OF A HAZARDOUS CHEMICAL SPILL, SPLASH, BURN, OR OTHER ACCIDENTS.
- E) IT IS THE RESPONSIBILITY OF THE DEPARTMENT USING THE HAZARDOUS MATERIAL TO DETERMINE IF A LESS HAZARDOUS ONE MAY BE SUBSTITUTED.
- F) ALL PERSONS REQUIRED TO HANDLE THE HAZARDOUS CHEMICALS OR MATERIALS WILL BE PROVIDED WITH APPROPRIATE ORIENTATION, EQUIPMENT, AND ON THE JOB TRAINING.

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REVISED: 7/19

TITLE: **N-240 HAZARDOUS MATERIALS**

- G) EACH DEPARTMENT THAT GENERATES OR HANDLES CHEMICAL WASTE WILL HAVE WRITTEN, SPECIFIC POLICIES AND PROCEDURES THAT CONTAIN INFORMATION PERTINENT TO THAT DEPARTMENT. THESE POLICIES AND PROCEDURES WILL BE REVIEWED ANNUALLY AND APPROVED BY THE QA COMMITTEE.

HAZARDOUS MATERIALS RIGHT TO KNOW:

OSHA MAINTAINS A REGULATION TO PROTECT EMPLOYEES FROM POSSIBLE ADVERSE EFFECTS OF POTENTIALLY HAZARDOUS CHEMICALS THEY MAY ENCOUNTER IN THE WORKPLACE. EMPLOYEES WILL BE PROVIDED WITH INFORMATION REGARDING:

- A) THE POTENTIALLY HAZARDOUS CHEMICALS THEY MAY COME INTO CONTACT WITHIN THEIR WORK AREA.
- B) THE NATURE OF THE POTENTIALLY HAZARDOUS CHEMICALS WITH WHICH THEY WORK.
- C) THE PERSONAL PROTECTIVE EQUIPMENT THAT SHOULD BE WORN IN DEALING WITH CHEMICALS.
- D) WHERE THEY CAN GO FOR ADDITIONAL INFORMATION ABOUT THE CHEMICALS, THEY MAY ENCOUNTER.
- E) STORAGE OF POTENTIALLY HAZARDOUS CHEMICALS.
- F) LOCATION OF EXISTING SAFETY AIDS SUCH AS SHOWERS, EYE WASHES, ETC.

LABELING INFORMATION:

THE FOLLOWING LABELING INFORMATION IS REQUIRED ON ALL POTENTIALLY HAZARDOUS MATERIALS:

- A) CHEMICAL NAME.
- B) CHEMICAL ABSTRACT NUMBER ("CAS"), A UNIQUE NUMBER ASSIGNED BY THE FEDERAL GOVERNMENT TO EACH CHEMICAL.
- C) APPROPRIATE HAZARD WARNINGS (FIRE, REACTIVITY, HEALTH);

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TITLE: **N-240 HAZARDOUS MATERIALS**

- D) TARGET ORGAN INFORMATION, SUCH AS THE SPECIFIC ORGAN OR ORGAN GROUPS THAT EXPOSURE TO THE CHEMICAL MAY EFFECT.
- E) IN SOME CASES, THE PERSONAL PROTECTIVE EQUIPMENT TO BE USED IN HANDLING THE CHEMICAL IS STATED.

SAFETY DATA SHEETS:

ALL SAFETY DATA SHEETS WILL CONTAIN THE FOLLOWING INFORMATION IF APPLICABLE:

- A) IDENTITY: WHO MAKES IT, THEIR ADDRESS, EMERGENCY TELEPHONE NUMBER, AND DATE PREPARED.
- B) HAZARDOUS INGREDIENTS: HAZARDOUS COMPONENTS, CHEMICAL ID, AND COMMON NAMES. WORKER EXPOSURE LIMITS SUCH THE OSHA PEL AND ACGIH TLV AND OTHER RECOMMENDED LIMITS ARE ALSO INCLUDED IN THIS SECTION.
- C) PHYSICAL/CHEMICAL CHARACTERISTICS: ITEMS SUCH AS BOILING POINT, VAPOR PRESSURE, VAPOR DENSITY, MELTING POINT, EVAPORATION RATE, WATER SOLUBILITY, APPEARANCE, AND ODOR UNDER NORMAL CONDITIONS.
- D) PHYSICAL HAZARDS: SUCH AS FIRE, EXPLOSION, WAYS TO HANDLE THOSE HAZARDS, APPROPRIATE FIRE FIGHTING EQUIPMENT, ETC.
- E) REACTIVITY: THIS TELLS YOU WHETHER THE SUBSTANCE IS STABLE. THIS TELLS YOU WHICH SUBSTANCE AND SITUATIONS TO KEEP IT AWAY FROM SO IT WON'T REACT.
- F) HEALTH HAZARDS: HOW THE CHEMICAL CAN ENTER THE BODY, ALL POSSIBLE HEALTH HAZARDS THAT COULD COME FROM EXPOSURE, SIGNS AND SYMPTOMS OF EXPOSURE, AND EXISTING MEDICAL CONDITIONS THAT COULD BE AGGRAVATED BY EXPOSURE. THIS AREA ALSO COVERS EMERGENCY AND FIRST AID PROCEDURES IF AN ACCIDENT DOES HAPPEN.
- G) PRECAUTIONS FOR SAFE HANDLING AND USE: THIS SECTION TELLS YOU WHAT TO DO IF A SUBSTANCE SPILLS OR LEAKS, HOW TO DISPOSE OF THE SUBSTANCE, EQUIPMENT AND PROCEDURES NEEDED FOR CLEANING UP SPILLS AND LEAKS, AND HOW TO HANDLE THE SUBSTANCE AND HOW TO STORE IT.

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REVIEWED: 3/12, 5/16

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- H) CONTROL MEASURES: THIS SECTION TELLS YOU HOW TO REDUCE HARMFUL EXPOSURE. IT DEALS WITH WHAT TYPE OF RESPIRATOR, GLOVES, EYE SHIELDS, PROTECTIVE CLOTHING, AND VENTILATION TO USE WHEN HANDLING THAT PARTICULAR CHEMICAL. ALSO, SPECIAL HYGIENE PRACTICES THAT SHOULD BE FOLLOWED WILL BE INCLUDED HERE.

IT MUST BE NOTED THAT NOT ALL INFORMATION WILL BE ON ALL SDS'S. SOME INFORMATION DOES NOT PERTAIN TO CERTAIN CHEMICALS. WHEN MANUFACTURERS OR SUPPLIERS USE A STANDARD FORMAT SHEET, THOSE AREAS WILL USUALLY SAY "N/A". IT IS REQUIRED, HOWEVER, THAT ALL PERTINENT INFORMATION BE DISCLOSED ON EACH CHEMICAL. THE OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION (OSHA) HAS ISSUED A HAZARD COMMUNICATION STANDARD THAT SAYS ALL EMPLOYEES HAVE A "RIGHT TO KNOW" WHAT HAZARDS THEY FACE ON THE JOB AND HOW TO PROTECT THEMSELVES AGAINST THOSE HAZARDS.

IN ADDITION, ALL HAZARDOUS CHEMICALS WILL BE IDENTIFIED USING THE CRITERIA DEFINED BY THE

RESOURCE CONSERVATION AND RECOVERY ACT OF 1976 (RCRA), SUBTITLE C, HAZARDOUS WASTE REGULATIONS, 40CFR, PART 261. A BRIEF SUMMARY OF THIS IDENTIFICATION CRITERIA IS AS FOLLOWS:

1) CHEMICAL CHARACTERISTICS:

- A) IGNITABLE (FLAMMABLE). EXAMPLES: XYLENE, BENZENE, ETHYL ETHER, ACETONE, AND METHANOL.
- B) CORROSIVE (PH 2.0 OR PH 12.5). EXAMPLES: SODIUM HYDROXIDE, HYDROCHLORIC ACID, SULFURIC ACID.
- C) REACTIVITY (UNSTABLE AT NORMAL TEMPERATURES AND PRESSURES, OR MAY RELEASE EXPLOSIVE VAPORS).
- D) TOXICITY (TOXIC DUE TO CONTAMINATED HEAVY METALS OR SPECIFIC CHLORINATED ORGANICS).

2) ACUTELY HAZARDOUS CHEMICAL WASTES: EXAMPLES: ARSENATE AND ARSENIC CONTAINING COMPOUNDS, CYANIDE CONTAINING COMPOUNDS, WARFARIN, PARATHION, SODIUM AZIDE.

3) COMMERCIAL CHEMICAL PRODUCTS AND MANUFACTURING CHEMICAL INTERMEDIATES: EXAMPLES: CARBON TETRACHLORIDE, CHLORDANE, CHLOROFORM, PYRIDINE, TOLUENE.

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REVIEWED: 3/12, 5/16, 1/21

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TITLE: N-240 HAZARDOUS MATERIALS

- 4) TOXIC WASTE: EXAMPLES: PHENOL, RESERPINE PCB'S.
- 3) STORAGE:
 - A) MATERIALS WHICH IGNITE EASILY UNDER NORMAL CONDITIONS (FLAMMABLES) ARE CONSIDERED FIRE HAZARDOUS AND WILL BE STORED IN A COOL, DRY, WELL VENTILATED STORAGE SPACE. THESE MATERIALS WILL BE KEPT WELL AWAY FROM SOURCES OF HEAT, FIRE, OR FLAME.
 - B) HIGHLY FLAMMABLE MATERIALS WILL BE KEPT IN AN AREA SEPARATE FROM OXIDIZING AGENTS (MATERIALS SUSCEPTIBLE TO SPONTANEOUS COMBUSTION OR HEATING, EXPLOSIVES, ETC).
 - C) THE STORAGE AREA FOR FLAMMABLES WILL BE SUPPLIED WITH FIRE FIGHTING EQUIPMENT, EITHER AUTOMATIC OR MANUAL. THERE WILL BE "NO SMOKING" SIGNS POSTED IN AND AROUND THE STORAGE AREA.
 - D) OXIDIZERS WILL NOT BE STORED CLOSE TO LIQUIDS OF LOW FLASH POINT.
 - E) ACIDS AND ACID FUME SENSITIVE MATERIALS WILL BE STORED IN A COOL, DRY, WELL VENTILATED AREA, PREFERABLY WOODEN.
 - F) MATERIALS WHICH ARE TOXIC AS STORED, OR CAN DECOMPOSE INTO TOXIC COMPONENTS WILL BE KEPT FROM CONTACT WITH HEAT, MOISTURE, ACIDS, OR ACID FUMES.
 - G) CORROSIVE MATERIALS WILL BE STORED IN A COOL, WELL VENTILATED AREA, BUT WILL BE KEPT ABOVE THE FREEZING POINT. THE CONTAINERS WILL BE INSPECTED AT REGULAR INTERVALS TO ENSURE THAT THEY ARE LABELED, INTACT, AND KEPT CLOSED.
 - H) CORROSIVES WILL BE ISOLATED FROM OTHER MATERIALS.
 - I) PROTECTIVE CLOTHING AND EQUIPMENT WILL BE AVAILABLE FOR USE WHEN HANDLING THESE MATERIALS.

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SECTION: N SAFETY

DATE: 11/97, 7/03

REVIEWED: 3/12, 5/16, 1/21

REVISED: 7/19

TITLE: **N-240 HAZARDOUS MATERIALS**

4) **DISPOSAL:**

- A) DISPOSAL OF SMALL AMOUNTS OF LIQUID CHEMICAL WASTES (60CC OR 2 OZ) MAY BE DISPOSED OF BY DILUTING 1 PART OF THE CHEMICAL WITH 100 PARTS OF WATER AND FLUSHED DOWN THE SEWER SYSTEM. THESE AMOUNTS SHOULD BE DILUTED AND FLUSHED DOWN THE SEWER AT VARYING TIMES DURING THE DAY AND APPROXIMATED ACCORDING TO THE QUALITY OF CHEMICALS NEEDING DILUTION.
- B) IN DILUTING CHEMICALS FOR FLUSHING DOWN THE SEWER SYSTEM, ALWAYS ADD THE 1 PART CHEMICAL TO THE 100 PARTS WATER. NEVER ADD WATER TO THE CHEMICAL AS THIS CAN CAUSE THE CHEMICAL TO SPLASH OUT OF THE CONTAINER.
- C) WEAR RUBBER GLOVES, A MASK, AND/OR SAFETY EQUIPMENT AS REQUIRED WHEN PREPARING LIQUID CHEMICALS FOR DISPOSAL.
- D) NO EMPTY DRUMS OR BUCKETS, OR ANY OTHER CONTAINERS THAT HAVE HELD TOXIC OR CORROSIVE CHEMICALS WILL EVER BE REUSED FOR ANYTHING. THESE CONTAINERS WILL BE DISPOSED OF AS FOLLOWS:
 - 1) WHILE WEARING PROTECTIVE GARB, WASH THE CONTAINER WITH HOT WATER AND SODA ASH OR A 5% CAUSTIC SOLUTION.
 - 2) FLUSH THE CONTAINER AND WASH TWICE MORE.
 - 3) PERFORATE TOP SIDES, AND BOTTOM OF THE CONTAINER TO PREVENT ITS BEING USED.
- E) THE ADMINISTRATOR OF THE CENTER IS RESPONSIBLE FOR ENSURING THAT PROPER PERMITS ARE OBTAINED FOR DISPOSAL OF ALL HAZARDOUS CHEMICAL WASTES GENERATED AT THE FACILITY.
- F) A CERTIFICATE OF DISPOSAL WILL BE OBTAINED FROM THE RECEIVER FOR ALL HAZARDOUS CHEMICALS DISPOSED OF OFF-SITE.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

SECTION: N SAFETY

DATE: 11/97, 7/03
REVIEWED: 3/12, 5/16, 1/21
REVISED: 7/19

TITLE: N-240 HAZARDOUS MATERIALS

WILDCREEK SURGERY CENTER WILL MAINTAIN AN UP-TO-DATE PROGRAM FOR THE PURPOSE OF COMMUNICATING TO EMPLOYEES ON HAZARDOUS CHEMICALS IN THE WORKPLACE.

RECORD KEEPING:

- 1) SAFETY DATA SHEETS:
THESE WILL BE KEPT UP TO DATE WITH ALL CURRENT AND ANY NEW CHEMICALS IN THE CENTER.
- 2) EMPLOYEE SIGN OFF SHEETS:
WHEN EMPLOYEES ATTEND THE HAZARDOUS COMMUNICATIONS PROGRAM AS PART OF THEIR ORIENTATION, THEY WILL SIGN AND DATE A FORM ACKNOWLEDGING THIS.
- 3) RESPONSIBILITIES:
THE CENTER'S NURSING MANAGER WILL BE RESPONSIBLE FOR ASSURING THAT ALL EMPLOYEES RECEIVE THE HAZARDOUS MATERIAL INFORMATION. THE OSHA PROGRAM COORDINATOR WILL OVERSEE AND MANAGE THE PROGRAM.

THE NURSING MANAGER OF WILDCREEK SURGERY CENTER WILL BE RESPONSIBLE FOR ALL HAZARDS, RECALLS, AND ALERTS. THIS PERSON WILL COLLECT AND REVIEW ALL DATA CONCERNING DEFECTIVE EQUIPMENT, PRODUCTS AND SUPPLIES WHICH MAY AFFECT THE GENERAL SAFETY OR PRESENT A RISK TO PATIENT CARE, VISITORS, OR CENTER STAFF.

PROCEDURE: 1) THE NURSE MANAGER WILL:

- A) REVIEW ALL DATA COLLECTED FROM ALL SOURCES CONCERNING RECALLS OR ALERTS OF DEFECTIVE OR HAZARDOUS EQUIPMENT, PRODUCTS, OR SUPPLIES.
 - B) INFORM THE CENTER'S ADMINISTRATOR AND MEDICAL DIRECTOR.
 - C) DISSEMINATE HAZARDOUS RECALL OR ALERT INFORMATION TO APPROPRIATE MEMBERS INVOLVED IN THE UTILIZATION OF THE POTENTIAL HAZARDOUS PRODUCTS, OR SUPPLIES.
- STAFF
EQUIPMENT,

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

SECTION: N SAFETY

DATE: 11/97, 7/03

REVIEWED: 3/12, 5/16, 1/21

REVISED: 7/19

TITLE: **N-240 HAZARDOUS MATERIALS**

- AND
- POTENTIAL
- PROTECTION OF
- D) COLLECT, COORDINATE, AND EVALUATE INFORMATION RETURNED FROM THE INVOLVED AREAS TO ASSURE ANY ACTION REQUIRED HAS BEEN ADDRESSED HANDLED TO MINIMIZE RISK ASSOCIATED WITH THE ITEM IN QUESTION.
 - E) MONITOR ALL OUTSTANDING RECALLS TO ASSURE THAT ALL ISSUES OR PRODUCT LIABILITIES HAVE BEEN RESOLVED TO COMPLETION.
 - F) MAINTAIN SUPPORTING DOCUMENTATION WITHIN THE CENTER.
 - G) REPORT RESULTS INCLUDING ANY ACTIONS TAKEN TO THE QAPI COMMITTEE.
 - H) TAKE IMMEDIATE ACTION AS NECESSARY TO PROVIDE THE PROPER ALL PATIENTS, VISITORS, AND STAFF MEMBERS.
 - I) CALL IN OTHER PERSONNEL TO ASSIST IN FINDING RESOLUTIONS TO IDENTIFIED ISSUES AS NECESSARY.

WILDCREEK SURGERY CENTER WILL COMPLY WITH ALL LOCAL, STATE, AND FEDERAL LAWS, RULES, AND REGULATIONS GOVERNING THE HANDLING AND DISPOSAL OF CONTAMINATED MEDICAL WASTE. THE CENTER WILL PROTECT ALL EMPLOYEES, VISITORS, AND STAFF MEMBERS FROM POSSIBLE EXPOSURE TO INFECTIOUS DISEASES THROUGH A WASTE MANAGEMENT PROGRAM.

IN ADDITION, THE CENTER WILL PROTECT THE PUBLIC AND THE ENVIRONMENT IN GENERAL BY CONTAINING ALL CONTAMINATED WASTES PRIOR TO THEIR DISPOSAL SO AS NOT TO CAUSE INFECTIOUS DISEASE TO BE SPREAD. THESE CONTAMINATED WASTES WILL BE CONTAINED AND DISPOSED OF IN A SAFE AND APPROVED MANNER.

PROCEDURE:

DEFINITION-INFECTIOUS MEDICAL WASTE:

BIOHAZARDOUS WASTE IS ANY SOLID OR LIQUID WASTE WHICH MAY PRESENT A THREAT OF INFECTION TO HUMANS. THE REQUIREMENTS FOR INDUCTION OF DISEASE IS THE PRESENCE OF A PATHOGEN WITH SUFFICIENT VIRULENCE AND IN A QUANTITY SUBSTANTIAL ENOUGH SO THAT EXPOSURE TO THE WASTE BY A SUSCEPTIBLE HOST OR ORGANISM COULD RESULT IN AN INFECTIOUS DISEASE.

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SECTION: N SAFETY

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REVISED: 7/19

TITLE: **N-240 HAZARDOUS MATERIALS**

IDENTIFICATION OF MEDICAL WASTE:

- ISOLATION WASTE FROM PATIENTS WITH INFECTIOUS DISEASE
- CULTURES AND STOCKS OF INFECTIOUS AGENTS AND ASSOCIATED BIOLOGICALS
- HUMAN BLOOD AND BLOOD PRODUCTS; USED, ABSORBENT MATERIALS SUCH AS BANDAGES, SPONGES, AND GAUZE SUPERSATURATED WITH BLOOD OR BODY FLUIDS HAVING THE POTENTIAL TO DRIP OR SPLASH
- PATHOLOGICAL WASTE; TISSUES, ORGANS, OR BODY PARTS
- CONTAMINATED SHARPS; HYPODERMIC NEEDLES, SYRINGES, PIPETTES, BROKEN GLASS, SCALPEL BLADES, SUTURING NEEDLES, TROCHARS, ETC.

MEDICAL WASTE MANAGEMENT:

- 1) THE NURSE MANAGER WILL BE RESPONSIBLE FOR THE DEVELOPMENT AND MAINTENANCE OF A MEDICAL WASTE MANAGEMENT PROGRAM.
- 2) THE WASTE MANAGEMENT PROGRAM WILL INCLUDE:
 - A) EMPLOYEE TRAINING IN MEDICAL WASTE HANDLING
 - B) MONITORING OF PROPER PACKAGING AND LABELING
 - C) FOLLOW-THROUGH ON TRACKING PROCEDURES
 - D) CONTINGENCY/EMERGENCY PLAN
- 3) ALL POTENTIALLY INFECTIOUS MEDICAL WASTE WILL BE SEPARATED FROM GENERAL FACILITY GARBAGE AT ITS POINT OF ORIGIN.
- 4) ALL POTENTIALLY INFECTIOUS MEDICAL WASTE WILL BE PLACED IN BOXES LABELED "BIOHAZARD WASTE" THAT CONSPICUOUSLY DISPLAYED THE BIOHAZARD SYMBOL. THESE BOXES WILL BE LINED WITH TWO (2) RED PLASTIC BAGS THAT ARE IMPERVIOUS, AND TEAR RESISTANT.
- 5) EACH HAZARDOUS WASTE BOX WILL NOT EXCEED A FIFTY (50) POUND MAXIMUM WEIGHT LIMIT.

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SECTION: N SAFETY

DATE: 11/97, 7/03

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REVIEWED: 3/12, 5/16

REVISED: 7/19

TITLE: N-240 HAZARDOUS MATERIALS

- 6) ALL FLUIDS PLACED IN THE HAZARDOUS WASTE BOX WILL BE CONTAINED; CAPS WILL BE PLACED SECURELY ON ALL PORTS OF SUCTION CONTAINERS. BULK BLOOD, SUCTIONED FLUIDS, EXCRETIONS, AND SECRETIONS MAY BE CAREFULLY POURED DOWN A DRAIN CONNECTED TO SANITARY SEWER.
- 7) ALL SHARPS WILL FIRST BE PLACED IN A PUNCTURE PROOF SHARPS CONTAINER. WHEN FILLED THE SHARPS CONTAINER WILL BE SECURELY CLOSED AND DISPOSED OF IN THE HAZARDOUS WASTE BOX.
- 8) FILLED HAZARDOUS WASTE BOXES WILL BE SECURED BY FOLDING THE INNER RED BAG OVER THE CONTENTS, THEN TWISTING THE OUTER RED BAG, CLOSED AND SECURED WITH A TIE. THE LID MUST BE ABLE TO FIT SNUGLY ON TO THE BOX; BOXES WILL NOT BE OVERFILLED.
- 9) A SECURED BIO-HAZARDOUS WASTE BOX WILL BE KEPT IN LOCKED STORAGE IN THE SOILED WORK AREA UNTIL PICKED UP. THIS AREA HAS BEEN DESIGNATED FOR CONTAMINATED WASTE CONTAINERS AND HAS RESTRICTED ACCESS BY UNAUTHORIZED PERSONS.
- 10) PICK-UP WILL BE ARRANGED ON A AS NEEDED BASIS, OFTEN ENOUGH TO PREVENT INFESTATION.
- 11) IN THE EVENT OF LEAKAGE OR ACCIDENTAL SPILL OF A HAZARDOUS WASTE BOX, PROTECTIVE ATTIRE WILL BE WORN, AND THE CONTENTS WILL BE PLACED IN AN INTACT HAZARDOUS WASTE BOX. SPILLS WILL BE CLEANED UP USING A GERMICIDAL AGENT AND DISPOSABLE TOWELS. ALL MATERIALS USED IN CLEANING THE SPILL WILL THEN BE DISPOSED OF IN A HAZARDOUS WASTE BOX; SATURATED OR DRIPPING MATERIALS WILL FIRST BE PLACED IN A PLASTIC BAG.
- 12) TRANSPORTATION OF THE FILLED HAZARDOUS WASTE BOXES OFF THE PREMISES WILL BE BY ENCLOSED, LEAK PROOF TRUCKS.
- 13) DOCUMENTATION OF PICK-UP WILL BE MAINTAINED BY THE CENTER; DOCUMENTATION OF APPROPRIATE DISPOSAL WILL BE MAINTAINED BY THE RECEIVING SERVICE AS WELL AS TRACKING OF CENTER VOLUME.
- 14) WASTE MANAGEMENT IS A STATE APPROVED BIO-HAZARDOUS WASTE DISPOSAL SERVICE, AND WILL BE UTILIZED FOR THE COLLECTION OF WILDCREEK SURGERY CENTER'S BIO-HAZARDOUS WASTE.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

SECTION: N SAFETY

DATE: 11/97, 7/03

REVIEWED: 3/12/ 5/16, 1/21

REVISED: 7/19

TITLE: N-240 HAZARDOUS MATERIALS

15) POLICIES AND PROCEDURES RELATING TO THE OPERATION OF THE HAZARDOUS MATERIALS AND WASTE MANAGEMENT SYSTEM WILL BE REVIEWED ANNUALLY.

16) THE QUALITY ASSURANCE/RISK MANAGEMENT COMMITTEE WILL BE RESPONSIBLE FOR TRACKING THE MANAGEMENT OF HAZARDOUS WASTE, SECURING REGULATIONS, AND MAINTAINING COMMUNICATION FOR OPERATION WITH WASTE MANAGEMENT.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

SECTION: N SAFETY

DATE: 11/97, 7/03, 1/21

REVIEWED: 3/12, 5/16

TITLE: N-250 EMERGENCY GENERATOR

POLICY: WILDCREEK SURGERY CENTER WILL MAINTAIN AN EMERGENCY GENERATOR TO PROVIDE CONSISTENT ELECTRICAL POWER TO ALL NECESSARY EQUIPMENT IN THE EVENT OF AN ELECTRICAL POWER FAILURE. THE EMERGENCY GENERATOR IS LOCATED OUTSIDE THE BUILDING IN THE NORTHWEST CORNER OF THE CENTER. THE CENTER WILL MAINTAIN A SERVICE CONTRACT FOR MAINTENANCE AND REPAIR WITH A LOCAL OUTSIDE AGENCY. THE CENTER WILL DO WEEKLY GENERATOR CHECKS AND A MONTHLY 30 MINUTE LOADED RUN WHICH WILL BE DOCUMENTED IN THE GENERATOR LOGBOOK.

PROCEDURE:

- 1) THE GENERATOR LOGBOOK WILL BE KEPT IN THE NURSE MANAGER'S OFFICE.
- 2) THE ADMINISTRATOR WILL MONITOR TESTING OF THE EMERGENCY GENERATOR, MAINTAIN THE LOG, AND ASSURE PERIODIC TESTING IS DONE BY OUTSIDE CONTRACTOR PER SERVICE AGREEMENT.
- 3) FUEL FOR THE GENERATOR IS NATURAL GAS THEREFORE WILL RUN THROUGH OUT THE POWER OUTAGE.
- 4) PROBLEMS ENCOUNTERED, MAINTENANCE OR REPAIRS NEEDED, OR OTHER AREAS OF CONCERN NOTED WILL BE REPORTED TO, AND TAKEN CARE OF BY THE CENTER'S ADMINISTRATOR, BUSINESS OFFICE OR NURSE MANAGER.
- 5) MAINTENANCE AND REPAIRS WILL BE SCHEDULED AND CONDUCTED ON A TIMELY BASIS.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

SECTION: N SAFETY

DATE: 11/97, 7/03, 5/16

REVIEWED: 3/12, 1/21

TITLE: N-260 WHEELCHAIR AND STRETCHER SAFETY

POLICY: WILDCREEK SURGERY CENTER WILL ENSURE THAT SAFETY IS A PRIORITY IN THE CARE OF PATIENTS BEING TRANSPORTED BY WHEELCHAIR OR STRETCHER THROUGHOUT OUR FACILITY

PROCEDURE: WHEELCHAIR SAFETY:

1. URINARY DRAINAGE BAGS SHALL BE HUNG TO FACILITATE GRAVITY FLOW AND TO AVOID ENTANGLEMENT IN THE WHEELS OF THE CHAIR.
2. PATIENTS WITH IV'S, OXYGEN THERAPY, TUBES, EQUIPMENT, ETC., SHALL BE ASSESSED BY THE NURSING PERSONNEL BEFORE TRANSPORT.
3. UPON TRANSFER OF PATIENTS INTO AND OUT OF A WHEELCHAIR, THE WHEELS WILL BE LOCKED.
4. WHEN A PATIENT IS STATIONARY IN A WHEELCHAIR, THE WHEELS WILL BE LOCKED.
5. WHEN A WHEELCHAIR, OR ANY PART OF IT IS FOUND TO BE WORN OR DEFECTIVE, THE DEPARTMENT MANAGER WILL BE NOTIFIED AND THE WHEELCHAIR WILL BE TAKEN OUT OF SERVICE AND REPAIRED.
6. WHEELCHAIRS SHALL BE PULLED RATHER THAN PUSHED OVER DOORWAY ELEVATION CHANGES AND EXTREMITIES SHALL BE POSITIONED TO PREVENT INJURY UPON TRANSPORT.

PROCEDURE: STRETCHER SAFETY

1. UPON TRANSFER FROM THE OPERATING ROOM TABLE TO THE STRETCHER, OR OPPOSITE, THE LEVEL SHALL BE EQUAL.
2. THE WHEELS OF THE STRETCHER AND OPERATING ROOM TABLE SHALL BE LOCKED BEFORE TRANSFER
3. ALL IV BAGS AND TUBING, OXYGEN TUBING, DRAINAGE TUBING, DEVICES, ETC., ATTACHED TO THE PATIENT SHALL BE ARRANGED AND SECURED BEFORE TRANSPORT.
4. TRANSPORT PATIENTS FEET FIRST ON STRETCHERS WITH THE SIDE RAILS UP.
5. IN THE EVENT THAT ONLY ONE PERSON IS PERFORMING THE TRANSPORT OF A STRETCHER THAT PERSON SHALL BE AT THE HEAD OF THE STRETCHER.
5. PROTECT PATIENTS EXTREMITIES UPON TRANSPORTING THROUGH DOORWAYS.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

SECTION: N SAFETY

DATE: 11/97, 7/03, 5/16, 1/21
REVIEWED: 3/12

TITLE: N-270 LIFTING AND MOVING SAFETY

POLICY: WILDCREEK SURGERY CENTER WILL ENSURE THE MAINTENANCE OF EMPLOYEE AND PATIENT SAFETY AS PRIORITIES IN THE WORKPLACE.

PROCEDURE: THE CENTERS WORK ENVIRONMENT CONTAINS TASKS THAT REQUIRE HEAVY LIFTING AND MOVING OF PATIENTS, EQUIPMENT, AND SUPPLIES. BACK INJURY AND HERNIAS ARE THE MOST COMMON RESULTS OF IMPROPER BODY MECHANICS AND LIFTING TECHNIQUES. ALL EMPLOYEES WILL BE RESPONSIBLE FOR KNOWING AND UTILIZING PROPER BODY MECHANICS TO PREVENT AND AVOID SUCH INJURIES.

LIFTING AND MOVING GUIDELINES:

1. UTILIZE MECHANICAL DEVICES FOR LIFTING PATIENTS OR HEAVY OBJECTS WHEN APPROPRIATE
2. UTILIZE APPROPRIATE CARTS FOR TRANSPORTING HEAVY OBJECTS
3. ENLIST THE HELP OF A CO-WORKER WHEN LIFTING HEAVY OBJECTS OR PATIENTS
4. CARRY THE LOAD IN A MANNER THAT PERMITS YOU TO SEE WHERE YOU ARE GOING
5. CARRY THE LOAD THE SHORTEST POSSIBLE DISTANCE
6. KEEP THE BACK STRAIGHT
7. THE LOAD SHALL BE BALANCED AND CARRIED WITH A FULL PALM GRIP
8. THE LOAD SHALL BE CARRIED CLOSE TO THE BODY
9. DO NOT ATTEMPT TO CARRY A LOAD THAT IS TOO HEAVY OR BULKY
10. UTILIZE LEG AND ARM MUSCLES TO DO THE LIFTING, NOT YOUR BACK
11. MAINTAIN A WIDE LEG STANCE WHEN LIFTING

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

SECTION: N SAFETY

DATE: 04/10

REVIEWED: 3/12, 5/16

TITLE: **N-280 FIRE WATCH**

PURPOSE: To establish a plan of action should the fire alarm system **or** sprinkler system be out of service for more than 4 hours in a 24-hour period. (Procedures must address both the fire alarm and sprinkler systems.)

ACCESS: Available in writing at staff stations and comprehended by training of all facility staff.

STAFF: Facility staff trained in Rescue, Alarm, Contain, and Extinguish/ Evacuate (RACE) and the implementation of a facility-wide fire watch.

DOCUMENTATION: Each tour is recorded with findings noting date time, and staff initials. A fire watch tour is a periodic walking tour of the entire facility by one or more assigned and trained staff. This **MUST BE** staffs **ONLY** responsibility during the Fire Watch. The tour monitors the facility through direct observation of all rooms for possible signs of fire.

OCCURANCES: Fire alarm system outages or sprinkler system outages can occur during construction, maintenance, renovation, electrical storms or other unplanned events which eliminate part or all of the fire alarm system. Sprinkler systems may also be made inoperable by a variety of planned and unplanned events.

PROCEDURE:

1. Contact the facility administrator, nurse director and business office manager when any problems are encountered with the fire alarm system or sprinkler system.

(Action: staff)

2. Contact the fire alarm or sprinkler contractor at (775) 823-7300 should maintenance be unable to correct the problem.

(Action: nurse director or business manager).

3. Contact the facility alarm company at (888) 289-2647 should maintenance be unable to correct the problem.

(Action: nurse director or business manager).

4. Fire alarm or sprinkler contractor shall be on site or on contract until system is repaired, replaced or reinitialized and working.

5. Notify the fire department at (775) 353-2255 that the sprinkler system or fire alarm system is not working correctly.

(Action: administrator/nurse director/ business manager).

6. If the sprinkler or fire alarm system is inoperable for a time period of more than 4 hours in a 24 hour period, notify the Nevada Department of Health District Office. They can be contacted at (775) 688-2811.

(Action: administrator/ nurse director/business manager).

7. Fire watch procedure shall designate facility tours designating floor and building identifier.

(Action: Facility Administrator/ nurse director)

8. Fire watch tours shall occur at ¼ hour intervals, 24 hours a day.

(Action: Facility Administrator/ nurse director)

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

NOTICE

**THE BUILDING FIRE ALARM SYSTEM IS
INOPERATIVE**

FROM _____ TO _____

EVERY EFFORT IS BEING MADE TO COMPLETE THE REPAIRS AS SOON AS POSSIBLE.

IMMEDIATELY CONTACT 775-674-1100 IF YOU DETECT ANY OF THE FOLLOWING:

- ***SEE OR SMELL, OR***
- ***DETECT THE PRESENCE OF FIRE, OR***
- ***SMELL NATURAL GAS, OR***
- ***DETECT THE PRESENCE OF ANY OTHER CONDITION WHICH
ENDANGERS THE LIFE OF BUILDING OCCUPANTS.***

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

FIRE WATCH LOG

[illegible]



Barton Health

2021 Patient Safety Plan

Dawn Evans, MSN, MBA, RN, PHN, CPPS, CPHQ
Director of Patient Safety

Executive Summary

The purpose of the Patient Safety Plan is to set the foundation for patient safety at Barton Health in accordance with state and regulatory requirements. The breadth of Patient Safety is vast and includes event reporting, review, follow up on errors and harm that impact or have the potential to impact patients, hazard mitigation through evidence-based tools, and reporting to internal committees and external agencies. The Patient Safety Plan addresses high reliability processes to correct opportunities for improvement and prevent identified hazards from recurrence. 2020 high priorities are reviewed which included: continued assessment of communication in handoffs/hand overs; decreasing alarms, alerts, and notification overload; evaluation and monitoring of staffing needs; the development of a pediatric strategic plan; the Leapfrog Hospital Survey; reassessing staff perceptions of patient safety through the Hospital Survey on Patient Safety; and expanding the current employee support program after serious events. 2021 high priorities are tubing connections; improvements to patient identification bands; decreasing alarms, alerts, and notification overload; the development of a neonatal strategic plan; continued evaluation and monitoring of staffing needs; a controlled substance FMEA; the Leapfrog Hospital Survey; culture measurement of patient safety through the Hospital Survey on Patient Safety; updating the electronic event reporting and patient relations platforms; and the ongoing evaluation and implementation of best practices around the SARs-CoV-2/COVID-19 pandemic. The Patient Safety Plan grants authority for Patient Safety oversight across the organization to the Chief Medical Officer and the Director of Patient Safety. This plan is revised and updated annually or more often as needed.

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Section A

2021 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 (TJC) 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, providers, and leaders within the organization identify and manage actual and potential risks to patient safety thereby resulting in zero harm. All patients, providers, 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 provider and employee perform a critical role in patient safety and thus, Barton Health's journey to becoming a high reliability organization. All Barton Health team members are focused on providing consistently exceptional care through an environment that supports teamwork, collaboration, and respect for other people, regardless of their position in the organization. Leaders demonstrate their commitment to quality and safety while setting expectations for those who work in the organization. Leadership evaluates the culture of safety on a regular basis.

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

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

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

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

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

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

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

Scope of the Patient Safety Plan

The Joint Commission, CDPH, NRS, Centers for Medicare and Medicaid Services (CMS) and other regulatory agencies provide the defining framework for patient safety events. The Patient Safety Department is informed of safety event information and hazardous conditions from team members, volunteers, and medical staff practitioners across the organization through completion of event reports and verbal or written communication. This information includes actual or potential (near miss/good catch) occurrences involving inpatients, outpatients, volunteers, employees, 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 (2020), 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/ 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 (TJC, 2020).
- **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 (TJC, 2020).
- **Never Event/Serious Reportable Event (SRE):** An event or situation that should never occur in a healthcare facility. When Never Events occur, actions are taken to ensure compliance with the Never Event Policy which includes key steps be completed such as disclosure, apologizing, analysis, and reporting.
- **Sentinel Event:** A patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in death, permanent harm, or severe temporary harm (Refer to *Sentinel Event* section below) and is reported to The Joint Commission. For Lake Tahoe Surgery Center, located in Nevada, a sentinel event is defined in NRS 439.830 by the National Quality Forum. (Refer to Appendix A).
- **Healthcare Associated Infection (HAI):** A localized or systemic condition resulting from an adverse reaction to the presence of an infectious agent(s) or its toxin(s) as defined by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN) in addition to monthly submission of all surgical site infections associated with different procedures performed at Barton Health. Potential HAIs are reviewed by the HAI Review Committee. Confirmed HAIs are reported to the Patient Safety Committee. HAIs are also reported to the Infection Control and Prevention Committee and Board Quality Committee.

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

Event Reporting

Identification and reporting of adverse events, including those that result from practitioner error are critical to Barton Health's efforts to continuously improve patient safety and reduce harm. To support and encourage this culture of safety, reporting of patient safety events or near misses is highly encouraged. Reporting of events is the responsibility of all employees, volunteers, providers, patients, visitors, and guests. Events can be reported through many modalities including electronic, verbal, and

written communication. Electronic event reporting is available on all Barton Health System computer terminals. An event is reported via the electronic safety learning system/event reporting system by the individual(s) involved with and most knowledgeable about the event. (Refer to Barton Health Organizational Event Reporting Policy.)

Events are reviewed daily. 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 (2020) 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

- Administration of blood or blood products having unintended ABO and non-ABO (Rh, Duffy, Kell, Lewis, and other clinically important blood groups) incompatibilities, hemolytic transfusion reactions, or transfusions resulting in severe temporary harm, permanent harm, or death.
- 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
- Surgery or other invasive procedure performed at the wrong site, on the wrong patient, or that is the wrong (unintended) procedure for a patient. Invasive procedure is defined as a procedure in which skin or mucous membranes and/or connective tissue are incised or punctured, an instrument is introduced through a natural body orifice, or insertion of foreign material into the body for diagnostic or treatment-related purposes. Examples of invasive procedures include central line and chest tube insertion, biopsies and excisions, and all percutaneous procedures (e.g., electrophysiology, interventional radiology). Exclusions include venipuncture, which is defined as a collection of blood from a vein. These exclusions are still considered patient safety events and should be reviewed by the appropriate teams.
- 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 direct patient care caused by equipment operated and used by the hospital. To be considered a sentinel event, equipment must be in use at the time of the event; staff do not need to be present.
- 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.

The above list is consistent across all Joint Commission accreditation programs, though some of these events may be unlikely to occur in certain settings.

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

Adverse Event

Barton Health shall report an adverse event as defined within Health and Safety Code §1279.1 (below)

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

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

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

14. Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy, including events that occur within 42 days post-delivery and excluding deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy, or cardiomyopathy.
15. Patient death or serious disability directly related to hypoglycemia, the onset of which occurs while the patient is being cared for in a health facility.
16. Death or serious disability, including kernicterus, associated with failure to identify and treat hyperbilirubinemia in neonates during the first 28 days of life. "Hyperbilirubinemia" means bilirubin levels greater than 30 milligrams per deciliter.
17. A Stage 3 or 4 ulcer, acquired after admission, excluding progression from Stage 2 to Stage 3 if Stage 2 was recognized upon admission.
18. A patient death or serious disability due to spinal manipulative therapy performed at the health facility.
19. A patient death or serious disability associated with an electric shock while being cared for in a health facility, excluding events involving planned treatments, such as electric countershock.
20. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by a toxic substance.
21. A patient death or serious disability associated with a burn incurred from any source while being cared for in a health facility.
22. A patient death associated with a fall while being cared for in a health facility.
23. A patient death or serious disability associated with the use of restraints or bedrails while being cared for in a health facility.
24. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider.
25. The abduction of a patient of any age.
26. The sexual assault on a patient within or on the grounds of the facility.
27. The death or significant injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds of a facility.
28. An adverse event or series of adverse events that cause the death or serious disability of a patient, personnel, or visitor.

Never Events/Serious Reportable Events

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

1. Surgical or Invasive Procedure Events
 - 1A. Surgery or other invasive procedure performed on the wrong site.
 - 1B. Surgery or other invasive procedure performed on the wrong patient.
 - 1C. Wrong surgical or other invasive procedure performed on a patient.
 - 1D. Unintended retention of a foreign object in a patient after surgery or other invasive procedure.
 - 1E. Intraoperative or immediately postoperative/postprocedure death in an ASA Class 1 patient.
2. Product or Device Events
 - 2A. Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting.
 - 2B. Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended.
 - 2C. Patient death or serious injury associated with intravascular air embolism that occurs while being

cared for in a healthcare setting.

3. Patient Protection Events

3A. Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person.

3B. Patient death or serious injury associated with patient elopement (disappearance).

3C. Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting.

4. Care Management Events

4A. Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration).

4B. Patient death or serious injury associated with unsafe administration of blood products.

4C. Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting.

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

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

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

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

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

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

5. Environmental Events

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

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

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

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

6. Radiologic Events

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

7. Potential Criminal Events

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

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

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

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

Provider-Preventable Conditions

Federal law requires Provider-Preventable Conditions (PPCs) that occur during treatment of Medi-Cal and Medicaid patients be reported. These include both healthcare-acquired conditions (HCAC) and other provider-preventable conditions (OPPC). California HCACs and OPPCs are reported to the

Department of Health Care Services after discovery and confirmation that the patient is a Medi-Cal beneficiary. Nevada HCACs are reported through the Nevada sentinel event registry.

HCACs are defined as:

- Air embolism
- Blood incompatibility
- Catheter-associated urinary tract infection (UTI)
- Falls and trauma that result in fractures, dislocations, intracranial injuries, crushing injuries, burns and electric shock
- Foreign object retained after surgery
- Iatrogenic pneumothorax with venous catheterization
- Manifestations of poor glycemic control
 - Diabetic ketoacidosis
 - Nonketotic hyperosmolar coma
 - Hypoglycemic coma
 - Secondary diabetes with ketoacidosis
 - Secondary diabetes with hyperosmolarity
- Stage III and IV pressure ulcers
- Surgical site infection following:
 - Mediastinitis following coronary artery bypass graft (CABG)
 - Bariatric surgery, including laparoscopic gastric bypass, gastroenterostomy and laparoscopic gastric restrictive surgery
 - Orthopedic procedures for spine, neck, shoulder, and elbow
 - Cardiac implantable electronic device (CIED) procedures
- Vascular catheter-associated infection
- Deep vein thrombosis (DVT)/ pulmonary embolism (PE) excluding pregnant women and children under 21 years of age

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

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

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

Patient Safety Organization Reporting

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

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

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

Sentinel Events shall be subject to an immediate in-depth RCA.

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

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

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

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

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

Disclosure

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

Patient Safety Committee

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

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

The Patient Safety Committee shall review and discuss serious patient events, reportable adverse event and sentinel events, HAIs, mortality rates, Sentinel Event Alerts, and systems issues identified by peer review processes. Adverse/sentinel patient events include unanticipated events that affect patient care or patient safety and encompass all service lines of care.

The Committee promotes the application of evidence-based methods in the resolution of patient safety events and reviews RCA, CCA, and PI workgroup recommendations which ultimately minimize the recurrence of comparable patient events or near misses. Recommendations can be revised, added, or deleted through this committee.

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

Department Directors, Managers or designees are active participants who complete assigned action items within an appropriate timeframe designated by the work group, Director of Patient Safety, Patient Safety Team, Chief Medical Officer, or Patient Safety Committee. Directors/Managers 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/Managers are responsible to ensure continued compliance exists with their direct reports and implemented process changes are sustained.

Events and PIs shall be closed through the Patient Safety Committee when all assigned action items have been completed, any associated audits exhibit compliance, and all remaining concerns are addressed.

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

Patient Safety Risk Reduction

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

National Patient Safety Goals

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

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

Sentinel Event Alerts

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

Culture of Safety Surveys

Annually, Barton Health will offer valid and reliable surveys on patient safety to assess the culture of safety within the organization.

Scientific Model Integration

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

- James T. Reason's Swiss Cheese Model of Accident Causation
- Shewhart cycle or Model for Improvement (Plan, Do, Study, Act –PDSA)
- Failure Mode and Effects Analysis (FMEA) or Failure Mode, Effects and Criticality Analysis (FMECA)
- Re-engineering (Human factor re-engineering such as signage for High Alert Medications, Pop up alert in Pyxis medication dispensing system, Tall man lettering for look-alike sound alike drugs in medication usage process, etc.)
- Rapid Cycle Improvement (IHI Collaborative approach termed the 'Breakthrough Series', to bring about rapid cycle improvements. Fundamental to the collaborative approach is the acceptance of a model and establishment of infrastructure through which collaborating organizations can identify and prioritize aims for improvement and gain access to the methods, tools, materials etc.)
- 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 providers is offered through various teaching strategies including, but not limited to, newsletters, 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 high reliability team training such as TeamSTEPPS by the American Hospital Association to foster an interdisciplinary, collaborative approach to the delivery of patient care and reinforces the need and mechanisms to report patient safety concerns.

Patient Safety Evaluation

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

Patient Safety Plan Approval, Revision, and Review

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

Authority

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

Approval

This plan was approved by the following committees:

Patient Safety Committee on 12/11/2020

Board Quality Committee on 1/7/2021

Section B:

2020 Patient Safety Priority Evaluation

Barton Health's 2020 Patient Safety priorities were redirected due to the SARs-CoV-2/COVID-19 pandemic. As such, 2020 was focused on ensuring a safe environment for all staff, providers, and patients during the SARs-CoV-2/COVID-19 pandemic. Incident Command and teams across the organization prioritized and successfully implemented plans around preparations for and addressing the virus within the organization and community. Plans were constantly revised based on ever changing best practices, regulatory requirements, and scientific data to ensure compliance, a safe environment for teams to work in, and the utilization of best practices around patient care.

Measures to prevent adverse events associated with misconnecting intravenous, enteral feeding, and epidural lines remained a priority in 2020. A conversion to the new ISO standard enteral feeding lines occurred in 2015. Manufacturers continued to distribute tubing that could be mistakenly interconnected. Reengineering, approval by the ISO and FDA, and distribution throughout the healthcare industry was greatly impacted by the pandemic, Barton Health took a proactive approach to address prevention of adverse events associated with misconnecting IV, enteral, and epidural lines., Neuraxial (NRFit®) connector transition with redesigned incompatible connectors will occur as the product line becomes available to ensure compliance with California state law.

The communication FMEA concluded which ensured best practices were implemented in accordance with The Joint Commission's Sentinel Event Alert 58. The FMEA produced an average risk priority number (RPN) reduction of 52% with a range of 16-83% across participating departments. Examples of employed strategies included electronic medical record modifications, the use of whiteboards, tool standardization, and staff education. A new FMEA evaluating controlled substance processes will commence early 2021.

The burden from alarms, alerts, and notifications from medical and communication devices as well as health information technology systems can lead to staff fatigue and increases the potential for an immediate response to a clinically significant event to be delayed or go unaddressed. While 2020 required focus on the SARs-CoV-2/COVID-19 pandemic, Barton Health remained committed to evaluating new patient care devices brought into the hospital for alarm burden. Alarm fatigue will remain a high priority for Barton Health in 2021.

In accordance with SB 227, which amends section 1279 of the California Health and Safety Code and went into effect on January 1, 2020, Barton Health monitored for appropriate staffing levels to ensure all patient care needs were met in 2020. This included staffing levels and competencies for all patient populations that presented to Barton Health.

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

The Leapfrog Hospital Survey was evaluated in 2020. Given the SARs-CoV-2/COVID-19 pandemic, Leapfrog modified survey criteria. Survey responses were solicited from key stakeholders. The survey was submitted in December 2020.

The AHRQ Hospital Survey on Patient Safety Culture version 2.0 provides information related to several domains that impact patient safety as well as measuring conditions that can lead to adverse events and patient harm. Barton Health administered this updated survey in conjunction with Patient Safety Week

in March with the intent of measuring any change within the acute care setting since Just Culture training was completed. Findings were comparable with national statistics and showed a 5% improvement in the “Response to Error” questions, a reflection of the Just Culture program implemented in 2019. Analyses of the results were shared with the Executive Team, leadership, and staff from all departments that participated in the survey.

Finally, in 2020 Barton Health began the development of a new comprehensive staff support program focused on enhancing peer intervention for second victims. The employee assistance program (EAP) was moved to a new vendor that offers EAP twenty-four hours a day. Critical Incident Stress Management (CISM) debriefs remained in use. A contract to participate in the Northern Nevada Peer Support Network (NNPSN), a local peer intervention program, was signed in the third quarter with plans to become more involved in 2021.

Section C:

2021 Patient Safety Priorities

The Patient Safety Plan identifies and defines goals and specific objectives to be accomplished each year. In 2021, Barton Health's high priorities for Patient Safety include tubing connections; improvements to patient identification bands; decreasing alarms, alerts, and notification overload; the development of a neonatal strategic plan; continued evaluation and monitoring of staffing needs; a controlled substance FMEA; the Leapfrog Hospital Survey; culture measurement of patient safety through the Hospital Survey on Patient Safety; updating the electronic event reporting and patient relations platforms; and the ongoing evaluation and implementation of best practices around the SARs-CoV-2/COVID-19 pandemic.

Measures to prevent adverse events associated with misconnecting intravenous, enteral feeding, and epidural lines will remain a priority in 2021. A complete conversion to the new ISO standard enteral feeding lines occurred in 2015. Manufacturers continue to distribute tubing that can be mistakenly interconnected. However, until connectors are reengineered, approved by the ISO and the FDA, and distributed throughout the healthcare industry, there remains the possibility of human error that can lead to patient harm. Barton Health proactively addresses prevention of adverse events associated with misconnecting IV, enteral, and epidural lines through product purchasing and assessment of availability of connectors throughout the organization as well as staff education and awareness. As described in the 2020 priority evaluation, neuraxial (NRFit®) connectors with redesigned incompatible connectors will be transitioned when the product line becomes available to ensure compliance with California state law.

Patient identification is an NPSG and must be performed prior to any patient interaction across Barton Health. In 2021, a new patient identification band process for those patients and residents who are required to have a wristband placed will be implemented. This revision will integrate patient identifiers with the color-coded wristband process. Further, the updated system will incorporate a standardized pediatric weight-based color-coded system on the bands for quick and easy weight reference by team members.

Alarms, alerts, and notification overload area threats to patient safety. The burden from alarms, alerts, and notifications from medical and communication devices as well as health information technology systems combined can lead to staff fatigue and increases the potential for an immediate response to a clinically significant event to be delayed or go unaddressed. In concert with this concern, NPSG.06.01.01 focusing on clinical alarm system safety will remain a high priority for Barton Health.

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

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

A new FMEA will evaluate and address controlled substances. The overall goal will be to enhance the processes around administering and documenting controlled substances. Upon closure of this FMEA, a new FMEA or FMECA will commence with topic selection based upon collaborative interprofessional discussion.

The Leapfrog Hospital Survey, focused on ensuring safe patient care is provided, will be completed in 2021. Assessment, analysis, and submission recommendations for each of the survey's sections will be completed with key stakeholder involvement.

The AHRQ Hospital Survey on Patient Safety Culture version 2.0 provides information related to several domains that impact patient safety as well as measuring conditions that can lead to adverse events and patient harm. Barton Health will administer this culture measurement tool in 2021. Based on the findings, action plans may focus on enhancing staff awareness about patient safety, identifying strengths and opportunities for improvement, evaluating trends in culture changes, and assessing the impact of patient safety initiatives and interventions.

The electronic patient relations and incident reporting systems will be upgraded in 2021. Both platforms are outdated, do not meet current best practices, and do not allow for utilization of the system's dynamic data dashboard. The goals of the redesign of both platforms are to enhance usability for end-users, increase event reporting, and improve data utilization. The incident reporting system will ensure compliance with AHRQ's Common Formats and the World Health Organization's (WHO) Minimal Information Model for Patient Safety (WHO, 2016).

Finally, Barton Health will continue to proactively address concerns related to the SARs-CoV-2/COVID-19 pandemic in 2021. Barton Health will ensure a safe environment for staff, providers, and patients by continually evaluating and following SARs-CoV-2/COVID-19 guidelines in accordance with all federal, state, and county recommendations.

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Appendix A:

***2021 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, or challenges and revise the program to better serve the patients and their families. To this end, Lake Tahoe Surgery Center has developed this Patient Safety plan.

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

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

Roles and Responsibilities

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

The Patient Safety Committee reporting hierarchy:

**Roles and Responsibilities**

- In accordance with [NRS 439.875](#), a patient safety committee must be comprised of:
- The Patient Safety Officer of the medical facility. At Barton Health, the Director of Patient Safety has oversight of the Patient Safety Officer and serves in this role;
- The infection preventionist of the medical facility;

- At least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility; and
- One member of the executive or governing body of the medical facility.

The roles and responsibilities are defined below.

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

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

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

- Report and discuss sentinel events which include:
 - Number of sentinel events from previous calendar month (or quarter).
 - Number of severe infections that occurred in the facility.
- Corrective Action Plan for the sentinel events and infections
 - Evaluate the corrective action plan.
- Patient safety policies and checklists
 - At least annually evaluate patient safety policies and checklists

- Revise the patient safety policies and checklists as needed.
- Monitor and document the effectiveness of the patient safety policy.
- A meeting agenda and minutes noting follow-up tasks will be kept.

Root Cause Analysis (RCA) Team Responsibilities

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

RCA Team Leader/Facilitator Responsibilities

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

Director of Patient Safety ([based on NRS 439.870](#))

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

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

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

Executive Member Responsibilities

- Provide vision and leadership to the Lake Tahoe Surgery Center Patient Safety Committee and develop and foster a safe learning and improving culture.
- Provides oversight to the integrated patient safety program
- Plan, discuss, and generate the organization patient safety goals and activities, in conjunction with the patient safety action plans.
- Ensure alignment of patient safety activities, compliance with regulations, and provide opportunities for all Barton Health team members to be educated and involved in patient safety initiatives.

Objectives and Goals of the Patient Safety Plan

Objective	Goals	Plan	Planned Completion Date	Responsible Party
To control known and potential safety hazards to patients, visitors, and staff.	Strive for zero harm.	Patient Safety Plan as presented	Ongoing	The Director of Patient Safety and Patient Safety Committee presiding over Barton Health are responsible for managing and coordinating the organization-wide safety program in collaboration with other departments, services and disciplines including Lake Tahoe Surgery Center.

To establish a safety program that incorporates all activities within Lake Tahoe Surgery Center which contribute to the maintenance and improvement of staff and patient safety and reduction of medical/health care errors.	Provide education to all staff on the elements of the Lake Tahoe Surgery Center Patient Safety Plan.	Education provided upon hire	Ongoing	The Director of Patient Safety and Patient Safety Committee presiding over Barton Health are responsible for managing and coordinating the organization-wide safety program in collaboration with other departments, services and disciplines including Lake Tahoe Surgery Center.
To create a culture in which patients, visitors and employees can identify and manage actual and potential risks to patient and staff safety.	In-service all personnel on the use and completion of event reports.	Education provided upon hire	Ongoing	The Director of Patient Safety and Patient Safety Committee presiding over Barton Health are responsible for managing and coordinating the organization-wide safety program in collaboration with other departments, services and disciplines including Lake Tahoe Surgery Center.

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

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

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

Patient Safety Risk Reduction

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

Sentinel Event Alerts

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

Scientific Model Integration

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

- Shewhart cycle or Model for Improvement (Plan, Do, Study, Act –PDSA)
- Failure Mode and Effects Analysis (FMEA)
- Re-engineering (Human factor re-engineering such as signage for High Alert Medications, pop up

alert in Pyxis medication dispensing system, tall man lettering for look-alike sound alike drugs in medication usage process, etc.)

- Rapid Cycle Improvement (Institute of Health Care Improvement [IHI]) Collaborative approach termed the 'Breakthrough Series', to bring about rapid cycle improvements. Fundamental to the collaborative approach is the acceptance of a model and establishment of infrastructure through which collaborating organizations can identify and prioritize aims for improvement and gain access to the methods, tools, materials etc.)
- RCA²: Improving Root Cause Analyses and Actions to Prevent Harm
- Process Improvement (PI) such as Lean and Six Sigma concepts
- Evidence-based practice and clinical practice guidelines

Educational Enhancement Activities

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

Investigation: Root Cause Analysis and Process Improvements

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

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

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

Define the healthcare issues or potential risks.

- Conduct Root Cause Analysis
 - Review and analyze the data.
 - Review the RCA process and improvement related activities and timelines.
 - Identify the contributing factors and conduct the Root Cause Analysis.
- Conduct Corrective Action Plan
 - Discuss corrective action process and activities.
 - Discuss and present possible changes in procedure to improve areas indicated.
 - Identify strengths and areas that need improvement.
 - Develop strategies, solutions, and steps to take next.
- Identify barriers and technical assistance needs for supporting the RCA efforts.

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

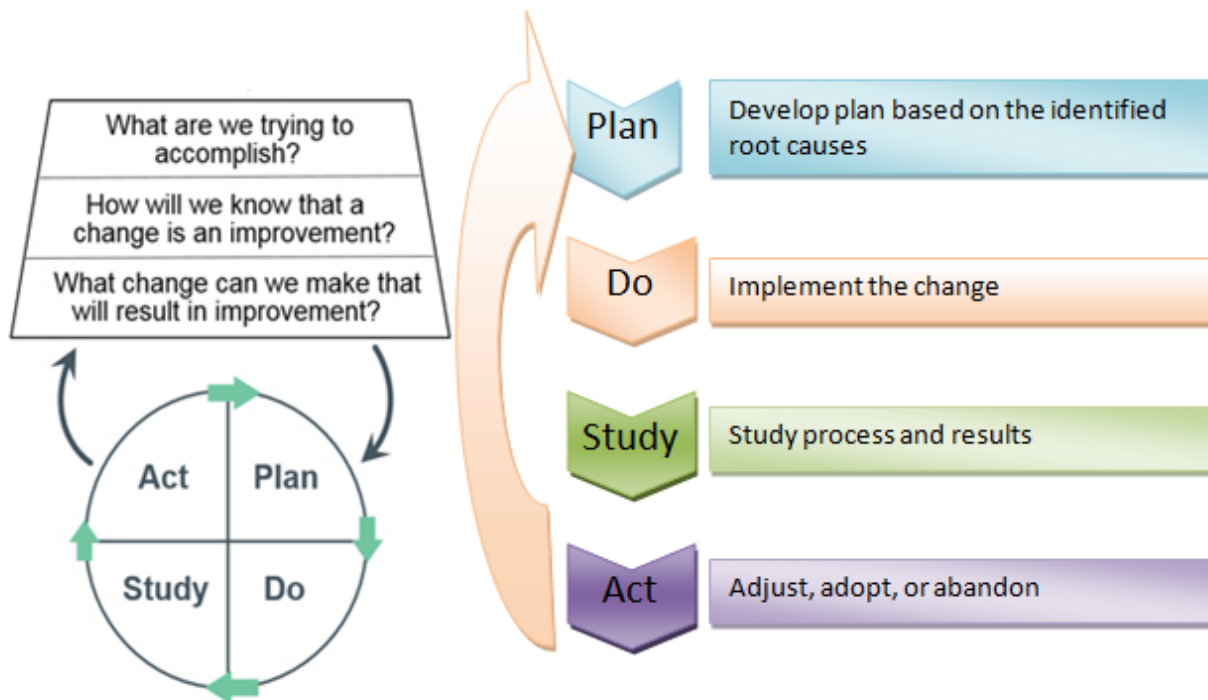
RCA and PI workgroups construct action items and assign them to appropriate individuals for completion. Staff involvement is considered essential since they are the team members on the front line with the most knowledge of the actual day-to-day workings of the processes. Individuals assigned action items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

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

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

Model for Improvement

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



The cycle is defined as follows:

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

- What do you need to do next?
- *Act*--If the result is successful or desirable, standardize the changes and then work on the next prioritized problem or the further improvements. If the outcome is not yet successful, look for different ways to identify the causes or change the testing process.

Data Collection and Reporting

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

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

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

Ongoing Reporting and Review

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

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

Assessment of the Patient Safety Plan

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

Patient Safety Checklists and Patient Safety Policies

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

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

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

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

The patient safety policies must include, without limitation:

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

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

- The current guidelines appropriate for the facility's scope of service developed by a nationally recognized infection control organization as approved by the State Board of Health which may

include, the Association for Professionals in Infection Control and Epidemiology (APIC), the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO) and the Society for Healthcare Epidemiology of America (SHEA); and

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

The patient safety checklists are listed in LTSC Attachment A.

The patient safety policies are listed in LTSC Attachment B.

Approval of Patient Safety Plan

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

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

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

Authority

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

2021 Lake Tahoe Surgery Center Patient Safety Priorities

During 2020, Lake Tahoe Surgery Center will strive to achieve two different priorities to ensure safe patient care. During 2020, the surgical site infection rate was zero. Staff education was provided during the year. In 2021, LTSC would like to maintain a surgical site infection rate of less than 0.5%.

Lake Tahoe Surgery Center had zero never events during 2020. In an effort to reduce the potential for harm, Lake Tahoe Surgery Center will strive to maintain zero harm during 2021. Physician and staff education is ongoing. The Patient Safety Committee reviews all event reports and action items will be assigned to the appropriate staff. Education will occur immediately following an event, near miss or good catch.

References

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

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

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

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

The Joint Commission Standard APR.09.02.01

The Joint Commission Standard LD.04.04.05

The Joint Commission. (2020). *Ambulatory Health Care: 2021 National Patient Safety Goals*. <https://www.jointcommission.org/standards/national-patient-safety-goals/ambulatory-health-care-national-patient-safety-goals/>

U. S. Department of Veterans Affairs. (2015). *Root cause analysis tools*. 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](#))

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-Acquired Infection ([NRS 439.802](#)):

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

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

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

Medical facility (NRS 439.805):

“Medical facility” means:

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

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

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

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

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

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

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

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

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

Lake Tahoe Surgery Center

212 Elks Point Rd Suite 201, Zephyr Cove NV 89448

Lindsey Wharton RN, Director and Administrator of Perioperative Services

YEAR – June 1, 2020 – June 30, 2021

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)		April 11, 2018	ASC	X
Infection Control Survey (monthly)			ASC	X
Surgical Services Audit		June 29, 2015	ASC	X
Medication Refrigerator		April 2019	PRE-OP/PACU/OR	X
IVF/Blanket Warmer Temperature		April 2019	PRE-OP/PACU/OR	X
Sage Warmer		February 3, 2016	PRE-OP	X
OR Temperature/Humidity		April 11, 2018	ASC	X

Washer Sterilizer Cleaning			STERILIZATION	X
Daily, weekly, monthly duties		September 4, 2019	PRE-OP/PACU/OR	X
Crash Cart		November 2019	NURSING	
Pediatric Crash Cart		April 2019	NURSING	
Malignant Hyperthermia Cart		June 4, 2019	NURSING	X
Hand Hygiene Audit			ASC	X
Medication Labeling Audit		December 8, 2016	ASC	
Patient Safety Policies Include:	Developed	Revisions	Usage	Review
Patient Identification		October 4, 2019	ASC	
Hand Hygiene		September 27, 2018	ASC	X
Patient Safety Checklist			ASC	X
National Patient Safety Goals		2020	ASC	
Medication Reconciliation		April 18, 2018	ASC	X
Handoff Communication		February 2020	ASC	
Universal Protocol		April 23, 2020	ASC	
Safe Preparation and Administration of Medications		December 5, 2019	ASC	
General Safety Policy- Patients/employees			ASC	X
Hazard Communications		February 22, 2019	ASC	X
Injury and Illness Prevention Program Plan		March 3, 2015	ASC	X
OSHA Reporting/Injury Reporting			ASC	X
Material Safety Data Sheets		April 3, 2015	ASC	X
Exposure Control Plan		August 22, 2019	ASC	

Abusive Behavior- Patients		March 30, 2015	ASC	X
Abusive Behavior- Non-patients		March 30, 2015	ASC	X
Disruptive Physician or Ancillary staff Behavior		September 21, 2017	ASC	X
Identification of Life Safety Code Deficiency			ASC	X
Fire Risk Assessment			ASC	X
Summary of Review	Total # developed	Total # revised	Total # Reviewed	
Patient Safety Checklists	0	2	20	
Patient Safety Policies	0	6	13	

*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: 2021
VERSION: 5



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.

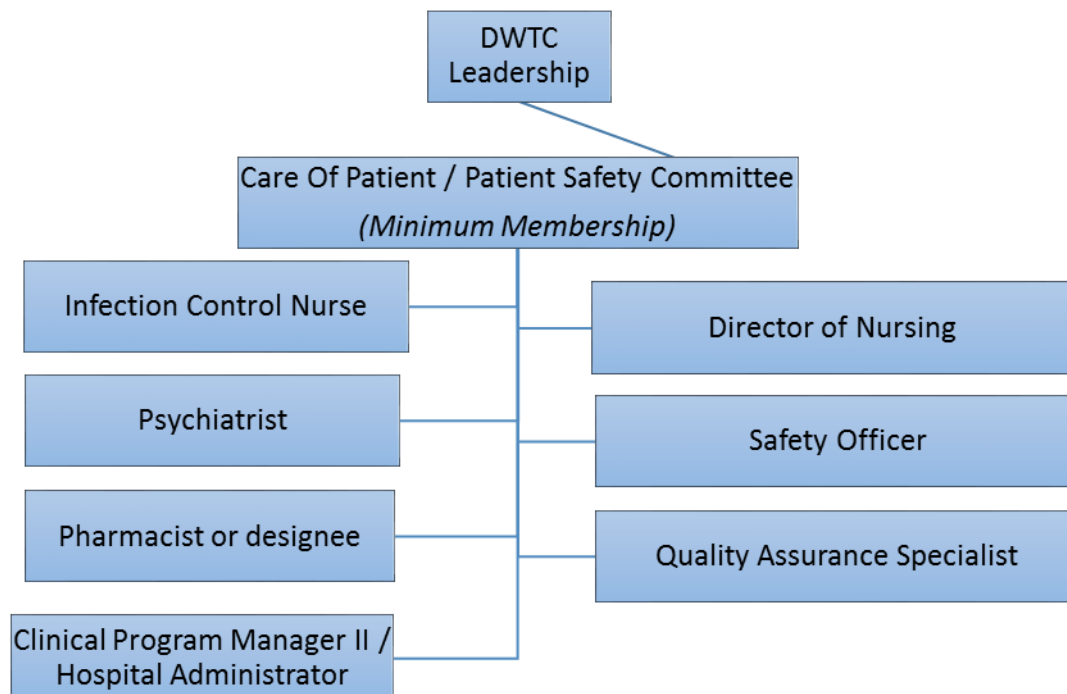
The plan focuses on the process rather than the individual, and recognizes both internal and external customers, as well as facilitates the need of analyzing and improving processes. The core principles of this plan include:

- 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.

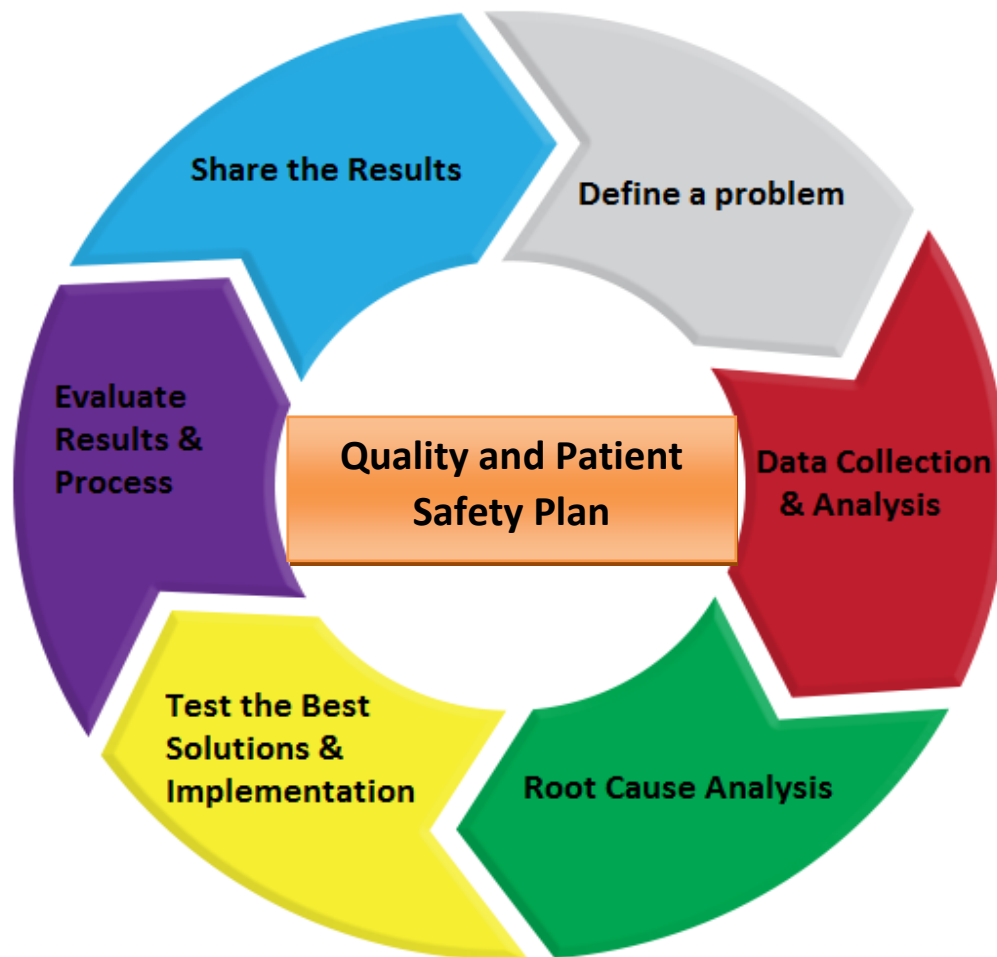
Objectives and Goals of the Quality and Patient Safety Plan

- National Patient Safety Goals guide the service delivery process.
 - Identify Patients Correctly.
 - Use Medications Safely.
 - Prevent Infections.
 - Identify Patients Safety Risks. Reduce the risk for suicide and injury.
- Prevent Sentinel Events
 - Identify and Resolve Safety Risks for Patients including Environmental Factors
 - Root cause analysis will be done if sentinel event occurs
- Medication Management to include but not limited to:
 - Monitoring processes for high alert and look-alike/sound-alike medications
 - Reviewing the storage of medication, including expiration and temperatures
 - Reviewing appropriateness of drug order
 - Monitoring that patients have swallowed the oral medication, medication effects, adverse medication reactions and medication errors
 - Monitoring management of unused/expired medication
 - Monitoring Food/Drug/Drug interaction
 - Reviewing after hours dispensing and administration of medications
 - Providing medication education and handouts
 - Reconciling medication information including recording and passing along correct medication information to healthcare providers
- Reduce the risk of infection
 - Identify risks for acquiring and spreading infection
 - Comply with the CDC hand hygiene guidelines. Monitor hand hygiene practices. Set goals and improve compliance with hand hygiene guidelines.
 - COVID-19 Infection;
 - 1. Screen and mitigate to prevent
 - 2. Management of positive cases
 - Increase staff influenza vaccination rates
 - Annually evaluate the effectiveness of the infection control and surveillance plan
- 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 physical activity.
 - Address potential dietary issues or medical concerns.
- Positive Behavior Interventions and Supports (PBIS)
 - Continue to implement, evaluate effectiveness and consistency of PBIS program.
 - Update the program as necessary.
- Staffing - Consider acuity when staffing the units. Staff to be mindful of their own emotional needs and contact EAP for assistance when needed.
- Maintain and revise, as necessary, a plan for the prevention of and response to workplace violence.

Components and Methods

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

Desert Willow Treatment Center will use a RCA process to determine the contributing factors and the underlying reasons for the deficiencies or failures. The Plan-Do-Study (check)-Act (PDSA or PDCA) is the model, which was developed by the Institute of Health Care Improvement that we will use to test the changes.



Root Cause Analysis

A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals.

Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

Root cause analysis and action plan framework table, which was introduced by the Joint Commission. It contains 24 analysis questions. It guides the organization to the steps in a root cause analysis. Not all the questions apply to all the events or cases. This table can be used individually or with the fishbone diagram.

5 Whys technique will be used in Desert Willow Treatment Center to explore the cause and effect relationship underlay a problem. One can find the root causes by asking “why” no less than five times. This technique can be used individually or as a part of the fishbone diagram. 5 Why’s technique also can be used to drill down the problem and find the root causes.

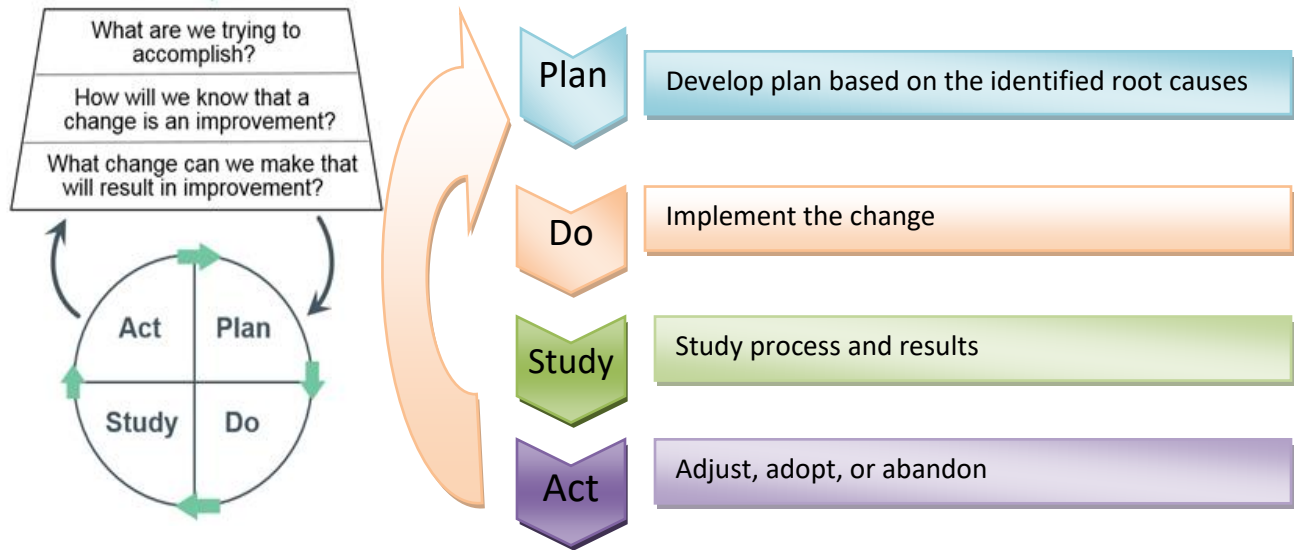
Fishbone Diagram

Once the problems are identified, a Fishbone Diagram (Appendix C) may be used for analyzing the problems. You may use the fishbone diagram individually to analyze the root causes or use it with the root cause analysis and action plan framework table.

A Fishbone Diagram, also called a Cause-and-Effect diagram, is a useful tool for a team to structurally brainstorm by discovering possible underlying factors or root causes from different major categories for the chosen problems. General categories used include people, methods, materials, measurements, education, procedures, process, location, environment, etc. RCA team members will brainstorm and ask multiple times, “why did this happen?” for each cause until all ideas are exhausted. The highest priority root causes will be chosen for PDSA topics.

Model for Improvement

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



The cycle is defined as follows:

- Plan--collect data and establish appropriate goals. Identify the problem and the possible root causes, and answer the following questions.
 - What is the objective of the test?
 - What are the steps for the test - who, what, when?
 - How will you measure the impact of the test?
 - What is your plan to collect the data needed?
 - What do you predict will happen?
- Do--make changes designed to correct or improve the situation. Use the following questions for the guidance.
 - What were the results of the test?
 - Was the cycle carried out as designed or planned?
 - What did you observe that was unplanned or expected?
- Study -- Study the effect of the changes on the situation. Data should be collected on the new process and compared to the baseline or expected results. Results should be evaluated and by using the following questions as guidance.
 - Did the results match your prediction?
 - What did you learn?
 - What do you need to do next?
- Act--If the result is successful or desirable, standardize the changes and then work on the next prioritized problem or the further improvements. If the outcome is not yet successful, look for different ways to identify the causes or change the testing process.

Data Collection and Reporting

Data should drive any quality and patient safety effort. Desert Willow Treatment Center is using DCFS Incident/ Accident Reports for tracking sentinel events, healthcare infection data, and Microsoft Excel and Access for internal data collection.

Data is submitted to the following external reporting entities:

- BHCQC: Bureau of Health Care Quality and Compliance
- CDC: Centers for Disease Control and Prevention
- CMS: Centers for Medicare & Medicaid Services
- DPBH: Department of Public and Behavioral Health
- Southern Nevada Health District
- State of Nevada Child Death Review Team
- TJC: The Joint Commission
- LCB: Legislative Council Bureau

Ongoing Reporting and Review

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

Monthly	Quarterly	Annually
1) Sentinel event monthly report 2) Severity of infection report 3) RCA assessment (if applicable)	1) Severity of infection report 2) Review and evaluate the measure of improvement of patient safety 3) Review and evaluate the measurement to prevent and control infections	1) Quality and Patient Safety Plan update 2) Checklists and Policies reviewing and revising

Assessment of the Quality and Patient Safety Plan

Quarterly Incident Accident Report including Trigger Identification reported to the Performance Improvement Team and to Leadership

Quarterly Consumer Complaint Report reported to Ethics Rights and Responsibilities Team and to Leadership

Infection Control information reported to Patient Safety Committee/Care of Patient Team and to Leadership

Root Cause Analysis for any Sentinel Event reviewed by all appropriate committees and to Leadership

Corrective Action Plans reviewed by all appropriate committees and Leadership

Patient Safety Checklists and Patient Safety Policies

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

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

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

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

- Any other instructions concerning his or her care upon discharge; and
- Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety policies must include, without limitation:

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

The patient safety checklists are listed in Appendix D.

Approval of Patient Safety Plan

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

2021 Behavioral Health Care National Patient Safety Goals

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

Identify individuals served correctly

NPSG.01.01.01

Use at least two ways to identify patients served. For example, use the patient's name and date of birth. This is done to make sure that each patient served gets the correct medicine and treatment.

Use medicines safely

NPSG.03.06.01

Record and pass along correct information about a patient's medicines. Find out what medicines the patient served is taking. Compare those medicines to new medicines given to the patient served. Give the patient served written information about the medicines they need to take. Tell the patient served it is important to bring their up-to-date list of medicines every time they visit a doctor.

Prevent infection

NPSG.07.01.01

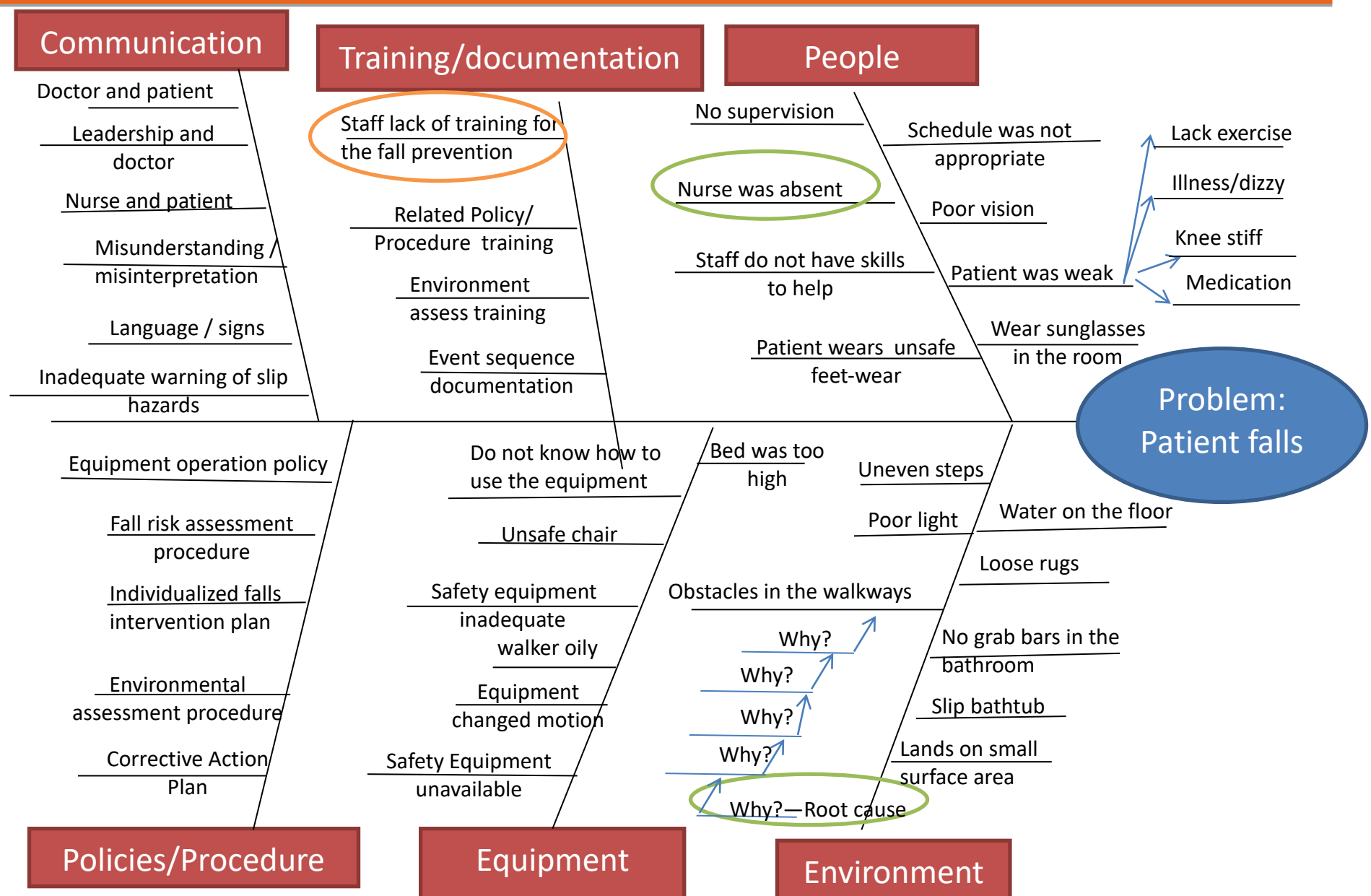
Use the hand cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization. Set goals for improving hand cleaning. Use the goals to improve hand cleaning.

Identify individuals served safety risks

NPSG.15.01.01

Reduce the risk for suicide and injury.

Appendix C: Fishbone Diagram



Appendix D: Checklists

Universal Assessments A & B

<S:\DWTC\DWTC FORMS\DWTC 18A Universal Assessment Part A 12-19.doc>

<S:\DWTC\DWTC FORMS\DWTC 18B Universal Assessment Part B 12-19.doc>

Personal Safety Assessment <S:\DWTC\DWTC FORMS\DWTC 163 Personal Safety Assessment 12-17.docx>

Pediatrician History & Physical Examination:

<S:\DWTC\DWTC FORMS\DWTC 19 Pediatrician History and Physical Examination 10-19.docx>

Aftercare Plan Located in Avatar (Electronic Health Record System)

ILSM Assessment Tool <S:\DWTC\DWTC FORMS\DWTC 192 Interim Life Safety Measure Assessment Tool 9-16.docx>

Monitoring Sheet <S:\DWTC\DWTC FORMS\DWTC 31 Patient Monitoring Sheet 02-21.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 10-20.pdf>

Critical Incident Report <S:\DWTC\DWTC FORMS\CIR - Critical Incident Report 7-30-2019.docx>

Seclusion Monitoring Form <S:\DWTC\DWTC FORMS\DWTC 197 Seclusion Monitoring Form 05-20.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 01-21.docx>

Q15 Audit <S:\DWTC\DWTC FORMS\DWTC 181 Q15 Audit 01-21.docx>

Unit Safety Contraband Checklist <S:\DWTC\DWTC FORMS\DWTC 182 Unit Safety Contraband Checklist 02-21.docx>

Temperature Logs:

<S:\DWTC\DWTC FORMS\DWTC 120 A - Food Refrigerator-Freezer Temperature Log 02-21.doc>

<S:\DWTC\DWTC FORMS\DWTC 120 B - Medication Refrigerator Temperature Log 05-18.doc>

<S:\DWTC\DWTC FORMS\DWTC 120 C - Medication Room Temperature Log 6-17.doc>

<S:\DWTC\DWTC FORMS\DWTC 120 D - Specimen Refrigerator Temperature Log 09-20.doc>

Ebola Screening Tool <S:\DWTC\DWTC FORMS\DWTC 184 Ebola Screening Tool 04-16.docx>

Infection Surveillance Report <S:\DWTC\DWTC FORMS\DWTC 73 Infection Surveillance Report 02-17.docx>

Environment of Care Monitors

<S:\DWTC\DWTC Policies & Procedures\DWTC POLICIES\10.0 - ENVIRONMENT OF CARE\10.50 - ENVIRONMENT OF CARE MONITORS 03-18.docx>

Suicide Risk Assessment

[S:\DWTC\DWTC FORMS\DWTC 195A Suicide Risk Assessment & Safety Plan \(Admission\) 10-20.docx](S:\DWTC\DWTC FORMS\DWTC 195A Suicide Risk Assessment & Safety Plan (Admission) 10-20.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)

COVID-19 Screening

<S:\DWTC\DWTC FORMS\COVID 19 - Visitor Questionnaire.docx>

<S:\DWTC\DWTC FORMS\COVID -19 Temperature Screening.docx>

Appendix E: Related Policies

DWTC Policy 1.19 Risk Management Plan

<S:\DWTC\DWTC Policies & Procedures\DWTC POLICIES\01.0 - ORGANIZATION\1.19 - RISK MANAGEMENT PLAN.doc>

DWTC Policy 2.27 Contraband Items / Searches Personal and Room

<S:\DWTC\DWTC Policies & Procedures\DWTC POLICIES\02.0 - ETHICS, RIGHTS, AND RESPONSIBILITIES\2.27 - CONTRABAND ITEMS - SEARCHES - PERSONAL & ROOM 6-16.docx>

DWTC Policy 2.29 Visitors & Guests

<S:\DWTC\DWTC Policies & Procedures\DWTC POLICIES\02.0 - ETHICS, RIGHTS, AND RESPONSIBILITIES\2.29 - VISITORS & GUESTS 05-19.docx>

DWTC Policy 4.32 Root Cause Analysis

<S:\DWTC\DWTC Policies & Procedures\DWTC POLICIES\04.0 - QUALITY ASSURANCE\4.32 - ROOT CAUSE ANALYSIS.doc>

DWTC Policy 4.33 Sentinel Events

<S:\DWTC\DWTC Policies & Procedures\DWTC POLICIES\04.0 - QUALITY ASSURANCE\4.33 - SENTINEL EVENTS 6-15.doc>

DWTC Policies included in Chapter 7 – Medical Services

<S:\DWTC\DWTC Policies & Procedures\DWTC POLICIES\07.0 - MEDICAL SERVICES>

7.02 Adverse Drug Reaction, Drug Interactions, & Side Effects	7.40 Professional Nursing Staff
7.03 Physical Health Assessment	7.41 Medical Staff
7.04 Nursing Assessment	7.50 Vital Signs
7.09 Medication Management	7.51 Glucose Monitoring via Glucometer
7.10 Medication Variances	7.53 Contract Laboratory Services
7.12 Medication Stop Order	7.54 Diagnostic Services
7.15 Destruction of Used Needles and Syringes	7.60 Employee Medical Emergency
7.16 Medication Induced Movement Disorder Monitoring	7.61 Employee Physical Examinations and TB Tests
7.18 Pain Management	7.63 Nursing Care Procedures
7.21 Physician Orders	7.64 Polypharmacy, High Dose & Off-Label Pharmacotherapy
7.22 Psychiatric Evaluation	7.83 Pharmacy Dispensing Procedures
7.24 Mental Status Examination	7.85 Critical Test Result Notification
7.25 Drug Samples	7.86 Medication Reconciliation
7.32 Emergency Medical Care / COBRA Packet	7.87 High Alert / LASA / Hazardous Medications
7.34 First Aid Nosebleeds	7.88 Shift Report
7.35 First Aid for Open Wounds	7.89 Respiratory Protection Program

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	10.62 Non-Dairy Beverage Substitutions
10.05 Health Safety Inspection	10.63 Diets and Food Requisitions
10.07 Interim Life Safety Measures	10.64 Meals DWTC
10.08 Use of Disposable Gloves During Handling of Foods and Fluids	10.66 Nutritional Screening and Assessment
10.10 Surveillance, Prevention and Control of Infection Guidelines	10.68 Dietetic Services Quality Improvement Plan
10.11 Personal Protective Equipment	10.69 Diet Orders
10.13 Work Practice Controls	10.70 Wellness Policy
10.14 Lice Policy	10.73 Nutrition Care Monitoring
10.15 Hand Washing	10.74 Nutrition Care Manuals and Menu
10.16 Tuberculosis Screening for Patients	10.75 Nutrition Education
10.17 Sanitation and Disinfection	10.76 Meal Service
10.18 Isolation Techniques	10.77 National School Lunch Program
10.19 Nosocomial Detection and Reporting	10.81 Incident-Accident Reporting
10.20 Occupational Illness	10.83 Incidents Involving State Vehicles
10.21 Infection Control and Surveillance Plan	10.85 Lockout-Tagout System
10.22 Standard Precautions	10.86 Employee Lockers
10.23 Transmission Based Precautions	10.91 911 Emergency Protocol
10.25 Emergency Preparedness External Disaster	10.92 Building Security
10.40 Maintenance Stand-By for After Hours	10.93 Threats / Behavioral Emergencies in the Lobby / Intake Room
10.41 Housekeeping/Maintenance	10.94 Natural Gas Leak
10.44 Use of State Vehicles	10.95 Potentially Dangerous Weapons
10.46 Non-Smoking/Smoking	10.96 Bomb Threats
10.47 Ordering of Supplies	10.99 Chemical Ingestion by Patient
10.50 Environment of Care Monitors	10.100 Hostage Situation
10.51 Safety Management Plan	10.101 CCSD / DWTC Evacuation
10.52 Utility Systems Management Plan	10.102 Decorations
	10.103 COVID-19

DWTC Policy 8.03 Restraint-Seclusion of Patients

<S:\DWTC\DWTC Policies & Procedures\DWTC POLICIES\08.0 - SPECIAL PROCEDURES\8.03 - RESTRAINT - SECLUSION OF PATIENTS 05-20.docx>

DWTC Policy 11.06 Patient Monitoring

<S:\DWTC\DWTC Policies & Procedures\DWTC POLICIES\11.0 - DWTC\11.06 - PATIENT MONITORING 05-20.docx>

Facility Name: Parkway Surgery Center Henderson, NV	Policy And Procedure Guideline Name: Safety Management Program (Environment Of Care)	Policy Number: SAFE 104
	Subject Category: SAFETY	Effective Date: 12/01/2016
		Reviewed Date: 12/14/2017, 1/10/19, 02/07/2020, 02/19/2021
		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.

**Dignity Health – St. Rose Dominican
Siena Campus**

PATIENT SAFETY/RISK MANAGEMENT PLAN

DATE: 01/2020



This plan was created and revised by the Dignity Health – St. Rose Dominican Patient Safety Officer with review and input from the Patient Safety Committee. Implementation of this plan is intended to optimize the healthcare quality and patient safety outcomes, encourage recognition, reporting, and acknowledgment of risks to patient, visitor, and employee safety, as well as reduce the medical/healthcare errors and /or preventable events.

**Patient Safety Committee/Program
St. Rose Dominican – Siena Campus**

3001 St. Rose Parkway
Henderson, NV 89052
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Commitment to Patient Safety

Dignity Health St. Rose Dominican Hospital – Siena Campus is committed to a comprehensive approach to improving healthcare quality and patient safety by aligning with our Mission, Vision, and Values, creating an environment that supports a dynamic, proactive, and safe culture for patients, family members, visitors, and employees, through continuous learning and improving patient safety policies, systems, and processes.

Mission, Vision, and Values

In support of our mission, vision, and values, Dignity Health – St. Rose Dominican, Siena Campus' Patient Safety/Risk Management program promotes:

- Honest, open collaboration and partnership of hospital leadership, medical staff, patients and their families, the community and other healthcare providers to deliver compassionate, high-quality, affordable healthcare.
- Promote justice and respect for those we serve.
- Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.
- Responsibility and accountability for every healthcare related decision and action.
- A focus on excellence, teamwork and innovation through continuous learning, improvement in system design, and the management of choices and changes, bringing the best possible outcomes or performances to the facility.
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare.
- Education of staff and physicians to assure participation of healthcare providers.

Scope and Purpose

The Patient Safety/Risk Management Program at St. Rose Dominican is an organization-wide/campus specific strategy that includes not only facility staff and medical staff, but is inclusive of patients, family and visitors. The Patient Safety/Risk Management Program at Siena Campus supports and encourages the active participation of each person in order to be an effective program. When processes, functions or services are designed or redesigned, information internal and external to the campus and/or organization regarding potential risks to patient safety will be considered and where appropriate, utilized to minimize the risk to patients affected by the new or redesigned process, function or services.

The purpose of this plan is to establish system-wide guidelines and processes supporting a comprehensive, effective, organization-wide Patient Safety/Risk Management Program Plan designed to promote and improve patient safety at Dignity Health – St. Rose Dominican, Siena Campus, by working to prevent medical/healthcare adverse events and reducing risk to patients and visitors.

Undesirable facility specific and system patterns or trends in performance and sentinel events will be intensively analyzed to determine where best to focus changes for improvement. Intensive analysis will be initiated when:

- Levels of performance, patterns or trends vary significantly and undesirably from those expected including significant near misses;
- Performance varies significantly and undesirable from that of other campuses/organizations;
- Performance varies significantly and undesirably from recognized standards; and/or
- A reportable event has occurred at that campus.

Minimally, data from the following areas will be gathered at each facility and presented at that facility for analysis with action plans developed reflective of the findings:

- Initial and on-going proactive risk assessments utilizing internal and external resources;
- Campus aggregate event reports reflective of all medical/healthcare events, with and without adverse outcomes, including but not limited to:
 - Hospital acquired infections
 - Medication events, to include delays in administration
 - Adverse drug events
 - Transfusion reactions
 - Patient falls
- Actual and near misses
- Hazardous conditions
- Restraint issues
- Medical record legibility issues
- Patient/family/staff opinions, needs, perceptions of risks to patients, and suggestions for improving patient safety;
- Identified data trends and analysis reports from sister facilities, Dignity Health Shared Learnings, etc.
- Others as defined by various campus committees, Leadership and/or Quality Council and Advisory Committee of the Board (QCAC).

Roles and Responsibilities

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

The Patient Safety Committee Organization

Roles and Responsibilities

- In accordance with [NRS 439.875](#), a patient safety committee must be comprised of:
- The infection control officer of the medical facility;
- The patient safety officer of the medical facility, if he or she is not designated as the infection control officer;

- At least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility; and
- One member of the executive or governing body of the medical facility.

The roles and responsibilities are defined below.

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

The Patient Safety Committee convenes monthly in accordance with NRS 439.875. In collaboration with the Patient Safety Officer, the committee represents the Siena Campus and includes multidisciplinary team members which has oversight responsibility to ensure that the responsibilities and functions outlined in this program are carried forward throughout the organization. The following are responsibilities assigned:

- Serve as champions of the Patient Safety/Risk Management Program within the facility/organization.
- Establish and evaluate data to identify patient safety performance indicators.
- Evaluate other sources of patient safety data utilizing internal and external resources including but not limited to adopted patient safety checklists, risk assessments, sentinel event report/alert information and event reporting information from a variety of available resources including the event reporting system, APIC, CHPSO, etc.;
- Selection of a high-risk patient safety process for proactive risk assessment and improvement annually;
- Collaborates with each facility's Quality Council to identify, address and conduct follow-up on patient safety related trends, analysis results, changes in processes, and policies.
- Annual review of the Patient Safety Program to ensure its appropriateness of focus and effectiveness of efforts for each campus.
- Monitor and document the effectiveness of the patient identification policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the patient safety officer pursuant to [NRS 439.870](#).
- Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred.
- Review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- Review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the executive or governing body of the facility regarding:
 - (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);

- (2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and
- (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

Root Cause Analysis (RCA) Team Responsibilities

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

Patient Safety Officer Responsibilities ([based on NRS 439.870](#))

The Manager of Patient Safety/Risk Management 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 Patient Safety/Risk Management in CY 2021.	May 2021
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
Quality/Patient Safety staff orientation	Quality/Patient Safety Services will review/update Patient Safety orientation.	March 31, 2020
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, and 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/Patient Safety 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 Privilege (PSWP Privilege) 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

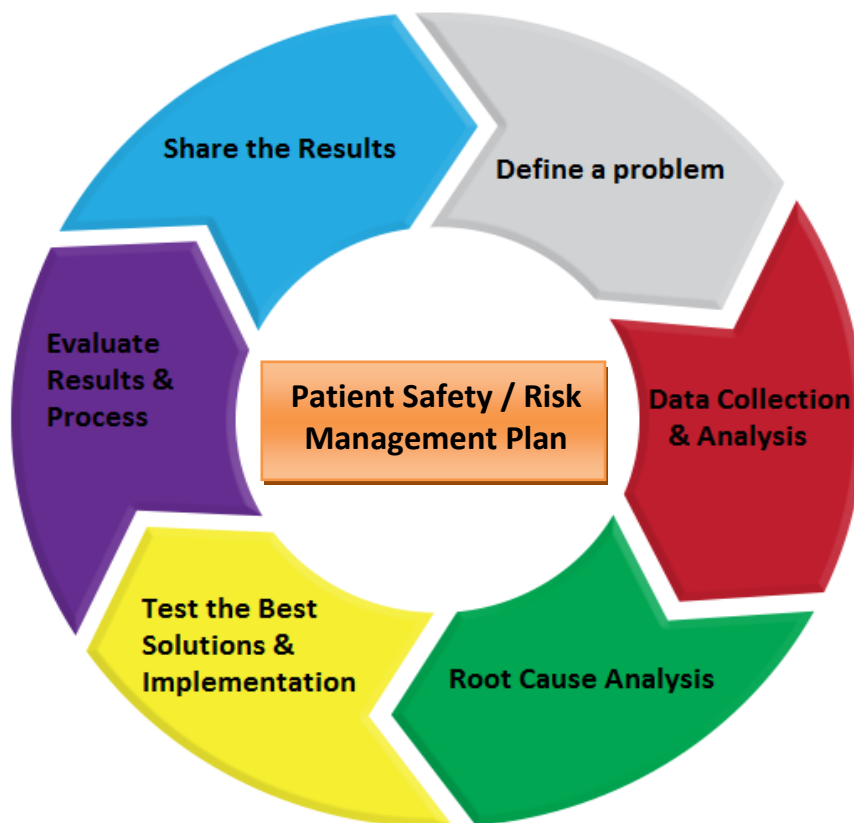
- iv. Manor discrepancies, or patterns of discrepancies, between preoperative and postoperative (including pathologic) diagnoses, including those identified during the pathologic review of specimens removed during surgical or invasive procedures; and
 - v. Significant adverse events associated with anesthesia 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 measure to prevent and control infections	1) Quality and Patient Safety Plan update 2) Checklists and Policies reviewing and revising

Assessment of the Quality and Patient Safety Plan

Please see the Patient Safety Assessment Tool (PSAT) from the VA National Center for Patient Safety for your reference.

Patient Safety Checklists and Patient Safety Policies

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

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

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

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

The patient safety policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include the name and date of birth of the patient.
- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.

- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

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

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

http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf

The following link provides you some patient safety policies for your reference

<https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies-and-guidelines>

Approval of Patient Safety Plan

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

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

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

Patient Safety Program Reporting and Review

All patient safety work product privilege (PSWP Privilege) 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.
- The review will be approved by QCAC.
 - Will be submitted to the Community Board for final review and approval.

References

- Root Cause Analysis Toolkit
<https://www.health.state.mn.us/facilities/patientsafety/adverseevents/toolkit/>
- Quality and Service Improvement Tools
<https://improvement.nhs.uk/resources/pdsa.cycles/>
- CQI 101 An Introduction to Continuous Quality Improvement:
<https://www.coursehero.com/file/13827355/CQI-Overviewppt/>
- Quality Improvement <http://www.hrsa.gov/quality/toolbox/>
- Root Cause Analysis <http://www.patientsafety.va.gov/professionals/onthejob/rca.asp>
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2
https://www.jointcommission.org/sentinel_event.aspx
- Hospital Policies <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies-and-guidelines>
- Checklists to Improve Patient Safety http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf
- Minutes of the Meeting of the Quality and Patient Safety Committee
<https://cookcountyhealth.org/wp-content/uploads/12-13-19-QPS-scan-Minutes.pdf>
- Title 40 – Public Health and Safety <https://www.leg.state.nv.us/NRS/NRS-439.html>

Reviewed/Approved:

Patient Safety Committee, January 2020

Quality Care Advisory Committee of the Board, January 2020

Community Board, January 2020

PAM Specialty Hospital of Las Vegas

2021 Patient Safety Plan

Purpose

PAM Specialty Hospital of Las Vegas 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

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. Infections
6. Near Misses
7. Sentinel Events
8. Hazardous Condition(s)
9. 2021 Hospital National Patient Safety Goals published by The Joint Commission

The role of the Patient Safety Program includes oversight of the 7 Environment of Care Plans:

1. Safety Management Plan
2. Security Management Plan
3. Life Safety Management Plan /Fire Safety
4. Medical Equipment Plan
5. Emergency Preparedness Plan
6. Hazardous Materials and Waste Management Plan,
7. Utilities – Utilities Management Plan

Annual Reviews of each of the 7 plans are performed and reported to the Environment of Care Committee/Quality Council and Patient Safety Committee as well as the Medical Executive Committee and the Governing Board of the Hospital.

Methodology

The Patient Safety Program includes both proactive and responsive components.

Proactive: The proactive patient safety component emphasizes a proactive error reduction and avoidance program. The following will be reviewed to proactively identify patient safety issues:

1. Medical equipment and medication risk assessment activities
2. Sentinel event alert risk reduction activities
3. Performance improvement indicators (department specific) and monitoring activities
4. Patient Satisfaction reports
5. Medical Record review reports
6. Staff orientation, evaluation, training, and education **activities to include a Culture of Patient Safety survey to be completed every 18 months. Completed in November 2020**
7. Failure Mode and Effect analysis (FMEA) activities
8. Medical Staff Credentialing/Peer Review issues
9. Incident Report trending

Failure Mode Event Analysis (FMEA) will be conducted at a minimum of every 18 months. The process to be studied each cycle will be determined in collaboration with medical staff, hospital leadership, and staff. Information from patient safety organizations such as the Institute for Medicine, Institute for Safe Medication Practices, and The Joint Commission will be disseminated to the appropriate departments and committees for action and implementation of recommendations.

Responsive: The hospital will utilize information gathered from risk assessments, sentinel event alerts, performance improvement measures, medical record review, and other data in order to track, trend, and respond to patient safety issues. Patient safety related issues will be ranked based on severity. The following will be reviewed for reactive patient safety issues.

1. Root Cause Analysis
2. Intensive Assessment and Analysis/FMEA
3. Occurrence Report Findings
4. Patient Complaint/Grievance Response
5. Performance Improvement Measures
6. Patient Satisfaction Survey Reports

7. Serious Event Notifications /Sentinel Event Reporting
8. Culture of Patient Safety Survey
9. Hazard Vulnerability Analysis

Patient Safety Committee and Reporting

Patient Safety is the responsibility of all employees and Medical Staff members. The Patient Safety Program will be multi-faceted and that responsibility will be shared among several individuals, groups, and teams. Each performance improvement team is multidisciplinary in nature with representatives from the hospital and medical staff. Medical staff as champions provides for the necessary support of initiatives. Imbedded in each performance improvement team are safety issues relevant to the team's focus. Reports from the performance improvement teams are sent to the Quality Council/Patient Safety Council and reported to the Medical Executive Committee and the Governing Board.

In compliance with **State of Nevada Regulations**, the Patient Safety Committee will be comprised of:

- (1) The patient safety officer (annually appointed) of the medical facility.
- (2) At least three providers of health care who treat patients at the medical facility, including, without limitation, at least one member of the medical, nursing, and pharmaceutical staff of the medical facility.
- (3) One member of the executive or governing body of the medical facility.

The Patient Safety Committee is also multidisciplinary with representation from the following areas: Clinical Departments, Pharmacy and Therapeutics Committee, Safety Committee, Quality/Risk Management, and the Hospital's Infection Control Preventionist.

The Patient Safety Committee functions include but are not limited to:

1. Review and evaluate internal and external patient safety data from the following sources for opportunities for improvement in the safety of patient care processes:
 - a. Risk and Safety Management
 - b. External Data Reports
 - c. Sentinel Event Alerts from The Joint Commission
 - d. Healthcare Reports
 - e. Regulatory Reports
 - f. Patient/Family Complaints and Grievances
2. Continually improve processes of care delivery based on data analysis.
3. Develop policies and procedures that result from process improvement activities.
4. Develop and approve Patient Safety Education for the medical and hospital staff.

5. Conduct an annual risk assessment of patient safety issues/strategies from internal and external reports.

The Hospital believes in a non-punitive reporting environment in order to maximize reporting of near misses, adverse outcomes, and sentinel events as it has been demonstrated that many errors are directly related to system and process failures. Progressive disciplinary action per hospital policy may be considered when an involved individual takes action to hide an 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/Corporate PAM.

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 PAM 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. Online training modules are available to staff to provide ongoing education on topics as these are identified. Additionally, education will be provided to patients and their families about their role in helping to facilitate the safe delivery of care.

References:

The Joint Commission

<http://dpbh.nv.gov/>

Post Acute Medical Policies and Procedures

Evergreen Residence
1305 Kings Ct. Reno, NV 89503
(775) 787-9520

PATIENT SAFETY PLAN

SAFETY COMMITTEE

Members: Comprised of the Administrator, General Manager (Patient Safety Officer) and 1 Caregiver.

Safety Committee Responsibilities:

1. Implements, maintains and monitors the safe plan of the facility.
2. Stays abreast of the state regulations.
3. Monitors the effectiveness of the facility's corrective measure and monitor the trend of injury with the staff and residents where additional safety measures need to be taken.
4. Monitors effectiveness of facility means for communicating safety and health matters to employees and ensure that the employee concerns and suggestions are being conveyed and responded by the General Manager and Administrator.
5. Ensures facility procedures for identifying and evaluating workplace hazards.
6. Review each medical incident report to ensure they are completed in thorough and timely manner and be sent to agency that needs it, like SOR.
7. Monitors effectiveness of facility procedures for correcting unsafe condition and work practices and that corrective action is completed in a timely manner.

Safety Rules and Practices to be followed at all times

Safety Rules and Practices Compliances

1. Counseling and additional training to staff.
 - a. Employee was noted to be breaking a safety practice and not following proper procedure.
 - b. Employee keeps on having repeated accidents which maybe similar or different accident.
2. Management shall observe that all caregivers are following the safety plan at all times.
3. Employee should be trained or retrained as appropriate if the cause of action is due to poor training.

Safety Communication

1. Management shall ensure that effective communication between the staff and residents.
2. There will be a regular meeting on a quarterly basis or if needed to discuss about safety issues or safety topics.
3. OSHA and Worker's compensation required notices are posted on the wall so staff can review any time. (Poster should be the latest version.

SAFETY COMMITTEE MEETING

1. Comprised of the Administrator, General Manager (Patient Safety Officer) and 1 Caregiver.
2. Will be held on a quarterly basis to assess the safety plan and evaluate any incidents that occur.
3. Minutes of the meeting must be documented. The safety and health issues discussed, the date of the meeting and the people who attended. This must be available for review by the other employees.
4. Conducts scheduled inspection and holds routine safety meeting.

5. Reviews all medical incident report and investigate accidents or incidents that result to injuries and unnatural death.
6. Recommends new safety policy and procedure.
7. Do inspection of the interior and exterior of the facility to ensure safety of the residents and staffs.
8. Provides safety and health training to all employees and new hires.

PATIENT SAFETY AND EMERGENCY ACTION PLAN

A. RESPONDING TO A FALL

1. Assess the resident in the event of fall. Check for any signs of pain, injury or confusion.
2. Provide first aid if needed. Check vital signs if possible.
3. Inform the Administrator, the Attending Physician, the relative or guardian and the social worker if applicable.
4. Follow the instruction from the Attending Physician.
5. Administrator will investigate and retrain the staff on patient's safety and how to avoid fall.

B. RESPONDING TO A MEDICATION ERROR

1. In the event that a medication occurs, inform the Administrator, the Primary Physician, the relative or guardian and the social worker if applicable.
2. Follow Attending Physician instruction on what to do.
3. Call 911 if needed.
4. Monitor the resident for any side effects of the medication and check vital signs if possible.
5. Administrator will investigate on what happened. Identify the type of medication error – Wrong medication, wrong dose, wrong patient, wrong frequency.
6. Do retraining to staff to avoid the incident to reoccur.

C. RESPONDING TO AN UNEXPECTED DEATH (UNNATURAL)

1. In the event of unnatural death, inform the Administrator, the Primary Physician, the relative or guardian and the social worker if applicable.
2. Call 911 if needed.
3. Administrator investigates on what, why and how it happened that result to unnatural death. All the caregivers will be talked to and must give their own statement of the incident. Administrator must find out the cause of unnatural death in collaboration with the Attending Physician.
4. Necessary actions and retraining should be done so the incident will never happen again.
5. Make necessary changes in the patient safety plan to avoid unnatural death to happen again.

D. RESPONDING TO ELOPEMENT

1. When one of the residents eloped, inform the Administrator, the Primary Physician, the relative or guardian and the social worker if applicable.
2. Call 911 if needed.
3. Look for the resident in the neighborhood.
4. Administrator investigates the situation, how and why it happened. Also, find out where the resident might go.
5. Make necessary changes in the patient safety plan to avoid elopement of the residents like additional security in the facility.

E. RESPONDING TO SUICIDE, ATTEMPTED SUICIDE, SELF HARM

1. When one of the residents committed/attempted suicide or harm her/himself, inform the Administrator, the Primary Physician, the relative or guardian and the social worker if applicable.
2. Call 911 if needed.
3. Administrator investigates the situation how and why it happened.
4. Make necessary changes in the safety plan to avoid suicide or self harm to happen in one of the residents.
5. Encourage residents to verbalize their feelings and let them know that the caregivers are always available when they need someone to talk to.

6. Counseling should be offered to the residents who are feeling to commit/attempt suicide or harm one self.

F. RESPONDING TO SEXUAL ABUSE, PHYSICAL ASSAULT, PHYSICAL RESTRAINT

1. When one of the residents had sexual abuse, physical assault, physical restraint, inform the Administrator, the Primary Physician, the relative or guardian and the social worker if applicable.
2. Call 911 if needed.
3. Administrator investigates the incident - what, how and why it happened. The resident will be talked to in private and statement from each staff about the incident will be taken.
4. Take necessary action and retraining for the staff.
5. Make appropriate changes in the patient safety plan to avoid these things to happen to the residents.

G. RESPONDING TO A FIRE

Note: Performed by facility employees

1. Call 911
2. Activate the nearest fire alarm pull station.
3. Clear anyone in immediate danger.
4. Evacuate quietly and calmly using the nearest emergency exit – See floor plan or look for the Exit sign.
 - Stay low for smoke and heat rises
 - Feel doors for heat before opening, keep it close if it's hot.
 - Report to pre-designated area outside the facility – in front of the facility near the mailbox
5. Confine the fire by closing all doors and windows to the area.
6. Extinguish the fire if it is safe to do so. Remember the word PASS.
 - Pull the safety pin
 - Aim the nozzle at the base of the fire
 - Squeeze the trigger handle
 - Sweep from side to side

7. Follow the instruction of the emergency personnel and do not re-enter the building until authorized to do so.

H. RESPONDING TO A NATURAL DISASTER

Note: Performed by facility employees

1. Assess the situation.
2. Determine timeline of possible event, if applicable.
3. Ensure that the environment is safe for both the staff and residents.
4. Evacuate if needed to a safe location if necessary and applicable.
5. There should be a predetermined location for assembly – in front of the facility near the mailbox
6. Take appropriate precautions – Stay away from windows, glass doors and anything that may fall during an earthquake.
7. Seek shelter under a desk or table for earthquake and severe storms
8. Stay safe inside until the event stops.

I. RESPONDING TO VIOLENT THREAT

Note: Performed by the facility employees.

1. Assess the situation
2. Call 911 for help if needed.
3. Ensure the environment is safe for the residents and staff.
Assemble in the pre-determined location – in front of the facility near the mailbox.

GENERAL WORKPLACE SAFETY

- **No Smoking** – Smoking is prohibited inside the facility except in the designated area, outside the patio or building. Keep the ashes in the ash tray.

- **Personal Protective Equipment** – Isolation gown, mask, face shield, gloves and hair net must be worn if there is active case of Covid-19. Gloves should be used every time when handling residents for infection control.
- **Reporting of Incidents** – no matter how minor must be reported promptly to relatives, social workers, facility administrator and resident's physician.
- **Proper Work Clothing** – Wear scrub suit and closed toe shoes. Must look presentable and clean at all times.
- **Housekeeping** – employees are required to keep the interior and exterior of the facility clean at all times.
- **Proper Lifting Techniques** – Always use proper lifting techniques when lifting or assisting residents.
- **Emergency Evacuation Procedure** – Employees should know the emergency evacuation exits, their responsibilities and actively take part in the drills and actual evacuation of the residents.

SPECIALTY SURGERY CENTER 2021 SAFETY MANAGEMENT PROGRAM

POLICY:

It is the policy of this Specialty Surgery Center to provide a physical environment free of physical hazards for the patients, employees and visitors. In addition, monitor those activities that have the potential to minimize the possibility or risk associated with those physical hazards. The Governing Board has final oversight of the safety program/plan

PURPOSE:

The purpose of the safety management program is to establish, organize, implement, monitor, and evaluate an effective program designed to provide a physical environment free of hazards and to manage staff activities to reduce the risk of human injury. Safety is an ongoing process and each employee and medical staff provider should be constantly aware of providing a safe environment for themselves, patients and visitors.

GOALS AND OBJECTIVES

The objectives and goals of the safety management program are to reduce and eliminate unnecessary hazards within the facility by:

1. Identification of individuals who will be responsible for the overall coordination, direction, and monitoring of safety activities within the Center.
2. Establishing a procedure whereby any Center employee or medical staff member will be encouraged to identify and present problems, deficiencies, and ideas for review and analysis in an effort to improve overall safety at Center.
3. Assuring the various problems and opportunities to improve safety are objectively assessed and that performance indicators designed to achieve an optimum level of safety are monitored.
4. Assuring that the safety activities are properly documented to indicate findings, conclusion, actions, recommendations, and evaluation of the effectiveness of the action that was taken.
5. Providing a method of communication that allows for effective collection and dissemination of information relating to safety activities.
6. Establishing and maintaining an ongoing mechanism for monitoring the resources necessary to ensure the safety of the patients, staff, visitors, building, grounds, and internal physical systems

AUTHORITY AND RESPONSIBILITY

The Governing Body shall maintain ultimate responsibility for the oversight and effectiveness of the safety management program and shall strive to assure a safe environment for patients, staff and visitors. The Governing Body, through Administration, Risk Manager, and managers shall provide whatever administrative assistance that is reasonably necessary to support and facilitate the implementation of ongoing operation of this effort.

The Governing Body has appointed the Safety Officer. His/her role includes:

1. Oversight of implementation and maintenance of safety practices at the Center.
2. Proactive with ergonomics in the workplace.
3. Integration of safety as part of the Center wide Quality and Risk Plans.
4. Assures investigation and follow through of any unsafe practices identified.

5. Work with managers to ensure ongoing education of employees through staff in-service, emergency (mock) drills, online training, and new employee orientation.
6. Surveillance and audits to identify areas of opportunity.

The Center, in conjunction with the building management if applicable, will maintain a safe building and grounds.

1. Routine maintenance is provided by building management.
2. Utilities and emergency backup systems are checked routinely.
3. The Center should report any unsafe conditions for the building or grounds immediately to the management.
4. The Center will conduct periodic safety rounds to assess for potential hazardous risks. Risks are corrected as soon as possible.

SCOPE OF SAFETY MANAGEMENT PROGRAM

The safety activities for the Center are a function of all employees, medical staff, the Medical Executive Committee (MEC), and Governing Body. The following delineates the scope of service of the safety management program.

1. All areas of the Center, including but not limited to:
 - a) Clinical areas
 - b) Public access areas
 - c) Employee areas
 - d) Outside sidewalks and grounds
 - e) Mechanical equipment areas
2. Maintenance of a safe environment
3. Life Safety
4. Equipment management
5. Utilities management
6. Hazardous Materials management
7. Emergency preparedness
8. Security management
9. Training and Education
10. Quality Improvement activities

COMPONENTS OF THE PROGRAM/PLAN

The safety management program shall contain the following components and related policies which includes but is not limited to:

1. **Safety Management**
 - a) General safety policies
 - b) Fall Risk assessment
 - c) Appointment of a Safety Officer
 - d) Staff Education and training
 - e) QI/Risk/Safety/Infection Control Committee
2. **Life Safety Management**
 - a) Buildings
 - b) Grounds
 - c) Fire warning and safety systems

3. **Equipment Management**
 - a) Patient care equipment
 - b) User errors/equipment failures
 - c) Product/equipment alerts/recall
 - d) Electrically powered equipment
4. **Utilities Management**
 - a) Life support systems
 - b) Infection control systems
 - c) Communications systems
 - d) Equipment support systems
 - e) Utilities outage/failure
5. **Hazardous Materials:**
 - a) Selection
 - b) Training
 - c) Inventory
 - d) SDS
6. **Emergency preparedness:**
 - a) Management of disasters, internal and external
 - b) Involvement of the Center in community disaster (drills and actual)
7. **Security Management**
 - a) Variance reporting
 - b) Security risk assessment
8. **Radiation Management**
 - a. Dosimetry monitoring
 - b. Radiation audits
 - c. C-arm logs to assure < 20 individual exposure time

MONITORING AND EVALUATION

There is ongoing monitoring of the safety program to ensure compliance with all regulatory agencies and Center policies. Results of the monitoring activities are reported to Administration, QI Committee, MEC and the Governing Body. The staff are informed through departmental meetings and staff in-services.

1. Data Resources Used for Monitoring

- a) Quality/Risk Monitors
- b) Variance reports
- c) Outside regulating agencies reports (AAAHC, TJC, CMS, State, Fire Marshall, OSHA etc)
- d) Preventive maintenance reports (engineering and biomed)
- e) Surveillance rounds (IFC, Safety, Radiation etc.)
- f) Fire drill critiques
- g) Disaster drill critiques
- h) Claims data/Probable Claims Reports

2. Areas of Improvement

Data information will be evaluated to determine if there are any problems or opportunities for improvements in the delivery of care. The source of the problem will be analyzed to determine if the problem occurred related to:

- a) Insufficient knowledge
- b) Problems in the system

- c) Poor performance due to lack of conformity to policy
- d) Other

3. Corrective Action

Appropriate actions will be implemented to eliminate or alleviate the identified problems. Actions may be taken by the manager, Risk Manager, Administrator, or QI Committee. Actions may include, but are not limited to:

- a) Education/training
- b) Revision of policies and procedures or implementation of new policies
- c) Staffing adjustments
- d) Change in equipment, vendors, repair services, etc.
- e) Counseling/guidance

4. Follow-up and Evaluation

- a) Follow-up and evaluation of the corrective actions will be done through the Quality Improvement/Risk Management Committee.
- c) Based on the evaluation by the Quality Improvement/Risk Management Committee, the need for further monitoring or additional corrective action will be determined.
- d) All evaluations of monitoring will be reflected in the Quality Improvement Committee, MEC, and Governing Body meeting minutes.

5. Safety Monitoring and Evaluation Reporting

Results of monitoring, corrective actions and evaluation shall be communicated to:

- a) Center Quality Improvement/Risk Management Committee (Quarterly)
- b) Medical Executive Committee (Quarterly)
- c) Governing Body (Quarterly)
- d) Managers (monthly or as appropriate for dissemination to Center employees)

Findings and change in policies and processes are communicated to the staff through staff meetings or other desired method of communication.

POLICIES

The Center has policies and procedures that promote safety as a priority. These policies and procedures are developed in accordance with regulatory standards and current trends in healthcare. These policies include, but are not limited to:

1. Fall Risk Assessment
2. Product Recalls
3. Medication Administration and Control policies
4. Exposure Control Plan
5. Sharps Prevention
6. Infection Control Plan
7. Equipment inventory and maintenance policies
8. Variance Reporting
9. Employee response grids to systems failure, noting closing the loop on corrections
10. Emergency Preparedness Plans- Bioterrorism, Weather, Evacuation, Fire Safety, Bomb Threats, etc.
11. Emergency Procedures- Respiratory Arrest, Malignant Hyperthermia. Child Abduction, Chemical Spills etc.
12. Procedures for Incapacitated and/or Impaired Healthcare provider

SAFETY MANAGEMENT PROGRAM APPRAISAL

The program is reviewed at least annually or as indicated by other activities or survey findings.

Reviewed: 1/12/2021

Reviewed by: KK RN/Administrator

References: *AAAHC, TJC, CMS, OSHA standards.* HCA Life Safety program

Kindred Hospital Las Vegas Flamingo Campus

PATIENT SAFETY PLAN

DATE: 02/10/21



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

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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

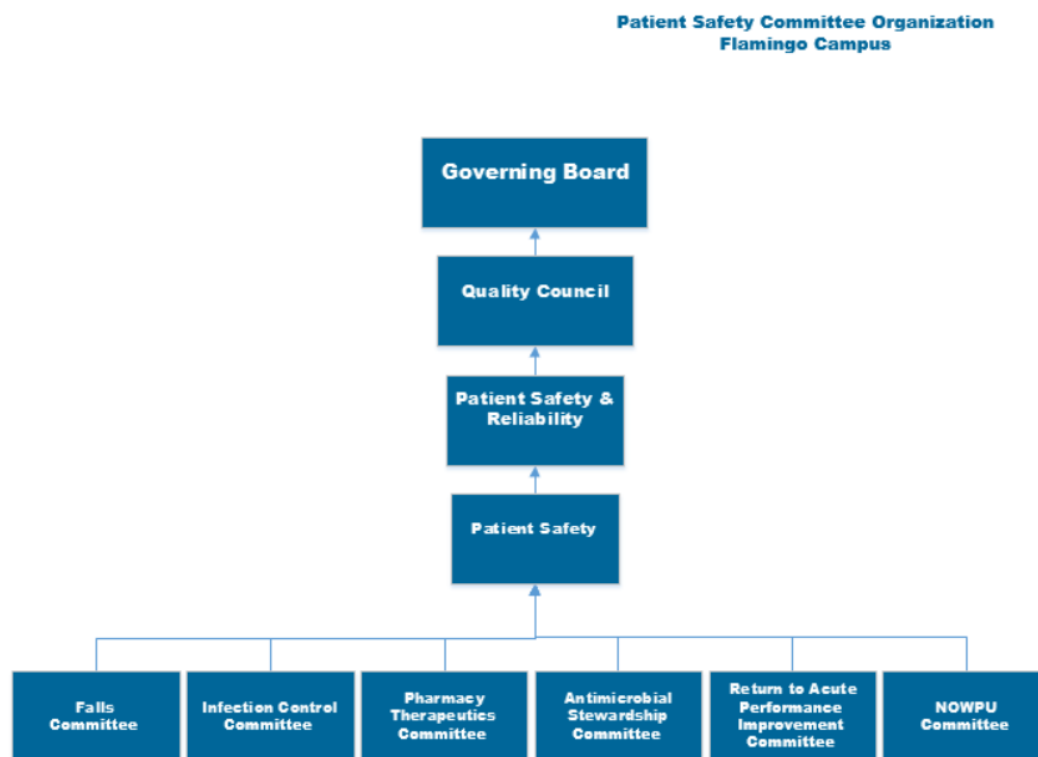
core principles of this plan include:

- 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	<p>GOAL: CLABSI rate to be = or < 1.0 infections per 1,000 central line days</p> <p>2020 CLABSI Rate: 0.69</p>	<ol style="list-style-type: none"> 1) Educate and enforce appropriate use of blood culture collection process by end of second quarter to reduce contamination rate. 2) Educate staff on blood collection from peripheral and central line sites. 3) Educate staff on the importance of patient bathing with CHG and initiate Hospital Specific Risk Reduction Strategy with CHG Bathing as a Quality Improvement effort. 4) Audit bathing processes with assistance from Education Department. 5) Central line audits to be conducted daily by Infection Preventionist 	6/30/2021	ICP/CCO
CAUTI Prevention	<p>GOAL: CAUTI rate to be = or < 1.22 infections per 1,000 indwelling catheter days</p> <p>2020 CAUTI Rate: 1.58</p>	<ol style="list-style-type: none"> 1) Educate and enforce staff compliance to the Urinary Catheter protocol approved by MEC/GB policy 2) Reeducate and continue to re-enforce physician understanding with previously approved protocol and daily need for assessment/ documentation of need for catheter to include medical rationale. 3) Continue with staff education to include return demonstration 	6/30/21	ICP/CCO

		<p>for competency of urinary catheter insertion for female and male</p> <p>4) Urinary catheter maintenance audits will be conducted daily by nurse manager and supervisor with report to ICP</p> <p>5) Involve nursing staff in education presentations regarding CAUTI prevention during staff meeting to enhance responsibility and knowledge to decrease occurrences.</p> <p>6) Work with Education Department to provide an in-service or lunch and learn specific to CAUTI prevention actions.</p>		
NOWPU Prevention	<p>Reduce NOWPU 10% 2020 NOWPU Rate Goal 2.99% 2020 Rate 3.79%</p>	<p>1) Wound assessment by admitting nurse and verified by the Wound Nurse with wound measurement within 48 hours.</p> <p>2) Weekly re-assessment by the wound team</p> <p>3) Braden Scale, Repositioning, Assessment and Wound Education to Patient Family Score</p> <p>4) Place patient on the appropriate bed surface as well as treatment plan</p> <p>5) Repositioning Q 2hours</p> <p>6) RCA done for each event</p>	12/31/21	Wound Care Coordinator/ Chief Clinical Officer
Employee Health	<p>Improve flu vaccine by 5% 2019-2020 season = 96% 2020-2021 season = 98%</p>	<p>1) Vaccine Education at time of hire to include required vaccines, influenza, and other mandated vaccines i.e. COVID - 19</p> <p>2) Provide CDC, state health department, and other regulatory education to staff and patients/families</p> <p>3) Monitor use of face masks, PPE, and hand hygiene by all personnel in patient care areas (TST audits)</p>	12/31/2021	Employee Health Nurse/ Chief Clinical Officer

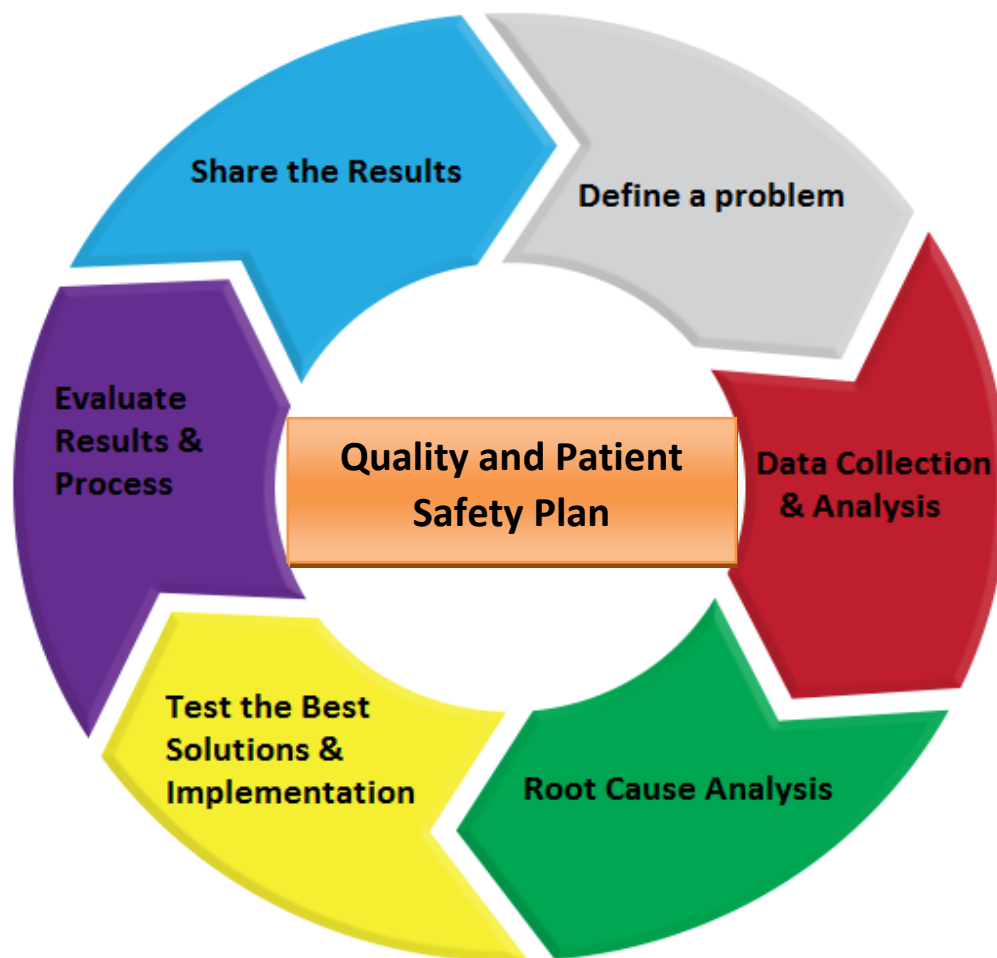
		4) Provide staff and patients/families with Just in-Time education for pandemic and other situations requiring vaccines i.e. COVID-19 vaccinations		
Antimicrobial Stewardship	Reduce Antibiotic usage to $\leq 35\%$ of total drug cost	1) Enhance the Patient Safety Dashboard for Antimicrobial Therapy Use 2) Incorporate the Pharmacist/ICP/ Infectious Disease MD rounding 3) Staff, physician and Leadership Education on antimicrobials.	12/31/21	Director Pharmacy/ICP/ CCO/ID Medical Director
Fall Reduction	Reduce falls by 10%	1) Fall risk assessment completed for each patient upon admission, every FRIDAY and with any change of condition or change in medication that increase tendency for falls. 2) Continue with Fall Reduction rounding 3) Staff education regarding Fall Prevention on hire and annually thereafter. 4) Post-fall assessment completed and a re-assessment of the Fall screening and complete/update Nursing Care Plan after each event	12/31/21	DQM/CCO
Unplanned Return to Acute Care within 30 days Performance Improvement Team (Market and Medical Staff)	Decrease current RTA rate to goal of 6.59. 2020 RTA rate 13.13	1.) RTA Performance Improvement Team formed with physician participation 2.) All RTA's are reviewed by clinical and medical staff	12/31/21	DQM

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.

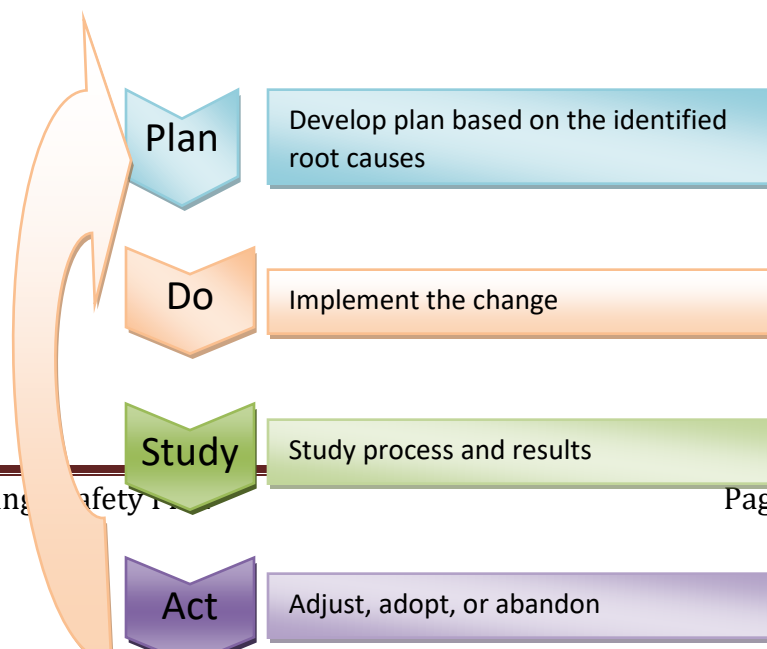
Fishbone Diagram

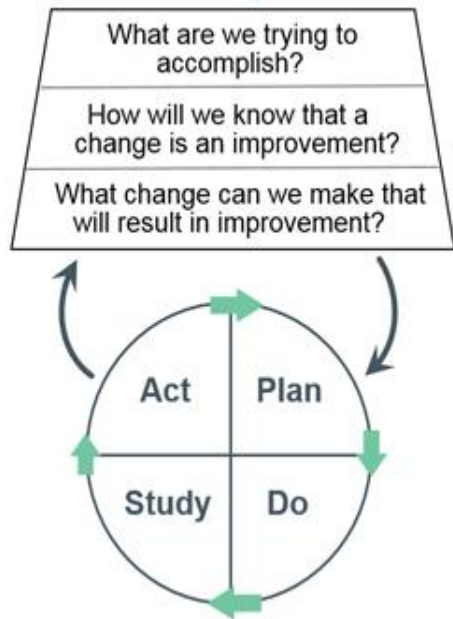
Once the problems are identified, a Fishbone Diagram (Appendix C) will be used for analyzing the problems. You can use the fishbone diagram individually to analyze the root causes, or use it with the root cause analysis and action plan framework table.

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 Flamingo 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_CURRent_b.pdf.)

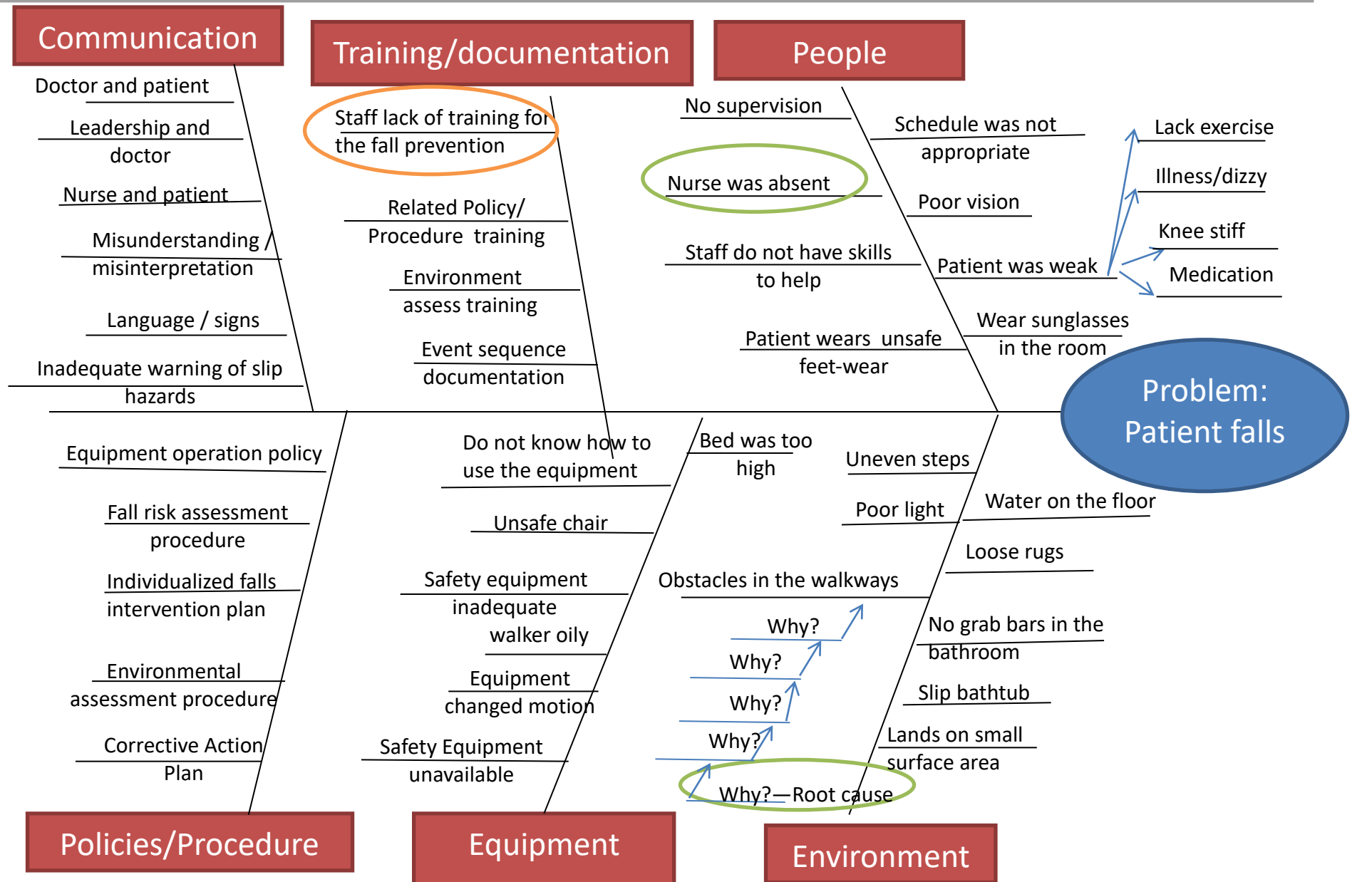
Central Line Associated Bloodstream Infections (CLABSI): Primary bloodstream infections that are associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection.

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. b. Establish an automated surveillance process. c. Conduct a proactive risk assessment in a high risk area.		Complete an in-depth analysis of risk point utilizing the methods of FMEA.	Implement Trigger Tools. Develop automated surveillance reports in Cerner.
2. Establish Structures for reporting and a process for managing reports in the event reporting system.	a. Implement new electronic Voluntary Reporting System & participate in Patient Safety Organization. b. Develop a structure to educate employees system-wide of the process for reporting hazards, errors and adverse events. c. Establish a process for providing feedback regarding reported events.	Implemented e-MERS & PSO with UHC. Create process for reviewing & closing reports in e-MERS. Create process for communicating outcome of reported events.	Increase number of events reported by 10%.	
3. Develop a Culture of Safety where providers feel safe and supported when they report medical errors or near misses & voice concerns about patient safety.	a. Provide education on patient safety plan that emphasizes importance of blending a systems focus with appropriate individual accountability. b. Establish a recognition program that rewards safe practices. c. Improve overall perceptions of safety as measured by the Culture of Safety Survey.		Educate Medical staff, Hospital Wide Oversight & the Quality Committees on the objectives and goals of the patient safety plan. Include patient safety presentation in monthly New Employee Orientation. Develop 'Great Catch' awards program.	Re-evaluate culture of safety and develop action plan.
4. Establish Safety Priorities & Targets.	a. Develop Patient Safety Dashboard that includes national measures and benchmarks. b. Facilitate the development of action plans associated with measures not meeting benchmarks. c. Assess and improve processes related to hand-off, transition and communication	Complete 2014 Leapfrog Safety Survey. Develop method to track & report departmental progress and compliance of RCA action plans.	Present Patient Safety Dashboard monthly to Hospital Wide Oversight Committee. Establish & implement a plan to improve performance of each leap.	
5. Charter Safety Programs through teams, workgroups or projects.	a. Coordinate Improvement Efforts in order to ensure that capital, people, facilities & technologies are matched to strategic priorities for safe practices. b. Reduce and eliminate variation in care.		Establish Patient Safety Council. Establish workgroups focused on medication safety, reducing patient falls & hospital acquired pressure ulcers. Revise or develop policies, procedures and protocols.	

Reference: Patient Safety Plan and Its Applicable Goals. 2014. Cook County Health and Hospitals System.

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

[Reference: Hospital Policies. MERCY Hospital. <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>]

 MERCY HOSPITAL	HOSPITAL POLICY AND INFORMATION MANUAL	
PERSONAL PROTECTIVE EQUIPMENT POLICY Page 1 of 2	Date Issued: Date Last Revised: Next Review Date: Approved By:	07/01 08/14 08/17 Policy Committee

Key Words: 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

Spring Valley Hospital Medical Center

Risk Management/ Patient Safety Plan

Nevada Acute Care Division

Revised 1/2021

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'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.

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 include:

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

B. Infection Control Officer

The infection control officer designated for each facility, based on NRS 439.873, responsibilities include:

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

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

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

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

C. Patient Safety

Spring Valley Hospital has an established Patient Safety Council (PSC) to support patient safety activities. The PSC should ensure that its Patient Safety Plan is promoted and executed successfully. **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 Riskconnect (STARS) and Midas) to maintain and manage PSWP.

I. Facility Patient Safety Committee

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

Membership:

In accordance with NRS 439.875, the committee core membership consists of the following Key Members: (CEO{member of the Executive or Governing Body}, CNO, Physician, Risk Management and others designated as Patient Safety Officer, Quality Designee, Infection Control Officer, , and Pharmacy). 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 (CFO) of the medical facility. A Patient Safety Committee established pursuant to this section must meet at least once every calendar year.

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'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 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.
- Monitor and document the effectiveness of the hand hygiene protocol or policy.
- Review policy to ensure compliance with the Patient Safety Checklists pursuant to NRS 439.877.
- **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)(d).
- Receive reports from the Patient Safety Officer pursuant to NRS 439.870.
- Evaluate actions of the Patient Safety Officer in connection with all reports of sentinel events alleged to have occurred.

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

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

II. Patient Safety Advisories

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

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

C. TERM Program

The facility has utilized its formalized risk management program identified as TERM: the Technical Elements of Risk Management. Each element focuses on a separate organizational function and details specific strategies for managing risk in these areas. In addition to the delineated elements, the TERM program also includes an evaluation of clinical practices that have or are likely to result in liability or patient harm. The TERM elements are summarized as follows:

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

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

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

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

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

Element VI. Environment of Care; Safety and Security Programs: The safety and security programs in the facility serve to protect and preserve both life and property.

Areas of safety include licensing, accreditation and federal, state, and local safety practices and programs, including the EPA, TJC, etc.

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

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

D. MIDAS

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

E. Riskonnect (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 **Spring Valley Hospital's** RM to the Governing Board of all claims activities.

F. Event Notification Site

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

G. Root Cause Analysis (RCA)

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

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

The Joint Commission's root cause analysis framework and action plan table should be used as a reference. 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, NRS 439.877, for use by:

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

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

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

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

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

I. Patient Safety Policies

The Patient Safety Policies must include, without limitation:

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

J. MEMBER PATIENT SAFETY EVALUATION SYSTEM (PSES)

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

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

K. Training and Education

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

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

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

IV. Acute Care Division Patient Safety Priorities, Goals and Objectives for 2021

- **Surgical and Procedural Safety**
 - **Wrong Site Surgery (WSS)**
 - **Goal:** A 50% reduction in WSS events for 2021. Ultimately, the goal is zero (0).
 - Monitor through Midas event reporting and the Patient Safety Dashboard. Report monthly with oversight by CPSC.
 - **Retained Procedural items (RPIs)**

- **Goal:** Prevent RPIs- a 50% reduction in RPIs with harm for 2021. Ultimately, the goal for RPIs is 0.
 - Monitor through Midas event reporting and the Patient Safety Dashboard. Report monthly with oversight by CPSC.
- **OBHRU**
 - **Reduction/Elimination of serious harm by reducing the response time to excessive obstetrical bleeding initiative.** As evidenced by:
 - **Goal:** Quantification of blood loss will occur at 95% of all deliveries as evidenced by facility results in a Healthy Intent / Analytics dashboard.
 - **Goal:** A debrief will be completed on 100% of hemorrhages >1500ml.
 - Monitor through Healthy Intent/ Analytics dashboard, Midas/ENS/Claims data, facility education reports, and the Patient Safety Dashboard. Report monthly with oversight by CPSC.
 - **Reduction / elimination of serious harm by increasing the intervention rate for uterine tachysystole and fetal heart rate category II algorithm compliance.**
 - **Goal:** To be developed in 2Q 2021.
- **CLABSI Initiative**
 - **Goal:** CLABSI will be reduced to less than the national CMS mean Standardized Infection Ratio (SIR: CLABSI 0.736) in 2021.
 - Monitor through CDC's National Healthcare Safety Network (NHSN) and the Patient Safety Dashboard. Report quarterly with oversight by CPSC.
- **Safe Medication Use**
 - **Reduce the preventable occurrences of Opioid Induced Respiratory Events (OIRD) in 2021.**
 - **Goal:** Decrease the number of preventable OIRD events by 10%.
 - **Goal:** Each facility will track and trend naloxone administrations and will identify a performance improvement project related to safe use of opioids by March 1, 2021.
 - **Goal:** 100% of Acute Care facilities will have a medication safety committee that utilizes a standardized charter and agenda by June 1, 2021
 - Monitor through MIDAS reports, Cerner ICD-10 codes and other intervention data and the Patient Safety Dashboard. Report quarterly with oversight by CPSC.
- **Reduce Falls and Falls with Injury**
 - **Goal:** 10 % reduction in the number of falls by end of 2021.
 - **Goal:** 10% reduction in the rate of falls by the end of 2021.
 - **Goal:** 10% reduction in the rate of falls with injury by the end of 2021.
 - **Goal:** A debrief will be completed within 72 hours for 100% of falls with injury.

- Monitor through MIDAS event reporting and the Patient Safety Dashboard. Report quarterly with oversight by CPSC.
- **Decreasing Hospital Acquired Pressure Injuries**
 - **Goal:** 10% reduction of NPOA rate for all HAPI stages in the Acute Care Division by the end of 2021.
 - Monitor through Midas event reporting and the Patient Safety Dashboard. Report quarterly with oversight by CPSC.
- **Culture of Safety**
 - **Goal:** reduce the number of GHI events (serious safety event rate) for the Acute Care Division by the end of 2021. Ultimately, the goal is 0.
 - Monitor through MIDAS event reporting and the Corporate Patient Safety Dashboard. Report monthly with oversight by CPSC.
 - **Goal:** 100% of 2021 Patient Safety Plan Priorities will be implemented within the hospitals.
- **Workplace Violence**
 - **Goal:** reduce the number of workplace violence events by 10% by the end of 2021.
 - Monitor through MIDAS event reporting with oversight by the EOC and PSC committees.
 - **Goal:** Quarterly WPV meeting with minutes that reflect issues, best practice, implementation and monitoring.

V. Monitoring and Accountability

A. Evaluation of TERM Program

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

B. Patient Safety Committee

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

C. Dashboards

The Risk Management/Patient Safety Dashboard and the Environment of Care includes multiple indicators to demonstrate the facility's performance as to patient safety markers. These include event reporting statistics, overall harmful event rate,

fall rate including harmful event rate, medication event rate including harmful medication events or adverse drug events, serious harm OB events, pressure injury rates, infection variances, and procedural events.

VI. Evaluation/Review:

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

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

VII. Confidentiality

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

VIII. Approval of Patient Safety Plan

According to NRS 439.865, a medical facility shall submit its patient safety plan to the Governing Board of the facility for approval. After a facility’s patient safety plan is

approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan.

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

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

Appendix A: Checklist Example: Injuries from Falls and Immobility

Process Change	In Place	Not Done	Will Adopt	Notes (Responsible & By When?)
Conduct fall and injury risk assessment upon admission				
Reassess risk daily and with changes in patient condition				
Implement patient-specific intervention to prevent falls and injury				
Communicate risk across the team; use handoff forms, visual cues, huddles				
Round every 1 to 2 hours for high-risk patients; address needs (e.g., 3Ps: pain, potty, position-pressure). Combine with other tasks(vital signs)				
Individualize interventions. Use non-skid floor mats, hip protectors, individualized toileting schedule; adjust frequency of rounds				
Review medications (by pharmacist); avoid unnecessary hypnotics, sedatives				
Incorporate multidisciplinary input for falls				

Prevention from PT, OT, MD, RN and Phar.D.				
Include patients, families and caregivers in efforts to prevent falls. Educate regarding fall prevention measures; stay with patient				
Hold post-fall huddles immediately after event; analyze how and why; implement change to prevent other falls				

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

Southern Hills Hospital and Medical Center

Patient Safety Plan

Updated: 3/5/18, 2/18/19, 2/18/2020

Medical Executive Committee: 3/15/18;3.21.2019;3.19.2020

Board of Trustee: 3/22/2017, 3/21/18 ;3.27.2019;3.25.2020

2020 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

Accountability:

An obligation or willingness to accept responsibility for one's actions.

<u>Adverse Event:</u>	A consequence of care that results in an undesired outcome.
<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>	Physical damage that substantially limits one or more of the major life activities of an individual in the short term, which may become a disability if extended in the long term Level of Injury: None- patient had no injury, all imaging if any completed with results in a finding of no injury Minor- resulted in application of dressing, ice, cleaning of a wound, limb elevation, topical medication, pain, bruise, or abrasion Moderate- Resulte din suturing, application of steri-stripsskin glue, spinting, or muscle/joint strain

Major- resulted in surgery, casting, traction, consultation for neurological or internal injury or patients with coagulopathy who receive blood products as a result

Death- the patient dies as a result from injuries

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, 2020). (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 – (2015)).

Sentinel Event Alert Gap Analysis:

A model for prioritizing and addressing potential risks related to publish external sentinel or warning alerts.

Unusual Occurrence:

Any event or condition not consistent with the normal or usual operation of the hospital or department and which has the potential for causing patient or visitor injury or property damage.

II. Policy

The Board of Trustees delegates responsibility for oversight of the patient safety program to the Quality Care/Patient Safety Committee. The Quality Care/Patient Safety Committee monitors and evaluates the effectiveness of the Patient Safety Program and generates feedback and actions as appropriate. The Quality Care/Patient Safety Committee prepares a quarterly report to the Quality Care/Patient Safety Committee, Medical Executive Committee (MEC), and the Board of Trustees (BOT). The report includes at a minimum, occurrence or trending of patient safety indicators and actions taken in response to actual occurrences as well as proactive assessments of high-risk activities. The Patient Safety and Environment of Care Committee oversees non-clinical

safety related processes and system issues that affect patients, employees, and visitors in the environment of care.

Patient Safety and 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:

<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.
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.

<i>Role</i>	<i>Accountability</i>	<i>Specific Tasks</i>
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.

<i>Role</i>	<i>Accountability</i>	<i>Specific Tasks</i>
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 Southern Hills Hospital Quality Care/Patient Safety Committee/ Infection Control (QC/PSC) or equivalent is a multidisciplinary team involving department representatives that meets monthly. The Quality Care/Patient Safety committee or equivalent committee, is comprised of various health care professionals including but not limited to physicians, nurses, pharmacists and administrators, and is chartered to oversee the implementation of the Hospital's Patient Safety Program. The Patient Safety Officer coordinates activities within the Patient Safety Program.

Structures that support the QC/PSC or equivalent works in conjunction with other safety committees, including but not limited to:

- Medication Safety

- Quality Council
- Environment of Care
- Falls Committee
- Infection Prevention Committee

The QC/PSC reviews and develops implementation strategies for the NPSG's. Strategies include assessing and developing a culture of patient safety, encouraging a non-punitive reporting environment, developing a best practice infrastructure to foster the design of safety into our systems, and monitoring of systems risks and improvements. The QC/PSC networks with other committees as appropriate per topic to gain consensus (e.g. Quality Care Committee, Infection Prevention, Pharmacy, other). Sentinel Event Alerts and other industry alerts are routed to the appropriate committee or teams to ensure evaluation of current care processes incorporate recommended changes.

The Director of Quality/Risk Management and the Patient Safety Officer reviews Sentinel Event Alerts, other industry alerts, compliance to The Joint Commission National Patient Safety Goals, State regulatory requirements, adverse events and potential adverse events that are deemed to be preventable, health care associated infections as defined by the CDC that are deemed to be preventable, and assures recommendations are integrated into processes. Additional resources such as national and local professional organizations/associations are monitored for changes in standards and potential risk events. Regular summary reports of progress are reported to the designated Quality Care Committee, Medical Executive Committee, and the Board of Trustees.

The QC/PSC reviews and approves plans to address key organizational concerns, such as Falls, Restraint Reduction, Patient/Family Education, Patient Mobility, Blood and Blood Components, Medication Safety, Adverse Drug Reactions (ADR's), Pressure Ulcer Prevalence, Health Care Associated Infections and Environmental issues updates. The QC/PSC recommends and provides direction for training on key initiatives and educational strategies related to patient safety.

VI. Communicating with Patients about Safety

It is Southern Hills Hospital's philosophy that accountability for patient safety is imbedded in a collaborative relationship involving our Board of Trustees, administrative leadership, our medical staff, employees, patients and family.

Patient safety awareness information is posted in public areas throughout the hospital. This information contains basic strategies for patients to assist in assuring their safety. The admission and discharge patient information also contains information on the patient role in safety. Patient Guides are provided to in-patients upon admission, and includes strategies prevent untoward events such as falls, medication errors, and infections while in the hospital. Annually, Patient Safety Awareness Week activities are planned to educate and inform staff, patients and the community. The Southern Hills Hospital consumer web page also includes access to an electronic version of the Patient Guide.

Information and additional resources are provided to assure patient involvement in their care.

Patients or their families may contact the hospital to report patient safety concerns as well as to the State of Nevada Department of Health and Human Services or to the Joint Commission. The hospital's website and other patient materials include information on how to report issues internally as well as to the Joint Commission.

Patients are randomly selected to participate in completing the Patient Experience Survey after discharge, which include questions related to the patient safety experience. These results are reported to the hospital.

VII. Education

1. Staff Education

- General orientation, on-going in-service and other education and training programs will emphasize specific job-related aspects of patient safety
- Specific Patient Safety Program training at orientation and annually thereafter will include:
 - An overview of the Patient Safety Program
 - Staff's role and responsibilities in the Patient Safety Program
 - Event reporting, including the events requiring reporting and the process for reporting events.
 - Methods to support and foster an interdisciplinary and collaborative approach to the delivery of patient care;
 - Examples of specific job-related aspects of patient safety.

2. Physician Education - An overview of the Patient Safety Program is provided to physicians at time of initial appointment and periodically thereafter that describes the program, emphasizes their role and responsibilities in the program and informs them of the event reporting mechanism and Culture of Safety processes.

3. Organizational Learning: Patient safety is everyone's responsibility. Everyone has a responsibility to report. By reporting concerns, it enables the organization to learn and improve processes, procedures, and systems.

VIII. Safety Improvement Activities

Prioritization of Patient Safety Activities

Prioritization elements are defined in the annual performance improvement plan and apply to patient safety initiatives. The QC/PSC annual goals are listed at the end of this plan and meet the prioritization elements.

Routine safety-related data collection analysis

- Unusual Occurrence reporting (see SPAE Guidance Policy)
- Medication Error Reporting
- Infection Surveillance
- Culture of Patient Safety Survey
- Environmental Safety Rounds and Assessment
- Patient Experience Survey
- Executive Safety Rounds
- 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.

Monitoring and Compliance

Nevada statute NRS 439.877 requires medical facilities to adopt patient safety checklists and patient safety policies. These patient safety checklists are protocols used to improve the outcomes of patients at the hospital to include:

1. Patient Discharge Process-Healthy Living (Meditech)
2. Patient Identification Process (Policy)
3. Patient room/environment sanitation and cleaning (Sodexo 7-Step Cleaning Process)
4. Additional patient safety checklists which may be appropriate to ensure the safety of patients in the facility. These include, but are not limited to the following:
 - a. Universal Protocol (Safe Procedural and Surgical Verification)
 - b. Central Line Insertion Bundle (Meditech)
 - c. Hand Hygiene (Audit)

and Reduction:

1. Opportunities for improvement regarding patient safety issues and hazardous conditions are identified through trending of actual or potential occurrences involving patients or visitors and/or evidence-based literature (e.g. The Joint Commission Sentinel Event Alerts).
 2. When an identified opportunity for improvement is identified, it is analyzed by the involved care providers according to level of severity, frequency of occurrence, potential for harm and liability.
 3. At least every 18 months, one high-risk or error-prone process is selected for Failure Mode Effect Analysis (FMEA) process. The underlying systems are examined and modified or redesigned to minimize the risk of the identified failure mode.
 4. Trending of adverse events, environmental safety issues, aggregate data collection, and review of intensive assessments are part of the identification and management of risks to safety and are used to prevent reoccurrences.
 5. Serious unusual occurrences and sentinel events are reviewed with determination made for intensive assessment and root cause analysis according to the SPAE policy.
 6. Near miss events are reviewed and root cause analysis conducted as deemed appropriate.
 7. Regular communication about patient safety and risk management is conducted with designated Quality Care Committee, Medical Executive Committee, and the Board of Trustees.
- Disclosure of an adverse event to a patient is in accordance with the SPAE policy.

IX. Reporting Patient Safety Results:**To the QC/PSC:**

The Quality Care/Patient Safety Committee reviews and recommends actions on the following reports:

- Audits and performance improvement activities on Patient Safety
- National Patient Safety Goals and Safe Practices compliance (including accordance with NRS 439.877)
- Culture of Patient Safety Survey
- Leapfrog Survey

To organization staff and medical staff:

Organizational staff receives patient safety results and information on:

- Culture of Safety Survey
- Patient experience survey results on patient safety components.
- National Patient Safety Goals and Safe Practices compliance (including accordance with NRS 439.877)
- Leapfrog Survey

To executive leadership and Board of Trustees:

The Board of Trustees and Executive Leadership receives periodic reports on:

- Culture of Safety Survey

- Leapfrog Survey
- Results of intensive analyses related to patient safety issues

X. Annual Review

The Patient Safety Program is reviewed annually and revised as necessary. It is submitted annually for review and approval by the Medical Executive Committee and the Board of Trustees.

XI. References/Authority

- The Joint Commission 2020 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 2020 - Goals

- ☐ 95% Facility Leadership to attend 2020 Leadership Safety Curriculum III by 10/15/2020
- ☐ Continue Non-punitive reporting program with recognition of a minimum of one employee; four appreciation opportunities throughout the year “Great Catch Award”
- ☐ Continue weekly Executive Leader Safety Briefs and Rounds
- ☐ Achieve 95% compliance with oxytocin process measures each quarter 4Q19 – 3Q20.
- ☐ 95% of all new leadership and staff will complete viewership of “Hindsight” educational videography by end of 3Q20
- ☐ All new in 2020 will complete viewership of “Hindsight” educational in orientation
- ☐ Complete and submit all Serious Event Analyses (SEAs) to the PSO
- ☐ Submit 2 Lessons learned documents from 2 completed SEAs to the PSO
- ☐ Submit 95% of all patient event and close call reports designated as PSWP within 60 days
- ☐ Continue Monthly Falls Committee in 2020
- ☐ Weekly Executive Leader Safety Briefs
- ☐ Standardize Facility Safety Huddle & Implement tool by 10/15/202
- ☐ Attend Patient Safety Director Development Program
- ☐ Attend National Patient Safety Foundation Patient Safety Congress
- ☐ Develop a comprehensive continuous survey readiness plan by 4/15/2020

HOLY CHILD RESIDENTIAL CARE LLC

2225 Jester Ct. Reno, NV 89503
(775)787-2100

PATIENT SAFETY PLAN

Our facility is licensed for 6 beds. We provide care for the elderly that needs help with their day to day activities. Our facility is also equipped with ramps and handrails for our resident's safety.

In Case of Emergency:

Our caregivers are CPR/First Aid certified. They are trained to handle emergency situations. Most of our emergency situations are referred by calling 911, informing the resident's primary physician or bringing them to the urgent care.

In Case of an Incident/Accident:

Our caregivers are trained to report any incidents to the Manager/Patient Safety Officer. These incidents are communicated to the resident's primary care physician and family/guardian. The primary care physician and guardian will then come up with a plan of care for the resident.

In case of a Sentinel Event:

Our caregivers are trained to report sentinel event to the Patient Safety Officer, who then will report it to the Red Cap System.

Patient Safety Committee:

Our facility does not have a Patients Safety Committee. Our plan is to provide care to our residents that conforms to the Plan of Care provided by their primary care physician and guardian.



CARSON VALLEY MEDICAL CENTER	Section/number	Revision Date:
Department: Quality	QA 2.004	Revision Date:
Assurance and Risk Management		6/22/09 7/17/09 3/4/11 7/12/11 12/9/11 5/21/12, 2/27/15, 2/26/16, 02/28/17, 3/29/18, 3/1/19
	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 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 resulting in an adverse event
- Any Adverse Drug Reaction
- Any Transfusion Reaction
- Hazardous Condition - any set of circumstances, exclusive of the disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious physical or psychological adverse patient outcome.

Sentinel Event –NRS 439.830

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

- The event has resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition.
- The event is one (1) of the following (even if the outcome was not death or major permanent loss of function):

Reporting Requirements NRS 439.835 Appendix A:

1. Surgical or Invasive Procedure Events

- A. Surgery or other invasive procedure performed on the wrong site
- B. Surgery or other invasive procedure performed on the wrong patient
- C. Wrong surgical or other invasive procedure performed on a patient
- D. Unintended retention of a foreign object in a patient after surgery or other invasive procedure

- E. Intraoperative or immediately postoperative/post procedure death in an ASA Class 1 patient
- 2. Product or Device Events
 - A. Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting
 - B. Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended
 - C. Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting
- 3. Patient Protection Events
 - A. Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person
 - B. Patient death or serious injury associated with patient elopement (disappearance)
 - C. Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting
- 4. Care Management Events
 - A. Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)
 - B. Patient death or serious injury associated with unsafe administration of blood products
 - C. Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting
 - D. Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy
 - E. Patient death or serious injury associated with a fall while being cared for in a healthcare setting
 - F. Any Stage 3, Stage 4, or unstageable pressure ulcers acquired after admission/presentation to a healthcare setting
 - G. Artificial insemination with the wrong donor sperm or wrong egg
 - H. Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen
 - I. Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results
- 5. Environmental Events
 - A. Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting
 - B. Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances
 - C. Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting
 - D. Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting
- 6. Radiologic Events

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

7. Potential Criminal Events

- A. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider
 - B. Abduction of a patient/resident of any age
 - C. Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting
 - D. Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting
- Near Miss - any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome.

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

- Ethics, Rights and Responsibilities
- Provision of Care, Treatment and Services
- Medication Management
- Surveillance, Prevention and Control of Infection
- Improving Organization Performance
- Leadership
- Management of the Environment of Care
- Management of Human Resources
- Management of Information

Methodology:

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

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

- (1) The Infection Control Officer of the medical facility.
- (2) The patient safety officer of the medical facility.

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

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

The Patient Safety Committee shall:

- (a) Receive reports from the patient safety officer pursuant to [NRS 439.870](#).
- (b) Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred at the medical facility.
- (c) Review and evaluate the quality of measures carried out by the medical facility to improve the safety of patients who receive treatment at the medical facility.
- (d) Review and evaluate the quality of measures carried out by the medical facility to prevent and control infections at the medical facility.
- (e) Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur at the medical facility.
- (f) At least once each calendar quarter, report to the executive or governing body of the medical facility regarding:
 - 1) The number of sentinel events that occurred at the medical facility during the preceding calendar quarter; and
 - 2) The number and severity of infections that occurred at the medical facility during the preceding calendar quarter
 - 3) Any recommendations to reduce the number and severity of sentinel events that occur at the medical facility.
- (g) Adopt patient safety checklists and patient safety policies as required by NRS 439.877, review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

The Patient Safety Officer duties include:

- (a) Serve on and facilitate the patient safety committee.
- (b) Supervise the reporting of all sentinel events alleged to have occurred at the medical facility, including, without limitation, performing the duties required pursuant to **NRS 439.835**.
- (c) Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the medical facility.
- (d) Report to the patient safety committee regarding any action taken in accordance with paragraph (c).

All departments within the organization (patient care and non-patient care departments) are responsible to report patient safety occurrences and potential occurrences to the Patient Safety Officer and complete an occurrence report. The Patient Safety Officer in conjunction with Risk will aggregate occurrence information and present a report to the Patient Safety Committee on at least a monthly basis. The report will contain aggregated information related to type of occurrence, severity of occurrence, number/type of occurrences per department, occurrence impact on the patient, remedial actions taken, and patient outcome. The Patient Safety Committee will analyze the report information and determine further patient safety activities as appropriate.

- Through review of internal data reports and reports from external sources (including, but not limited to Core Measure performance data, occurrence reporting information from state and federal sources and current literature), and through the Risk Performance Improvement report, the Patient Safety Committee will review Patient Safety occurrences. The Quality Manager, Patient Safety Officer, or Department Leader will:
 - Redesign the process and/or underlying systems to minimize the risk of that undesirable variation or to protect patients from the effects of that undesirable variation
 - Test and implement the redesigned process
 - Identify and implement measures of the effectiveness of the redesigned process
 - Implement a strategy for maintaining the effectiveness of the redesigned process over time
 - Keep the Quality Manager informed regarding any process improvements.

The following include description of mechanisms to ensure that all components of the healthcare organization are integrated into and participate in the organization wide program.

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

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

- As appropriate to the occurrence, perform necessary healthcare interventions to contain the risk to others - example: immediate removal of contaminated IV fluids from floor stock should it be discovered a contaminated lot of fluid solutions was delivered and stocked.
- Contact the patient's family/caregivers to report the incident as directed by the Quality or department leader if necessary. Contact the attending physician and other physicians, as appropriate, to report the error, carrying out any physician orders as necessary. Document that this has been done in the medical record.

- Preserve any information related to the error (including physical information). Examples of preservation of physical information are: Removal and preservation of blood unit for a suspected transfusion reaction; preservation of IV tubing, fluids bags and/or pumps for a patient with a severe drug reaction from IV medication; preservation of medication label for medications administered to the incorrect patient. Preservation of information includes documenting the facts regarding the error on an occurrence report, and in the medical record as appropriate to organizational policy and procedure.
- Report the process/system failure or medical/health care error to the staff member's immediate supervisor.
- Submit the occurrence report to the Risk Management Department per organizational policy.

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

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

- No Harm Failures or Errors - (including "no harm" medication errors) - staff will document appropriately in the medical record according to organizational policy, document the circumstances regarding the no harm error on an occurrence report form, submit the form to the Risk Management Department and notify their immediate supervisor.
- Mild-Moderate Adverse Outcome Failures or Errors (including medication errors) - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then preserve any physical evidence as appropriate, notify his/her immediate supervisor, document facts appropriately in the medical record and on an occurrence report - submitting the report to the Risk Management Department per organizational policy.
- Medication Errors - the staff member identifying a medication error (no harm and mild-moderate harm) will complete an occurrence report or respond appropriately to the Medication Safety Committee email.
- Adverse Drug Reaction - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then preserve any physical evidence as appropriate, notify his/her immediate supervisor, document facts appropriately in the medical record and on an occurrence report, submitting the report to the Risk Management Department per organizational policy. Staff will also notify the Pharmacy Department.

- Transfusion Reaction - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then follow the Suspected Transfusion Reaction Nursing Worksheet Policy and Procedure BB-35.
- Hazardous Condition/Patient Safety Issue - as appropriate, and if possible, staff will contain the hazardous condition or patient safety issue. Staff identifying a hazardous condition or potential patient safety issue will immediately notify his or her supervisor and document the findings on an occurrence report. The occurrence report will be submitted to the Risk Management Department and Patient Safety Officer per organizational policy.
- Sentinel Event - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. The staff will also notify the patient's family/caregiver to notify them of the incident and will document all notifications and interventions in the medical record. Staff will then follow the organizational Sentinel Event Policy and Procedure. The Patient Safety Officer will organize a Root Cause Analysis (RCA) as soon as possible after the event.
- Near Miss - staff will report the near miss event to his/her immediate supervisor, describe the facts of the near miss on an occurrence report and submit the report to the Risk Management Department.

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

- Further remedial action activities necessary for identified occurrences
- Proactive occurrence reduction activities
- Necessity and benefit of root cause analysis performance for identified occurrences or proactive reduction activities

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

- All personnel are required to report suspected and identified medical/health care errors, and should do so without the fear of reprisal in relationship to their employment. This organization supports the concept that errors occur due to a breakdown in systems and processes, and will focus on improving systems and processes, rather than disciplining those responsible for errors and occurrences. A focus will be placed on remedial actions to assist rather than punish staff members

using the Just Culture method, with the Patient Safety Committee and the Environment of Care Committee and the individual staff member's department supervisor determining the appropriate course of action to prevent error recurrence.

- Sentinel Events – Quality Assurance and Risk Management encourages the staff member's involvement in the root cause analysis and action plan processes, to allow the staff member an active role in process resolution. Additionally, any staff member involved in a sentinel event or other medical/health care error may request and receive supportive personal counseling from the Human Resources Department and/or his or her department supervisor (Refer to the Critical Incident Stress policy).
- The Patient Safety Program includes implementation of the recommendations set forth by the Joint Commission, or identified alternative recommendations defined by this institution, to achieve compliance with the Joint Commission established National Patient Safety Goals. The selected recommendations will be monitored on a routine basis to evaluate the organization's effectiveness in the implementation of the recommendations in achieving compliance with the identified National Patient Safety Goals.
- Patients, and when appropriate, their families are informed about the outcomes of care, including unanticipated outcomes, or when the outcomes differ significantly from the anticipated outcomes. ***See Managing the Disclosure of Unanticipated Outcomes policy # 2.049.***
- Observation will be used ensure compliance with patient safety checklists and will offer opportunities for corrective feedback. This approach is a learning opportunity not intended for disciplinary purposes. ***See Active Surveillance of Patient Safety Checklist Use policy # 2.030.***
- Staff will receive education and training during their initial orientation process and on an ongoing basis regarding job-related aspects of patient safety, including the need and method to report medical/health care errors. And, because the optimal provision of healthcare is provided in an interdisciplinary manner, staff will be educated and trained on the provision of an interdisciplinary approach to patient care.
- Medical/health care errors and occurrences, including sentinel events, will be reported internally and externally, per hospital policy and through the channels established by this plan. External reporting will be performed in accordance with all state, federal and regulatory body rules, laws and requirements.
- A quarterly patient safety report will be forwarded to the Governing Body on the occurrence of medical/health care errors and actions taken to improve patient safety, both in response to actual occurrences and proactively.

Pursuant to NRS 439.877 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

PATIENT SAFETY PLAN

2021

Effective:	February 2005 (combines Organization Safety and Patient Safety Plans)
Revised:	October, 2005
Revised:	December, 2006
Revised:	December, 2007
Revised:	January, 2009
Revised:	January, 2010
Revised:	January, 2011
Revised:	January, 2012
Revised:	February, 2014
Revised:	November 2014
Revised:	November 2015
Revised:	December 2016
Revised:	December 2017
Revised:	February 2019
Revised:	December 2019
Revised:	January 2021

INTRODUCTION

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

MISSION

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

CORE VALUES

Putting patients first

Treating everyone with dignity and respect.

I. PURPOSE/ROLE

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

II. FRAMEWORK FOR SAFE, RELIABLE AND EFFECTIVE CARE

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



© Institute for Healthcare Improvement and Safe & Reliable Healthcare

Source: Frankel A, Haraden C, Federico F, Lenoci-Edwards J. *A Framework for Safe, Reliable, and Effective Care*. White Paper. Cambridge, MA: Institute for Healthcare Improvement and Safe & Reliable Healthcare; 2017. (Available on ihi.org)



III. ROLES and RESPONSIBILITIES/COMPOSITION

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

IV. AUTHORITY AND RESPONSIBILITY

The authority and responsibilities of the Committee shall include:

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

Committee shall include:

- Infection Prevention Program to prevent and control infections within the medical facility (this is a document separate from the Patient Safety Plan that meets the requirements for NRS 439.865)
- Patient Safety checklists and patient safety policies as required by NRS. 439.877
- 2021 Checklist Inventory *Attachment A*
- Annual review and revision of checklists and policies
- Annual Report to Legislative Committee on Health Care
- Integration of all patient safety activities both ongoing and developing
- Ongoing orientation, education and training to emphasize specific job related aspects of patient

safety to maintain and improve staff awareness

- Internal reporting of medical / healthcare incidents and events, effectively respond to actual occurrences, manage occurrences and events with a non-punitive approach, and focus on processes and systems to minimize individual blame and retribution
- Periodic survey of the staff regarding willingness to report unsafe conditions, near misses, and adverse events as well as actions taken to prevent recurrence
- Organizational learning and communication of occurrence and event information
- Consideration of patient safety priorities when designing and redesigning of relevant processes, functions and services
- Involvement and education of patients, their families about their role in facilitating safe delivery of care, identifying potential risks and suggesting improvement to patient safety

V. SCOPE OF ACTIVITIES

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

- Patient Safety
- Visitor Safety
- Employee Safety

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

Patient Safety Committee activities include:

- Performing analysis of patient safety event data in order to identify trends and system issues for use in decision-making and identification of improvement opportunities
- Participating in standardizing work and designing processes consistent with the science of patient safety
- Reporting of Sentinel Events pursuant to NRS Chapter 439
- Recommendations, as appropriate to the executive or governing body for reducing the number and severity of serious safety and sentinel events and infections that occur
- Providing emotional support for staff involved in incidents or events, through Human Resources leadership, department supervisors and other resources as appropriate
- Report at least quarterly to the executive or governing body
- The number of events by type and severity, including unsafe condition and near miss events
- The number of sentinel events occurring in the previous quarter
- The number/severity of infections occurring in the previous quarter
- Quality Measures: Review and evaluate to improve the safety of patients who receive treatment to prevent and control infections
- Monitor patient/ environmental safety issues identified throughout the organization
- Promote internal and external knowledge and experience to prevent patient harm, adverse events and occurrences, to maintain and improve patient safety
- Dashboard Trending Report: Review aggregated or trended data including but not limited to:
 - no harm events
 - mild or moderate adverse outcomes
 - near misses
 - medication events

- falls
- adverse drug reactions
- transfusion reactions
- and hazardous conditions
- Utilize a proactive approach to recognize and acknowledge medical/healthcare events and risks to patient safety, and initiate actions and recommendations to reduce or prevent such events and risks
- Prioritize and recommend Patient Safety activities, as appropriate, utilizing trended data from Environmental Safety, Security, Employee Health, Emergency Management, Lab or Radiation Safety, Utilities Management, Bio Med, Fire Drills or Inspections
- Identify opportunities and mechanisms to educate and involve patients and families in the patient safety program
- Foster a culture of reporting and learning by identifying ‘good catch’ events as these events provide opportunities to recognize potential system vulnerabilities and proactively address, mitigate and prevent mistakes before they reach the patient

VI. METHODS

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

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

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

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

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

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

In 2021, Carson Tahoe Health will pilot and implement Safety STOP as another method to prevent patient harm. Safety STOP is a timely response to potential threats to patient and caregiver safety identified by

any caregiver or provider.

Safety STOP provides the following:

- An immediate and comprehensive response to serious safety events
- Ensures appropriate care and attention is given to the patient, family, caregivers, and providers
- Reduces the risk of additional harm or a similar event from happening and
- Allows concerns to be escalated when the usual chain of command process has failed

PATIENT SAFETY OFFICER

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

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

STRUCTURE

Attachment B depicts the reporting structure.

Attachment A

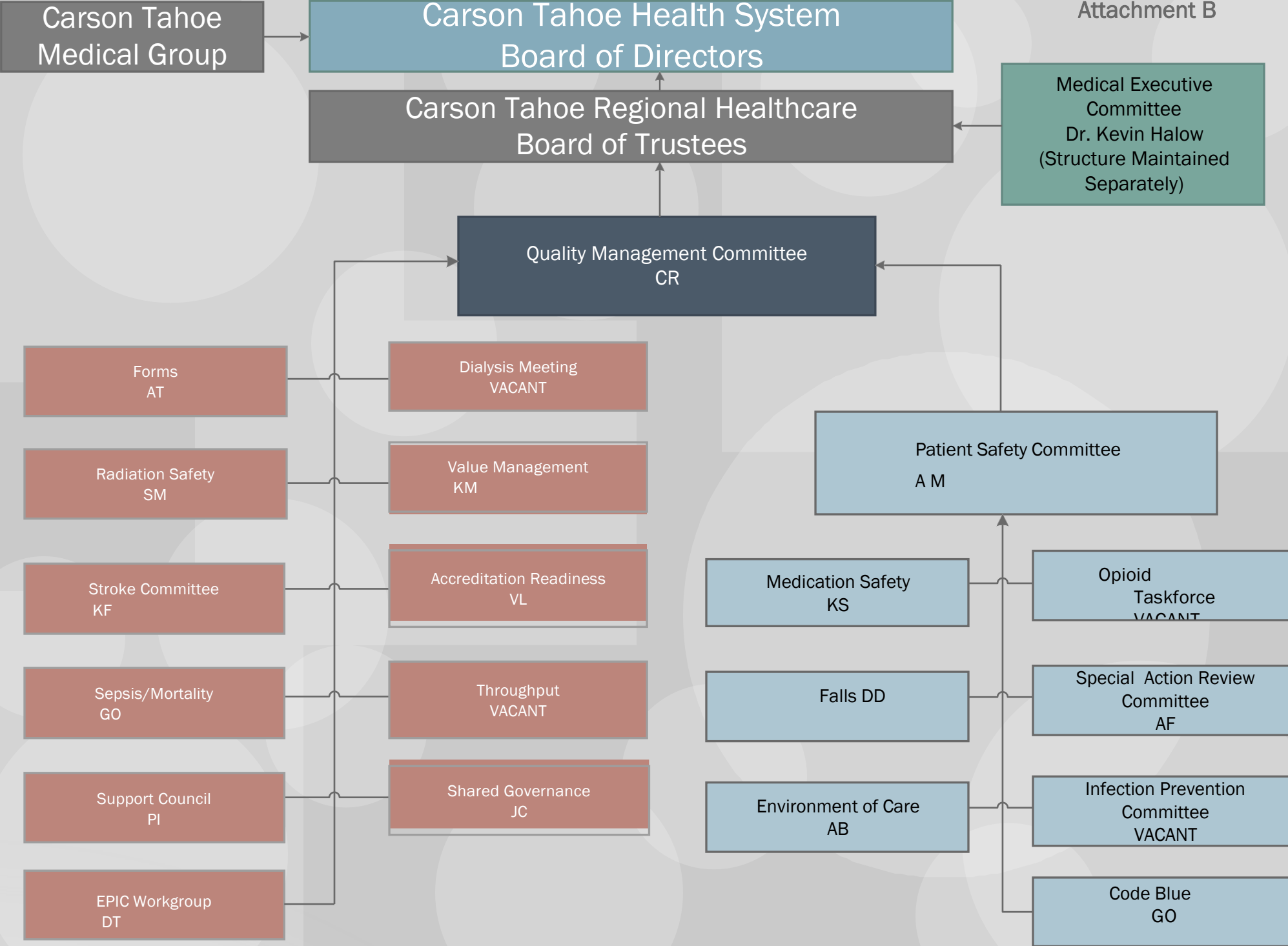
Carson Tahoe Regional Medical Center 2021 Checklist Inventory			
Checklist Title		Checklist Category	Department
1	HERT Team Leader Checklist	Other Safety	Emergency Mgt.
2	HERT Activation Checklist	Other Safety	Emergency Mgt.
3	HERT Ambulatory and Non-Ambulatory Set-Up Checklist	Other Safety	Emergency Mgt.
4	HERT Dirty Water Set-up Checklist	Other Safety	Emergency Mgt.
5	HERT Triage/Morgue Set-up Checklist	Other Safety	Emergency Mgt.
6	HERT Tent Set-up Checklist	Other Safety	Emergency Mgt.
7	HERT Receiving Checklist	Other Safety	Emergency Mgt.
8	217 Telemetry, Medical/Oncology & Pharmacy Swing	Environment	Housekeeping
9	304 Projects/Floor Care	Environment	Housekeeping
10	Form 100 Lead/Admin	Environment	Housekeeping
11	Form 101 Telemetry	Environment	Housekeeping
12	Form 102 Medical Oncology A & Pharmacy	Environment	Housekeeping
13	Form 103 Medical Oncology B Therapy Gym	Environment	Housekeeping
14	Form 104 OB/Peds	Environment	Housekeeping
15	Form 105 Surgical/Orthopedics	Environment	Housekeeping
16	Form 106 ICU/CVU	Environment	Housekeeping
17	Form 107 ER/OBS/Fast Track Days	Environment	Housekeeping
18	Form 108 OR Days	Environment	Housekeeping
19	Form 109 Cath Lab/Outpatient Days	Environment	Housekeeping
20	Form 110 Public Area	Environment	Housekeeping
21	Form 111 Waste Management Days	Environment	Housekeeping
22	Form 112 BHS Check Sheet	Environment	Housekeeping
23	Form 113 BHS 'C' Unit	Environment	Housekeeping
24	Form 114 Floor Care	Environment	Housekeeping
25	Form 200 Lead	Environment	Housekeeping
26	Form 202 Tele/OB Swing	Environment	Housekeeping
27	Form 203 Swing Surgical/Orthopedics, CVU and ICU	Environment	Housekeeping
28	Form 204 ICU/CVU Swing	Environment	Housekeeping
29	Form 205 ER/OBS Fast Track Swing	Environment	Housekeeping
30	Form 206 OR Swing	Environment	Housekeeping
31	Form 207 Cath Lab/X-Ray Outpatient	Environment	Housekeeping
32	Form 208 Waste Management Swing	Environment	Housekeeping
33	Form 209 SMC First Floor	Environment	Housekeeping
34	Form 210 Cancer/Merriner	Environment	Housekeeping
35	Form 211 Minden Checklist	Environment	Housekeeping
36	Form 212 Mica Surgery/Pain Clinic	Environment	Housekeeping
37	Form 213 Projects/Floor Care	Environment	Housekeeping
38	Form 214 Projects/Floor Care	Environment	Housekeeping
39	Form 215 Projects/Floor Care	Environment	Housekeeping
40	Form 216 Lab/Office Swing	Environment	Housekeeping
41	Form 217 Telemetry, Med Oncology A and Phm Swing	Environment	Housekeeping
42	Form 301 ER/OBS/Fast Track	Environment	Housekeeping

Attachment A

Carson Tahoe Regional Medical Center 2021 Checklist Inventory			
	Checklist Title	Checklist Category	Department
43	Form 302 OR	Environment	Housekeeping
44	Form 303 Basement/Discharges/OR	Environment	Housekeeping
45	Form 304 Projects/Floor Care	Environment	Housekeeping
46	Quality Assurance Checklist	Environment	Housekeeping
47	Pediatric Unit Department Checklist	Environment	PEDS
48	Discharge Checklist for Patients	Discharge	BHS
49	Discharge Checklist for Nursing	Discharge	BHS
50	Admission Checklist Nurse and Tech/Unit Clerk	Other Safety	BHS
51	AMA Intervention Checklist	Other Safety	BHS
52	Shift Checklist for Nursing Staff	Other Safety	BHS
53	Psychosocial Treatment Plan Tracking Form	Treatment	BHS
54	Sharp Contraband Tracking Form	Treatment	BHS
55	Fire Drill Participation	Environment	House wide-Security
56	Fire Report	Environment	Security
57	Fire Watch Form	Environment	Security
58	Life (Fire) Safety Inspection/Business Occupancy	Environment	Security
59	Life (Fire) Safety Inspection/Healthcare Occupancy	Environment	Security
60	Patient Observation Checklist	Other Safety	Security
61	Adult Crash Cart Checklist	Other Safety	House wide
62	Newborn Nursery Crash Cart Checklist	Other Safety	House wide
63	OB Hemorrhage Cart Checklist	Other Safety	House wide
64	Pediatric Crash Cart Checklist	Other Safety	House wide
65	OB Recovery Room Red Cart	Other Safety	House wide
66	OB OR Checklist	Other Safety	Women's/Children
67	3M Steam Flash Sterilization Log	Other Safety	House wide
68	AED Checklist	Other Safety	House wide
69	Breast Milk Refrigerator Temperature Log	Other Safety	Women's/Children
70	Refrigerator/Freezer Temperature Record	Other Safety	House wide
71	List and Process Monitor Documentation System	Other Safety	GBI
72	NV State Immunization Program Temperature Log	Other Safety	Women's/Children
73	Nursery Blanket Warmer Temperature Log	Other Safety	Women's/Children
74	OB/RR Blanket Warmer Temperature Log Top Compartment	Other Safety	House wide
75	Ticket to Ride	Other Safety	House wide
76	Central Line Associated Blood Stream Infection (CLABSI) and Catheter Associated Urinary Tract Infection (CAUTI) surveillance	Other Safety	Infection Control
77	CAUTI Bundle Audit Data Collection	Other Safety	Infection Control
78	Hand Hygiene Compliance Monitoring	Other Safety	Infection Control
79	Infection Control Risk Assessment	Other Safety	Infection Control
80	Emergency Equipment Checklist	Other Safety	ICU
81	Urgent Heart Chart Daily Checklist	Other Safety	ICU

Attachment A

Carson Tahoe Regional Medical Center 2021 Checklist Inventory			
	Checklist Title	Checklist Category	Department
82	Chemotherapy Administration Checklist	Other Safety	Medical Oncology
83	Pre-Op/Circ/PACU Chart Deficiency Checklist	Treatment	Surgical Areas
84	Hand-off Communication Sheet Pre-Op/OR/PACU	Treatment	Surgical Areas
85	Surgical Checklist	Treatment	Surgical Areas
86	Universal Protocol Checklist/Hand-off Communication	Treatment	Surgical Areas (not SSH)
87	Universal Protocol Checklist for Injection Procedures	Treatment	Surgical Areas (not SSH)
88	Pre-op/Procedural Checklist	Other Safety	Surgical Areas (not SSH)
89	Ventilator Calibration Checklist	Other Safety	Respiratory
90	BHS Unit Safety Rounds Worksheet	Other Safety	House wide
91	Carson Tahoe Emergency Department Triage Protocol	Other Safety	Emergency Dept.
92	Carson Tahoe Emergency Department Stroke Protocol (MD Guidelines)	Other Safety	Emergency Dept.
93	Magnetic Resonance Imaging (MRI) History and Assessment	Treatment	Medical Imaging
94	MRI Invasive Procedure Checklist	Treatment	Medical Imaging
95	Non-Ionic and/or Ionic Contrast Consent Form	Treatment	Medical Imaging
96	Pre-Catheterization/Vascular Lab Checklist	Treatment	Catheterization Lab
97	Patient Room Safety Inspection	Other Safety	House wide
98	Pre-op Education	Treatment	Mica Surgery



**Dignity Health – St. Rose Dominican
San Martin Campus**

PATIENT SAFETY/RISK MANAGEMENT PLAN

DATE: 01/2020



This plan was created and revised by the Dignity Health – St. Rose Dominican Patient Safety Officer with review and input from the Patient Safety Committee. Implementation of this plan is intended to optimize the healthcare quality and patient safety outcomes, encourage recognition, reporting, and acknowledgment of risks to patient, visitor, and employee safety, as well as reduce the medical/healthcare errors and /or preventable events.

Patient Safety Committee/Program
St. Rose Dominican – San Martin Campus
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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 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, 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 undesirably from that of other campuses/organizations;
- Performance varies significantly and undesirably from recognized standards; and/or
- A reportable event has occurred at that campus.

Minimally, data from the following areas will be gathered at each facility and presented at that facility for analysis with action plans developed reflective of the findings:

- Initial and on-going proactive risk assessments utilizing internal and external resources;
- Campus aggregate event reports reflective of all medical/healthcare events, with and without adverse outcomes, including but not limited to:
 - Hospital acquired infections
 - Medication events, to include delays in administration
 - Adverse drug events
 - Transfusion reactions
 - Patient falls
- Actual and near misses
- Hazardous conditions
- Restraint issues
- Medical record legibility issues
- Patient/family/staff opinions, needs, perceptions of risks to patients, and suggestions for improving patient safety;
- Identified data trends and analysis reports from sister facilities, Dignity Health Shared Learnings, etc.
- Others as defined by various campus committees, Leadership and/or Quality Council and Advisory Committee of the Board (QCAC).

Roles and Responsibilities

Per NRS 439.875, a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plan is promoted and executed successfully.

The Patient Safety Committee Organization

Roles and Responsibilities

- In accordance with NRS 439.875, a patient safety committee must be comprised of:
- The infection control officer of the medical facility;

- The patient safety officer of the medical facility, if he or she is not designated as the infection control officer;
- At least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility; and
- One member of the executive or governing body of the medical facility.

The roles and responsibilities are defined below.

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

The Patient Safety Committee convenes monthly in accordance with NRS 439.875. In collaboration with the Patient Safety Officer, the committee represents the San Martin Campus and includes multidisciplinary team members which has oversight responsibility to ensure that the responsibilities and functions outlined in this program are carried forward throughout the organization. The following are responsibilities assigned:

- Serve as champions of the Patient Safety/Risk Management Program within the facility/organization.
- Establish and evaluate data to identify patient safety performance indicators.
- Evaluate other sources of patient safety data utilizing internal and external resources including but not limited to adopted patient safety checklists, risk assessments, sentinel event report/alert information and event reporting information from a variety of available resources including the event reporting system, APIC, CHPSO, etc.;
- Selection of a high-risk patient safety process for proactive risk assessment and improvement annually;
- Collaborates with each facility's Quality Council to identify, address and conduct follow-up on patient safety related trends, analysis results, changes in processes, and policies.
- Annual review of the Patient Safety Program to ensure its appropriateness of focus and effectiveness of efforts for each campus.
- Monitor and document the effectiveness of the patient identification policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the patient safety officer pursuant to [NRS 439.870](#).
- Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred.
- Review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- Review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur.

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

Root Cause Analysis (RCA) Team Responsibilities

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

Patient Safety Officer Responsibilities (based on NRS 439.870)

The Manager of Patient Safety/Risk Management 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 2021.	May 2021
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
Quality/Patient Safety staff orientation	Quality/Patient Safety Services will review/update Manager orientation.	March 31, 2020
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, and 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 Privilege (PSWP Privilege) to maintain confidentiality as defined in the Federal Regulation.

- A. San Martin shall respond to all reported potential and actual adverse/sentinel events. (See Sentinel Event policy).
- B. Minimally, all adverse events will be analyzed utilizing a team of individuals including Risk Management/Patient Safety and Quality Departments, to conduct root cause analysis (RCA), incident review and/or a failure mode effects analysis (FMEA), implementation in action plan to reduce further risk to patients and establish measures of effectiveness.
 - a. The following events always elicit an intense analysis:
 - i. Confirmed transfusion reactions
 - ii. Significant adverse drug reactions
 - iii. Significant medication events and hazardous conditions

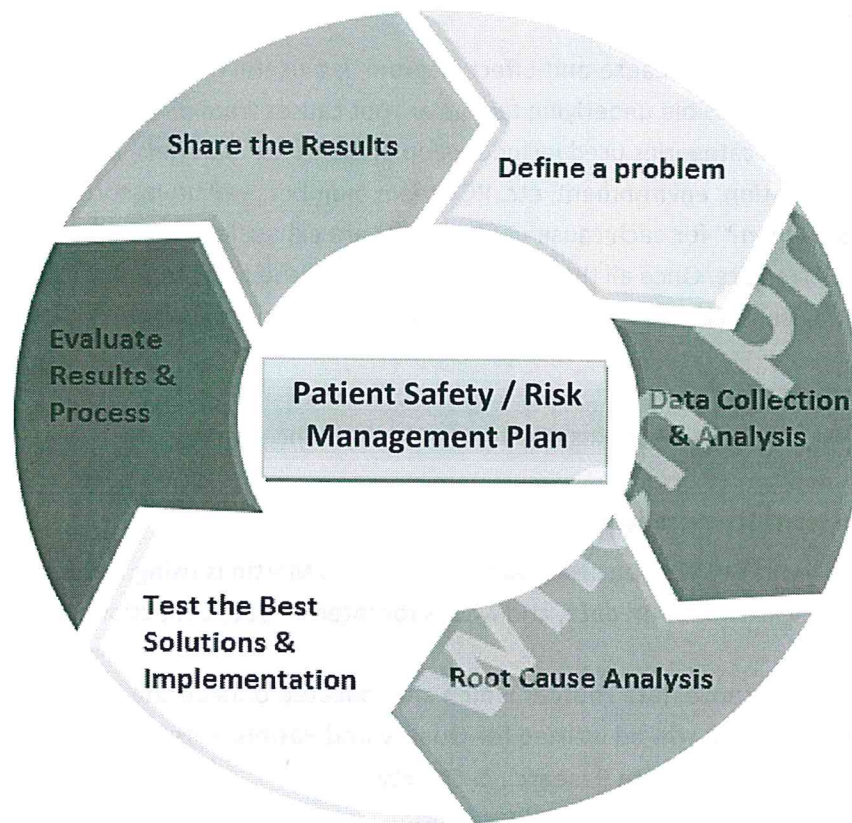
- iv. Minor discrepancies, or patterns of discrepancies, between preoperative and postoperative (including pathologic) diagnoses, including those identified during the pathologic review of specimens removed during surgical or invasive procedures; and
 - v. Significant adverse events associated with anesthesia use.
 - vi. Hospital acquired infections
 - vii. All events meeting the definition of Sentinel Events in the State of Nevada.
- b. A root cause analysis is performed when a sentinel or State reportable event occurs.
- c. An incident review is performed when a near miss or other event with significant areas for improvement are identified.
- C. Staff involved in an adverse/sentinel event shall be treated with respect and dignity.
 - a. A “JUST CULTURE” approach shall be taken in order to facilitate changes in systems and processes to prevent further risk to patient safety, as well as promote future reporting by other staff.
 - b. Involved staff should be involved in the RCA process.
 - c. The Department Manager will provide ongoing support to the staff member(s) as needed.
 - d. Whenever necessary, Crisis Intervention or Employee Assistance Programs (EAP) will be offered as support to the involved employee.

Education

- A. Staff Education
 - a. General orientation and other education and training programs as needed will emphasize specific job related aspects of patient safety and risk reduction strategies.
 - b. Specific Patient Safety/Risk Management Program training at orientation and annually thereafter will include:
 - i. An overview of the Patient Safety Program
 - ii. Overview of TJC National Patient Safety Goals
 - iii. Staff’s role and responsibilities in the Patient Safety/Risk Management Program
 - iv. Event reporting criteria and process
 - v. Methods to support and foster an interdisciplinary and collaborative approach to the delivery of patient care
 - vi. Examples of specific job related aspects of patient safety.
 - c. Staff participating at a higher level of the Patient Safety/Risk Management Program will receive appropriate training necessary to understand and complete their assigned responsibilities.
- B. Physician Education
 - a. An overview of the Patient Safety/Risk Management Program will be provided to physicians at time of initial appointment and annually thereafter that describes the program, emphasizes their role and responsibilities in the program and informs them of the event reporting mechanism.
 - b. Specific physicians may receive additional training to support their involvement at a higher level in the Patient Safety/Risk Management Program.

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

San Martin Campus will use RCA process to determine the contributing factors and the underlying reasons for the deficiencies or failures. The Plan-Do-Study (check)-Act (PDSA or PDCA) is the model, developed by the Institute of Health Care Improvement, that we will use to test the changes.



Root Cause Analysis

A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals.

Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

Root cause analysis and action plan framework table, which was introduced by the Joint Commission. It contains 24 analysis questions. It guides the organization to the steps in a root cause analysis. Not all the questions apply to all the events or cases. This table can be used individually or with the fishbone diagram.

5 Whys technique will be used in San Martin Campus to explore the cause and effect relationship underlay a problem. One can find the root causes by asking “why” no less than five times. This technique can be used individually or as a part of the fishbone diagram.

Fishbone Diagram

Once the problems are identified, a Fishbone Diagram will be used for analyzing the problems. You can use the fishbone diagram individually to analyze the root causes, or use it with the root cause analysis and action plan framework table.

A Fishbone Diagram, also called a Cause-and-Effect diagram, is a useful tool for a team to structurally brainstorm by discovering possible underlying factors or root causes from different major categories for the chosen problems. General categories used include: people, methods, materials, measurements, education, procedures, process, location, environment, etc. RCA team members will brainstorm and ask multiple times, “why did this happen?” for each cause until all ideas are exhausted. The highest priority root causes will be chosen for PDSA topics. Once all the categories are established on the fishbone diagram, 5 Whys technique also can be used to drill down the problem and find the root causes.

Model for Improvement

Please refer to the Dignity Health – St. Rose Dominican Performance Improvement Plan.

Data Collection and Reporting

Data should drive any quality and patient safety effort. San Martin is using IVOS for tracking the sentinel events, healthcare infection data, and Midas for internal data collection.

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

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

Ongoing Reporting and Review

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

Monthly	Quarterly	Annually
1) Sentinel event monthly report 2) Severity of infection report 3) RCA assessment	1) Sentinel event quarterly report 2) Severity of infection report 3) Review and evaluate the measure of improvement of patient safety 4) Review and evaluate the measurement to prevent and control infections	1) Quality and Patient Safety Plan update 2) Checklists and Policies reviewing and revising

Assessment of the Quality and Patient Safety Plan

Please see the Patient Safety Assessment Tool (PSAT) from the VA National Center for Patient Safety for your reference.

Patient Safety Checklists and Patient Safety Policies

By NRS 439.865, the patient safety plan must include the patient safety checklists and patient safety policies for use by:

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

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

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

The patient safety policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include the name and date of birth of the patient.
- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.

- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

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

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

http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf

The following link provides you some patient safety policies for your reference

<https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies-and-guidelines>

Approval of Patient Safety Plan

According to NRS 439.865, a medical facility shall submit its patient safety plan to the governing board of the facility for approval. After a facility's patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan.

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

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

Patient Safety Program Reporting and Review

All patient safety work product privilege (PSWP Privilege) 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.
- The review will be approved by QCAC.
 - Will be submitted to the Community Board for final review and approval.

References

- Root Cause Analysis Toolkit <http://www.health.state.mn.us/patientsafety/toolkit/>
- Quality and Service Improvement Tools http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html
- CQI 101 An Introduction to Continuous Quality Improvement: <https://www.coursehero.com/file/13827355/CQI-Overviewppt/>
- Quality Improvement <http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/>
- Root Cause Analysis <http://www.patientsafety.va.gov/professionals/onthejob/rca.asp>
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2 https://www.jointcommission.org/sentinel_event.aspx
- Hospital Policies <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies-and-guidelines>
- Checklists to Improve Patient Safety http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf
- Minutes of the Meeting of the Quality and Patient Safety Committee <http://www.cookcountyhhs.org/wp-content/uploads/2013/12/09-23-14-QPS-scan-Minutes.pdf>
- Title 40 – Public Health and Safety <https://www.leg.state.nv.us/NRS/NRS-439.html>

Reviewed/Approved:

Patient Safety Committee, January 2020

Quality Care Advisory Committee of the Board, January 2020

Community Board, January 2020

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Document Metadata

Document Name:	Patient Safety Plan 2020_SAN MARTIN.pdf
Original Location:	/St. Rose Dominican (520,521,524)/SRDH Hospitals Plans/Patient Safety & Risk Management Plans
Created on:	04/24/2020
Published on:	04/24/2020
Last Review on:	01/01/2020
Next Review on:	01/01/2023
Effective on:	01/01/2020
Creator:	Cullum, Peggy <i>Policy & Procedure Mgr</i>
License Name:	St. Rose Dominican Hospital - Rose de Lima Campus, St. Rose Dominican Hospital - San Martin Campus and St. Rose Dominican Hospital - Siena Campus

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HOLY CHILD RESIDENTIAL CARE LLC

5828 Tappan Dr. Reno NV 89523

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PATIENT SAFETY PLAN

Our facility is licensed for 5 beds. We provide care for the elderly that needs help with their day to day activities. Our facility is also equipped with ramps and handrails for our resident's safety.

In Case of Emergency:

Our caregivers are CPR/First Aid certified. They are trained to handle emergency situations. Most of our emergency situations are referred by calling 911, informing the resident's primary physician or bringing them to the urgent care.

In Case of an Incident/Accident:

Our caregivers are trained to report any incidents to the Manager/Patient Safety Officer. These incidents are communicated to the resident's primary care physician and family/guardian. The primary care physician and guardian will then come up with a plan of care for the resident.

In case of a Sentinel Event:

Our caregivers are trained to report sentinel event to the Patient Safety Officer, who then will report it to the Red Cap System.

Patient Safety Committee:

Our facility does not have a Patients Safety Committee. Our plan is to provide care to our residents that conforms to the Plan of Care provided by their primary care physician and guardian.

Facility Name: Durango Outpatient Surgery Center	Policy And Procedure Guideline Name:	Policy Number:
	Performance Improvement Plan (Improving Organizational Performance)	PI 100
	Subject Category:	Effective Date:
	Improving Organizational Performance	2008
		Revised Date:
		12/ 2020
		Page 1 Of

Policy:

It is the policy of the center to follow a planned systematic approach to improving organizational performance. A FOCUS-PDCA model will be utilized for the framework for improvement.

Purpose:

The purpose of the Quality Assessment and Performance Improvement Plan is to ensure the facility's ability to carry out the mission and vision. The Quality Assessment and Performance Improvement program has been developed utilizing the EDGE tools and other facility specific monitoring to be an ongoing data driven process. The EDGE program utilizes systems approaches which assess both systems and processes. The overall goals include, but are not limited to, demonstration of measurable improvement in patient outcomes and improvement in patient safety by using quality indicators associated with improved health outcomes and by identification and reduction of medical errors.

Procedure Guidelines:

The Performance Improvement Plan at Durango Outpatient Surgery Center is a customer driven, facility-wide process and philosophy of improving both the quality of patient care and productivity at the lowest cost. It is an integrated effort in which the entire organization works to provide optimum healthcare, patient satisfaction, risk reduction, and proper utilization of resources by competent healthcare practitioners, business office and other support staff.

SECTION I. MISSION AND VISION OF (insert facility name)

Our Mission

The mission of the (insert facility name) is to provide first class surgical services for the local community in a safe, comfortable and welcoming environment; one in which we would be happy to treat our own families.

Our Vision

The (insert facility name) through the combined efforts of our physicians, Governing Board, and our staff, shall provide healthcare services that shall be recognized in the local community as the optimal standard of excellence for the services we provide.

Our Value Statement

In pursuit of our mission, we believe the following value statements are essential and timeless.

- We recognize and affirm the unique and intrinsic worth of each individual.
- We treat all those we serve with compassion, kindness, and dignity.
- We conduct all of our business in an ethical and honest manner.
- We recognize our colleagues and partners as valuable members of our healthcare organization, and pledge to treat each other with loyalty, dignity, and respect.

QUALITY DEFINITION

At (insert facility name), the pursuit of quality is the never-ending process of evaluation with intent to improve the services, which shall ultimately meet and exceed the expectations of our customers. Quality shall be measured by the feedback received through our customers (internal and external), and through recognized regulatory and accrediting agencies.

PERFORMANCE IMPROVEMENT DEFINITION

PI is embracing a continual organizational wide effort to find new and better ways of doing things.

SECTION II. PHILOSOPHY/OBJECTIVES/SCOPE OF SERVICES

1. PHILOSOPHY of the PERFORMANCE IMPROVEMENT PROGRAM

A. Utilizes principles of quality measurement based on data collection, objective analysis, and results dissemination (EDGE™ processes).

I. Components of EDGE include:

- Today's Proven Process (TPP)
 - Evidence based action steps or best practices that when put in place for every patient improves results.
- Measures-Focus Studies
 - Measures are the data gathered at the facility to access how well the processes are working or where improvements may be needed. Because we cannot manage what we cannot measure, Audit tools have been created to assist in proactively collecting data to determine if key elements of a process are in place.
- Risk Incidents and Close Calls/Good Catches

- Risk incident reporting provides a tool to enhance Patient Safety by providing a confidential, uniform, electronic method of reporting outcomes and close calls. Presenting standard data for learning, benchmarking, and performance improvement.
- Patient Relations- Complaints and Compliments
 - Patient relations reporting provides a tool to track and trend patient relation occurrences such as grievance or compliments.
- Patient Satisfaction Measurements
 - Seeks feedback from our primary customer allowing for improvement.

II. Today's Proven Process (TPP) includes the following areas:

- Keep a Safe Environment
- Know and Provide Surgeon preferences
- Medication Safety
- Prevent Surgical Site Infections
- Prevent Wrong Site- Universal Protocol
- Schedule My First Choice/Handle My First Call
- Start My Cases on Time/Minimize Turnover Time

Measure/Focus Studies are as follows:

Measure	Timing	Qualification for Reporting
Prevent Wrong Site	Each Month	5% of case volume
ASCQC <ul style="list-style-type: none"> • Inappropriate Hair Removal • Prophylactic IV Antibiotic Timing • VTE Risk Assessment 	Each Month	Report only on those patients who qualified but did not receive appropriate treatment
Prevent Injury- Pre-Operative and Post Operative Calls	Each Month	Report only those patients not contacted per the facility policy
Prevent Surgical Site Infections	Each Month	5% of case volume
Start My Cases on Time/Minimize My Turnover Time	Each Month	Report only those patients with times outside the facility's average
Patient Satisfaction	Each Month	Complete audit tool and data enter information into EDGE system.
Know and Provide Surgeon Preferences	1 st Quarter	Only cases surgeon preferences not provided
Prevent Surgical Fires	1 st Quarter	5% of case volume

Prevent Injury- Prevent Burns	2 nd Quarter	5% of case volume
Prevent Injury-Laser Safety	2 nd Quarter	5% of case volume
Schedule My First Choice/Handle My First Call	2 nd Quarter	Only scheduling calls that went to voicemail
Prevent Infection Hand Hygiene	2 nd Month of Each Quarter	30 Personnel Audits
Keep a Safe Environment	Last Month of Each Quarter	Completed audit tools and data enter information into EDGE system
Prevent Medication Variances- Medication Safety	3 rd Quarter	5% of case volume
Prevent Injury- Safe Positioning	3 rd	5% of case volume
Prevent Injury- Prevent Falls	4 th	5% of case volume

Other areas for ongoing monitoring:

Process	Frequency
Operative and other invasive procedures that place patients at risk.	Quarterly
All significant discrepancies between pre-operative and post-operative diagnoses, including pathologic diagnoses.	Quarterly
Documentation in the Medical Record of the medical necessity for the procedure/treatment, and appropriateness of care provided.	Quarterly
Adverse events related to using moderate or deep sedation of anesthesia. (identified via Risk Incident Reports)	Quarterly
Medication errors/adverse drug reactions, medication labeling errors or inappropriate labeling (identified via Risk Incident Reports)	Quarterly
Blood and blood component usage	Quarterly
All confirmed blood transfusion reactions.	Quarterly
Risk assessment and management activities	Quarterly
Employee Satisfaction Survey to include: Staff opinions and needs Staff perception of risk to individuals Staff suggestions for improving patient safety* Staff willingness to report adverse events	Annually

*Employees may make suggestions for improving patient safety at anytime.

- B. Offers physicians and staff objective information, which they can use for purposes of review, patient management, and quality measurement.
- C. Is grounded in the concept of continuous quality improvement, through regular feedback of information on performance and clinical / environmental risk assessment.
- D. Promotes integration and communication between facility departments, medical staff, and administration to continuously improve processes which affect patient care.

2. OBJECTIVES

- A. Continually evaluate clinical and operational processes to identify opportunities for improvement.
- B. Identify, focus, analyze, and correct processes or systems which have the potential to impede quality patient care.
- C. Integrate and coordinate all organizational performance improvement activities in order to increase effectiveness, eliminate duplication of efforts, and promote proper utilization of staff and resources.
- D. Comply with standards of practice and meet all requirements of the accrediting body, state/federal agencies, and other regulatory bodies.
- E. Eliminate unnecessary risks and hazards within the facility.

These objectives are accomplished by:

- I. The employment of qualified and effectively supervised personnel for patient care, utilizing clear channels of supervision, responsibility, and accountability.
- II. Patient care, which is appropriate to the ages and needs of patients, is delivered as follows:
 - In a timely manner.
 - Within the range of available resources.
 - In a cost-efficient manner as possible.
 - Consistent with achievable goals.
 - Properly documented to facilitate evaluation.
 - Continuously evaluated and improved.

- III. A system in which one level of care is provided to all patients and is subject to periodic review prospective or concurrent with the use of pre-established objective indicators and documentation of findings.
- IV. A system in which the findings of patient care monitoring and evaluation are utilized by the facility in concrete ways to fulfill the objectives of the performance improvement program.
- V. The maintenance of a continuing education program utilizing, in part, results of patient care monitoring and evaluation.
- VI. Continuous evaluation and improvement of customer satisfaction (patients, physicians, employees, family and community).

3. SCOPE OF SERVICES

- A. The scope of the performance improvement program of Durango Outpatient Surgery Center includes monitoring and evaluation of activities, which addresses patients of age groups of pediatric to geriatrics served by the facility. All staff employees and physicians on staff are responsible for utilizing the concepts of the PI program to assist in the delivery of quality care considering the following concepts:
 - I. Emphasis on the safe, timely delivery of services to identified customers.
 - II. Delivery of services accomplished within a range of available resources.
 - III. Care and services provided in the most cost efficient manner.
 - IV. Services planned or provided are consistent with achievable goals.
 - V. All care delivery and business transactions are properly documented to facilitate effective evaluation.
 - VI. Aspects of identified care practices are continuously evaluated with opportunities for improvement identified and implemented when deemed appropriate. This process is facilitated through peer review and education regarding cases requiring Root Cause Analysis.
 - VII. Efforts are guided by standards established through leadership, accrediting agency and state, federal and other regulatory bodies.
 - VIII. On-going and organized education initiatives designed to educate all staff, physicians and leaders in Performance Improvement and patient safety concepts and to facilitate their participation in the process through department meetings and facility wide.

SECTION III. LEADERSHIP'S ROLE AND RESPONSIBILITY FOR PERFORMANCE IMPROVEMENT

Leadership plays a central role in performance improvement. At Durango Outpatient Surgery Center Leadership includes the Governing Board, elected officers of the medical staff, the medical director, the Medical Executive Committee, the Performance Improvement Committee, the facility Administrator and senior management of the facility, and department managers. The leaders set expectations, develop plans and manage processes to measure, analyze, and improve the quality of facility's governance, management, clinical and support activities. The leaders are responsible for adopting an approach to performance improvement, which is utilized in reporting and team activities. The leaders are responsible for setting priorities and reprioritizing in response to sentinel events, risk assessments, unexpected or unusual occurrences, patient safety concerns, and expressed opportunities for improvement by internal and external customers served.

Leaders are responsible for establishing a policy and procedure for sentinel events, educating staff on sentinel events and responding appropriately when they occur. The policy shall include a process for conducting a timely root cause analysis (RCA) that focuses on processes, systems and development of risk reduction strategies, as well as an action plan, which includes evaluating the effectiveness of actions taken.

Leaders set a positive performance improvement and safety culture in the organization through planning, education, providing support, such as time and resources, and empowering staff as appropriate. Leaders also actively participate in interdisciplinary performance improvement activities, as appropriate.

The performance improvement program is the shared responsibility of the Governing Board, the medical staff, and the administration of the facility with specific areas of the program delegated to each. The program involves the Board, medical and other professional staff, administrative, technical and all support services, and includes education concerning the approaches and methods of performance improvement. PI teams/ committees may include both management and non-management staff from all departments in the problem solving process.

1. GOVERNING BOARD

The Governing Board shall review and evaluate facility activities to assess, preserve and improve the overall quality and efficiency of patient care in the facility. While maintaining overall responsibility, the board delegates operational authority of this function to the Medical Executive Committee and Administrator. In exercising its supervisory responsibility, the board shall:

- A.** Receive, review and accept or reject periodic reports related to outcomes.
- B.** Assess the program's effectiveness and efficiency and require modification in organizational structure and systems where necessary to improve program performance.

- C. Provide for allocation of resources and support systems for performance improvement and functions related to patient care and safety.
- D. Verify that the overall goal of patient care enhancement is being achieved.
- E. Require a process designed to assure that all individuals responsible for the assessment, treatment or care of patients are competent.
- F. Receive and review minimally an annual report regarding the facility contracts to ensure compliance with regulatory requirements and patient safety and quality of care. The Board shall receive the report from the Medical Executive Committee and Administrator.

2. MEDICAL EXECUTIVE COMMITTEE

- A. The Medical Executive Committee (MEC) of the medical staff is accountable to the Governing Board for oversight of the monitoring and evaluation functions to determine that safe and quality driven medical care is rendered to all patients in the facility through performance improvement monitoring, actions taken when indicated, and by reporting these activities to the Governing Board.
- B. The MEC delegates the responsibility for the operations of the monitoring and evaluation functions to the medical director, Performance Improvement Committee (PIC) and appropriate medical staff committees. The MEC is responsible for functional oversight of key areas of operations to include but not limited to:
 - I. Pharmacy: Coordinates periodic review of the processes related to medication management to include procurement, efficacy of use, dispensing and adverse drug events.
 - II. Environment of Care: Monitors environmental safety, security infection control, and disaster preparedness issues.
 - III. Credentialing of medical staff: Reports on credentials issues for licensed independent providers and allied health professionals assigned to the medical staff. Function includes evaluation of the results of monitoring and evaluation functions at the time of initial, ongoing and reappointment to the medical staff.
 - IV. Contract Services: The MEC shall receive from the Administrator minimally annually a report regarding the quality and safety of the services provided by contract. More frequent reports will be provided on an as needed or as requested basis. The MEC will review the services and make

recommendation to the Governing Board to continue, modify, or cancel the contract based on quality of services and patient safety.

- C. The Medical Executive Committee (MEC) supports and acts upon recommendations of the PIC; include the investigation of variances, implementation of actions, monitoring of results, and approval/revision of policies. The medical director presents the performance improvement report to MEC which includes, but is not limited to, a quarterly summary of PI project activity and a quarterly trending of house-wide indicators.
- D. The Medical Executive Committee is the oversight body of the sentinel event process.

3. ADMINISTRATION

Administration, through the facility Administrator is accountable to the Governing Board for the quality of care and performance of all staff. The facility Administrator coordinates efforts to:

- A. Promote the participation of the appropriate members of professionals and technical staffs and departments in the program through interdisciplinary monitoring and evaluation of patient care and important facility functions through Performance Improvement Committee.
- B. Establish and maintain operational linkages between the functions of risk management, quality management and performance improvement.
- C. Assure that sufficient resource, and personnel are provided to support continuous performance improvement activities.
- D. Assure staff are provided adequate time to participate in performance improvement activities.
- E. Participates on Governing Board, Medical Executive Committee, and Performance Improvement Committee.

Other administration staff includes the Chief Nursing Officer and Business Office Manager. Both of these individuals participate in facility committees as assigned.

1. QUALITY MANAGEMENT NURSE

Administration shall provide adequate resources to the medical staff and facility departments to conduct performance improvement functions. The assigned QM Nurse shall facilitate the following services and functions:

- A. Orientation and training on performance improvement functions.

- B. Reports of changes in regulations, laws, and JC standards to the medical staff, clinical and non-clinical departments
- C. Facilitate data retrieval functions from the various departments. Coordinates data collection and submission for accrediting purposes, USPI's EDGE™ data and other regulatory data collection requirements as assigned by facility administrator.
- D. Aggregate performance improvement findings for presentation to Medical Staff and Professional Activities Committee.
- E. The Nurse Quality Manager shall facilitate that appropriate actions from PI findings are implemented, and within established time frames, as directed by the Performance Improvement Committee.
- F. The Quality Management Nurse shall attend meetings of the Performance Improvement Committee, facilitate performance improvement subcommittees, and present data to the MEC and Governing Board for communication of performance improvement activities as designated.
- G. Leadership provides opportunities for training to assist the Quality Management Nurse in efforts to stay informed on current accreditation requirements, local, state and national health care regulatory requirements and reports change to the Medical staff and facility leadership.

2. EVALUATION OF LEADERS EFFECTIVENESS

At least annually, the Quality Management Nurse shall prepare an annual appraisal of the performance improvement program. The facility leaders, through the Performance Improvement Committee shall evaluate the effectiveness of the performance improvement program through annual appraisal. In addition, the leaders shall perform a self-evaluation of their effectiveness in participating in the PI program.

The leaders shall ultimately evaluate their effectiveness by accomplishment of goals and improvements through performance improvement monitoring and PI teams. If the goals and objectives are found to be ineffective, new actions may be taken or new teams may be formed.

SECTION IV: PLAN

Durango Outpatient Surgery Center participates in facility-wide interdisciplinary monitoring of important functions. Performance improvement activities include how the facility designs, measures, assesses, and improves important processes. All PI activities are incorporated into a systematic, organization-wide approach through integrated monitoring and performance improvement teams.

1. METHODOLOGY

A variety of methods exists that can be utilized by a facility to assist in identification, trending and monitoring quality processes. The methodology utilized by USPI's EDGE™ process is simplistic with the underlying purpose being to help staff exceed customer expectations in the clinical, service and financial areas of the organization. The EDGE™ process is outlined in the following table:

1. What is the problem?	Record and analyze data to find areas where improvement is needed. Unlike many other PI programs, USPI's EDGE™ utilizes process measures to serve as warnings that a bad outcome might be pending
2. What is the Solution?	Use USPI's EDGE™ Today's Proven Processes as a springboard for solutions that could work for your facilities problem areas identified
3. How do we implement change?	Change is tough, and we need to think out of the box in order to implement Today's Proven Processes
4. How do we know if it worked?	Continue to report process and outcome measures, so you can see if your implemented solutions worked. This is a question to continually ask and is asked consistently by accreditation agencies

The FOCUS-PDCA methodology is an adjunct method for staff to utilize in conjunction with the EDGE process to assist in establishing a systematic method for teams to address issues within the organization. It should be stressed that there is no one method for creating a culture of continuous quality improvement. In fact, a variety of methodologies should be benchmarked and utilized by staff to assist in developing and monitoring processes within the organization.

Sampling Size (recommended by Joint Commission) for performance improvement shall be as follows:

- For a population of fewer than 30 cases, sample size 100% of available cases
- For a population of 30 – 100 cases, sample size 30 cases
- For a population of 101 – 500 cases, sample size 50 cases
- For a population size greater than 500 cases, sample size 70 cases

STEP	FUNCTION	TEAM TOOLS
F	<u>FIND</u> A PROCESS TO IMPROVE	<ul style="list-style-type: none"> • Data from customer concerns, staff observation, occurrence reports, Physician input.
O	<u>ORGANIZE</u> A TEAM THAT KNOWS THE PROCESS	<ul style="list-style-type: none"> • Department/Administrative Level teams. • Quality Management Committee established teams.
C	<u>CLARIFY</u> CURRENT KNOWLEDGE OF PROCESS	<ul style="list-style-type: none"> • Review current data related to process. • Review EDGE Proven Processes. • Ask questions/Brain storm ideas. • Flow chart current process. • Consider benchmarking for evidenced based and best practices.
U	<u>UNDERSTAND</u> CAUSES OF VARIATION	<ul style="list-style-type: none"> • Data collection/analysis. • Display with graphs, run charts, control chart, histogram, scatter diagram, pareto diagram.
S	<u>SELECT</u> THE PROCESS IMPROVEMENT	<ul style="list-style-type: none"> • Define the process in simplistic terms. • Examine criteria related to the process. • Present data to leadership for support.
P	<u>PLAN</u> THE IMPROVEMENT AND CONTINUED DATA COLLECTION	<ul style="list-style-type: none"> • Planning Matrix. • Responsibility Matri. • Who/What/When/Where? EDGE™ Requirement owners.
D	<u>DO</u> THE IMPROVEMENT, DATA COLLECTION AND ANALYSIS	<ul style="list-style-type: none"> • QM audit tools/EDGE™ DATA. • Discuss in Unit team meeting. • Educate staff on the process.
C	<u>CHECK</u> THE RESULTS AND LESSONS LEARNED FROM THE TEAM EFFORT	<ul style="list-style-type: none"> • Data Collection Analysis. • Same QM tools used in (U). • Document in Department & committee reports to leadership. • Celebrate accomplishments of staff.

A	ACT TO HOLD THE GAIN AND TO CONTINUE TO IMPROVE THE PROCESS	<ul style="list-style-type: none"> • Data reporting to leadership. • Track & Trend at Unit level. • Utilize QM tools to assist (U & C). • Revise policy & procedures if needed. • Staff /Physician Education Customer Education.
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2. ONE LEVEL OF CARE

The Governing Board, through the medical staff and administration, shall ensure that mechanisms are in place to provide a uniform level of care to all patients with the same health needs. The following mechanisms shall be utilized to ensure consistent compliance:

- A. Access to and appropriateness of care and treatment does not depend on the patient's ability to pay or source of payment.
- B. Acuity of the patient's condition determines resources allocated to meet patient's needs.
- C. The level of care provided to patients who have been administered anesthesia in areas outside the operating room is comparable to that provided in the operating room.
- D. Patients with the same nursing care needs receive comparable levels of nursing care throughout the facility departments.

3. FACILITY-WIDE PRIORITIES

Priorities for facility-wide performance improvement activities at (insert facility name) shall be designed to improve patient outcomes. These priorities shall be developed by the Performance Improvement Committee with participation of all facility disciplines, and approved by the Medical Executive Committee and Governing Board. Priorities that relate to improving patient outcomes may include but are not limited to:

- A. High risk patient issues.
- B. High volume patient issues.
- C. Problem prone patient issues.

4. DASHBOARD BENCHMARKS

The assigned Quality Manager and/or member of the Administrative Leadership Team provides a Quality Management report to the Governing Board on a quarterly basis

and may include but is not limited to customer service satisfaction measures, patient safety indicators (including the National Patient Safety Goals), environment of care issues, employee safety, regulatory measures of success, data from USPI's EDGE™ reporting measures and other outcome indicators prioritized as significant quality management issues. The report to the Governing Board provides a snap shot of priority areas. The dashboard may be utilized to provide performance information as measures of success within the organization and comparison to external entities as determined.

5. **REPRIORITIZING:** Priorities to focus on may be recalled in response to unusual or urgent events such as those identified through PI monitoring and evaluation, changing regulatory requirements, significant patient/staff needs; changes in patient population; changes in the environment of care; changes in the community, or in response to sentinel events.

These priorities shall be reviewed and approved by the facility administrative leaders, Chief of Medical Staff, and Governing Board in the approval of the facility-wide performance improvement plan.

SECTION V: DESIGN

When a need or opportunity to establish new services, extend product lines, or significantly change existing functions or processes, the following factors shall be considered:

1. The process shall be consistent with the facility's mission, vision, values and plans.
2. The needs and expectations of patients, staff, medical staff, and others served, shall be considered in the design of the process.
3. The design shall be clinically sound and current (by use of appropriate practice guidelines and clinical nursing and medical standards as deemed necessary)
4. The process shall be consistent with sound business practices.
5. It shall incorporate available information from other organizations about the occurrence of sentinel events to reduce the risk of similar sentinel events.
6. The design should incorporate results of performance improvement activities.

Consideration of these factors shall provide basic performance expectations that can be measured, assessed, and improved, targeting sustained over time. All disciplines, which shall be involved in the new service, product line, function, or process, shall be included in the design.

SECTION VI. MEASURE

Measurement is the basis for determining the level of performance of existing processes and

the outcomes resulting from these processes. Measures shall be used to help identify areas for more focused or targeted data collection. Continuous and ongoing measurement activities may include:

- Measures of both processes and outcomes.
- Measurement of high volume, high risk and problem prone issues.
- Identification for focused or targeted data collection.
- Establish a performance baseline.
- Comparison of outcomes to internal and external databases, when available, as appropriate.
- Measures shall focus on sustaining improvement.

The sampling shall consist of a minimum of 30 patients per quarter or 100% for population size of fewer than 30 cases. Method of sampling for each measure shall be determined by the Performance Improvement Committee or PI team that has identified a process study.

1. MONITORING OF IMPORTANT FACILITY FUNCTIONS

In addition to participation in Performance Improvement Committee, facility departments shall participate in monitoring of important facility functions (as appropriate). Indicators shall be prioritized for the following functions:

FUNCTIONS	RATIONALE		
	High Risk	High Volume	Problem Prone
1. Rights And Responsibilities Of The Individual			#
2. Provision Of Care, Treatment And Services	#	#	#
3. Medication Management	#	#	#
4. Performance Improvement	#	#	#
5. Leadership			#
6. Environment Of Care	#	#	#
7. Human Resources			#
8. Information Management		#	#
9. Infection Prevention And Control	#	#	#

10. Emergency Management	#		#
11. Record of Care, Treatment, And Services		#	#
13. Life Safety	#		#
14. Waived Testing		#	#

All monitoring and evaluation of facility functions shall include identifying the processes, which make up the key facility functions and identifying indicators (and appropriate clinical criteria) for monitoring the important facility functions.

Results of the monitoring, along with the Performance Improvement Committee and subcommittee's conclusions, recommendations, actions, and evaluation shall be communicated to all departments/services and to the medical staff, Medical Executive Committee and Governing Board.

2. PI MONITORING ACTIVITIES

The following Quality Management activities are targeted for monitoring through a variety of methods to include monthly monitoring through USPI's proven processes accessible in EDGE™ Online.

- A. Operative/other invasive procedures.**
- B. Anesthesia adverse outcomes sedation outcomes.**
- C. Medication errors/adverse drug reaction rate, medication labeling.**
- D. Blood usage.**
- E. Customer satisfaction.**
- F. Autopsies and results.**
- G. Risk assessment and management activities.**
- H. Medical staff assessment & treatment of patients, efficiency of clinical practice patterns, significant departures from established clinical practice patterns, education of patients and families, and coordination of patient care with other disciplines.**
- I. Patient health record review.**
- J. Infection prevention surveillance results.**
- K. Environment of care/safety performance standards.**
- L. Resuscitation outcomes.**

M. Appropriateness and effectiveness of pain management.

N. National patient safety goals.

3. MEDICAL STAFF MONITORING AND EVALUATION

A. Medical staff is responsible for involving members of the medical staff in interdisciplinary monitoring and evaluation activities. Medical staff responsibilities include:

- I. Identify indicators, collect data for each indicator, reach conclusions, make recommendations and initiate actions.**
- II. Communicate findings, conclusions, recommendations and actions, effectiveness of actions taken to Medical Executive Committee.**
- III. Assess the effectiveness of actions and document improvement in patient care.**
- IV. Make recommendations related to credentialing for clinical privileges.**
- V. Participate on performance improvement teams.**
- VI. Review and evaluate the findings of:**
 - Operative and other invasive and non-invasive procedures.
 - Blood and blood components review.
 - Medical record review for clinical pertinence.
 - Medical record timeliness and delinquency review.
 - Mortality.
 - Infection prevention.
 - Resource/case management.
 - Resuscitation outcomes.
 - Appropriateness and effectiveness of pain management.
 - Risk management assessment and risk reduction activities .
 - Restrain usage.

- Assessment and treatment of patients.
- Efficiency of clinical practice patterns.
- Significant departures from established clinical practice patterns.
- Education of patients and family.
- Coordination of patient care with other disciplines

B. All medical staff PI activities shall be reported to the Medical Executive Committee. The medical staff is responsible for participating in and evaluation of PI activities. All PI activities are reported to the governing board.

SECTION VII. AGGREGATE AND ANALYZE

1. AGGREGATE AND ANALYZATION PROCESS

Aggregating and analyzing data allows the organization to use this information to draw conclusions about its performance of a process or outcome. The organization shall also compare its performance over time and with other sources of information.

- A.** Performance compared internally over time (patterns/trends).
- B.** Performance compared with similar processes in other organizations.
- C.** Performance compared to up-to-date external sources (benchmarking).
- D.** Control limits established for expected variation.
- E.** Data analysis is interdisciplinary when appropriate.

2. INTENSIVE ANALYSIS

Intensive analysis shall be conducted when the following factors are identified:

- A.** Single events, performance, and patterns or trends vary significantly from expectations.
- B.** Performance varies significantly and undesirably from other USPI facilities.
- C.** Performance varies significantly and undesirably from recognized standards.
- D.** Sentinel event has occurred.

3. ANALYSIS OF FINDINGS RELEVANT TO INDIVIDUAL PERFORMANCE

When the findings of the analysis process are relevant to an individual's performance, the following process shall be followed:

A. Medical Staff

Peer review process shall be utilized for individual medical staff performance. The case shall be referred to the Medical Executive Committee and reviewed by a peer physician. Final determination shall be made at the Medical Executive Committee and an improvement strategy, such as education determined as necessary. The Quality Manager maintains peer review findings in individual medical staff PI Files. The peer review findings are used in consideration for reappointment to the medical staff, and could result in modification of clinical privileges.

B. Facility Staff

The Department Manager shall review information relevant to individual staff performance and an improvement strategy, such as education, determined as necessary. Documentation of this action shall be maintained in individual personnel files of the manager and utilized in the performance evaluation process as appropriate.

4. USE OF DIMENSIONS OF PERFORMANCE AND SCIENTIFIC TOOLS

These definitions of dimensions of performance are utilized in assessing how performance was improved:

DIMENSIONS OF PERFORMANCE

I. Doing The Right Thing

- The **efficacy** of the procedure or treatment in relation to the patient's condition. Efficacy is the degree to which the care/intervention for the patient has been shown to accomplish the desired/projected outcome (s).
- The **appropriateness** of a specific test, procedure, or service to meet a patient's needs. Appropriateness is the degree to which the care/intervention provided is relevant to the patient's clinical needs, given the current state of knowledge.

II. Doing The Right Thing Well

- The **availability** of a needed test, procedure, treatment, or service to the patient who needs it. Availability is the degree to which appropriate care/intervention is available to meet the patient's needs.
- The **timeliness** with which a needed test, procedure, treatment, or service is provided to the patient. Timeliness is the degree to which the care/intervention is

provided to the patient at the most beneficial or necessary time.

- The **effectiveness** with which tests, procedures, treatment, or service is provided to the patient. Effectiveness is the degree to which care/intervention is provided in the correct manner, given the current state of knowledge, in order to achieve the desired/projected outcome for the patient.
- The **continuity** of the services provided to a patient with respect to other services, practitioners, and providers, and over time. Continuity is the degree to which care/intervention for the patient is coordinated among practitioners, among organizations, and over time.
- The **safety** of the patient (and others) to whom the services are provided. Safety is the degree to which the risk of an intervention and risk in the care environment are reduced for the patient and others, including the health care provider.
- The **efficiency** with which services are provided. Efficiency is the relationship between the outcomes (results of care) and the resources used to deliver patient care.
- The **respect and caring** with which services are provided. Respect and caring is reflected by the degree to which the patient or a designee is involved in his/her own care decisions and to which those providing services do so with sensitivity and respect for patients' needs, expectations, and individual differences.

Various scientific tools may be used to assist in assessment, including flowcharts, Pareto charts (bar graphs), histograms, cause-and-effect diagrams (fishbone diagram), and run charts.

5. REFERENCE DATABASES

The facility may use InfoSource to compare performance in cost per case with other peer facilities. In addition the EDGE system will be used to benchmark clinical outcomes with peer facilities. All facilities using EDGE will benchmark with the external data base for ASQC.

SECTION VIII. IMPROVE

Monitoring activities identify a variety of opportunities for improvement. These include improving existing processes, designing new processes, and/or reducing variation or eliminating undesirable variation in processes or outcomes. Improved changes, which are made, shall be implemented into standard operating procedures and monitored for sustained improvement. Staff shall be educated about redesigned processes or changes. The following reporting structure is utilized for performance improvement reporting:

1. PERFORMANCE IMPROVEMENT COMMITTEE STRUCTURE

Performance Improvement Committee

Created For USPI Affiliated Facilities

The Performance Improvement Committee meets at least quarterly for the purpose of overseeing functional process improvement activities. The chairperson is the facility medical director. The committee serves to evaluate the results of monitoring and evaluation of facility functions conducted by departments, prioritize projects, approve new PI teams and review the progress of the current PI teams. Findings, conclusions, recommendations, and actions taken are communicated to medical staff members. This committee reports activities to the facility leadership, medical staff, Medical Executive Committee and the Governing Board.

2. DECISIONS FOR IMPROVEMENTS

Decisions for making improvements are made by the Performance Improvement Committee based on the following factors:

- A.** Opportunities to improve processes within the important functions.
- B.** Results of risk management activities and quality control activities.
- C.** Resources needed to improve, such as staffing, facilities, training, equipment, etc.
- D.** Organization's mission and priorities.

Opportunities to improve care may be referred to the Performance Improvement Committee from the following sources:

- E.** Patients and families.
- F.** Governing Board.
- G.** Medical staff.
- H.** Employees.
- I.** Administration.
- J.** JV Partners of the facility.
- K.** Quality/Risk Manager.
- L.** Safety Officer.
- M.** Infection Control Practitioner.
- N.** PI team.

3. ACTIONS FOR IMPROVEMENT

Once results have been evaluated and the decision is made that improvement is necessary, the performance improvement teams may determine actions to be implemented for the improvement. These actions are reported to the Performance Improvement Committee, which oversees process improvement activities. When action is taken to improve a process:

- A. The action may be tested on a trial basis.
- B. The action's effectiveness is evaluated using the dimensions of performance.
- C. When the initial action is not effective, a new action may be taken and may include the continuation or formation of a PI team, if appropriate.
- D. Successful actions are implemented.

4. REPORTING CHANNELS

Reports of findings, conclusions, recommendations and actions shall be reported to the Performance Improvement Committee, the Medical Executive Committee, and the Governing Board.

5. PERFORMANCE IMPROVEMENT TEAMS

The facility utilizes Performance improvement teams (PI teams) to study processes, which occur in the facility, design new processes, and to make improvements in these processes utilizing the PDCA model. The processes may be studied because a problem was determined or because the process can be improved even if a problem has not been identified. The PI teams are interdisciplinary and include members of management and non-management from all involved departments and medical staff members, as necessary.

The following factors may be utilized in determining when to use a team approach:

TEAM DECISION	INDIVIDUAL MANAGER'S DECISION
The need exists to combine old and new information-requires brainstorming, data-gathering, and innovation.	No need for extensive data-gathering. Quick decision is required.
The situation doesn't require an immediate solution.	Consensus is not needed.
Consensus is needed to make the solution work	When the problem is a people or performance problem.
When the problem is a process problem	
When the process crosses departmental	

boundaries.	
When the process seems to be very complex	

The Performance improvement teams are groups of people who work together for a common objective. The teams identify processes or problems needing improvement, and then study the processes methodically to improve them by eliminating root causes of problems. The Performance Improvement Committee shall approve all new PI teams. Team meetings shall be conducted as often as determined necessary by the team to work on the process. Each team shall have a team leader and a facilitator. Department managers shall encourage employees to serve on performance improvement teams as needed for performance improvement functions.

6. DESIGN TEAMS

A design team may be formed anytime a new service is added or expanded. Design teams may be approved by the Performance Improvement Committee as another PI team. These teams are called design teams to differentiate them from other PI teams focused on processes. All design teams shall consider the following factors in the development or expansion of new services:

- A.** Consistent with the facility's mission, vision, and other plans.
- B.** Meets the needs of individuals served, staff, and others.
- C.** Clinically sound and current, using nursing and medical clinical standards and considering practice guidelines.
- D.** Incorporate available information about sentinel events to reduce risk.
- E.** Incorporate results of performance improvement activities.

The PI representative shall meet with each new team, as indicated, to offer or provide continuous performance improvement education on the purpose of teams, the PDCA model, and the most common CPI tools which may be used. Minutes of all team meetings should be maintained and shall include the members who are present, purpose of the meeting, summary of items discussed, any actions to be taken, and any follow-up. A copy of all team minutes is to be forwarded to the Quality Manager. A summary of the design teams' activities shall be presented at the Performance Improvement Committee, Medical Executive Committee, and the Governing Board meetings.

7. Reporting Schedule:

REPORTING SCHEDULE (Minimum Reporting Requirements)

DATA	WHEN & WHERE REPORTED	
Performance Improvement	Every Quarter	QC/MEC/GB
Environment of Care (Form B)	Every Quarter	QC/MEC/GB
Safety/Risk Management	Every Quarter	QC/MEC/GB
Infection Control	Every Quarter	QC/MEC/GB
Patient Satisfaction	Every Quarter	QC/MEC/GB
Medical Staff Reports & Appointment	Every Quarter	MEC/GB
Financial Review	Every Quarter	GB
Report from any review/survey, licensure or accreditation	Every Quarter	MEC/GB
Medical Records Review	Every Quarter	QC/MEC/GB
Privacy Officer Report	Every Quarter	QC/MEC/GB
Compliance Officer Report	Every Quarter	MEC/GB
Human Resource Report to GB (form C)	1 st Quarter	GB
Review of Employee Competency (Form D)	1 st Quarter	GB
Review of Human Resource Policies	1 st Quarter	GB
Evaluation of Administrator	1 st Quarter	GB
Review of Contracts (Form E)	2 nd Quarter	MEC/GB
Review the Organizational Chart	2 nd Quarter	GB
Review Conflict of Interest & Indemnification Liability	3 rd Quarter	GB
Evaluate MEC Performance in PI (Form F)	3 rd Quarter	MEC
Evaluate GB Performance (Form G)	3 rd Quarter	GB
Review Information Management Plan, PI Plan, Scope of Services, Leadership Plan, Environment of Care Plans, Infection Control Plan, Patient Rights and Responsibilities Policy	3 rd Quarter	GB
Review Operating Agreement, Purpose of GB and MEC	4 th Quarter	MEC/GB

QC = Quality Council MEC = Medical Executive Committee GB = Governing Board

PI = Performance Improvement

SECTION IX. SENTINEL EVENTS

Definition: A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function.

Leaders of the organization shall be responsible for defining the policy and procedure for responding to a sentinel event. If a sentinel event occurs in the facility, the facility shall form a PI team, composed of persons close to the involved process, to review the incident and conduct a credible root-cause analysis to determine if there was either:

1. Special cause variation – human error.
2. Common cause variation – underlying system or process issue.

Once the root cause analysis has been conducted, the team shall develop an appropriate action plan to address any variations identified and establish measures for any changes made. The action plan shall be presented to the Performance Improvement Committee for approval. Periodic progress reports shall be reported to the Performance Improvement Committee until the issue is determined to be resolved. Once resolved, PI indicators may be continued to ensure that the problem remains corrected.

SECTION X. ANNUAL APPRAISAL

At least annually the Performance Improvement Committee, Medical Executive Committee and Governing Board shall be responsible for review of the performance improvement plan and the evaluation of improvements made in patient care and facility functions. The review shall include an evaluation of the performance improvement program and the impact of patient care through direct and indirect improvements and an evaluation of leadership's PI contributions. A summary report shall be prepared by the quality manager and facility administrator evaluating the individual components and overall effectiveness of the program. The department leaders, Performance Improvement Committee, the Medical Executive Committee, and the Governing Board shall review the summary.

References:

- Joint Commission Standards for Ambulatory Surgery Centers 2020
- CMS Conditions of Overage, State Operations Manual

Attachments:

Form A	Sample Quality Council Agenda
Form B	Governing Board Report for Environment of Care
Form C	Human Resources Report to Governing Board
Form D	Review of Employee Competency
Form E	Annual Contracts Review

Form F	Medical Staff Leadership Effectiveness
Form G	Governing Board Self Evaluation
Form H	Governing Board Annual Performance Improvement Evaluation
Form I	Quality/Performance Improvement Form
Form J	Sample Pathology PI-QA Study
Form K	Sample Performance Improvement Priority Key
Form L	Sample Medical Record Review
Form M	Sample Chart Audit

Facility Name: Durango Outpatient Surgery Center	Policy And Procedure Guideline Name: Patient Safety + Quality Improvement Program (Environment Of Care)	Policy Number: SAFE 104
	Subject Category: SAFETY	Effective Date: 10/01/2016
		Revised Date: 1/15/20
		Page 1 Of 6

Policy: Durango Surgery Center shall provide guidelines and implement proactive practices, which provide a safe environment of care in relation to property, equipment, patients, personnel and the public. The facility and each OR must be designed and maintained so that all types of surgery can be performed in a manner that protects the lives and assures the physical safety of all individuals

Purpose: This plan is action oriented and solution focused. The purpose of this plan is to address patient safety related concerns, environment, challenges and revise the program to better serve the patients and their families. To this end, Durango Surgery Center has developed this Patient Safety + Quality Improvement Plan.

Our plan focuses on the process rather than the individual, and recognizes both internal and external customers, as well as facilitates the need of analyzing and improving processes.

Mission Vision and Value: As we seek to improve the quality of our patients' lives, to serve our communities, to provide an exceptional environment for our employees and physicians. We are guided by:

- **Quality:** is at the core of everything we do and every decision we make.
- **Integrity:** We manage our business with integrity and the highest ethical standards. Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.
- **Service:** We have a culture of service that values teamwork and focuses on the needs of others. We operate with transparency by measuring our results.
- **Collaboration** of healthcare, leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high quality healthcare.

- Communicate honestly and openly to foster trusting and cooperative relationships among healthcare providers, staff members, and patients and their families, to ensure accountability for the patient safety priorities.

Procedure Guidelines:

Responsibility:

This committee will be comprised of at least: Safety Officer, Infection Control Officer, Pharmacy, Executive Member, and Medical Director

1. Durango Surgery Center leadership takes action to minimize identified safety risks in the physical environment. Employees are responsible for:
 - A. Intervention when, safety conditions pose a threat to life or health, or threaten damage to equipment or buildings.
 - B. The continuing maintenance of the facility property, eliminating hazards upon discovery.
 - C. Reporting equipment or maintenance problems and incidents of property damage to the Administrator/ Clinical Director upon discovery.
 - D. Reporting injuries and illness to the Administrator/Clinical Director.
 - E. Obtaining the information necessary to perform tasks in a manner that prevents injury to themselves, patients and others.
2. The Administrator/Clinical Director, and Safety Officer, as agents of the Quality Assurance Committee are responsible for:
 - A. Patient safety + Environment of Care development, implementation and monitoring.
 - B. Report of Safety Surveillance and activities to the Quality Assurance Committee/PI committee.
 - C. Every 12 months the organization evaluates the Environment of Care Plan for objectives, scope, performance and effectiveness.

Maintenance and Supervision:

1. Comply with the NFPA 101®, Life Safety Code® (LSC) for maintaining and supervising the facility grounds, buildings and equipment.
2. Maintain equipment and utilities following a preventative maintenance schedule.
3. Maintain sufficient light in the parking and entrance areas to reduce the potential for falls and security concerns.
4. Maintain signs and emergency systems to meet the needs of the visual and hearing impaired.

5. Maintain smoke free environment.
6. Provide facility cleaning, maintenance, and inspection, following a schedule for daily, weekly, monthly, semi-annual and annual activities
7. Construction and Renovation (Interim Life Safety Plan):
 - A. Meet the existing ambulatory health care occupancy health code requirements for construction or renovation.
 - B. Train staff in alternative safety processes including the use of new specialized equipment and space.
 - C. Train staff to compensate for changes in Life Safety Plan.
 - D. Provide increased facility safety monitoring with construction and renovation included reference to the NFPA 101®, Life Safety Code® (LSC).
 - E. Inspect and monitor components of Life Safety Plan weekly or more frequently if indicated.

Risk Assessment:

1. Provide risk assessment and hazard surveillance to evaluate the impact of the center building, grounds, equipment, occupants, and internal physical systems on patient, employee and public safety.
 - A. Assign a Safety Officer to maintain risk and hazard surveillance.
 - B. Record Hazard surveillance.
 - C. Report environmental hazard and safety surveillance to the Quality Assurance Committee. Provide follow-up to staff concerning safety issue recommendations
2. Report and document patient, personnel or visitor injury, and occupational illness. Document incidents on a Variance Report, Occurrence Report, or Incident Report.
 - A. Investigate and evaluate each report for opportunities to improve performance using: **Root Cause Analysis Framework:**

Root Cause Analysis (RCA) Team Responsibilities

Root Cause interviews, analysis, investigation, and corrective action plan implementations. Participates in the RCA meetings and discussions. Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders. Include injuries and occupational illness in the report to the Quality Assurance Committee.

- B. Patient Safety QA Committee Responsibilities (based on NRS 439.875 and NRS 439.877)
 - i. Monitor and document the effectiveness of the patient identification policy.

- ii. Clinical Director will supervise the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to NRS 439.835. Each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to NRS 439.877(4)(b).
- iii. Receive reports from the patient safety officer pursuant to NRS 439.870.
- iv. Based on NRS 439.865, the patient safety plan must also include an infection control program see: infection control policies.
- v. Review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- vi. Review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- vii. At least once each calendar month (or quarter), report to the executive or governing body of the facility by way of Administrator or Clinical Director regarding:
 - 1. The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);
 - 2. The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; with recommendations to reduce such events.

The Patient Safety Committee will meet monthly (or quarterly) to accomplish the following:

Monthly	Quarterly	Annually
1) Sentinel event monthly report 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

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. (2020) Accreditation Standards and Requirements for Ambulatory Surgery Centers

Facility Name: Durango Outpatient Surgery Center	Policy And Procedure Guideline Name:	Policy Number:
	Risk Management Plan	RM 100
	Subject Category:	Effective Date: 2008
	Risk Management	Revised Date: 12/ 2016, 12/2018, 12/ 2020
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The Risk Management program is an essential part of monitoring performance. The program is set in place to continuously monitor data within the facility and provides guidance for the selection and implementation of loss controls measures. Such a program will also assist us to prevent/reduce risk exposures to our patients, employees, physicians and visitors in our facility, select and maintain equipment and technology appropriately, and conserve facility property.

PURPOSE

The purpose of Facility's program is to

1. Identify the sources from which losses may arise;
2. Evaluate the financial risk involved in each exposure in terms of expected frequency, severity, and impact;
3. Management of risks by elimination, reduction, or control through the operation of a coordinated and effective program
4. Monitoring of risks continuously and systematically;
5. Initiate proactive programs to reduce liability.

SCOPE

Risk Management at Facility is inclusive of all departments, services, and health care professionals. Performance Improvement activities provide on-going monitoring, evaluation, and resolution of actual or potential threats to the quality of health care delivered at Facility.

AUTHORITY

The Governing Board of Facility has the ultimate responsibility to monitor the quality of care provided in the facility. In addition, the Governing Board strives to provide a safe environment for patients, employees, physicians and visitors by requiring and supporting the establishment and maintenance of effective Risk Management strategies. The Governing Board delegates Risk Management to the Administrator who may appoint a designated individual responsible for Risk Management. The Risk Management Program operates with the support and under the authority of the Governing Board through the Board's approval for the plan.

**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: 6/2020

Purpose: Gastroenterology Consultants, Ltd (GIC) and affiliated Endoscopy Centers are committed to ensuring the ongoing safety of our patients. To ensure the ongoing safety and care of our patients we follow specific guidelines and policies which, at a minimum, include:

I. Infection Control (IC): Refer also to the Infection Control (IC) Policy

1. Guidelines followed include:

- a. American Society for Gastrointestinal Endoscopy (ASGE) Multisociety Guideline on Reprocessing Flexible Gastrointestinal Endoscopes 2016
- b. Society of Gastroenterology Nurses and Associates, Inc. (SGNA) Standards of Infection Prevention in Reprocessing Flexible Gastrointestinal Endoscopes 2018
- c. Society of Gastroenterology Nurses and Associates, Inc. (SGNA) Standards 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 2017
- e. American Society for Gastrointestinal Endoscopy (ASGE) Infection Control during GI Endoscopy 2018
- 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 2016
- h. Association for Professionals in Infection Control and Epidemiology (APIC) Guide to the Elimination of Clostridium difficile in Healthcare Settings 2013
- i. CDC Safe Injection Practices

2. The IC Policy includes, at a minimum, processes or guidelines for:

- a. Patient selection and placement within the facility
- b. Infection Control Monitoring and Surveillance, Reporting
- c. Standard and Transmission Precautions, Hand Hygiene, Personal Protective Equipment, Respiratory Hygiene / Cough Etiquette and General Infection Control Practices in Healthcare Facilities as developed by the CDC and APIC
- d. Environmental and Terminal Cleaning
- e. Infection Control Officer
- f. Equipment Processing: Cleaning, Disinfection, High Level Disinfection and Sterilization

Approved Board of Managers REC/SEC/ CEC 10/11/11; Revised 8/9/12, Approved Board of Managers REC/SEC 1-31-16; CEC 1-25-16; Approved Medical Directors 4/2016, minor changes approved by Director of Center Operations 6/2020

The proceedings and records of a patient safety committee are subject to the same privilege and protection from discovery as the proceedings and records described in NRS 49.117 - 49.123 and NRS 49.265.

- II. Patient Selection and Screening:** Refer also to the Criteria for Scheduling Patients at ASC Policy.
1. To ensure patients are appropriate for the planned procedure in the planned setting patients undergo:
 - a. Pre-procedure scheduling evaluation with referral for office visit or consultation as appropriate
 - b. Pre-procedure assessment which includes at a minimum:
 - i. Review of past medical & surgical history
 - ii. Medication reconciliation, review
 - iii. Allergy and reaction, review of
 - iv. Physical assessment; assessment for communicable diseases
 - v. Vital signs
- III. Patient Identification:** Refer to Patient Identification Policy. Patient identity is verified with at minimum two (2) identifiers at check-in and at multiple points throughout care.
- IV. Safe Surgery Checklist:** Refer to Safe Surgery Checklist Policy. Patient and procedure are verified immediately prior to procedures.
- V. Discharge Teaching:** Patients are provided with written discharge instructions which are reviewed with patient and driver, as applicable, prior to discharge. Medications are reconciled prior to discharge if any new medications are ordered. Information specific to diagnosis, as best as known, is given to the patient. Patients are educated about signs and symptoms to report and given a twenty-four (24) hour telephone number to call in event of questions or concerns.
- VI. Post Procedure Callbacks:** Patients are contacted one (1) to two (2) business days post-procedure for follow up of any concerns and questions regarding discharge instructions.
- VII. Pathology follow up:** Patients are notified of pathology results and given information and follow up orders as applicable within two (2) weeks.
- VIII. Pharmaceutical Services:** Refer to Pharmaceutical Services Policy. Safe injection practices are strictly followed. Pharmaceutical services are overseen by a contracting pharmacist on a monthly basis.
- IX. Quality Assurance and Benchmarking:** Refer to the Quality Management Plan. More than one hundred (100) quality assurance checkpoints are monitored on per patient, per case, per day, per week or per month basis as applicable. Benchmarking of multiple facility and nursing care factors are completed on an ongoing basis. In addition, multiple procedure-related factors are tracked and trended in aggregate and specific to individual physicians on an ongoing basis. Incidents, procedure complications/events, adverse and sentinel events are investigated tracked and trended by facility, staff and physician. All data is reported to the Quality Management Committee.

X. Staff Training: Extensive staff training is done at time of hire. Annual staff retraining is mandatory; ongoing training is provided as applicable. Staff are evaluated for customer service and performance on an ongoing basis.

1. New Hire and Annual training for employees and credentialed providers (including anesthesia and endoscopists) includes:

- a. Infection control training
- b. Safe injection practices
- c. PPE
- d. Bloodborne pathogens
- e. Emergency Preparedness Plan (completed every two (2) years).
- f. Fire safety
- g. HIPAA
- h. Hazard communication

XI. Checklists: All items above are monitored via specific checklists, logs and / or chart documentation.

Refer to:

- Infection Control Policy
- Criteria for Scheduling Patients at ASC Policy
- Identification of Patient Policy
- Pharmaceutical Services Policy
- Quality Management Plan
- Safe Surgery Checklist Policy
- Incident Reports Policy
- Emergency Preparedness Plan
- Complications: Procedure Event, Adverse and Sentinel Events Policy
- Staff Training Competencies and Logs
- NRS 439.865; 439.877
- CMS §416.54 (Appendix Z)

Centennial Hills Hospital Medical Center

Risk Management/ Patient Safety Plan

Nevada Acute Care Division

Revised 1/2021

I. Overview

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

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

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

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

GENERAL STATEMENTS ON GOALS AND OBJECTIVES

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

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

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

II. Mission and Vision

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

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

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

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

III. ROLES AND RESPONSIBILITIES

A. Risk Management/Patient Safety Officer

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

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

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

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

B. Infection Control Officer

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

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

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

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

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

C. Patient Safety

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

I. Facility Patient Safety Committee

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

Membership:

In accordance with [NRS 439.875](#), the committee core membership consists of the following Key Members: (CEO{member of the Executive or Governing Body}, CNO, Physician, Risk Management and others designated as Patient Safety Officer, Quality Designee, Infection Control Officer, , and Pharmacy). 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 (CFO) of the medical facility. A Patient Safety Committee established pursuant to this section must meet at least once every calendar year.

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 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.
- Monitor and document the effectiveness of the hand hygiene protocol or policy.
- Review policy to ensure compliance with the Patient Safety Checklists pursuant to NRS 439.877.
- **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\(4\)\(d\)](#).
- Receive reports from the Patient Safety Officer pursuant to [NRS 439.870](#).

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

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

II. Patient Safety Advisories

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

Centennial Hills Hospital is required to address the Safety Watch newsletters, Clinical Risk Alerts and Medication Safety Alerts via their Patient Safety Committee and this is

evidenced in their monthly minutes. Responses to the Safety Watch are reviewed for the opportunity to generate a best practice to implement.

C. TERM Program

The facility has utilized its formalized risk management program identified as TERM: the Technical Elements of Risk Management. Each element focuses on a separate organizational function and details specific strategies for managing risk in these areas. In addition to the delineated elements, the TERM program also includes an evaluation of clinical practices that have or are likely to result in liability or patient harm. The TERM elements are summarized as follows:

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

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

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

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

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

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

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

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

D. MIDAS

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

E. Riskonnect (STARS)

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

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

Trending of claim information is performed on a scheduled basis to operations leadership metrics to form strategies on facilitating risk reduction efforts. Previous examples of this function include the formation of an OB HRU and Perioperative

concepts. Quarterly reports should be provided by Centennial Hills Hospital's RM to the Governing Board of all claims activities.

F. Event Notification Site

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

G. Root Cause Analysis (RCA)

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

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

The Joint Commission's root cause analysis framework and action plan table should be used as a reference. 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, NRS 439.877, for use by:

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

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

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

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

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

I. Patient Safety Policies

The Patient Safety Policies must include, without limitation:

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

J. MEMBER PATIENT SAFETY EVALUATION SYSTEM (PSES)

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

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

K. Training and Education

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

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

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

IV. Acute Care Division Patient Safety Priorities, Goals and Objectives for 2021

- **Surgical and Procedural Safety**
 - **Wrong Site Surgery (WSS)**
 - **Goal:** A 50% reduction in WSS events for 2021. Ultimately, the goal is zero (0).
 - Monitor through Midas event reporting and the Patient Safety Dashboard. Report monthly with oversight by CPSC.
 - **Retained Procedural items (RPIs)**

- **Goal:** Prevent RPIs- a 50% reduction in RPIs with harm for 2021. Ultimately, the goal for RPIs is 0.
 - Monitor through Midas event reporting and the Patient Safety Dashboard. Report monthly with oversight by CPSC.
- **OBHRU**
 - **Reduction/Elimination of serious harm by reducing the response time to excessive obstetrical bleeding initiative.** As evidenced by:
 - **Goal:** Quantification of blood loss will occur at 95% of all deliveries as evidenced by facility results in a Healthy Intent / Analytics dashboard.
 - **Goal:** A debrief will be completed on 100% of hemorrhages >1500ml.
 - Monitor through Healthy Intent/ Analytics dashboard, Midas/ENS/Claims data, facility education reports, and the Patient Safety Dashboard. Report monthly with oversight by CPSC.
 - **Reduction / elimination of serious harm by increasing the intervention rate for uterine tachysystole and fetal heart rate category II algorithm compliance.**
 - **Goal:** To be developed in 2Q 2021.
- **CLABSI Initiative**
 - **Goal:** CLABSI will be reduced to less than the national CMS mean Standardized Infection Ratio (SIR: CLABSI 0.736) in 2021.
 - Monitor through CDC's National Healthcare Safety Network (NHSN) and the Patient Safety Dashboard. Report quarterly with oversight by CPSC.
- **Safe Medication Use**
 - **Reduce the preventable occurrences of Opioid Induced Respiratory Events (OIRD) in 2021.**
 - **Goal:** Decrease the number of preventable OIRD events by 10%.
 - **Goal:** Each facility will track and trend naloxone administrations and will identify a performance improvement project related to safe use of opioids by March 1, 2021.
 - **Goal:** 100% of Acute Care facilities will have a medication safety committee that utilizes a standardized charter and agenda by June 1, 2021
 - Monitor through MIDAS reports, Cerner ICD-10 codes and other intervention data and the Patient Safety Dashboard. Report quarterly with oversight by CPSC.
- **Reduce Falls and Falls with Injury**
 - **Goal:** 10 % reduction in the number of falls by end of 2021.
 - **Goal:** 10% reduction in the rate of falls by the end of 2021.
 - **Goal:** 10% reduction in the rate of falls with injury by the end of 2021.
 - **Goal:** A debrief will be completed within 72 hours for 100% of falls with injury.

- Monitor through MIDAS event reporting and the Patient Safety Dashboard. Report quarterly with oversight by CPSC.
- **Decreasing Hospital Acquired Pressure Injuries**
 - **Goal:** 10% reduction of NPOA rate for all HAPI stages in the Acute Care Division by the end of 2021.
 - Monitor through Midas event reporting and the Patient Safety Dashboard. Report quarterly with oversight by CPSC.
- **Culture of Safety**
 - **Goal:** reduce the number of GHI events (serious safety event rate) for the Acute Care Division by the end of 2021. Ultimately, the goal is 0.
 - Monitor through MIDAS event reporting and the Corporate Patient Safety Dashboard. Report monthly with oversight by CPSC.
 - **Goal:** 100% of 2021 Patient Safety Plan Priorities will be implemented within the hospitals.
- **Manager RDE Completion:**
 - 95% Department Manager RDE completion within 10 days
- **Heparin Independent Double Check:**
 - 10% increase in documented independent double check for heparin infusions by the end of 2021

V. Monitoring and Accountability

A. Evaluation of TERM Program

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

B. Patient Safety Committee

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

C. Dashboards

The Risk Management/Patient Safety Dashboard and the Environment of Care includes multiple indicators to demonstrate the facility's performance as to patient safety markers. These include event reporting statistics, overall harmful event rate, fall rate including harmful event rate, medication event rate including harmful

medication events or adverse drug events, serious harm OB events, pressure injury rates, infection variances, and procedural events.

VI. Evaluation/Review:

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

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

VII. Confidentiality

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

VIII. Approval of Patient Safety Plan

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

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

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

Appendix A: Checklist Example: Injuries from Falls and Immobility

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

Include patients, families and caregivers in efforts to prevent falls. Educate regarding fall prevention measures; stay with patient				
Hold post-fall huddles immediately after event; analyze how and why; implement change to prevent other falls				

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



CARSON TAHOE
— HEALTH —
Continuing Care Hospital

PATIENT SAFETY PLAN

Carson Tahoe Continuing Care Hospital

2021

Effective: February 2005 (combines Organization Safety and Patient Safety Plans)
Revised: October, 2005
Revised: December, 2006
Revised: December, 2007
Revised: January, 2009
Revised: January, 2010
Revised: January, 2011
Revised: January, 2012
Revised: February, 2014
Revised: November 2014
Revised: January 2016
Revised: January 2017
Revised: January 2018
Revised: January 2019
Revised: January 2020
Revised: February 2021

INTRODUCTION

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

MISSION

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

CORE VALUES

Putting patients first

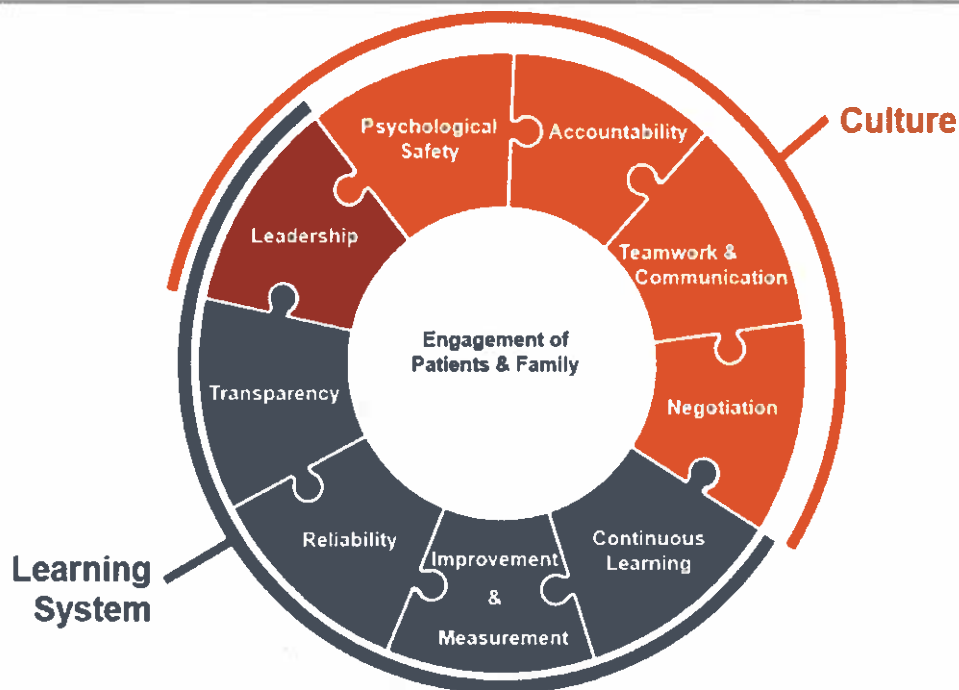
Treating everyone with dignity and respect.

I. PURPOSE/ROLE

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

II. FRAMEWORK FOR SAFE, RELIABLE AND EFFECTIVE CARE

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



© Institute for Healthcare Improvement and Safe & Reliable Healthcare

Source: Frankel A, Haraden C, Federico F, Lenoci-Edwards J. *A Framework for Safe, Reliable, and Effective Care*. White Paper. Cambridge, MA: Institute for Healthcare Improvement and Safe & Reliable Healthcare; 2017. (Available on ihi.org)



III. ROLES and RESPONSIBILITIES/COMPOSITION

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

IV. AUTHORITY AND RESPONSIBILITY

The authority and responsibilities of the Committee shall include:

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

Committee shall include:

- Infection Prevention Program to prevent and control infections within the medical facility (this is a document separate from the Patient Safety Plan that meets the requirements for NRS 439.865)
- Patient Safety checklists and patient safety policies as required by NRS. 439.877
- 2021 Checklist Inventory *Attachment A*
- Annual review and revision of checklists and policies
- Annual Report to Legislative Committee on Health Care
- Integration of all patient safety activities both ongoing and developing
- Ongoing orientation, education and training to emphasize specific job related aspects of patient safety to maintain and improve staff awareness

- Internal reporting of medical / healthcare incidents and events, effectively respond to actual occurrences, manage occurrences and events with a non-punitive approach, and focus on processes and systems to minimize individual blame and retribution
- Periodic survey of the staff regarding willingness to report unsafe conditions, near misses, and adverse events as well as actions taken to prevent recurrence
- Organizational learning and communication of occurrence and event information
- Consideration of patient safety priorities when designing and redesigning of relevant processes, functions and services
- Involvement and education of patients, their families about their role in facilitating safe delivery of care, identifying potential risks and suggesting improvement to patient safety

V. SCOPE OF ACTIVITIES

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

- Patient Safety
- Visitor Safety
- Employee Safety

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

Patient Safety Committee activities include:

- Performing analysis of patient safety event data in order to identify trends and system issues for use in decision-making and identification of improvement opportunities
- Participating in standardizing work and designing processes consistent with the science of patient safety
- Reporting of Sentinel Events pursuant to NRS Chapter 439
- Recommendations, as appropriate to the executive or governing body for reducing the number and severity of serious safety and sentinel events and infections that occur
- Providing emotional support for staff involved in incidents or events, through Human Resources leadership, department supervisors and other resources as appropriate
- Report at least quarterly to the executive or governing body
- The number of events by type and severity, including unsafe condition and near miss events
- The number of sentinel events occurring in the previous quarter
- The number/severity of infections occurring in the previous quarter
- Quality Measures: Review and evaluate to improve the safety of patients who receive treatment to prevent and control infections
- Monitor patient/ environmental safety issues identified throughout the organization
- Promote internal and external knowledge and experience to prevent patient harm, adverse events and occurrences, to maintain and improve patient safety
- Dashboard Trending Report: Review aggregated or trended data including but not limited to:
 - no harm events
 - mild or moderate adverse outcomes
 - near misses

- medication events
- falls
- adverse drug reactions
- transfusion reactions
- and hazardous conditions
- Utilize a proactive approach to recognize and acknowledge medical/healthcare events and risks to patient safety, and initiate actions and recommendations to reduce or prevent such events and risks
- Prioritize and recommend Patient Safety activities, as appropriate, utilizing trended data from Environmental Safety, Security, Employee Health, Emergency Management, Lab or Radiation Safety, Utilities Management, Bio Med, Fire Drills or Inspections
- Identify opportunities and mechanisms to educate and involve patients and families in the patient safety program
- Foster a culture of reporting and learning by identifying 'good catch' events as these events provide opportunities to recognize potential system vulnerabilities and proactively address, mitigate and prevent mistakes before they reach the patient

VI.METHODS

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

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

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

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

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

In 2021, Carson Tahoe Health will pilot and implement Safety STOP as another method to prevent patient harm. Safety STOP is a timely response to potential threats to patient and caregiver safety identified by any caregiver or provider.

Safety STOP provides the following:

- An immediate and comprehensive response to serious safety events

- Ensures appropriate care and attention is given to the patient, family, caregivers, and providers
- Reduces the risk of additional harm or a similar event from happening and
- Allows concerns to be escalated when the usual chain of command process has failed

PATIENT SAFETY OFFICER

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

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

STRUCTURE

Attachment B depicts the reporting structure.

**REPORT TO THE DIRECTOR OF THE LEGISLATIVE COUNSEL BUREAU
PURSUANT TO NRS 439.877(4)(D) - Submitted by:**

Carson Tahoe Continuing Care Hospital
775 Fleischmann Way
Carson City, NV 89703
775.445.7786

July 2020 - June 2021 Checklist Inventory				
Checklist Title	Checklist Category	Department	Review	Revision
Discharge Checklist for nursing	Discharge		2018	
Discharge Checklist for patient	Discharge		2018	
Discharge Planning Checklist	Discharge		2018	
Discharge Checklist	Discharge	Electronic Health Record	2018	
Fire Drill Participation	Environment	Housewide	2018	
Fire Report	Environment	CTH Facility Staff/Spruce Engineering	2018	
Fire Watch Form	Environment	CTH Facility Staff/Spruce Engineering	2018	
Life (Fire) Safety Inspection / Business Occupancy	Environment	CTH Facility Staff/Spruce Engineering	2018	
Life (Fire) Safety Inspection /Healthcare Occupancy	Environment	CTH Facility Staff/Spruce Engineering	2018	
CTCCH Rounding Checklist	Environment	CTH Facility Staff/Spruce Engineering/EOC Committee	new	
Patient Room Housekeeping Checklist by area /by shift	Environment	Spruce	2018	
Environmental Rounds Performed by Charge RN each shift	Environment	Nursing	2018	
Quality Assurance Checklist	Environment	Housekeeping	2018	
Unit Department Checklist	Environment	Nursing	2018	
CRASH CARTS			2018	
Adult Crash Cart Checklist	Other Safety	Nursing	2018	
AED Checklist	Other Safety	Nursing	2018	
Refrigerator / Freezer Temperature Record	Other Safety	Nursing/Pharmacy/Dietary	2018	
Blanket Warmer Temp Logs	Other Safety	Nursing	2018	
Transfer Checklist for Transportation	Other Safety	Housewide	2019	
Ventilator Calibration Checklist	Other Safety	Respiratory	2018	
Central Line Associated Blood Stream Infection and CAUTI surveillance	Other Safety	Infection Control & Nursing	2018	
Emergency Equipment checklist	Other Safety	Nursing Administration/Emergency Preparedness	2018	
Hand Hygiene	Other Safety	Infection Control	2018	
Infection Control Monitoring during construction	Other Safety	Infection Control	2018	
Central Line Insertion	Other Safety	Nursing	2018	
Charge Nurse checklist	Other Safety	Nursing	2019	

Hand Off Communication sheet Pre-op/OR/PACU	Treatment	Receiving CTH facilities	2018	
Magnetic Resonance Imaging History & Assessment	Treatment	Medical Imaging	2018	
Medical Imaging Invasive Procedure Checklist	Treatment	Medical Imaging	2018	
Non Ionic and/or Ionic Contrast Consent Form	Treatment	Medical Imaging	2018	
Foley Catheter Tracking	Treatment	Infection Control & Nursing	2018	

**List Reviewed and approved at
CTCCH Patient Safety Committee
Meeting on June 24, 2020**

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.

**STONECREEK SURGERY CENTER
EMERGENCY CODES**

EMERGENCY	CODE
FIRE	<i>RED</i>
SECURITY	<i>GREY</i>
DISASTER	<i>ORANGE</i>
MEDICAL	<i>BLUE</i>
EVACUATE	<i>GREEN</i>
ACTIVE SHOOTER	<i>SILVER</i>

**STONECREEK SURGERY CENTER
EMERGENCY PHONE NUMBERS**

<i>AGENCY</i>	<i>PHONE NUMBER</i>
FIRE DEPARTMENT <i>non-emergency</i>	(702) 455-7311
LOCAL POLICE <i>non-emergency</i>	(702) 828-2843
POLICE <i>emergency</i>	911
POISON CONTROL	(800) 222-1222
ELECTRIC COMPANY	(702) 402-8400
GAS COMPANY	(877) 860-6020
MEDICAL GAS COMPANY	(702) 734-2182
WATER COMPANY	(702) 870-4194

Section 3 Disaster Safety	Stonecreek Surgery Center, Las Vegas Nevada	
Policy Name:	COMPREHENSIVE EMERGENCY MANAGEMENT PLAN	Page 1 of 1
Approved:	Revised:	

POLICY:

The Governing Body supports the establishment and maintenance of an effective risk assessed for all hazards Comprehensive Emergency Management Plan (CEMP). Risk control and agency reporting are the responsibility of Director of Nursing. This emergency management plan is established to provide an effective response to disasters or emergencies impacting the environment of care. The objectives of the CEMP are to:

- Designate and authorize key person(s) to be responsible for CEMP implementation.
- Define and, as appropriate, integrate the facility's role into community-wide emergency preparedness efforts.
- Include mitigation, preparedness, response and recovery in emergency management planning activities.
- Identify specific response procedures to a variety of disasters, based on hazard vulnerability analysis.
- Establish procedures to notify personnel and external authorities of emergencies when emergency response measures are implemented.
- Assign staff primary and secondary roles and responsibilities to cover all needed positions during an emergency.
- Effectively manage patient, staff and family activities, critical supplies, security and interaction with the public.
- Establish evacuation procedures, or establish an alternate care site, when the facility environment cannot support adequate patient care and treatment.
- Provide and alternate source of essential utilities and internal and external communication systems in the event of failure during a disaster or emergency.
- Include emergency management procedures and responsibilities in staff orientation and inservice programs.

The CEMP is evaluated and updated annually by ongoing assessment of its objectives, scope, performance and efficacy to validate that the plan continues to meet the needs of the facility.

Section 3 Disaster Safety	Stonecreek Surgery Center	
Policy Name: CEMP: 1135 WAIVER	Page 1 of 1	
Approved:	Revised:	

POLICY:

Stonecreek Surgery Center management will understand how to apply for an 1135 Waiver should it be deemed necessary to accept patients during a disaster without the benefit of federal insurance verification (Medicare, Medicaid, CHIP Beneficiaries).

PROCEDURE:

Should it be required, the facility will request an 1135 Waiver from the Regional CMS office. See attached and <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/1135-Waivers.html> for information.

Section 3 Disaster Safety	Stonecreek Surgery Center	
Policy Name: CEMP: EMERGENCY RESPONSE	Page 1 of 4	
Approved:	Revised:	

PURPOSE:

To define the facility's role in community-wide disaster preparedness, and to establish processes for effective facility response to disasters or emergencies, and notification of external authorities.

POLICY:

This Governing Body will designate key individual(s) to authorize and assume responsibility for the implementation of facility emergency response plans. The facility will notify civil authorities of the facility scope of care and available resources. The facility is not staffed or equipped to offer emergency services, which limits our participation in community wide disaster programs. The facility emergency management plans aim to mitigate or minimize danger and the impact of staff, patients and visitors as well as prepare for, respond to and provide for recovery during a potential disaster or emergency. In the event of an emergency or disaster, actual or impending, which may affect the provision of services, (e.g., hurricane, flood, earthquake), patients and staff will be informed and scheduled procedures will be cancelled. Plans will include triage, emergency treatment (within the scope of the facility capabilities) and transfer of victims to the nearest emergency treatment facility to address an emergency which causes damage or injury in or near the facility.

If possible, the facility will coordinate its disaster preparedness plan with local, tribal, regional, state and federal emergency preparedness officials. The facility must document efforts made to contact pertinent emergency preparedness officials, and, as applicable, its participation in any collaborative and cooperative planning efforts.

PROCEDURE:

- The Governing Body designates the Director of Nursing to be responsible for the implementation of emergency response plans.
 - All staff is informed of Director of Nursing responsibility to implement emergency response plans during orientation to the facility.
 - The designated back-up to the Director of Nursing will implement emergency response plans if the Director of Nursing is not available.
 - The clinical RN in charge will implement emergency response plans if the Director of Nursing and back-up to the Director of Nursing are not available.

Section 3 Disaster Safety	Stonecreek Surgery Center
Policy Name: CEMP: EMERGENCY RESPONSE	Page 2 of 4

- Names and contact information will be available in order to contact staff, physicians and local emergency preparedness staff, if needed. Volunteers will not be utilized at this facility.
- A communication method to access the Director of Nursing is identified (e.g., overhead paging, telephone paging, cell phones, etc.).
 - The facility telephone system will be utilized, if operational.
 - Cell phones will be utilized, if the facility telephone system is not operational.
 - Two-way radios will be utilized if both the facility telephone system and cell towers are not operational.
 - All staff is inserviced on a one-step method to notify the Director of Nursing in the event of an emergency.
- Any individual who perceives an indication of an emergency, performs a cursory inspection of the situation (e.g., identifies smoke or fire).
- Call the appropriate **code and location** to alert staff and activate the appropriate plan:

Fire	Security	Evacuate	Disaster	Medical	Active Shooter
Red	Gray	Green	Orange	Blue	Silver

- Announce the appropriate code and location three times in succession, slowly and distinctly.
- The designated and authorized individuals respond to the location of the emergency and take appropriate action.
 - The Director of Nursing will delegate staff responsibilities including, but not limited to:
 - assigning staff to cover all necessary positions
 - security (access, traffic control, crowd control)
 - identification and monitoring of all personnel and others (patients, visitors)
 - interaction with the media
 - screening incoming telephone calls
 - shut down of equipment and utilities, as appropriate
 - patient activities including scheduling, modification or discontinuation of services, control of patient information and patient transportation

Section 3 Disaster Safety	Stonecreek Surgery Center	
Policy Name: CEMP: EMERGENCY RESPONSE		Page 3 of 4

- if needed, triage of incoming patients and recovering patients
 - staff/family support activities
 - logistics of critical supplies (medications, disposables, food, linen and water)
- o If the source is identified (e.g. fire) and evacuation is indicated (environment cannot support adequate patient care and treatment):
- Move ambulatory patients, visitors and family outside of the building to the designated evacuation point.
 - Move non-ambulatory patients across smoke walls away from the heat.
 - Move critical equipment and supplies necessary to maintain life support (crash cart, monitors, oxygen with regulators).
 - Shut down equipment and utility systems as indicated, if it can be done without compromising patients, visitors or staff.
 - Protect, move or secure computer back-up media, medical records, logs, etc.
- o If the source is identified (e.g. a hazardous materials release for which actions such as sealing up windows and doors may be necessary, inclement weather such as extreme winds which may require sheltering in place but away from windows or an active shooter or active threat situation) and shelter in place is indicated:
- Secure areas within the facility, if applicable.
 - Move ambulatory patients, visitors and family to a designated safe area, depending on the hazard.
 - Move non-ambulatory patients to a designated safe area, depending on the hazard.
 - Staff, patients and visitors may be sheltered in place, if needed, for 30 hours as this is the length of time the generator will function. This facility is not equipped with supplies for long term needs.
 - A list of names and location of patients sheltered in place will be maintained by the Director of Nursing or designee.
- o Determine if an alternate care site is required and include processes that include management of patient necessities (medications, medical records) to and from the site, patient tracking to and from the site, and inter-facility communication and transportation of patients, staff and equipment to and from the alternate site.

Section 3 Disaster Safety	Stonecreek Surgery Center	
Policy Name: CEMP: EMERGENCY RESPONSE		Page 4 of 4

- If the source is unidentified, take appropriate precautions and actions to protect patients, visitors and staff.
 - Notify civil authorities as appropriate via land line or cell phone.
 - Director of Nursing or designee will call 911 if appropriate to the emergency and verify the notification with the civil authorities.
- Upon arrival of the civil authorities, define the authority and responsibilities and determine if further evacuation of the facility is necessary. The Director of Nursing will cooperate with the civil authorities to direct all further activities. The Director of Nursing will discuss the facility's capabilities for assistance with additional patient populations with the civil authorities in person or via land line or cell phone.
 - Relatives of staff or patients may obtain information concerning victims from the civil authorities or the Director of Nursing.
 - Upon direction of the civil authority and the medical staff, transfer patients to a higher level of care, if required, discharge patients from the facility. Suspend all elective, non-emergent procedures and all routine clinical activities.
 - If patients are transferred, provide copies of pertinent medical records (if available) per policy and notify a family member or an individual designated by the patient of the transfer.
 - If patients are not transferred and remain under the care of the facility, the Director of Nursing or designee is able to discuss information on general conditions and locations of patients to public and private entities assisting with disaster relief.
 - Director of Nursing or designee will communicate, as needed, via land line (if functional) or cell phone with suppliers of supplies, equipment and essential services.
 - Director of Nursing or designee will communicate, as needed, via land line (if functional) or cell phone with federal, state, and local emergency management agencies.
 - Director of Nursing or designee will communicate with family or others designated by the patient via telephone if the patient is evacuated.
- Implement measures to restore the facility to pre-disaster capabilities when the civil authorities have authorized re-entry.

Section 3 Disaster Safety	Stonecreek Surgery Center	
Policy Name:	CEMP: NOTIFICATION AND LOGISTICS	Page 1 of 3
Approved:	Revised:	

PURPOSE:

To notify and assign staff to cover all essential functions when emergency response measures are initiated.

POLICY:

The Director of Nursing will initiate notification and logistic support for the facility. Emergency response staff and alternates will be identified and assigned specific responsibilities.

The facility maintains surveillance of impending threats by monitoring internet news and by emergency alert device (e.g., smoke alarm). In the event that an imminent threat or emergency situation is verified, operations at the facility will cease and staff, patients and visitors will be notified.

For emergencies occurring during operational hours, a plan will be activated, as necessary, for ceasing routine operations, triage, emergency treatment, transfer of victims to the nearest emergency treatment facility, and evacuation of the facility. The current employee roster with telephone numbers, when applicable will be available for employees at home as well as in the facility. Scheduling information will be available for assigned personnel to complete patient notification in a timely manner.

When an alarm is activated or a code is announced, emergency response staff will respond immediately with appropriate equipment and supplies while awaiting the arrival of civil authority. If immediate evacuation is required, designated staff members will initiate evacuation while awaiting arrival of civil authority.

The facility is responsible for tracking the patients and staff before and during an emergency. In an emergency situation, services will be suspended until it is safe to reopen. The facility will maintain agreements with an area hospital and local ambulance service to facilitate patient transfer. If patients or staff are transferred for continued or additional care, the facility will document the specific name and location of the receiving facility for those relocated during an emergency.

Section 3 Disaster Safety	Stonecreek Surgery Center	
Policy Name: CEMP: NOTIFICATION AND LOGISTICS	Page 2 of 3	

PROCEDURE:

Upon verification of a disaster, immediately notify emergency services (911) and activate the appropriate alarms. Inform the Director of Nursing for activation of the appropriate disaster plan.

- Monitor tracking of impending disasters (e.g., storms). When a “watch” changes to a “warning”, the Director of Nursing informs staff, patients and visitors of the impending threat and the estimated time that operations of the facility will be curtailed.
- Impending threat during non-operational hours:
 - Notify the medical staff, employees and patients that operations at the facility have been cancelled until further notice. The Director of Nursing provides the designated staff with names and telephone numbers of patients to be notified.
- Impending threat during operational hours:
 - Assign staff to respond immediately to the emergency as designated by the code announcement.
 - Move patients and visitors to the nearest exit away from danger in preparation for rescue assistance by civil authority.
- The staff will communicate via cell phone if the telephone utility is disrupted.
- The Director of Nursing will determine if an evacuation must be initiated before the arrival of the civil authorities, and as the conditions allow:
 - Recommend discharge or, if necessary, transfer patients to another health care facility. Notify a family member or emergency contact person of the transfer.
 - Advise the medical staff, employees and visitors to go home.
 - Move and, if possible, secure logs and medical records.
 - Remove all computer back-up files to a safe off-site location.
 - Upon arrival of the civil authorities, assist with evacuation, as directed.

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Policy Name: CEMP: NOTIFICATION AND LOGISTICS		Page 3 of 3

- The emergency response team does not enter areas that would jeopardize their own safety, but directs civil authority representatives to areas not inspected.
- The emergency response team brings equipment (e.g. stretchers, wheelchairs) to be used as transportation to the evacuation area.
- Search all rooms (including bathrooms, lounges, closets) to confirm that all persons have been accounted for and removed from danger.
 - The designated emergency response team turns off natural and medical gas central valves.

Section 3 Disaster Safety	Stonecreek Surgery Center	
Policy Name:	CEMP: EMERGENCY SHUT-OFF VALVES	Page 1 of 1
Approved:	Revised:	

POLICY:

All emergency shut-off valves will be clearly marked and all employees will be inserviced on location and the procedure for shut off.

EMERGENCY SHUT-OFF VALVES

	Location	How Marked	Type	How to Shut Off	When to Shut Off
Natural Gas	Propane – parking area	On outside wall	Propane tank	Press emergency button	Leak, fire
Electricity	Sterile corridor	Panel S1, S2, S3	Wall panel	Open/panel manual	Fire, short
Water	Sterile room exit	None	Gate main valve	Manual pull	Issue with water leaks
Oxygen	OR 1, OR 2, OR 3	Marking on ceiling	Wall/ceiling mount	Pull ring – pull valve forward	Fire
Suction/Vacuum	OR 1, OR 2, OR 3	Med Vac on wall	Suction base	Manual turn knob	Leak, fire

Section 3 Disaster Safety	Stonecreek Surgery Center	
Policy Name:	CEMP: EMERGENCY POWER AND SUPPLIES	Page 1 of 1
Approved:	Revised:	

PURPOSE:

To maintain electrical power and an adequate inventory of supplies in an internal or external disaster to facilitate emergency measures until operations can be fully reinstated or evacuation of the facility occurs.

POLICY:

Emergency backup power will be available on a limited basis as required by code and generator size.

The facility does not provide emergency services or overnight care; therefore planning and provisions are only for short periods of confining or sequestering emergencies. It is not feasible for the facility to stockpile supplies to support emergency situations not within the facility scope of services due to the limited storage space. The facility maintains only the supplies, food and water required for scheduled procedures.

PROCEDURE:

The facility provides emergency backup power through the use of an emergency generator powered by propane with a capacity of 499 gallons and can maintain emergency power for up to 30 hours.

Maintain medical supplies to meet the needs of scheduled procedures.

Maintain food and water supplies to support the needs of scheduled patients for nourishment immediately postoperatively.

In the event of a confining or sequestering emergency, the facility activates means of evacuation or transfer as soon as possible.

- Non-Urgent: Minor injuries (cuts, sprains, etc.) will be handled in family waiting room.
- Surgical: Those requiring surgical procedures will be handled in preop area.
- Critical: Those requiring life saving methods will be handled in the operating suite.

OPERATING ROOM EMERGENCY LIGHTS LOG

Year _____

Month	OR 1	OR 2	OR 3
January			
February			
March			
April			
May			
June			
July			
August			
September			
October			
November			
December			

Emergency lights are tested every month for 30 seconds to ensure they are in good working condition. Make a check if they are in good working condition. Notify the Director of Nursing if there are any non-functional lights.

Annual Check Completed **Date:** _____ **Initials:** _____

Annual check includes testing the units for 1.5 hours to ensure they are in good working condition.

Section 3 Disaster Safety	Stonecreek Surgery Center	
Policy Name: CEMP: EMERGENCY EVACUATION	Page 1 of 2	
Approved:	Revised:	

PURPOSE:

To provide an efficient plan for evacuation of the facility in the event of an emergency that could endanger patients, staff or visitors.

POLICY:

The Director of Nursing will determine the level of evacuation required for emergency management. Upon arrival at the facility, the civil authorities will assume responsibility for evacuation decisions.

In the event of uncontained danger (e.g., smoke, fire, bomb, or other disaster), complete facility evacuation will be conducted by the Director of Nursing or the civil authority present at the scene. Evacuees will assemble in a designated area furthest from the building.

PROCEDURE:

The Director of Nursing determines if immediate partial or total evacuation is necessary (e.g., fire, equipment malfunction causing explosion or air contamination, bomb threat, breach of security, spilling or venting of hazardous materials).

Partial evacuation:

- Move patient and visitors away from immediate area of danger.
 - Refer to the evacuation plan and move patients and visitors behind the nearest firewalls or doors.
 - Activate the appropriate alarm for the situation.
 - Confine danger, if possible (e.g., close all doors and windows, shut off air conditioning/heating thermostats, shut off circulating fans, shut off electricity to the area if warranted).
 - If total evacuation is unnecessary, staff stays in their area(s) until ordered to evacuate.

Section 3 Disaster Safety	Stonecreek Surgery Center
Policy Name: CEMP: EMERGENCY EVACUATION	Page 2 of 2

Total evacuation:

- If an uncontrollable danger occurs, evacuate all patients, visitors and staff through fire doors or the nearest exit and away from the building to the designated area (include a destination in the evacuation announcement).

Notify the medical staff of the emergency evacuation and proceed according to the patient needs. Move patients who are not ambulatory by stretcher or wheelchair to the designated area.

- Assign staff to accompany and monitor evacuated patients and visitors during an emergency.
- Protect the patients, visitors and staff (during and after evacuation) against environmental threats.

The Director of Nursing and/or civil authority will confirm that all patients, visitors and staff are out of the building.

- Use the staffing schedule, surgery schedule, sign-in logs and staffing rosters to verify complete evacuation.

The Director of Nursing will designate a RN to coordinate patient transfers.

Maintain a concise log of each patient and visitor evacuated, including: name, physical status, approximate evacuation time and place of transfer. Compare the evacuation log with the occupancy documents to account for all facility occupants.

When re-entry has been authorized, take measures to restore the facility to pre-emergency operational capabilities and safety.

Section 3 Disaster Safety	Stonecreek Surgery Center	
Policy Name:	CEMP: EMERGENCY EXIT ROUTES	Page 1 of 2
Approved:	Revised:	

POLICY:

- Stonecreek Surgery Center will maintain emergency exit routes to be used should immediate evacuation of the organization be needed. These exits are located as far away as practical from each other in case others are blocked by fire, smoke or obstruction.
- Emergency exit routes are identified throughout the facility by a floor plan drawing (see Fire Safety – section 1).

PROCEDURE:

- Exits are separated from the workplace by fire-resistant materials. This material has a one (1) hour fire-resistance rating if the exit connects three (3) or fewer stories; and a two (2) hour fire-resistance rating if the exit connects more than three (3) floors.
- Exits are protected by self-closing, approved fire doors that remain closed or automatically close in an emergency.
- The line-of-sight to exit signs shall always be clearly visible.
- “EXIT” signs shall be installed using plainly legible letters.
- The fire retardant properties of paints or solutions are maintained and are renewed as often as necessary to maintain their fire retardant properties.
- Exit routes shall be free of explosives or highly flammable furnishings and other decorations.
- Exit routes shall be arranged so employees will not have to travel toward a high-hazard area unless the path of travel is effectively shielded from the high-hazard area.
- Exit routes shall be free and unobstructed by materials, equipment, locked doors or dead-end corridors.
- Exit routes shall have adequate lighting for employees with normal vision.

Section 3 Disaster Safety	Stonecreek Surgery Center	
Policy Name: CEMP: EMERGENCY EXIT ROUTES		Page 2 of 2

- Exit route doors shall be free of decorations or signs that obscure the visibility of exit route doors.
- Signs shall be posted along the exit access indicating the direction of travel to the nearest exit and exit discharge if that direction is not immediately apparent.
- Doors or passages shall be marked along an exit access that could be mistaken for an exit "Not an Exit" or with a sign identifying its use (such as "Closet").
- Exit routes shall be maintained during construction, repairs or alterations.
- Exit routes shall be permanent parts of the workplace.
- Exit discharges shall lead directly outside or to a street, walkway, refuge area, public way or open space with access to the outside.
- The street, walkway, refuge area, public way or open space to which an exit discharge leads must be large enough to accommodate the building occupants likely to use the exit route.
- Exit route doors shall unlock from the inside. They shall be free of devices or alarms that could restrict use of the exit route if the device or alarm fails.
- Exit routes that are connected to rooms are done so only by side-hinged doors, which swing out in the direction of travel. This type of route exists only if the room can be occupied by more than 50 people.
- Exit routes shall support the maximum permitted occupant load for each floor served, and the capacity of an exit route does not decrease in the direction of exit route travel to the exit discharge.
- Exit routes shall have ceilings at least seven feet, six inches (7'6") high.
- An exit access is at least 28 inches wide at all points. Objects that project into the exit shall not reduce its width.

EMERGENCY EXIT SIGNS LOG

Year _____

Month	Location #1	Location #2
January		
February		
March		
April		
May		
June		
July		
August		
September		
October		
November		
December		

Emergency Signs are visually checked every month to ensure they are in good working condition. Make a check if they are in good working condition. Notify the Director of Nursing if there are any non-functional lights.

Section 3 Disaster Safety	Stonecreek Surgery Center	
Policy Name: CEMP: EMERGENCY TRANSFER	Page 1 of 1	
Approved:	Revised:	

PURPOSE:

To provide guidelines for safe and efficient transfer of patients and victims if a disaster occurs and the physician determines that a higher level of care is needed.

POLICY:

Patients or victims that may require a higher level of care will be transferred to a hospital with which the facility maintains a transfer agreement or to the nearest emergency treatment facility. If the condition warrants, facility staff may accompany the patient(s).

PROCEDURE:

The Director of Nursing or designee coordinates emergency transportation and notifies the hospital emergency room(s) of pending transfers.

- Provide as much information as possible about the person being transferred (e.g., name, admitting physician, age, religion, advance directives, circumstances requiring transfer, means of transportation and estimated time of arrival).
- If a patient requires transfer and the medical record is accessible, a copy of the pertinent medical information must accompany the patient (e.g., history and physical, diagnostic studies, operative report, physician orders, progress notes, consents, insurance information).

Notify the patient's family and physician of the transfer. Gather the patient's clothing and possessions and make arrangements for valuables.

Facility staff may accompany the patient to the designated health care facility if ordered by the physician. Transfer intravenous lines, patient transfer information, copy of the pertinent medical information, and patient clothing and possessions.

Place a copy of the patient transfer record in the medical record.

Request information from the hospital and document follow-up in the medical record.

Section 3 Disaster Safety	Stonecreek Surgery Center	
Policy Name: CEMP: RE-ENTRY		Page 1 of 1
Approved:	Revised:	

PURPOSE:

To propose guidelines for the safe re-entry to the facility and the resumption of operations.

POLICY:

After an evacuation or a disaster that caused structural damage, the facility will be inspected by the civil authorities, the Director of Nursing, and the Administrator to determine that conditions are safe for re-entry and resumption of operations. In the event of significant structural damage, approval also may be required from the local or state construction offices.

The Director of Nursing or civil authority in charge is responsible for authorizing re-entry into the facility and the resumption of operations.

PROCEDURE:

After a hazardous occurrence, the civil authorities, and the Director of Nursing will inspect the premises for damage and determine if systems are operational.

- If the facility sustained significant structural damage, repairs must be completed, and if required, approval received from local or state construction offices before it is reoccupied.

When permission has been received from the civil authority, the Director of Nursing authorizes the re-entry.

- Take measures to restore the facility to pre-disaster operational capabilities (e.g., staff, equipment and supplies, cleanup and repair).
- Reestablish medical gas flow and electrical connections.

Section 3 Disaster Safety	Stonecreek Surgery Center	
Policy Name: CEMP: BOMB THREAT		Page 1 of 2
Approved:	Revised:	

POLICY:

In the event of a bomb threat the following procedure will be followed.

RECEIVING A THREATENING PHONE CALL:

- Take the message
 - Keep the caller on the line as long as possible. Ask him/her to repeat the message. Attempt to record every word spoken by the caller.
 - If the caller does not indicate the location of the bomb or the time of detonation, ask for this information.
 - Inform the caller that the building is occupied and detonation of a bomb could result in death or serious injury to many innocent people.
 - Be alert for distinguishing background noises such as traffic, music, aircraft, voices, etc.
 - Note distinguishing characteristics (sex, voice quality, etc.)
 - Note if caller indicates knowledge of the facility by his/her description of locations.
 - Complete a Bomb Threat Record while you are on the phone or as soon as you hang up.
- Notify administration
 - Immediately notify the Director of Nursing that you have received a bomb threat.
 - Supply details and follow instructions.
 - The Director of Nursing will notify the police and fire department.
 - Do not alert patients and other personnel that you have received a threat.
 - Follow directions of the police and/or bomb squad when they arrive.

FINDING A SUSPICIOUS PACKAGE:

- Notify administration
 - If a suspicious package is received or found within the facility, notify the Director of Nursing immediately.
 - Do not handle the package.
 - Clear the area of patients and personnel.
 - The Director of Nursing will call the police.
 - Keep the area clear until the police or bomb squad arrive.
 - Follow directions of the police and/or bomb squad when they arrive.

Section 3 Disaster Safety	Stonecreek Surgery Center
Policy Name: CEMP: BOMB THREAT	Page 2 of 2

SEARCH PROCEDURES – REMEMBER THE FOLLOWING:

- There is no predefined appearance for a bomb.
- The area to be searched will be searched by police personnel and, if possible, by the personnel routinely working in and familiar with the area. Look to see if everything is in its place and nothing has been added.
- Be thorough. Eliminate areas locked and not available to the public.
- If a suspicious item is located do not touch or disturb it no matter how harmless it looks. Do not activate the fire alarm. Isolate the object by clearing the area of patients and personnel and await instructions from the police or bomb squad.

EVACUATION:

- Evacuate only on instruction from the Director of Nursing, Administrator or police or fire personnel.

RE-ENTRY INTO THE FACILITY:

- Do not allow re-entry into the facility until authorized.

BOMB THREAT RECORD

Date of Call: _____

Time of Call _____

IDENTITY OF CALLER:

Age: _____

Sex: ☐ Male

☐ Female

VOICE:

☐ Loud

☐ Soft

☐ Low

☐ Raspy

☐ Pleasant

SPEECH:

☐ Nasal

☐ Stutter

☐ Garbled

☐ Distinct

☐ Other _____

LANGUAGE:

☐ Good

☐ Poor

☐ Obscene

ACCENT:

☐ Foreign

☐ Regional

☐ Local

MANNER:

☐ Calm

☐ Angry

☐ Emotional

☐ Incoherent

☐ Rational

☐ Nervous

BACKGROUND NOISES:

☐ Music

☐ Traffic

☐ Voices

☐ Quiet

☐ _____

COMMENTS:

(Signature of Person Receiving Call)

Section 3 Disaster Safety	Stonecreek Surgery Center	
Policy Name: CEMP: BIOTERRORISM THREAT		Page 1 of 3
Approved:	Revised:	

PURPOSE:

To provide for an effective response to a real or suspected bioterrorism attack.

PROCEDURE:

- If a bioterrorism event is suspected, the emergency response system will be activated. Notification includes:
 - Facility Administration
 - Local emergency medical systems (EMS)
 - Police and Fire Departments
 - Local and state health departments
 - FBI field office
 - CDC
- Agents likely to be used in bioterrorism attacks:
 - Anthrax
 - Botulism
 - Smallpox
 - Plague
 - Cyanide
 - Tularemia, etc.
- Detection of a bioterrorism attack:
 - In an announced attack, persons are warned that an event has occurred. Notification and preparation should proceed, as per the Emergency Management Plan, until the attack is ruled as a “hoax” by proper authorities.
 - A designated decontamination area will be prepared for use.
 - A designated area will be assigned for the media

Section 3 Disaster Safety	Stonecreek Surgery Center
Policy Name: CEMP: BIOTERRORISM THREAT	Page 2 of 3

- At the time of the activation of the Emergency Management Plan, facility personnel will lock all exits and entrances with the exception of an ambulance entrance. Employees and medical staff will be required to wear nametags or carry cards identifying themselves as employees/medical staff. Only persons with proper identification will be allowed to enter the facility during this emergency.
- All elective admissions and procedures will be canceled until authorities rule out the actual attack.
- Patient/public informational material and home care instructions for the most likely biological agents to be used in an attack will be available (Information will be obtained from the CDC and state Departments of Health as appropriate to respond to a bioterrorist threat).
- Patient Management:
 - As with any patient, Standard Precautions are to be used:
 - Hand Hygiene
 - Gloves are used when in contact with blood or body fluids
 - Gowns to protect clothing and skin during patient procedures likely to generate splashes
 - Face shields or masks and eye protection are worn when splashes may be generated during patient procedures
 - Respiratory/droplet precautions may also be required
 - In large-scale events, triage procedures will be necessary following the facility's Emergency Management Plan.
 - Environmental cleaning will follow the principles of Standard Precautions unless otherwise indicated by the bioterrorism agent.
 - Clinical laboratories, pathology, Coroner's Office and mortuaries must all be informed of the potential infectious outbreak prior to submitting specimens for examination or disposal.
 - Specimen packaging and handling must be coordinated with local and state health departments and the FBI. A chain of custody document must accompany the specimen from time of collection. **For specific instructions on specimen transport contact the CDC Emergency Response Office, Bioterrorism Emergency, (770) 488-7100.**

Section 3 Disaster Safety	Stonecreek Surgery Center
Policy Name: CEMP: BIOTERRORISM THREAT	Page 3 of 3

- Decontamination of Patients (general guidelines):
 - Remove contaminated clothing and place in labeled plastic bags; avoid agitation of clothing, which may cause re-aerosolization of spores.
 - The FBI may consider the contaminated clothing as evidence.
 - Patient must shower thoroughly with soap and water.
 - Staff are to use Standard Precautions and appropriate PPE when handling contaminated clothing or equipment.
 - Decontaminate environment with EPA registered, facility approved sporicidal/germicidal agents.
 - Patient decontamination is not necessary for all agents. The exception would be in an announced attack with gross surface contamination of the victims. The CDC or state health department may be contacted for specific recommendations.
- Post-exposure Prophylaxis:
 - Post-exposure prophylaxis/treatment is subject to change due to the development of new antibiotics and treatment protocols. The local and state Health Departments and the CDC should be contacted for up-to-date guidelines.

Section 3 Disaster Safety	Stonecreek Surgery Center	
Policy Name: CEMP: CIVIL DISTURBANCE	Page 1 of 2	
Approved:	Revised:	

PURPOSE:

A civil disorder may escalate a minor disturbance to a major riot, through the actions of one or a group of individuals who are well organized. The first ingredient is a "cause" or reason for upsetting the normal routine or committing aggressive action against the facility, its personnel or one or more of its patients.

A healthcare facility is particularly susceptible to incursions by malcontents or individuals with a "cause," because of its lack of security and open admissibility to the public. An individual determined to enter the facility to start trouble will pay no attention to signs restricting entrance, such as "Authorized Personnel Only", "Facility Personnel Only", and other similarly restrictive notices. In fact, such an individual will probably go to the rear or side entrance where he/she is not likely to be observed and probably won't be challenged if he/she is seen entering the building.

PROCEDURE:

- As soon as it is determined or suspected that a person with no official business or medically-related reason for being in the facility is, in fact, circulating within the premises, he/she shall be challenged, preferably by an official of the facility and escorted out of the building as discreetly as possible, on the basis that he/she has no reason for being in any part of the facility except the reception area, and that it is a private institution. If he/she objects, the facility official shall notify the police department, and the challenged individual shall be allowed to speak to the police department on the telephone. In most cases, the person will not avail himself/herself of the opportunity, but the facility will have protected itself from any charges of unfair treatment or discrimination.
- When it has been determined that a group of individuals are in the facility on other than official or medically-related business, all entrances shall be secured and, where possible, the group shall be isolated, by activating the fire doors, and prevented from circulating through the rest of the facility. The police shall be summoned by the Director of Nursing / Administrator, who shall brief the police watch commander over the telephone.
- Potentially Violent Situation:
 - Be prepared to call the police if a trouble situation appears to be developing. If there is any doubt, it is better to inform them too early rather than too late, as the situation can often be resolved before violence occurs.

Section 3 Disaster Safety	Stonecreek Surgery Center	
Policy Name: CEMP: CIVIL DISTURBANCE		Page 2 of 2

- All non-public entrances to the facility shall be posted with restrictive notices to establish legal basis for possible subsequent recourse measures against illegal entrants.
- Special precautions shall be taken to protect the liquid oxygen storage area and tank; a supply of auxiliary cylinders shall be maintained in the facility as back-up to the main storage and supply source and for use in an emergency situation. The generator shall also be guarded against actions by intruders.
- Maintain a current list of phone numbers for the police, fire departments and key facility personnel to be notified in an emergency situation.
- Code Grey is designated to alert facility personnel to a possible or actual security issue.
- Be prepared to report any disturbance in accurate detail. It is essential that the true nature of the disturbance be reported, in order that the appropriate course of action and corrective measures can be applied.
- Violence Imminent or in Progress:
 - Contact police and fire departments. Carefully report the incident in terms of numbers of participants, reasons for unrest, observed conduct of group leaders and any other information requested by the police. Write down any instructions given by the police and follow their procedures precisely.
 - Notify the Director of Nursing / Administrator or his/her designee, and give details of the incident or disorder.
 - The Director of Nursing / Administrator will decide on a course of action to be taken, pending arrival of police.
 - The facility should be closed to all except emergency response personnel.
 - The Director of Nursing / Administrator will direct the facility staff to prepare for a fire alert and to be ready to shut off electrical power, natural gas or any source of ignition. It is imperative that the facility cooperate fully with the police and fire services of the community responding to the disturbance.
- In the final analysis, any local condition of unrest or social upheaval, which affects the orderly conduct of the facility shall be handled by the local public protection services with full assistance and cooperation from the facility and its staff.

Section 3 Disaster Safety	Stonecreek Surgery Center	
Policy Name: CEMP: CYBER SECURITY	Page 1 of 3	
Approved:	Revised:	

POLICY:

This Cyber Security policy is a formal set of rules by which employees and other authorized users of their requirements for protecting the technology and information assets of the facility from unauthorized access, theft and destruction.

The technology and information assets of the facility are made up of the following components:

- Computer hardware, CPU, disc, email, web, application servers, PC systems, application software, system software, etc.
- System Software including: operating systems, database management systems, and backup and restore software, communications protocols, and so forth.
- Application Software including: custom written software applications, and commercial off the shelf software packages.
- Communications Network hardware and software including: routers, routing tables, hubs, modems, multiplexers, switches, firewalls, private lines, and associated network management software and tools.

PROCEDURE:

The term “security incident” is defined as any irregular or adverse event that threatens the security, integrity, or availability of the information resources on any part of the company network.

Employees must mitigate risk for cyber security incidents by doing the following:

- Only give out appropriate rights to systems. Limit access to only business hours.
- Don't share accounts to access systems. Never share your login information with co-workers.
- When employees are separated or disciplined, you remove or limit access to systems.
- Advanced – Keep detailed system logs on all computer activity.
- Physically secure computer assets, so that only staff with appropriate need can access.

Employees and authorized users are to use company computer systems only for business of the company and not to be used for personal activities. Unauthorized use of the system may be in violation of the law, constitutes theft and can be punishable by law.

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Users are personally responsible for protecting all confidential information used and/or stored on their accounts. This includes their logon IDs and passwords. They are prohibited from making unauthorized copies of such confidential information and/or distributing it to unauthorized persons outside of the company.

In the case of an internal, external or community wide disaster, employees will shut down PCs and the computer system.

Users shall not purposely engage in activity with the intent to: harass other users; degrade the performance of the system; divert system resources to their own use; or gain access to company systems for which they do not have authorization.

Users shall not attach unauthorized devices on their PCs or workstations, unless they have received specific authorization from the employees' manager and/or the company IT designee. Users shall not download unauthorized software from the Internet onto their PCs or workstations.

Users are required to report any weaknesses in the company computer security, any incidents of misuse or violation of this policy to their immediate supervisor. The company will provide Internet access to employees and authorized users who are connected to the internal network **and** who has a business need for this access.

Stonecreek Surgery Center has the right and capability to monitor electronic information created and/or communicated by persons using company computer systems and networks, including e-mail messages and usage of the Internet.

Users may not install personal software designed to provide remote control of the PC or workstation. This type of remote access bypasses the authorized highly secure methods of remote access and poses a threat to the security of the entire network. Upon violation of this policy, an employee of company may be subject to discipline up to and including discharge.

Some other examples of security incidents are:

- Illegal access of a company computer system. For example, a log onto a production server and copies the password file.
- Damage to a company computer system or network caused by illegal access. Releasing a virus or worm would be an example.
- Denial of service attack against a company web server. For example, a hacker initiates a flood of packets against a Web server designed to cause the system to crash.

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- Malicious use of system resources to launch an attack against other computer outside of the company network. For example, the system administrator notices a connection to an unknown network and a strange process accumulating a lot of server time.
- Hijacking of Medical Records or other part(s) of the computer system for ransom or other purpose.

Employees, who believe their terminal or computer systems have been subjected to a security incident, or has otherwise been improperly accessed or used, should report the situation to their supervisor immediately. The employee shall not turn off the computer or delete suspicious files. Leaving the computer in the condition it was in when the security incident was discovered will assist in identifying the source of the problem and in determining the steps that should be taken to remedy the problem.

The Administrator and/or Director of Nursing will inform the appropriate authorities of the security incident, depending on the circumstance. In a case where the accused person is not an employee of company the matter shall be submitted to the Administrator and/or Director of Nursing. The Administrator and/or Director of Nursing may refer the information to law enforcement agencies and/or prosecutors for consideration as to whether criminal charges should be filed against the alleged violator(s).

Also refer to Employee Add/Edit/Delete Policy, in Administration section 1, for facility policy on the creation of new employee network accounts, editing existing employee network accounts, adding, editing or deleting group membership and properly handling these accounts and associated data upon termination of employees.

Section 3 Disaster Safety	Stonecreek Surgery Center	
Policy Name: CEMP: EARTHQUAKE		Page 1 of 3
Approved:	Revised:	

POLICY:

The actual movement of the ground in an earthquake is seldom the direct cause of death or injury. Most casualties result from falling objects and debris because the shocks can shake, damage or demolish buildings and generate huge ocean waves (seismic sea waves), each of which can cause great damage. Earthquakes usually strike without warning. In most cases the shock occurs and ends in seconds, which precludes any personal protective action during the tremor. If the seismic action is a prolonged shaking and rolling, it is sometimes prudent to take protective measures. These might include taking cover in a doorway or under a table. In any event, if you have time, cover your head and shoulders and try to protect yourself from falling objects or shattered glass. The scope of this procedure covers response to all types of earthquakes.

PROCEDURE:

Injuries are Commonly Caused by:

- Partial building collapse, collapsing walls, falling ceiling plaster, light fixtures and pictures;
- Flying glass from broken windows and mirrors;
- Overturned bookcases, fixtures and other furniture and appliances;
- Fires, broken gas lines and similar causes; the danger may be aggravated by the lack of water due to broken mains;
- Fallen power lines;
- Drastic human actions resulting from panic.

Immediate Response Measures - All Personnel:

- Upon detection of shock - remain in place.
- Remain calm. Think through the consequences of any action you take. Try to calm and reassure others.

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- If indoors, watch for falling plaster, light fixtures and other objects. Watch out for high storage areas, shelves and tall equipment, which might slide or topple. Stay away from windows and mirrors. If in danger, get under a table, desk, or in a corner away from windows; or in a strong doorway. Encourage others to follow your example. Usually it is best not to run outdoors.
- After the initial shock has ended, and a reasonable interval has passed with no further shock, survey immediate surroundings to determine injuries and damage.
- Do not attempt to move seriously injured persons unless they are in immediate danger of further injury.
- If you are in a patient care area and are not seriously injured, your first responsibility is to the patients in the vicinity. If possible, reassure them and attempt to calm those who may be hysterical or panic stricken. If there are obvious injuries from falling objects, shattered glass or if patients or personnel are trapped under debris, you must request assistance and perform first aid within your capability where possible until additional medical personnel arrive to assist in treatment or rescue.
- Check for fire or fire hazards from broken electrical lines or short circuits and follow the facility fire response procedure in the facility's fire plan if a fire is discovered or reasonably expected.
- Do not attempt to lead or assist any patients to leave the facility until you are directed to do so by the Administrator, Director of Nursing or designee. If the facility has not been rendered untenable by the earthquake, it is advisable to keep the patients inside.
- Make sure all ambulatory patients wear shoes in areas near debris and glass.
- Immediately clean up spilled medications, drugs and other potentially harmful materials.
- Check to see that sewage lines are intact before permitting continued flushing of toilets.
- Check closets and storage shelf areas. Open closet and cupboard doors carefully and watch for objects falling from shelves.
- Be prepared for additional "aftershocks". Although most of these are smaller than the main shock, some may be large enough to cause additional damage.

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Responsibilities:

- Administrator / Director of Nursing or designee:
 - Determine the advisability of partial or complete evacuation of the facility.
 - If evacuation is deemed advisable, determine condition of exit areas and avoid those that are obstructed or otherwise hazardous.
 - Conduct an immediate check of all communications systems including the facility's nurse call system and telephones.
 - Direct implementation of evacuation procedures outlined in the facility's comprehensive emergency management plan.
 - Ensure that all local emergency service authorities are informed of the degree of damage and extent of injuries sustained by the facility, its patients and personnel.
 - Barricade entrances to facility areas.
 - Provide for a free flow of emergency vehicle traffic.
- Nursing Services:
 - Provide supplies and services to all facility areas as required.
 - Assess damage of all involved patient care areas and report information to Operations Center, as applicable.
 - Direct and assist with evacuation of patients as necessary.
 - Follow internal emergency management plan as outlined in the manual.

Section 3 Disaster Safety	Stonecreek Surgery Center	
Policy Name: CEMP: EDUCATION AND TRAINING	Page 1 of 3	
Approved:	Revised:	

PURPOSE:

To review, at specified intervals, policies and procedures, staff response, equipment, and utility systems for appropriateness before, during and after a disaster.

POLICY:

Orientation and inservice programs will be conducted to train all employees on their roles and responsibilities, and to review the CEMP.

Disaster drills will include all employees, medical staff and other occupants of the building. If utilization requires more than one shift of operation, drills will be held on each shift.

Two disaster drills will be conducted per year. These drills should be evaluated, including identification of deficiencies and opportunities for improvement. The facility should make an effort to participate in a community mock disaster drill annually. If participation in a community drill is not available, the facility will conduct an additional drill. The drills will be an external and an internal drill. Tabletop exercises are not acceptable. Tabletop drills are acceptable, per Medicare Appendix L, as a substitute to an individual drill, but not The Joint Commission (TJC). If a tabletop exercise is conducted in place of a community drill, then two additional disaster drill will be conducted to test the emergency preparedness plan.

Eight emergency drills are required per year. Four must be fire drills (with at least one being an operating room fire scenario), one must be a documented cardiopulmonary resuscitation technique drill, one must be a malignant hyperthermia drill and two must be documented disaster drills. All drills should be appropriate to the facility's activities and environment and may include drills for medical emergencies, weather related emergencies, bomb threats and/or other emergencies.

Documentation of disaster drills includes, but is not limited to types of emergencies, staff responsibilities in responding to an emergency, effectiveness of staff response, adequacy of equipment and the alarm system, the needs identified and the plan for staff training to correct deficiencies.

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PROCEDURE:

The safety coordinator conducts disaster drills and trains the staff on the procedures, their roles and the importance of drill evaluation.

- Drills should consider the possible impact of the disaster on the facility utility systems (e.g., electrical, water, communication and other systems).
- The safety coordinator assigns at least two staff members to serve as disaster drill monitors.

Before a disaster drill is performed, the safety coordinator notifies the appropriate agencies (e.g., security company, fire department), that a drill will be taking place.

- At least once a year, request the participation of the security monitoring services to determine appropriate responses.

Without advance notice, select an area of the facility and announce to staff that a disaster drill is to commence.

- Hold the drill when fewest patients and visitors are in the facility, the maximum number of staff is present, and minimal interruption to normal functions and activities will occur.

When a disaster drill is announced, proceed with the drill as realistically as possible.

- The receptionist or designee simulates a call to local emergency services (e.g., 911) and relates information to the safety coordinator.
- The emergency response team reports to designated areas; assigned staff report to duty stations for traffic control, building security and simulated triage activities.
- Inform patients and visitors that a drill is in progress; move them to a safe area in preparation for possible evacuation.
- The safety coordinator notifies the receptionist or designee to announce the end of the drill (e.g., "All Clear").
- The receptionist notifies the fire department and security monitoring company, as appropriate that the drill is over and a designated, trained individual resets the alarm.

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After the drill, the safety coordinator documents the disaster drill report on the Emergency Management Plan Activation Evaluation. The evaluation is reviewed and discussed by the QAPI Committee. When appropriate recommendations for improvement or corrective action is taken.

During the next drill, attention is focused on the recommendations approved for implementation, if indicated.

CEMP ACTIVATION EVALUATION

1 of 2

Disaster Type :	Date:	Time:	# of Staff present:	<input type="checkbox"/> Actual <input type="checkbox"/> Drill	Evaluation Completed by:
INDICATORS					COMMENTS
How was the plan activated?					
Was there communication with? <input type="checkbox"/> Police <input type="checkbox"/> Fire <input type="checkbox"/> Hospitals					
If this was an actual disaster rather than a drill, were the following communication modes used? <input type="checkbox"/> Radio <input type="checkbox"/> Telephone <input type="checkbox"/> Other:_____					
Were roles/responsibilities clearly delineated, understood and executed?	YES	NO			
Was an alarm activated?	YES	NO			
Was the facility's ability to function compromised? (If yes, explain)	YES	NO			
Was a damage assessment done?	YES	NO			
Were all patients and facility personnel accounted for and moved appropriately within the facility toward the nearest exit away from danger?	YES	NO			
Was anyone within the facility injured? (If yes, explain)	YES	NO			
Did personnel know where and how to shut off utilities?	YES	NO			
Were equipment and/or utilities shut off?	YES	NO			
Was emergency power required? Did the electrical load transfer properly?	YES	NO			
Were critical supplies available?	YES	NO			
Were triage areas identified per facility protocol (non-urgent, surgical, critical)?	YES	NO			

CEMP ACTIVATION EVALUATION

2 of 2

INDICATORS			COMMENTS
Were computer back up files, medical records, logs secured?	YES	NO	
Were there adequate supplies of food and water?	YES	NO	
Was evacuation necessary?	YES	NO	
Was “all clear” communicated before re-entry?	YES	NO	
Were arrangements made with outside agencies to assist with transport?	YES	NO	
Was staffing adequate to handle the situation?	YES	NO	
Were additional staff members called to come in?	YES	NO	
Were they responsive?	YES	NO	
If no, were additional physicians called to come in?	YES	NO	
Were they responsive?	YES	NO	
Was there feedback from outside agencies?	YES	NO	
What areas of the emergency management plan implementation worked well?			
What areas of the emergency management plan implementation need improvement?			
List all staff members who participated in this drill:			

ANNUAL EVALUATION OF THE EFFECTIVENESS OF THE CEMP

INDICATORS			COMMENTS
What are the most likely threats to your facility?			
What additional resources or changes need to be made to reduce the impact on the facility of a disaster/emergency? Please explain.			
Was implementation of the CEMP conducted on at least a semi-annual basis? (Please attach evaluation)	YES	NO	
Were problems identified in the evaluation?	YES	NO	
What actions were taken to address the issues?			
Were the results of the implementation of the Emergency Management Program communicated to:			
Quality Assessment and Performance Improvement Committee?	YES	NO	
Medical Advisory Committee?	YES	NO	
Governing Body?	YES	NO	
Please rate the overall effectiveness of the CEMP: 1 = ineffective, 5 = highly effective			
	Facility Preparedness	1 2 3 4 5	
	Staff Preparedness	1 2 3 4 5	
	Patient Management	1 2 3 4 5	

ANNUAL EVALUATION OF THE EFFECTIVENESS OF THE CEMP

INDICATORS	COMMENTS
What opportunities for improvement have been identified?	
Are the CEMP scope and objectives appropriate?	
What goals have been set for the Emergency Management Program for the upcoming year?	
Have changes in the capabilities of the facility been addressed?	
Have changes in the community been evaluated?	

AMBULATORY SURGICAL CENTER OF SOUTHERN NEVADA

SUBJECT: QA	POLICY: RISK MANAGEMENT/ PATIENT SAFETY PROGRAM
DEPARTMENT: AMBULATORY CARE SERVICES	PAGE 1 OF 10
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	REVISED: JANUARY 3, 2016

I. PURPOSE:

Attention to maintaining and improving patient safety and well being is inherent in Ambulatory Surgical Center of Southern Nevada's (ASC of Southern Nevada) commitment to the relief of suffering and improvement in the quality of life to those in the community it serves. In committing ourselves to safeguarding individuals, ASC of Southern Nevada must fully understand the processes and systems that are utilized by the organization to deliver patient care. From this deeper understanding, ASC of Southern Nevada will be able to analyze, evaluate, develop and implement changes that will continuously improve the way we deliver care to patients.

The results of these efforts will:

- Demonstrate ASC of Southern Nevada's commitment to the community it serves.
- Unite ASC of Southern Nevada and individuals who work and practice at ASC to respond appropriately to adverse events, proactively identify risk reduction strategies and participate in process and system redesigns to reduce risk of patient harm.
- Allow ASC to implement processes technology or systems that will reduce the risk of errors reaching patients and causing harm.
- Promote greater medical staff and employee involvement in improving clinical care which will result in improved employee and medical staff satisfaction.
- Translate into a more efficient and cost-effective model of care at ASC.

Ambulatory Surgical Center of Southern Nevada's leadership and employees must actively embrace and support the patient safety plan in order to achieve the results outlined above.

II. SCOPE:

The Ambulatory Surgical Center of Southern Nevada Patient Safety Plan is an all-inclusive, integrated method to planning, designing, measuring, assessing and improving patient safety, quality care and outcomes. Assessing day to day operations, employee input and customer needs are integrated into the development of the program. This program will incorporate all patient related activities and use interdisciplinary teams whenever possible.

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

- Complications of anesthesia
- Post procedure bleeding
- Post procedure infection
- Medication errors/Look alike sound alike medications

AMBULATORY SURGICAL CENTER OF SOUTHERN NEVADA

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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.

AMBULATORY SURGICAL CENTER OF SOUTHERN NEVADA

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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

AMBULATORY SURGICAL CENTER OF SOUTHERN NEVADA

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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 Officer and Patient Safety Committee

Owner: Center

Date last updated: Revised 2/2020

Purpose: To ensure the ongoing safety of our patients.

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

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

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

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

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

The proceedings and records of a patient safety committee are subject to the same privilege and protection from discovery as the proceedings and records described in NRS 49.117 - 49.123 and NRS 49.265.

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

Refer to:

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

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

The proceedings and records of a patient safety committee are subject to the same privilege and protection from discovery as the proceedings and records described in NRS 49.117 - 49.123 and NRS 49.265.

CORONADO SURGERY CENTER

QUALITY AND PATIENT SAFETY PLAN



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**

2779 W. Horizon Ridge Parkway Suite 140
P 702-589-9250 F 702-589-9257

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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

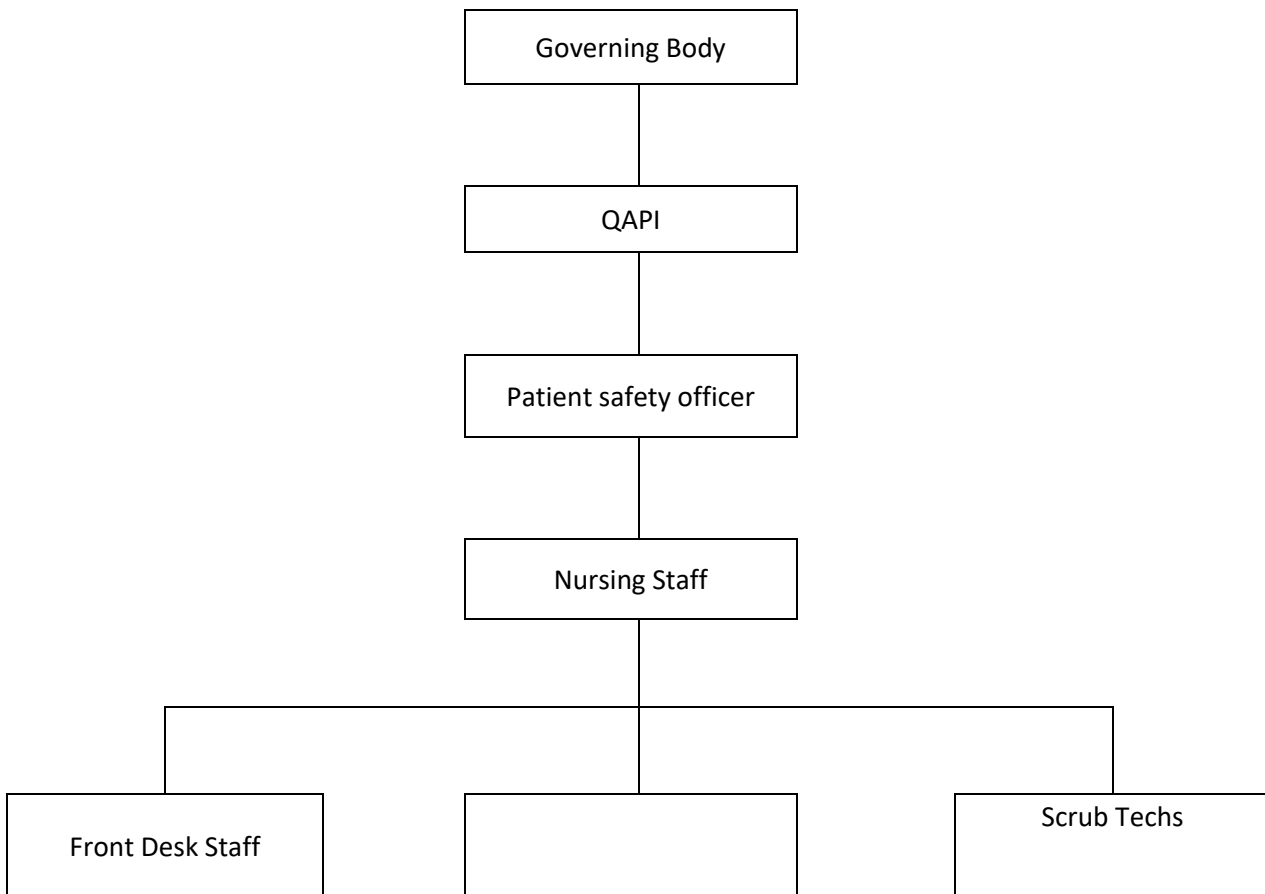
external customers, as well as facilitates the need of analyzing and improving processes. The core principles of this plan include:

- 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.

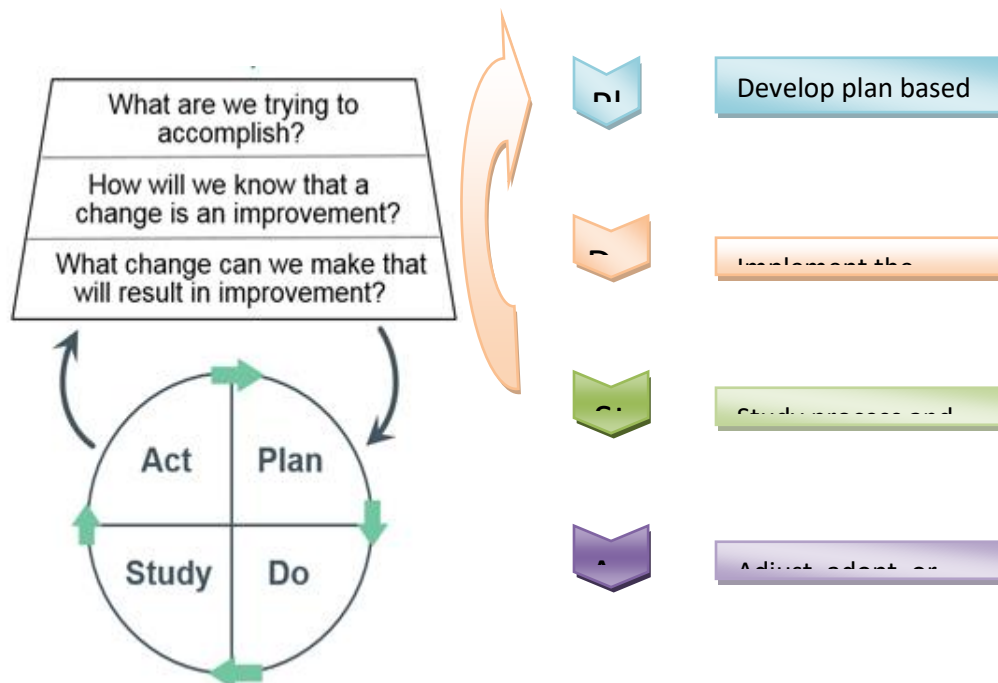
Fishbone Diagram

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

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_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.

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. Create process for reviewing & closing reports in e-MERS. Create process for communicating outcome of reported events.	Increase number of events reported by 10%.
3. Develop a Culture of Safety where providers feel safe and supported when they report medical errors or near misses & voice concerns about patient safety.	a. Provide education on patient safety plan that emphasizes importance of blending a systems focus with appropriate individual accountability. b. Establish a recognition program that rewards safe practices. c. Improve overall perceptions of safety as measured by the Culture of Safety Survey.		Educate Medical staff, Hospital Wide Committees on the objectives and goals. Include patient safety presentation in Orientation. Develop 'Great Catch' awards program.
4. Establish Safety Priorities & Targets.	a. Develop Patient Safety Dashboard that includes national measures and benchmarks. b. Facilitate the development of action plans associated with measures not meeting benchmarks. c. Assess and improve processes related to hand-off, transition and communication	Complete 2014 Leapfrog Safety Survey. Develop method to track & report departmental progress and compliance of RCA action plans.	Present Patient Safety Dashboard to Hospital Committee. Establish & implement a plan to improve performance.
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.

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?)
----------------	----------	----------	------------	-----------------------------------

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:

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:

Coronado Surgery Center	POLICY AND INFORMATION MANUAL		
PERSONAL PROTECTIVE EQUIPMENT POLICY Page 2 of 2		Date Issued:	1/1/2017
		Date Last Revised:	
		Next Review Date:	1/1/2018
		Approved By:	Policy Committee

- They use PPE whenever it is required;
- Attend and comply with training, instruction and information;
- Check the condition of their PPE;
- Store, clean and maintain their PPE;
- Report losses, defects or other problems with PPE to their manager.

Evaluation:

- Staff health and safety orientation
- Environmental audits
- Incident reports

SUBJECT: PATIENT SAFETY PLAN	REFERENCE #6038
DEPARTMENT: HOSPICE	PAGE: 1 OF: 5
APPROVED BY: NAH BOARD OF TRUSTEES	EFFECTIVE: 1/27/2011 REVISED: 2/13/2012, 11/4/13, 5/24/16

PURPOSE:

- Nathan Adelson Hospice strives 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
- 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 NAH. .

PATIENT SAFETY

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

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- 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.
 -
 -
 -
 -
 - Hazardous Condition - any set of circumstances, exclusive of the disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious physical or psychological adverse patient outcome.
 - Sentinel Event - an unexpected event or occurrence involving death or serious physical or psychological injury or the risk thereof - including any process variation for which a recurrence would carry a significant chance of serious adverse outcome. Serious injury specifically includes loss of limb or function. Sentinel event criteria includes:
 - ◆ The event has resulted in an unexpected death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition, or
 - 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.

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- The scope of the 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 Hospice and patient care functions of:
 -
 - Environment of Care
 - Emergency Management
 - Human Resources
 - Infection Prevention and Control
 - Information Management
 -
 - Life Safety
 -
 - Staff
 -
 -
 - Performance Improvement
 -
 -
 - Rights and Responsibilities of the Individual
 -

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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 Chief Compliance Officer and Process Improvement, who will aggregate occurrence information and present a report to the Quality Assurance Performance Improvement (QAPI) Committee. The report will contain aggregated information related to type of occurrence, severity of occurrence, number/type of occurrences per department, occurrence impact on the patient, remedial actions taken, and patient outcome. The Safety Committee will analyze the report information and determine further patient safety activities as appropriate.
- Through review of internal data reports and reports from external sources (including, but not limited to, Joint Commission sentinel event report information, and occurrence reporting information from state and federal sources and current literature), the QAPI Committee will select Performance Improvement Projects (PIP).. . The PIPs will include:
 - Identification of the ways in which the process could break down or fail to perform. This will be done through assessment of the intended and actual implementation of the process to identify the steps in the process where there is, or may be, undesirable variation. Identify the possible effects of the undesirable variation on patients, and how serious the possible effect on the patient could be
 - Prioritizing the potential processes breakdowns or failures
 - For the most critical effects, conduct a root cause analysis to determine why the undesirable variation leading to that effect may occur
 - Redesign the process and/or underlying systems to minimize the risk of that undesirable variation or to protect patients from the effects of that undesirable variation
 - Test and implement the redesigned process
 - Identify and implement measures of the effectiveness of the redesigned process
 - Implement a strategy for maintaining the effectiveness of the redesigned process over time

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- 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 provider and other providers, as appropriate, to report the error, carrying out any provider orders as necessary.
 - Report the safety issue the staff member's immediate supervisor.
 - Submit Quality Data Indicator (QDI) Report in the electronic system.
- Any individual in any department identifying a t safety issue will immediately notify his or her supervisor and document the findings on a QDI.
- Staff responsible for safety issues will be counseled by their supervisor and Human Resources to determine the level of discipline.
- The Safety Program includes implementation of the recommendations set forth by The Joint Commission, or identified alternative recommendations defined by this organization, 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.

Facility Name: Parkway Surgery Center Henderson, NV	Policy And Procedure Guideline Name: Safety Management Program (Environment Of Care)	Policy Number: SAFE 104
	Subject Category: SAFETY	Effective Date: 12/01/2016
		Reviewed Date: 12/14/2017, 1/10/19, 02/07/2020, 02/19/2021
		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.

GOLDEN MANOR CARE

CRISIS CONTINGENCY

&

EMERGENCY EVACUATION PLAN

Developed for Golden Manor Care
2301 East 9th St.
Reno, NV 89512
Created 03/13/2014

CRISIS CONTINGENCY PLAN

BACKGROUND

GOLDEN MANOR CARE in the event of an incident constituting a threat to its residents, employees, guests and/or visitors, has provided this CRISIS CONTINGENCY PLAN & EMERGENCY EVACUATION PLAN as a guide for the owner, administrator, caregivers, employees and the residents. The procedures contained in this publication are not to be considered all inclusive but moreover to provide general response procedures based upon acceptable practices for evacuation and/or safeguarding of life and property in the event of an emergency.

DUTIES AND RESPONSIBILITIES

OWNER/S, ADMINISTRATOR, CAREGIVERS, EMPLOYEES AND RESIDENTS are to familiarize themselves with all aspects of these plans. Owner/s or Administrator in the event that they are unavailable or unable to respond to the emergency, the Lead Caregiver On-duty, or any caregivers or employees should be capable of assuming their duties. It is the responsibility of the owner/s and administrator to familiarize their employees with these plans. Caregivers and employees assigned to assist evacuation are to be trained in their duties and responsibilities by the owner/s and administrator..

OWNER/S AND ADMINISTRATOR is responsible for ensuring the caregivers and employees carry out their duty assignments quickly and efficiently.

EMERGENCY EVACUATION PLAN

(EEP)

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BACKGROUND

GOLDEN MANOR CARE, in the event of an incident constituting a threat to the owner, administrator, caregiver, employees, guests and residents, has provided this EMERGENCY EVACUATION PLAN as a guide for the owner, administrator, caregiver, employees and the residents. The procedures contained in this publication are not to be considered as being all inclusive but moreover provide response guidelines based upon acceptable practices for evacuation and/or safe guarding of life and property in the event of an emergency.

GOLDEN MANOR CARE is an ADULT GROUP CARE facility licensed by the Bureau of Health Care and Quality Compliance and is located at 2301 East 9th St., Reno, NV 89512 its cross streets are Silverada Blvd. on the east and Manhattan St., on the west, other notable factors to consider regarding our location is that we are situated adjacent and just below 395 freeway going either North or South.

Although remote, the possibility of an incident, whether externally or internally generated, always exists. GOLDEN MANOR CARE recognizes this potential and has prepared the following EMERGENCY EVACUATION PLAN for just such an eventuality.

EVACUATION PLAN

A complete evacuation can be a time consuming endeavor and in an emergency time can be of the essence. To facilitate a timely, safe evacuation, key employees have been designated respective duties and responsibilities. Employees during EMERGENCY DRILL EXERCISE will be pre-assigned for emergency situations, whenever possible assigned employees must be bi-lingual in order to verbally communicate critical instructions to non-English speaking persons.

The employees may change but the manner, formation and assignment will remain constant. It shall be the responsibility of the Administrator to update and practice the fire drill once a month so that they key positions are not lost to attrition. The Administrator shall train every new employees of the facility and give them their key assignments in an emergency situation within five (5) working days after they are hired.

Residents should also be trained to familiarize themselves what to do in case of emergency. Response time should be recorded so that the facility can anticipate the actual evacuation time.

Problems should also note and addressed during the Emergency Drill Exercise.

Employee Assignments

There are Twelve (2) exits from the facility. If ever possible employee will be assigned to each of the exits.

Door #	Location	Description	Employee
1	Front Door Exit	towards the front yard	Caregiver 1
2	Side Door Exit	right side of the house going towards the porch	Caregiver 2

NOTE: Should any of the above emergency exits be unavailable due to the emergency, Assigned Caregiver will divert to the available exits listed. In case two exits are unavailable – assigned caregiver will locate the safest exit possible eg. Windows, etc.

Alternative Exits

Alternative Exit	<u>Description</u>	In -charge
<u>Laundry room Exit doors</u>	Two doors at the laundry doors not equipped with exit ramps for residents but can be used as alternative exits	Any available employees
Various windows of the facility	In case two exits are unavailable assigned caregiver will locate the safest, nearest window exit going towards the designated evacuation area	Any available employees

Note: Owner/Administrator and any unassigned caregiver will assist all the residents from their rooms and proceed to the assembly area.

Order of Evacuation Priority:

1. Anybody which is near the fire or emergency area will be evacuated first
2. Category 2 residents will be taken out of the building second
3. Category 1 residents will be taken out third
4. All other people: visitors, employees will be evacuated in the area

ASSEMBLY POINT

ADMINISTRATOR/OWNER is to assemble all the residents, visitors, employees to the ‘FRONT YARD’ of the facility adjacent to the street. Administrator/Owner is to account all the people in the facility: residents, visitors and employees.

DECISION TO EVACUATE

a. Authority

Only the Owner, Administrator or the Lead Caregiver on Duty (LCOD) will make the decision to evacuate all or any part of the facility.

b. Response

Immediately upon receipt of the decision to evacuate the facility, the LCOD will announce the evacuation and start the evacuation as soon as possible.

The LCOD will be responsible for announcing the need to evacuate the building. Should electrical power not be present the owner, administrator, caregivers and employees will be responsible for communicating the need to evacuate the residents and guests.

DUTIES AND RESPONSIBILITIES

1. The Owner

- a. Only the Owner, Administrator or the Lead Caregiver on Duty (LCOD) will make the decision to evacuate all or any part of the facility
- b. The owner will make every effort to safeguard the safety of the residents and employees. Secondary to this are funds and valuables of the facility and residents, important documents and papers and last will be computers and other electrical equipment that may be impacted by electrical current fluctuations.
- c. Upon arriving at the assembly area, Owner/Administrator will account for all the residents, employees and guests who were at the facility at the time of the evacuation. Anybody of the aforementioned not actually observed at the assembly area will be reported as missing to the proper authority.
- d. The Owner upon notification by the Lead Caregiver on Duty (LCOD) of a Missing resident, or employee, or guest will immediately notify the Police Authority with the missing person's Name, and a brief description, and location.
- e. The owner or whoever is in-charge will be in possession of the facility's "Key Set" in the event that doors need to be opened.
- f. The owner/administrator will lead and assist in the evacuation process making sure that everybody in the Facility will proceed directly to the assembly area.

2. The Administrator

- a. The Administrator shall train every new employees of the facility and give them their key assignments in an emergency situation within five (5) working days after they are hired.
- b. The Administrator upon decision that the emergency is on phase 3 or Code red will hold a meeting with the owner, on-duty Caregiver, Caregiver and other employees at a predetermined location for planning and implementation of evacuation/defend in place or other suitable contingencies to deal with the incident.
- c. The Administrator will assemble all the residents, visitors, employees to the 'ASSEMBLY AREA ('FRONT YARD)'' of the facility adjacent to the street. Administrator is to account all the people in the facility: residents, visitors and employees.
- d. **Note:** Owner/Administrator and any unassigned caregiver will assist all the residents from their rooms and proceed to the assembly area.

3. The Lead Caregiver On-Duty (LCOD)

The Lead on-duty Caregiver/s (LCOD Immediately upon receipt of the decision to evacuate the facility, will announce the evacuation and start the evacuation as soon as possible.

The LCOD will be responsible for announcing the need to evacuate the building. Should electrical power not be present the owner, administrator, caregivers and employees will be responsible for communicating the need to evacuate the residents and guests.

LCOD will assume overall responsibility for conducting the Emergency Evacuation Plan (EEP). All subordinate employees of the facility shall take direction from the LCOD during an incident requiring the evacuation of the building. All employees shall render such assistance as may be required by the LCOD to discharge his/her duties. The LCOD shall, unless relieved by higher authority, act on behalf of Golden Manor Care to safeguard life and property.

If condition permits LCOD:

- will ensure that the facility's records and valuable are secured and then conduct a sweep of the building, in pairs, to ensure that everyone is out of the building.
- will close doors to individual areas after determining all occupants have departed.
- after completing the sweep, LCOD will proceed to the assembly area.
- After the evacuation is complete, and if possible, will maintain observation points at a safe distance outside the Northeast and Southwest corners of the building.

4. The Caregiver and Other Employees

- Shall take orders from the LCOD
- Will assist in communicating the need to evacuate residents, guest and employees.
- Assist in the evacuation process and make sure that everybody will proceed to the assembly area.
-

The owner will make every effort to safeguard the safety of the residents and employees. Secondary to this are

funds and valuables of the facility and residents, important documents and papers and last will be computers and other electrical equipment that may be impacted by electrical current fluctuations.

Upon arriving at the assembly area, Owner/Administrator will account for all the residents, employees and guests who were at the facility at the time of the evacuation. Anybody of the aforementioned not actually observed at the assembly area will be reported as missing to the proper authority.

NOTE: Nobody shall risk their life or serious injury to retrieve or preserve any personal or facility property.

SPECIAL NOTE

All newly hired caregivers and employees should include in their orientation the policies and procedures and what their responsibilities are in case of crisis contingency.

EMERGENCY NOTIFICATION PROCEDURES

The following procedures are to be implemented in the event of an incident whether on or off property which may have an effect to Golden Manor Care operations. The events portrayed are only representative of the types of incidents that may be encountered and are not all inclusive.

The Lead Caregiver On-duty (LCOD) will determine the level of alert based upon his/her understanding of the seriousness of the incident.

Phase 1 Alert

Phase 1 Alert consists of the following types of events which may affect the Golden Manor Care operations and should be monitored closely but do not necessarily constitute an immediate threat to life or property. Call outs of other caregiver/s and employees will be at the discretion of the LCOD

- ✓ Structure fires in close proximity to Golden Manor Care
- ✓ Broken water or gas mains in the vicinity of Golden Manor Care
- ✓ Law Enforcement operations such as barricaded armed subjects, armed confrontations or standoffs with armed subject where chemical weapons may be employed.
- ✓ Civil disturbances which may overflow into or onto Golden Manor Care property,
- ✓ Loss of power
- ✓ Bomb Threats (telephonic)

Phase 2 Alert

Structure fires adjacent to the Golden Manor Care

Utility breaks (gas, water etc.) effecting Golden Manor Care operations.

Bomb threats (suspect device located on property)

Riot or civil disturbance disruptive to Golden Manor Care operations

Phase 3 Alert

Any incident requiring the evacuation of all or part of Golden Manor Care

Any incident requiring implementation of the Emergency Evacuation Plan

Any incident which will, if allowed to continue, have a significant effect on Golden Manor Care operations

CALL OUT PROCEDURES

The following will be notified should a specific alert level be activated.

Phase 1 (Green Alert)

Owner
Administrator
Caregivers
Other Employees

PHASE 1 (Green)

The Lead On-duty Caregiver should ensure that the owner and administrator are aware of the situation. Other Caregiver and Employees should be kept informed and alert for any escalation in the incident which could lead to a higher level of response. LCOD or his/her designee should stay in contact with the Owner and Administrator until the incident is resolved.

Phase 2 (Amber Alert)

Owner
Administrator
Lead Caregiver On-Duty
Caregivers
Other Employees

PHASE 2

Owner/Administrator should report for duty or remain on duty. Ensure adequate supplies and employees are available to respond to the situation.

Phase 3 (Red Alert)

Owner
Administrator
Lead Caregiver On-duty
Caregivers
Other Employees

PHASE 3 (Red)

The Owner, Lead Caregiver On-duty, Caregivers and other employees will meet with the Administrator at a predetermined location for planning and implementation of evacuation/defend in place or other suitable contingencies to deal with the incident.

CALL – OUT ROSTER

Call Out Roster

The following roster is to be utilized in the event of a call-out or notification requirement as a result of an incident or situation affecting or having the potential to affect the operations of GOLDEN MANOR CARE. Individuals on this call-out roster listed as primary contacts will be called in the order they are listed for their department or position.

NAME	DESIGNATION	PHONE NOS.
Ernesto D. Beltejar Jr.	(owner/administrator)	775/762-2162 (cell) 410-9034 (home)
Leonila Beltejar	(owner)	775/762-2160 (cell) 410-9034 (home)
_____	<u>Lead On Duty Caregiver</u>	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

EVACUATION ANNOUNCEMENT
(Scripted)

EVACUATION ANNOUNCEMENT

THE FOLLOWING SCRIPT IS TO BE ANNOUNCED BY THE LEAD CAREGIVER ON-DUTY, IN THE EVENT OF AN INCIDENT NECESSITATING THE EVACUATION OF GOLDEN MANOR CARE. THIS ANNOUNCEMENT IS TO BE MADE ONLY AT THE DIRECTION OF THE OWNER OR ADMINISTRATOR AND IF THE TWO ARE NOT AVAILABLE IT IS THE DISCRETION OF LEAD CAREGIVER ON-DUTY TO GIVE THE CALL.

"LADIES AND GENTLEMEN MAY I HAVE YOUR ATTENTION PLEASE".

"IT HAS BECOME NECESSARY TO EVACUATE GOLDEN MANOR CARE."

"OUR CAREGIVER WILL ASSIST YOU FOR A SAFE EVACUATION"

"PLEASE REMAIN CALM AND FOLLOW THE DIRECTIONS OF OUR CAREGIVERS"

"WE HAVE CAREGIVERS AT EACH EXIT WHO WILL ASSIST YOU IN A SAFE AND ORDERLY EVACUATION AND WILL SHOW YOU THE EVACUATION AREA.

"AGAIN, WE ASK THAT YOU REMAIN CALM AND FOLLOW THE DIRECTIONS OF OUR CAREGIVERS – THANK YOU"

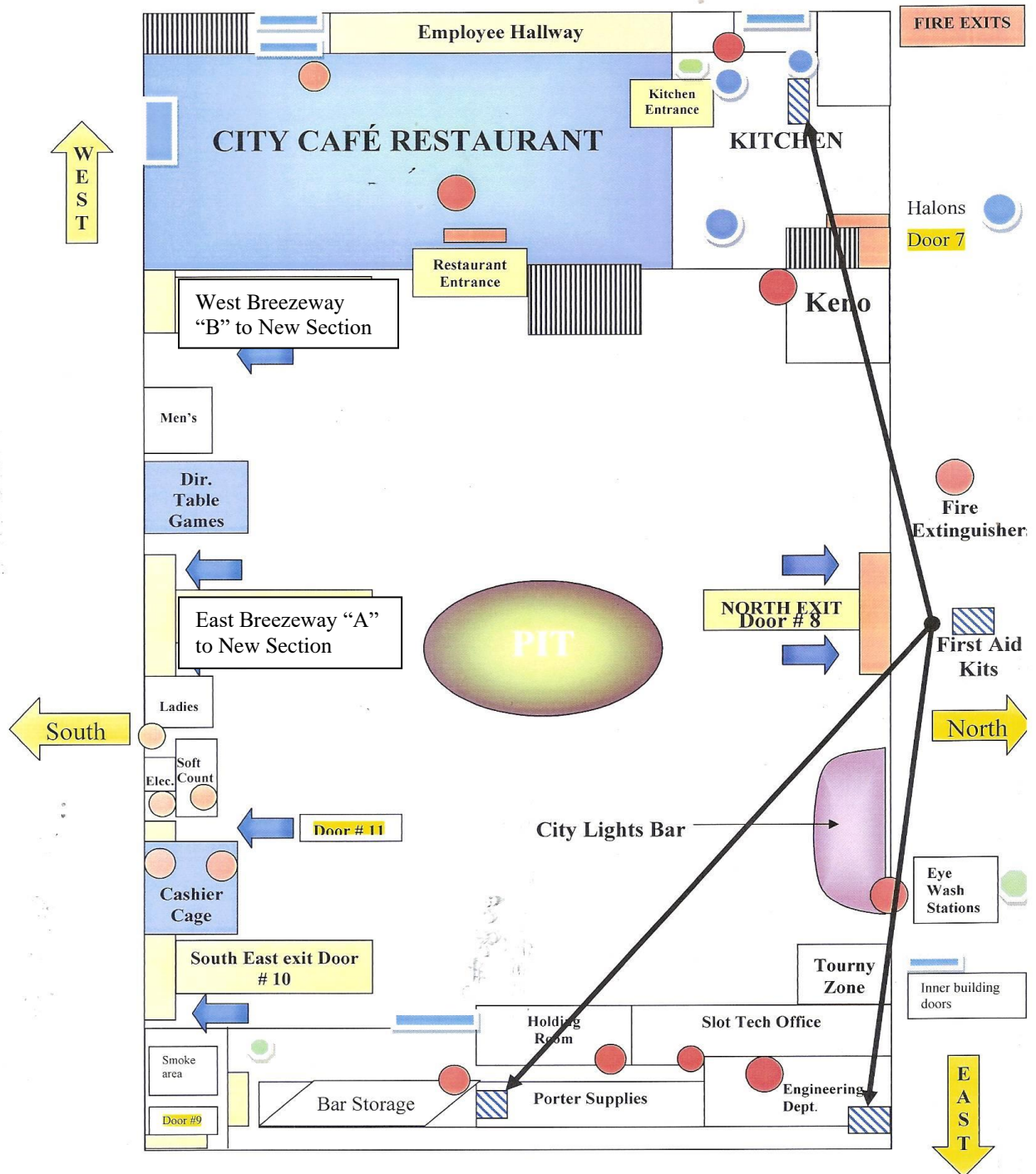
KEY POINTS TO REMEMBER

- 1) Secure the safety of all the people in the facility first and direct them to the assembly area.**
- 2) Depending on the situation the Lead Caregiver On-Duty will sweep the area to ensure that everybody has been completely evacuated.**
- 3) Again, depending on the situation; the Owner, Administrator or Lead Caregiver On-Duty will secure all the valuables and important documents of the facility, ensure that all electrical (if needed) appliances is disconnected and is shut down, that all gas service (if needed) is shut down.**
- 4) The Lead on duty caregiver will have in his/her possession: name of residents, all on duty roster of employees for their shift and all visitors for day if any. Once all residents, employees and visitors are evacuated in the assembly area – he will call these names one after another and make sure that everybody is accounted for.**

APPENDIX "C" EVACUATION PLAN

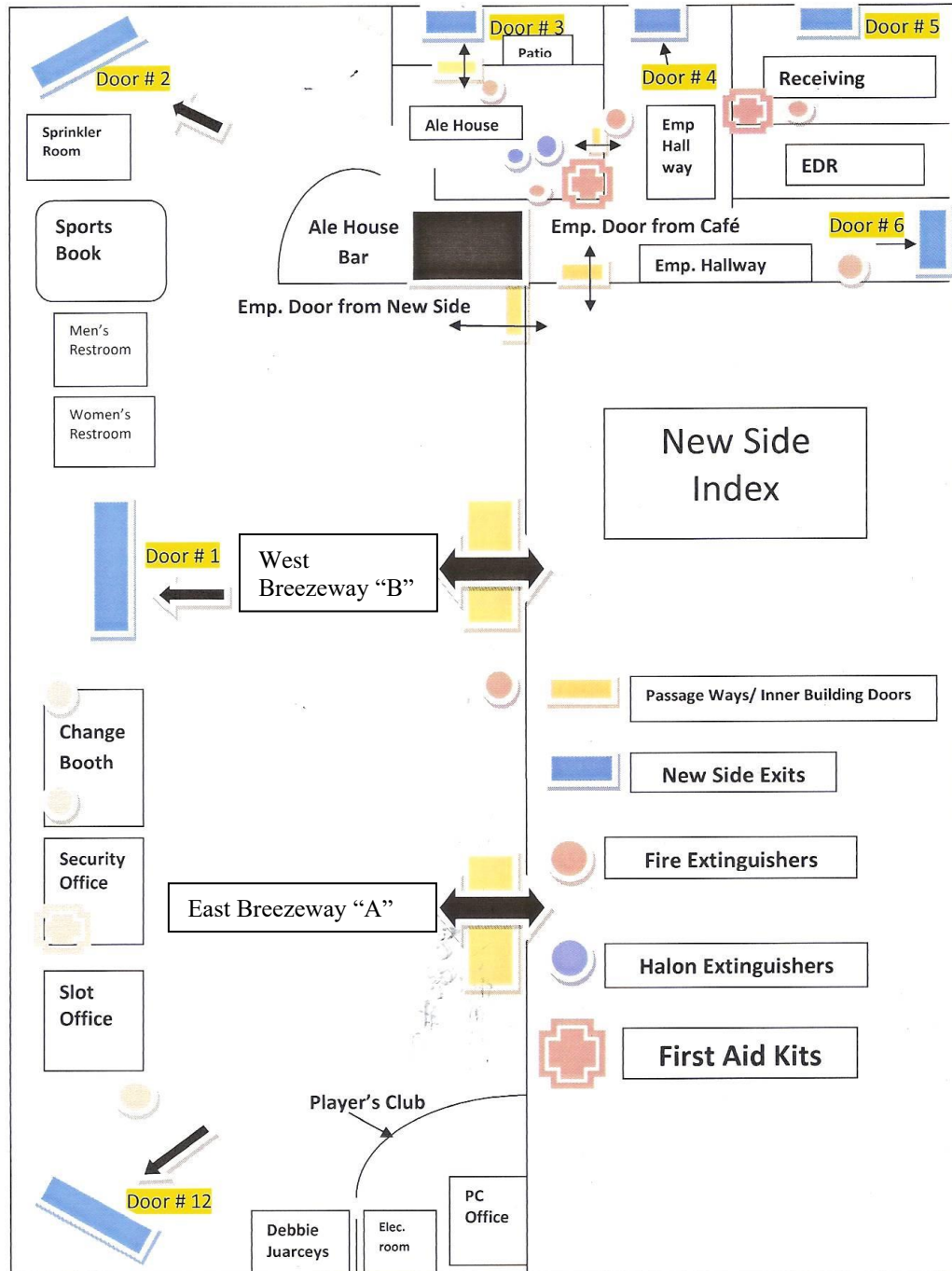


Exits, Fire Extinguishers & First Aid Kit Locations Original Side

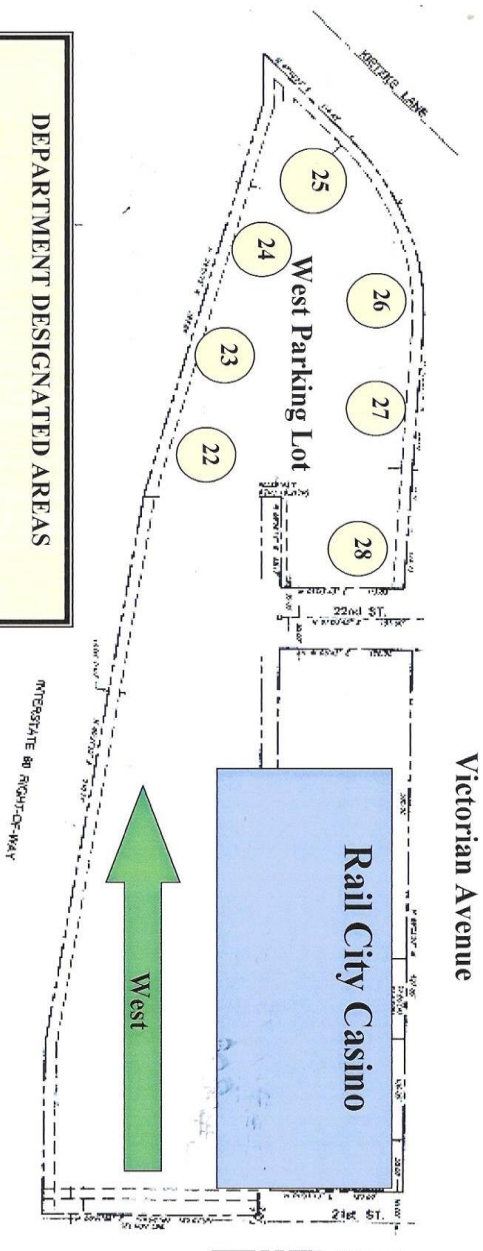




Exits, Fire Extinguishers and First Aid Kits New Side



APPENDIX "E" ASSEMBLY POINT



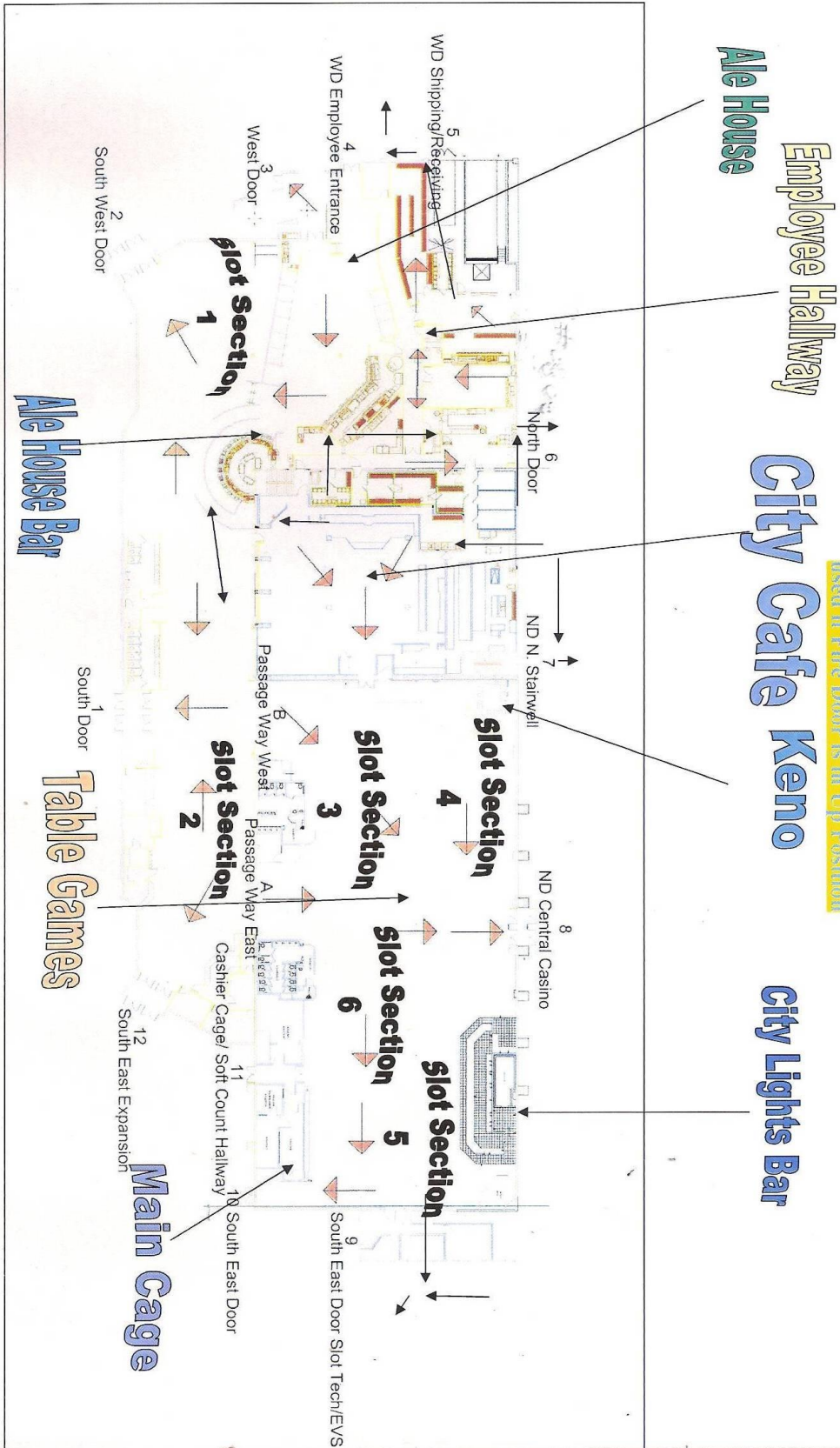
DEPARTMENT DESIGNATED AREAS

- 22. Table Games, Human Resources, Accounting
EVS
- 23. Cashier Cage, Keno,
- 24. City Lights Bar, Surveillance, Players Club
- 25. Slot Department
- 26. City Café Ale House Bar and Restaurant
- 27. Kitchen Workers
- 28. Executive Offices Security Engineering and
CSM

EVACUATION ROUTES MAIN CASINO

EVACUATION ROUTES

Note: Red arrows in City Cafe are used if Fire Door is in Up Position



Sierra Manor Care Home
327 River Flow Dr. Reno, NV 89523
(775) 787-7960

PATIENT SAFETY PLAN

SAFETY COMMITTEE

Members: Comprised of the Administrator, General Manager (Patient Safety Officer) and 1 Caregiver.

Safety Committee Responsibilities:

1. Implements, maintains and monitors the safe plan of the facility.
2. Stays abreast of the state regulations.
3. Monitors the effectiveness of the facility's corrective measure and monitor the trend of injury with the staff and residents where additional safety measures need to be taken.
4. Monitors effectiveness of facility means for communicating safety and health matters to employees and ensure that the employee concerns and suggestions are being conveyed and responded by the General Manager and Administrator.
5. Ensures facility procedures for identifying and evaluating workplace hazards.
6. Review each medical incident report to ensure they are completed in thorough and timely manner and be sent to agency that needs it, like SOR.
7. Monitors effectiveness of facility procedures for correcting unsafe condition and work practices and that corrective action is completed in a timely manner.

Employee Safety Rules and Practices to be followed at all times

Safety Rules and Practices Compliances

1. Counseling and additional training for staff.
 - a. Employee was noted to be breaking a safety practice and not following proper procedure.
 - b. Employee keeps on having repeated accidents which maybe similar or different accident.
2. Management shall observe that all caregivers are following the safety plan at all times.
3. Employee should be trained or retrained as appropriate if the cause of action is due to poor training.

Safety Communication

1. Management shall ensure that effective communication between the staff and residents.
2. There will be a regular meeting on a quarterly basis or if needed to discuss about safety issues or safety topics.
3. OSHA and Worker's compensation required notices are posted on the wall so staff can review any time. (Poster should be the latest version.

SAFETY COMMITTEE MEETING

1. Comprised of the Administrator, General Manager (Patient Safety Officer) and 1 Caregiver.
2. Will be held on a quarterly basis to assess the patient safety plan and evaluate any incidents that occur.
3. Minutes of the meeting must be documented. The safety and health issues discussed, the date of the meeting and the people who attended. This must be available for review by the other employees.
4. Conducts scheduled inspection and holds routine safety meeting.

5. Reviews all medical incident report and investigate accidents or incidents that result to injuries and unnatural death.
6. Recommends new safety policy and procedure.
7. Do inspection of the interior and exterior of the facility to ensure safety of the residents and staffs.
8. Provides safety and health training to all employees and new hires.

PATIENT SAFETY AND EMERGENCY ACTION PLAN

A. RESPONDING TO A FALL

1. Assess the resident in the event of fall. Check for any signs of pain, injury or confusion.
2. Provide first aid if needed. Check vital signs if possible.
3. Inform the Administrator, the Attending Physician, the relative or guardian and the social worker if applicable.
4. Follow the instruction from the Attending Physician.
5. Administrator will investigate and retrain the staff on patient's safety and how to avoid fall.

B. RESPONDING TO A MEDICATION ERROR

1. In the event that a medication occurs, inform the Administrator, the Primary Physician, the relative or guardian and the social worker if applicable.
2. Follow Attending Physician instruction on what to do.
3. Call 911 if needed.
4. Monitor the resident for any side effects of the medication and check vital signs if possible.
5. Administrator will investigate on what happened. Identify the type of medication error – Wrong medication, wrong dose, wrong patient, wrong frequency.
6. Do retraining to staff to avoid the incident to reoccur.

C. RESPONDING TO AN UNEXPECTED DEATH (UNNATURAL)

1. In the event of unnatural death, inform the Administrator, the Primary Physician, the relative or guardian and the social worker if applicable.
2. Call 911 if needed.
3. Administrator investigates on what, why and how it happened that result to unnatural death. All the caregivers will be talked to and must give their own statement of the incident. Administrator must find out the cause of unnatural death in collaboration with the Attending Physician.
4. Necessary actions and retraining should be done so the incident will never happen again.
5. Make necessary changes in the patient safety plan to avoid unnatural death to happen again.

D. RESPONDING TO ELOPEMENT

1. When one of the residents eloped, inform the Administrator, the Primary Physician, the relative or guardian and the social worker if applicable.
2. Call 911 if needed.
3. Look for the resident in the neighborhood.
4. Administrator investigates the situation, how and why it happened. Also, find out where the resident might go.
5. Make necessary changes in the patient safety plan to avoid elopement of the residents like additional security in the facility.

E. RESPONDING TO SUICIDE, ATTEMPTED SUICIDE, SELF HARM

1. When one of the residents committed/attempted suicide or harm her/himself, inform the Administrator, the Primary Physician, the relative or guardian and the social worker if applicable.
2. Call 911 if needed.
3. Administrator investigates the situation how and why it happened.
4. Make necessary changes in the safety plan to avoid suicide or self harm to happen in one of the residents.
5. Encourage residents to verbalize their feelings and let them know that the caregivers are always available when they need someone to talk to.

6. Counseling should be offered to the residents who are feeling to commit/attempt suicide or harm one self.

F. RESPONDING TO SEXUAL ABUSE, PHYSICAL ASSAULT, PHYSICAL RESTRAINT

1. When one of the residents had sexual abuse, physical assault, physical restraint, inform the Administrator, the Primary Physician, the relative or guardian and the social worker if applicable.
2. Call 911 if needed.
3. Administrator investigates the incident - what, how and why it happened. The resident will be talked to in private and statement from each staff about the incident will be taken.
4. Take necessary action and retraining for the staff.
5. Make appropriate changes in the patient safety plan to avoid these things to happen to the residents.

G. RESPONDING TO A FIRE

Note: Performed by facility employees

1. Call 911
2. Activate the nearest fire alarm pull station.
3. Clear anyone in immediate danger.
4. Evacuate quietly and calmly using the nearest emergency exit – See floor plan or look for the Exit sign.
 - Stay low for smoke and heat rises
 - Feel doors for heat before opening, keep it close if it's hot.
 - Report to pre-designated area outside the facility – in front of the facility near the mailbox
5. Confine the fire by closing all doors and windows to the area.
6. Extinguish the fire if it is safe to do so. Remember the word PASS.
 - Pull the safety pin
 - Aim the nozzle at the base of the fire
 - Squeeze the trigger handle
 - Sweep from side to side

7. Follow the instruction of the emergency personnel and do not re-enter the building until authorized to do so.

H. RESPONDING TO A NATURAL DISASTER

Note: Performed by facility employees

1. Assess the situation.
2. Determine timeline of possible event, if applicable.
3. Ensure that the environment is safe for both the staff and residents.
4. Evacuate if needed to a safe location if necessary and applicable.
5. There should be a predetermined location for assembly – in front of the facility near the mailbox
6. Take appropriate precautions – Stay away from windows, glass doors and anything that may fall during an earthquake.
7. Seek shelter under a desk or table for earthquake and severe storms
8. Stay safe inside until the event stops.

I. RESPONDING TO VIOLENT THREAT


Note: Performed by the facility employees.

1. Assess the situation
2. Call 911 for help if needed.
3. Ensure the environment is safe for the residents and staff.
Assemble in the pre-determined location – in front of the facility near the mailbox.

GENERAL WORKPLACE SAFETY

- **No Smoking** – Smoking is prohibited inside the facility except in the designated area, outside the patio or building. Keep the ashes in the ash tray.

- **Personal Protective Equipment** – Isolation gown, mask, face shield, gloves and hair net must be worn if there is active case of Covid-19. Gloves should be used every time when handling residents for infection control.
- **Reporting of Incidents** – no matter how minor must be reported promptly to relatives, social workers, facility administrator and resident's physician.
- **Proper Work Clothing** – Wear scrub suit and closed toe shoes. Must look presentable and clean at all times.
- **Housekeeping** – employees are required to keep the interior and exterior of the facility clean at all times.
- **Proper Lifting Techniques** – Always use proper lifting techniques when lifting or assisting residents.
- **Emergency Evacuation Procedure** – Employees should know the emergency evacuation exits, their responsibilities and actively take part in the drills and actual evacuation of the residents.

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Effective Date: 12-2-2013	Revised:	Reviewed: 07/2020,03/18/2019, 01/2019, 01/2018, 12/2016, 12/2015, 12/2014	Page 1 of 9


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.

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.

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- 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
 - 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):

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- 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
 - 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

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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:
 - 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

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

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

- Report the process/system failure or medical/health care error to the staff member's immediate supervisor.
- Submit the occurrence report to the Performance Improvement Department per organizational policy.
- Any individual in any department identifying a process/system failure and/or potential patient safety issue will immediately notify his/her supervisor and document the findings on an incident report. The report will be submitted to the Director of 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


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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. 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

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

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

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

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

DESERT PARKWAY  Behavioral Healthcare Hospital 3247 South Maryland Parkway Las Vegas, Nevada 89109		Title: PATIENT SAFETY PLAN	
		Section : LEADERSHIP	
Policy Number: 600.22		Responsible Department(s):	
Effective Date: 12-2-2013	Revised:	Reviewed: 07/2020,03/18/2019, 01/2019, 01/2018, 12/2016, 12/2015, 12/2014	Page 9 of 9

- 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)

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)	Patient was waiting to be seen and leaned forward in his chair in the preoperative area. He slipped off chair and fell to the ground.	Yes	Yes	Yes
ITL identified by ITL Non-compliant Sterilization Practices AAHC	Yes NO CP	When did the event occur? (Date, day of week, time)	01/29/2020, Wednesday, 1325	No	N/A	No
		What area/service was impacted?	Preop 1	No	N/A	No
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)	Child arrived for dental appointment Child was taken into PREOP Bay 1 where preoperative assessment was done by RN Per patient's mother, she said child leaned too far forward in his chair and slipped off.	No	N/A	No
		What steps were involved in (contributed to) the event?	Child had been waiting in the PREOP area for over an hour and was leaning forward in his chair	Yes	Yes	Yes
	Human factors	What human factors were relevant to the outcome?	Child is an energetic 8-year old and had been waiting in a small space for an extended amount of time	No	N/A	No
	Equipment factors	How did the equipment performance affect the outcome?	N/A. Chair was sturdy and was able to bear the weight of the patient.	No	N/A	No
What were the proximate factors? (Typically "special cause" variation)	Controllable environmental factors	What factors directly affected the outcome?	Longer than anticipated wait time. The child may have been fidgeting due to boredom.	Yes	Yes	Yes
	Uncontrollable external factors	Are they truly beyond the organization's control?	No	No	N/A	No
		Are there any other factors that have directly influences this outcome?	No	No	N/A	No
	Other	What other areas of services are impacted?	None. Nursing staff immediately addressed the incident	No	N/A	No

ROOT CAUSE ANALYSIS AND ACTION PLAN

Level of Analysis		Questions	Findings	Root Cause?	Ask Why?	Take Action?
What happened? Why did that happen? What processes underlie those proximate factors? (common cause variation here may lead to special cause variation in dependent processes)	Human Resources Issues.	To what degree is staff properly qualified and currently competent for their responsibilities?	Both OR and PACU nursing staff are trained to recognize symptoms of distress. RN's are also trained on procedures to take in the event of an unanticipated incident.	No	N/A	No
		How did actual staffing compare with ideal levels?	Staffing is not an issue; nursing department is completely-staffed with competent employees	No	N/A	No
		What are the plans for dealing with contingencies that would tend to reduce effective staffing levels?	Staffing shortage was not an issue in this instance	No	N/A	No
		To what degree is staff performance in the operating process (es) addressed?	OR nurse responded immediately to the incident and completed all necessary assessments	No	N/A	No
		How can orientation and in-service training be improved?	All new employees are oriented to the facility and its policies immediately upon hire, and all staff attend quarterly meetings. If an incident occurs, it is immediately discussed amongst the nursing department members and each RN will give their suggestions on how incidents can be avoided.	No	N/A	No

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?	Policies and manuals are always available, complete, and accurate. All staff are aware of their locations.	No	N/A	No
		To what degree is communication among participants adequate?	Communication among staff and between departments is excellent.	No	N/A	No
		To what degree was the physical environment appropriate for the processes being carried out?	Physical environment is completely adequate for performing operations and recovering patients. Environment is non-cluttered and is cleaned daily.	No	N/A	No
Environmental management issues.		What systems are in place to identify environmental risks?	Environment is fully functional to meet the needs of daily operations. Spaces are kept clean, non-cluttered, and assessed daily for safety. Tamper-resistant outlet covers are on each outlet.	No	N/A	No
		What emergency and failure-mode responses have been planned and tested?	Rapid Response buttons are installed in each OR, PREOP, and PACU Bay. RNs are trained and certified in delivery of emergency care.	No	N/A	No
		To what degree is the culture conducive to risk identification and reduction?	Care is taken to avoid risk at all times. Patients are assessed before, during, and after treatment by qualified personnel.	No	N/A	No
Leadership issues: -corporate culture		What are the barriers to communication of potential risk factors?	No barriers to communication between staff-members exist within this facility.	No	N/A	No
-encouragement communication		To what degree is the prevention of adverse outcome communicated as a high priority?	Prevention of Risk is our most important goal at SVSC. Any potential threat to patient safety is eradicated at the source if found and all employees are well-versed in the importance of this practice.	No	N/A	No
- clear communication of priorities		What can be done to protect against the effects of these uncontrollable factors?	The potential for the presence of uncontrollable factors is an ever-present possibility in the medical field, which is why staff are well-trained in skills of vigilance and assessment	No	N/A	No
- uncontrollable factors				No	N/A	No

ROOT CAUSE ANALYSIS AND ACTION PLAN

Action Plan	Risk Reduction Strategies	Measures of Effectiveness
<p>For each of the findings identified in the analysis as reading an action, indicate the planned action expected, implementation data and associated measure of effectiveness OR</p> <p>-If after consideration of such a finding a description is made not to implement as associated risk reduction strategy, indicate the rationale for not taking action at this time.</p> <p>-Check to be sure that the selected measure will provide data that will permit assessment of the effectiveness of the action.</p> <p>-Consider whether pilot testing of a planned improvement should be conducted.</p> <p>-Improvements to reduce risk should ultimately be implemented in all areas where applicable, not just where the event occurred. Identify where the improvements will be implemented.</p>	<p>ACTION ITEM #1 Educate parent as soon as they are assessed in PREOP how long their anticipated waiting time will be</p>	Incident will not be repeated
	<p>ACTION ITEM #2 RN to check in on patient after 15 minutes of Preop and CNO how much longer the wait will be.</p>	Incident will not be repeated
	<p>ACTION ITEM #3 Ensure that patient/child has enough to do to keep them from getting bored and fidgeting; staff can offer coloring books or activity pads. Extend a suggestion that child may also take a short walk outside if they would like</p>	Incident will not be repeated
	ACTION ITEM #4	
	ACTION ITEM #5	
	ACTION ITEM #6	
	ACTION ITEM #7	
	ACTION ITEM #8	
Cite any books or journal articles that were considered in developing this analysis and action plans:		

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PURPOSE:

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

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PATIENT SAFETY PROGRAM:

- Scope of Activities:
 - The scope of the Patient Safety Program includes an ongoing assessment, using internal and external knowledge and experience, to prevent error occurrence, maintain and improve patient safety. Patient safety occurrence information from aggregated data reports and individual incident occurrence reports will be reviewed by the Safety Committee to prioritize organizational patient safety activity efforts. Types of patient safety or medical/health care errors included in data analysis are:
 - No Harm Errors - those unintended acts, either of omission or commission, or acts that do not achieve their intend outcome - that do not result in a physical or psychological negative outcome, or the potential for a negative outcome, for the patient.
 - Mild-Moderate Adverse Outcome Errors - those unintended acts, either of omission or commission, or acts that do not achieve their intend outcome, that result in an identified mild to moderate physical or psychological adverse outcome for the patient.
 - Any Medication Error
 - Any Adverse Drug Reaction
 - Hazardous Condition - any set of circumstances, exclusive of the disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious physical or psychological adverse patient outcome.
 - Sentinel Event – as defined in Appendix A of the National Quality Forum Serious Reportable Events in Health-Care-2011 Update: A Consensus Report
 - ◆ The event has resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition.

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

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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.

GRACEFUL LIVING HOMECARE
CRISIS CONTINGENCY
&
EMERGENCY EVACUATION PLAN

Developed for Graceful Living Homecare
2690 Trail Rider Dr.,
Reno, NV 89521
Created 02/4/2016

CRISIS CONTINGENCY PLAN

BACKGROUND

GRACEFUL LIVING HOMECARE an Adult Group Care (AGC) facility address at 2690 Trail Rider Dr., Reno, NV 89521 - in the event of an incident constituting a threat to its residents, staff, and guests has provided this CRISIS CONTINGENCY PLAN & EMERGENCY EVACUATION PLAN as a guide for the owner, staffs and the residents for their safety. The procedures contained in this publication are not to be considered all inclusive but moreover to provide general response procedures based upon acceptable practices for evacuation and/or safeguarding of life and property in the event of an emergency.

DUTIES AND RESPONSIBILITIES

OWNER/S, STAFF AND RESIDENTS are to familiarize themselves with all aspects of these plans. Owner/s or Licensee - in the event that they are unavailable or unable to respond to the emergency, the staff-on-duty or any employees should be capable of assuming their duties. It is the responsibility of the owner/s and /or Licensee to familiarize their employees with these plans. Caregivers and employees assigned to assist evacuation are to be trained in their duties and responsibilities by the owner/Licensee. All of these can be done on a monthly EMERGENCY DRILL.

OWNER/S OR LICENSEE is responsible for ensuring the STAFF carry out their duty assignments quickly and efficiently.

EMERGENCY EVACUATION PLAN

(EEP)

EMERGENCY EVACUATION PLAN

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BACKGROUND

GRACEFUL LIVING HOMECARE, in the event of an incident constituting a threat to the Owner/Licensee, employees, guests and residents, has provided this guide for EMERGENCY EVACUATION PLAN. The procedures contained in this publication are not to be considered as being all inclusive but moreover provide response guidelines based upon acceptable practices for evacuation and/or safe guarding of life and property in the event of an emergency.

GRACEFUL LIVING HOMECARE is an Adult Group Care facility licensed by the Bureau of Health Care and Quality Compliance and is located at 2690 Trail Rider Dr. Reno, NV 89521 its nearest cross street is Desert Way, then to Yee Haw Way, then to Rio Wrangler Parkway then Veterans Pkwy.

Although remote, the possibility of an incident, whether externally or internally generated, always exists. This Facility recognizes this potential and has prepared the following EMERGENCY EVACUATION PLAN for just such an eventuality.

EVACUATION PLAN

A complete evacuation can be a time consuming endeavor and in an emergency time can be of the essence. To facilitate a timely, safe evacuation, key employees have been designated respective duties and responsibilities. Employees during EMERGENCY DRILL EXERCISE will be pre-assigned for emergency situations, whenever possible assigned employees must be bi-lingual in order to verbally communicate critical instructions to non-English speaking persons.

The employees may change but the manner, formation and assignment will remain constant. It shall be the responsibility of the Licensee (owner) to update and practice the fire drill once a month so that they key positions are not lost to attrition. The Licensee shall train every new employees of the facility and give them their key assignments in an emergency situation within five (5) working days after they are hired.

Residents should also be trained to familiarize themselves what to do in case of emergency. Response time should be recorded so that the facility can anticipate the actual evacuation time.

Problems should also note and addressed during the Emergency Drill Exercise.

Employee Assignments

There are Twelve (2) exits from the facility. If ever possible employee will be assigned to each of the exits.

Door #	Location	Description	Employee
1	Front Door Exit	towards the front yard	Caregiver 1
2	Side Door Exit	leftside exit of the house going towards the side of the frontyard	Caregiver 2

NOTE: Should any of the above emergency exits be unavailable due to the emergency, Assigned Caregiver will divert to the available exits listed. In case two exits are unavailable – assigned caregiver will locate the safest exit possible eg. Windows, etc.

Alternative Exits

Alternative Exit	Description	In -charge
Various windows of the facility	In case two exits are unavailable assigned caregiver will locate the safest, nearest window exit going towards the designated evacuation area	Any available employees

Note: Owner and any unassigned caregiver will assist all the residents from their rooms and proceed to the assembly area.

Order of Evacuation Priority:

1. Anybody which is near the fire or emergency area will be evacuated first
2. Category 2 residents will be taken out of the building second
3. Category 1 residents will be taken out third
4. All other people: visitors, employees will be evacuated in the area

ASSEMBLY POINT

LICENSEE/OWNER is to assemble all the residents, visitors, employees to the ‘FRONT YARD’ of the facility adjacent to the street. Licensee/Owner is to account all the people in the facility: residents, visitors and employees.

DECISION TO EVACUATE

a. Authority

Only the Owner or the Lead Caregiver on Duty (LCOD) will make the decision to evacuate all or any part of the facility.

b. Response

Immediately upon receipt of the decision to evacuate the facility, the LCOD will announce the evacuation and start the evacuation as soon as possible.

The LCOD will be responsible for announcing the need to evacuate the building. Should electrical power not be present the owner, administrator, caregivers and employees will be responsible for communicating the need to evacuate the residents and guests.

DUTIES AND RESPONSIBILITIES

1. The Owner

- a. Only the Licensee/Owner or the Lead Caregiver on Duty (LCOD) will make the decision to evacuate all or any part of the facility
- b. The owner or employee in-charge will make every effort to safeguard the safety of the residents and employees. Secondary to this are funds and valuables of the facility and residents, important documents and papers and last will be computers and other electrical equipment that may be impacted by electrical current fluctuations.
- c. Upon arriving at the assembly area, Owner/employee in charge will account for all the residents, employees and guests who were at the facility at the time of the evacuation. Anybody of the aforementioned not actually observed at the assembly area will be reported as missing to the proper authority.
- d. The Owner upon notification by the Lead Caregiver on Duty (LCOD) of a Missing resident, or employee, or guest will immediately notify the Police Authority with the missing person's Name, and a brief description, and location.
- e. The owner or whoever is in-charge will be in possession of the facility's "Key Set" in the event that doors need to be opened.
- f. The owner/licensee will lead and assist in the evacuation process making sure that everybody in the Facility will proceed directly to the assembly area.
- g. The owner shall train every new employees of the facility and give them their key assignments in an emergency situation within five (5) working days after they are hired.
- h. The owner upon decision that the emergency is on phase 3 or Code red will hold a meeting with the owner, on-duty Caregiver, Caregiver and other employees at a predetermined location for planning and implementation of evacuation/defend in place or other suitable contingencies to deal with the incident.
- i. The owner will assemble all the residents, visitors, employees to the 'ASSEMBLY AREA ('FRONT YARD)'' of the facility adjacent to the street. Administrator is to account all the people in the facility: residents, visitors and employees.

Note: Owner and any unassigned caregiver will assist all the residents from their rooms and proceed to the assembly area.

2. The Lead Caregiver On-Duty (LCOD)

The Lead on-duty Caregiver/s (LCOD) Immediately upon receipt of the decision to evacuate the facility, will announce the evacuation and start the evacuation as soon as possible.

The LCOD will be responsible for announcing the need to evacuate the building. Should electrical power not be present the owner, administrator, caregivers and employees will be responsible for communicating the need to evacuate the residents and guests.

LCOD will assume overall responsibility for conducting the Emergency Evacuation Plan (EEP). All subordinate employees of the facility shall take direction from the LCOD during an incident requiring the evacuation of the building. All employees shall render such assistance as may be required by the LCOD to discharge his/her duties. The LCOD shall, unless relieved by higher authority, act on behalf of Golden Manor Care to safeguard life and property.

If condition permits LCOD:

- will ensure that the facility's records and valuable are secured and then conduct a sweep of the building, in pairs, to ensure that everyone is out of the building.
- will close doors to individual areas after determining all occupants have departed.
- after completing the sweep, LCOD will proceed to the assembly area.
- After the evacuation is complete, and if possible, will maintain observation points at a safe distance outside the Northeast and Southwest corners of the building.

3. The Caregiver and Other Employees

- Shall take orders from the LCOD
- Will assist in communicating the need to evacuate residents, guest and employees.
- Assist in the evacuation process and make sure that everybody will proceed to the assembly area.
-

The owner will make every effort to safeguard the safety of the residents and employees. Secondary to this are funds and valuables of the facility and residents, important documents and papers and last will be computers and other electrical equipment that may be impacted by electrical current fluctuations.

Upon arriving at the assembly area, Owner/Administrator will account for all the residents, employees and guests who were at the facility at the time of the evacuation. Anybody of the aforementioned not actually observed at the assembly area will be reported as missing to the proper authority.

NOTE: Nobody shall risk their life or serious injury to retrieve or preserve any personal or facility property.

SPECIAL NOTE

All newly hired caregivers and employees should include in their orientation the policies and procedures and what their responsibilities are in case of crisis contingency.

EMERGENCY NOTIFICATION PROCEDURES

The following procedures are to be implemented in the event of an incident whether on or off property which may have an effect to Golden Manor Care operations. The events portrayed are only representative of the types of incidents that may be encountered and are not all inclusive.

The Lead Caregiver On-duty (LCOD) will determine the level of alert based upon his/her understanding of the seriousness of the incident.

Phase 1 Alert

Phase 1 Alert consists of the following types of events which may affect the Golden Manor Care operations and should be monitored closely but do not necessarily constitute an immediate threat to life or property. Call outs of other caregiver/s and employees will be at the discretion of the LCOD

- ✓ Structure fires in close proximity to Golden Manor Care
- ✓ Broken water or gas mains in the vicinity of Golden Manor Care
- ✓ Law Enforcement operations such as barricaded armed subjects, armed confrontations or standoffs with armed subject where chemical weapons may be employed.
- ✓ Civil disturbances which may overflow into or onto Golden Manor Care property,
- ✓ Loss of power
- ✓ Bomb Threats (telephonic)

Phase 2 Alert

Structure fires adjacent to the Golden Manor Care

Utility breaks (gas, water etc.) effecting Golden Manor Care operations.

Bomb threats (suspect device located on property)

Riot or civil disturbance disruptive to Golden Manor Care operations

Phase 3 Alert

Any incident requiring the evacuation of all or part of Golden Manor Care

Any incident requiring implementation of the Emergency Evacuation Plan

Any incident which will, if allowed to continue, have a significant effect on Golden Manor Care operations

CALL OUT PROCEDURES

The following will be notified should a specific alert level be activated.

Phase 1 (Green Alert)

Owner/Licensee
Caregivers
Other Employees

PHASE 1 (Green)

The Lead On-duty Caregiver should ensure that the owner are aware of the situation. Other Caregiver and Employees should be kept informed and alert for any escalation in the incident which could lead to a higher level of response. LCOD or his/her designee should stay in contact with the Owner and Administrator until the incident is resolved.

Phase 2 (Amber Alert)

Owner
Lead Caregiver On-Duty
Caregivers
Other Employees

PHASE 2

Owner should report for duty or remain on duty. Ensure adequate supplies and employees are available to respond to the situation.

Phase 3 (Red Alert)

Owner
Lead Caregiver On-duty
Caregivers
Other Employees

PHASE 3 (Red)

The Owner, Lead Caregiver On-duty, Caregivers and other employees will meet at a predetermined location for planning and implementation of evacuation/defend in place or other suitable contingencies to deal with the incident.

CALL – OUT ROSTER

Call Out Roster

The following roster is to be utilized in the event of a call-out or notification requirement as a result of an incident or situation affecting or having the potential to affect the operations of GOLDEN MANOR LLC.. Individuals on this call-out roster listed as primary contacts will be called in the order they are listed for their department or position.

NAME	DESIGNATION	PHONE NOS.

EVACUATION ANNOUNCEMENT
(Scripted)

EVACUATION ANNOUNCEMENT

THE FOLLOWING SCRIPT IS TO BE ANNOUNCED BY THE LEAD CAREGIVER ON-DUTY, IN THE EVENT OF AN INCIDENT NECESSITATING THE EVACUATION OF GOLDEN MANOR CARE. THIS ANNOUNCEMENT IS TO BE MADE ONLY AT THE DIRECTION OF THE OWNER OR ADMINISTRATOR AND IF THE TWO ARE NOT AVAILABLE IT IS THE DISCRETION OF LEAD CAREGIVER ON-DUTY TO GIVE THE CALL.

"LADIES AND GENTLEMEN MAY I HAVE YOUR ATTENTION PLEASE".

"IT HAS BECOME NECESSARY TO EVACUATE GOLDEN MANOR CARE."

"OUR CAREGIVER WILL ASSIST YOU FOR A SAFE EVACUATION"

"PLEASE REMAIN CALM AND FOLLOW THE DIRECTIONS OF OUR CAREGIVERS"

"WE HAVE CAREGIVERS AT EACH EXIT WHO WILL ASSIST YOU IN A SAFE AND ORDERLY EVACUATION AND WILL SHOW YOU THE EVACUATION AREA.

"AGAIN, WE ASK THAT YOU REMAIN CALM AND FOLLOW THE DIRECTIONS OF OUR CAREGIVERS – THANK YOU"

KEY POINTS TO REMEMBER

- 1) Secure the safety of all the people in the facility first and direct them to the assembly area.
- 2) Depending on the situation the Lead Caregiver On-Duty will sweep the area to ensure that everybody has been completely evacuated.
- 3) Again, depending on the situation; the Owner, or Lead Caregiver On-Duty will secure all the valuables and important documents of the facility, ensure that all electrical (if needed) appliances is disconnected and is shut down, that all gas service (if needed) is shut down.
- 4) The Lead on duty caregiver will have in his/her possession: name of residents, all on duty roster of employees for their shift and all visitors for day if any. Once all residents, employees and visitors are evacuated in the assembly area – he will call these names one after another and make sure that everybody is accounted for.

Graceful Living

2690 Trail Rider Dr
Reno, NV 89521

H: (775) 971-4421 C: (805) 304-7821

Emergency Evacuation Drill Log Forms

FIRE DRILL	
Date of Drill: _____	Time of Day: _____
Time it took to Evacuate residents: _____	Area of Simulated Fire: _____
Name of Residents Participating: _____	_____
Problems: _____	_____
Action Taken: _____	_____
Signature of Staff Conduction Drill: _____	_____
FIRE DRILL	
Date of Drill: _____	Time of Day: _____
Time it took to Evacuate residents: _____	Area of Simulated Fire: _____
Name of Residents Participating: _____	_____
Problems: _____	_____
Action Taken: _____	_____
Signature of Staff Conduction Drill: _____	_____
FIRE DRILL	
Date of Drill: _____	Time of Day: _____
Time it took to Evacuate residents: _____	Area of Simulated Fire: _____
Name of Residents Participating: _____	_____
Problems: _____	_____
Action Taken: _____	_____
Signature of Staff Conduction Drill: _____	_____

PAM Specialty Hospital SPARKS

2021 Patient Safety Plan

Purpose

PAM Specialty Hospital of Sparks has developed a Patient Safety Program in conjunction with the Performance Improvement Plan and Program, the Risk Management Plan and Program, and the Hospital Scope of Services, in order to provide guidelines for implementation of an integrated patient safety program throughout the hospital and to comply with the requirements of the State of Nevada. It is the intent of the leadership of the hospital to foster a safe and safety-conscious environment that promotes wellbeing, acknowledges and addresses risks, and encourages interdisciplinary safety and education focusing on process improvement.

Scope

Overall Patient Safety responsibilities in conjunction with the 2021 NPSG's include the following:

1. **Improve the accuracy of patient identification.** Improve the accuracy of patient identification. Through the use of two patient identifiers whenever performing procedures, administering medications or blood, taking blood samples or other specimens or providing treatment or procedures
2. **Improve the effectiveness of communication among caregivers** as contained in Handoff Communication Guidelines, Located under Best Practices in Post Acute Medical (PAM) Policies and Procedures Utilization of SBAR tools.
3. **Improve the safety of using high-alert medications** as contained in the PAM policy, Medication Safety: High Alert Medications
4. **Ensure the identification**, reporting, prevention and control of infections, including the role of proper hand hygiene as contained in the PAM policies, The Infection Control Plan and its addendums (Covid-19) 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 Infection Control and Quality Management policy section.
5. **Reduce patient falls and injuries from falls** as contained in the PAM Policy and Falls Prevention Program. Fall Preventions, through recommendations from the Falls Committee Performance Improvement Team and information about falls gathered from the Post Fall Assessment Forms and the intensive Analysis investigation of all fall events.
6. **Improve the effectiveness of clinical alarms systems** as contained in the PAM policy, Safety – Alarms-Clinical Equipment.

7. Identifying, preventing and correcting errors in the labeling, storing, prescription or administration of medications as contained in the PAM policies in conjunction with Cardinal Health, Medication Storage, Dispensing – Labels, Dispensing Medications – General, and other policies contained in the Pharmacy Program through Cardinal.

8. Ensuring the safe administration of prescription drugs, controlled substances, pharmaceutical services and other medications as contained in the Cardinal and PAM policy, Administration of Drugs, and other policies contained in the Pharmacy section.

9. The identification, investigation and reporting of Sentinel Events as contained in the PAM policy, Sentinel Events, and as prescribed by NRS 439.800 and following guidelines established by the Nevada State Health Department’s Sentinel Event Registry. The Patient Safety Officer, who is appointed annually, will also be responsible for the maintenance of Sentinel Event records.

10. Oversight of the maintenance of a sanitary environment by the facility through conduction of Environmental Rounds, Infection Control Rounds and day to day observations by supervisory and charge staff, as contained in the PAM policies, Safety Management Plan; the Infection Control Plan, and other policies under Quality Management and Engineering. **Ongoing collaboration with the EVS and Plant Operations of the Host Hospital (Northern Nevada Medical Center) is in place**

11. Adoption and implementation of patient safety checklists to improve the health outcomes of patients in the medical facility and ensure the knowledge to provide care safely is applied consistently and correctly. These checklists may include best practices and competencies for treatments ordered by an independent licensed practitioner. Other examples may include the proper sequence for environmental cleaning and proper use of personal protective equipment. Also included are discharge checklists explaining discharge medications, aftercare instructions and other instructions needed to facilitate a safe discharge for each PAM Patient.

Current checklists in use include:

- a. Insertion of PICC lines.
- b. Maintenance of Foley catheters
- c. Discharge checklist
- d. Respiratory Treatment competencies
- e. Wound care education

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. Infections
6. Near Misses
7. Sentinel Events
8. Hazardous Condition(s) to include **Workplace violence added in 2020.**

The role of the Patient Safety Program also crosses over into the safety of the environment of the hospital in conjunction with the Host hospital NNMC including oversight of the 7 Environment of Care Plans:

1. Safety Management Plan
2. Security Management Plan
3. Life Safety Management Plan /Fire Safety
4. Medical Equipment Plan
5. Emergency Preparedness Plan
6. Hazardous Materials and Waste Management Plan,
7. Utilities – Utilities Management Plan

Annual Reviews of each of the 7 plans are performed and reported to the Environment of Care Committee/Quality Council and Patient Safety Committee as well as the Medical Executive Committee and the Governing Board of the Hospital.

Methodology

The Patient Safety Program includes both proactive and responsive components.

Proactive: The proactive patient safety component emphasizes a proactive error reduction and avoidance program. The following will be reviewed to proactively identify patient safety issues:

1. Medical equipment and medication risk assessment activities
2. Sentinel event alert risk reduction activities
3. Performance improvement indicators (department specific) and monitoring activities
4. Patient Satisfaction reports
5. Medical Record review reports
6. Staff orientation, evaluation, training, and education **activities to include a Culture of Patient Safety survey to be completed every 18 months. Completed in November 2020**
7. Failure Mode and Effect analysis (FMEA) activities (Falls 2020)
8. Medical Staff Credentialing/Peer Review issues
9. Occurrence Report trending

Failure Mode Event Analysis (FMEA) will be conducted at a minimum of every 18 months. The process to be studied each cycle will be determined in collaboration with medical staff, hospital leadership, and staff. Information from patient safety organizations such as the Institute for Medicine, Institute for Safe Medication Practices, and The Joint Commission will be disseminated to the appropriate departments and committees for action and implementation of recommendations.

Responsive: The hospital will utilize information gathered from risk assessments, sentinel event alerts, performance improvement measures, medical record review, and other data in order to track, trend, and respond to patient safety issues. Patient safety related issues will be ranked based on severity. The following will be reviewed for reactive patient safety issues.

1. Root Cause Analysis
2. Intensive Assessment and Analysis/FMEA
3. Occurrence Report Findings
4. Patient Complaint/Grievance Response
5. Performance Improvement Measures
6. Patient Satisfaction Survey Reports
7. Serious Event Notifications /Sentinel Event Reporting
8. Culture of Patient Safety Survey
9. Hazard Vulnerability Analysis

Patient Safety Committee and Reporting

Patient Safety is the responsibility of all employees and Medical Staff members. The Patient Safety Program will be multi-faceted and that responsibility will be shared among several individuals, groups, and teams. Each performance improvement team is multidisciplinary in nature with representatives from the hospital and medical staff. Medical staff as champions provides for the necessary support of initiatives. Imbedded in each performance improvement team are safety issues relevant to the team's focus. Reports from the performance improvement teams are sent to the Quality Council/Patient Safety Council and reported to the Medical Executive Committee and the Governing Board.

In compliance with **State of Nevada Regulations**, the Patient Safety Committee will be comprised of:

- (1) The patient safety officer (annually appointed) of the medical facility.
- (2) At least three providers of health care who treat patients at the medical facility, including, without limitation, at least one member of the medical, nursing, and pharmaceutical staff of the medical facility.
- (3) One member of the executive or governing body of the medical facility.

The Patient Safety Committee is also multidisciplinary with representation from the following areas: Clinical Departments, Pharmacy and Therapeutics Committee, Safety Committee, Quality/Risk Management, and the Hospital's Infection Control Preventionist.

The Patient Safety Committee functions include but are not limited to:

1. Review and evaluate internal and external patient safety data from the following sources for opportunities for improvement in the safety of patient care processes:
 - a. Risk and Safety Management
 - b. External Data Reports
 - c. Sentinel Event Alerts from the Joint Commission
 - d. Healthcare Reports
 - e. Regulatory Reports
 - f. Patient/Family Members to include Complaints and Grievances
2. Continually improve processes of care delivery based on data analysis.
3. Develop policies and procedures that result from process improvement activities **and corresponding checklists.**
4. Develop and approve Patient Safety Education for the medical and hospital staff.
5. Conduct an annual risk assessment of patient safety issues/strategies from internal and external reports.

The Hospital believes in a non-punitive reporting environment in order to maximize reporting of near misses, adverse outcomes, and sentinel events as it has been demonstrated that many errors are directly related to system and process failures. Disciplinary action may be considered when an involved individual takes action to hide the incident, is malicious or untruthful in reporting, when facts and circumstances suggest that the error was deliberate or in reckless disregard to patient and staff safety, or when the individual consistently fails in the detection, reporting or remedies to prevent mistakes. Reporting of patient safety issues to an outside agency will be done when required by regulation or as determined by the Administrator/CEO/Corporate PAM.

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 PAM 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. Relias training modules are introduced to provide ongoing education

on topics as these are identified. Additionally, education will be provided to patients and their families about their role in helping to facilitate the safe delivery of care.

~~Hospital Name~~Henderson Hospital

Risk Management/ Patient Safety Plan

Nevada Acute Care Division

Revised 1/2021

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'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.

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](#) include:

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

B. Infection Control Officer

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

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

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

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

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

C. Patient Safety

Henderson Hospital has an established Patient Safety Council (PSC) to support patient safety activities. The PSC should ensure that its Patient Safety Plan is promoted and executed successfully. **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 Riskconnect (STARS) and Midas) to maintain and manage PSWP.

I. Facility Patient Safety Committee

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

Membership:

In accordance with [NRS 439.875](#), the committee core membership consists of the following Key Members: (CEO{[member of the Executive or Governing Body](#)}, CNO, Physician, Risk [Management and others designated as](#) / Patient Safety Officer, [Quality Designee](#), Infection [Control Officer, Prevention Nurse, and 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 (CFO) of the medical facility. [A Patient Safety Committee established pursuant to this section must meet at least once every calendar year.](#)

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'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 pPatient iIdentification pPolicy- 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.](#)
- [Monitor and document the effectiveness of the hand hygiene protocol or policy.](#)
- [Review policy to ensure compliance with the Patient Safety Checklists pursuant to NRS 439.877.](#)
- **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\(4\)\(db\)](#).
- 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.

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

II. Patient Safety Advisories

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

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

C. TERM Program

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

In addition to the delineated elements, the TERM program also includes an evaluation of clinical practices that have or are likely to result in liability or patient harm. The TERM elements are summarized as follows: ~~These elements are summarized as follows:~~

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

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

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

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

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

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

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

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

D. MIDAS

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

E. Riskconnect (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 **Henderson Hospital's** RM to the Governing Board of all claims activities.

F. Event Notification Site

The Event Notification Site or ENS, is a web-based system that allows for contemporaneous reporting of serious adverse events and key near miss sentinel events

to facility and management. The ENS also provides an environment in which stakeholders can post questions and additional information to the facility reporting the event. Updates to the event are reported in real-time to all identified facility and stakeholders via the ENS. The Risk Management staff reviews each ENS to determine if follow-up is needed; if follow-up is indicated, it is to be completed within 45 days.

G. Root Cause Analysis (RCA)

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

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

The Joint Commission's root cause analysis [framework](#) and action plan [framework](#) table should be ~~utilized-used~~ as [a](#) references. 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.

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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, [NRS 439.877](#), 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.

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

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

I. Patient Safety Policies

The Patient Safety Policies must include, without limitation:

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

J. MEMBER PATIENT SAFETY EVALUATION SYSTEM (PSES)

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

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

K. Training and Education

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

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

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

IV. Acute Care Division Patient Safety Priorities, Goals and Objectives for 2021

- Surgical and Procedural Safety
 - **Wrong Site Surgery (WSS)**
 - **Goal:** A 50% reduction in WSS events for 2021. Ultimately, the goal is zero (0).
 - Monitor through Midas event reporting and the Patient Safety Dashboard. Report monthly with oversight by CPSC.
 - **Retained Procedural items (RPIs)**
 - **Goal:** Prevent RPIs- a 50% reduction in RPIs with harm for 2021. Ultimately, the goal for RPIs is 0.
 - Monitor through Midas event reporting and the Patient Safety Dashboard. Report monthly with oversight by CPSC.
- OBHRU

- **Reduction/Elimination of serious harm by reducing the response time to excessive obstetrical bleeding initiative.** As evidenced by:
 - **Goal:** Quantification of blood loss will occur at 95% of all deliveries as evidenced by facility results in a Healthy Intent / Analytics dashboard.
 - **Goal:** A debrief will be completed on 100% of hemorrhages >1500ml.
 - Monitor through Healthy Intent/ Analytics dashboard, Midas/ENS/Claims data, facility education reports, and the Patient Safety Dashboard. Report monthly with oversight by CPSC.
- **Reduction / elimination of serious harm by increasing the intervention rate for uterine tachysystole and fetal heart rate category II algorithm compliance.**
 - **Goal:** To be developed in 2Q 2021.
- **CLABSI Initiative**
 - **Goal:** CLABSI will be reduced to less than the national CMS mean Standardized Infection Ratio (SIR: CLABSI 0.78336) in 2021.
 - Monitor through CDC's National Healthcare Safety Network (NHSN) and the Patient Safety Dashboard. Report quarterly with oversight by CPSC.
- **Safe Medication Use**
 - **Reduce the preventable occurrences of Opioid Induced Respiratory Events (OIRD) in 2021.**
 - **Goal:** Decrease the number of preventable OIRD events by 10%.
 - **Goal:** Each facility will track and trend naloxone administrations and will identify a performance improvement project related to safe use of opioids by March 1, 2021.
 - **Goal:** 100% of Acute Care facilities will have a medication safety committee that utilizes a standardized charter and agenda by June 1, 2021
 - Monitor through MIDAS reports, Cerner ICD-10 codes and other intervention data and the Patient Safety Dashboard. Report quarterly with oversight by CPSC.
- **Reduce Falls and Falls with Injury**
 - **Goal:** 10 % reduction in the number of falls by end of 2021.
 - **Goal:** 10% reduction in the rate of falls by the end of 2021.
 - **Goal:** 10% reduction in the rate of falls with injury by the end of 2021.
 - **Goal:** A debrief will be completed within 72 hours for 100% of falls with injury.
 - Monitor through MIDAS event reporting and the Patient Safety Dashboard. Report quarterly with oversight by CPSC.
- **Decreasing Hospital Acquired Pressure Injuries**
 - **Goal:** 10% reduction of NPOA rate for all HAPI stages in the Acute Care Division by the end of 2021.

- Monitor through Midas event reporting and the Patient Safety Dashboard. Report quarterly with oversight by CPSC.
- **Culture of Safety**
 - **Goal:** reduce the number of GHI events (serious safety event rate) for the Acute Care Division by the end of 2021. Ultimately, the goal is 0.
 - Monitor through MIDAS event reporting and the Corporate Patient Safety Dashboard. Report monthly with oversight by CPSC.
 - **Goal:** 100% of 2021 Patient Safety Plan Priorities will be implemented within the hospitals.
- **Reduce Workplace Violence**
 - **Goal:** 10 % reduction in the number workplace violence events by end of 2021.
 - Monitor through MIDAS event reporting and the Patient Safety Dashboard. Report quarterly with oversight by CPSC.
- **Pump Interoperability**
 - **Goal:** 10 % improvement in pump association percentage by end of 2021.
 - Monitor through Alaris pump reporting and the Patient Safety Dashboard. Report quarterly with oversight by CPSC.

V. Monitoring and Accountability

A. Evaluation of TERM Program

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

B. Patient Safety Committee

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

Commented [RM1]: This is a public document that is sent to the state each year with the SE Annual Report. It is discoverable, so this language is not in the NV policy.

C. Dashboards

The Risk Management/Patient Safety Dashboard and the Environment of Care includes multiple indicators to demonstrate the facility's performance as to patient safety markers. These include: event reporting statistics, overall harmful event rate, fall rate including harmful event rate, medication event rate including harmful medication events or adverse drug events, serious harm OB events, pressure injury rates, infection variances, and procedural events.

VI. Evaluation/Review:

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

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

VII. Confidentiality

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

VIII. Approval of Patient Safety Plan

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

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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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Appendix A: Checklist Example: Injuries from Falls and Immobility

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

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



PAM Rehabilitation Hospital of Centennial Hills

2021 Patient Safety Plan

Purpose

PAM Rehabilitation Hospital of Centennial Hills has developed a Patient Safety Program that is data driven and focuses on the prevention and reduction of medical errors and adverse events.

Scope

Overall Patient Safety responsibilities in conjunction with the 2021 NPSG's include the following:

1. **Improve the accuracy of patient identification.** Improve the accuracy of patient identification. Through the use of two patient identifiers whenever performing procedures, administering medications or blood, taking blood samples or other specimens or providing treatment or procedures
2. **Improve the effectiveness of communication among caregivers** as contained in Handoff Communication Guidelines, Located under Best Practices in Post Acute Medical (PAM) Policies and Procedures Utilization of SBAR tools.
3. **Improve the safety of using high-alert medications** as contained in the PAM policy, Medication Safety: High Alert Medications
4. **Ensure the identification**, reporting, prevention and control of infections, including the role of proper hand hygiene as contained in the PAM policies, The Infection Control Plan and its addendums (Covid-19) 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 Infection Control and Quality Management policy section.
5. **Reduce patient falls and injuries from falls** as contained in the PAM Policy and Falls Prevention Program. Fall Preventions, through recommendations from the Falls Committee Performance Improvement Team and information about falls gathered from the Post Fall Assessment Forms and the intensive Analysis investigation of all fall events.
6. **Improve the effectiveness of clinical alarms systems** as contained in the PAM policy, Safety – Alarms-Clinical Equipment.

7. Identifying, preventing and correcting errors in the labeling, storing, prescription or administration of medications as contained in the PAM policies in conjunction with Cardinal Health, Medication Storage, Dispensing – Labels, Dispensing Medications – General, and other policies contained in the Pharmacy Program through Cardinal.

8. Ensuring the safe administration of prescription drugs, controlled substances, pharmaceutical services and other medications as contained in the Cardinal and PAM policy, Administration of Drugs, and other policies contained in the Pharmacy section.

9. The identification, investigation and reporting of Sentinel Events as contained in the PAM policy, Sentinel Events, and as prescribed by NRS 439.800 and following guidelines established by the Nevada State Health Department's Sentinel Event Registry. The Patient Safety Officer, who is appointed annually, will also be responsible for the maintenance of Sentinel Event records.

10. Oversight of the maintenance of a sanitary environment by the facility through conduction of Environmental Rounds, Infection Control Rounds and day to day observations by supervisory and charge staff, as contained in the PAM policies, Safety Management Plan; the Infection Control Plan, and other policies under Quality Management and Engineering. **Ongoing collaboration with the EVS and Plant Operations of the Host Hospital (Northern Nevada Medical Center) is in place**

11. Adoption and implementation of patient safety checklists to improve the health outcomes of patients in the medical facility and ensure the knowledge to provide care safely is applied consistently and correctly. These checklists may include best practices and competencies for treatments ordered by an independent licensed practitioner. Other examples may include the proper sequence for environmental cleaning and proper use of personal protective equipment. Also included are discharge checklists explaining discharge medications, aftercare instructions and other instructions needed to facilitate a safe discharge for each PAM Patient.

Current checklists in use include:

- a. Insertion of PICC lines.
- b. Maintenance of Foley catheters
- c. Discharge checklist
- d. Respiratory Treatment competencies
- e. Wound care education

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. Infections
6. Near Misses
7. Sentinel Events
8. Hazardous Condition(s) to include **Workplace violence added in 2020.**

The role of the Patient Safety Program also crosses over into the safety of the environment of the hospital oversight of the 7 Environment of Care Plans:

1. Safety Management Plan
2. Security Management Plan
3. Life Safety Management Plan /Fire Safety
4. Medical Equipment Plan
5. Emergency Preparedness Plan
6. Hazardous Materials and Waste Management Plan,
7. Utilities – Utilities Management Plan

Annual Reviews of each of the 7 plans are performed and reported to the Environment of Care Committee/Quality Council and Patient Safety Committee as well as the Medical Executive Committee and the Governing Board of the Hospital.

Methodology

The Patient Safety Program includes both proactive and responsive components.

Proactive: The proactive patient safety component emphasizes a proactive error reduction and avoidance program. The following will be reviewed to proactively identify patient safety issues:

1. Medical equipment and medication risk assessment activities
2. Sentinel event alert risk reduction activities
3. Performance improvement indicators (department specific) and monitoring activities
4. Patient Satisfaction reports
5. Medical Record review reports
6. Staff orientation, evaluation, training, and education **activities to include a Culture of Patient Safety survey to be completed every 18 months. Completed in November 2020**
7. Failure Mode and Effect analysis (FMEA) activities (Falls 2020)
8. Medical Staff Credentialing/Peer Review issues
9. Occurrence Report trending

Failure Mode Event Analysis (FMEA) will be conducted at a minimum of every 18 months. The process to be studied each cycle will be determined in collaboration with medical staff, hospital leadership, and staff. Information from patient safety organizations such as the Institute for Medicine, Institute for Safe Medication Practices, and The Joint Commission will be disseminated to the appropriate departments and committees for action and implementation of recommendations.

Responsive: The hospital will utilize information gathered from risk assessments, sentinel event alerts, performance improvement measures, medical record review, and other data in order to track, trend, and respond to patient safety issues. Patient safety related issues will be ranked based on severity. The following will be reviewed for reactive patient safety issues.

1. Root Cause Analysis
2. Intensive Assessment and Analysis/FMEA
3. Occurrence Report Findings
4. Patient Complaint/Grievance Response
5. Performance Improvement Measures
6. Patient Satisfaction Survey Reports
7. Serious Event Notifications /Sentinel Event Reporting
8. Culture of Patient Safety Survey
9. Hazard Vulnerability Analysis

Patient Safety Committee and Reporting

Patient Safety is the responsibility of all employees and Medical Staff members. The Patient Safety Program will be multi-faceted and that responsibility will be shared among several individuals, groups, and teams. Each performance improvement team is multidisciplinary in nature with representatives from the hospital and medical staff. Medical staff as champions provides for the necessary support of initiatives. Imbedded in each performance improvement team are safety issues relevant to the team's focus. Reports from the performance improvement teams are sent to the Quality Council/Patient Safety Council and reported to the Medical Executive Committee and the Governing Board.

In compliance with **State of Nevada Regulations**, the Patient Safety Committee will be comprised of:

- (1) The patient safety officer (annually appointed) of the medical facility.
- (2) At least three providers of health care who treat patients at the medical facility, including, without limitation, at least one member of the medical, nursing, and pharmaceutical staff of the medical facility.
- (3) One member of the executive or governing body of the medical facility.

The Patient Safety Committee is also multidisciplinary with representation from the following areas: Clinical Departments, Pharmacy and Therapeutics Committee, Safety Committee, Quality/Risk Management, and the Hospital's Infection Control provider.

The Patient Safety Committee functions include but are not limited to:

1. Review and evaluate internal and external patient safety data from the following sources for opportunities for improvement in the safety of patient care processes:
 - a. Risk and Safety Management
 - b. External Data Reports
 - c. Sentinel Event Alerts from the Joint Commission
 - d. Healthcare Reports
 - e. Regulatory Reports
 - f. Patient/Family Members to include Complaints and Grievances
2. Continually improve processes of care delivery based on data analysis.
3. Develop policies and procedures that result from process improvement activities **and corresponding checklists.**
4. Develop and approve Patient Safety Education for the medical and hospital staff.
5. Conduct an annual risk assessment of patient safety issues/strategies from internal and external reports.

The Hospital believes in a non-punitive reporting environment in order to maximize reporting of near misses, adverse outcomes, and sentinel events as it has been demonstrated that many errors are directly related to system and process failures. Disciplinary action may be considered when an involved individual takes action to hide the incident, is malicious or untruthful in reporting, when facts and circumstances suggest that the error was deliberate or in reckless disregard to patient and staff safety, or when the individual consistently fails in the detection, reporting or remedies to prevent mistakes. Reporting of patient safety issues to an outside agency will be done when required by regulation or as determined by the Administrator/CEO/Corporate PAM.

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 PAM 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. Relias training modules are introduced to provide ongoing education

on topics as these are identified. Additionally, education will be provided to patients and their families about their role in helping to facilitate the safe delivery of care.

Desert View Hospital - Pahrump

Risk Management/ Patient Safety Plan

Nevada Acute Care Division

Revised 1/2020

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

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

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

GENERAL STATEMENTS ON GOALS AND OBJECTIVES

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

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

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

II. Mission and Vision

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

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

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

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

III. ROLES AND RESPONSIBILITIES

A. Risk Management/Patient Safety Officer

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

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

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

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

B. Infection Control Officer

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

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

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

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

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

C. Patient Safety

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

I. Facility Patient Safety Committee

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

Membership:

In accordance with [NRS 439.875](#), the committee core membership consists of the following Key Members: (CEO, CNO, Physician, Risk/ Patient Safety Officer, Infection Prevention Nurse, Pharmacy, and Quality). The 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's PSC is charged with the assessment and improvement of high-risk processes related to patient safety. This is to be carried out using a four-step methodology.

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

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

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

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

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

II. Patient Safety Advisories

When an untoward event occurs at the facility or in the industry, it is important that we respond in a positive manner. Systems that lead to failure at one facility can be assessed at other facilities to avoid the same or similar occurrence. To this end, Safety Watch newsletters are distributed. These alerts detail the circumstances that lead to a negative outcome and the facility is charged with assessment and improvement of their own processes to prevent similar occurrences. In addition, Clinical Risk Alerts and Medication Safety Alerts are also formulated to apprise the facilities of a specific safety issue that needs to be assessed to prevent reoccurrence.

Desert View Hospital is required to address the Safety Watch newsletters, Clinical Risk Alerts and Medication Safety Alerts via their Patient Safety Committee and this is evidenced in their monthly minutes. Responses to the Safety Watch are reviewed for the opportunity to generate a best practice to implement.

C. TERM Program

The facility has utilized its formalized risk management program identified as TERM: the Technical Elements of Risk Management. Each element focuses on a separate organizational function and details specific strategies for managing risk in these areas. These elements are summarized as follows:

Element I. Administration of the Risk Management Program: The tenets outlined in Element 1 lay the foundation for an effective risk management program. The Risk Manager/Director must be seen as a resource to administration, facility, and medical staff. Written plans, goals, and objectives provide a clear vision to meet the purpose of the risk program. Although the TERM program uses the title “Risk Manager,” this applies equally to Risk Directors.

Element II. Risk Identification: Risk identification is essential in order to avoid, mitigate, and eliminate risk-generating practices. This Element focuses on those steps taken to identify exposures faced by the facility.

Element III. Risk Education: Education is a cornerstone of the TERM program. Risk management education is intended to reduce and eliminate risk-generating practices and to promote best practices that enhance the provision of safe patient care.

Element IV. Patient Safety Initiative: Imperative to a comprehensive RM program is one that focuses on the improvement of patient and staff safety through the creation of an environment that maximizes safety and reduces liability claims exposure. The mechanism used to drive the culture of safety is the Patient Safety Committee (PSC). The PSC operates using a four-step process. These steps include: identification of the problem, determining best practice, implementing the recommendations, and monitoring and accountability. Corrective actions are discussed, monitored, and validated by the PSC.

Element V. Patient Safety Priority: Root Cause Analysis (RCA): The cornerstones of an effective Patient Safety and Risk Management Program are (i) the performance of a thorough and credible RCA when a serious, sentinel, never event or a significant near miss event occurs; and (ii) implementation of systemic improvements to enhance patient safety and improve healthcare outcomes going forward.

Element VI. Environment of Care; Safety and Security Programs: The safety and security programs in the facility serve to protect and preserve both life and property. Areas of safety include licensing, accreditation and federal, state, and local safety practices and programs, including the EPA, TJC, etc.

Element VII. Claims and Litigation Management: The risk manager serves as the on-site representative of the insurance program in the management of general and professional claims and litigation.

Element VIII. Patient Safety Organization (PSO): Participants of the Member Workforce are expected to perform identified patient safety activities and to be trained in their responsibilities. They must also understand and acknowledge their obligations, including maintaining the confidentiality of PSWP, as required by the Patient Safety and Quality Improvement Act (PSQIA), and of Protected Health Information, as required by the

Health Insurance Portability and Accountability Act (HIPAA) and its regulations, and other federal and state laws.

D. AMES-CCD

The AMES -- CCD system is the electronic event reporting system utilized by the facilities to report patient and visitor safety events. The risk management module allows for the collection, categorization, and analysis of incident data using electronic reporting functions (Remote Data Entry - RDE). The facility enters incidents into AMES -- CCD through identification of the type of incident and characteristics of the event using risk parameters and outcomes. Additional information can be attributed to a department, physician, or individual, along with further details of the event. This allows the retrieval of information in a variety of ways for analysis and review.

E. Risk Connect (STARS)

STARS is an integrated claims management program that allows for complete claims management, including extensive analysis of reportable fields associated with reported claims. STARS also provides for the electronic submission of potential claims by user facilities.

Delineation of issues featured in the probable claim module allows for the facility staff to identify causation factors associated with any reported event. The system also provides for the entry of details that will describe the event and liability concerns.

Trending of claim information is performed on a scheduled basis to operations leadership metrics to form strategies on facilitating risk reduction efforts. Previous examples of this function include the formation of an OB HRU and Perioperative concepts. Quarterly reports should be provided by Desert View Hospital RM to the Governing Board of all claims activities.

F. Event Notification Site

The Event Notification Site or ENS, is a web-based system that allows for contemporaneous reporting of serious adverse events and key near miss sentinel events to facility and management. The ENS also provides an environment in which stakeholders can post questions and additional information to the facility reporting the event. Updates to the event are reported in real-time to all identified facility and stakeholders via the ENS. The Risk Management staff reviews each ENS to determine if follow-up is needed; if follow-up is indicated, it is to be completed within 45 days.

G. Root Cause Analysis (RCA)

Pursuant to [NRS 439.837](#), a medical facility shall, upon reporting a sentinel event pursuant to [NRS 439.835](#), conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both of the sentinel event.

A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals. Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

It is recommended that The Joint Commission's root cause analysis and actions plan framework table are utilized. It contains analysis questions and guides the organization in the steps of a root cause analysis. Not all of the questions apply to all of the events or cases.

Utilization of the "5 Whys" technique should be used to explore the cause and effect relationship underlying a problem. One can find the root causes by asking "why" no less than five times.

RCA Responsibilities

- Organize and coordinate the RCA process. For Serious OB events, RCAs are to be done within 72Hrs, or as soon as possible, of the event.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA and corrective action plan implementation process.
- Communicate the progress of the investigation, institutional barriers and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.



H. Patient Safety Checklists

By [NRS 439.865](#), the Patient Safety Plan must include the Patient Safety Checklists and Patient Safety Policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

The Patient Safety Checklists must follow protocols to improve the health outcomes of patients at the medical facility and must include, without limitation:

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.

- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - Proper instructions concerning prescription medications;
 - Instructions concerning aftercare;
 - Any other instructions concerning his or her care upon discharge; and
 - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

(For your reference— a checklist example is shown in **Appendix A.**)

I. Patient Safety Policies

The Patient Safety Policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include, the name and date of birth of the patient.
- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.
- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

J. MEMBER PATIENT SAFETY EVALUATION SYSTEM (PSES)

The Patient Safety and Quality Improvement Act of 2005 (PSQIA) and its regulations govern the operations and activities of the UHS Acute Care PSO and its Members. This includes assembling a “workforce” of employees, volunteers, trainees, contractors, and other persons who carry out patient safety activities on behalf of the Members within the Member Patient Safety Evaluation System (“Member PSES”). Participants in the Member Workforce are expected to perform identified patient safety activities and to be well trained in their responsibilities. They must also understand and acknowledge their obligations, including maintaining the confidentiality of PSWP, as required by the PSQIA, and of Protected Health Information, as required by the Health

Insurance Portability and Accountability Act (HIPAA) and its regulations, and other federal and state laws. The Member PSES serves as a means by which patient safety information is collected, maintained, reported, and analyzed for the UHS Acute Care PSO for the purposes of improving patient safety.

K. Training and Education

Training is essential to successful implementation of the Patient Safety and TERM program. All facility risk managers undergo extensive orientation and education related to Patient Safety, TERM program and other healthcare, risk-related topics. Newly hired Risk Directors/Managers receive both on-site and collaborative corporate-based education and training to afford them the requisite skills to manage their facility assignment. Each Risk Director/Manager is provided a copy of the TERM source documents and other reference materials that guide the risk management function. In addition, formalized supplemental training is provided to all facility risk managers as needed, including quarterly risk management meetings. Risk leadership provides ongoing support and consultation to their assigned facility to facilitate the minimization of liability exposures and enhancement of safe patient care.

The leadership risk management staff provides consultative services to each facility and as members of designated projects. These activities include on-site assistance, research, and consulting from off-site. Examples of designated projects are as follows.

- Facility specific risk Issues
- Safety Watch newsletters
- AMES -- CCD Focus advisories
- Clinical Risk Alerts
- Medication Safety Alerts

IV. Acute Care Division Patient Safety Priorities, Goals and Objectives for 2020

- Surgical and Procedural Safety:
 - **Wrong Site Surgery (WSS).**
 - **Goal:** A 50% reduction in WSS events for 2020. Ultimately the goal is zero (0).
 - Monitor through AMES -- CCD event reporting. Report monthly.
 - **Retained Procedural items (RPIs)**
 - **Goal:** Prevent RPIs- a 50% reduction in RPIs with harm for 2020. Ultimately the goal for RPIs is 0.
 - Monitor through AMES -- CCD event reporting. Report monthly.

○ **OBHRU:**

- **Reduction/Elimination of serious harm by reducing the response time to adverse obstetrical bleeding initiative. As applicable to facilities with in patient OB services.**
 - **Goal:** As evidenced by:
 - Education Module X: All new hire staff and providers to complete Hemorrhage module within 1st 3 months of employment. All current staff and providers who care for perinatal patients to complete Hemorrhage module every 2 years (even years).
 - Quantification of blood loss will occur at 95% of all deliveries as evidenced by facility results of Power Insights Hemorrhage report/dashboard.
 - All patients will receive POST BIRTH warning signs education for inpatient stay and discharge as evidenced by Power Insights report on education completion.
 - POST BIRTH collaborative benchmarking and assessment data from AWHONN/Premier collaborative.
 - Monitor through Powers Insights QBL compliance report/ AMES -- CCD /ENS/Claims data, GNOSIS results, and facility education reports. Report monthly.

○ **CLABSI/CAUTI Initiative**

- **Goal:** CLABSI and CAUTI will both be reduced to less than the National CMS mean Standardized Infection Ratio (SIR: CLABSI 0.783; CAUTI 0.857) in 2020.
- Monitor through CDC's National Healthcare Safety Network (NHSN). Report quarterly.

○ **Safe Medication Use**

- Opioid Analgesic Event Reduction Initiative
 - **Goal:** Decrease the number of preventable OIRD events by 10%.
 - Monitor through AMES -- CCD reports, Cerner, ICD-10 Codes, and other intervention data. Report monthly.

○ **Reduce Falls and Falls with Injury**

- **Goal:** 10 % overall reduction in the number of falls in the facility by end of 2020.
- Review of the progressive mobility (PM) documentation in the facility.

- Correlation of PM documentation and fall incidents.
 - Review of the documentation of PM in the Medical Surgical unit with LOS.
 - Review of documentation of mobility and progression of mobility.
 - Monitor through AMES -- CCD event reporting. Report quarterly.
- **Culture of Safety**
- **Goal:** 100% of 2020 Patient Safety Plan Priorities will be implemented within the facility.
 - Monitor through AMES -- CCD event reporting with monthly reporting to PSC.

Desert View Hospital:

- **Goal:** Slip/Fall: Found on Floor for 2019 resulted in 299 events. 5% reduction per 2020 quarter is to be achieved.
- **Goal:** Against Medical Advice departures from the emergency department in 2019 equaled 429. The Emergency department Director/Staff will reduce patients leaving against medical advice reducing AMA's by 10% for each quarter of 2020.
- **Goal:** Left before triage and left without being seen departures from the emergency department in 2019 equaled 78. The Emergency department Director/Staff will reduce left before triage and left without being seen departures from the Emergency Department by 10% for each quarter of 2020.
- **Goal:** Violence within Desert View Hospital equaled 51 related event. 100% of the Emergency department staff are to receive Handle with Care Certification by July 2020 to reduce violence by a 5 % reduction from 2019 to 2020.
- **Goal:** Pyxis Optimization – Automatic Dispensing Cabinet there were 12 facility override events and 62 incorrect narcotic counts in 2019, and 71 Narcan usage events. Override events, incorrect narcotic events will be reduced by 10% for 2020. 100 % Emergency Department Registered Nursing staff will complete bar code medication administration training by April 2020.
- **Goal:** 100% of the emergency department registered nursing staff will adhere to bar code medication administration with a 90% or better compliance on a monthly basis.
- **Goal:** 2019 - High alert medication error reduction related to warfarin and insulin resulted in 5 events and 26 events respectively. A 10% reduction goal with warfarin and insulin medication administration errors is to be achieved in 2020.

V. Monitoring and Accountability

A. Evaluation of TERM Program

These evaluations consist of both a core risk and clinical risk review. The facility is required to submit a written corrective action plan for noted deficiencies determined during the TERM evaluation. All information is shared with senior staff and monitored through the facility PSC.

B. Patient Safety Committee

As detailed above, each facility is required to post their monthly reports or minutes that details the work conducted by their Patient Safety Committee to the facility PSES site. These are then reviewed and detailed feedback is provided to coach the committee on their form and function.

C. Dashboards

The Risk Management/Patient Safety Dashboard and the Environment of Care Dashboard include multiple indicators to demonstrate the facility's performance as to these markers. These include: event reporting statistics, fall rate including harmful event rate, medication event rate including harmful medication events, timeliness of event review and closure.

VI. Evaluation/Review:

The risk staff reviews the effectiveness of the Patient Safety/Risk Management Plan to ensure activities are appropriately focused on improving patient safety, decreasing harmful errors, decreasing rate of compensable events, facility risk program consistency/functionality and support of clinical delivery in the field. Evaluation will include the following:

- The culture supports the identification and reporting of "Near Miss" events
- The framework advances a "Just Culture" approach to patient safety
- Accountability is promoted when acts of "human error", "at risk", or "reckless behavior" are identified and corrected resulting in a reduction of potential/actual adverse outcomes.
- Comparison of trended incident data to include analysis of performance to stated targets, submission of incident data in compliance to SOX stipulations and review of trended data submitted to the PSC for potential action
- Review of annualized and prior year's probable claim reports to determine needs for corporate-based projects designed to improve outcomes in an identified service line

- Review of educational products distributed for the concluding operating year that were intended to improve outcomes associated with a particular clinical emphasis
- Review information, analyses and reports from the Acute Care PSO for integration into the Patient Safety Evaluation System.

VII. Confidentiality

All PSWP reported, stored, or generated in the Member PSES is confidential and privileged under Federal law. The Member PSES will only be accessed by authorized staff. Workforce participants will be trained on policies and procedures governing their patient safety activities and responsibilities. The PSC annually reviews the effectiveness of the Safety Plan to ensure goals and objectives are appropriately focused on improving patient safety.

VIII. Approval of Patient Safety Plan

According to [NRS 439.865](#), a medical facility shall submit its patient safety plan to the Governing Board of the facility for approval. After a facility's patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan.

The Patient Safety Plan must be reviewed and **updated annually** in accordance with the requirements for approval set forth in this section.

According to [NRS 439.843](#), on or before March 1 of each year, a copy of the most current Patient Safety Plan established to [NRS 439.865](#) must be submitted to the Division of Public and Behavioral Health.

Appendix A: Checklist Example: Injuries from Falls and Immobility

Process Change	In Place	Not Done	Will Adopt	Notes (Responsible & By When?)
Conduct fall and injury risk assessment upon admission				
Reassess risk daily and with changes in patient condition				

Implement patient-specific intervention to prevent falls and injury				
Communicate risk across the team; use handoff forms, visual cues, huddles				
Round every 1 to 2 hours for high-risk patients; address needs (e.g., 3Ps: pain, potty, position-pressure). Combine with other tasks(vital signs)				
Individualize interventions. Use non-skid floor mats, hip protectors, individualized toileting schedule; adjust frequency of rounds				
Review medications (by pharmacist); avoid unnecessary hypnotics, sedatives				
Incorporate multidisciplinary input for falls				
Prevention from PT, OT, MD, RN and Phar.D.				
Include patients, families and caregivers in efforts to prevent falls. Educate regarding fall prevention measures; stay with patient				
Hold post-fall huddles immediately after event; analyze how and why; implement change to prevent other falls				

Reference: Checklists to Improve Patient Safety. June 2013. Health Research & Educational Trust.

GOLDEN MANOR CARE

CRISIS CONTINGENCY

&

EMERGENCY EVACUATION PLAN

Developed for Golden Manor Care
2301 East 9th St.
Reno, NV 89512
Created 03/13/2014

CRISIS CONTINGENCY PLAN

BACKGROUND

GOLDEN MANOR CARE in the event of an incident constituting a threat to its residents, employees, guests and/or visitors, has provided this CRISIS CONTINGENCY PLAN & EMERGENCY EVACUATION PLAN as a guide for the owner, administrator, caregivers, employees and the residents. The procedures contained in this publication are not to be considered all inclusive but moreover to provide general response procedures based upon acceptable practices for evacuation and/or safeguarding of life and property in the event of an emergency.

DUTIES AND RESPONSIBILITIES

OWNER/S, ADMINISTRATOR, CAREGIVERS, EMPLOYEES AND RESIDENTS are to familiarize themselves with all aspects of these plans. Owner/s or Administrator in the event that they are unavailable or unable to respond to the emergency, the Lead Caregiver On-duty, or any caregivers or employees should be capable of assuming their duties. It is the responsibility of the owner/s and administrator to familiarize their employees with these plans. Caregivers and employees assigned to assist evacuation are to be trained in their duties and responsibilities by the owner/s and administrator..

OWNER/S AND ADMINISTRATOR is responsible for ensuring the caregivers and employees carry out their duty assignments quickly and efficiently.

EMERGENCY EVACUATION PLAN

(EEP)

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BACKGROUND

GOLDEN MANOR CARE, in the event of an incident constituting a threat to the owner, administrator, caregiver, employees, guests and residents, has provided this EMERGENCY EVACUATION PLAN as a guide for the owner, administrator, caregiver, employees and the residents. The procedures contained in this publication are not to be considered as being all inclusive but moreover provide response guidelines based upon acceptable practices for evacuation and/or safe guarding of life and property in the event of an emergency.

GOLDEN MANOR CARE is an ADULT GROUP CARE facility licensed by the Bureau of Health Care and Quality Compliance and is located at 2301 East 9th St., Reno, NV 89512 its cross streets are Silverada Blvd. on the east and Manhattan St., on the west, other notable factors to consider regarding our location is that we are situated adjacent and just below 395 freeway going either North or South.

Although remote, the possibility of an incident, whether externally or internally generated, always exists. GOLDEN MANOR CARE recognizes this potential and has prepared the following EMERGENCY EVACUATION PLAN for just such an eventuality.

EVACUATION PLAN

A complete evacuation can be a time consuming endeavor and in an emergency time can be of the essence. To facilitate a timely, safe evacuation, key employees have been designated respective duties and responsibilities. Employees during EMERGENCY DRILL EXERCISE will be pre-assigned for emergency situations, whenever possible assigned employees must be bi-lingual in order to verbally communicate critical instructions to non-English speaking persons.

The employees may change but the manner, formation and assignment will remain constant. It shall be the responsibility of the Administrator to update and practice the fire drill once a month so that they key positions are not lost to attrition. The Administrator shall train every new employees of the facility and give them their key assignments in an emergency situation within five (5) working days after they are hired.

Residents should also be trained to familiarize themselves what to do in case of emergency. Response time should be recorded so that the facility can anticipate the actual evacuation time.

Problems should also note and addressed during the Emergency Drill Exercise.

Employee Assignments

There are Twelve (2) exits from the facility. If ever possible employee will be assigned to each of the exits.

Door #	Location	Description	Employee
1	Front Door Exit	towards the front yard	Caregiver 1
2	Side Door Exit	right side of the house going towards the porch	Caregiver 2

NOTE: Should any of the above emergency exits be unavailable due to the emergency, Assigned Caregiver will divert to the available exits listed. In case two exits are unavailable – assigned caregiver will locate the safest exit possible eg. Windows, etc.

Alternative Exits

Alternative Exit	<u>Description</u>	In -charge
<u>Laundry room Exit doors</u>	Two doors at the laundry doors not equipped with exit ramps for residents but can be used as alternative exits	Any available employees
Various windows of the facility	In case two exits are unavailable assigned caregiver will locate the safest, nearest window exit going towards the designated evacuation area	Any available employees

Note: Owner/Administrator and any unassigned caregiver will assist all the residents from their rooms and proceed to the assembly area.

Order of Evacuation Priority:

1. Anybody which is near the fire or emergency area will be evacuated first
2. Category 2 residents will be taken out of the building second
3. Category 1 residents will be taken out third
4. All other people: visitors, employees will be evacuated in the area

ASSEMBLY POINT

ADMINISTRATOR/OWNER is to assemble all the residents, visitors, employees to the ‘FRONT YARD’ of the facility adjacent to the street. Administrator/Owner is to account all the people in the facility: residents, visitors and employees.

DECISION TO EVACUATE

a. Authority

Only the Owner, Administrator or the Lead Caregiver on Duty (LCOD) will make the decision to evacuate all or any part of the facility.

b. Response

Immediately upon receipt of the decision to evacuate the facility, the LCOD will announce the evacuation and start the evacuation as soon as possible.

The LCOD will be responsible for announcing the need to evacuate the building. Should electrical power not be present the owner, administrator, caregivers and employees will be responsible for communicating the need to evacuate the residents and guests.

DUTIES AND RESPONSIBILITIES

1. The Owner

- a. Only the Owner, Administrator or the Lead Caregiver on Duty (LCOD) will make the decision to evacuate all or any part of the facility
- b. The owner will make every effort to safeguard the safety of the residents and employees. Secondary to this are funds and valuables of the facility and residents, important documents and papers and last will be computers and other electrical equipment that may be impacted by electrical current fluctuations.
- c. Upon arriving at the assembly area, Owner/Administrator will account for all the residents, employees and guests who were at the facility at the time of the evacuation. Anybody of the aforementioned not actually observed at the assembly area will be reported as missing to the proper authority.
- d. The Owner upon notification by the Lead Caregiver on Duty (LCOD) of a Missing resident, or employee, or guest will immediately notify the Police Authority with the missing person's Name, and a brief description, and location.
- e. The owner or whoever is in-charge will be in possession of the facility's "Key Set" in the event that doors need to be opened.
- f. The owner/administrator will lead and assist in the evacuation process making sure that everybody in the Facility will proceed directly to the assembly area.

2. The Administrator

- a. The Administrator shall train every new employees of the facility and give them their key assignments in an emergency situation within five (5) working days after they are hired.
- b. The Administrator upon decision that the emergency is on phase 3 or Code red will hold a meeting with the owner, on-duty Caregiver, Caregiver and other employees at a predetermined location for planning and implementation of evacuation/defend in place or other suitable contingencies to deal with the incident.
- c. The Administrator will assemble all the residents, visitors, employees to the 'ASSEMBLY AREA ('FRONT YARD)'' of the facility adjacent to the street. Administrator is to account all the people in the facility: residents, visitors and employees.
- d. **Note:** Owner/Administrator and any unassigned caregiver will assist all the residents from their rooms and proceed to the assembly area.

3. The Lead Caregiver On-Duty (LCOD)

The Lead on-duty Caregiver/s (LCOD Immediately upon receipt of the decision to evacuate the facility, will announce the evacuation and start the evacuation as soon as possible.

The LCOD will be responsible for announcing the need to evacuate the building. Should electrical power not be present the owner, administrator, caregivers and employees will be responsible for communicating the need to evacuate the residents and guests.

LCOD will assume overall responsibility for conducting the Emergency Evacuation Plan (EEP). All subordinate employees of the facility shall take direction from the LCOD during an incident requiring the evacuation of the building. All employees shall render such assistance as may be required by the LCOD to discharge his/her duties. The LCOD shall, unless relieved by higher authority, act on behalf of Golden Manor Care to safeguard life and property.

If condition permits LCOD:

- will ensure that the facility's records and valuable are secured and then conduct a sweep of the building, in pairs, to ensure that everyone is out of the building.
- will close doors to individual areas after determining all occupants have departed.
- after completing the sweep, LCOD will proceed to the assembly area.
- After the evacuation is complete, and if possible, will maintain observation points at a safe distance outside the Northeast and Southwest corners of the building.

4. The Caregiver and Other Employees

- Shall take orders from the LCOD
- Will assist in communicating the need to evacuate residents, guest and employees.
- Assist in the evacuation process and make sure that everybody will proceed to the assembly area.
-

The owner will make every effort to safeguard the safety of the residents and employees. Secondary to this are

funds and valuables of the facility and residents, important documents and papers and last will be computers and other electrical equipment that may be impacted by electrical current fluctuations.

Upon arriving at the assembly area, Owner/Administrator will account for all the residents, employees and guests who were at the facility at the time of the evacuation. Anybody of the aforementioned not actually observed at the assembly area will be reported as missing to the proper authority.

NOTE: Nobody shall risk their life or serious injury to retrieve or preserve any personal or facility property.

SPECIAL NOTE

All newly hired caregivers and employees should include in their orientation the policies and procedures and what their responsibilities are in case of crisis contingency.

EMERGENCY NOTIFICATION PROCEDURES

The following procedures are to be implemented in the event of an incident whether on or off property which may have an effect to Golden Manor Care operations. The events portrayed are only representative of the types of incidents that may be encountered and are not all inclusive.

The Lead Caregiver On-duty (LCOD) will determine the level of alert based upon his/her understanding of the seriousness of the incident.

Phase 1 Alert

Phase 1 Alert consists of the following types of events which may affect the Golden Manor Care operations and should be monitored closely but do not necessarily constitute an immediate threat to life or property. Call outs of other caregiver/s and employees will be at the discretion of the LCOD

- ✓ Structure fires in close proximity to Golden Manor Care
- ✓ Broken water or gas mains in the vicinity of Golden Manor Care
- ✓ Law Enforcement operations such as barricaded armed subjects, armed confrontations or standoffs with armed subject where chemical weapons may be employed.
- ✓ Civil disturbances which may overflow into or onto Golden Manor Care property,
- ✓ Loss of power
- ✓ Bomb Threats (telephonic)

Phase 2 Alert

Structure fires adjacent to the Golden Manor Care

Utility breaks (gas, water etc.) effecting Golden Manor Care operations.

Bomb threats (suspect device located on property)

Riot or civil disturbance disruptive to Golden Manor Care operations

Phase 3 Alert

Any incident requiring the evacuation of all or part of Golden Manor Care

Any incident requiring implementation of the Emergency Evacuation Plan

Any incident which will, if allowed to continue, have a significant effect on Golden Manor Care operations

CALL OUT PROCEDURES

The following will be notified should a specific alert level be activated.

Phase 1 (Green Alert)

Owner
Administrator
Caregivers
Other Employees

PHASE 1 (Green)

The Lead On-duty Caregiver should ensure that the owner and administrator are aware of the situation. Other Caregiver and Employees should be kept informed and alert for any escalation in the incident which could lead to a higher level of response. LCOD or his/her designee should stay in contact with the Owner and Administrator until the incident is resolved.

Phase 2 (Amber Alert)

Owner
Administrator
Lead Caregiver On-Duty
Caregivers
Other Employees

PHASE 2

Owner/Administrator should report for duty or remain on duty. Ensure adequate supplies and employees are available to respond to the situation.

Phase 3 (Red Alert)

Owner
Administrator
Lead Caregiver On-duty
Caregivers
Other Employees

PHASE 3 (Red)

The Owner, Lead Caregiver On-duty, Caregivers and other employees will meet with the Administrator at a predetermined location for planning and implementation of evacuation/defend in place or other suitable contingencies to deal with the incident.

CALL – OUT ROSTER

Call Out Roster

The following roster is to be utilized in the event of a call-out or notification requirement as a result of an incident or situation affecting or having the potential to affect the operations of GOLDEN MANOR CARE. Individuals on this call-out roster listed as primary contacts will be called in the order they are listed for their department or position.

NAME	DESIGNATION	PHONE NOS.
Ernesto D. Beltejar Jr.	(owner/administrator)	775/762-2162 (cell) 410-9034 (home)
Leonila Beltejar	(owner)	775/762-2160 (cell) 410-9034 (home)
_____	<u>Lead On Duty Caregiver</u>	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

EVACUATION ANNOUNCEMENT
(Scripted)

EVACUATION ANNOUNCEMENT

THE FOLLOWING SCRIPT IS TO BE ANNOUNCED BY THE LEAD CAREGIVER ON-DUTY, IN THE EVENT OF AN INCIDENT NECESSITATING THE EVACUATION OF GOLDEN MANOR CARE. THIS ANNOUNCEMENT IS TO BE MADE ONLY AT THE DIRECTION OF THE OWNER OR ADMINISTRATOR AND IF THE TWO ARE NOT AVAILABLE IT IS THE DISCRETION OF LEAD CAREGIVER ON-DUTY TO GIVE THE CALL.

"LADIES AND GENTLEMEN MAY I HAVE YOUR ATTENTION PLEASE".

"IT HAS BECOME NECESSARY TO EVACUATE GOLDEN MANOR CARE."

"OUR CAREGIVER WILL ASSIST YOU FOR A SAFE EVACUATION"

"PLEASE REMAIN CALM AND FOLLOW THE DIRECTIONS OF OUR CAREGIVERS"

"WE HAVE CAREGIVERS AT EACH EXIT WHO WILL ASSIST YOU IN A SAFE AND ORDERLY EVACUATION AND WILL SHOW YOU THE EVACUATION AREA.

"AGAIN, WE ASK THAT YOU REMAIN CALM AND FOLLOW THE DIRECTIONS OF OUR CAREGIVERS – THANK YOU"

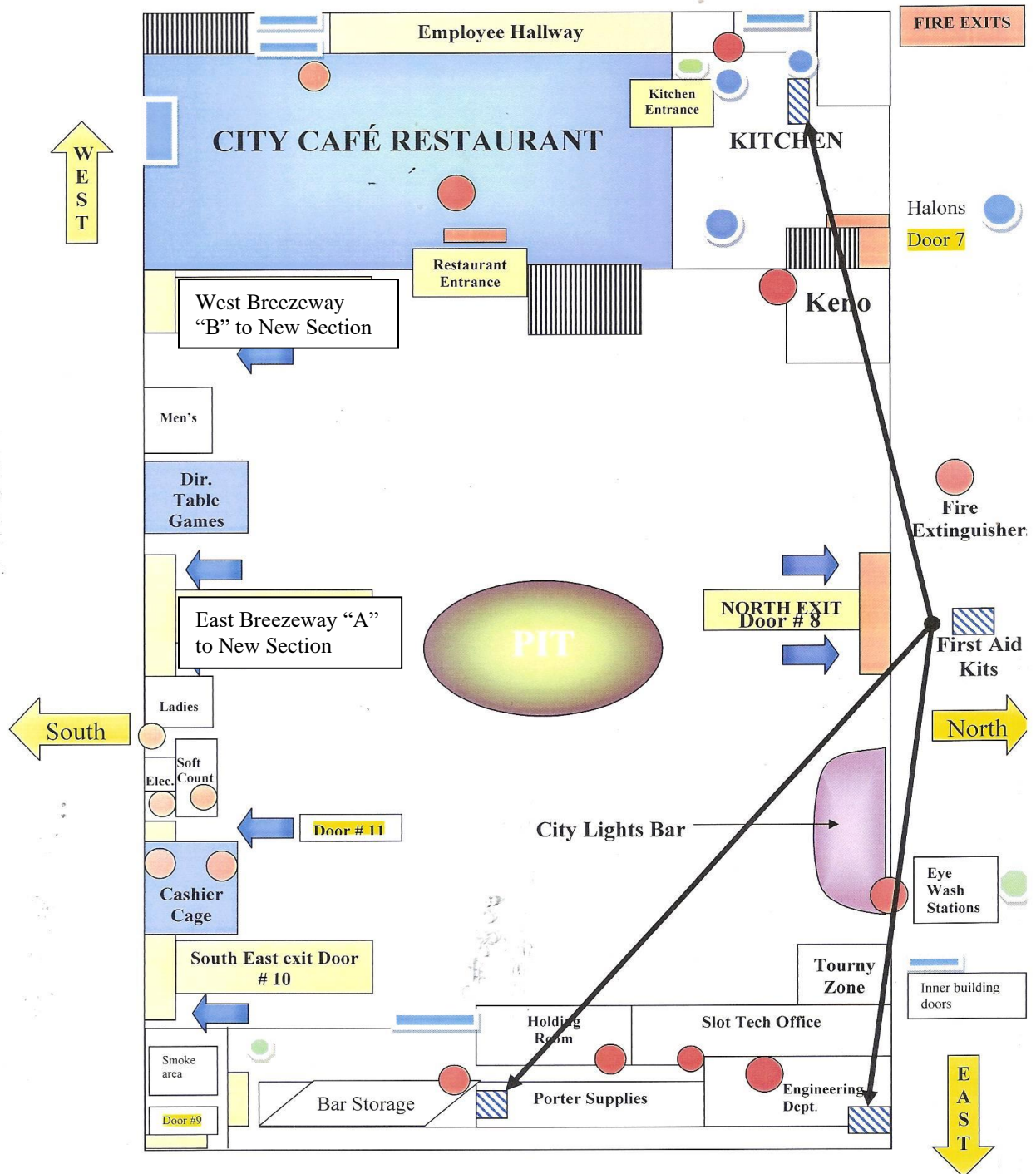
KEY POINTS TO REMEMBER

- 1) Secure the safety of all the people in the facility first and direct them to the assembly area.**
- 2) Depending on the situation the Lead Caregiver On-Duty will sweep the area to ensure that everybody has been completely evacuated.**
- 3) Again, depending on the situation; the Owner, Administrator or Lead Caregiver On-Duty will secure all the valuables and important documents of the facility, ensure that all electrical (if needed) appliances is disconnected and is shut down, that all gas service (if needed) is shut down.**
- 4) The Lead on duty caregiver will have in his/her possession: name of residents, all on duty roster of employees for their shift and all visitors for day if any. Once all residents, employees and visitors are evacuated in the assembly area – he will call these names one after another and make sure that everybody is accounted for.**

APPENDIX "C" EVACUATION PLAN

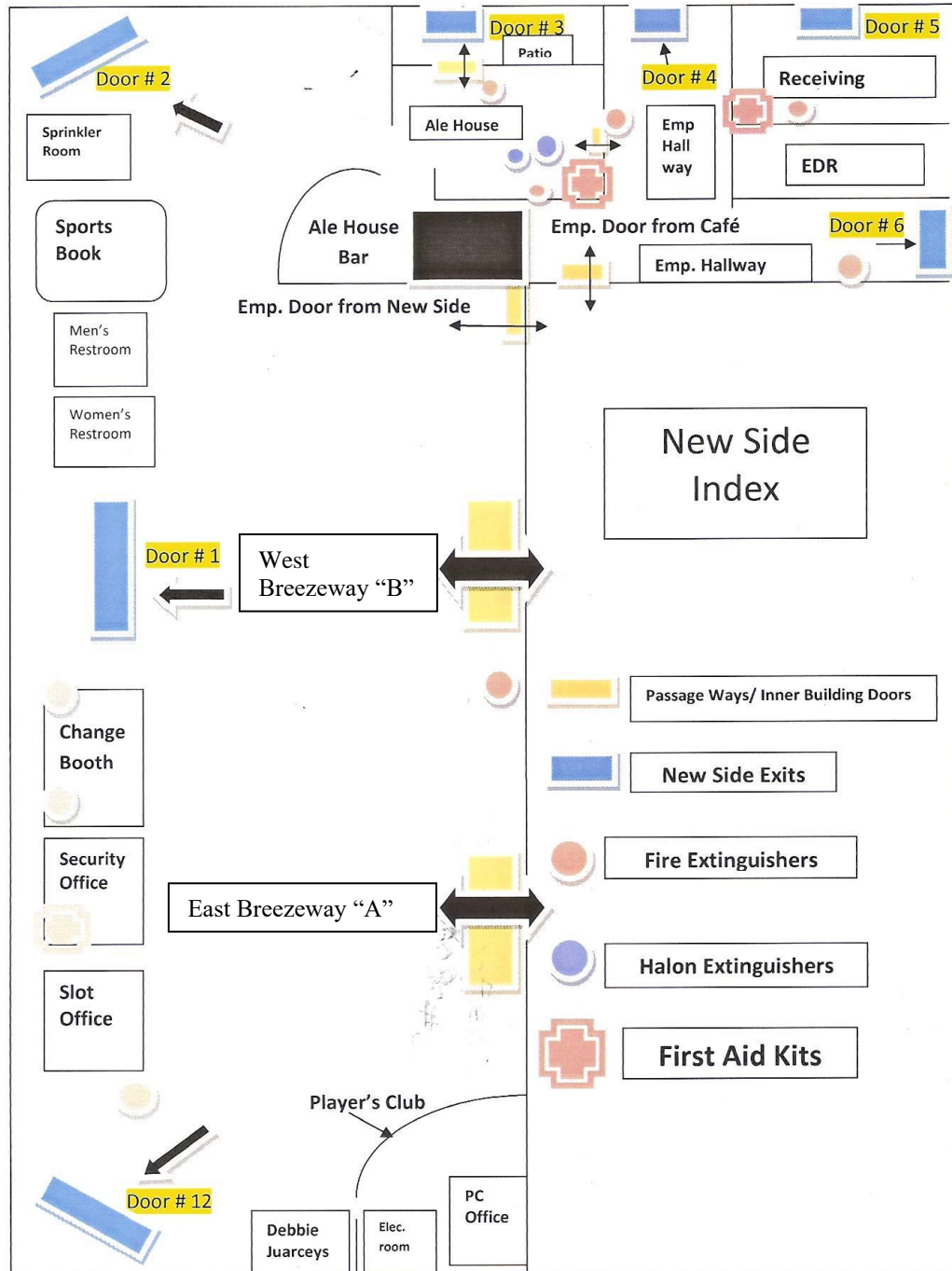


Exits, Fire Extinguishers & First Aid Kit Locations Original Side

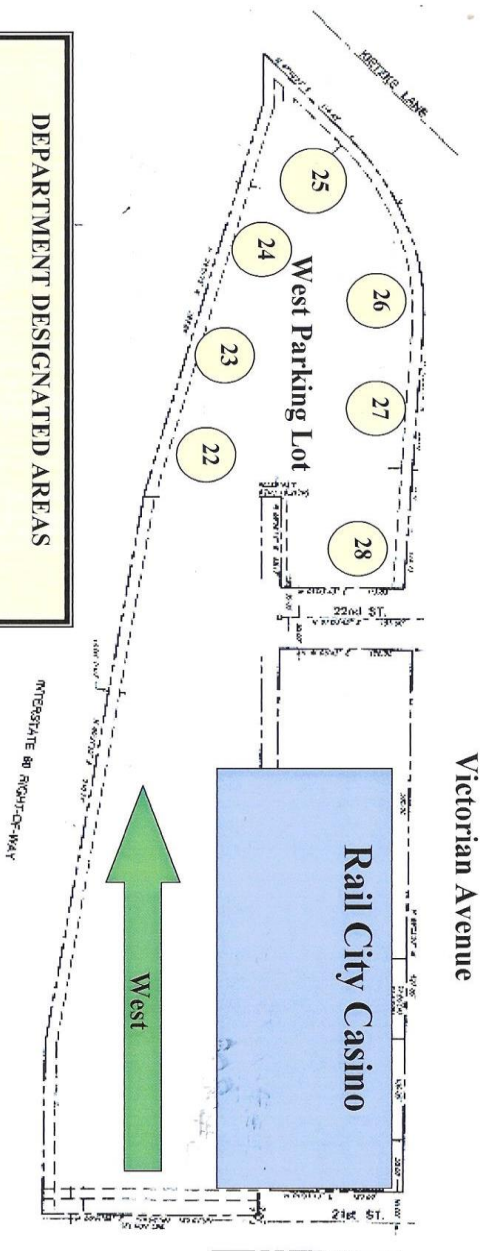




Exits, Fire Extinguishers and First Aid Kits New Side



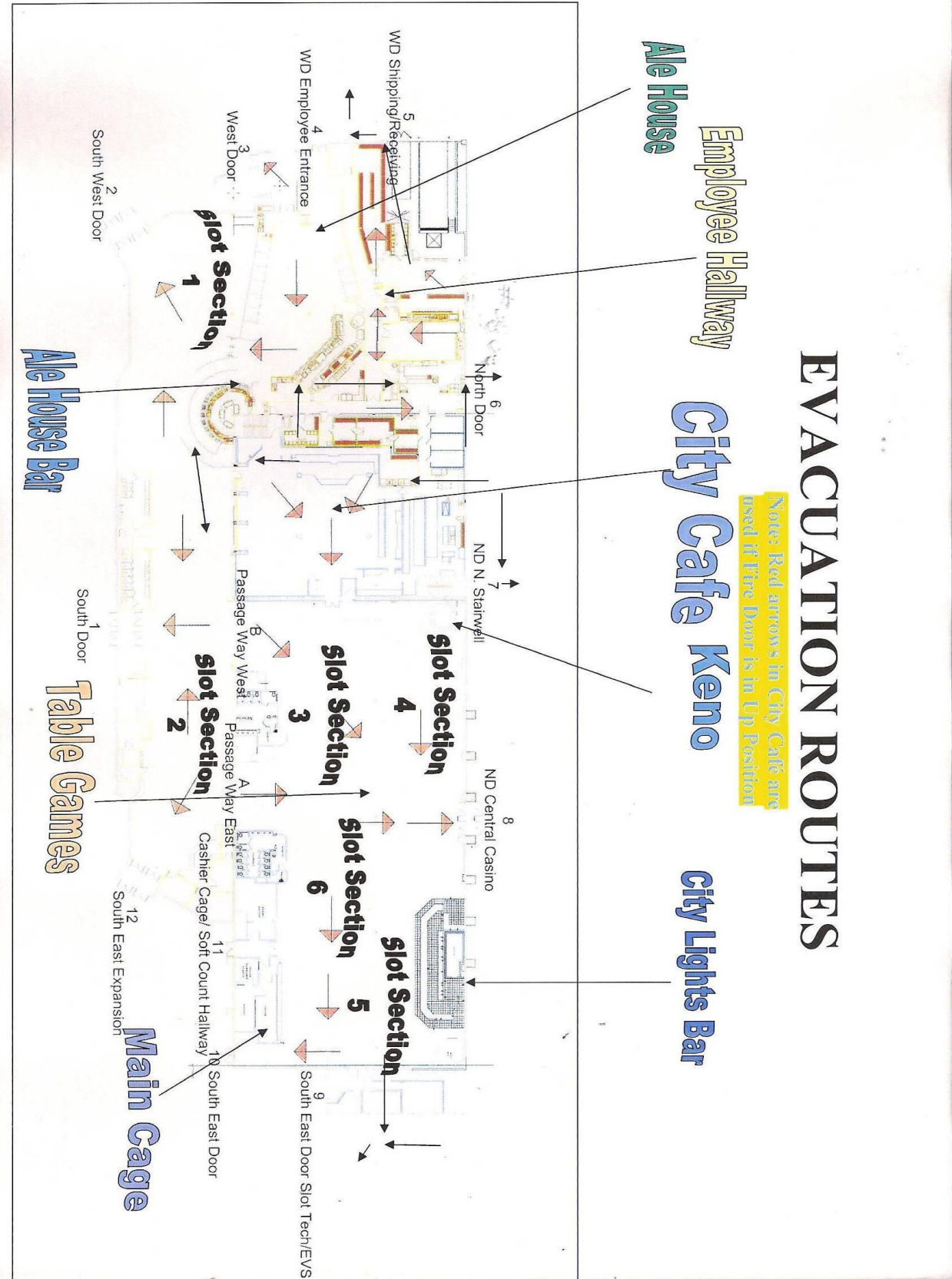
APPENDIX "E" ASSEMBLY POINT



DEPARTMENT DESIGNATED AREAS

- 22. Table Games, Human Resources, Accounting
EVS
- 23. Cashier Cage, Keno,
- 24. City Lights Bar, Surveillance, Players Club
- 25. Slot Department
- 26. City Café Ale House Bar and Restaurant
- 27. Kitchen Workers
- 28. Executive Offices Security Engineering and
CSM

EVACUATION ROUTES MAIN CASINO



Name of Facility: Cure 4 The Kids Foundation

City of Facility: Las Vegas

VASCULAR CARE

Emergency Response Plan

**Kidney Specialists Surgical
Center**

7326 W. Cheyenne Ave. Suite 110

OVERVIEW

Each Lifeline Vascular Care center will establish and maintain a center specific Emergency Response Plan, designed to respond to and manage the consequences of an emergency that impacts the center, patients or its teammates.

PURPOSE

The purpose of the Emergency Response Plan (ERP) is to:

- Establish mitigation and preparedness practices.
- Provide response strategies for different emergencies to include the recovery phase.

The ERP is a plan to respond to the effects of potential emergencies that fall on a continuum from disruptive to disastrous. ERP is not intended to include procedures for every possibility that may impact a center, but includes basic strategies for handling the most common emergencies based on the center specific Hazard Vulnerability Analysis (HVA).

COPE

This ERP has been customized for the Lifeline Vascular Care Center listed on the cover page. Information included in the plan may only be applicable to that location.

Due to the physical limitation of this facility, staffing and assets, we do not have the capabilities to be first responders. There will be no additional services and/or treatment provided during an emergency/disaster in the community. We will not be caring for additional patient populations during an emergency/disaster. There is no alternative site designated because of the nature of our services and number of staff and patients given at any certain time, we would not be transferring patients to continue their services. They would either be sent home with a responsible adult or to the hospital to be stabilized. Therefore, we do not have a procedure for requesting an 1135 waiver for an Alternative Care Site. We would follow The Joint Commission process for applying for an 1135 waiver as it relates to when there is a Public Health Emergency and the president declares an emergency.

MITIGATION AND PREPAREDNESS

- HVA
- Posted evacuation routes/Exit signs
- Emergency Kit
- Established contact numbers
- Community Monitoring (weather, infectious outbreaks, civil responses)
- Conducting drills
- Education and Training

PATIENT POPULATION WE SERVE

- Limited mobility
- Physical and mental disabilities
- Language barrier
- Lacks transportation
- Pharmacological dependency
- Nursing home patients

COMMUNICATION

1. Center Manager, or designee, can declare an emergency or event by contacting the following:
 - a. Local emergency services via 911
 - b. Medical Director
 - c. SOS contact sheet
 - d. Corporate Office - 877-658-6800
2. Backup communication systems may be used in the event of a disaster
 - a. Cellular phone/device
 - b. SMS/text messaging
 - c. Email, fax or social media
3. If appropriate, patients will be contacted by phone or in person
4. Staff will communicate to outside agencies as appropriate during a disaster regarding patient information needed to be consistent with the continuity of care. If staff is unsure if communication to an outside agency is appropriate, then staff will call the corporate office of clarification regarding government agencies.



1. TEAMMATE NOTIFICATION

the event of a building closure or other emergency, it may be necessary to relay information to teammates via telephone. A telephone call tree for the center should be established and maintained.

The following call tree should incorporate all teammates. Center Managers and/or Safety Designee will maintain contact information and call trees for their teammates. If appropriate, a mass text message could be used to distribute information to teammates.

Call Tree Initiator: (insert name)			Calling Tree 2 nd Person: (insert name)	
	Name	Cell Phone #	Name	Cell Phone #
1	DS		MF	
2				
3				
4				
5				
6				
7				
Calling Tree 3 rd Person: (insert name)			Calling Tree 4 th Person: (insert name)	
	Name	Cell Phone #	Name	Cell Phone #
1	PH		VB	
2				
3				
4				
0				
7				

2. EXTERNAL CONTACTS

In an emergency, there may be a need to contact external resources for assistance. Contact information for emergency resources are listed below.

Emergency Services			
Resource	Department Name	Telephone #	Notes
Police	LVPD	702-828-3111	911
Fire Department	LVFD	702-455-7311	911
Ambulance (EMS)	EMS	911	
Ambulance (non ER)	AMR	702-384-3400	
Critical Vendors			
Service	Vendor Name	Telephone #	Account #
Health Department	State of Nevada Health and Human Services	702-486-6515	
Transportation Vendors			
Service	Vendor Name	Telephone #	Account #
, Jab	Desert Cab	702-789-5001	

J«.			
Facilities Vendors			
Resource	Contact/Vendor Name	Telephone #	Account #
Property Management	KS		
Building Security			
Electric Company	NV Energy	702-402-5555	
Water	LV Water District	702-810-4194	
Sewer	LV Sewer Dept.	702-229-6227	
Gas	Southwest Gas	877-860-6020	
Telephone	Cox	702-383-4000	
Alarm Company	NextGen	702-270-4499	
Emergency Cleaning	Janiking	702-737-6116	
Other Resources			
Resource	Name	Telephone #	Notes
Local Media	Fox News	702-435-5555	
National Weather Service		http://www.weather.gov	
American Red Cross		http://www.redcross.org	
National Hurricane Center		http://www.nhc.noaa.gov	
Federal Emergency Management Agency (FEMA)		http://www.fema.gov	

JDLES AND RESPONSIBILITIES

Key Leaders during an emergency are listed in order of reporting responsibilities (chain of command). If for whatever reason the current leader cannot fulfill the duties of the leadership responsibilities the next key leader in this list will take responsibility for leadership.

1. Center Manager
2. Medical Director
3. Safety Designee

****Volunteers will NOT be used during an emergency/disaster

Tracking of patients and on duty teammates will be completed by a visual check in the center. Because of the square footage of the center, it would be appropriate to visually check the center to ensure patients and teammates working during the disaster are accounted for.

RESOURCES AND ASSETS

1. Each center is equipped with standard emergency equipment and supplies, including fire extinguishers and fire pull stations, Emergency Kit, defibrillators and suction on battery backup.
2. Each center has posted evacuation routes and EXIT signs.
3. Critical vendors are listed above for additional supplies
4. Repairs to physical center are entered into Work Order Online System

5. Teammate injuries during an emergency should follow the current process for reporting it to our worker's compensation carrier.
6. Patient or visitor injuries, should be reported through the Risk Event Management online system.

SAFETY AND SECURITY

Teammates will be provided an identification badge that must be worn at all times while in the center. Visitors and contractors will only be permitted in the center during an event if the Center Manager, or designee, approves them. The center everyday security measures will stay in place and if needed the locking of all doors will be done to secure the safety of everyone inside the center.

RESPONSE PROCEDURES

EVACUATION

In the event that the building needs to be evacuated, the following procedures should be followed.

Evacuation Routes

Primary and alternate evacuation routes should be identified from all areas of the center. "You are Here" maps identifying evacuation routes should be posted in key locations in the center, and provided to teammates during orientation.

Elevators should not be used during an evacuation.

Once the building has been evacuated, no teammates should reenter the center unless the "All Clear" has been given by either Building Management or responding outside agencies personnel.

In the event of a center is closed for longer than a day, please contact the Regional Operation Director and Senior Manager of EOC.

Building Evacuation Staff Responsibilities

The Leader, as defined below, is responsible for searching the building following an evacuation in order to verify all teammates have been evacuated safely.

Teammates will be assigned to one of three different roles during an evacuation:

- **Leader** monitors the overall evacuation process and works closely with responding emergency personnel.
- **Search Leader** searches designated areas of the building to ensure that all teammates and patients have safely evacuated. Reports back to the Leader on evacuation status or missing teammates and/or patients.
- **Stair Leader** (if appropriate) monitors the stairwells and evacuation routes during a building evacuation. If stairwell is blocked or unavailable during an evacuation, the Stair Leader will guide people to a safe evacuation route. The Stair Leader will provide additional help for those needing help on the stairs.

tgSi Lifeline

VASCULAR CARE

- ❖ **TEAM MEMBERS SHOULD NOT ENTER ANY UNSAFE AREAS OR PUT THEMSELVES AT RISK DURING A BUILDING SEARCH,** If an area of the building is not accessible or unsafe, this information should be relayed to the Leader immediately.

Meeting location outside of the Building

Once teammates are evacuated, they will report to designated meeting location outside of the building. In the event that the primary location is inaccessible, an alternate meeting location should also be identified. For larger offices, multiple meeting locations should be considered.

Primary and alternate Assembly Points for this location are:

Outside Meeting Locations	
Primary Location	Parking Spaces #5 & #6
Alternate Location	Parking Lot Near Dumpster

****Due to the services we perform and the stability of our patients, there will not be an alternative site established. When in an emergency/disaster, patients will be sent home with a responsible adult, if safe, or sent to the hospital if unable to stabilize patient.**

A. PROCEDURE FOR TRANSFERRING PATIENTS TO ANOTHER FACILITY DURING AN EMERGENCY

- a. Emergent transportation will be provided by emergency service provider local to the center if required
- b. Photocopies of all appropriate medical records will be transmitted to the admitting hospital:
 - i. Nursing Assessment, History and Physical, Progress Note, and Physician's Orders

Teammates or Patients with Disabilities

Teammates or patients who may need assistance during a building evacuation should be identified in advance, and plans developed to assist. Teammates can be assigned to assist those with disabilities during a building evacuation. If a person, is unable to safely evacuate the building due to mobility issues, Teammates will assist them to a designed refuge area.

The number and location of those in refuge areas will be reported immediately to responding emergency personnel.

For multi-story buildings, at least one area of refuge must be assigned for each floor in the building where teammates reside. Refuge areas should be in or near a stairwell or elevator shaft, and behind fire doors, if possible.

Area of Refuge	
1 st Floor	Hallway Outside of Procedure Rooms
2 nd Floor	

SHELTER-IN-PLACE

In some situations, it may be safer to remain inside the building and Shelter-in-Place, rather than evacuating outside.

Depending on the nature of the emergency, a determination will be made whether to instruct teammates to Shelter-in-Place. If this occurs, teammates should move to designated Safe Areas of the building, away from potential hazards.

Designated Safe Areas for Sheltering-in-Place include:

- Areas and rooms away from windows and exterior doors
- Interior offices, conference rooms, stairwells, large closets, and bathrooms
- Areas large enough for teammates to sit down and remain in for an extended period
- Patient will only be sheltered until safe enough to send them home if deemed stable or transferred to an

Shelter in Place Locations		
	Primary Location	Pre-Op (RN Station)
	Alternate Location	MD Office

MEDICAL EMERGENCY - CODE BLUE

In the event a Medical Emergency:

- All teammates maintain valid BLS.
- Clinical team will fulfill team designated roles related to “Code Blue” event to ensure patient safety.
- If appropriate, dial 911 immediately
- Assign a teammate to meet emergency personnel at the building entrance to guide them to the ill or injured person
- Transfer of care will be completed based on the person’s clinical condition determined by physician.
- Clinical team will continue to provide emergency medical services until proper transfer of care is complete.
- Physician and/or designated team member will communicate with the person’s emergency contact regarding the emergency.

FIRE ALARM

LAM MEMBERS SHOULD NOT ENTER ANY UNSAFE AREAS OR PUT THEMSELVES AT RISK.

Upon the activation of the center's fire alarm, use the procedure below:

1. The essential actions for protecting the patients, teammates, and visitors. Teammates will remember the acronym **"RACE"**:
 - R** - Rescue/remove the patients; remove visitors and teammates from fire area beyond the fire doors
 - A** - Activate the fire alarm, alert the team, and call 911.
 - C** - Contain the fire and smoke as much as possible by closing all doors.
 - E** - Extinguish (if safe to do so) or evacuate the center immediately.
2. To Use a Fire Extinguisher, teammates will remember the acronym **"PASS"**
 - P** - Pull pin on handle
 - A** - Aim nozzle at the base of the fire, do not get too close to the fire-4 feet
 - S** - Squeeze the handle to discharge the fire extinguisher
 - S** - Sweep from side to side to extinguish the flames

Only attempt to extinguish the fire if properly trained to do so and without putting yourself in danger.

Under no circumstances shall a teammate re-enter the facility following an evacuation without the approval of the local fire department and/or Center Manager.

UTILITY OUTAGE

In the event of a loss of a utility system in the building:

- If power outage and the building has emergency power, verify the emergency power has activated properly
- Ensure all battery operated back up equipment is functioning appropriately.
- Notify staff that is effected by the utility outage.
- No procedures should be started in Procedure Room unless directed by the physician.
- If in the middle of procedure, follow the directions of the physician to finish or terminate the procedure.
- Attempt to contact the utility company to collect information regarding the outage
- If the duration of the outage appears to be significant, and it is safe to do so, consider closing the center after patients are discharged home.

WORKPLACE VIOLENCE

THREAT OF VIOLENCE

In the event of a threat of violence in the office:

- Determine if there is an immediate threat or risk to teammates
- If needed, call 911 and report the situation to local authorities
- If safe to do so, attempt to de-escalate the situation and separate the offending parties from the rest of the people
- Do not put yourself, or others, in danger
- If the situation escalates, follow procedures for Act of Violence
- When it is safe to do so, notify Human Resources at 847-949-3819.

ACT OF VIOLENCE

In the event of an act of violence incident in the center:

- If there is an actual threat to teammates, utilize the Department of Homeland Security's
Run, Hide, Fight
- Call 911 as soon as possible and request assistance
- Always follow instructions of responding Emergency Services personnel
- When it is safe to do so, notify Human Resources at 847-949-3819.

SEVERE WEATHER (TORNADO, HURRICANE, SNOW/ICE, FLOODING)

In the event of severe weather impacting the center or surrounding area:

DURING BUSINESS HOURS

- Instruct teammates and patients to report to the Shelter in Place area in the center, do not let people leave until safe to do so
- Monitor local news and weather reports to get updates on the situation
- Return to work once it is safe to do so
- If an emergency arises, call 911 for assistance

AFTER HOURS

- If severe weather is forecasted in the area, and it is not safe for teammates to report to work, consider closing the office or delaying opening until the situation improves
- Utilize the Teammate Notification procedures in the Communication section to notify teammates of any closures or changes

EARTHQUAKE

in the event of an earthquake during business hours, impacting the center:

- Pick a “safe place”. A safe place could be under a sturdy table, desk or against an interior wall away from windows. The shorter the distance to move to safety the less likely you will be injured
- Use the “Drop, Cover and Hold-On” procedure. Drop under a sturdy desk or table and hold onto one of the leg of the desk or table. Protect your eyes by keeping your head down.
- After the earthquake, teammates will search the center to verify there are no injuries to patients or damage to the building
- If any serious injuries are identified, call 911 immediately
- Be prepared for delays in response of emergency personnel due to the possibility of widespread damage
- If the office is severely damaged, initiate evacuation procedures
- Be aware of the possibility of aftershocks following the initial earthquake

CHEMICAL, BIOLOGICAL, RADIOLOGICAL, NUCLEAR, OR EXPLOSIVE INCIDENT

In the event of a CBRNE incident impacting the center during business hours:

- If the center is still intact, initiate the Shelter-in-Place procedures
- If the center is severely damaged, initiate evacuation procedures
- If possible, monitor local news stations to get updates on the situation

Expect further instructions from local Emergency Management and Emergency Services.

- If instructed to evacuate, utilize evacuation procedures

BOMB THREATS AND/OR SUSPICIOUS PACKAGES

BOMB THREATS

In the event a bomb threat is received by **telephone**:

- Instruct teammate who received call to collect as much information as possible
 - Utilize the Bomb Threat Information Sheet attached in [Appendix A](#)
- Contact 911 immediately. Relay as much information as possible.
 - If instructed to evacuate, initiate evacuation procedures
- Upon arrival of local Law Enforcement, provide them with any information collected
- Always follow instructions of responding law enforcement personnel

In the event a **written** bomb threat is received:

- Instruct teammates not to touch the letter
- Contact Center Manager and/or Medical Director
- Contact 911 immediately
 - If instructed to do so, evacuate the area until law enforcement personnel arrive

- Upon arrival of law enforcement, provide them with the location of the threat, and any additional information you collected
- Always follow instructions of responding law enforcement personnel

SUSPICIOUS PACKAGES

In the event a suspicious package is found in the office or received via mail:

- Instruct teammates not to touch the suspicious package
- Contact 911 immediately
- If instructed to do so, evacuate the area until law enforcement personnel arrive
- Upon arrival of law enforcement, provide them with the location of the suspicious package, and any additional information you collected
- Always follow instructions of responding law enforcement personnel

CIVIL DISORDER

In the event of civil disorder near the center or in surrounding areas:

DURING BUSINESS HOURS

- Initiate Shelter-in-Place procedures
- v • Monitor local news to get updates on the situation
- Return to work once it is safe to do so
- If an emergency arises, call 911 for assistance

AFTER HOURS

- If the issue is expected to continue into the next business day, and it is not safe for teammates to report to work, consider closing the office or delay opening until the situation improves
- Utilize the Teammate Notification procedure to notify teammates of any closures or status changes

PANDEMICS AND EMERGING INFECTIOUS DISEASES

Teammates are expected to monitor local news media and teammate absences in the event of a pandemic or any emerging infectious disease outbreak.

If a teammate is diagnosed with a contagious disease, the teammate shall be instructed not to return to work until they are no longer contagious.

During their absence, cleaning procedures shall be increased and the teammate's work area shall be thoroughly cleaned to prevent the spread of the disease.

In a situation where multiple teammates are diagnosed with a contagious disease, or there is an outbreak in the local area, the Center Manager shall:

- ® Closely monitor situation and track teammate absences
 - » Report absences and trending to ROD/ROM and the Sr. Director of Quality, Clinical Education and Training.
- ® Disinfect work areas of infected teammates to prevent additional spread

If there is a large-scale disease outbreak impacting teammates, the Team shall:

- v « Consider closing the office until the outbreak has subsided
 - ® Consider instructing teammates to work from home
 - Coordinate efforts for operations and safe patient care to include evaluation of available PPE and risk assessment with coordination with the Facility & Organizational Designee for Infection Control and Prevention.

We will follow the personal protective equipment recommendations from the CDC and/or Local Public Health for the infectious and pandemic outbreaks.

IT SECURITY - CYBER AND RANSOMWARE INCIDENTS

If you suspect an IT security breach or a potential IT incident, contact the **IT**. IT teammates will take you through the steps to minimize any of the risks regarding the incident and start the process for any investigations.

ADDITIONAL CENTER RESPONSE PLAN

This space is left intentional blank for the center to place additional center specific response plans not listed above.

RECOVERY STRATEGIES AND RESPONSIBILITIES

The initiation of the Recovery phase will terminate the Response phase. It will be determined by the Center Manager or the Medical Director with the collective input from functioning departments at the corporate office. The Center Manager and/or Medical Director are responsible to restore the center's care, treatment and services after an emergency.

Information Technology (IT) has a Continuity of Operation Plan (COOP) that will be initiated as appropriate.

Lifeline

LAN REVIEW, TESTING, AND DISTRIBUTION

PLAN REVIEW AND APPROVAL

The Emergency Response Plan (ERP) will be reviewed and updated on an annual basis, or sooner if there are any significant business changes. The Center Manager and/or Safety Designee are responsible for plan

Training

Teammates with roles in the ERP should complete training on their roles when they first join the team, then at least annually thereafter. Training will be documented.

Drills

The ERP should be tested quarterly. Drills scenarios may include emergency drills, utility disruption drills and natural disaster drills. These drills will be evaluated and sent to SafetvatUfeline@rmslifeline.com or fax to 866-424-5603.

Critique Form is attached in Appendix B

PLAN DISTRIBUTION

One copy of the ERP should remain at the center and one will be provided to each teammate. The one provided to the teammate should be taken offsite and stored in their home or vehicle.

Electronic copies of the plan will also be distributed as appropriate to the team.

APPENDIX A - BOMB THREAT INFORMATION SHEET

Number at which call received: _____
 Time: _____ Date: _____

Questions to Ask:

1. When is the bomb going to explode? _____
2. Where is it right now? _____
3. What does it look like? _____
4. What kind of bomb is it? _____
5. What will cause it to explode? _____
6. Did you place the bomb? _____
7. Why? _____
8. What is your address? _____
9. What is your name? _____

Exact Wording of the Threat:

Sex of caller: _____ Race: _____ Age: _____

Caller's Voice:

Calm	Crying	Deep
Angry	Normal	Ragged
Excited	Distinct	Clearing Throat
Slow	Slurred	Deep
^ Rapid	Nasal	Breathing
Soft	Stutter	Cracking
Loud	Lisp	Voice
Laughter	Raspy	Disguised
If voice is familiar, who did it sound like?		Accent
		Familiar

Background Noises:

Street Noises	House Noises	Clear
Dishes	Motor	Static
Voices	Office Machines	Cell Phone
P.A. System	Factory Machines	Other:
Music	Animal Noises	

Threat Language:

☐ Well-spoken (educated) ☐ Incoherent
☐ Foul ☐ Taped
☐ Irrational ☐ Message read by threat maker

Did the individual call more than one time? _____

Bomb Threat Reported To: _____

Phone Number: _____

Date: _____ Time: _____

Person receiving call: _____ Position: _____

APPENDIX B.1 - EMERGENCY DRILL CRITIQUE FORM

EMERGENCY DRILL RECORD AND EVALUATION

Date of drill: _____ Time _____ Center #: _____

Person Conducting the Drill: _____

Active Drill _____ Tabletop _____
(Need one active drill a year)

Scenario:

- | | | |
|---|------------------------------------|---|
| <input type="radio"/> Earthquake | <input type="radio"/> Tornado | <input type="radio"/> Armed Intruder |
| <input type="radio"/> Cardiac Arrest | <input type="radio"/> Hurricane | <input type="radio"/> Generator Failure |
| <input type="radio"/> Hazard Material Spill | <input type="radio"/> Flood | <input type="radio"/> Civil Disturbance |
| <input type="radio"/> Anaphylaxis Shock | <input type="radio"/> Power Outage | <input type="radio"/> Ice/Snow Storm |
| <input type="radio"/> Other: _____ | | |

Please give comments on what went well or any issues regarding the areas below. List any ideas for improvement:

	Were there issues?	In this space, identify what went well during the drill and any opportunity for improvement.
Communication	Yes No	
Equipment/Supplies	Yes No	
Security (staff & property)	Yes No	
Staff knowledge of Responsibilities	Yes No	
Utilities	Yes No	
Patient Clinical Activities	Yes No	

Signatures of teammates participating and giving feedback:

E-mail: SafetyAtLifeline@rmslifeline.com or fax: 866-424-5603

APPENDIX B.2 - TIP SHEET FOR EVALUATING A DRILL

We complete drills to evaluate the effectiveness of your preparedness and the center's response plan. We need to make sure teammates know their responsibilities. We use it to help find weaknesses in plans and any resource gaps. We want to reinforce knowledge of procedures and resources.

When evaluating the six areas, things to consider:

Communication	<p>Did the centers phones work?</p> <p>Someone was in charge of making the contact with teammates and outside people?</p> <p>Were the phone numbers updated quarterly and correct?</p> <p>If phones were down, could you text or use social media to contact teammates?</p>
Equipment & Supplies	<p>Was the emergency kit available and in an appropriate location?</p> <p>Was the crash cart readily available and in an appropriate location?</p> <p>Were the supplies and equipment that were needed available and used safely?</p> <p>Did you have the equipment you needed to move patients?</p> <p>Any ideas on supplies that could have help with the emergency?</p> <p>Was personal protective equipment available and used?</p>
Security (staff and property)	<p>Did staff feel safe and know how to protect themselves and the patients?</p> <p>Was the building damaged and how will it be secured at the end of day?</p> <p>Did staff have their badges on to identify them to emergency personnel?</p>
Staff Knowledge	<p>Did they know their role for fire safety, evacuation, shelter in place, code blue?</p> <p>Did they know the meeting places, both inside and outside?</p> <p>Who makes the decision to evacuate or come back in the center?</p> <p>Where hazardous chemical involved, did staff know where to go for information?</p> <p>Who was assigned to let emergency personnel in the center?</p>
Utilities	<p>Shut off valves were labeled and teammates knew where they were?</p> <p>They knew how to shut off the utility systems?</p> <p>Would the emergency lighting be enough, does staff know where the flashlights are located in you have them?</p> <p>Would the situation involve the generator, does staff know what will run on generator power?</p>
Patient Clinical Activities	<p>Process for stopping treatment or procedure. Did you have what you needed?</p> <p>Can you get patients to a safe areas with no issues?</p> <p>Any medication issues?</p> <p>What clinical interventions happened during a utility system disruption?</p> <p>If services were interrupted, how did you continue ensure patient safety?</p> <p>If patients needed to be isolated, did you have what you needed?</p>

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PURPOSE:

- The purpose of the Organizational Patient Safety Plan at Sunset Pain Surgery Center at 9120 W Russell Rd Unit 100 Las Vegas, NV 89148 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 Sunset Pain Surgery Center.

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PATIENT SAFETY PROGRAM:

- Scope of Activities:
 - The scope of the Patient Safety Program includes an ongoing assessment, using internal and external knowledge and experience, to prevent error occurrence, maintain and improve patient safety. Patient safety occurrence information from aggregated data reports and individual incident occurrence reports will be reviewed by the Quality Assurance Committee to prioritize organizational patient safety activity efforts. Types of patient safety or medical/health care errors included in data analysis are:
 - No Harm Errors - those unintended acts, either of omission or commission, or acts that do not achieve their intend outcome - that do not result in a physical or psychological negative outcome, or the potential for a negative outcome, for the patient.
 - Mild-Moderate Adverse Outcome Errors - those unintended acts, either of omission or commission, or acts that do not achieve their intend outcome, that result in an identified mild to moderate physical or psychological adverse outcome for the patient.
 - Any Medication Error
 - Any Adverse Drug Reaction
 - Any Transfusion Reaction
 - Hazardous Condition - any set of circumstances, exclusive of the disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious physical or psychological adverse patient outcome.
 - 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

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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):
 - 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

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- Management of the Environment of Care
 - Surveillance, Prevention and Control of Infection
- Methodology:

The Interdisciplinary Quality Assurance Committee is responsible for the oversight of the Patient Safety Program.

 - **All departments** within the organization (patient care and non-patient care departments) are responsible to report patient safety occurrences and potential occurrences to the Safety Officer, who will aggregate occurrence information and present a report to the Quality Assurance Committee on a quarterly basis. The report will contain aggregated information related to type of occurrence, severity of occurrence, number/type of occurrences per department, occurrence impact on the patient, remedial actions taken, and patient outcome. The Quality Assurance 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 Quality Assurance Committee will select at least one high-risk safety process for proactive risk assessment annually. 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. Identify the possible effects of the undesirable variation on patients, and how serious the possible effect on the patient could be;
 - 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;

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- 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 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.
 - 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 Quality Assurance 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 Quality Assurance 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 staff responsible for the patient, carrying out any necessary physician orders. Staff will then preserve any physical evidence as appropriate, notify his/her immediate supervisor, document facts appropriately in the medical record and on an occurrence report - submitting the report to the Quality Assurance Committee per organizational policy.
 - ◆ Medication Errors - the staff member identifying a medication error (no harm and mild-moderate harm) will notify administration of the event.
 - Adverse Drug Reaction - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then preserve any physical evidence as appropriate, notify his/her immediate supervisor, document facts appropriately in the medical record and on an occurrence report - submitting the report to the Quality Assurance Committee per organizational policy. Staff will also notify administration.

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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 his or her supervisor and document the findings on an occurrence report. The occurrence report will be submitted to the Quality Assurance Committee per organizational policy.
- Sentinel Event - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then follow the organizational Sentinel Event Policy and Procedure.
- Near Miss - staff will report the near miss event to his/her immediate supervisor, describe the facts of the near miss on an occurrence report and submit the report to the Quality Assurance Committee.
- Established organizational policy (such as the Sentinel Event Policy) and/or the Quality Assurance 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 Quality Assurance Committee members, based on internal and external data analysis and prioritizing of patient safety criticality, will determine:
 - Further remedial action activities necessary for identified occurrences
 - Proactive occurrence reduction activities
 - Necessity and benefit of root cause analysis performance for identified occurrences or proactive reduction activities
- 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

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occurrences. A focus will be placed on remedial actions to assist rather than punish staff members, with the Quality Assurance Committee and the individual staff member's department supervisor determining the appropriate course of action to prevent error recurrence

- Sentinel Events - staff members involved in a sentinel event occurrence will receive support from the Quality Assurance Committee regarding the staff member's professional and emotional reconciliation of the sentinel event. The Quality Assurance Committee encourages the staff member's involvement in the root cause analysis and action plan processes, to allow the staff member an active role in process resolution. Additionally, any staff member involved in a sentinel event or other medical/health care error may request and receive supportive personal counseling from his or her department supervisor.
- On at least an annual basis, staff will be queried regarding their willingness to report medical/health care errors.
- 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.
- Patient safety reports from the Quality Assurance Committee will be submitted to the organizational Quality Assurance Committee, which exists as the oversight committee for the Quality Assurance Committee.
- 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.