2021 Sentinel Event Registry Patient Safety Plans

In accordance with **NRS 439.865**, each healthcare facility is required to develop an internal patient safety plan to protect the health and safety of patients who are treated at their healthcare facility.

The patient safety plan is to be submitted to the governing board of the facility for approval and the facility must notify all health care providers who provide treatment to patients in their facility of the plan and its requirements.

One hundred seven (107) patient safety plans were submitted from one-hundred-twenty-one (121) Annual Summary Reports filed, out of more than 1,800 facilities that are expected per NRS to file an annual summary sentinel event report.

The Division of Public and Behavioral Health has prepared a base template for the Patient Safety Plan to help guide those facilities that are unable to build their own Patient Safety Plan (PSP). Each facility is expected to incorporate appropriate content to fit their specific needs. **SER Patient Safety Plan Template**.

Sentinel Events Registry Website.

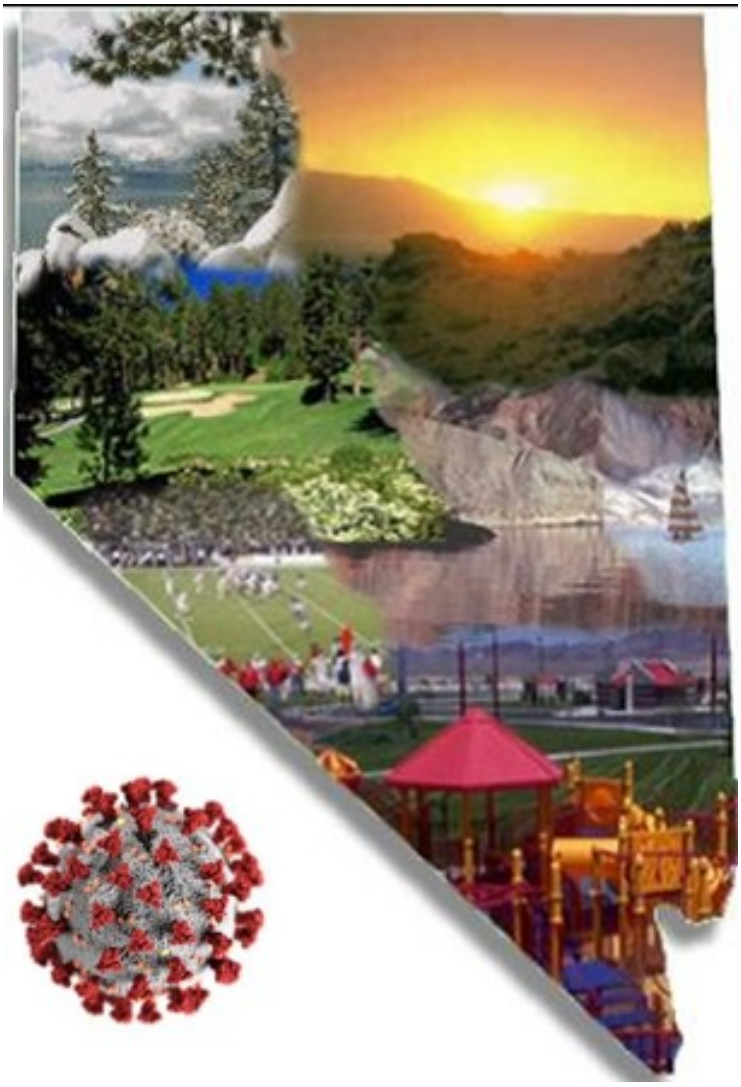
NOTE: This document is currently in the process of ADA remediation. We recognize that every page may not be ADA compliant during this process. If you have difficulty reading any portion of this document, please contact us at data@dhhs.nv.gov. We will prioritize your page(s) to make them ADA accessible, and if a page cannot be made accessible, we will work to make a text version available to you.

Steve Sisolak Governor State of Nevada

Richard Whitley, MS Director Department of Health and Human Services

Lisa Sherych Administrator Division of Public and Behavioral Health

Ihsan Azzam, PhD, MD Chief Medical Officer



Sentinel Events Registry Patient Safety Plans Cover Page and ADA Disclosure

Agency to Provide Nursing in the Home - Advanced Care Group LLC - 7936 - Las_Vegas

Agency_To_Provide_Nursing_In_The_Home__Caring_Nurses_Inc.__517__Las_Vegas

Agency_To_Provide_Nursing_In_The_Home__Golden_Home_Health_Nevada__6181__Las_Vegas

Agency_To_Provide_Nursing_In_The_Home__Mountain_Crest_Home_Health_Llc__5713__Las_Vegas

Agency_To_Provide_Nursing_In_The_Home__Nursecore__580__Las_Vegas

Agency_To_Provide_Nursing_In_The_Home__Positively_Kids__5551__Las_Vegas

Agency_To_Provide_Nursing_In_The_Home__Professional_Case_Management__9817__Las_Vegas

Agency_To_Provide_Nursing_In_The_Home__Signal_Health_Group_Inc.__9714__Las_Vegas

Agency_To_Provide_Personal_Care_Services_In_The_Home__Golden_Cross_Home_Care_Llc__5308__Las_Vegas

Agency_To_Provide_Personal_Care_Services_In_The_Home__Professional_Case_Management_Of_Nevada_Llc__9828__Las_Vegas

Agency_To_Provide_Personal_Care_Services_In_The_Home__Visiting_Angels__5291__Henderson

Facility_For_Hospice_Care__Procare_Hospice_Of_Nevada__10340__Las_Vegas

Facility_For_Skilled_Nursing__Marquis_Centennial_Hills__5691__Las_Vegas

Facility_For_Skilled_Nursing__Marquis_Plaza_Regency__9879__Las_Vegas

Facility_For_Skilled_Nursing__Sierra_Ridge_Health_And_Wellness_Suites__8656__Reno

Home_For_Individual_Residential_Care__Jesusa_Dela_Cruz_Residential_Care__6312__Sparks

Hospice_Care_-_Program_Of_Care__Comprehensive_Hospice_Care_Llc.__9455__Las_Vegas

Hospice_Care_-_Program_Of_Care__Nathan_Adelson_Hospice1111__5575__Henderson

Hospital__Carson_Tahoe_Continuing_Care_Hospital__5213__Carson_City

Hospital__Carson_Tahoe_Regional_Medical_Center__4466__Carson_City

Hospital__Centennial_Hills_Hospital_Medical_Center__5086__Las_Vegas

Hospital__Desert_Parkway_Behavioral_Healthcare_Hospital_Llc__7579__Las_Vegas

Hospital__Desert_Springs_Hospital_Medical_Center_641_Las_Vegas

Hospital__Desert_Willow_Treatment_Center__2128__Las_Vegas

Hospital__Dini-Townsend_Hospital_At_Nnamhs__652__Sparks

Hospital__Encompass_Health_Of_Desert_Canyon__4531__Las_Vegas

Hospital__Encompass_Health_Rehabilitation_Hospital_Of_Henderson__3190__Henderson

Hospital__Encompass_Health_Rehabilitation_Hospital_Of_Las_Vegas__656__Las_Vegas

Hospital__Harmon_Hospital__647__Las_Vegas

Hospital__Henderson_Hospital__8436__Henderson

Hospital__Horizon_Specialty_Hospital__644__Las_Vegas

Hospital__Horizon_Specialty_Hospital__7261__Henderson

Hospital__Kindred_Hospital_Las_Vegas_Flamingo__3368__Las_Vegas

Hospital__North_Vista_Hospital__649__North_Las_Vegas

Hospital__Northern_Nevada_Medical_Center__653__Sparks

Hospital__Pam_Health_Specialty_Hospital_Of_Las_Vegas__9962__Las_Vegas

Hospital__Pam_Health_Specialty_Hospital_Of_Sparks__9976__Sparks

Hospital__Pam_Rehabilitation_Hospital_Of_Centennial_Hills__8682__Las_Vegas

Hospital__Rawson_Neal_Psychiatric_Hospital_At_Southern_Nevada_Adult_Mental_Health_Services__661__Las_Vegas

Hospital__Reno_Behavioral_Healthcare_Hospital__8764__Reno

Hospital__Renown_Regional_Medical_Center__669__Reno

Hospital__Renown_Rehabilitation_Hospital__657__Reno

Hospital__Renown_South_Meadows_Medical_Center__2373__Reno

Hospital__Saint_Mary'S_Regional_Medical_Center__658__Reno

Hospital__Southern_Hills_Hospital_And_Medical_Center__3641__Las_Vegas

Hospital__Spring_Valley_Hospital_Medical_Center__3420__Las_Vegas

Hospital__St._Rose_Dominican-_Rose_De_Lima_Campus__659__Henderson

Hospital__St._Rose_Dominican_San_Martin_Campus__4576__Las_Vegas

Hospital__St._Rose_Dominican-_Siena_Campus__2969__Henderson

Hospital__Summerlin_Hospital_Medical_Center__662__Las_Vegas

Hospital__Sunrise_Hospital_And_Medical_Center__639__Las_Vegas

Hospital__University_Medical_Center_Of_Southern_Nevada__666__Las_Vegas

Hospital__Valley_Hospital_Medical_Center__667__Las_Vegas

Hospital__Willow_Springs_Center__671__Reno

Hospital_Mountainview_Hospital_640_Las_Vegas

Nursing_Pool__Trustaff_Travel_Nurses_Llc__9322__Las_Vegas

Outpatient_Facility__Green_Valley_Fertility__7848__Henderson

Outpatient_Facility__Sdmi_Limited_Partnership__6123__Las_Vegas

Outpatient_Facility__Sdmi_Limited_Partnership__6124__Las_Vegas

Outpatient_Facility_Cure_4__The_Kids_Foundation_9330__Las_Vegas

Residential_Facility_For_Groups__Golden_Manor__6389__Reno

Residential_Facility_For_Groups__Golden_Manor_Serenity__10513__Reno

Residential_Facility_For_Groups__Graceful_Living__7914__Reno

Residential_Facility_For_Groups__Holy_Child_Residential_Care_Home__3879__Reno

Residential_Facility_For_Groups__Holy_Child_Residential_Care_Iv__4582__Reno

Residential_Facility_For_Groups__Holy_Family_Home_Care__3658__Sparks

Residential_Facility_For_Groups__Kryston'S_Homecare__3266__Reno

Residential_Facility_For_Groups__Little_Angel_Care_Home__178__Reno

Residential_Facility_For_Groups__Little_Angel_Care_Home__4740__Sparks

Residential_Facility_For_Groups__Longevity_Residential_Care__7479__Reno

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Residential_Facility_For_Groups__Park_Place_Assisted_Living__333__Reno

Residential_Facility_For_Groups__Providence_Home_Care__6028__Reno

Residential_Facility_For_Groups__Sierra_Manor_Care_Home__3275__Reno

Residential_Facility_For_Groups__Sofia'S_Home__8989__Sparks

Residential_Facility_For_Groups__South_Meadows_Residential_Care_Home__8743__Reno

Residential_Facility_For_Groups__Vista_Adult_Care_4501_Sparks

Rural_Hospital__Banner_Churchill_Community_Hospital__638__Fallon

Rural_Hospital__Boulder_City_Hospital__633__Boulder_City

Rural_Hospital__Carson_Valley_Medical_Center__3986__Gardnerville

Rural_Hospital__Desert_View_Hospital__8696__Pahrump

Rural_Hospital__Grover_C._Dils_Medical_Center__643__Caliente

Rural_Hospital__Humboldt_General_Hospital__645__Winnemucca

Rural_Hospital__Incline_Village_Community_Hospital__646__Incline_Village

Rural_Hospital__Mesa_View_Regional_Hospital__3818__Mesquite

Rural_Hospital__Mt_Grant_General_Hospital__651__Hawthorne

Rural_Hospital__Northeastern_Nevada_Regional_Hospital__642__Elko

Rural_Hospital__Pershing_General_Hospital__655__Lovelock

Rural_Hospital__South_Lyon_Medical_Center__660__Yerington

Rural_Hospital__William_Bee_Ririe_Critical_Access_Hospital__670__Ely

Surgical_Center_For_Ambulatory_Patients__Affinity_Surgery_Center__7871__Las_Vegas

Surgical_Center_For_Ambulatory_Patients__Ambulatory_Surgical_Center_Of_Southern_Nevada__5334__Las_Vegas

Surgical_Center_For_Ambulatory_Patients__Carson_Endoscopy_Center__5368__Carson_City

Surgical_Center_For_Ambulatory_Patients__Coronado_Surgery_Center__5381__Henderson

Surgical_Center_For_Ambulatory_Patients__Durango_Outpatient_Surgery_Center__4784__Las_Vegas

Surgical_Center_For_Ambulatory_Patients__Eye_Surgery_Center_Of_Northern_Nevada__4848__Reno

Surgical_Center_For_Ambulatory_Patients__Institute_Of_Orthopaedic_Surgery__3303__Las_Vegas

Surgical_Center_For_Ambulatory_Patients__Lake_Tahoe_Surgery_Center__1888__Zephyr_Cove

Surgical_Center_For_Ambulatory_Patients__Parkway_Surgery_Center__2147__Henderson

Surgical_Center_For_Ambulatory_Patients__Reno_Endoscopy_Center__484__Reno

Surgical_Center_For_Ambulatory_Patients__Seven_Hills_Asc__3011__Las_Vegas

Surgical_Center_For_Ambulatory_Patients__South_Meadows_Endoscopy_Center__4914__Reno

Surgical_Center_For_Ambulatory_Patients__Southwest_Medical_Ambulatory_Surgery_Center__487__Las_Vegas

Surgical_Center_For_Ambulatory_Patients__Southwest_Medical_Ambulatory_Surgery_Center_At_Tenaya__8704__Las_Vegas

Surgical_Center_For_Ambulatory_Patients__Stonecreek_Surgery_Center__5309__Las_Vegas

Surgical_Center_For_Ambulatory_Patients__Sun_Valley_Surgery_Center_Llc__7591__North_Las_Vegas

Surgical_Center_For_Ambulatory_Patients__Sunset_Pain_Surgery_Center__9677__Las_Vegas

Surgical_Center_For_Ambulatory_Patients__Surgery_Center_Of_Reno__461__Reno

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Surgical_Center_For_Ambulatory_Patients_Ear_Nose_Throat_Surgery_Center_8003_Las_Vegas

ADVANCED CARE GROUP, LLC
EMERGENCY PREPAREDNESS PLAN
2021-2022

Advanced Care Group, LLC will plan accordingly for the following emergencies:

1. Power Outage
2. Earthquake
3. Drought
4. Excessive Heat
5. Flash Floods
6. Terrorism (Active Shooter)

SAMPLE Individual Patient Emergency Preparedness Plan

Identifying Information

Patient Name:_____ SOC Date:_____

Phone Number:_____ Physician:_____

Address:_____

City:_____ State:_____ Zip:_____

Relevant Healthcare Information

Primary Dx:_____ Secondary Dx:_____

Daily or more frequently Agency Services: No___ Yes____

If Yes, describe:_____

Oxygen dependent: Flow Rate_____ Hours of Use:_____ Delivery Device:_____

Life-Sustaining Infusion: No____ Yes____

If Yes, describe:_____

Other IV Therapy: No____ Yes____

If Yes, describe:_____

Patient/caregiver Independent: No____ Yes____

Ventilator Dependent: No____ Yes____

Dialysis: No____ Yes____

If Yes, describe:_____

Tube Feeding: No____ Yes____

If Yes, describe:_____

Patient/caregiver Independent with Self-Administered Medications: No____ Yes____

Functional Disabilities (check all that apply): ____Walker/cane ____Wheelchair ____Bedbound

____Hearing Impairment ____Visual Impairment ____Mental/Cognitive Impairment

Emergency Plan

Emergency Contact Name:_____ Phone Number:_____

If necessary, patient will evacuate to: Relative/Friend/Shelter

(Name/PhoneNumber):_____

Hotel (Name/PhoneNumber):_____

Shelter (Location):_____

Is patient registered for special needs shelter? No____ Yes ____

Other (Describe):_____

Priority/Acuity Level:_____

_____

Clinician/Date

*Copy to patient and original on medical record.

2022

SECTION IV: EMERGENCY PREPAREDNESS ADVANCED PLANNING

1. Agency Emergency Preparedness Assessment

Advanced Care Group conducts a thorough Emergency Preparedness Assessment on an annual basis to determine the readiness of the Agency and associated supplies/provisions within the Agency that will be utilized to manage a crisis or disaster situation.

An adequate supply of emergency items and equipment is maintained in appropriate quantities and in accordance with all applicable regulations to accommodate the needs of patients and staff for emergency situations requiring evacuation or sheltering-in-place. Supplies and equipment will be stored in clearly designated locations and easily accessible during a crisis or disaster situation.

Emergency Medical Supplies

	Number of Supplies Needed	Total Number of Supplies on 1/2022 (date)	Total Number of Supplies on ____ (date)	Total Number of Supplies on ____ (date)	Total Number of Supplies on ____ (date)
A FIVE- TO SEVEN-DAY SUPPLY WILL BE MAINTAINED AS APPLICABLE:					
First Aid Supplies	2	2			
Band-Aids					
Gauzes and Bandages	7	7			
Alcohol/Hydrogen Peroxide	2	2			
Neosporin / Ist Aid Ointment	12	12			
Disposable Gloves	2 boxes	500 pcs			
Disposable Gowns	2	2			
Surgical Masks	1 box				
Eyewash Saline Solution	8	8			
Incontinence Products	0	0			
Barrier Cream	1	1			
Sanitizing Wipes	1				
Hand Sanitizer					
Catheter Supplies	8	8			
Ostomy Supplies	0	0			
Sterile 4x4s	1 box	35 pcs			
Alcohol/Peroxide	2 boxes	400 pkgs			
First Aid Tape	2	2			
Syringes	5	5			
Kling/Ace Bandages	4	4			
Normal Saline	8	8			
Face Shield	4	4			

SECTION IV: EMERGENCY PREPAREDNESS ADVANCED PLANNING

Emergency Equipment and Supplies

	Number of Supplies Needed	Total Number of Supplies on (date)	Total Number of Supplies on (date)	Total Number of Supplies on (date)	Total Number of Supplies on (date)
LOCATION OF EMERGENCY EQUIPMENT AND SUPPLIES:					
Flashlights and Batteries	2	2			
Portable Radio, NOAA Radio, and Batteries	1	1			
Non-Electric Can Openers	~~0~~	~~0~~			
Coolers	~~0~~	~~0~~			
Duct Tape	2	2			
Garbage Bags for Sanitation	50 pcs	50			
Cleaning Disinfectant Solutions	4	4			
Approved Heavy-Duty Extension Cords	1	1			
Fire Extinguishers	2	2			
Extra Sleeping Provisions (Pillows, Blankets, etc)	~~0~~	~~0~~			
Toilet Paper					
Hand-Washing Soap	4	4			
Two-way Radios	2	2			
Storage Bags-Red Bags	10	10			
Self-Illuminating Light Sticks	2	2			
Box Cutters, Packing Tape, and String	1	1			
Writing Utensils, Note Pads, Scissors, and Tape	4,4,2,2	4,4,2,2			
Cleaning Materials, including bleach, sponges, mops, rags, etc.	1 bleach	1			
Analog Telephone	1	1			
Cell Phone Battery Charger	1	1			
Wound Cleanser	2	2			
Universal Drsg	1 box	100			
Syringe 10mL	5	5			

SECTION IV: EMERGENCY PREPAREDNESS ADVANCED PLANNING

Emergency "Go Box"

Advanced Care Group will establish an Emergency "Go Box" and shall place it in a secure location, so the Administrator and/or Incident Commander can have immediate access to it in an emergency situation. The "go-box" should contain at least the following items:

Emergency Go Box Items for Agency	
Boxes are located:	
✓	Item
✓	Cell phone
✓	Cell phone charger
✓	Additional keys for the Agency
✓	Emergency key contacts list and phone numbers
✓	List of employees and contact numbers
	Copies of the Agency floor plans (enlarged)
✓	N95 Masks/Latex gloves

2. Employee Emergency Preparedness

Advanced Care Group ensures that information for all staff members are updated at least annually. This information includes telephone numbers, emergency numbers, and their plans and family arrangements during an emergency situation.

Advanced Care Group will attempt to accommodate immediate family members of staff members as best it can during a shelter-in-place situation at Agency.

Sheltering staff members and their immediate families bring the following items with them to Agency:

- Sleeping bags/air mattresses.
- At least two changes of clothing.
- Toiletries.
- Prescription medications.
- Flashlights and extra batteries.
- Special items for children and pets.

3. Crisis Public Relations – Staff, Patients and Community

In advance of an impending crisis or disaster situation, it is important for Advanced Care Group staff members, patients, family members, and the community-at-large to understand that the Agency has developed a relationship with local emergency responders as well as the Clark County Emergency Management Agency to properly plan for, prepare for, respond to and recover from such situations.

Advanced Care Group has designated an individual to adequately educate staff and other applicable members/organizations within the community to understand that the Agency has initiated a comprehensive program to address issues pertaining to emergency preparedness and planning in order to lessen its perceived burden on the community.

2.38 SAFETY-PATIENT/CLIENT SETTING

Purpose:

To ensure a safe home environment for the patient/client and his/her family/caregivers as well as for the Agency staff member

Policy:

The safety of the home will be evaluated and corrective action taken. Safety education will be provided to the patient/client and family.

Procedure:

1. A Home Safety Checklist will be completed during the initial home visit. Unsafe conditions should be reported immediately to the Director or designee and a corrective action plan developed with the patient/client and family.
2. Instruct patients/clients and family upon admission and as needed in basic home safety including but not limited to: methods for preventing falls, use of equipment, correct performance of tasks, care and disposal of hazardous waste and fire/emergency safety procedures.
3. Instruct the patient/client to have emergency telephone numbers for the police, fire department, and poison control center along with a neighbor's number readily available near the phone where they can be easily seen.
4. Appropriate emergency back-up systems will be documented and in place as needed, i.e. contacting public utility companies of home ventilator patients/clients.
5. The 24 hour on call telephone number to access Agency staff will be provided to the patient/client and family.
6. Patient/client related safety hazards will be documented in the clinical record.
7. All accidents or injuries will be reported to the Agency Administrator, documented on the Variance Occurrence document and reviewed by the Quality Improvement Committee.

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2.39 HOME SAFETY GUIDELINES

Environmental:

1. Maintain clear passage ways in every room of your home and on steps.
2. Avoid the use of throw rugs as they contribute to tripping and falls.
3. Keep your home well lit. This practice enhances safety as you move from room to room.
4. Use exterior lights at night. Burglars are least likely to enter your home when outside lights are on.
5. Use a bath mat or other nonskid material in your bathtub to avoid falls. Add grab bars and use bath benches if necessary to aid mobility.

Emergency Response:

1. Have a plan in case fire strikes your home. Consider possibilities of fire in various parts of your home. Where will you exit? Where will you meet?
2. Avoid smoking in bed.
3. Keep emergency telephone numbers for fire, ambulances, and police at or on every telephone.

Electrical Safety:

1. Cover electrical outlets to prevent children from inserting objects.
2. Check electrical cords for wear. Do not use cords that are frayed or have exposed wires. Be sure to check the junction between the cord and plug.
3. Ground all three-pronged plug adapters.
4. Check heating pads for cracks prior to use. Do not use if present.

Medication:

1. Store all medications out of reach of children.
2. Secure all caps on medication bottles.
3. Store syringes behind a closed door and do not talk about the fact that you have syringes in your home.
4. Never expose medications to sunlight. (This precaution also applies to injectable medications, such as insulin.)

Oxygen:

1. Place a "No Smoking" placards on all entrances to your home. These placards are provided by the oxygen agency.
2. Do not use more than 50 feet of tubing between the oxygen source and the patient/client.

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3. Do not place oxygen tanks within 1-1/2 feet of windows or doors.
4. Roll the tubing and carry it to avoid tripping and falling when walking.
5. Do not have open flames, such as pilot lights of gas stoves or water heaters, within 12 feet of any oxygen equipment. (This warning also applies to the tubing.)

Place the number of your Electric Company on or at every telephone. Call if there is a power outage.

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2.40 HOME SAFETY ASSESSMENT

In order to alert the patient/client and caregiver on home safety measures in order to minimize the hazard risk in the home, the Agency performs a home safety assessment which includes environmental mobility and bathroom safety risks as a part of the patient/client's admission process and annually home safety will be assessed on an ongoing basis.

1. The admitting RN or therapist will explain the home safety assessment to the patient/client and/or caregiver and perform the assessment, including giving any recommendations or comments for improvements.
2. Patient/client handouts discussing home safety measures will be left in the home folder.
3. The home safety assessment will be repeated as needed.

ADVANCED CARE GROUP, LLC

SECTION IV: EMERGENCY PREPAREDNESS ADVANCED PLANNING

The following persons will be the official spokesperson with alternates designated:

Name/Contact Information	Title	Department
Moses Irubor	Administrator	Admin
Ma. Virginia Pagdanganan	Director of Nursing	Clinical
Arlene Hernandez	Intake	Clinical

In advance of a crisis or disaster scenario that may require the Agency to evacuate or shelter-in-place at Agency and present media and public relations issues/concerns, the following points will be considered:

- Identify standardized ways of disseminating information (regular briefings, scheduled press conferences, etc.), as well as what to release, when to release it, whom to release it to and why to release information.
- Appropriate training shall be provided to anyone in the organization who may deal with the media or perform public relations duties.
- Appropriate training will be provided to all employees to clearly define responsibilities and limitations regarding contact with the media and the release of information as part of the employees' conditions of employment.
- Factors that should be considered when releasing information should balance:
    - Protection of the privacy, health, and welfare of patients.
    - When the information cannot be released, the release should be refused with an explanation. If delays are encountered, the media should be so advised.
    - Addressing the public's need for information and reassurance, including:
        - Methods of apprising the public of the situation.
        - Anticipated "next steps."
        - Coordination of messages to patients, physicians, and staff members.

4. Communication with Patients and Family Members

Ebony HHA maintains emergency contact numbers in addition to primary telephone numbers for patient and family members.

Staff members are briefed on the following elements to share with patients and family members as assigned:

- Type of emergency.
- Estimated time and severity of impact.
- General outlook at the current time.
- Expected disruptions to services.
- When to expect updated status reports.
- What the patients and family members can do to help with patient's care.

5. Emergency Communications

Advanced Care Group will establish methods of communicating both internally and externally during a crisis or disaster situation. Traditional communication systems may not be available (failure) or may be overwhelmed (overload) during such a critical event.

SECTION IV: EMERGENCY PREPAREDNESS ADVANCED PLANNING

Examples of alternate communication methods are cellular phones (possibly cellular phones with outside area codes), satellite phones (both of which may not always be reliable), Internet (if computer systems are operable), two-way radios and CB or Ham radios. Mass notification systems are another option.
Advanced Care Group has identified and secured Cell phone as the primary communication method for internal usage in the event of a disaster event.

2-way radio has been designated as the alternate and supplemental method of internal communication in the event the primary system is inoperable.

Cell Phone has been identified as the primary means of external communication in the event of a disaster.

2-way radio has been designated as the alternate and supplemental method of external communication in the event of a disaster.

6. Agency Communication Plan

A. The Agency has developed and maintains an emergency preparedness communication plan that complies with federal, state and local laws. The communication plan is reviewed and updated at least annually. The communication plan includes the following:

- Names and contact information for the following:
  - Staff.
  - Entities providing services under arrangement or contract.
  - Patients' physicians (available in a printed list or on computer system).
  - Volunteers, if applicable.
- Contact information for the following:
  - Federal, state, tribal, regional or local emergency preparedness staff.
  - Other sources of assistance.
- Primary and alternate means for communicating with the Agency's staff, federal, state, tribal, regional and local emergency management agencies:
  - During an emergency, staff will primarily communicate by telephone or cellular phone. When no internal or external means of communication exists, available staff should report to the command structure at the Agency as soon as feasible for assignment. The Director of Clinical Services and Managers are ultimately responsible for assuring continuation of service.
  - Alternate means of communication may include: radio and television announcements, pagers, NOAA weather radios and in-person coordination with applicable emergency management agencies by the Administrator or Director of Clinical Services.
- A method for sharing information and medical documentation for patients under the Agency's care, as necessary, with other health care providers to maintain the continuity of care:
  - If a patient has to be transferred to another setting, the Agency will provide relevant information and medical documentation about the patient in compliance with HIPAA regulations. Such information may be provided by telephone or in person and may include:
    - Patient name, age, date of birth, allergies, current medications, advance directives, next of kin and medical diagnoses.
- A means of providing information about the general condition and location of patients under the Agency's care as permitted under law and regulation.
  - The Administrator or Director of Clinical Services will provide such information by telephone or in person.
- A means of providing information about the Agency needs, and its ability to provide assistance, to the authority having jurisdiction (local and state emergency management agencies, local and state public health departments, Emergency Operations Center, the Incident Command Center or designee).

2022

SECTION IV: EMERGENCY PREPAREDNESS ADVANCED PLANNING

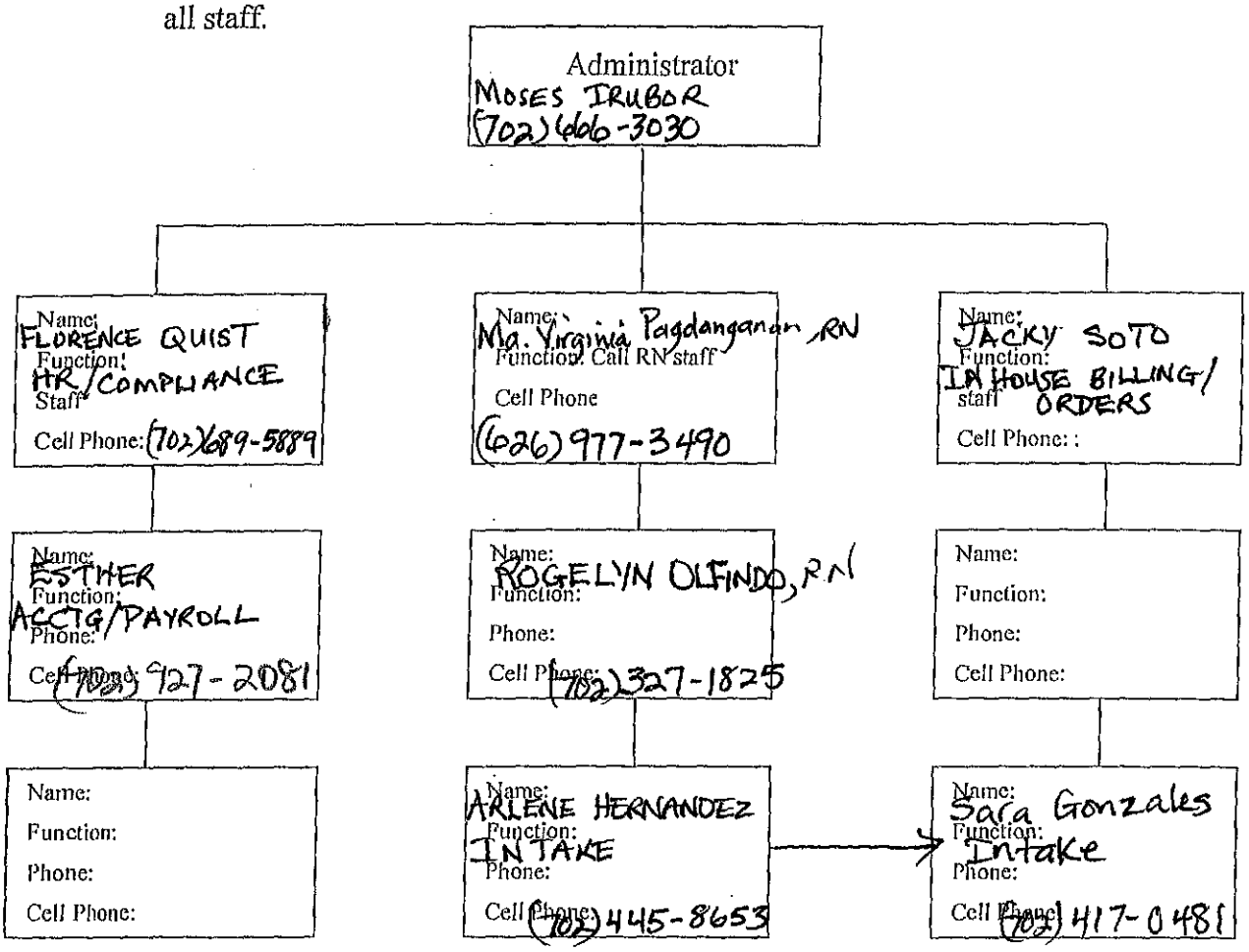
Communication Plan: Other Sources of Assistance Contact Information

1. Federal emergency preparedness staff (list names and telephone numbers).
   - _____
   - See attached
   - _____
   - _____
2. State emergency preparedness staff (list names and telephone numbers).
   - _____
   - _____
   - _____
   - _____
3. Tribal emergency preparedness staff (list names and telephone numbers).
   - _____
   - _____
   - _____
   - _____
4. Regional emergency preparedness staff (list names and telephone numbers).
   - _____
   - _____
   - _____
   - _____
5. Local emergency preparedness staff (list names and telephone numbers).
   - _____
   - _____
   - _____
   - _____
6. Other Sources of emergency preparedness assistance (list names and telephone numbers including hospitals and nursing homes for use if patient transfers are required).
   - _____
   - _____
   - _____
   - _____

Emergency Phone Tree

Use this phone tree to identify people you will need to contact, such as your spokespersons, partners, and safety and health officials. Share this contact information with your crisis communication team.

- Limit the number of people each person must call.
- Leave a message for unavailable contacts. The caller should continue down the phone tree and continue attempting contact with unavailable persons.
- Each unit should have provisions for getting the information to a person who was not contacted.
- The last person called should report back to a designated person to signal the end of the calling process.
- Keep the message short and concise. Only the facts should be given and each caller should avoid speculation. Confidentiality should be stressed.
- Update the phone tree at least annually to insure accurate phone numbers and inclusion of all staff.



SECTION I: INTRODUCTION TO THE EMERGENCY PREPAREDNESS PLAN

5. Key Contacts Information

Complete all information for the following key contacts.

Administrator
Name: Moses Irubor
Contact Number(s): (281) 235-3417

Assistant Administrator
Name: In the absence of Administrator = The DON
Contact Number(s):

Director of Clinical Services
Name: Ma. Virginia Pagdanganan
Contact Number(s): (626) 977-3490

Clinical Manager
Name: Ma. Virginia Pagdanganan / Arlene Hernandez - Intake
Contact Number(s) (626) 977-3490 (702) 445-8653

Staff Development Coordinator
Name: Florence Quist / Arlene Hernandez
Contact Number(s): (702) 445-8653

Business Office Manager / Payroll
Name: Esther Dadson-Hamilton
Contact Number(s): (702) 826-8781

Maintenance Director
Name: Haarsch / Shmitzer Property Mgmt
Contact Number(s): (725) 500-3785

Human Resources Director
Name: Florence D. Quist
Contact Number(s): (702) 689-5889

Safety/Security Director
Name: Virginia Pagdanganan
Contact Number(s): (626) 977-3490

Environmental Director
Name: Property Mgmt
Contact Number(s): (725) 500-3785

Other Staff Positions

SECTION I: INTRODUCTION TO THE EMERGENCY PREPAREDNESS PLAN

Name/Title: Jackelin Ibarra / Billing
Contact Number(s): (702) 771-8077
Name/Title:
Contact Number(s):
Name/Title:
Contact Number(s):
Name/Title:
Contact Number(s):

Medical Director
Name: David Rosenstein
Contact Number(s): (702) 242-2737

Division of Health Service Regulation
Name: Bureau of Healthcare Quality and Compliance
Contact Number(s): (775) 684-1030

Police
Name of Contact: Cpt. Gregory Munson - Airport Bureau
Contact Number(s): (702) 828-3111 Email: MetroPDAirport@lvmpd.com

Fire
Name of Contact: 7525 Dean Martin Dr, LV, NV 89139
Contact Number(s): 911 Station #24

EMS
Name of Contact: AMR Las Vegas
Contact Number(s): (702) 384-3400

Emergency Management County Coordinator
Name:
Contact Number(s): (702) 455-7311 or (702) 455-5710, Email: Oem@clarkcountynv.gov

Alternate Agency/Relocation Sites
Name of Agency/Relocation Site: 3530 E. Flamingo Rd, Suite 105, LV, NV 89121
Contact Name: Moses Irubor / Zhanna Irubor
Contact Number(s): (702) 399-7154

SECTION I: INTRODUCTION TO THE EMERGENCY PREPAREDNESS PLAN

Transportation

Name of Transportation Company: Medlife Transportation - Handicapped
Contact Name: (702)648-8000
Contact Number(s):
Name of Transportation Company: Medical Transportation - Nevada 211
Contact Name:
Contact Number(s): 211 or 1-866-535-5654, Text 898211
Name of Transportation Company: GMTCare - Non Medical
Contact Name:
Contact Number(s): (702)979-9696

Electric Company

Name: NV Energy
Contact Name: Outages and Emergencies
Contact Number(s): (702)402-2900
Account Number(s): Through property Mgmt

Gas Company

Name: Southwest Gas
Contact Name:
Contact Number(s): 1 877-860-6020

Telephone

Name: Cox Communication
Contact Name:
Contact Number(s): (702)383-5054

Cell Phone Provider

Name: 1-mobile
Contact Name:
Contact Number(s): 1(800)937-8997

Medical Supplies

Name: Independent Medical
Contact Name:
Contact Number(s): 1 800-860-8027 Ext 4211

SECTION I: INTRODUCTION TO THE EMERGENCY PREPAREDNESS PLAN

6. Succession of Command

Advanced Care Group has developed the following list of specific key personnel based on job title to clearly identify the order of succession of command. The Succession of Command structure considers the Agency's ability to manage and direct an emergency situation during normal hours of operation as well as during nights and weekends.

	Succession of Command
1.	Name: Moses Irubor Job Title: Administrator Contact Information: 281-235-3417
2.	Name: Ma. Virginia Pagdanganan Job Title: Director of Nursing Contact Information: (626)977-3490
3.	Name: Rogelyn Olfindo Job Title: RN Contact Information: (702)824-3277
4.	Name: Arlene Hernandez Job Title: Intake Coordinator Contact Information (702)445-8653

7. Incident Command Post

The Incident Command Post is a designated area where the Incident Commander, management team, and other staff members convene to review the situation and develop tactics and strategies to manage the incident. Advanced Care Group has determined Parking Lot Post Road the Incident Command Post during an emergency or disaster situation.

If the disaster occurs in the designated Incident Command Post, the alternate Incident Command Post is the Across Street of Post Rd In the event that both Incident Command Post locations are involved in the emergency, the Incident Command Post is determined by the Emergency Management/Fire/EMS personnel and/or evacuation site.

If an Incident Command Post cannot be established and maintained within the Agency due to a hazardous condition inside of the building, an alternate/remote Incident Command Post outside of the Agency is established at Town Square Parking Lot on Sunset

The emergency preparedness program includes but is not limited to, the following elements:

- The Agency has developed and maintains an emergency preparedness plan and policies that are reviewed and updated at least annually. The plan:
  - Is based on and includes a documented, agency-based and community-based risk assessment, utilizing an all-hazards approach.
  - Includes strategies for addressing emergency events identified by the risk assessment.

CLARK COUNTY

EMERGENCY PREPAREDNESS

GUIDE

BROUGHT TO YOU BY:

NEVADA STATEWIDE EVACUATION, MASS CARE, AND SHELTERING IN PLACE INITIATIVE

FUNDED BY:

U.S. DEPARTMENT OF HOMELAND SECURITY

EM
PUBLIC SAFETY, PUBLIC TRUST

NEVADA STATEWIDE EVACUATION PLANNING

WELCOME MESSAGE FROM NV-DEM:

This brochure, funded through the U.S. Department of Homeland Security, is the result of statewide participation from public safety officials and first responders in addressing "Evacuation and Mass Care" preparedness. It is developed to provide helpful tips and techniques in preparing your family, friends and pets for emergency conditions.

While it is difficult to envision a catastrophic event of such magnitude that it would require the evacuation of an entire jurisdiction within Nevada, we do commonly experience such events as wildland fires, floods, severe storms, hazardous materials incidents and the potential for earthquakes. These events, if significant, could prompt public safety officials to ask residents to temporarily relocate to established shelters. In addition to our state's residents, Nevada also has a large number of visitors at our convention centers and resort hotels everyday. Further, our state must be prepared to host evacuees from neighboring states.

Moving large numbers of citizens and visitors throughout our jurisdictions is often difficult even under normal circumstances. Knowing that evacuations can be potentially dangerous, our preferred method is to have citizens shelter-in-place recognizing that there may be occurrences when it is safest to evacuate.

The development of this brochure was completed with the intent to provide a general guide for you in developing your own personal emergency plans. The shelters and routes listed for your reference have been selected by public safety officials and have been tested successfully in small-scale incidents and exercises. However, recognizing that the circumstances surrounding each incident is unique, specific guidance on shelter locations and routes will commonly be issued through the media and emergency public notification systems during an incident.

I hope you will find this information useful as you prepare your personal emergency plan, assemble a disaster supplies kit and assist other family and friends.

Thank you,

Frank Siracusa, Chief
Nevada Department of Public Safety
Division of Emergency Management

IMPORTANT INFORMATION:

ANY LIFE THREATENING EMERGENCY CALL 911

Phone Numbers

Non-emergency Police	Boulder City	311 or 293-9224
	Henderson	311 or 267-5000
	Las Vegas	311 or 229-3111
	Mesquite	311 or 702-346-5262
	North Las Vegas	311 or 633-9111
Non-Emergency Fire	Boulder City	293-9228
	Clark County	455-7311
	Henderson	267-2222
	Las Vegas	383-2888
	Mesquite	702-346-2690
	North Las Vegas	633-1102
Offices of Emergency Management	Boulder City	293-9228
	Clark County	455-5710
	Henderson	267-2212
	Las Vegas	383-2888
	Mesquite	702-346-2690
	North Las Vegas	633-1125
American Red Cross		791-3311
F.B.I.		385-1281
Secret Witness		385-5555

9-1-1 VS. 3-1-1 WHAT'S THE DIFFERENCE?

Call 9-1-1 When You . . .
- See fire.
- Smell smoke or gas.
- See or hear an explosion.
- See or have a need for medical assistance.
- See a suspicious person enter/leave a secured area.
- See a person with a weapon.
- See a suspicious package in a public area.
- See someone being forcibly detained or taken.
- Or anytime you see or become aware of an immediate threat to life and/or property.

Call 3-1-1 When You . . .
- Hear someone planning a crime.
- Hear someone making verbal threats about future acts.
- Hear someone discussing or bragging about a past crime.
- Receive a suspicious letter or package.
- Or anytime to report a past or future threat to life and/or property.

GET INFORMED AND MAKE A FAMILY PLAN

In the midst of rushing through everyday life, it is important to take a minute to prepare for emergencies. Being prepared helps you and your family minimize the impact of a disaster such as an earthquake or an emergency such as a broken leg. Knowing what to do is your best protection and your responsibility. The best way to make your family and your home safe is to be prepared before disaster strikes.

- In our area we have the potential of disasters from earthquakes, wildland fire, and weather related emergencies. Take time to plan for the problems related to each type of disaster.
- If you have pets make a pet plan. Animals may not be allowed inside emergency shelters due to health regulations.
- Find out how to help elderly or disabled person in your home or neighborhood.
- Ask about disaster plans at your workplace, your children's school or daycare center and other places where your family spends time.

MAKE A FAMILY EMERGENCY PLAN

- *Meet with household members* – Explain the dangers to children and work with them as a team to prepare your family to deal with emergencies.
- *Discuss* what to do about power outages and personal injuries.
- *Post emergency telephone numbers* near telephones.
- *Learn* how to turn off the water, gas and electricity at your home.
- *Decide where to meet* – in the event of an emergency; you may become separated from family members. Choose a place right outside your home in case of a sudden emergency, like a fire. Choose a location outside your neighborhood in case you cannot return home.
- *Choose an "out-of-town" contact* – Ask an out-of-town friend or relative to be your contact in the event of a disaster. Everyone must know the contact's phone number. It is often easier to make a long distance phone call than a local call from a disaster area.
- *Teach children* how to make long distance telephone calls.
- *Complete a family communications plan* – Your plan should include contact information for family members, work and school.
- *Escape routes and safe places* – In a fire or other emergency, you may need to evacuate very quickly. Be ready to get out fast. Be sure everyone in your family knows the best escape routes out of your home as well as where the safe places are in your home for each type of disaster. Draw a Home Family Escape Plan with your family outlining 2 escape routes from each room.

EVACUATE OR SHELTER IN PLACE:

EVACUATION –

MAKE A PLAN IF YOU MUST LEAVE YOUR HOME

- *Begin evacuation immediately* when the official warning is issued. Your life might be in danger so do not waste time in leaving your home.
- *Have a place to go*-home of a family member or friend, or a shelter. Plan your route before the disaster.
- *Listen to the AM radio* for updates of the situation.
- *Notify family or friends* of your plans if possible. Tell them when you are leaving and where you are going.
- *Use travel routes* specified by local officials (see attached map for routes). Know where you are going before you leave.
- *Bring extra cash.* Banks may be closed, ATMs may not work.
- *Take your disaster supplies kit.*
- *Secure and lock* your home before you leave.
- *Bring* toys, books and games for entertainment.
- *If driving in smoke,* turn on headlights and move as far to the right as possible and drive slowly.
- *When you arrive* at a shelter make sure you register with official personnel.
- *Don't panic,* drive slowly and arrive safely at your destination.

SHELTER –

MAKE A PLAN IF YOU MUST STAY AND SHELTER IN PLACE.

- *Have your disaster* supplies kit in hand, including pet supplies.
- *You need to store at least a three-day* supply of water for each person in your household. Stored water should be changed every six months.
- *Notify family or friends* of the situation if possible.
- *Work with neighbors* to develop a neighborhood plan that keeps everyone informed.
- *Listen* to your battery operated radio for emergency updates.
- *Once you have decided to stay,* remain in your home until the emergency is over.

EAS RADIO STATIONS –

KXTE 107.5 FM

KNPR 88.9 FM

EVACUATION AND SHELTER IN PLACE PLAN:

- *Learn* about any warning systems where you live and work. Your local emergency planning committee or office of emergency services can give you information about the sirens, such as when they are tested and for how long.
- *Prepare* a shelter-in-place kit appropriate for the type(s) of emergencies that could occur near you. The kit should contain duct tape for sealing cracks around doors and windows; plastic (preferably, precut to size) to cover windows; a battery-operated AM/FM radio; flashlight with fresh batteries; bottled water; towels; toys for young children; candles; matches; first-aid kit; medicine and other items essential for your family's survival. Check the kit every six months to make sure all the supplies are still there and that they are fresh.
- *The room* should have a telephone although you should use it only for emergency calls. If you use it otherwise, you may be taking up a line needed by emergency response officials.
- *Find* out which radio, television and cable systems in your area broadcast emergency information.
- *Learn* CPR and first-aid.
- *For a place to shelter,* select a room in your house that has few or no windows.
- *Make sure all family* members know what to do in a chemical emergency whether they are at home, school, work or outdoors.
- *Review* your plan periodically and conduct drills.
- *Turn on a radio* or television to a local station that broadcasts emergency information. Stay tuned until the "all clear" message is broadcast.
- *Stay off of the phone.* It should be used for emergency calls only.
- *Be prepared* to evacuate if ordered to do so by public safety officials. Evacuation instructions will be announced over the emergency broadcast system.

SHELTER LOCATIONS:

The Clark County Office of Emergency Management and Homeland Security facilitates shelter activation. The Clark County School District and the Southern Nevada Chapter of the American Red Cross coordinate Sheltering operations. Clark County School District and the American Red Cross have identified middle and high-schools as primary shelters for the County.

In addition to the Clark County School District facilities, the following facilities can be activated as shelters during large-scale or regional emergencies: Thomas and Mack Center; Cashman Field; Las Vegas Convention Center; Las Vegas International Speedway; and, Sam Boyd Silver Bowl. These facilities have also been identified as potential Casualty Collection Points in Appendix C of the Clark County Multi-Jurisdictional Mass Casualty Plan.

KID'S ACTIVITY SURVIVAL KIT

You may have to leave your home during a disaster. It is a good idea to put together your own activity kit so they will have things to do and share with other children. May we suggest you pack:

- A few favorite books, toys and board games.
- Crayons, pencils, sharpeners, and plenty of paper.
- Scissors & glue.
- Favorite stuffed animals, blankets and/or pillows.
- Pictures of family pets.

If an evacuation is needed in your community, you might hear about it during a routine radio or television news broadcast or, through the Emergency Alert System (EAS) which broadcasts critical information on local radio and television stations and local cable providers as well as on NOAA Weather Radios. Where available, officials might use telephone notification systems such as Reverse 911 or community sirens. Sometimes officials will go door-to-door, in which case they will have proper identification so that you will know the evacuation order is accurate.

The evacuation order message will be brief and include basic instructions on what to do and possibly some information about the threat. There may not be enough time for a lot of details so it is important to follow the instructions as quickly as possible. Then, look for more information from local radio or television stations over battery powered receivers or car radios.

When an evacuation involves a school, school officials will work with the local media to inform parents about when and where to pick up their children. If available, school officials will also use a telephone notification system to inform parents about the evacuation.

When the emergency that led to evacuation order is over, officials will provide information to the local media and to the agencies operating local shelters about the conditions for returning to the area. You may be able to return home without any restrictions but in some cases, there may be damage to roads or other travel problems. Utility services such as electricity or telephone may not be available. In some cases, officials may determine that the damage is so extensive that you can't stay in the area for any length of time. You may have a chance to determine the condition of their property and possibly search for and retrieve belongings. No matter what the situation is, the official instructions for returning to the area are developed to keep you safe.

The EAS Local Primary stations in Nevada are the "entry points" for warning messages about local or regional emergencies. These stations will be the first to broadcast these warnings. All other radio and television stations and cable operators in Nevada participate in the Emergency Alert System although they may not carry all local or regional warnings. You should contact your favorite radio or television station or cable provider and ask them about their level of participation in the Emergency Alert System.

The National Weather Service also carries EAS messages on their NOAA Weather Radio stations in Nevada. If you are considering a weather radio, be sure it has the "Public Alert" function. That means it has a setting that will sound an alarm if an EAS activation has been issued, even if it is turned off. NOAA Weather Radio can be heard in Nevada on 162.400 MHz, 162.425 MHz, 162.450 MHz, 162.475 MHz, 162.500 MHz, 162.525 MHz and 162.550 MHz.

The EAS Local Primary Stations

In an emergency tune to: KXTE 107.5 FM
KNPR 88.9 FM

TERRORISM:

TERRORISM

Terrorism is defined as the unlawful use of violence, or the threat of it, to scare or intimidate people or governments.

There are four general types of terrorism:

Conventional – such as bombing or hijacking
Chemical – use of poisons or chemicals (nerve gas)
Biological – use of bacterias, viruses or other harmful organisms
Radiological – use of nuclear or radiological materials.

Terrorists tend to strike targets that are highly populated (large cities, airports, tourist attractions, major events), business centers (government buildings, financial districts, military bases, transportation, or power plants) and institutions (schools, hospitals).

Terrorist incidents usually happen without warnings. Here are some safety tips:

- *If you are in public,* be aware of your surroundings. Know where emergency exits are.
- *Never leave shopping bags* or luggage unattended.
- *Stay calm.* Exit a public place as soon as it is safe to do so. Do not try to rescue people in a public building.
- *If at home,* stay alert and listen for instructions given on the radio or television. Have a plan in case you are told to evacuate or to shelter in your home.

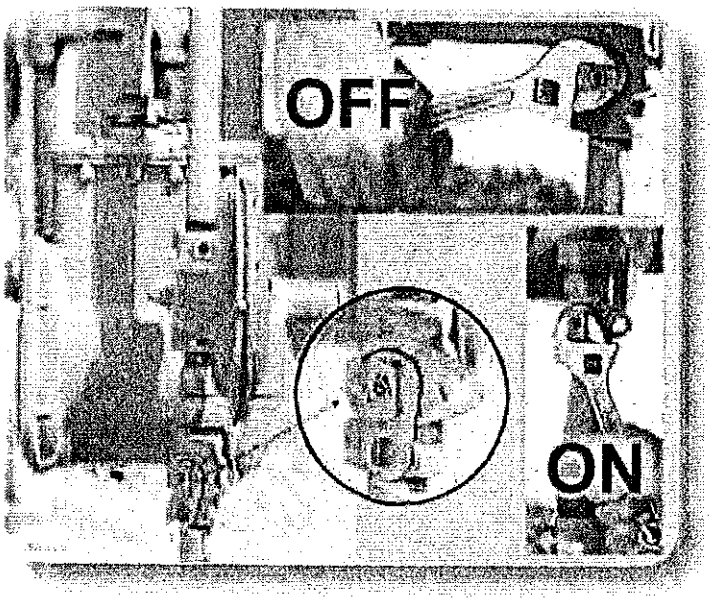
Talk to your children about the subject. Avoid stereotyping. Explain that only a few "bad" people are behind terrorist attacks. Let them know that they are safe and that your family is prepared if anything happens.

You may never be impacted by a terrorist incident but it pays to be aware. Let common sense be your guide.

HOW TO TURN OFF GAS:

Make sure all family members know how and when to shut off the gas supply.

- *If you smell gas* after an earthquake, shut off the main gas valve.
- *Use a wrench* to turn the valve either way until it is perpendicular to the pipe.
- *Attach the wrench* to the gas meter with a wire.
- *Be aware* that once your gas is turned off, it is advisable to contact your gas provider when it is time to turn the gas back on because all of the pilot lights will need to be relit.



WHAT TO EXPECT IN AN EARTHQUAKE

During an earthquake the "solid" earth moves like the deck of a ship. The actual movement of the ground 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. Earthquakes may also trigger landslides, cause fires and disrupt utilities.

BEFORE AN EARTHQUAKE

- *Check you home for potential hazards.* Place large and heavy objects on lower shelves. Securely fasten shelves to walls. Brace or anchor high or top-heavy objects. Strap water heaters to keep them from falling.
- *Know where and how to shut off electricity, gas, and water* at main switches and valves. Have the proper tools close by so that there is no delay when it is time to shut off the utilities.
- *Hold occasional drills* so each member of your family knows what do in an earthquake.
- Have your Disaster Supply Kit *ready and accessible.*

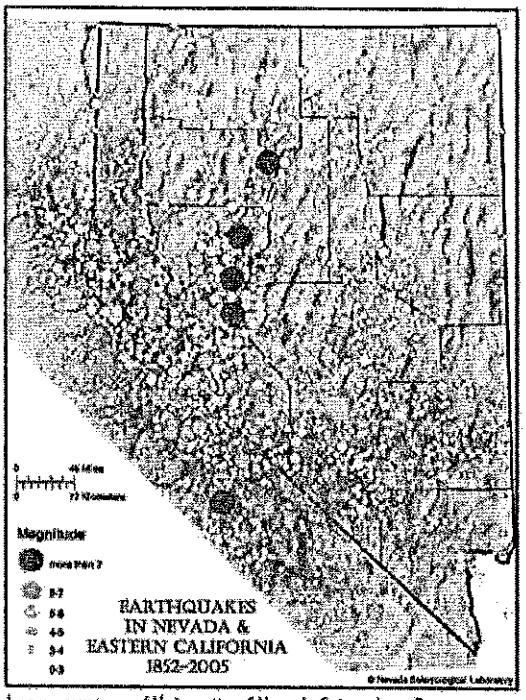


Image courtesy of University of Nevada Seismology Department

WHAT TO DO DURING AN EARTHQUAKE

- *First and foremost, stay calm.* Think through the consequences of any action you take.
- *If you are inside, stay inside;* take cover under a heavy desk or table. Stand under a supported doorway or along an inside wall away from any windows.
- *If you are outside stay there;* stay away from tall buildings, look up and watch for falling objects. If you are in a moving car, safely stop the car and remain inside.

WHAT TO DO AFTER AN EARTHQUAKE

- *Check yourself and people nearby for injuries.* Provide first aid if needed. Be prepared for additional earthquake shocks called "aftershocks". These are smaller than the main shock, some may be large enough to cause additional damage or bring weakened structures down.
- *Check gas, electric, and water lines.* If damaged, shut off valves. Turn off appliances. Do not light matches or candles. Check for natural gas leaks by odor only. If a gas leak is detected, open all windows and doors. Leave immediately and do not reenter the building until a utility official says it is safe.
- *Check your home for damage;* approach chimneys with caution. If there is any question of safety leave your home and do not reenter until the item can be checked. Open any closet and cupboards cautiously due to falling objects.
- *Do not flush toilets* until sewer lines are checked.
- *Check with neighbors* to see if your assistance is needed.

Wildland fires continue to be the largest threat to Nevada. During a fire emergency, safety of lives is the number one priority. In order for the Fire District to effectively work to control the fire or protect homes, it is best if citizens are safely evacuated. Your life is the highest importance and if you, your family and neighbors are in a safe place, the responders have accomplished the most important goal.

WHAT TO EXPECT DURING A WILDLAND FIRE.

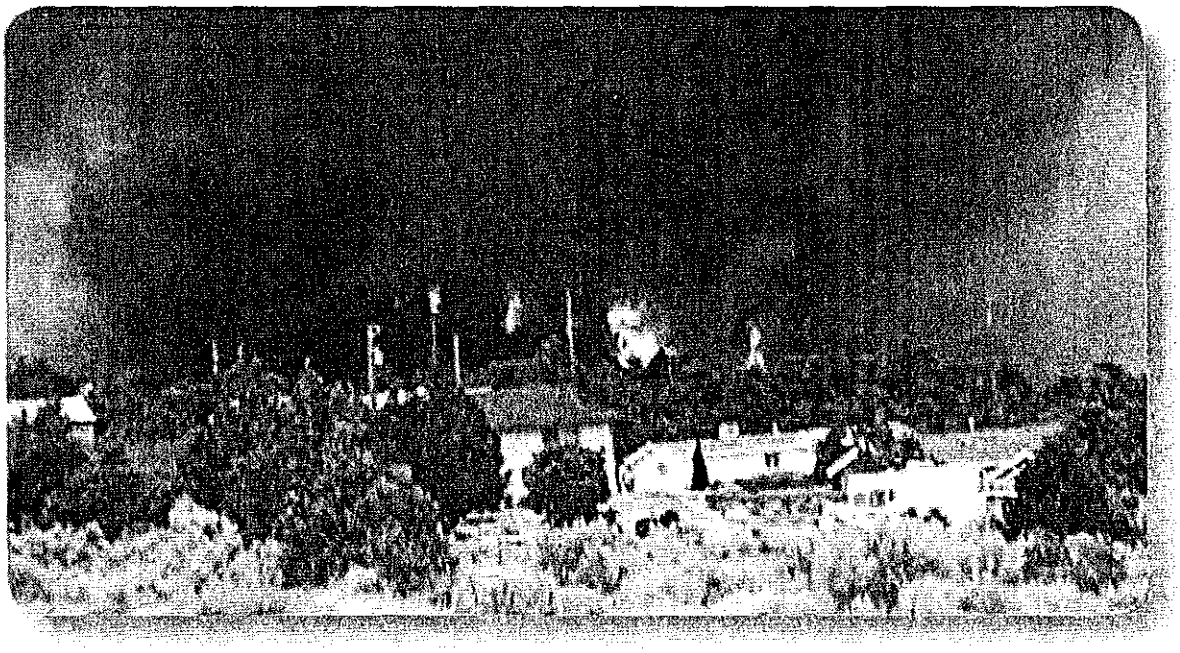
- *Wildland fires can start and move very quickly.* Smoke and embers will be moved by the wind created by the fire. The situation can change in minutes. Listen to the radio or television for updates and be ready to leave if necessary.

BEFORE A WILDLAND FIRE OCCURS

- *Preparation is key to a successful evacuation* and now is the time to plan on what you are going to do if ordered to leave your home. Plan your evacuation route and if possible, map out at least two routes out of your neighborhood. Have your evacuation kit and necessary items in a known location and ready to go.

DURING A WILDLAND FIRE

- *Stay calm and do not panic.* You will think more rationally if you remain calm. Keep family members and pets together. Wear long pants, long sleeved shirts made from natural fibers, and boots or sturdy shoes for protection from heat. If advised to evacuate, DO SO IMMEDIATELY. Drive slowly, turn on your vehicle headlights and stay as far to the right of the road as possible.
- *If evacuation routes are blocked* you will be required to stay in your home during the fire. If you shelter in place, stay away from windows, move to an interior room or hallway. If the house does catch fire there will still be time to get out. Do not try to leave until after the fire has passed and you can safely drive to a shelter location.



WHAT TO EXPECT DURING A FLOOD EVENT

Flash floods, abundant rain, and rain-on-snow events are the three types of flood phenomena that occur throughout the state. In many places these events cause small creeks to overflow and homes in low lying areas can experience some localized flooding.

BEFORE A FLOOD

› *Check drains and drainage* to divert water away from your home. Build barriers and landscape around your home or buildings to reduce or stop floodwaters and mud from entering. Seal lower walls with waterproofing compounds and install "check valves" in sewer traps to prevent flood water from backing up into drains.

DURING A FLOOD

› *Listen for updates from the radio and television.* Know the location for sandbags and sand. Move valuables out of the path of water or mud. Contact local authorities and notify them of the location of the flooding. If necessary, turn off utilities before problems escalate.

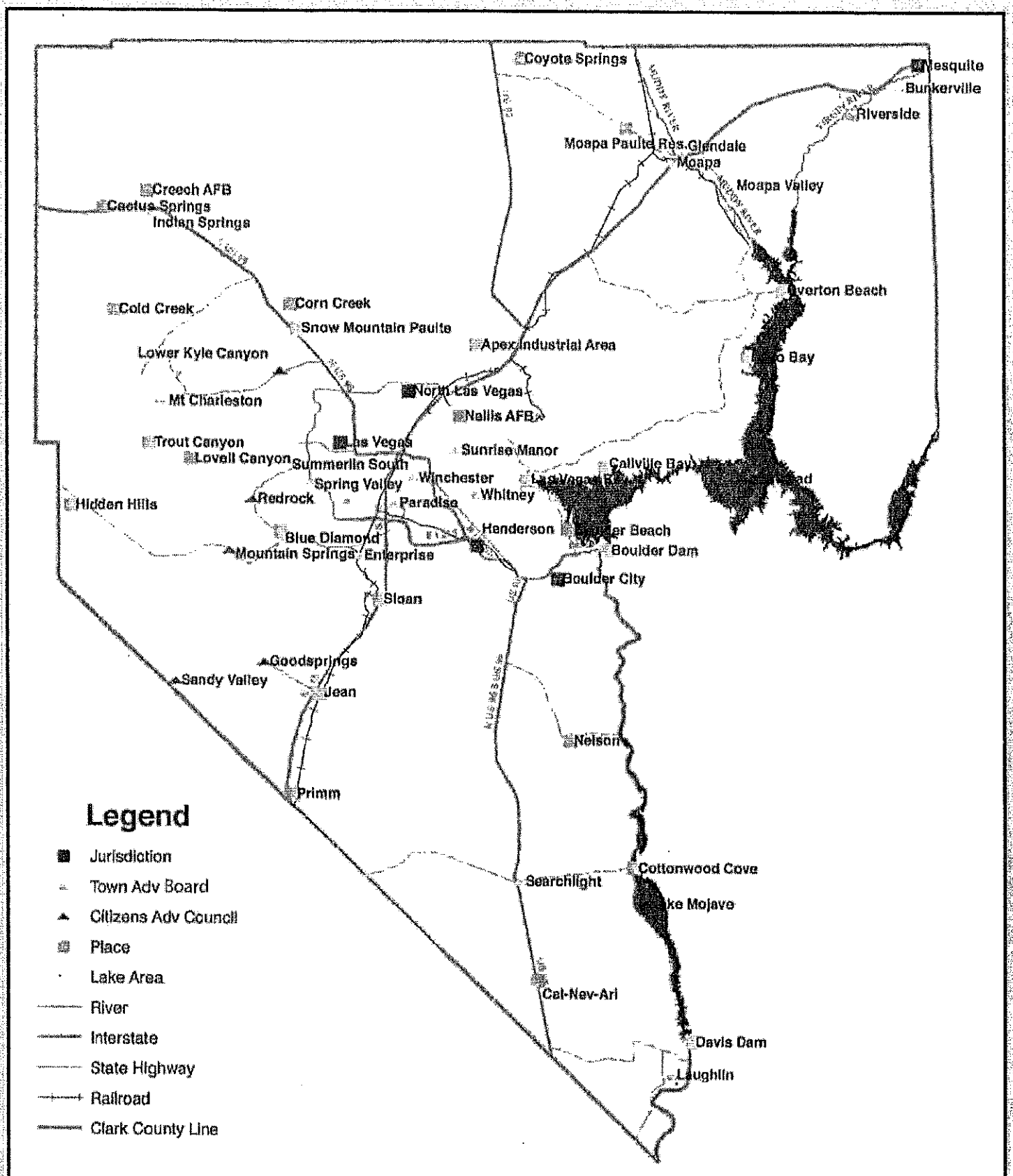
› *If water is diverted* check with neighboring property to insure that additional damage is not occurring.

Photo courtesy Truckee River Flood Project

AFTER THE FLOOD

› *Prior to entering a building, check for structural damage.* Make sure it is not in danger of collapsing. Watch for electrical shorts or live wires before making certain that the main power switch is turned off. Remove all floodwaters from under structures as soon as possible.

Photos courtesy Truckee River Flood Project


Coyote Springs
Mesquite
Bunkerville
Riverside
Moapa Paiute Res
Glendale
Moapa
Moapa Valley
Creech AFB
Cactus Springs
Indian Springs
Cold Creek
Corn Creek
Snow Mountain Paiute
Apex Industrial Area
Lower Kyle Canyon
Mt Charleston
North Las Vegas
Nellis AFB
Trout Canyon
Lovell Canyon
Las Vegas
Sunrise Manor
Summerlin South
Spring Valley
Winchester
Whitney
Paradise
Redrock
Hidden Hills
Henderson
Blue Diamond
Mountain Springs
Enterprise
Boulder Beach
Boulder Dam
Boulder City
Sloan
Goodsprings
Sandy Valley
Jean
Nelson
Primm
Searchlight
Cottonwood Cove
Cal-Nev-Ari
Davis Dam
Laughlin
Legend
Jurisdiction
Town Adv Board
Citizens Adv Council
Place
Lake Area
River
Interstate
State Highway
Railroad
Clark County Line
0 5 10 20 Miles
Date: March 5, 2007
This information is for display purposes only. No liability is assumed as to the accuracy of the data delineated herein.
Clark County Communities
Clark County, Nevada
Vicinity Map - No Scale

PANDEMICS:

FLU PANDEMICS

A flu pandemic is when a new flu strain starts spreading quickly around the world. Depending on the strength of the strain, it can cause many people to become severely ill or die. It may cause a short supply of food, goods, and services if many workers stay at home or travel is restricted. Medical services will certainly become overwhelmed.

The flu spreads mainly through coughing and sneezing. People can also leave the virus on things they touch if they have flu germs on their hands.

Catching the flu from an infected animal is rare, but if pandemic flu (like Avian Flu) evolved so it could infect humans, it could start a pandemic.

Flu pandemics have happened before. Experts believe that another pandemic is likely. Flu viruses are easily spread. With modern travel, viruses can circle the globe faster than ever.

Take steps to help avoid getting or spreading flu germs:

- Wash your hands often and well
- Cover coughs and sneezes
- Don't share personal items
- Teach children how to protect themselves
- Thoroughly cook meat, poultry, and eggs
- Get available flu shots
- Check the news. Officials will announce a pandemic and provide instructions
- Support "common good" efforts. Authorities may make decisions in a pandemic to restrict gatherings (Schools, movies, sporting events, etc) or asking people stay home. It is important to support these decisions.

To learn more about pandemic flu, go to www.pandemicflu.gov

EXTREME HEAT:

WEATHER RELATED EXTREME HEAT

Temperatures that hover 10 degrees or more above the average high temperature and last for several weeks are defined as extreme heat conditions.

Heat disorders occur because a person has been overexposed to heat, has over-exercised, or has been exposed to high temperatures and poor air quality. Children, the elderly, and individuals with medical problems are at greatest risk when exposed to extreme heat.

Some things you can do to protect yourself and others from extreme heat are:

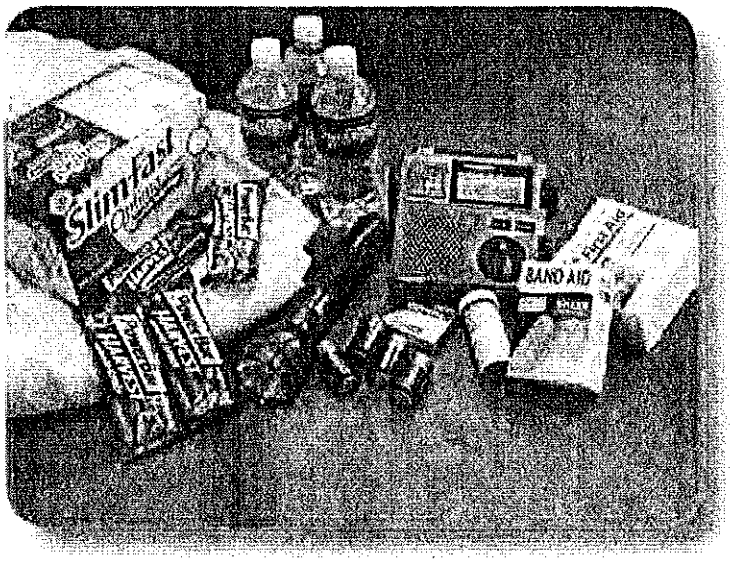
- Stay indoors. If air conditioning is not available, stay on the lowest level out of the sunshine.
- Drink plenty of water. People with medical conditions should consult their doctors before significantly increasing their liquid intake.
- Limit intake of alcoholic beverages.
- Dress in loose fitting, lightweight and light colored clothes that cover as much skin as possible.
- Wear a wide brimmed hat to protect the face and head.
- Avoid too much sunshine and use sunscreen with a high SPF rating.
- Reduce, eliminate or reschedule strenuous activities. Get plenty of rest to allow your natural "cooling system" to work.

PREPARE A DISASTER SUPPLIES KIT

PREPARE A DISASTER SUPPLIES KIT

Prepare for at least three days. The best time to assemble a disaster supplies kit is well before you need it. Most of these items are already in your home, it is matter of assembling them before a disaster occurs.

- Water – 1 gallon per person per day. Store water in unbreakable containers. Identify the storage date and replace every 6 months.
- Food – A supply of non-perishable packaged or canned foods with a can opener.
- Anti-bacterial hand wipes or gel.
- First Aid Kit- a first aid book and required prescription medications.
- Blankets or sleeping bags- at least one per person.
- Battery-powered radio, flashlight, and plenty of extra batteries.
- Fire extinguisher – ABC type.
- Credit cards and cash and change.
- An extra set of car and house keys.
- Extra pair of eyeglasses.
- Toothbrush, toothpaste, shampoo and toilet paper.
- A list of family physicians.
- List of important family information; phone numbers.
- Special items for infants, elderly, or disabled family members.



SANITATION SUPPLIES

- Large plastic trash bags for waste, tarps and rain ponchos.
- Large trash cans.
- Bar soap and liquid detergent.
- Household bleach.
- Rubber gloves.

Stocking up now on emergency supplies can add to your family's safety and comfort during and after a disaster. Store enough supplies for at least three days, preferably seven days.

WEATHER TERMS:

IS IT A WATCH OR IS IT A WARNING?

A watch is intended to provide lead time for those who need to set their plans in motion. A watch means that hazardous weather is possible in and close to the watch area.

A warning means that weather conditions pose a threat to life or property; people in the path of the hazard need to take protective action.

These terms are used for Thunderstorms, Flashfloods, and Floods:

WINTER STORMS – WATCHES & WARNINGS

- *Winter Storm Watch* – Conditions are favorable for hazardous winter weather conditions including heavy snow, blizzard conditions, significant accumulations of freezing rain or sleet, and dangerous wind chills. The watches are usually issued 12 to 36 hours in advance.
- *Winter Storm Warning* – Hazardous winter weather conditions that pose a threat to life and/or property are occurring, imminent, or likely. The term winter storm warning is used for a combination of two or more of the following winter weather events: heavy snow, freezing rain, sleet, and strong winds. The following event-specific warnings are issued for a single weather hazard: blizzard warning, heavy snow warning, ice storm warning.
- *Snow Advisory* – Snowfall roughly ½ the amount required for a winter storm warning.

EVACUATION TERMS:

- *Exclusion Zone* – An area established by the commander in charge of the disaster scene into which entry is temporarily forbidden due to extreme danger. Only official responder vehicles are allowed entry until the situation is deemed safe again for private vehicle traffic.
- *Evacuation Advisory* – An advisory is issued when there is reason to believe that the emergency will escalate and require mandatory evacuations. An advisory is meant to give residents as much time as possible to prepare transportation arrangements.
- *Voluntary Evacuation* – Is used when an area is going to be impacted and residents are willing and able to leave before the situation gets worse. This is helpful for residents with medical issues, people with pets, and those who will have difficultly making travel arrangements.
- *Mandatory Evacuation* – In the state of Nevada, the governor has the authority to order mandatory evacuations. If this ever occurs, you MUST leave the area IMMEDIATELY, your life is in danger. Under these circumstances the situation is severe and you may not have time to gather special belongings or paperwork, every minute you delay could increase your danger. Please do not take this order lightly; it is for your safety. Remember to follow any instruction you receive from a law enforcement officer or fire official.

GENERAL EMERGENCY PREPAREDNESS

An emergency can happen anytime. You and your co-workers should know what to do if an emergency happens at work. Even if you think you are not in a disaster-prone area, something like a chemical tanker truck overturning or a flood can prevent you from getting to or from work. No business should operate without a disaster plan. If you are a business owner developing a business disaster plan, consider how the disaster could affect your employees, customers and the workplace. Consider how you could continue doing business if the area around your facility is closed or streets are impassable. Consider what you would need to serve your customers if your facility closed.

EMPLOYEES SHOULD:

- Learn and practice emergency plans.
- Know at least two exits from each room (if possible).
- Be able to escape in the dark by knowing, for instance, how many desks or cubicles are between your workstation and two of the nearest exits.
- Know the post-evacuation meeting location.
- Know the location of fire extinguishers and how to use them.
- Keep a copy of co-workers phone numbers at home.
- Make a list of important personal numbers. Keep a printed list at your desk or near other phones. Do not rely on electronic lists, direct-dial phone numbers or computer organizers that may not work in an emergency.
- Gather personal emergency supplies in a desk drawer: include a flashlight, walking shoes, dust mask, a water bottle and non-perishable food.
- Report safety system damage or malfunctions.
- Never lock or block fire exits or doorways. However, keep fire doors closed to slow the spread of smoke and fire.
- Make specific plans to help each other. Determine how you will help each other in the event that public transportation is shut down or throughways are impassable. Offer to temporarily house, transport or feed your co-workers in case of emergency.

EMPLOYERS SHOULD:

- Ensure that an emergency plan is developed and practiced at least every six months.
- Make specific plans for employees who are disabled or who may require assistance during an emergency.
- Put together an office phone tree. Develop a list of everyone's home phone numbers and who is responsible for making each contact. Provide a copy for each employee.
- Keep a phone list of all key employees with you at all times.
- If you have a voice mail system, designate one remote number on which you can record messages for employees and provide them the number.
- Arrange for programmable call forwarding for your main business lines.
- Leave keys and the alarm codes with a trusted employee or friend in case you cannot get to your facility.
- Backup computer data frequently.
- Purchase a NOAA Weather Radio with a tone alert system.

PRESERVING YOUR FAMILY DOCUMENTS

In a disaster where you might have to leave your home quickly, important documents may be left behind and ultimately destroyed. Before the emergency occurs, decide which records are most essential to you and your family. One factor to consider is how readily a lost record could be replaced. Loss of some records could result in major financial damage (like tax records), or would be irreplaceable (like family photographs and historical documents).

The following is a list of the documents you should safeguard and be able to retrieve quickly to take with you:

- Licenses or other ID's.
- Social Security Cards.
- Passports.
- Medical history information and health insurance cards.
- Immunization records.
- Birth, marriage and death certificates.
- Records of bank accounts.
- Credit card information.
- Insurance policies.
- A list of important or valuable belongings.
- Wills, contract, deeds.
- Records of stocks, bonds or retirement accounts.
- Back up of key computer files.

In order to ensure that you can quickly retrieve these documents, it is suggested that you:

- Keep these documents (or copies of these documents) in a water or fire proof container with your disaster kit.
- Keep them in a safe place away from home, like a safe deposit box.
- Be sure trusted family members know where these items can be found.

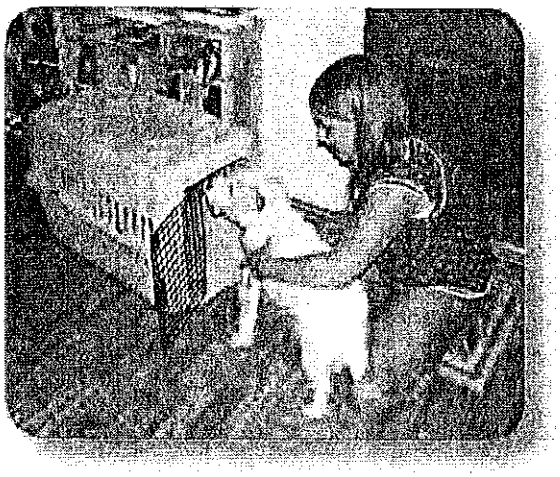
There are many ways to prepare your essential records for an emergency. Whatever method you use, remember to keep your records updated. At the very least, choose one day each year to make certain they are current and ready to evacuate.

SPECIAL NEEDS POPULATIONS: DEVELOP A PET PLAN:

DEVELOP A PET PLAN

In the event of a disaster, if you must evacuate, the most important thing you can do for your pets is to evacuate them too. If you are away from you home when your neighborhood is evacuated you will not be allowed back to retrieve you pet, so make arrangements with neighbors before a disaster strikes.

- Make sure that your *pets are current on their vaccinations.* Pet shelters may require proof of vaccines.
- Keep a *collar with identification* on your pet and have a leash on hand to control your pet.
- If possible have a properly-sized *pet carrier for each animal.*
- Have a supply of *food, water and any required medications.*



Animals brought to a pet shelter are required to have a proper identification collar, and all belongings (leash, food bowl and food, water, and their medications).

SPECIAL NEEDS AND VULNERABLE POPULATIONS

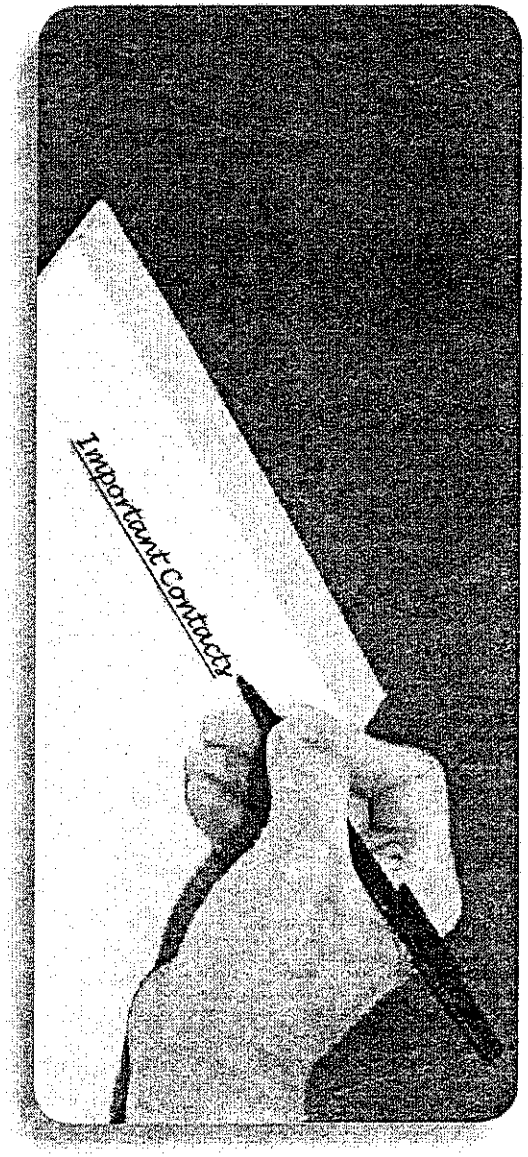
Certain individuals in the community may have special problems to deal with in a disaster, including the elderly, people with medical problems, and people with certain disabilities (mobility, visually impaired, hard of hearing, developmental or cognitive disabilities). If you have a family member who is one of these individuals, there are special considerations to think about and plan for before a disaster occurs.

- *If the family member has medications or equipment* that they are dependent on, plan to bring those items with you if an evacuation is necessary. Shelters will not have additional medication or medical equipment available. Documentation about insurance and medical conditions should also accompany the person.
- *Plan ahead for transportation needs* for family members with special needs. Transportation for the general public in an emergency evacuation may not be suitable for their situation.
- *If the family member has special dietary needs,* bring these special foods and supplements with you.
- *Many special needs populations* are easily upset and stressed by sudden and frightening changes. Plans should be made to ensure that a caregiver or trusted family member is able to stay with them at all times during an evacuation.

YOUR PERSONAL EVACUATION PLAN

Spend a few minutes and write a detailed plan below of what you plan to do when an emergency happens, and include *your* evacuation route:

YOUR IMPORTANT CONTACTS:



CLARK COUNTY
OFFICE OF EMERGENCY MANAGEMENT &
HOMELAND SECURITY
P.O. BOX 551713
500 S. GRAND CENTRAL PKWY., 6TH FLOOR
LAS VEGAS, NEVADA 89155-1713
(702) 455-5710 OFFICE
(702) 455-5718 FAX

CARING NURSES, INC.

(800) HOMECARE (466-3227)

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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CARING NURSES, INC.

(800) HOMECARE (466-3227)

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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CARING NURSES, INC.

Our Name Says Who We Are

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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 beans and extra batteries
- Place security lights in each room to light paths of travel.

Assistive Devise 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 devise.

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.

    - 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.

    - 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.

GOLDEN
HOME HEALTH NEVADA, LLC
3750 S. Jones Blvd. Suite 160 Las Vegas, NV 89103-2209
Office: (702) 778-8365 Fax: (702) 778-3368

GOLDEN HOME HEALTH NEVADA LLC

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PATIENT SAFETY PLAN

***

3750 S. JONES BLVD SUITE 160 LAS VEGAS NV 89103

<><>2022<><>

GOLDEN
HOME HEALTH NEVADA, LLC
3750 S. Jones Blvd. Suite 160 Las Vegas, NV 89103-2209
Office: (702) 778-8365 Fax: (702) 778-3368

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(EC)

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Safety Management Program

POLICY

The Agency Administrator and staff will implement safety procedures as appropriate.

PURPOSE

To maintain the safety of the environment and equipment which support patient care or services.

REFERENCE

The Joint Commission CAMHC Standards: EC.02.01.01, NPSG: .15.02.01; CHAP Standards: APC.6.I.M1, HRM.6.D; ACHC Standards: HH5-12A.01, HH7-2A.01, HH7-2B.01, HH7-5A.01

RELATED DOCUMENTS

"*Annual Agency Site Environment Assessment*" form

PROCEDURE

1. Home safety assessments are done on all patients at time of admission that include:
   - Fire hazards from smoking.
   - Oxygen safety, including the presence and functioning of smoke detectors, fire extinguishers and fire safety (exit) plans.
   - Fire safety within the home.
   - Electrical safety.
   - Bathroom safety.
   - Environmental safety.
   - Mobility safety.
   - Equipment usage and safety.
   - Adequate storage and handling of medical gases, drugs and hazardous wastes.

2. An Agency program is established which includes:
   - Emergency operations plan.
   - Fire safety, evacuation plan and maintenance of fire detection systems.
   - Office disaster plan including, but not limited to, a severe weather watch.
   - Equipment safety.
   - Body mechanics.
   - Safe storage of office supplies, equipment and hazardous products.
   - Controlling access to and from security sensitive areas, e.g., medical records storage.

3. Smoking is prohibited throughout the Agency's office(s) and building(s).

4. Staff is responsible for giving oral or written education to patients/caregiver(s) at the initial visit and on an ongoing basis as appropriate. Education will include:
   - Basic home safety (environmental, bathroom, electrical, and mobility).
   - Fire prevention.
   - Security.
   - Utility systems.
   - Managing hazardous materials and wastes.
   - Patient medical equipment safety, if applicable.
   - Compliance monitoring measures relating to patient's medications.

5. Office equipment safety is ensured through vendor contracts.

6. Manufacturers' written materials are available onsite as a resource.

7. New employees are instructed on office equipment safety during the orientation process.

8. The Agency will conduct an annual environmental site tour to identify hazards, unsafe practices, environmental deficiencies and opportunities for improvement for all Agency sites.

9. Fire drills are conducted at least annually, evaluated and results communicated to all staff (ACHC requirements).

ANNUAL AGENCY SITE ENVIRONMENT ASSESSMENT

SAFETY:	**YES**	**NO**
Agency clean, well lit, free of hazards?	✓	
Office supplies stored appropriately?	✓	
Hazardous materials stored appropriately?	✓	
Cytotoxic materials stored appropriately, if applicable?	✓	
All chemicals used in the workplace appropriately labeled and SDS Sheets present or access to SDS information?	✓	
Staff verbalizes location of flush station?	✓	
If medications are stored onsite, stored properly?	✓	

FIRE SAFETY:	**YES**	**NO**
Fire extinguishers checked monthly?	✓	
Fire extinguishers present and charged?	✓	
Fire detection system maintained?	✓	
Exit signs posted appropriately?	✓	
Exits clear and not blocked?	✓	
Site floor plans posted?	✓	

SECURITY:	**YES**	**NO**
Building has adequate lighting at night?	✓	
Building has adequate locks/security system?	✓	

UTILITIES MANAGEMENT:	**YES**	**NO**
Communication/telephones – appropriate?	✓	
Outlets/electrical support appropriate?	✓	
Hot water available for staff handwashing?	✓	

Recommendations: _____

_____

_____

_____ 1/1/22

Reviewer Signature *Date*

Staff Personal Safety Education

POLICY

Personal safety for employees is addressed through an educational process available to all staff.

PURPOSE

To ensure personal safety in the work environment.

REFERENCE

The Joint Commission CAMHC Standard: EC.02.02.01; CHAP Standard: HRM.6.D; ACHC Standards: HH7-2A.01, HH7-2B.01

PROCEDURE

During new employee orientation and on an ongoing basis, an inservice is provided for all employees that include:

- Safety while making home visits.
- General safety practices.
- Self-defense measures/personal safety techniques relating to home care/service safety.
- Obtaining an escort.
- Handling unsafe situations.
- Car accident reporting.
- Body mechanics.
- Workplace fire safety management and evacuation plan.
- Workplace or office security.
- Common environmental hazards (e.g., icy parking areas, blocked exists, cluttered stairways, etc.).
- Office equipment safety.

Personal Safety in the Community Guidelines

POLICY

The Agency will ensure a safe environment for employees at all times.

PURPOSE

To maximize the personal safety of staff working in the community and home setting.

REFERENCE

The Joint Commission CAMHC Standard: EC.02.01.01; CHAP Standard: HRM.6.D; ACHC Standard: HH7-2B.01

PROCEDURE

1. The following precautions will be taken by staff before making visits:
   - Wear name badge and appropriate Agency uniform that clearly identifies that you are from the Agency.
   - Call patients in advance and alert them to the approximate time of your visit.
   - Request that pets be properly secured before making visits.
   - Keep change on your person for a phone call.
   - Before leaving the Agency, lock your purse in the trunk of your car or cover it with a blanket if it will be visible.
   - Consider use/advantages of a personal cell phone.

2. When traveling by vehicle:
   - Keep your vehicle in good working order with plenty of gas.
   - Consider storing a blanket in your vehicle in the winter and a thermos of cool water in the summer. Keep a snack in the glove compartment.
   - Turn on emergency flashers and wait for the police if you have car trouble.
   - Keep your car locked when parked or driving. Keep windows rolled up if possible.
   - Park in full view of the patient's residence when possible.
   - Know your route. If you get lost, look for a safe place to get additional directions or view your map. If you have a car phone, call for directions.

3. When walking to the patient's home:
   - Have your nursing bag/equipment ready when exiting from the vehicle. Keep one arm free.
   - Walk directly to the patient's residence in a professional manner.
   - Be alert of surroundings – buildings, people and animals.

- Carry car keys in your hand when leaving the patient's residence. (The pointed ends of keys between fingers may make an effective weapon.)

4. Some common sense rules regarding personal safety and defense are:
   - Use common walkways in buildings; avoid isolated stairs.
   - Always knock on the door before entering a patient's home.
   - If a relative or neighbor becomes a safety problem:
     - Make joint visits or arrange for escort services.
     - Schedule visit times when they are not present.
   - Request escort services as appropriate. Consider working in teams of two or obtaining a police escort in high crime areas.
   - Scream or yell "fire"; blow a whistle attached to your key ring.
   - Kick shins, instep or groin; scratch.
   - Use your nursing bag as a defense weapon.
   - **Never** permit an assailant to remove you from the site.

5. When in neighborhoods with questionable safety or drug/gang related problems, make visits in the morning.
   - Some areas may have to be declared unsafe and therefore not serviced by the Agency.

Employee Security and Safety – Managing Undesirable Behavior

POLICY

Employee security and safety for managing patients with undesirable behavior is addressed through an educational process available to all staff.

PURPOSE

To ensure personal safety in the work environment.

REFERENCE

The Joint Commission CAMHC Standard: EC.02.01.01; CHAP Standard: HRM.6.D; ACHC Standard: HH7-2B.01

PROCEDURE

1. If a patient, family member and/or caregiver exhibits undesirable behavior to an employee, the employee will confront the person with a statement to stop the behavior. (Direct confrontation is required to alter undesirable behavior.)

2. Employee is to leave the patient's home immediately, if the undesirable behavior should persist.

3. The employee will report the behavior to his/her supervisor as soon as possible. The supervisor will investigate the incident and may need to consult with the patient, caregiver and/or physician regarding the behavior and the effect of the behavior on staff safety.

Hazardous Materials/Waste

POLICY

The Agency will comply with federal/state/local laws and regulations regarding the identification, handling, transportation and disposal of hazardous materials/waste, e.g., Environmental Protection Agency, OSHA and Medical Waste Tracking Act.

PURPOSE

To provide for the safe, appropriate handling of hazardous materials/waste.

REFERENCE

The Joint Commission CAMHC Standard: EC.02.02.01; Medicare CoP #: 484.100; CHAP Standards: IPC.6.I.M2, LG.3.I; ACHC Standards: HH7-1A.01, HH7-6A.01, HH7-6B.01

RELATED DOCUMENTS

"*Variance/Incident Report: Patient or Employee*" form

PROCEDURE

1. Hazardous materials/waste includes, but is not limited to:
   - Chemicals.
   - Chemotherapy agents.
   - All materials and wastes that require special handling.
   - Infectious and regulated medical waste, including sharps.

Hazardous materials/waste policy as it pertains to patients

1. Staff will assess the patient's plan of care for the need to address hazardous materials/waste.

2. The patient's home will be assessed for the presence of appropriate supplies and information in the event of an exposure incident, e.g., disposal bags and personal protective equipment for chemotherapy administration, including a chemotherapy spill kit.

3. Agency staff will communicate the need for hazardous materials/waste supplies to the appropriate company, e.g., to the infusion company for chemotherapy disposal containers.

4. The Agency will implement appropriate work practice controls, engineering controls and personal protective equipment in the provision of patient care.

Hazardous materials/waste as it pertains to the Agency

1. The Agency will assess each site and the activities supported and/or provided by each site for the need to safely handle/dispose of sharps, cytotoxic waste and infectious waste.

2. The Agency will provide the necessary supplies, environment or services to meet any needs identified.

3. The Agency will provide inservices to staff upon hire and annually thereafter on all policies/procedures related to the identification, handling, transportation, disposal and exposure to hazardous materials/waste. This includes the Hazard Communication Standard and the Hazardous Chemical Right-To-Know Law.

4. All areas with hazardous materials/waste within the Agency site(s) are identified with the appropriate signs/labels.

5. In the event of exposure to a hazardous material, staff will:
   - Implement immediate action as indicated by the type of hazardous material.
   - Notify the supervisor.
   - Seek follow up care as necessary.
   - Complete a *Variance/Incident Report: Patient or Employee* form.

Hazardous Waste Disposal

POLICY

- All potentially hazardous non-biological waste, including all disposable medical products, is to be discarded into a color coded container before being transported.
- Employees will not transfer waste into another container or sort through the contents of hazardous waste bags.
- All patients are instructed in the appropriate procedure for disposal of medical (hazardous) waste in the home.

PURPOSE

To ensure that hazardous waste is removed from the patient's home, transported and disposed of safely, efficiently and without threat to patients, staff, Agency or the environment.

REFERENCE

The Joint Commission CAMHC Standard: EC.02.02.01; Medicare CoP #: 484.100; CHAP Standards: IPC.6.I.M2, LG.3.I; ACHC Standards: HH7-1A.01, HH7-6A.01, HH7-6B.01

PROCEDURE

1. Hazardous waste is defined as cytotoxic/chemotherapy waste.
2. Gloves will be worn when gathering, transporting or destroying waste which has a chance of having been exposed to hazardous wastes.
3. Containers will not be over filled so that they cannot be easily and tightly closed.
4. All containers will be tightly closed or sealed prior to being taken from the home.
5. If the outside of the container or bag is observed to be punctured or damp from internal leakage, the container will be placed into another container or bag by a gloved employee prior to handling/moving.
6. Spills of hazardous material and waste will be cleaned up immediately utilizing a chemo spill kit with disposal per kit directions.
7. All materials used in the administration of cytotoxic agents are placed in a rigid chemotherapy container, e.g., chemo bags, tubing and syringes. Gloves are worn to prevent possible exposure.

8. When the containers become full, close and secure lid to avoid accidental opening. Company providing chemotherapy should be notified to pick up container and provide replacement.

9. Hazardous waste/biohazard bags and containers will be closed and stored in designated area in the office.

Hazard Communication Program

POLICY

- All employees who work with or may be exposed to hazardous materials under normal working conditions or foreseeable emergencies have the need and "Right-To-Know" what health and physical hazards exist from chemicals found in the workplace.
- The Hazard Communication Program is to be readily accessible to all employees. The written program will be located and available in each site.
- The written program will be reviewed on an annual basis by the Director of Clinical Services to ensure a complete and accurate list of chemicals used in the workplace.

PURPOSE

The Department of Labor Occupational Safety and Health Administration (OSHA) has mandated the implementation of a Hazard Communication Standard as stated in 29 CFR 1910, 1200. The purpose of the OSHA Hazard Communication Program is to provide information about chemicals in the workplace and their hazards to all employees. The program will include the following elements:

- Employee training.
- Safety Data Sheets (SDS) or access to SDS via internet or other site.
- Container labeling.
- List of hazardous materials present in the workplace.

REFERENCE

The Joint Commission CAMHC Standard: EC.02.02.01; Medicare CoP #: 484.100; CHAP Standards: IPC.6.I.M2, LG.3.I; ACHC Standards: HH7-1A.01, HH7-6A.01, HH7-6B.01

RELATED DOCUMENTS

OSHA Hazard Communication Standard 29 CFR 1910, 1200

CATEGORIES

Skin irritant: chemicals that cause irritation to the skin when the chemical is placed in direct contact with the skin.

Eye irritant: chemicals that cause irritation to the eye when the chemical is placed in direct contact with the surface of the eye.

Oral toxicant: chemicals when swallowed cause irritation or other toxicities.

Dermal toxicant: chemicals that are absorbed into the body through the skin following contact of the chemical with the skin.

Inhalation toxicant: chemicals which are irritating to the lining of the nose, mouth, esophagus or lungs when the chemicals are inhaled. These chemicals may also enter the body through the lungs and exhibit internal toxicities.

LABELING PROCEDURE

1. Containers of hazardous chemicals must be labeled, tagged or marked with the identity of the material and appropriate hazard warnings. Chemical manufacturers, importers and distributors are required to ensure that every container of hazardous chemicals they ship is appropriately labeled. The label must include:
   - Product identifier.
   - Supplier information (name, address and phone number).
   - Signal word (used to indicate the relative level of severity of hazard and alert reader to potential hazard on the label. "Danger" is used for more severe hazards. "Warning" is used for less severe hazards).
   - Pictogram (a symbol plus other graphic elements that is intended to convey specific information about the hazards of a chemical).
   - A hazard statement for each hazard class and category.
   - Precautionary statements.
2. All hazardous chemical containers will be labeled with the identity of the material and appropriate hazard warnings. Unlabeled containers will not be used. Contents of unlabeled containers will be discarded. Labels must be legible and prominently displayed.
3. Hazardous chemicals will remain in the original manufacturer's container until the time of use and will not be transferred into any other container without warning labels. The chemical name stated on the warning label must be identifiable/linkable to the chemicals described in the Safety Data Sheets (SDS).
4. The Director of Clinical Services will be notified of any unlabeled containers found.

SAFETY DATA SHEETS (SDS)

1. The role of the SDS is to provide detailed information on each hazardous chemical, including its potential hazard effects, its physical and chemical characteristics and recommendations for appropriate protective measures. Chemical manufacturers and importers are required to develop or obtain a SDS for each hazardous chemical they produce or import. Distributors are responsible for ensuring that their customers are provided a copy of these SDS. Employers must have access to a SDS for each hazardous chemical in use.
2. The Agency will maintain a list of all hazardous chemicals known to be present using a product identifier that is referenced on the appropriate SDS and the corresponding SDS.

A master list will be located in the written program and available from the Director of Clinical Services at any time.

3. A SDS for each hazardous chemical will be located in the written program or via internet or other site.

4. The Director of Clinical Services is responsible for acquiring and updating SDS. Contact with the chemical manufacturer or vendor will be made if the SDS is not received at the time of shipment.

5. The SDS contains the following information:
   - The chemical identity of the product.
   - Physical and chemical characteristics of the product.
   - Known acute and chronic effects and related health information.
   - Exposure limits.
   - If the chemical is known to be a carcinogen.
   - Emergency and first aid procedures.
   - The identification of the company preparing the SDS.

EMPLOYEE PROTECTION

Skin irritant: rubber or latex gloves are worn to protect the hands from the chemical, according to the information provided on SDS. Gowns and other body coverings that are impervious to the chemical are worn to protect exposed skin from the chemical.

Eye irritant: protective goggles are worn to prevent the chemical from contact with the eyes.

Oral toxicant: eating or drinking is not permitted when handling hazardous chemicals.

Dermal toxicant: rubber or latex gloves, impervious gowns or body coverings, according the SDS, are worn to prevent the hazardous chemical from direct contact with the skin.

Inhalation toxicant: use hazardous chemicals in a well-ventilated area. Follow specific instructions in SDS for the use of respirators or other protective equipment.

Flammable products: liquids, gases or solids identified as flammable are stored in areas designated for flammable substances only. Flammable chemicals are not stored, delivered or handled near areas of heat, spark or fire. Follow the instructions for handling of the flammable chemical identified on the SDS.

Detection methods and observations: refer to SDS for each hazardous chemical for specific information on the color, appearance or odor of the product to detect the presence of the chemical in the workplace. Follow the instruction on the SDS for containment of the chemical, clean up and disposal.

EMPLOYEE TRAINING

1. All employees who work with or are potentially exposed to hazardous chemicals will receive initial and annual training on the Hazard Communication Standard and the safe use of those hazardous chemicals. Whenever a new hazard is introduced, additional information and training will be provided.

2. Hazard Communication training will emphasize the following items:
   - Summary of the standard and the written program.
   - Chemicals and physical properties of hazardous materials and methods that can be used to detect the presence or release of chemicals.
   - Physical hazards of chemicals, e.g., potential for fire, explosion, etc.
   - Health hazards, including signs and symptoms of exposure to chemicals and any medical condition known to be aggravated by exposure to the chemical.
   - Procedures to protect against hazards including: personal protective equipment and attire required, proper use; work practices or methods to assure proper use and handling of chemicals; and procedures for emergency response.
   - Work procedures to follow to assure protection when cleaning hazardous chemical spills and leaks.
   - Where SDS is located, how to read and interpret the information on both labels and SDS and how employees may obtain additional information.
   - Documentation of Hazardous Communication training will be maintained in each employee's personnel file.

Variance/Incident Reporting

POLICY

The Agency will establish a consistent documentation and reporting process, in consideration of all federal/state laws and regulations, and define those incidents that require reporting.

PURPOSE

To define the types of incidents/variances to be reported in patients and employees as well as the process for reporting.

REFERENCE

The Joint Commission CAMHC Standards: EC.04.01.01, EC.04.01.03, EC.04.01.05; Medicare CoP #s: 484.65(a)(2), 484.65(b)(2); CHAP Standards: CQI.1.I.M1, CQI.2.D.M2; ACHC Standard: HH7-7A.01

RELATED DOCUMENTS

"*Variance/Incident Report: Patient or Employee*" and "*Variance/Incident Reports: Quarterly Data Aggregation*" forms

PROCEDURE

1. The Agency will document and report all incidents (accidents, injuries, safety and security hazards) that deviate from routine Agency operations and will result in injury or potential harm to a patient/caregiver or Agency staff. Such incidents may include, but are not limited to:
   - Security incidents involving patients, staff and others in Agency office or staff in the field.
   - Employee needlesticks with contaminated needles.
   - Equipment and/or medical device failure with resulting injury or harm.
   - Procedure error which results in trauma and/or injury.
   - Untoward outcome, including adverse drug events and reactions.
   - Medication errors.
   - Motor vehicle accidents involving an Agency vehicle or the employee's vehicle while employee is on Agency business.
   - Any staff accidents that require treatment, lost work days, hospitalization or that identify new safety hazards that were previously unrecognized.
   - Alleged/suspected patient abuse.
   - Unexpected patient death within twenty-four (24) hours of admission.

- Witnessed patient falls.
- Unwitnessed patient falls that require medical intervention.
- Sentinel events.
- Hazardous materials or wastes exposures, spills or other incidents.
- Fire safety management problems, deficiencies and failures.
- Environmental safety hazards.

2. No copies will be made of variance/incident reports and confidentiality of involved individuals will be maintained.

Variance/Incident Reporting

1. A *Variance/Incident Report: Patient or Employee* will be completed on all incidents, as defined in policy, by the staff member involved or the first person to become aware of the incident.

2. The report will be submitted to the immediate supervisor, who is responsible for immediate investigation of the incident and taking any appropriate action.

3. The supervisor will review the *Variance/Incident Report: Patient or Employee* and will document awareness of the incident.

4. The supervisor will assure all applicable federal/state reports/forms are completed, e.g., OSHA 300 Log.

5. The *Variance/Incident Report: Patient or Employee* will be forwarded to the QAPI committee for the purpose of reviewing, analyzing, aggregating, trending and making performance improvement recommendations (see *Variance/Incident Reports: Quarterly Data Aggregation*).

6. Follow up data needed to resolve the incident, e.g., lab reports, physical exams and police reports, will be collected by the supervisor.

7. A file will be maintained of all reported variance/incident reports, as well as any additional data/information pertaining to the *Variance/Incident Report: Patient or Employee*.

VARIANCE/INCIDENT REPORT
Patient or Employee

Name: _____ ID#: _____
Last First Middle

Date of Variance/Incident: _____ Time: _____ am/pm

Place: _____

Was it necessary to notify physician? NO _____ YES _____

Name of physician: _____

Date/time of notification: _____ Time: _____ am/pm

Name of supervisor notified: _____

Date/time of notification: _____ Time: _____ am/pm

Describe nature of variance/incident and injuries received:

_____

_____

_____

_____

Outcome: _____

_____

_____

Recommendations/Corrective Actions: _____

_____

_____

_____ _____
Signature *Date*

VARIANCE/INCIDENT REPORTS
Quarterly Data Aggregation

Quarter: _____

I. Patient Variances/Incidents:

A. Total number variances/incidents reported:_____

B. Types of variances/incidents: _____

_____

C. Trends in findings: YES ____ NO____ If YES, describe:

_____

_____

D. QAPI Committee recommendations for improvement opportunities:

_____

_____

II. Employee Variances/Incidents:

A. Total number variances/incidents reported: _____

B. Types of variances/incidents:_____

_____

C. Trends in findings: YES ____ NO____ If YES, describe:

_____

_____

D. QAPI Committee recommendations for improvement opportunities:

_____

_____

_____

Reported to QAPI Committee _____
Date

_____ _____
Signature Date

OSHA 300 Log

POLICY

The Occupational Safety and Health Act (OSHA) of 1970 and 29 CFR Part 1904 require employers to prepare and maintain records of occupational injuries and illnesses. To ensure that Agency meets the record keeping requirements as stated by OSHA, the OSHA No. 300 Log is utilized. The Agency must report to OSHA:

- All work-related fatalities that occur within 30 days of the work-related incident: within 8 hours.
- All work-related in patient hospitalizations, all amputations and all losses of an eye within 24 hours (if incident occurs within 24 hours of the work-related incident).

PURPOSE

To meet OSHA requirements for reporting, recording and maintaining records of occupational injuries and illnesses.

REFERENCE

The Joint Commission CAMHC Standard: EC.04.01.01; Medicare CoP #: 484.100; CHAP Standard: LG.3.I; ACHC Standard: HH7-7A.01

RELATED DOCUMENTS

Occupational Safety and Health Act of 1970 and 29 CFR Part 1904; www.osha.gov

PROCEDURE

1. The Director of Clinical Services is responsible for completing, maintaining and posting the OSHA 300 Log in accordance with OSHA record keeping requirements.

2. All work-related illnesses are recorded on an OSHA form 301 (Injury and Illness Report). Injuries requiring medical treatment (other than first aid) or involve loss of consciousness, restriction of work or motion or transfer to another job are recorded. Medical treatment does not include: one-time treatment and/or subsequent observation of minor scratches, cuts, burns, splinters, etc., which do not ordinarily require medical care even though provided by a physician or registered professional personnel. Exposures to and/or contraction of reportable communicable diseases in the course of work performance are considered reportable on the log. Employee needlestick injuries with contaminated needles must also be recorded on the log. Each injury or illness is recorded within 7 days after learning of the occurrence and maintained for each calendar year.

3. The OSHA 300 Log, 300A and 301 are retained for a 5-year period and available for inspection by employees, former employees and authorized federal and state officials.

4. The *Summary*, a separate form (Form 300A), is posted by February 1 of the following year covered by the form and kept posted until April 30 of that year. The *Summary* is posted even if there are no recorded injuries or illnesses.

5. The OSHA 300 Log may be obtained from the local regional OSHA office.

Security Plan

POLICY

The Agency will ensure a secure environment for employees at all times.

PURPOSE

To maintain staff security.

REFERENCE

The Joint Commission CAMHC Standard: EC.02.01.01; CHAP Standard: HRM.6.D; ACHC Standard: HH7-2A.01

PROCEDURE

1. Employees will use designated, secured entrances for entering Agency's office.

2. All persons entering the Agency's office will be identified.

3. Patients, vendors, sales representatives and others who come to Agency's office must enter through the designated front door. The receptionist will security-screen all visitors.

4. Visitors are not permitted in any area of Agency's office other than reception area, unless given permission by Administrator or Director of Clinical Services.

5. The potential for workplace violence will be included in staff education, environmental tours and proactive risk assessments, when conducted.

Utility Systems

POLICY

The Agency will maximize patient's utility systems when equipment is used by the patient.

PURPOSE

To identify and decrease potential risks of utility systems failures.

REFERENCE

The Joint Commission CAMHC Standard: EC.02.01.01; CHAP Standard: APC.6.I.M1; ACHC Standard: HH7-2B.01

PROCEDURE

1. Agency staff will determine if the patient's utility systems are compatible and safe for equipment use during initial and ongoing home safety assessments.

2. Such assessments and reassessments include:
   - Electrical outlets.
   - Space heaters.
   - Electrical cord and use of extension cords: grounding, cord condition, circuit overload and exposure to liquids.
   - Battery condition and charge, e.g., for oxygen concentrators, intravenous pumps and ventilators.
   - Any special electrical requirements for equipment, e.g., ventilators, intravenous pumps and concentrators.
   - Any special power requirements.

Fall Reduction Program

POLICY

The Agency will implement a fall reduction program.

PURPOSE

To reduce the risk of patient harm resulting from falls.

REFERENCE

The Joint Commission CAMHC Standard: PC.01.02.01; NPSG: .09.02.01; ACHC Standards: HH2-12A.01, HH5-2C; "Preventing Falls and Fall-Related Injuries in Health Care Facilities," The Joint Commission Sentinel Event Alert, Issue 55, Sept. 28, 2015.

PROCEDURE

1. At time of admission, each patient will be assessed for fall risk.

2. Reassessment for fall risk will be performed when a patient experiences a fall or changes physical location.

3. Staff will provide risk reduction strategies to patient/family for each identified risk, including appropriate patient transfer protocols and patient education.

4. Staff will be educated about the fall reduction program including:
   - Assessment criteria.
   - Reassessment criteria.
   - Risk reduction strategies.
   - Patient transfer protocols.
   - Appropriate patient education.

5. The Agency will establish an interdisciplinary falls injury prevention team to reduce injury risk from falls.

6. Staff involved in the patient's care will communicate the patient's risk for falls with injury which will include patient-specific areas of risk and interventions to decrease risks. Communication may include: patient's care plan, communication notes or electronic medical record alerts.

7. When a witnessed patient fall or patient fall with injury occurs, staff involved in the care of the patient will conduct a post-fall huddle discussion, which may include:
   - What happened.
   - Why it happened.
   - Environmental issues that may have contributed to the fall.
   - If appropriate patient-specific interventions were observed.
   - Necessary changes to the patient's plan of care.

8. The Agency will monitor the effectiveness of the fall reduction program through the incident/variance reporting system. The Agency will report, aggregate and analyze contributing factors on an ongoing basis. Results will be communicated to the interdisciplinary falls reduction team for evaluation and suggestions for improvement to the fall prevention and reduction program.

FALL RISK ASSESSMENT/REASSESSMENT

Patient: _____ ID# _____

SOC Date: _____ Resumption of Care Date: _____

Risks	Yes	No	If "Yes" Risk Reduction Strategies Provided	Yes	No
1. Impaired balance or mobility.			Educated to use assistive devices and to rise slowly from sitting to standing position. Pt. educated to call for assistance before getting OOB or getting up from chair.		
2. Musculoskeletal problems.			Educated to use assistive devices and to rise slowly from sitting to standing position.		
3. Cognitive impairment (short term memory changes or poor impulse control, etc.).			Educated caregiver in appropriate supervision for ADL's.		
4. Nutritional problems affecting ADL's.			Educated in MD ordered diet.		
5. Use of narcotics, hypnotics, analgesics, psychotropics, laxatives, diuretics, sedatives or antihypertensive medications, including multiple medications (polypharmacy = 10 or more medications).			Educated in side effects of medications, including potential for increased fall risk due to side effects of drowsiness, motor disturbances and ataxia.		
6. History of previous falls.			Educated in safe ambulation, use of assistive devices and relevant home safety issues.		
7. Abnormal sleep pattern for patient.			Educated in appropriate sleep techniques.		
8. Specific environmental issues.			Improve lighting. Needed objects should be placed within easy reach.		

____ Yes ____ No Recent changes in Level of Independence.
____ Yes ____ No Sensory changes.
____ Yes ____ No Communication difficulties.
____ Yes ____ No Patient's risk for falling communicated to patient and/or caregiver.

_____ _____
Signature Date

Identifying and Reporting Possible Victims of Alleged/Suspected Abuse, Neglect or Exploitation

POLICY

Agency will identify and report possible victims of alleged/suspected abuse, neglect or exploitation.

PURPOSE

To define the processes for identifying and reporting possible victims of alleged/suspected abuse, neglect or exploitation.

REFERENCE

The Joint Commission CAMHC Standards: PC.01.02.09, RI.01.06.03; Medicare CoP #s: 484.50(e)(2), 484.100; CHAP Standard: PCC.8.I.M1; ACHC Standard: HH2-3A

PROCEDURE

1. Agency staff will be oriented to signs and symptoms indicating possible abuse, neglect or exploitation.

2. Any Agency staff (whether employed directly or under arrangement) in the normal course of providing services to patients, who identifies, notices or recognizes incidences or circumstances of mistreatment, neglect, verbal, mental, sexual and/or physical abuse, including injuries of unknown sources, or misappropriation of patient property, must report these findings immediately (within 24 hours) to the Agency and other appropriate authorities in accordance with state law.

3. Criteria to identify child neglect or abuse, physical assault and domestic abuse include:
   - Injuries to the trunk of the body that could be intentional.
   - Femoral fractures or retinal hemorrhages in children under two years old.
   - Fractures that do not correlate with the child's gross motor ability or rib fractures in infants and children.
   - An imprint from a hot object on the back, buttocks or back of the hands.
   - CNS signs/symptoms that may indicate a head injury from violent shaking.
   - Inadequate supervision with resulting effect on ADL provision, e.g., bathing, toileting, food, etc.
   - Unexplained injuries, frequent falls or multiple hematomas of various colors.
   - Delinquent or run-away behavior.
   - Child's clothing inappropriate in relation to weather condition.

4. Criteria to identify elder neglect or abuse, physical assault and domestic abuse include:
   - Injuries to the trunk of the body that could be intentional.

- An imprint from a hot object on the back, buttocks or back of hands.
- Inadequate supervision with resulting effect on ADL provision, e.g., bathing, toileting, food, etc.
- Unexplained injuries, frequent falls or multiple hematomas of various colors.
- Withdrawal and/or crying.
- Any patient who reports an abusive incident.

5. Criteria to identify victims of exploitation include:
   - Abuse and/or misuse of patient's money.
   - An inability of caregiver/family to account for patient's money or property.
   - Discrepancies between patient's resources and living situation.
   - Reports of demands for goods in exchange for services.

6. Criteria to identify victims of rape or sexual molestation include:
   - Feelings of humiliation, degradation, shame, guilt, embarrassment, self-blame, anger and revenge.
   - Fear of injury, mutilation and death.
   - Complete disruption of patient's normal activities of daily living and life-style.
   - Presence of abrasions, bruises, swelling, lacerations and/or teeth marks.
   - Tearful, trembling, sobbing, hyperventilation and/or withdrawal.
   - Long periods of silence.
   - Sudden marked irritability, avoidance of relationships and/or marked change in sexual behavior.
   - Phobic reactions to being alone, going outside and/or staying inside.

7. Staff will immediately report an assessment of patient's condition which might indicate exploitation, abuse or neglect to the Director of Clinical Services, who will assign a supervisor to assess the patient for abuse, neglect and/or exploitation.

8. The Director of Clinical Services will communicate assessment findings to the physician/practitioner and the appropriate agency according to state regulations/laws. All findings and communications will be documented in the patient's medical record. The Agency will report allegations, observations and suspected cases of exploitation, abuse and/or neglect to appropriate authorities.

9. The Agency maintains a list of private and public organizations that provide or arrange for assessment of possible victims of suspected or alleged abuse or neglect, e.g., women's shelters, National Child Abuse Hotline, Parents Anonymous, Child & Adult Protective Services through the Department of Human Services, etc.

10. Agency staff receives ongoing education regarding:
    - Signs and symptoms indicative of possible victims of abuse, neglect or exploitation.
    - Community agencies (public and private) for reporting possible victims of abuse or neglect.
    - State laws regarding the reporting of possible victims of abuse, neglect or exploitation.
    - Role of staff.

11. The Agency ensures this right and investigates all alleged violations involving mistreatment; neglect; verbal, mental, sexual and physical abuse, including injuries of unknown source; and misappropriation of patient property by anyone furnishing services on behalf of the Agency. Alleged violations are reported immediately to the Administrator or appropriate designee.

12. The Agency immediately investigates all alleged violations involving anyone furnishing services on behalf of the Agency and immediately takes action to prevent further potential violations while the alleged violation is being verified. Investigations and/or documentation of all alleged violations are conducted.

13. The Agency takes appropriate corrective action in accordance with state law if the alleged violation is verified by administration or an outside body having jurisdiction, e.g., accrediting organization, the state survey agency or local law enforcement agency. The Agency ensures that verified violations are reported to accrediting organization, state and local bodies having jurisdiction (including to the State survey and certification agency) within 5 working days of becoming aware of the verified violation, unless state regulations are more stringent.

14. The patient has a right to be free from abuse from Agency staff and others in his or her home environment. The Agency will address any allegations or evidence of patient abuse to determine if immediate care is needed, a change in the plan of care is indicated, or if a referral to an appropriate agency is warranted. (State laws vary in the reporting requirements of abuse. Agency will be knowledgeable of these laws and comply with the reporting requirements.) In addition, the Agency will intervene immediately if, as indicated by the circumstances, any injury is the result of an Agency staff member's actions. Agency will also immediately remove staff from patient care if there are allegations of misconduct related to abuse or misappropriation of property.
    - "Abuse" means the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. Abuse may be verbal, mental, sexual or physical and includes abuse facilitated or enabled through the use of technology.
    - "Verbal abuse" refers to abuse perpetrated through any use of insulting, demeaning, disrespectful, oral, written or gestured language directed toward and in the presence of the patient.
    - "Mental abuse" is a type of abuse that includes, but is not limited to: humiliation, harassment and threats of punishment or deprivation, sexual coercion and intimidation (e.g., living in fear in one's own home).
    - "Sexual abuse" is a type of abuse that includes any incident where a patient is coerced, manipulated or forced to participate in any form of sexual activity for which the patient did not give affirmative permission (or gave affirmative permission without the mental capacity required to give permission), or sexual assault against a patient who is unable to defend him/herself.
    - "Physical abuse" refers to abuse perpetrated through any action intended to cause physical harm or pain, trauma or bodily harm (e.g., hitting, slapping, punching, kicking, pinching, etc.). It includes the use of corporal punishment as well as the use of any restrictive, intrusive procedure to control inappropriate behavior for purposes of punishment.

- "Injury of unknown" source is an injury that was not witnessed by any person and the source of the injury cannot be explained by the patient.
- "Misappropriation of property" is theft or stealing of items from a patient's home. Agency staff must investigate and take immediate action on any allegations of misappropriation of patient property by Agency staff and refer to authorities when appropriate.
- Neglect means a failure to provide goods and/or services necessary to avoid physical harm, mental anguish or mental illness.

STATE OF NEVADA

Patient Safety Program

POLICY

Agency leaders ensure implementation of a patient safety program.

PURPOSE

To define the agency-wide patient safety program. To promote a safe environment for patients and staff. To reduce process and system failures and risks.

REFERENCE

The Joint Commission CAH C Standard: QM.04.04.05 CHAP Standard: QM.3.1 CHC Standard: HH6-6A.01

RELATED DOCUMENTS

"*Annual Safety Program Evaluation: Governing Body Report*" form

PROCEDURE

1. The Administrator and Director of Clinical Services is responsible to oversee and manage the Agency's Safety Program.

2. The scope of the program's oversight includes (but is not limited to):
   - Patient and employee incident/variance reporting and investigation.
   - Significant medication error/adverse drug reaction and adverse drug event investigation.
   - Quality Assessment/Performance Improvement data including OASIS and OQIES data indicative of patient safety issues.
   - Sentinel events.

3. All services and staff will coordinate and implement patient safety policies/procedures and processes.

4. Procedures for immediately responding to process or system failures include:
   - Caring for the affected patient and/or employee.
   - Containing risks to others.
   - Preserving factual information for subsequent analysis.

5. □nternal systems for reporting system or process fail□res incl□de incident/variance reporting□root ca□se analysis and reports to staff and □overning □ody as appropriate.

6. □□ternal systems for reporting system or process fail□res □ill comply □ith any applica□le la□ or reg□lation.

7. Responses to □nanticipated adverse events incl□de analysis and investigations □ith potential proactive ris□assessments and/or ris□red□ction activities.

8. □efined s□pport system for staff mem□ers □ho have □een involved in a sentinel event incl□des co□nseling thro□gh the h□man reso□rces department or the employee assistance program.

9. □eaders □ill provide an ann□al report to the □overning □ody regarding actions ta□en to improve patient safety □in response to act□al occ□rrences or proactively□and on process or system fail□res.

STATE OF NEVADA

Annual Safety Program Evaluation: Governing Body Report

Requirement	Expectation	Expectation Met				Corrective Action Taken & Date
		Yes	No	N/A	Comments	
□ Safety	1. □ndivid□al assigned to manage.					
	2. Scope of program defined.					
	3. Safety integrated org-□ide.					
	4. Proced□res to respond to fail□res.					
	5. □nternal □ e□ternal reporting systems.					
	6. Response to □nanticipated adverse events					
	7. □f sentinel event occ□rred□staff s□pport system in place.					

STATE OF NEVADA

Annual Safety Program Evaluation: Governing Body Report

Requirement	Expectation	Expectation Met				Corrective Action Taken & Date
		Yes	No	N/A	Comments	
□. □ata Collection	1. Staff perceptions of ris□s □ s□ggestions for improvement.					
	2. Staff □illingness to report □nanticipated adverse events.					
	3. Pt perception of care incl□des: ho□ □e can improve safety.					
	4. Ha□ardo□s conditions analy□ed.					
	5. □nvironmental safety monitored in office.					
	6. Safety iss□es comm□nicated to program manager.					

STATE OF NEVADA

Annual Summary of System/Process Failures

System or Process Failures	Actions Taken to Improve Safety	Action Effective		
		Yes	No	If No: Explain

System or Process Failures	Date Corrective Action Outcome will be Assessed	Individual Responsible	Date Corrective Action Outcome Assessed	Corrective Action Effective		
				Yes	No	If, No, Explain

Concl□sions: Program is □ppropriate: □es □□□□ No □□□□
Program is □de□□ate: □es □□□□ No □□□□
Program is □ffective: □es □□□□ No □□□□
Program is □fficient: □es □□□□ No □□□□

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□dministrator Signat□re □ate

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□overning □ody President Signat□re □ate

Sentinel Event

POLICY

The Agency will identify and analyze all sentinel events.

PURPOSE

To identify processes for responding to sentinel events.

REFERENCE

The Joint Commission CAMH Standards: PC.04.04.05 RI.01.02.01 Medicare CoP's: 484.65(a)(1)(c)(2) CHAP Standard: C(1).2.1.(1) 2(2) CHC Standard: HH6-6(1).01

PROCEDURE

1. The Agency defines a sentinel event as a patient safety event (not 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.

2. Sentinel events for patients include:
   - Unexpected, unanticipated death not related to the normal course of the patient's disease process.
   - Blood transfusion reactions involving administration of blood/blood products having major blood group incompatibilities.
   - A major permanent loss of function or limb not present at time of admission to Agency that requires continued treatment or lifestyle change.
   - Any patient death paralysis coma or other major permanent loss of function associated with a medication error.
   - Unanticipated death or major permanent loss of function associated with a healthcare associated infection.
   - Rape assault (sexual) leading to death permanent harm or severe temporary harm (1) homicide or other crime of any patient receiving care or staff member visitor vendor or licensed independent practitioner while onsite at the Agency office.
   - A patient fall that results in death or major loss of function as a direct result of injuries sustained from the fall.

- □nvasive proced□re on the □rong patient□at the □rong site or that is the □rong proced□re.
- □nintended retention of a foreign o□□ect in a patient after an invasive proced□re.
- □□d□ction of any patient.
- Severe neonatal hyper□ilir□□inemia □□ilir□□in greater than 30 milligrams/deciliter□.
- □nanticipated death of a f□ll-term infant.

3. All staff will be educated during orientation and on an ongoing basis of the Agency's sentinel event policy.

4. □he □gency □ill identify and respond appropriately to all sentinel events as defined□ incl□ding:
   - □ formali□ed team response that sta□ili□es the patient□discloses the event to the patient and family and provides s□pport for the family as □ell as staff involved in the event.
   - Notification of leadership.
   - □mmediate investigation.
   - Completion of a comprehensive□systematic analysis for identifying the ca□sal and contri□□tory factors.
   - Corrective actions □ased on cas□al and/or contri□□tory factors that □ill lead to s□stained improvement.
   - □ime line for implementation of corrective actions.
   - Systematic improvement.

5. □he □irector of Clinical Services and □dministrator □ill initiate a comprehensive systematic analysis of the sentinel event □y performing a thoro□gh and credi□le root cause analysis, which will focus on systems and processes. Appropriate staff, patient's physician and legal co□nsel □ill □e involved in the root ca□se analysis.

6. □he □gency □ill create□doc□ment and implement ris□-red□ction activities and corrective action plan. □he effectiveness of system and/or process improvements □ill □e meas□red and analy□ed.

7. Sentinel events □ill □e reported to e□ternal organi□ations as re□□ired □y applica□le federal or state la□.

8. On an ongoing □asis□□gency leaders □ill monitor p□□lished data regarding sentinel events in home care. S□ch data □ill □e considered for improvement strategies and ris□ red□ctions □ithin the □gency.

9. □he □gency ma□es s□pport systems availa□le for staff □ho have □een involved in an adverse or sentinel event thro□gh the employee assistance program.

PURPOSE

To ensure all patients/clients, their representatives (if any) and NurseCore staff acknowledge, observe and implement the patient's/client's rights and responsibilities.

POLICY

I. The patient/client and representative (if any), will be informed of the patient's/client's rights and responsibilities in a language and manner the individual understands. NurseCore will protect and promote the exercise of these rights.

II. NurseCore will orient staff and staff under arrangement on hire regarding patient/client rights.

DEFINITIONS

I. In Advance means that NurseCore staff must complete the task prior to performing any hands-on care or any patient/client education.

II. Representative means the patient's/client's legal representative, such as a guardian, who makes health-care decisions on the patient's/client's behalf, or a patient/client-selected representative who participates in making decisions related to the patient's/client's care or well-being, including but not limited to, a family member or an advocate for the patient/client. The patient/client determines the role of the representative, to the extent possible.

PROCEDURE

I. NurseCore staff will be responsible for knowing, observing, and implementing the patient's/client's rights, patient/client conduct and patient/client responsibilities on an ongoing basis.

II. NurseCore will:

A. Provide the patient/client and the patient's/client's legal representative (if any), the following information during the initial evaluation visit, in advance of furnishing care to the patient/client:

1. Written notice of the patient's/client's rights and responsibilities, and NurseCore's transfer and discharge policies. Written notice must be understandable to persons who have limited English proficiency and accessible to individuals with disabilities. The notice will be provided hard copy unless the patient requests that the document be provided electronically;

2. Certified Offices Only

   Contact information for the Administrator, including the Administrator's name, business address, and business phone number in order to receive complaints;

3. **CERTIFIED OFFICES ONLY**

An OASIS privacy notice to all patients/clients for whom the OASIS data is collected. The notice will include the patient/client rights in regard to OASIS including the right:

a. To be informed that OASIS information will be collected and the purpose of the collection;

b. To have the information kept confidential;

c. To be informed that OASIS information will not be disclosed except for legitimate purposes allowed by Federal Privacy Acts;

d. To refuse to answer questions;

e. To see, review, and request changes on the assessment;

B. Obtain the patient's/client's or legal representative's signature confirming that he or she has received a copy of the notice of rights and responsibilities;

1. The patient's/client's or representative's signature will be witnessed by a NurseCore staff member;

2. If the patient/client cannot sign the form, the person acting on behalf of the patient/client may do so;

3. The reason why the patient/client is unable to sign will be stated on the form;

4. NurseCore will maintain documentation of patient/client acknowledgment of receipt of rights in the patient/client file.

C. Provide verbal notice of the patient's/client's rights and responsibilities in the individual's primary or preferred language and in a manner the individual understands, free of charge, with the use of a competent interpreter if necessary, no later than the completion of the second visit from a skilled professional;

D. If the patient/client speaks a language which the Agency has not translated into written material, NurseCore may delay the notification of rights and responsibilities until an interpreter is present (either physically, electronically or telephonically) to verbally translate. However, this may be delayed no later than the second visit. NurseCore staff must document that verbal discussion of rights took place and that the patient and/or representative was able to confirm his or her understanding of rights.

E. Provide written notice of the patient's/client's rights and responsibilities and NurseCore's transfer and discharge policies to a patient/client-selected representative within 4 business days of the initial evaluation visit;

III. If a patient/client has been adjudged to lack legal capacity to make health care decisions as established by state law by a court of proper jurisdiction, the rights of the patient/client may be exercised by the person appointed by the state court to act on the patient's/client's behalf. NurseCore record should include official documentation of any adjudication by the courts which indicates that the patient/client lacks capacity to make their own health care decisions and the names of the person(s) identified by the courts who may exercise the patient's/client's rights.

IV. If a state court has not adjudged a patient/client to lack legal capacity to make health care decisions as defined by state law, the patient's/client's representative may exercise the patient's/client's rights.

V. If a patient/client has been adjudged to lack legal capacity to make health care decisions under state law by a court of proper jurisdiction, the patient/client may exercise his or her rights to the extent allowed by court order.

VI. The patient/client has the right to:

A. Have his or her property and person treated with respect;

B. Be free from verbal, mental, sexual, and physical abuse, including injuries of unknown source, neglect and misappropriation of property;

C. Make complaints to NurseCore regarding treatment or care that is (or fails to be) furnished, and the lack of respect for property and/or person by anyone who is furnishing services on behalf of NurseCore;

D. Participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, with respect to:

1. Completion of all assessments;
2. The care to be furnished, based on the comprehensive assessment;
3. Establishing and revising the plan of care;
4. The disciplines that will furnish the care;
5. The frequency of visits;
6. Expected outcomes of care, including patient/client-identified goals, and anticipated risks and benefits;
7. Any factors that could impact treatment effectiveness; and
8. Any changes in the care to be furnished;

E. Receive all services outlined in the plan of care;

F. Have a confidential clinical record. Access to or release of patient/client information and clinical records is permitted in accordance with 45 CFR parts 160 and 164 (relating to the HIPAA privacy rule);

G. Receive written information regarding advance directives prior to care being provided;

H. **CERTIFIED OFFICES ONLY -** Be advised of:

1. The extent to which payment for NurseCore services may be expected from Medicare, Medicaid, or any other federally-funded or federal aid program known to NurseCore;
2. The charges for services that may not be covered by Medicare, Medicaid, or any other federally-funded or federal aid program known to NurseCore;
3. The charges the individual may have to pay before care is initiated; and
4. Any changes in the information provided related to charges when they occur. NurseCore must advise the patient/client and representative (if any), of these changes as soon as possible, in advance of the next home health visit. NurseCore must comply with the patient/client notice requirements at 42 CFR 411.408(d)(2) and 42CFR 411.408(f) (relating to the Advance Beneficiary Notice).

I. Receive proper written notice, in advance of a specific service being furnished, if NurseCore believes that the service may be non-covered care; or in advance of NurseCore reducing or terminating on-going care. NurseCore must also comply with the requirements of 42 CFR 405.1200 through 405.1204 (relating to notice prior to termination, expedited determination and review);

J. Be advised of the state toll free home health telephone hot line, its contact information, its hours of operation, and that its purpose is to receive complaints or questions about local Agencies;

K. **CERTIFIED OFFICES ONLY -** Be advised of the names, addresses, and telephone numbers of the following Federally-funded and state-funded entities that serve the area where the patient/client resides:

1. Agency on Aging
2. Center for Independent Living
3. Protection and Advocacy Agency,
4. Aging and Disability Resource Center; and
5. Quality Improvement Organization;

L. Be free from any discrimination or reprisal for exercising his or her rights or for voicing grievances to NurseCore or an outside entity;

M. Be informed of the right to access auxiliary aids and language services, and how to access these services (for persons with disabilities and for persons with low English proficiency); and

N. The patient/client and representative (if any), have a right to be informed of NurseCore's

policies for transfer and discharge.

O. CLIENT REFUSAL OF SERVICES

1. The Clinical Director or designee will explain the potential consequences of a refusal of care to the client or the client's representative.
2. When the services are being provided under physician's order, the physician is notified of the client's refusal and NurseCore's intended action which will include discharge if the client is refusing all care.
3. The Clinical Director or designee will document the following in the clinical record:
    A. The client's refusal, and
    B. Notice of potential consequences provided by NurseCore staff, and
    C. Physician notification, if applicable
4. The Clinical Director or designee will refer the client to available alternative community resources to meet the client's needs in the event of a discharge.
5. The Clinical Director or designee will document referral/transfer efforts and the client's response and disposition in the clinical record.

VII. TEXAS

A. NurseCore respects the Rights of the Elderly for clients age 60 and over.

1. The Clinical Director or RN provides a copy of the Rights of the Elderly during the initial home visit for all appropriate clients.
2. The Clinical Director or RN reviews the Rights of the Elderly with the client/client representative during the initial visit and as needed.
3. The Clinical Director or RN provides education to the direct care providers during orientation on the client's rights including the Rights of the Elderly.
4. Client receipt of a copy of the Rights of the Elderly is documented in the clinical record.

B. NurseCore will provide a copy of its Drug Screening policy to any person who applies for services and to any person who requests it.

Federal Regulation	State Specific Regulation
G406-484.50; G424-484.50(b)(1); G426-484.50(c); G428-484.50(c)(1); G430-484.50(c)(2); G432-484.50(c)(3); G434-484.50(c)(4); G436-484.50(c)(5); G438-484.50(c)(6); G440-484.50(c)(7); G442-484.50(c)(8); G444-484.50(c)(9); G446-484.50(c)(10); G448-484.50(c)(11); G450-484.50(c)(12).	Texas Human Resources Code Chapter 102, clients 60 years of age or older. Texas Admin Code §558.253 - Disclosure of Drug Testing Policy

POLICY STATEMENT

The health and safety of each employee of Foundation for Positively Kids is of primary importance. Prevention of occupational injuries and illnesses is of such consequence that it will be given priority over productivity whenever necessary. To the greatest degree possible, Positively Kids will provide the equipment, procedures and training required to maintain a safe and healthful workplace.

RESPONSIBILITIES

MANAGEMENT:

Positively Kids management will provide the time and financial resources necessary to create and maintain a safe and healthful workplace. This will be accomplished by providing Positively Kids Workplace Safety Plan (PKWSP), which will detail all needed safety and health procedures, and equipment pertinent for the department. Positively Kids will also provide documented appropriate training for hazards identified in the workplace as well as the appropriate personal protective equipment.

Each Vice President with the Foundation is required to conduct a workplace hazard assessment annually as well as schedule periodic ongoing inspections of the workplace and investigate accidents or incidents within their programs. If a hazard is identified, the VP will fill out the Supervisor's Annual Workplace Hazard Assessment (Appendix 1). This form will be reviewed by the PK Quality Assurance Performance Team (QAPI) and the CEO. The Workplace Safety Inspection Checklist (Appendix 2), will also be completed yearly and turned into the QAPI Team Coordinator and kept on file.

EMPLOYEES:

Each employee of Positively Kids is required to follow all safety and health regulations described in the plan, as well as to report any unsafe or unhealthy situations or conditions to their supervisor immediately.

HAZARD IDENTIFICATION ANALYSIS AND CONTROL

IDENTIFICATION:

A. Immediate Hazard:
   An employee who observes an unsafe or unhealthy work environment or condition will contact their supervisor immediately. The supervisor will immediately evaluate the situation and abate or isolate the hazard. The supervisor will immediately document, using the Supervisor's Hazard Evaluation Report (Appendix 3), The findings and actions taken to abate or isolate the hazard. If only isolated, the documentation will include what actions were taken to eventually abate the hazard. Additionally, the documentation will include what actions will be taken to prevent further occurrences of this hazard, unsafe, or unhealthy situation. A copy of the Supervisor's Hazard Evaluation Report will be given to the Quality Assurance Performance Team coordinator and the CEO.

B. Potential Hazard:
If an employee observes a potentially unsafe or unhealthy condition or situation, the employee will fill out the "Potential Unsafe or Unhealthy Condition or Situation Report Form" (Appendix 4) and give it to their immediate supervisor. The supervisor will evaluate the employee's concern and will take steps to abate the potential unsafe condition or situation. The supervisor will fill out the "Supervisor" portion of the "potential Unsafe or Unhealthy Condition or Situation Report Form". The completed form will be turned into the Quality Assurance Performance Team coordinator and the CEO.

ANALYSIS :

A. Review results of the Supervisor's Annual Workplace Hazard Assessment form, the Supervisor's Hazard Evaluation Report Forms, and the Potential Unsafe or Unhealthy Condition or Situation Report Forms with QAPI Team Coordinator and CEO.

B. Review Workplace Safety Inspection Checklist forms with QAPI Team Coordinator and CEO.

CONTROL:

A. Immediately eliminate or isolate all identified hazards.

B. Use appropriate personal protective equipment.

C. Complete the Supervisor's Hazard Evaluation Report or the Potential Unsafe or Unhealthy Condition or Situation Report Forms.

D. QAPI Team Coordinator will report on all incidents and findings to the Quality Assurance Performance Improvement (QAPI) Team at the next available meeting.

TRAINING

Per Positively Kids policy all employees must be trained on their Workplace Safety Plan, and on the Rights and Responsibilities pamphlet. The Rights and Responsibilities pamphlet is given to new employees as part of their hiring packet which they read, sign and return to PK.

PK is responsible for providing ongoing documented safety training for their employees. All training programs need to address the following basics:

A. The specific policies and procedures contained in the Positively Kids Workplace Safety Plan (PKWSP);

B. The specific training requirements of any applicable standard;

C. All training will be documented as to date, title of training, and name and title of instructor. On-line training will have a return receipt documenting that the employee completed the training and will be returned to the training instructor and placed in the employees personnel file.

The following training with test questionnaire will be renewed yearly for all PK employees as cited in the PK Policy & Procedure Manual:

1. Blood Borne Pathogens; PK**-HR-052/PK-CL-010**
2. Emergency Evacuation Procedure/Fire Safety; PK**-HR-056/PK-CL-010**
3. Respiratory Protection. **PK-CL-010**

BLOODBORNE PATHOGENS

The Bloodborne Pathogen (BBP)Program applies to all PK Department employees who, through the course and scope of their employment, have the potential for becoming exposed to a bloodborne pathogen.

The Chief Nursing Officer for PK will ensure the administration of the Bloodborne Pathogen Control Program.

1. Determining exposure hazards in the workplace
2. Training of employees
3. Ensuring the employee has access to the HBV vaccination program
4. Post-exposure evaluation and follow-up
5. Maintaining documentation

DEFINITIONS

Blood – means human blood, human blood components and products made from human blood or from experimental animals infected with HIV or HBV.

Bloodborne Pathogen – refers to pathogenic microorganisms that are present in human blood and can cause disease in humans.

Contaminated – means the presence or reasonable anticipated presence of blood or other potentially infectious materials on an item or surface.

Decontamination – means the use of physical or chemical means to remove, inactivate or destroy bloodborne pathogens on an item or surface to the point where they are no longer capable of transmitting infectious particles, and the surface or item is rendered safe for handling, use or disposal.

Engineering Controls – means controls (i.e. sharps disposal containers, self-sheathing needles, brooms and dustpans, etc.) that isolate or remove the blood borne pathogens hazard from the workplace.

Exposure Control Plan – refers to the written program that outlines the protective measures that PK will take to eliminate or minimize employee exposure to blood and other potentially infectious materials.

Other potentially infectious materials (OPIM) – refers to human body fluids including semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal

fluid, amniotic fluid, saliva in dental procedures, any blood fluid that is visibly contaminated with blood, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids. This definition also refers to any unfixed tissue or organ (other than intact skin) from a human (living or dead); and HIV-containing cell or tissue cultures, organ vultures and HIV or HBV containing culture medium or other solutions; and blood, organs, or other tissues from experimental animals infected with HIV or HBV.

Regulated Waste – means liquid or semi-liquid blood or other potentially infectious materials; contaminated items that would release blood or other potentially infectious materials in a liquid or semi-liquid state if compressed; items that are caked with dried blood or other potentially infectious materials and are capable of releasing these materials during handling; contaminated sharps, and pathological and microbiological wastes containing blood or other potentially infectious materials.

Universal Precautions – refers to all employees treating blood or other body fluids as if they contain blood borne pathogens.

Work Practice Controls – refers to controls that reduce the likelihood of exposure by altering the manner in which a task is performed (i.e., using a broom and dustpan to pick up broken glass, contaminated with blood).

EXPOSURE DETERMINATION

OSHA requires an exposure determination be performed concerning which employees may incur occupational exposure to blood or other potential infectious materials. The exposure determination is made without regard to the use of personal protective equipment (i.e., employees are considered to be exposed even if they wear personal protective equipment). This exposure determination is required to list all job classifications in which all employees may be expected to incur such occupational exposure, regardless of frequency.

Additionally, OSHA requires a listing of job classifications in which some employees may have occupational exposure. Since not all employees in these categories would be expected to incur exposure to blood or other potentially infectious materials, tasks or procedures that would cause these employees to have occupational exposure are also required to be listed in order to clearly understand which employees in the categories are considered to have occupational exposure. (See Appendix 5).

IMPLEMENTATION SCHEDULE AND METHODOLOGY

OSHA requires a method of implementation for the various requirements of the standard.

Universal precautions will be observed in all facilities in order to prevent contact with blood or other potentially infectious materials. All blood or other potentially infectious material will be considered infectious regardless of the perceived status of the source individual.

Engineering and work practice controls will be utilized to eliminate or minimize exposure to employees. Where occupational exposure remains after institution of these controls, personal protective equipment (PPE) shall also be utilized.

Personal protective equipment will be provided without cost to employees. Personal protective equipment will be chosen based on the anticipated exposure to blood or other potentially infectious materials. The protective equipment will be considered appropriate only if it does not permit blood or other potentially infectious materials to pass through or reach the employees clothing, skin, eyes, mouth, or other mucous membranes under normal conditions of use and for the duration of time, which the protective equipment will be used.

All PPE must be provided, replaced, and/or disposed of by PK with no cost being borne by the employee.

Hepatitis B vaccinations will be offered to all employees of PK. The vaccine will be offered at the time of the employment application process. If the employee has previously had the vaccine, declines the vaccine they will sign a Declaration Form. (See Appendix 6). Employees who initially decline the vaccine may later decide to receive the vaccine at no cost to the employee.

POST-EXPOSURE EVALUATION AND FOLLOW-UP

All employees who incur an exposure incident will be offered post-exposure evaluation and follow-up in accordance with OSHA standards to include:

Documentation of route of exposure and the circumstances related to the incident shall be recorded on the Occupational Exposure Report Form, Part 1 and 2. (See Appendix 7).

If possible, identify the source individual and the status of the source individual. The blood of the source individual will be tested, after consent is obtained, for HIV or HBV infectivity. Consent of Source Individual form in Appendix 8.

Results of testing of the source individual will be made available to the exposed employee with the exposed employee informed about applicable laws and regulations concerning disclosure of the identity and infectivity of the source individual.

The exposed employee will go to a PK's contracted medical clinic for workman's compensation claims and begin the testing process for HIV/HBV.

The exposed employee will be offered post exposure prophylaxis in accordance with the current recommendations of the United States Public Health Services. These include the employee being given appropriate counseling concerning precautions to take during the period of the exposure incident; the exposed employee will also be given information on what potential illnesses to be alert for and to report any related experiences to appropriate personnel.

INTERACTION WITH HEALTH CARE PROFESSIONALS

A written opinion will be obtained from the health care professional that evaluates following the exposure incident. The health care professionals shall be instructed to limit their opinions to: Whether the Hepatitis B vaccine is indicated, and if the employee has received the vaccine; that the employee has been informed of the results of the evaluation; that the employee has been informed of any medical conditions resulting from an exposure.

NOTE: Written opinions to the employer may not reference personal medical information.

EVALUATION OF CIRCUMSTANCES SURROUNDING AN EXPOSURE INCIDENT

The evaluation of circumstances surrounding an exposure incident is to be done by the Chief Nursing Office and Vice President of the Unit.

1. A review of the Occupational Exposure Report – Part 1 completed by the employee.
2. Documentation regarding plan to reduce the likelihood of future exposure incidents.
3. Notification to the QAPI Team Coordinator for review at next scheduled QAPI meeting.

TRAINING

Training for affected employees will be conducted prior to initial assessment and will include annual refresher training. Training will include the following:

1. OSHA standard for blood borne pathogens as outlined in PK Administration and Operations Policy. **PK-HR-052**
2. Training records must be retained for 3 years from the training date.

RECORDKEEPING

PK will maintain all records required by the OSHA standard. PK is responsible for the establishment and maintenance of medical records.

The medical record includes the name and social security number of the employee; a copy of the employee's Hepatitis B vaccination status including the dates of all the Hepatitis B vaccinations; and any medical records relative to the employee's ability to receive the vaccination; copies of all results of examinations, medical testing, and the follow-up procedures; copies of the healthcare professional's written opinion; and a copy of the information provided to the healthcare professional.

Medical records must be kept for the duration of employment plus 30 years.

EMERGENCY EVACUATION PROCEDURES

EVACUATION

The highest level of management at a PK location may direct the evacuation of a facility. There are two PK locations plus the PK equipment yard located on Elliot St., Henderson. Nursing staff located at the Child Haven campus will follow Clark County's direction on facility evacuations. The PK Healthcare Clinic will adhere to any directives from Clark County in the event of an emergency on that campus along with the directives outlined here if only the PK Healthcare clinic is impacted by the emergency.

A plan exists at each of the PK location sites and is posted throughout the area, showing all exits and routes of escape for employees and visitors to our facilities, in the event of an emergency. All employees should familiarize themselves with the escape routes and seek clarification from management if needed. All doors in the escape route must be marked with lighted exit signs, unobstructed and unlocked during normal business hours.

Protect life first, property second. All non-essential employees and visitors will evacuate the building after being alerted to the particular emergency situation. Healthcare clinic staff need to determine where they will meet to ensure that all employees are evacuated and accounted for. Notify emergency authorities if there are any employees or visitors not accounted for while the emergency is in progress.

FIRES

A. If an employee observes fire or heavy smoke in any area of a PK facility, he/she should sound the fire alarm and then immediately evacuate the building according to the evacuation procedures outlined above. Use the stairways, NOT the elevators. The door should be closed after evacuation if it appears that doing so will isolate the fire.

B. If an employee observes smoke. Flames or other dangers in the immediate surrounding area, he/she should:

1. Drop to the floor and crawl to the nearest exit.
2. Before opening any door, touch it, if the door is hot to the touch, do **NOT** open it.
3. If the door is not hot to the touch, proceed through the door, and then close it to prevent fire and smoke from entering the area.

C. If an employee is unable to evacuate the building, he/she should:

1. Return to an undisturbed area.
2. Close all doors into that area, remain in the room and stay calm.
3. If a phone is available, call 9-1-1- to summon emergency workers.
4. If possible, block off any openings where smoke may enter into the room.
5. Cover mouth and nose with an article of clothing that will act as a filter against smoke.
6. Wait for rescue personnel to evacuate employees from the area.

D. All employees should be instructed on the use of portable fire extinguishers. All employees are trained yearly and take the OSHA Fire Safety and Emergency Evacuation Quiz. PK mandates that all employees are trained in first aid and CPR.

FLASH FLOODS

The National Weather Service issues a "Flash Flood Warning" when there is actual flooding, or a "Flash Flood Watch" when there is a possibility of flooding.

A. If an employee is in a facility that is being flooded, follow the evacuation procedures.

B. Employees traveling to homes and is in a vehicle which becomes trapped in water and cannot safely be abandoned, wait for rescue crews to arrive. Do not attempt to cross a flowing stream of floodwater.

HAZARDOUS MATERIALS ACCIDENTS

The Clark County Fire Department, City of Las Vegas Fire Department, Las Vegas Metropolitan Police Department, and Nevada Highway Patrol have primary responsibility for responding to and coordinating hazardous material emergencies or disasters in Clark County.

A. If a hazardous materials emergency/disaster has occurred or exists in the facility or area:

1. Immediately notify the supervisor at the site.
2. Upon the issuance of an evacuation order, evacuate and assist visitors in evacuating the facility in an orderly manner.

B. If employees are directed to remain in the facility, they should:

1. Return to an undisturbed area.
2. Close all doors into that area, remain in the room and stay calm.
3. If a phone is available, call 9-1-1- to summon emergency workers.
4. If possible, block off any openings where smoke may enter into the room.
5. Cover mouth and nose with an article of clothing that will act as a filter against smoke.
6. Wait for rescue personnel to evacuate employees from the area.

OFFICE VIOLENCE

A. If an employee receives notification or believes that a suspicious package is in the area, he/she should report it to a supervisor.

B. If an employee is directly confronted by or witnesses a hostile person who appears on the verge of causing physical injury or property damage, he/she should immediately leave the area if possible and call 9-1-1. If confronted by a belligerent (potentially hostile) person, the employee should:

1. Allow the person to express his/her frustration.
2. Attempt to address the person's concerns or problems.
3. If the person remains combative or appears to be getting hostile, leave the area and call 9-1-1, notify a supervisor.
4. Report to a supervisor any weapons or bizarre behavior observed.

The PK CEO is the designated spokesperson for PK in the event of an emergency. No other employees are authorized to talk with the media as a spokesperson for PK. Any requests for interviews regarding the emergency must be directed to the PK CEO.

Workplace violence or hostilities between employees is addressed in the PK Policies & Procedures manual. Policy: PK-HR-039.

WORKPLACE AND MOTOR VEHICLE ACCIDENTS

Positively Kids provides a vehicle only to the employees assigned to the Clothing Donations Dept. All other Home Health Nurses and Therapists who practice in patient's homes drive their own personal vehicles. They are required to carry the appropriate insurance for their vehicle. They are never authorized to transport a PK patient when they are "on the clock", being paid by PK. All employees will abide by the policy and procedures dealing with cell phone usage while in their vehicles as outlined in the PK Policy and Procedures manual. **PK-HR-040**

1. Workplace Injuries:

    1. The employee will contact their supervisor.
    2. The employee will fill out Workman's Comp form C-1 "Notice of Injury or Occupational Disease" and C-3 "Employer's Report of Industrial Injury or Occupational Disease".
    3. If medical care is warranted the employee will fill out Workman's Comp form C-4 "Employee's Claim For Compensation/Report of Initial Treatment", and take it with them for the treating physician to fill out the bottom portion of the form.

All forms will be turned into their immediate supervisor.

2. Accidents involving PK vehicles:

    1. All motor vehicle accidents involving a PK vehicle will be reported to the CEO immediately.
    2. The police will be called so the proper reports can be filed.
    3. If a person is injured, 9-1-1 will be called for first aid.
    4. A drug test will be administered to the employee even if the accident is not their fault.
    5. The employee will fill out Workman's Comp form C-1 "Notice of Injury or Occupational Disease" and C-3 "Employer's Report of Industrial Injury or Occupational Disease".
    6. If medical care is warranted the employee will fill out Workman's Comp form C-4 "Employee's Claim for Compensation/Report of Initial Treatment and take it with them for the treating physician to fill out the bottom portion of the form.

3. Accidents involving PK employees in personal vehicles:

    1. All motor vehicle accidents involving a PK vehicle will be reported to the employee's supervisor.
    2. The police will be called so the proper reports can be filed.
    3. If a person is injured, 9-1-1 will be called for first aid.
    4. If PK employee is injured, they will fill out the Workman's Comp forms C-1, C-3 and C-4

A copy of the Workman's Comp C-1, C-3 and C-4 form are at the end of this document. (Appendix 9)

ENFORCEMENT (COMPLIANCE)

Department heads and supervisors are responsible for enforcing safety in the workplace.

MINOR VIOLATIONS

Minor violations may be dealt with on a case-by-case basis.

If the violation is determined to be an accident in which the employee is found **not** to be at fault, no action will be taken.

Minor violations for which the employee is found to be at fault may be dealt with through progressive discipline which is defined as the following in this order: oral warning, admonishment, written reprimand, a final written warning, and, thereafter termination.

All forms of discipline are to be documented by the Department head.

MAJOR VIOLATIONS

Major violations may be dealt with on a case-by-case basis.

The severity of the major violation will determine which steps of progressive discipline is considered appropriate action.

If the results of the investigation conclude that an intentional violation has occurred, that employee or employees may be terminated.

APPENDIX 1

SUPERVISOR'S ANNUAL WORKPLACE HAZARD ASSESSMENT FORM

SUPERVISOR'S ANNUAL WORKPLACE HAZARD ASSESSMENT

Foundation For Positively Kids	Department	Date	
Hazard			
Method of Abatement			
Hazard			
Method of Abatement			
Hazard			
Method of Abatement			
Hazard			
Method of Abatement			

SEND A COPY TO THE QAPI COORDINATOR AND CEO.

ALL FINDINGS WILL BE REVIEWED AT THE NEXT SCHEDULED QUALITY ASSURANCE PERFORMANCE TEAM MEETING

Supervisor/VP Signature: _____

Date: _____

APPENDIX 2

WORKPLACE SAFETY INSPECTION CHECKLIST

FOUNDATION FOR Positively kids

WORKPLACE SAFETY INSPECTION CHECKLIST

Location Inspected: _____

Date: _____

1. Was a site plan showing evacuation routes visible?	Yes	No	N/A
Action:			
2. Are exits visible and unobstructed?	Yes	No	N/A
Action:			
3. Are exit signs in place and lighted?	Yes	No	N/A
Action:			
4. Are doors unlocked during business hours?	Yes	No	N/A
Action:			
5. Is the work area adequately lighted?	Yes	No	N/A
Action:			
6. Are restrooms clean and properly maintained?	Yes	No	N/A
Action:			
7. Is trash disposed of properly?	Yes	No	N/A
Action:			
8. Are floors swept and free of debris?	Yes	No	N/A
Action:			
9. Are stairways in good condition and free of debris?	Yes	No	N/A
Action:			
10. Are portable fire extinguishers mounted in proper locations?	Yes	No	N/A
Action:			
11. Are fire extinguishers obstructed in any way?	Yes	No	N/A
Action:			
12. Are any items leaning, unrestrained, against walls; i.e., equipment, or other items?	Yes	No	N/A
Action:			
13. Are first aid supplies adequate for department?	Yes	No	N/A
Action:			
14. Is first-aid cabinet clean and well stocked with supplies?	Yes	No	N/A
Action:			
15. Electrical cords - fraying, splits or breaks in insulation, free of oils, chemicals	Yes	No	N/A
Action:			

APPENDIX 3

SUPERVISOR'S HAZARD EVALUATION REPORT FORM

FOUNDATION FOR Positively kids

SUPERVISOR'S HAZARD EVALUATION REPORT FORM			
Foundation for Positively Kids	Department	Date	
Unsafe or Unhealthy Condition or Situation			
Has the situation been isolated? Yes No Method used?			
Has the situation been abated? Yes No Method used?			
What action will be taken to prevent this from reoccurring?			
SEND A COPY TO THE QAPI COORDINATOR AND CEO. **ALL FINDINGS WILL BE REVIEWED AT THE NEXT SCHEDULED QUALITY ASSURANCE PERFORMANCE TEAM MEETING**			

DEPARTMENT RESPONSE	
Date Received:	Name:
Additional action to be taken	

APPENDIX 4

POTENTIAL UNSAFE OR UNHEALTHY CONDITION OR SITUATION REPORT FORM

FOUNDATION FOR Positively kids

POTENTIAL UNSAFE OR UNHEALTHY CONDITION OR SITUATION REPORT FORM

Foundation for Positively Kids			Department			Date		
Potential Unsafe or Unhealthy Condition or Situation								
Why do you feel this is a potential unsafe or unhealthy condition or situation?								
Requested solution to the potential unsafe or unhealthy condition or situation.								

VICE PRESIDENT RESPONSE	
Date Received:	Name:
If a potential unsafe or unhealthy condition or situation does exist, what is your plan of action to resolve it.	

Supervisor/VP Signature: _____

Date: _____

SEND A COPY TO THE QAPI COORDINATOR AND CEO.
ALL FINDINGS WILL BE REVIEWED AT THE NEXT SCHEDULED QUALITY ASSURANCE PERFORMANCE TEAM MEETING

APPENDIX 5

Risk Assessment for Exposure to Bloodborne Pathogens by Job Description

2480 E Tompkins Ave., Ste. 222, Las Vegas, Nevada 89121, Office 702-262-0037 – Fax 702-262-0252

Risk Assessment for Exposure to Bloodborne Pathogens by Job Description

Job Title	High Risk	Moderate Risk	Low Risk
CEO			X
Behavior Health Therapist			X
Care Coordinators			X
Certified Nursing Assistant	X		
Clinic Check-Out		X	
Chief Nursing Officer	X		
Clothing Donation Coordinator		X	
Clothing Donation Manager		X	
Credentialing/Billing Coordinator			X
Early Intervention Assistant Director			X
Early Intervention Behaviorist			X
Early Intervention Care Coordinator			X
Early Intervention Development Specialist			X
Early Intervention Service Coordinator			X
Early Intervention Supervisor			X
Executive Assistant			X
Grant Coordinator			X
Home Health Office Manager			X
License Practical Nurse	X		
Medical Assistant	X		
Medical Doctor	X		
Medical Receptionist		X	
Nurse Practitioner	X		
Occupational Therapist			X
Office Assistant			X
Physical Therapist			X
Registered Nurse	X		
Scanner			X
Speech Therapist			X
Translator			X
Vice President Behavioral Health			X
Vice President Early Intervention			X
Vice President Medical Clinics		X	
Vice President of Business Development			X

APPENDIX 6

HEPATITIS B VACCINE ACCEPTANCE/DECLINATION FORM

HEPATITIS B VACCINE ACCEPTANCE / DECLINATION

ACCEPTANCE

I, _____ consent to the administration of Hepatitis B Vaccine to me by a physician's service approved by POSITIVELY KIDS. I have read the package insert concerning the vaccine, including the contraindications and precautions. I understand there is no charge to me for receiving this vaccine. I hereby release POSITIVELY KIDS from all liability associated with the administration of the vaccine.

I Accept _____ Date _____

DECLINATION

I, _____ understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk for acquiring Hepatitis B Virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B Vaccine at no charge to myself. However, I decline the Hepatitis B Vaccine at this time. I understand that by declining this vaccination, I continue to be at risk of acquiring Hepatitis B, a serious disease. If, in the future, I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B Vaccine, I can receive the vaccination series at no charge to me.

I Decline _____ Date _____

Employee Name (please print)

Last	**First**	**Middle**
Social Security #	**Telephone (hm)** **( )**	**Telephone (cell)** **( )**
Address	**City**	**State Zip**

APPENDIX 7

OCCUPATIONAL EXPOSURE REPORT

2480 E Tompkins Ave., Ste. 222, Las Vegas, Nevada 89121, Office 702-262-0037 – Fax 702-262-0252

FOUNDATION FOR Positively kids

OCCUPATIONAL EXPOSURE REPORT - PART 1

Employee Name: _____ Date: _____

Exposure Date: _____ Exposure Time: _____

Dept: _____

Source Individual Name: _____

Circle PPE Used: Gloves Mask Eye Protection Gown

* Explain why PPE was not used, or what other PPE was used:

_____

_____

Check Exposure type:

_____ Blood/fluid plash to eyes _____ Blood/fluid to open wound, etc.

_____ Blood/fluid splash to mouth/nose _____ Needle stick

_____ Other Exposure - Explain/describe:

_____

_____

Was immediate medical attention sought? Yes No

If yes, explain: _____

_____

Have you had the HBV immunization? Yes No In Process

Workman's Comp Form C-3 completed and filed? Yes No

Employee Signature _____ Date: _____

2480 E Tompkins Ave., Ste. 222, Las Vegas, Nevada 89121, Office 702-262-0037 – Fax 702-262-0252

FOUNDATION FOR Positively kids

OCCUPATIONAL EXPOSURE REPORT - PART 2

To Be Completed By Investigating Personnel

Source individual tested for HBV/HIV? Yes No

Date of Test: If no, why: _____

Date results received: _____

HBV results: HBS-AG Positive Negative

HIV Antibody Reactive Non-Reactive

Date employee notified: _____

Notified By: _____

Post-exposure prophylaxis: Yes No If yes, type: _____

Post exposure counseling: Yes No

Referred to licensed physician: Yes No

_____ _____

Investigator's Signature/ Title Date

2480 E Tompkins Ave., Ste. 222, Las Vegas, Nevada 89121, Office 702-262-0037 – Fax 702-262-0252

APPENDIX 8

CONSENT OF SOURCE INDIVIDUAL

FOUNDATION FOR Positively kids

CONSENT OF SOURCE INDIVIDUAL

I hereby consent to the withdrawal of a sample of my blood for the purpose of Hepatitis B virus and Human Immunodeficiency Virus screening. The purpose of these screening procedures has been fully explained to me. I understand that test results will be provided to the exposed person but will otherwise be treated under the same confidentiality.

_____ _____

Signature of employee Date

_____ _____

Witness Date

2480 E Tompkins Ave., Ste. 222, Las Vegas, Nevada 89121, Office 702-262-0037 – Fax 702-262-0252

APPENDIX 9

WORKMAN'S COMPENSATION FORMS

C-1, C-3, C-4

PROFESSIONAL CASE MANAGEMENT OF NV

Quality and Patient Safety Plan

2022

Located in Las Vegas, NV

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Quality and Patient Safety Overview

PCM of Nevada (NV) has an established, on-going Quality, Process Improvement, and Patient Safety Program to ensure an adequate and effective operation that extends to all functions and services. This program's scope includes accreditation, infection control, incident reporting, quality performance reports, training, and client satisfaction.

All Agency personnel, providers, and other affiliates are responsible and accountable for delivering quality service according to Agency standards and the program's guidelines. Activities conducted as part of the Quality, Process Improvement, and Patient Safety Program are documented quarterly by the Administrator and Business Operations Manager, then reviewed annually by the Professional Advisory Board and the Governing Body.

Quarterly meetings are held to discuss the quality and patient safety reports, which includes information about falls, medication errors (including near misses), infection rates, best practices, and upcoming process improvements. This information is then further discussed as needed to monthly staff meetings.

Professional Case Management
Helping People Live at Home

2022 Quality and Patient Safety Plan

The annual Quality and Patient Safety Plan covers a variety of key metrics for the successful and safe delivery of patient care. Each metric has acceptable thresholds, detailed information about data collection, and remediation information if needed.

Standard	Description of Monitoring Activities	Method of Measurement	Frequency of Measurement	Method of Data Collection	Who Collects Data	Who Analyzes Data	Where Data Lives Long-term	Acceptable Threshold	Performance Improvement Activity or Ongoing Remediation?
PD6-2D & PD7-1B Clinical Care	Client infections are reported by clinical staff	Infection report	Quarterly	Infection report when client has symptoms of infection	Clinical staff	Business Operations Manager	Quarterly Quality Report	Infections per 100 clients does not increase more than 4% in single quarter.	Yes PIA - for 2022 are being developed
PD6-2F Administrative function -	Employees are assigned training based on state regulations and job description	Completed Classes Report	Annual	Workday Learning Management System	Director of Clinical Operations or designee	Business Operations Manager	Workday LMS and Smartsheet Dashboard	At least 95% completed	Ongoing Action and Remediation
PD6-2F Administrative function	Audit newly hired personnel files for completeness	All hiring components based on state regulation are present	Bi-annually	Using state HR audit tool in smartsheet	Human Resource Manager or designee	Human Resource Manager	Quarterly Quality Report	95% compliance across all files	Ongoing Action and Remediation
PD6-2G Client satisfaction survey	Client satisfaction survey	External vendor – Amplitude Research	Annually	Mail survey to active clients	Amplitude Research	Amplitude Research	Full survey available upon request from COO, portions also reside in Quarterly Quality Report	At least 90% of clients give a score of "Excellent or Nearly Excellent" Service.	No PIA or remediation at this time
PD6-2G Employee satisfaction survey	Office Health Survey	Survey to all employees by job description	Bi-annually	Email survey	Chief Operating Officer's Executive Assistant	Chief Operating Officer's Executive Assistant	Full survey available upon request from COO, portions also reside in Quarterly Quality Report	Combined scores of 3,4, and 5 is equal 90% of respondents.	No PIA or remediation at this time
PD6-2H Client chart review	Audits of closed and active charts, hospital visits, ETC	Audit tool	Quarterly	Electronic audit tools	Regional Director or designee	Business Operations Manager	Quarterly Quality Report	90% Compliance	Ongoing Action and Remediation
PD6-2I Client feedback (complaint)	Client feedback is reported by Regional Director, investigated, and resolved	Client feedback is recorded in CareLink database	Quarterly	CareLink-Feedback Report	Regional Director enters data in CareLink	Chief Operating Officer	Quarterly Quality Report	No more than a 10% increase in a single quarter	No PIA or remediation at this time

Standard	Description of Monitoring Activities	Method of Measurement	Frequency of Measurement	Method of Data Collection	Who Collects Data	Who Analyzes Data	Where Data Lives Long-term	Acceptable Threshold	Performance Improvement Activity in 2020
PD6-4A & PD7-7A Client incidents	Client Incident are reported by clinical staff to the Regional Director to evaluate and resolve	Incident Report	Quarterly	Incident report when issue occurs	Clinical Staff	Business Operations Manager	Quarterly Quality Report	Incidents per 100 clients does not increase more than 4% in single quarter.	Yes PIA - Improving repeat client falls program
PD7-3A Emergency Preparedness	The Agency has, at a minimum, an annual practice drill to evaluate the adequacy of its plan	Annual drill/event tracker	Yearly	Tracker used by Clinical Staff to report on drills/events	Business Operations Manager	Business Operations Manager	Quarterly Quality Report	100% compliance	Yes PIA – Emergency Preparedness Plan improvements
PD6-2E Clinical care-	Documentation average Soapier Score of nursing staff	New nurses are audited 30 days after first shift and annually if score is 70% or higher	Quarterly	Soapier documentation audit tool	Quality Auditor	Business Operations Manager	Quarterly Quality Report	Average score is at least 70%	Ongoing Action and Remediation
PD6-2E Clinical Care	Documentation Improvement after Remediation 1	Nurses under 70% are audited after taking Remediation I class	Quarterly	Soapier documentation audit tool	Quality Auditor	Business Operations Manager	Quarterly Quality Report	Score improves to at least 70	Ongoing Action and Remediation
PD6-2E Clinical Care	Documentation Improvement after Remediation 2	Nurses under 70% are audited after taking Remediation 2 course	Quarterly	Soapier documentation audit tool	Quality Auditor	Business Operations Manager	Quarterly Quality Report	Score improves to at least 70	Ongoing Action and Remediation
PD6-2E Clinical Care	Documentation Improvement after Remediation 3	Nurses under 70% are audited after taking Remediation 3 one on one	Quarterly	Soapier documentation audit tool	Quality Auditor	Business Operations Manager	Quarterly Quality Report	Score improves to at least 70	Ongoing Action and Remediation
PD7-1E	Employee Infection Rates	OSHA Log	Annually	Employees report qualifying events to HR	HR Manager or designee	Business Operations Manager	Quarterly Quality Report	Threshold to be set in 2022.	No PIA or remediation at this time
PD7-7A	Employee Incident Rates	OSHA Log	Annually	Employees report qualifying events to HR	HR Manager or designee	Business Operations Manager	Quarterly Quality Report	Threshold to be set in 2022.	Yes PIA– Employee Slips and Falls

Client Chart Audits

A new, standardized chart audit process was rolled out in Q1 2021. This process is overseen by the corporate office, which plans out the audit schedule for the year, provides the audit tools, and picks the clients to be audited. Every quarter, PCM of NV does an audit of client charts for completeness and accuracy, following this program. The Administrator then take the top deficiencies and develops remediation plans. Over the last four quarters, 90% of items have been compliant in charts, which is the goal set out by the corporate office (as outlined above).

Professional Case Management
Helping People Live at Home

2022 Employee Education Plan

The following is Professional Case Management's annual education plan for clinical staff. It follows state and ACHC regulations and is designed to enhance clinical outcomes and patient safety.

Annual Education:
All clinical staff members providing direct or non-direct client care will participate in in-service/continuing education programs annually.

- Direct care personnel (Nurses, Aides and Attendants) will have a minimum of 12 hours of in-service/continuing education per year.
- Non-direct personnel (Companion Sitters) will have a minimum of 8 hours of in-service/continuing education per year.

Topics will include, but are not limited to:

- Emergency/disaster training
- How to handle complaints/grievances
- Infection control training
- Cultural diversity
- Communication barriers
- Ethics training
- Performance Improvement and safety (OSHA)
- Client/Patient Rights and Responsibilities statement
- Compliance program
- Elder abuse, neglect & exploitation
- Alzheimer's disease and behavioral management
- COVID-19

Training is delivered through PCM's Learning Management System as well as in-person. Course completion will be recorded in PCM's HRIS (Human Resource Information System). In addition to the ACHC required in-service topics above, PCM will develop additional educational content as needed. For example, education may be created due to industry changes, grievances/complaints, and/or updated state-mandated training requirements.

2022 Health Risk Assessment

Research was conducted using CDC and other expert guidelines to determine if a change to policy was necessary based on state and federal health regulations and with consideration to the on-going pandemic and current events.

PCM did not find any state or federal recommendations that would warrant a change to it's policies and/or procedures; however, as new variants of COVID continue to emerge, PCM engages in frequent communication with staff to remind them of policies, the importance of wearing face masks, practicing standard precautions and social distancing with all interactions and symptoms that would warrant testing for COVID-19.

Fall Reduction Program

Reducing falls, particular repeat falls, is an ongoing process improvement goal. A Falls Pilot Program was deployed in early 2021 in order to test a new methodology that included additional documentation, a medical equipment and supply kit, client and employee education, and outcome assessment. The initial pilot reduced repeat falls by 65% company-wide; based on these results, the pilot was turned into a permanent program in late 2021. Falls are reported via incident reports to the Administrator, and this is analyzed and included in quarterly quality reports. Further improvements may be created based on this information.

Flu Vaccine

Each year, PCM sends out information to employees encouraging them to get the flu vaccine. Case Managers also educate clients on the importance of flu vaccines. This is a program intended to protect clients, employees, and the wider community.

Infection Control and Hand Hygiene

PCM of Nevada has a comprehensive program to educate clients and employees about hand hygiene and infection protection, track infection rates, and develop process improvement plans as needed. This includes annual training for employees, hand outs, verbal education of clients, and quarterly reports of infection rates.

PCM is seeking to match an American Journal of IC (2/2015) benchmark, which showed Medicare HH patients averaging 4.5% to 11.5% infection rates per 100 clients. PCM of Nevada has stayed within that boundary for the past year, but if it were to not reach this goal an improvement plan would be developed by the Administrator and Business Operations Manager.

Professional Case Management (PCM) recognizes the impact that communicable disease has on health care workers and the community served. To ensure that all PCM caregivers are aware of and practice appropriate infection control and emergency management procedures they were enrolled in annual training courses that included these topics. These training courses are reviewed and updated annually to ensure that encompass current processes, procedures, and events.

PCM continues to have a sufficient supply of personal protective equipment on hand with processes in place for contact tracing and notifications when an employee or client has tested positive for COVID.

Feedback/Complaint Process:

Client feedback/complaints are processed using the following system. The Initial complaint is entered by the Administrator or designee into Carelink (an administration tool built on the Salesforce platform). The Administrator then begins the investigation and findings are updated in the CareLink record. The status is changed to “Resolved” when all required activities are completed. The COO will review the complaint for completeness, ensuring resolution has been obtained and client has been notified of the resolution – the COO will then mark the complaint as “Closed”. PCM of NV has had only one complaint in the last seven quarters.

Signal Health Group Inc.
Las Vegas, Nevada
Patient Safety Plan – Fall Prevention

Step 1: Warning signs that may lead to a fall:

1. Unsteady gait during ambulation or physical activity
2. Change in mental status/confusion
3. Environment with trip hazards

Step 2: Strategies to prevent falls without needing to contact another person:

1. Use assistive devices (e.g. walker, cane, joint braces etc.) during ambulation and all physical activity
2. Take a break or rest if experiencing dizziness or change in mental status
3. Take all medications correctly as prescribed
4. Stay well hydrated

Step 3: People whom I can ask for help:

1. Name: Family Member- Phone:
2. Name: Friend- Phone:
3. Name: Other- Phone:

Step 4: Professionals or agencies I can contact if I feel like I am not safe to walk:

1. Clinician Name: Phone:
2. Clinician Name: Phone:
3. Local Urgent Care Services:
   Phone:
   Address:

Step 5: Making the environment safe:

1. Remove all trip hazards and clutter
2. Call for help!

GOLDEN CROSS HOME CARE, LLC.

7762 W. SAHARA AVE. ♦ LAS VEGAS, NV 89117
Phone: (702) 240-7711 ♦ Fax: (702) 240-7721
♥ Providing HOMECARE With Heart ♥

DISASTER / EMERGENCY SAFETY INFORMATION SHEET

Patient Name _____

Phone Number _____

Emergency Contact _____

Phone Number _____

Physician _____

Phone Number _____

RN Case Manager _____

Patient's Disaster Classification

_____ **"A" First Priority, patients with life threatening situations and no caregiver, Ventilator patients, Quadriplegics and Bed bound Patients.**

_____ **"B" Second Priority, persons living alone, those dependent on agency services for food, medication or tx, handicapped persons.**

_____ **"C" Third Priority, persons requiring minimal assistance or those with capable caregivers.**

Patient's Address: _____

Directions:_____

_____

_____

_____

_____

PROFESSIONAL CASE MANAGEMENT OF NV

Quality and Patient Safety Plan

2022

Located in Las Vegas, NV

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Quality and Patient Safety Overview

PCM of Nevada (NV) has an established, on-going Quality, Process Improvement, and Patient Safety Program to ensure an adequate and effective operation that extends to all functions and services. This program's scope includes accreditation, infection control, incident reporting, quality performance reports, training, and client satisfaction.

All Agency personnel, providers, and other affiliates are responsible and accountable for delivering quality service according to Agency standards and the program's guidelines. Activities conducted as part of the Quality, Process Improvement, and Patient Safety Program are documented quarterly by the Administrator and Business Operations Manager, then reviewed annually by the Professional Advisory Board and the Governing Body.

Quarterly meetings are held to discuss the quality and patient safety reports, which includes information about falls, medication errors (including near misses), infection rates, best practices, and upcoming process improvements. This information is then further discussed as needed to monthly staff meetings.

Professional Case Management
Helping People Live at Home

2022 Quality and Patient Safety Plan

The annual Quality and Patient Safety Plan covers a variety of key metrics for the successful and safe delivery of patient care. Each metric has acceptable thresholds, detailed information about data collection, and remediation information if needed.

Standard	Description of Monitoring Activities	Method of Measurement	Frequency of Measurement	Method of Data Collection	Who Collects Data	Who Analyzes Data	Where Data Lives Long-term	Acceptable Threshold	Performance Improvement Activity or Ongoing Remediation?
PD6-2D & PD7-1B Clinical Care	Client infections are reported by clinical staff	Infection report	Quarterly	Infection report when client has symptoms of infection	Clinical staff	Business Operations Manager	Quarterly Quality Report	Infections per 100 clients does not increase more than 4% in single quarter.	Yes PIA - for 2022 are being developed
PD6-2F Administrative function -	Employees are assigned training based on state regulations and job description	Completed Classes Report	Annual	Workday Learning Management System	Director of Clinical Operations or designee	Business Operations Manager	Workday LMS and Smartsheet Dashboard	At least 95% completed	Ongoing Action and Remediation
PD6-2F Administrative function	Audit newly hired personnel files for completeness	All hiring components based on state regulation are present	Bi-annually	Using state HR audit tool in smartsheet	Human Resource Manager or designee	Human Resource Manager	Quarterly Quality Report	95% compliance across all files	Ongoing Action and Remediation
PD6-2G Client satisfaction survey	Client satisfaction survey	External vendor – Amplitude Research	Annually	Mail survey to active clients	Amplitude Research	Amplitude Research	Full survey available upon request from COO, portions also reside in Quarterly Quality Report	At least 90% of clients give a score of "Excellent or Nearly Excellent" Service.	No PIA or remediation at this time
PD6-2G Employee satisfaction survey	Office Health Survey	Survey to all employees by job description	Bi-annually	Email survey	Chief Operating Officer's Executive Assistant	Chief Operating Officer's Executive Assistant	Full survey available upon request from COO, portions also reside in Quarterly Quality Report	Combined scores of 3,4, and 5 is equal 90% of respondents.	No PIA or remediation at this time
PD6-2H Client chart review	Audits of closed and active charts, hospital visits, ETC	Audit tool	Quarterly	Electronic audit tools	Regional Director or designee	Business Operations Manager	Quarterly Quality Report	90% Compliance	Ongoing Action and Remediation
PD6-2I Client feedback (complaint)	Client feedback is reported by Regional Director, investigated, and resolved	Client feedback is recorded in CareLink database	Quarterly	CareLink-Feedback Report	Regional Director enters data in CareLink	Chief Operating Officer	Quarterly Quality Report	No more than a 10% increase in a single quarter	No PIA or remediation at this time

Standard	Description of Monitoring Activities	Method of Measurement	Frequency of Measurement	Method of Data Collection	Who Collects Data	Who Analyzes Data	Where Data Lives Long-term	Acceptable Threshold	Performance Improvement Activity in 2020
PD6-4A & PD7-7A Client incidents	Client Incident are reported by clinical staff to the Regional Director to evaluate and resolve	Incident Report	Quarterly	Incident report when issue occurs	Clinical Staff	Business Operations Manager	Quarterly Quality Report	Incidents per 100 clients does not increase more than 4% in single quarter.	Yes PIA - Improving repeat client falls program
PD7-3A Emergency Preparedness	The Agency has, at a minimum, an annual practice drill to evaluate the adequacy of its plan	Annual drill/event tracker	Yearly	Tracker used by Clinical Staff to report on drills/events	Business Operations Manager	Business Operations Manager	Quarterly Quality Report	100% compliance	Yes PIA – Emergency Preparedness Plan improvements
PD6-2E Clinical care-	Documentation average Soapier Score of nursing staff	New nurses are audited 30 days after first shift and annually if score is 70% or higher	Quarterly	Soapier documentation audit tool	Quality Auditor	Business Operations Manager	Quarterly Quality Report	Average score is at least 70%	Ongoing Action and Remediation
PD6-2E Clinical Care	Documentation Improvement after Remediation 1	Nurses under 70% are audited after taking Remediation I class	Quarterly	Soapier documentation audit tool	Quality Auditor	Business Operations Manager	Quarterly Quality Report	Score improves to at least 70	Ongoing Action and Remediation
PD6-2E Clinical Care	Documentation Improvement after Remediation 2	Nurses under 70% are audited after taking Remediation 2 course	Quarterly	Soapier documentation audit tool	Quality Auditor	Business Operations Manager	Quarterly Quality Report	Score improves to at least 70	Ongoing Action and Remediation
PD6-2E Clinical Care	Documentation Improvement after Remediation 3	Nurses under 70% are audited after taking Remediation 3 one on one	Quarterly	Soapier documentation audit tool	Quality Auditor	Business Operations Manager	Quarterly Quality Report	Score improves to at least 70	Ongoing Action and Remediation
PD7-1E	Employee Infection Rates	OSHA Log	Annually	Employees report qualifying events to HR	HR Manager or designee	Business Operations Manager	Quarterly Quality Report	Threshold to be set in 2022.	No PIA or remediation at this time
PD7-7A	Employee Incident Rates	OSHA Log	Annually	Employees report qualifying events to HR	HR Manager or designee	Business Operations Manager	Quarterly Quality Report	Threshold to be set in 2022.	Yes PIA– Employee Slips and Falls

Client Chart Audits

A new, standardized chart audit process was rolled out in Q1 2021. This process is overseen by the corporate office, which plans out the audit schedule for the year, provides the audit tools, and picks the clients to be audited. Every quarter, PCM of NV does an audit of client charts for completeness and accuracy, following this program. The Administrator then take the top deficiencies and develops remediation plans. Over the last four quarters, 90% of items have been compliant in charts, which is the goal set out by the corporate office (as outlined above).

Professional Case Management
Helping People Live at Home

2022 Employee Education Plan

The following is Professional Case Management's annual education plan for clinical staff. It follows state and ACHC regulations and is designed to enhance clinical outcomes and patient safety.

Annual Education:
All clinical staff members providing direct or non-direct client care will participate in in-service/continuing education programs annually.

- Direct care personnel (Nurses, Aides and Attendants) will have a minimum of 12 hours of in-service/continuing education per year.
- Non-direct personnel (Companion Sitters) will have a minimum of 8 hours of in-service/continuing education per year.

Topics will include, but are not limited to:

- Emergency/disaster training
- How to handle complaints/grievances
- Infection control training
- Cultural diversity
- Communication barriers
- Ethics training
- Performance Improvement and safety (OSHA)
- Client/Patient Rights and Responsibilities statement
- Compliance program
- Elder abuse, neglect & exploitation
- Alzheimer's disease and behavioral management
- COVID-19

Training is delivered through PCM's Learning Management System as well as in-person. Course completion will be recorded in PCM's HRIS (Human Resource Information System). In addition to the ACHC required in-service topics above, PCM will develop additional educational content as needed. For example, education may be created due to industry changes, grievances/complaints, and/or updated state-mandated training requirements.

2022 Health Risk Assessment

Research was conducted using CDC and other expert guidelines to determine if a change to policy was necessary based on state and federal health regulations and with consideration to the on-going pandemic and current events.

PCM did not find any state or federal recommendations that would warrant a change to it's policies and/or procedures; however, as new variants of COVID continue to emerge, PCM engages in frequent communication with staff to remind them of policies, the importance of wearing face masks, practicing standard precautions and social distancing with all interactions and symptoms that would warrant testing for COVID-19.

Fall Reduction Program

Reducing falls, particular repeat falls, is an ongoing process improvement goal. A Falls Pilot Program was deployed in early 2021 in order to test a new methodology that included additional documentation, a medical equipment and supply kit, client and employee education, and outcome assessment. The initial pilot reduced repeat falls by 65% company-wide; based on these results, the pilot was turned into a permanent program in late 2021. Falls are reported via incident reports to the Administrator, and this is analyzed and included in quarterly quality reports. Further improvements may be created based on this information.

Flu Vaccine

Each year, PCM sends out information to employees encouraging them to get the flu vaccine. Case Managers also educate clients on the importance of flu vaccines. This is a program intended to protect clients, employees, and the wider community.

Infection Control and Hand Hygiene

PCM of Nevada has a comprehensive program to educate clients and employees about hand hygiene and infection protection, track infection rates, and develop process improvement plans as needed. This includes annual training for employees, hand outs, verbal education of clients, and quarterly reports of infection rates.

PCM is seeking to match an American Journal of IC (2/2015) benchmark, which showed Medicare HH patients averaging 4.5% to 11.5% infection rates per 100 clients. PCM of Nevada has stayed within that boundary for the past year, but if it were to not reach this goal an improvement plan would be developed by the Administrator and Business Operations Manager.

Professional Case Management (PCM) recognizes the impact that communicable disease has on health care workers and the community served. To ensure that all PCM caregivers are aware of and practice appropriate infection control and emergency management procedures they were enrolled in annual training courses that included these topics. These training courses are reviewed and updated annually to ensure that encompass current processes, procedures, and events.

PCM continues to have a sufficient supply of personal protective equipment on hand with processes in place for contact tracing and notifications when an employee or client has tested positive for COVID.

Feedback/Complaint Process:

Client feedback/complaints are processed using the following system. The Initial complaint is entered by the Administrator or designee into Carelink (an administration tool built on the Salesforce platform). The Administrator then begins the investigation and findings are updated in the CareLink record. The status is changed to “Resolved” when all required activities are completed. The COO will review the complaint for completeness, ensuring resolution has been obtained and client has been notified of the resolution – the COO will then mark the complaint as “Closed”. PCM of NV has had only one complaint in the last seven quarters.

Visiting Angels Las Vegas

Client / Caregiver SAFETY

INTRODUCTION

At Visiting Angels, we are committed to providing the best care and companionship for our clients so they can remain safe and comfortable in their own home, helping clients cope with the challenges of daily living that can often come with age or disability.

Visiting Angels has established a strong commitment to Client / Caregiver Safety and Quality. Our safety plan is designed to align and support our mission, vision and values and serve their needs of our clients and allow them to remain in the comfort of their own home. Appropriate policies and procedures have been developed and implemented. The primary focus of this policy is on preventing harm and promoting the safety of all clients and caregivers.

SAFETY

It is the company's policy to constantly strive for the highest level of safety in all services. The safety of employees and others on company premises is of utmost importance to us. The company is firmly committed to complying with applicable safety and health standards and will do its best to ensure that all work areas are free of hazardous conditions. We make every effort to provide working conditions that are as safe as possible, and we ask our employees to be just as careful. It is each employee's responsibility to know and comply with all health and safety rules, and to act in a safe manner.

GUIDING PRINCIPLES

-All staff, caregivers, clients, client's families are accountable and have a role to play in providing a safe and secure environment.

-Safety is promoted with the goal of developing an environment that is trusting and just for all, free from reprisal or recrimination.

-A safe and secure work environment for caregivers that contributes to safe client care.

-Reporting all incidents, no matter how minor

OVERVIEW

Visiting Angels promotes a safety culture that:

-Encourages reporting of any client / caregiver safety events.

-Educates caregivers to ensure safe practices are being deployed

-Ensures that all clients, family members or appropriate authorities are informed about the results of an incident

KEY OUTCOMES

1. A culture of client / caregiver safety
2. Caregiver working in a safe environment and safe manner
3. Caregiver reporting safety incidents immediately to supervisor

CONTINUE TO MONITOR / EDUCATE:

-Daily Covid Symptom Self-Assessment checker

-Hand Hygiene and Mask Compliance

-Initial Spot Check Worksheet

-Client Quality Care Satisfaction Surveys

PRIORITY GOALS:

As part of the company's commitment to client and caregiver safety, the following goals will be the focus

-Ensure all caregivers receive their annual retraining, with an emphasis on safety

-Ensure any negative surveys are followed up on

-Ensure new client initial spot check worksheet is completed

Measuring our Success

Determining the success of the Goal will be measured through ensuring all active caregivers have participated in their annual training session.

Ensuring all new client initial spot check worksheets compliancy 100%

Ensuring all completed and return surveys are addressed appropriately

ProCare Hospice of Nevada

QUALITY AND PATIENT SAFETY PLAN Template

DATE: 01/23/2022

VERSION: 01

This plan was created and revised by the_ ProCare Hospice of Nevada _ 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

ProCare Hospice of Nevada
8025 Amigo Street
Las Vegas, NV 89123
702-380-8300
702-380-3803 fax

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Commitment to Patient Safety

ProCare Hospice of Nevada is committed to a comprehensive approach to improving healthcare quality andpatient 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, ProCare Hospice of Nevada Patient Safety and Quality Improvement program promotes:

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

Scope and Purpose

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

- Patient safety
- Visitor safety
- Employee safety

All staff in ProCare Hospice of Nevada are required to fully support and participate in this plan, and devote their expertise to the patient safety and healthcare quality improvement process.

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

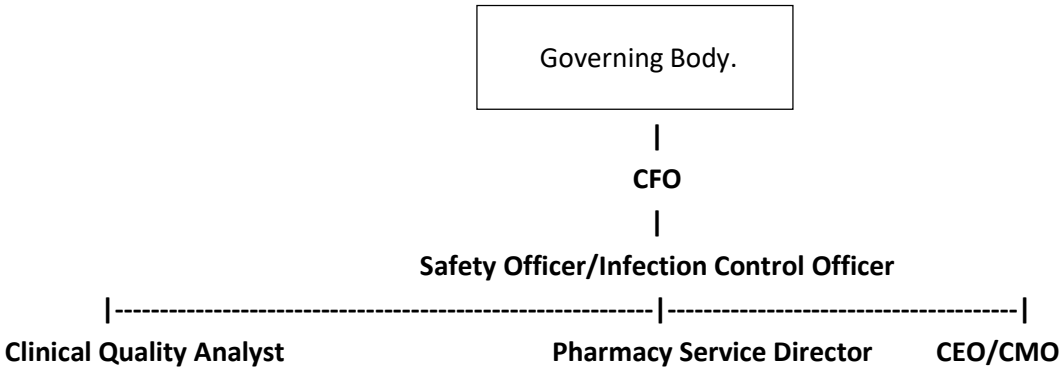
The plan focuses on the process rather than the individual, and recognizes both internal and external customers, as well as facilitates the need of analyzing and improving processes. The core principles of this plan include:

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

Roles and Responsibilities

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

The Patient Safety Committee Organization



Roles and Responsibilities

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.

(Additional responsibilities here if needed)

RCA team leader Responsibilities

Organize and coordinate the RCA process.

- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA, and corrective action plan implementation process.

- Communicate the progress of the investigation, institutional barriers, and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.
- Provide training, education and direction to create RCA process that incorporate the Patient Safety and Quality Improvement elements.

Executive or Governing Body Staff Responsibilities

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

The Patient Safety Committee will meet quarterly (at minimum) to accomplish the following:

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

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

- Define the healthcare issues or potential risks.
- Conduct Root Cause Analysis
  - Reviewing and analyzing the data.
  - Reviewing the RCA process and quality improvement related activities and timelines.
  - Brainstorming issues or the potential risks by using the fishbone diagrams.
  - Identify the contributing factors and conduct the Root Cause Analysis.
- Conduct Corrective Action Plan
  - Identifying the Plan-Do-Study-Act (PDSA) topics.
  - Discussing corrective action process and activities.
  - Discussing and presenting possible changes in procedure to improve areas indicated.
  - Identifying strengths and areas that need improvement.
  - Developing strategies, solutions, and steps to take next.
- Identify barriers and technical assistance needs for supporting the RCA efforts.

A meeting agenda and minutes noting follow-up tasks will be kept.

Objectives and Goals of the Quality and Patient Safety Plan

Objective	Goals	Plan	Planned Completion Date	Responsible Party

Components and Methods

Pursuant to NRS 439.837 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."

ProCare Hospice of Nevada will use RCA process to determine the contributing factors and the underlying reasons for the deficiencies or failures. The Plan-Do-Study (check)-Act (PDSA or PDCA) is the model, which was developed by the Institute of Health Care Improvement that we will use to testthe 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 ProCare Hospice of Nevada to explore the cause and effect relationship underlay a problem. One can find the root causes by asking "why" no less than five times. This technique can be usedindividually or as a part of the fishbone diagram.

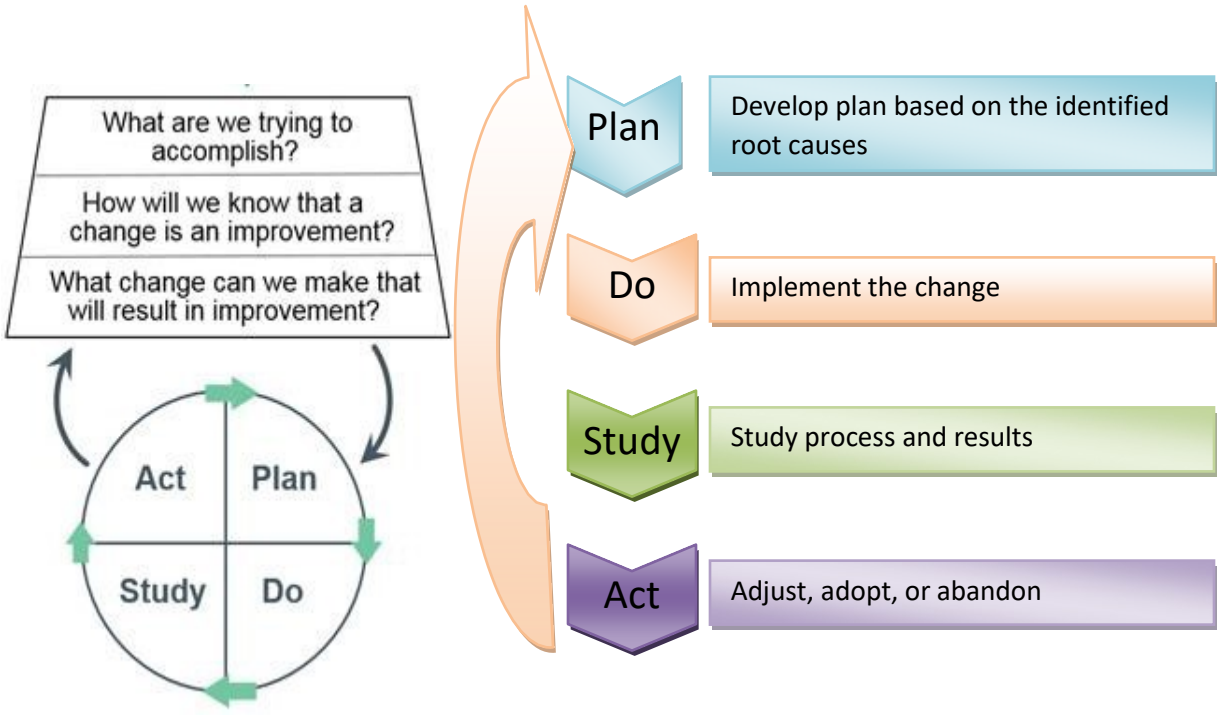
Fishbone Diagram

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 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. ProCare Hospice of Nevada is using MatrixCare for tracking the sentinel events, healthcare infection data, for internal data collection.

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

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

Ongoing Reporting and Review

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

Monthly	Quarterly	Annually
1) Sentinel event monthly report 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

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.)

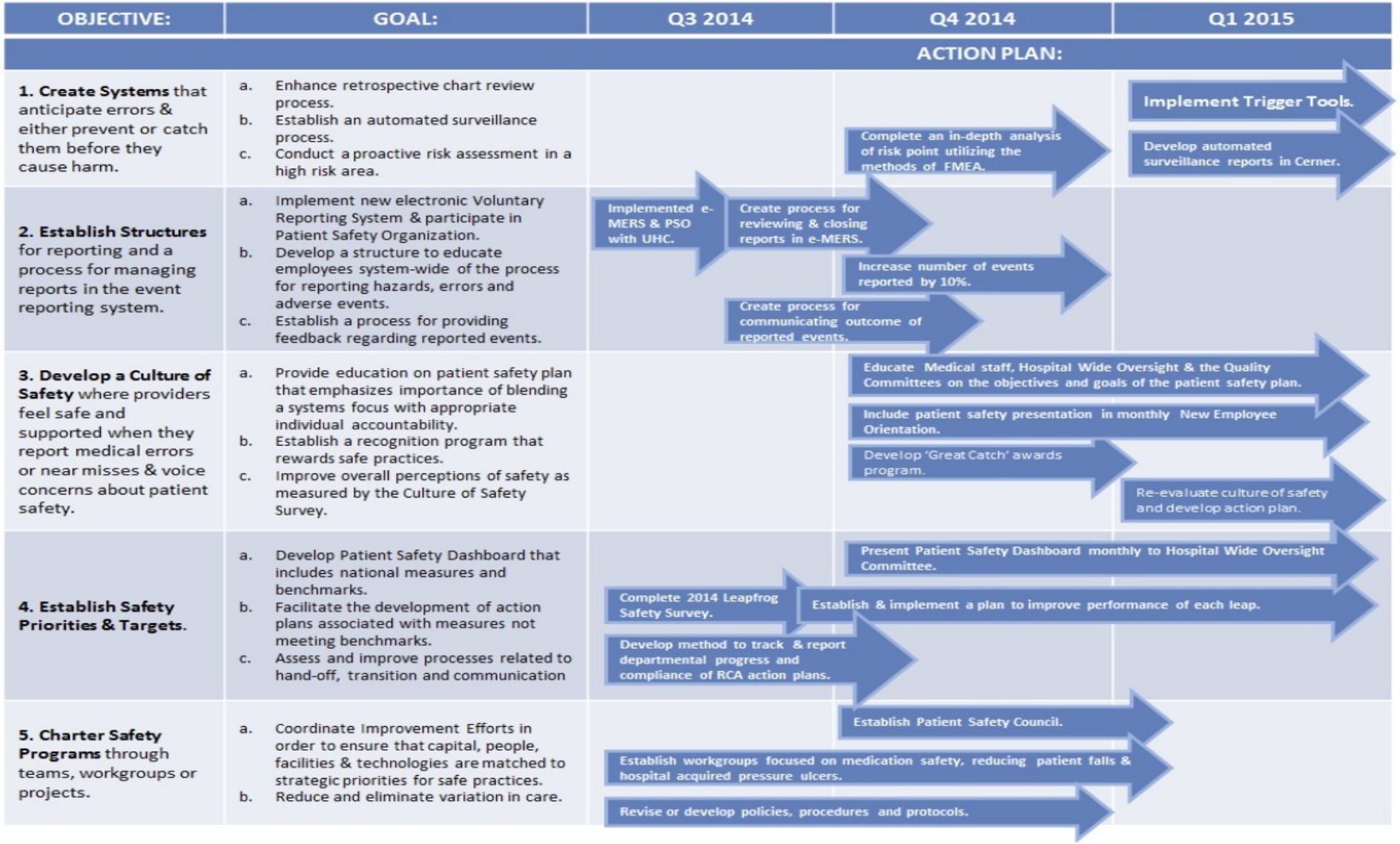
Risk: Possibility of loss or injury. (Merriam-Webster's Online Dictionary, Risk, Available at http://www.merriamwebster.com/dictionary/risk. Last Accessed August 2009.)

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.)

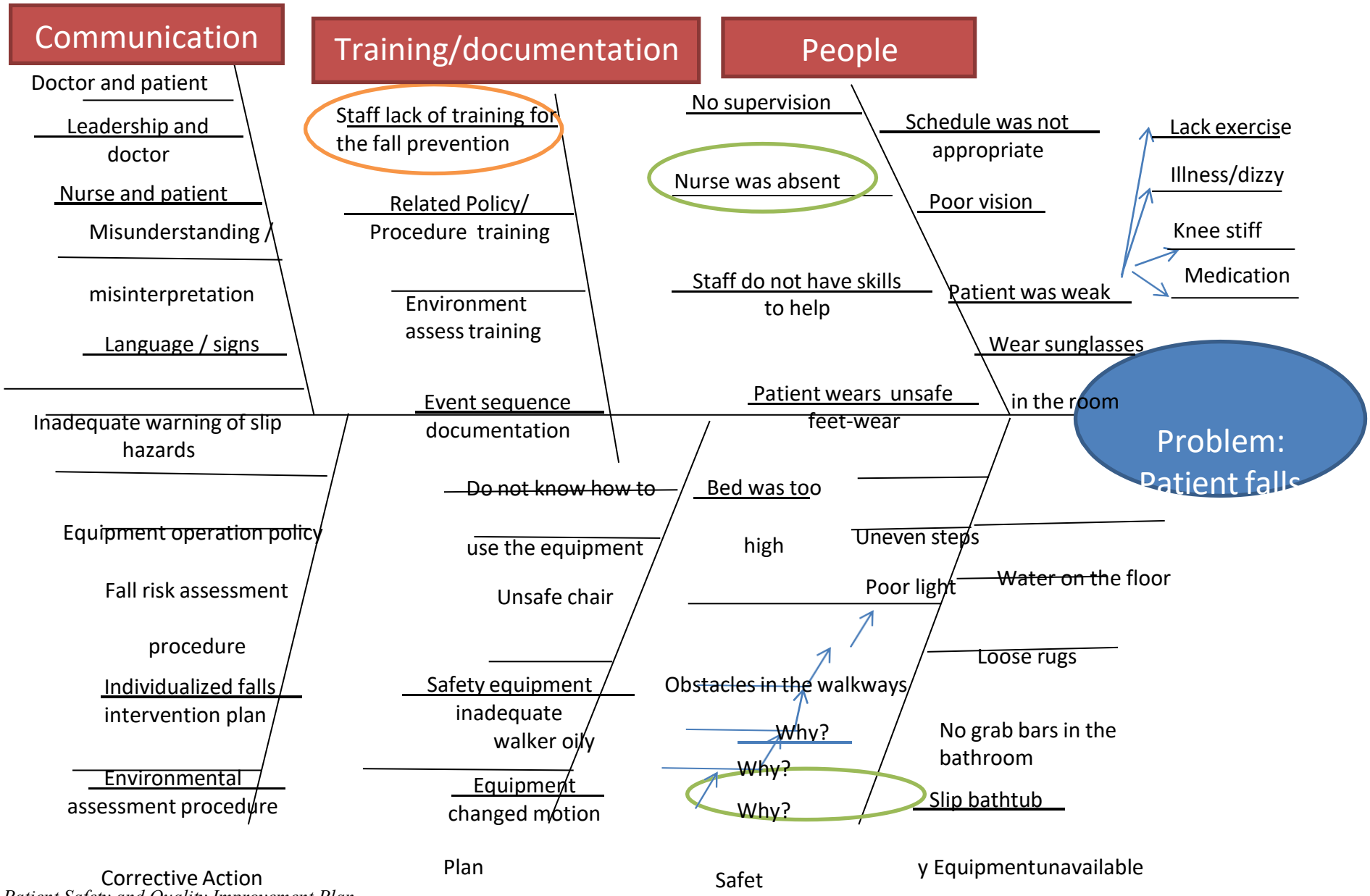
Central Line Associated Bloodstream Infections (CLABSI): Primary bloodstream infections that are associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection.

Appendix B: Patient Safety Goals



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

Appendix C: Fishbone Diagram



Why?

Landsonsmalll surfaceareaa

Why?—Root cause

Policies/Procedure

Equipment

Environment

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
- 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.

MERCY HOSPITAL	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:

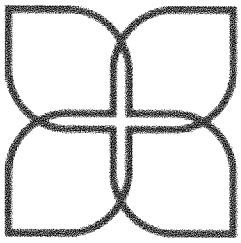
- PPE requirements are considered when risks are assessed;
- Suitable PPE is provided and made accessible to employees;
- PPE is properly stored, maintained, cleaned repaired and replaced when necessary;
- Adequate information and training is provided to those who require PPE;
- PPE is properly used;
- 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



MARQUIS

COMPANIES

Marquis Centennial Hills

Safety program

6351 N. Fort Apache Rd, Las Vegas, NV 89149

Reviewed: 01/01/2022

SAFETY POLICY

When an individual is employed, he or she has a right to expect a proper place in which to work and proper machines and tools with which to do the job, so that energy will be devoted to work without fear of possible harm to health. Only under such circumstances can the relationship between employer and employee be mutually advantageous. It is our desire to provide safe equipment with proper materials and to insist upon safe methods and practices.

Safe working habits on the part of all must be part of our operations. When you have a suggestion on how to reduce injuries or waste, tell your supervisor.

The success of our safety program depends solely on the cooperation, enthusiasm, and effort we all put into it. No job is so important that we cannot take time to do it safely.

Administrator

SAFETY PROGRAM

GOAL:

The goal of the program is to provide safe working conditions for employees and prevent injuries to workers due to unsafe practices and other conditions and at the same time minimize annual Worker Compensation Premiums for the entire corporation.

OBJECTIVES:

The program is aimed at providing a climate where working safely becomes the concern of all employees. It has 3 objectives, none of which can be completely successful without the others:

1. Involve employees in the design and maintenance of a safety program.

2. Reward employees who are successful in working without sustaining on the job injury.

3. Educate employees in the importance of work safety at New Employee Orientation and ongoing in services.

RESPONSIBILITY OF SUPERVISORS

Supervisors have the primary responsibility for our Safety Program and, as representatives of management, are delegated responsibility for carrying out certain objectives as follows:

1. Ensure that a conditional job offer (CJO) and medical review (when indicated) is completed with every new hire (See Appendix A for Safety Forms).

2. Educate new employees on the importance and expectation that they attend a minimum of three Safety Committee Meetings following hire.

3. Set the proper safety example.

4. Assume responsibility for employee safety.

5. Be responsible for a safe work place, personal protective items, storage of materials, and maintenance of equipment.

6. Enforce safety rules.

7. Counsel and train employees in safe work practices.

8. Conduct frequent safety inspections.

9. Investigate and properly report all accidents, in detail.

10. When an accident or incident is reported encourage affected employee(s) to attend the next Safety Committee meeting to participate in prevention planning.

11. See that injured employees receive prompt medical attention.

12. Contribute ideas to management.

13. Conduct new employee safety education on or before the employee begins working.

EMPLOYEE SAFETY RULES AND RESPONSIBILITIES

1. Employees are expected to conduct themselves in a professional manner at all times. Practical jokes or horseplay are forbidden. These acts cause accidents.

2. Report unsafe conditions or work habits to your supervisor. Suggestions are welcome.

3. New employees are expected to attend a minimum of the first 3 Safety Committee Meetings following hire in order to orient themselves to the company/facility Safety Programs, and the first 3 Safety Committee Meetings immediately following any on-the-job injuries to re-orient themselves to the Safety Programs.

4. Report all injuries to your supervisor, immediately. Complete an Incident Report on every injury sustained and turn into your supervisor by the end of the shift in which you are injured.

5. Employees are responsible for their own safety. DO YOUR PART.

6. Conduct work activities in a manner that will not endanger other people, and set an example for other employees.

7. Undertake only those jobs you are authorized to do and that you understand.

8. When making a lift, set feet solidly. Get as close to the object as possible, bend the legs, grip the object firmly, straighten the legs to lift the object comfortably. Do not be a hero. When an object is too heavy or awkward for you, get help. Use a gait belt.

9. Smoking must be confined to designated areas. There are no exceptions.

10. Personal protective equipment must be worn on jobs which require it.

11. Housekeeping is everyone's responsibility. Keep the facility clean and orderly. Clean up and put equipment away.

12. Know the location and use of fire extinguishers. Keep access areas clear.

13. If you are having health problems or feel that there are circumstances which could affect your well-being, mention it to your supervisor.

14. A violation of safety policies or posted safety rules will be cause for disciplinary action. Repeat violations will result in possible suspension or termination at the option of the Administrator.

15. If you are ever in doubt about a safety procedure, consult your supervisor immediately.

NO JOB IS SO URGENT, AND NO WORK SCHEDULE SO RIGID, THAT WE CANNOT TAKE TIME TO WORK SAFELY!

EMPLOYEE EDUCATION

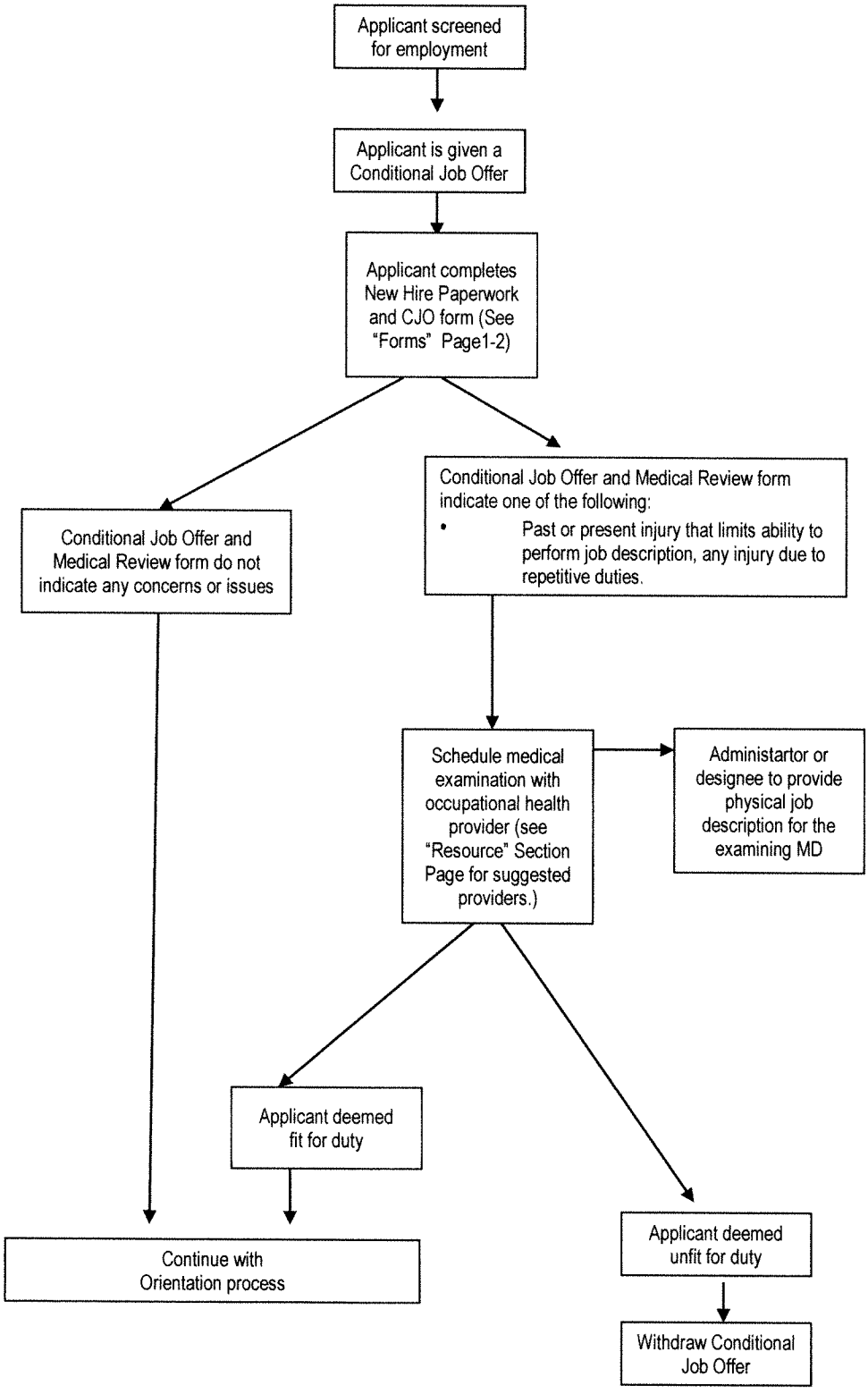
It is the responsibility of the facility to train employees in the performance of their job duties. This includes instruction in the safest techniques to be used.

All new employees should receive orientation in basic safety skills including lifting and bending techniques, resident transfers and hand washing. Special attention should be paid to lifting, bending and transfers as this is the area of highest risk and liability. If possible, have a physical therapist or other professional conduct hands on training.

Ongoing employee education cannot be stressed enough. Other ideas for this continuing education might be safety features held at in-services, bulletin board posters, guest speakers, reminders in the employee bulletin, paycheck stuffers, brochures/handouts, etc.

YOU CAN NEVER OVERDO THE REINFORCEMENT FOR WORKING SAFELY!

Conditional Job Offer & Medical Review Form Procedure



****Facility is responsible for cost of "Fit For Duty" Exams**

SAFETY COMMITTEE

Goal:

Promote employee awareness of the importance of working safely through employee involvement and interaction by setting and maintaining safety standards for the facility.

Objectives:

1. To assist in the evaluation and improvement of safety and health in the facility.

2. To provide a channel of communication for open discussion of problems that resulted, or could have resulted in an injury or illness;

3. To improve the spirit of cooperation among facility staff members.

Committee Membership:

Membership is recommended to be a minimum of four employees. Half of your members should be managers and half should be line staff. It is not recommended for the administrator to be a committee member.

It is recommended that the committee be composed of the following personnel:

Representative from the following departments:

Nursing
Dietary
Housekeeping and/or Laundry
Maintenance
Activities and/or Social Services

SAFETY COMMITTEE PROTOCOL

All Committee officers are responsible to the Administrator of the facility, as well as the membership of the Safety Committee.

If a member is experiencing difficulty concerning another member, or something pertaining to Safety Committee business, they should first take the problem to an officer of the committee, who in turn will discuss the problem with the remaining officers of the committee, in an effort to resolve it. In the event that a resolution cannot be found, the Chairperson will then consult the Administrator of the facility. If a member feels that the officers of the committee are not addressing the problem in a timely manner, they may then approach the Administrator themselves.

This is not to say that the membership at large cannot approach the Administrator on their own if that is felt to be the only solution, but that an attempt to resolve Committee problems, by the committee, should be the first step.

Acknowledging that nothing pertaining to Committee business is secret to the membership, but that some items need only be known by the officers in the interim between meetings, when all affairs of the committee are made known; it is suggested that topics pertaining to current affairs of the Safety Committee, be made known to the officers before they are made public, or become general knowledge, thereby lessening the opportunity that an officer will be embarrassed publicly due to a lack of knowledge pertaining to those affairs.

The Administrator of the facility will receive a copy of the minutes of each meeting, in a timely manner, from the Chairperson, at which time any new business can be discussed and made known.

It is expected that each member, will come to meetings prepared to discuss business, and that each officer or sub-committee person will be prepared to give a report on that area for which they are responsible.

A code of respectful silence will be maintained during each presentation, with comments or discussion on the subject matter, made only after making a request for the floor. In this way, each member will have the opportunity to voice an idea or opinion and be heard.

When a member of the Safety Committee is unable to attend a meeting, for whatever reason, they will notify the chairperson, as soon as possible, so that an awareness of the absence is known before the meeting.

DUTIES AND RESPONSIBILITIES

Employee Safety

1. Develop directives and programs, and identify standards for employee safety.

2. Design an annual safety inservice program for the education of all employees.

3. Review Incident Reports of all employee injuries for suggestions to correct potential safety hazards. Employees experiencing an on the job accident which necessitates in the filing of an 801 may be asked to attend the next Safety Committee meeting to discuss the accident.

4. Gather and evaluate information which is relevant to employee safety:
   - reports of employee incidents
   - suggestions of employees regarding improvement of employee safety
   - safety inspection reports
   - relevant standards, laws, regulations and safety communications

5. Review and analyze jobs to determine hazards, giving emphasis to those showing high incident occurrence.

6. Make recommendations to administration regarding improvement of employee safety.

Resident Safety

1. Develop directives and programs and identify standards for resident safety.

2. Promote education and training of employees regarding safe resident care practices.

3. Establish a system of reporting resident incidents.

4. Conduct regular periodic inspections throughout the facility.

5. Gather and evaluate information which is relevant to resident safety as directed:
   - resident incident reports
   - suggestions of employees and residents regarding improvement of resident safety
   - safety inspection reports relevant standards, laws, regulations and safety communications.

6. Make recommendations to administration for improvement of resident safety.

7. Coordinate programs with the Facility Infection Control Committee and/or Emergency Response Team (if and when applicable).

Fire Safety (as assigned)

1. Develop directives and programs, and identify standards relating to fire safety.

2. Review and evaluate fire drills, fire incidents, and fire safety inspections of the nursing home.

3. Review and evaluate fire safety inspection reports of the State Fire Marshall.

4. Promote training programs for new and existing personnel.

5. Make recommendations to administration for improvement of fire safety.

Other Emergency Plans (as assigned)

1. Develop and/or review for appropriateness an emergency plan for the facility covering such event as: wind storm, flood, explosion, power outage, etc. (See Facility Emergency Preparedness Manual)

2. Coordinate such plans throughout the facility and with exterior agencies as appropriate.

3. Systematically evaluate and update these plans.

4. Promote training programs for new and existing personnel.

SAFETY COMMITTEE JOB/RESPONSIBILITY DESCRIPTION

CHAIRPERSON: The chairperson shall serve a term of twelve, (12) months, after which the new chairperson will assume the duties, following a majority vote by the membership. If the membership requests that the serving chairperson serve a second, (2), term, and the chairperson consents to this, a majority vote is again needed. A member should only serve two, (2), consecutive terms in office. **Exceptions to this guideline will be reviewed by the Administrator of the facility for necessity.**

The Chairperson is responsible to the Administrator of this facility, and invites said person to all meetings, and/or gives a report of all business discussed. The Chairperson moderates all Safety Committee meetings and hears reports from all Committee members and officers. In the Chairpersons absence, the secretary will chair the meetings

SECRETARY: The secretary serves an elected term of six, (6), months, after which a new person will assume the duties following a majority vote by the membership. The secretary may serve a second, (2), terms, at the request of the membership, and a majority vote of the membership. The secretary may serve only two, (2) consecutive terms, but may be voted into office again after a six, (6) month interval. **Exceptions to this ruling will be reviewed by the Administrator of the facility for necessity.**

The Secretary is responsible to the committee as a whole, but to the Chairman, for job related duties. The Secretary records the minutes of all Safety meetings accurately, and gives copies of said minutes to each Safety Committee member in a timely manner. The Secretary will read the minutes of the previous meeting at each current meeting, and make all corrections and amendments.

The Secretary will serve in place of the Chairperson, at all Committee functions, if the Chairperson should be absent. The Secretary will keep the Chairperson informed of all communication received, relating to the committee, in the interval between meetings. The Secretary will also announce a meeting, to the employees at large, before the start of each meeting. An agenda for the current meeting will be available to the members.

OPTIONAL

TREASURER: The treasurer will be elected to a six (6) month term by the majority of the membership, and may not serve two (2) terms consecutively. After a six (6) month interval, a previous treasurer may be elected again. **Exceptions to this guideline will be reviewed by the Administrator of the facility for necessity.**

The Treasurer will give a report, at each meeting of the membership, of all expenses and moneys earned. A balance of money on hand will also be reported at that time. The Treasurer is responsible for keeping an accurate account of the financial state of the committee and safeguarding the monies entrusted to them, as well as receipts of expenses.

SAFETY COMMITTEE MEETING GUIDELINES

Safety Committee Meetings are to be held at least quarterly, but monthly is preferred. A suggested order of business might be as follows:

1. CALL TO ORDER: Meeting should be called together promptly.

2. ATTENDANCE: Names of persons present should be recorded and members who cannot attend should notify the Chairperson with reasons for absence noted in the minutes.

3. INTRODUCTION OF VISITORS: Name, title and facility or company.

4. MINUTES: Minutes of the previous meeting should be read and corrections made.

5. UNFINISHED BUSINESS: When definite decisions have not been made on previous action items, they should be brought up for reconsideration.

6. REVIEW OF INCIDENT REPORTS: Incident Reports for all employee and resident accidents will be reviewed. Injured workers will not be identifiable to the committee. Accident causes and preventive measures should be discussed to prevent reoccurrence of similar incidents.

7. SAFETY EDUCATION: The Chairperson should obtain speakers, if desired, and prepare an agenda. Subjects should be recorded in the minutes.

8. INSPECTION AND RECOMMENDATIONS: Regular facility inspections will be conducted to note unsafe conditions and work practices and recommendations for corrections included in the minutes. (See "Resource" Section for inspection / walkthrough checklists.)

Minutes will be posted on the employee bulletin board for the review of all employees.

Safety Committee Minutes, Incidents and OSHA Logs must be retained for a period of no less than 5 years.

Prior to a Safety Committee Meeting a "Meeting Notice" should be posted to notify facility staff members. (See "Forms" page 4).

During each Safety Meeting the Secretary or designee will keep Minutes – A suggested format for minutes is included in the "Forms" section page 5.

MONTHLY SAFETY FEATURE AGENDA

(See "Resource" Section – "Education Materials" for Inservices as listed below)

One aid to a successful program is to spotlight a monthly safety feature. Inspections and safety awareness materials should be discussed by the Safety Committee, Administrator and Supervisors.

Long term care industry programs, current facility accident reports, or other activities may suggest subjects to be featured.

The following are possible topics for a 12 month period (do not have to correlate to months noted):

January	Proper lifting techniques	Quarterly Inspection
February	Floors, aisles, and walking surfaces	
March	Machine/equipment hazards	
April	Eye and face protection	Quarterly Inspection
May	Stairs and ramps	
June	Electrical hazards	
July	Combative residents	Quarterly Inspection
August	Housekeeping	
September	Resident transfers	
October	Fire prevention	Quarterly Inspection
November	Stress management	
December	Facility safety inspection	

Safety and Supervision of Residents

Policy Statement

Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities.

Policy Interpretation and Implementation

Facility-Oriented Approach to Safety

1. Our facility-oriented approach to safety addresses risks for groups of residents.

2. Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes; QA&A reviews of safety and incident/accident reports; and a facility-wide commitment to safety at all levels of the organization.

3. When accident hazards are identified, the QA&A/Safety Committee shall evaluate and analyze the cause(s) of the hazards and develop strategies to mitigate or remove the hazards to the extent possible.

4. Employees shall be trained and inserviced on potential accident hazards and how to identify and report accident hazards, and try to prevent avoidable accidents.

5. The QA&A Committee and staff shall monitor interventions to mitigate accident hazards in the facility and modify as necessary.

Resident-Oriented Approach to Safety

1. Our resident-oriented approach to safety addresses safety and accident hazards for individual residents.

2. Staff shall use various sources to identify risk factors for residents, including the information obtained from the medical history, physical exam, observation of the resident, and the MDS.

3. The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for that resident. The care team shall target interventions to reduce the potential for accidents.

4. Implementing interventions to reduce accident risks and hazards shall include the following:

a. communicating specific interventions to all relevant staff;
b. assigning responsibility for carrying out interventions;
c. providing training, as necessary;
d. ensuring that interventions are implemented; and
e. documenting interventions.

5. Monitoring the effectiveness of interventions shall include the following:

a. ensuring that interventions are implemented correctly and consistently;
b. evaluating the effectiveness of interventions;
c. modifying or replacing interventions as needed; and
d. evaluating the effectiveness of new or revised interventions.

Systems Approach to Safety

1. The facility-oriented and resident-oriented approaches to safety are used together to implement a systems approach to safety, which considers the hazards identified in the environment and individual resident risk factors, and then adjusts interventions accordingly.

2. Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment.

3. The type and frequency of resident supervision may vary among residents and over time for the same resident. For example, resident supervision may need to be increased when there are temporary hazards in the environment (such as construction) or if there is a change in the resident's condition.

Resident Risks and Environmental hazards:

1. Due to their complexity and scope, certain resident risk factors and environmental hazards are addressed in dedicated policies and procedures. These risk factors and environmental hazards include:

a. Bed Safety
b. Safe Lifting and Movement of Residents
c. Falls
d. Smoking
e. Unsafe Wandering

f. Poison Control
g. Electrical Safety
h. Water Temperatures

2. Other topics related to resident risk and environmental hazards may be addressed within related policies and procedures (for example, adequate lighting is addressed under the topic of falls).

References

OBRA Regulatory Reference Numbers	N/A
Survey Tag Numbers	F689, F921
Related Documents	Accidents and Incidents – Investigating and Reporting; Poison Control; Smoking Policy – Residents; Resident-to-Resident Altercations (Resident Rights and Dignity); Falls and Fall Risk, Managing (Falls and Fall Risk); Wandering, Unsafe Resident (Behavior, Mood and Cognition)
Policy Revised	Date: *5/2010 By:* Marquis Companies

Accidents and Incidents - Investigating and Reporting

Policy Statement

All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the Administrator. All accidents and incidents involving residents on or off premises will be investigated and reported to the administrator. Investigations shall be completed within 5 days of the incident.

Policy Interpretation and Implementation

1. The Licensed Nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident. Incident would include, but are not limited to; found on floor, fall, bruise, skin tear, laceration, abrasion, excoriation, pressure ulcer, burn, elopement, resident to resident encounter, etc.

2. The following data, as applicable, shall be included in the resident's electronic clinical record.

   a. The date and time the accident or injury took place;
   b. The nature of the injury/illness (e.g., bruise, fall, nausea, etc.);
   c. The circumstances surrounding the accident or injury;
   d. Where the accident or injury took place;
   e. The injured resident's account of the accident or injury(as able);
   f. The Attending Physician who was notified;
   g. The injured resident's representative who was notified (for residents who are not their own responsible party;
   h. The condition of the injured resident, including his/her vital signs as applicable;
   i. The disposition of the resident (i.e., transferred to hospital, put to bed, sent home, returned to work, etc.);
   j. Any care plan changes made;
   k. Follow-up information;
   l. Other pertinent data as necessary or required; and
   m. The signature and title of the person completing the report.

3. Witnesses and/or those who may have knowledge of the accident or injury will be interviewed as part of the investigation. A summary of the interviews will be included as part of the investigation summary in the clinical record as applicable.

4. The Licensed Nurse and/or the department director or supervisor shall complete the appropriate resident event assessment within the clinical record.

5. For any accident/incident that may meet the definition of potential abuse/neglect, refer to Abuse Investigation policy and procedure.

References

OBRA Regulatory Reference Numbers	N/A
Survey Tag Numbers	F607; F943; F689
Related Documents	Abuse and Neglect protocols, Assessing falls, elopement assessment, skin and wound assessments, resident to resident assessment.
Policy Revised	Date: *5/2010 By:* Marquis Companies
	Date: 8*/2010 By:* Marquis Companies
	Date: *5/2011 By:* Marquis Companies
	Date: 8*/2017 By:* Marquis Companies
	Date: *5/2018 By:* Marquis Companies

Bed Safety

Policy Statement

Our facility shall strive to provide a safe sleeping environment for the resident.

Policy Interpretation and Implementation

1. The resident's sleeping environment shall be maintained by the interdisciplinary team, considering the resident's safety, medical conditions, comfort, and freedom of movement, as well as input from the resident and family regarding previous sleeping habits and bed environment.

2. To try to prevent deaths/injuries from the beds and related equipment (including the frame, mattress, assistive devices, headboard, footboard, and bed accessories), the facility shall promote the following approaches:

a. Inspection by maintenance staff of all beds and related equipment as part of our regular bed safety program to identify risks and problems including potential entrapment risks;
b. Review that gaps within the bed system are within the dimensions established by the FDA (Note: The review shall consider situations that could be caused by the resident's weight, movement or bed position.);
c. Ensure that when bed system components are worn and need to be replaced, components meet manufacturer specifications;
d. Ensure that assistive mobility devices are properly installed using the manufacturer's instructions and other pertinent safety guidance to ensure proper fit (e.g., avoid bowing, ensure proper distance from the headboard and footboard, etc.); and
e. Identify additional safety measures for residents who have been identified as having a higher than usual risk for injury including entrapment (e.g., altered mental status, restlessness, etc.).

3. The facility's education and training activities will include instruction about risk factors for resident injury due to beds, and strategies for reducing risk factors for injury, including entrapment.

4. If assistive devices for bed mobility are used, including but not limited to bed canes/arc rails, there shall be an assessment of the resident, consultation with the Attending Physician if indicated, and input from the resident and/resident representative.

5. The staff shall obtain consent for the use of the assistive device from the resident or the resident's representative prior to their use.

6. After appropriate review and consent as specified above, assistive devices may be used at the resident's request to increase the resident's sense of security (e.g., if he/she has a fear of falling, his/her movement is compromised, or he/she is used to sleeping in a larger bed).

7. Side rails may be used if assessment and consultation with the Attending Physician has determined that they are needed to help manage a medical symptom or condition, or to help the resident reposition or move in bed and transfer, and no other reasonable alternatives can be identified. (See Proper use of Side Rails policy)

8. Side rails shall not be used as protective restraints. Should a protective restraint be used, our facility's protocol for the use of restraints shall be followed.

9. The use of physical restraints on individuals in bed shall be limited to situations where they are needed to treat a resident's medical symptoms, and only after being reviewed by authorized individuals.

10. The staff shall report to the Director of Nursing and Administrator any deaths, serious illnesses and/or injuries resulting from a problem associated with a bed and related equipment including the bed frame, bed assistive device, side rails, and mattresses. The Administrator shall ensure that reports are made to the Food and Drug Administration or other appropriate agencies, in accordance with pertinent laws and regulations including the Safe Medical Devices Act.

References

OBRA Regulatory Reference Numbers	N/A
Survey Tag Numbers	F689; F908
Related References	See also FDA's Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment; and The Hospital Bed Safety Workgroup's Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings
Policy Revised	Date: *5/2010 By:* Marquis Companies

Electrical Safety for Residents

Policy Statement

The resident will be protected from injury associated with the use of electrical devices, including electrocution, burns and fire.

Policy Interpretation and Implementation

1. Orient the resident to basic electrical safety precautions as part of the admission process, and reinforce the following guidelines with the resident as indicated and/or appropriate:

    a. Ensure that the hands are dry before using an electrical device;
    b. Do not to use electrical devices while standing on a wet floor;
    c. Pull electrical cords out by the plug and never yank the cord;
    d. Report electrical devices if they cause even minor shocks;
    e. Unplug any electrical device that appears to be overheating by smell or touch;
    f. Do not use any electrical device that has been dropped or abused, or if liquid has spilled into it. Wait until it has been checked and declared safe for use; and
    g. Do not use electrical appliances where oxygen is being administered or stored.
    h. Do not use any additional electric adapters/plug ins that have not been approved by facility maintenance director.

2. Inspect electrical outlets, extension cords, power strips, and electrical devices as part of routine fire safety and maintenance inspections.

3. Portable space heaters are not permitted in the facility.

4. Halogen lamps shall be used with caution and away from combustible items in the resident's environment.

5. Extension cords shall not be used as a substitute for adequate wiring in the facility.

6. When extension cords are used, the following precautions must be taken and they must comply with NPFA standards;

    a. Secure extension cords and do not place overhead, under carpets, or where they can cause trips, falls, or overheat;
    b. Connect extension cords to only one device;
    c. Ensure that the type of cord used is appropriate of the size and type of electrical load;
    d. Ensure that cords have proper grounding; and
    e. Inspect regularly for fraying, cuts, or breakage.

7. Power strips shall not be used as a substitute for adequate electrical outlets in the facility. Power strips may be used for a computer, monitor, and printer. Power strips in use must comply with NFPA standards.

8. Power strips shall not be used with medical devices in resident-care areas.

9. When power strips are used, the following precautions must be taken, in addition to must meet NFPA standards;

    a. Install internal ground fault and over-current protection devices;
    b. Secure power strips so that they do not cause trips or falls; and
    c. Use power strips that are adequate for the number and types of devices used.

10. Ground fault circuit interruption devices shall be used in locations near water sources to prevent electrocution of residents and staff.

11. The use of electric blankets and electric heating pads is not allowed.

References

OBRA Regulatory Reference Numbers	N/A
Survey Tag Numbers	F689
Related Documents	N/A
Policy Revised	Date: *5/2010 By:* Marquis Companies

Hazardous Areas in the Facility

Policy Statement

Hazardous areas in the facility shall be identified with appropriate precautionary signs.

Policy Interpretation and Implementation

1. All hazardous areas are so designated and can be identified on floor plans posted throughout the facility.
2. Hazardous areas, such as power rooms, boiler rooms, oxygen or other flammable liquids storage rooms, etc., are posted with No Smoking signs.
3. Smoking is prohibited in all hazardous areas.
4. The facility's Safety Committee shall recommend measures to ensure that residents cannot access hazardous areas in the facility.
5. The Administrator is responsible for communicating all safety recommendations adopted by the Safety Committee to the appropriate departments within the facility.
6. The Safety Committee shall periodically check for the implementation and integrity of measures intended to prevent residents from entering hazardous areas.

References

OBRA Regulatory Reference Numbers	N/A
Survey Tag Numbers	F689; F836
Related Documents	N/A
Policy Revised	Date: *5/2010 By:* Marquis Companies

Poison Control

Policy Statement

Poison control information shall be readily available throughout the facility.

Policy Interpretation and Implementation

1. Information about poisoning and poison control, including key contact information, is located at Nursing stations/Medication rooms. This information shall be posted at each nurses' station and/or medication room and other areas of the facility where hazardous and poisonous substances may be used or stored.
2. Antidote information is also available at each nurses' station and/or Medication room.
3. If a resident is suspected of taking poison, nursing staff will notify the Attending Physician and Director of Nursing Services.
4. Administer treatment as ordered by the physician, based on poison control recommendations.
5. Nursing staff will document the resident's condition in the resident's clinical record, and the interventions that were made.
6. Staff will complete an incident report per the appropriate policy.

References

OBRA Regulatory Reference Numbers	N/A
Survey Tag Numbers	F689
Related Documents	N/A
Policy Revised	Date: *5/2010 By:* Marquis Companies

Proper Use of Side Rails - Level II

Purpose

The purposes of these guidelines are to ensure the safe use of side rails as resident mobility aids and to prohibit the use of side rails as restraints unless necessary to treat a resident's medical symptoms.

Definition

Physical restraints are defined by the Centers for Medicare and Medicaid Services (CMS) as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. (Note: The definition of restraints is based on the functional status of the resident and not on the device, therefore any device that has the effect on the resident of restricting freedom of movement or normal access to one's body could be considered a restraint.)

General Guidelines

1. Side rails are considered a restraint when they are used to limit the resident's freedom of movement (prevent the resident from leaving his/her bed). (Note: The side rails may have the effect of restraining one individual but not another, depending on the individual resident's condition and circumstances.)

2. Side rails are only permissible if they are used to treat a resident's medical symptoms or to assist with mobility and transfer of residents.

3. An assessment will be made to determine the resident's symptoms or reason for using side rails. When used for mobility or transfer, an assessment will include a review of the resident's:

   a. Bed mobility; and
   b. Ability to change position, transfer to and from bed or chair, and to stand and toilet.

4. The use of side rails as an assistive device will be addressed in the resident care plan.

5. Consent for using restrictive devices will be obtained from the resident or resident representative per facility protocol.

6. Less restrictive interventions that may be incorporated in care planning include:

   a. Providing restorative care to enhance abilities to stand safely and to walk;
   b. Providing a trapeze to increase bed mobility;
   c. Providing a bed cane/arc rail to increase bed mobility;
   d. Providing staff monitoring at night with periodic assisted toileting for residents attempting to arise to use the bathroom; and/or
   e. Furnishing visual and verbal reminders to use the call bell for residents who can comprehend this information.

7. Documentation will indicate if less restrictive approaches are not successful, prior to considering the use of side rails.

8. The risks and benefits of side rails will be considered for each resident.

9. Consent for side rail use will be obtained from the resident or resident's representative, after presenting potential benefits and risks. (Note: Federal regulations do not require written consent for using restraints. Signed consent forms do not relieve the facility from meeting the requirements for restraint use, including proper assessment and care planning. While the resident or representative may request a restraint, the facility is responsible for evaluating the appropriateness of that request.)

10. The resident will be checked periodically for safety relative to side rail use.

11. If side rail use is associated with symptoms of distress, such as screaming or agitation, the resident's needs and use of side rails will be reassessed.

12. When side rail usage is appropriate, the facility will assess the space between the mattress and side rails to reduce the risk for entrapment (the amount of safe space may vary, depending on the type of bed and mattress being used).

13. Side rails with padding may be used to prevent resident injury in situations of uncontrollable movement disorders, but are still restraints if they meet the definition of a restraint.

14. Facility staff, in conjunction with the Attending Physician, will assess and document the resident's risk for injury due to neurological disorders or other medical conditions.

References

MDS (RAPs)	N/A
Survey Tag Numbers	F689; F604

Related Documents	Bed Safety
Risk of Exposure	N/A
Policy Revised	Date: *5/2010 By:* Marquis Companies

Recall of Equipment / Drugs

Policy Statement

The Administrator, Consultant Pharmacist, Director of Nursing, and Safety Committee shall collaborate when equipment, medical supplies, or drugs have been recalled.

Policy Interpretation and Implementation

1. Upon receiving notice of a recall of equipment or medical supplies, the Director of Nursing Services, or designee, shall oversee the removal of such supplies from immediate use.
2. The Safety Committee and Administrator shall help the Director of Nursing ensure that such equipment, supplies, or medications have been removed from use and are destroyed, returned, or otherwise managed as requested or required by the vendor, manufacturer, government agencies, etc.

References

OBRA Regulatory Reference Numbers	N/A
Survey Tag Numbers	F689; F915
Related Documents	N/A
Policy Revised	Date: *5/2010 By:* Marquis Companies

Resident Identification System

Policy Statement

A resident identification system is used to help facility personnel provide medical and nursing care.

Policy Interpretation and Implementation

1. Our facility has adopted a photo identification system to help assure that medication and treatments are administered to the right resident.
2. Data contained on the photo identification is confidential and is used by nursing service personnel when administering medications and treatments.
3. Photo identification may only be released to authorized personnel in accordance with facility policy and current state/federal regulations governing the release of resident information.
4. Prior to or upon admission, the resident or his/her representative must authorize the facility in writing to photograph the resident and to release data contained in the identification file.
5. Nursing staff will review and update resident identification information as necessary, in conjunction with the business office.
6. Inquiries about our resident identification system should be referred to the Director of Nursing Services.

References

OBRA Regulatory Reference Numbers	N/A
Survey Tag Numbers	F583; F842; F675; F684; F697; F698; F744; F759; F760
Related Documents	N/A
Policy Revised	Date: *5/2010 By:* Marquis Companies

Routine Resident Checks

Policy Statement

Staff shall make routine resident checks to help maintain resident safety and well-being.

Policy Interpretation and Implementation

1. To ensure the safety and well-being of our residents, nursing staff shall make a routine resident check on each unit at least every 2 hours. Exceptions may exist for residents based on individualized assessment and care planning.

2. Routine resident checks involve entering the resident's room and/or identifying the resident elsewhere on the unit to determine if the resident's needs are being met, identify any change in the resident's condition, identify whether the resident has any concerns, and see if the resident is sleeping, needs toileting assistance, etc.

3. The person conducting the routine check shall report promptly to the Licensed Nurse any changes in the resident's condition and medical needs.

References

OBRA Regulatory Reference Numbers	N/A
Survey Tag Numbers	F558; F725
Related Documents	See Marquis Standards of Care
Policy Revised	Date: *5/2010 By:* Marquis Companies
	Date: *5/2011 By:* Marquis Companies

Signing Residents Out

Policy Statement

All residents leaving the premises must be signed out.

Policy Interpretation and Implementation

1. Each resident leaving the premises (excluding transfers/discharges) must be signed out.
2. A sign-out register is located at each nurses' station. Registers must indicate the resident's expected time of return.
3. Unless otherwise prohibited by law, medications that must be administered while the resident is out will be given to the resident/person signing the resident out.
4. Written and/or oral instructions on when and how to administer the medication will be provided to the resident or to the person signing the resident out. Only medications that must be administered while the resident is out will be issued.
5. The Licensed Nurse or designee is responsible for notifying the Dietary Manager when the resident will be away from the facility during meal hours and when the resident has returned. Such notification may be through oral, written or electronic communication.
6. Staff observing a resident leaving the premises, and having doubts about the resident being properly signed out, should notify their supervisor at once.
7. Restrictions noted on the resident's chart concerning who may not sign the resident out must be honored unless otherwise prohibited by facility policy or state/federal law governing such releases. If the resident chooses to go with the individual, the Director of Nursing Services and/or Administrator must be contacted and informed of the situation.
8. Residents must be signed in upon return to the facility.
9. Inquiries concerning the signing out of residents should be referred to the Director of Nursing Services or to the Administrator.

References

OBRA Regulatory Reference Numbers	N/A
Survey Tag Numbers	F561
Related Documents	N/A
Policy Revised	Date: *5/2011 By:* Marquis Companies

Smoking Policy - Residents

Policy Statement

This facility shall establish and maintain safe resident smoking practices.

Policy Interpretation and Implementation

1. Prior to, or upon admission, residents shall be informed about any limitations on smoking, including designated smoking areas, and the extent to which the facility can accommodate their smoking or non-smoking preferences; for example, in making room assignments.

2. Each facility may have specific smoking policies and/or restrictions, facility policies will be included within the facility admission packets.

3. No-Smoking signs shall be prominently displayed throughout the facility where smoking is prohibited.

4. Smoking restrictions shall be strictly enforced in all nonsmoking areas.

5. Only facility-approved ashtrays and other smoking equipment/paraphernalia shall be used on facility premises

6. Metal containers, with self-closing cover devices, shall be available in smoking areas.

7. Ashtrays shall only be emptied into designated receptacles.

8. The staff shall consult with the Attending Physician and the Director of Nursing Services to determine any restrictions on a resident's smoking privileges.

9. Nursing will complete a Smoking assessment upon admission and at least quarterly for all residents who wish to smoke, in facilities where smoking for residents is an option.

10. Any smoking-related privileges, restrictions, and concerns (for example, need for close monitoring) shall be noted on the care plan, and all personnel caring for the resident shall be alerted to these issues.

11. The facility may impose smoking restrictions on residents at any time if it is determined that the resident cannot smoke safely with the available levels of support and supervision.

12. Any resident with restricted smoking privileges requiring monitoring shall have the direct supervision of a staff member, family member, visitor or volunteer worker at all times while smoking.

13. The staff will review the status of a resident's smoking privileges periodically, and consult as needed with the Director of Nursing Services and the Attending Physician.

14. Smoking articles for residents with independent smoking privileges:

a. Residents who have independent smoking privileges shall have access to smoking articles kept at facility Nursing Station
b. Residents may only use disposable safety lighters.
c. Residents may not have or keep lighter fluids, including butane gas, or any other forms of gas or fluids, at any time.
d. Residents with independent smoking privileges may not give smoking articles to other residents with restricted smoking privileges. (Note: Anyone who observes this happening shall report it to the On-Duty Charge Nurse immediately.)
e. Smoking shall not be permitted in bed/resident room, at any time.

15. Smoking articles for residents without independent smoking privileges:

a. Residents without independent smoking privileges may not have or keep any types of smoking articles, including cigarettes, tobacco, etc., except when they are under direct supervision.
b. Smoking shall not be permitted in bed or in resident room at any time.
c. Anyone who provides smoking supervision to residents shall be advised of any restrictions/concerns and the plan of care related to smoking.

16. Staff members and volunteer workers shall not purchase and/or provide any smoking articles for residents unless approved by the Charge Nurse.

17. This facility may check periodically to determine if residents have any smoking articles in violation of our smoking policies. Staff shall confiscate any such articles, and shall notify the Charge Nurse/Supervisor that they have done so.

References

OBRA Regulatory Reference Numbers	N/A
Survey Tag Numbers	F579; F582; F572; F574; F575; F689; F920, F561

Related Documents	Smoking Policy – Employees (Personnel and Staffing) Smoking Assessment
Policy Revised	Date: *5/2011 By:* Marquis Companies
	Date: 12*/2011 By:* Marquis Companies

Suicide Threats

Policy Statement

Resident suicide threats shall be taken seriously and addressed appropriately.

Policy Interpretation and Implementation

1. Staff shall report any resident threats of suicide immediately to the Licensed Nurse.
2. The Licensed Nurse shall immediately assess the situation and shall notify the Director of Nursing Services of such threats.
3. A staff member shall remain with the resident until the Licensed Nurse arrives to evaluate the resident.
4. After assessing the resident in more detail, the Licensed Nurse shall notify the resident's Attending Physician and representative and shall seek further direction from the physician.
5. All nursing personnel and other staff involved in caring for the resident shall be informed of the suicide threat and instructed to report changes in the resident's behavior immediately.
6. As indicated, a psychiatric consultation or transfer for emergency psychiatric evaluation may be initiated.
7. If the resident remains in the facility, staff will monitor the resident's mood and behavior and update care plans accordingly, until a physician has determined that a risk of suicide does not appear to be present.
8. Staff shall document details of the situation objectively in the resident's medical record.

References

OBRA Regulatory Reference Numbers	N/A
Survey Tag Numbers	F580; F604; F605; F637; F639; F656; F657; F553; F742
Related Documents	Change in a Resident's Condition or Status (Assessments and Care Planning) Use of Restraints (Behavior, Mood and Cognition)
Policy Revised	Date: *5/2011 By:* Marquis Companies

Unusual Occurrence Reporting

Policy Statement

As required by federal or state regulations, our facility reports unusual occurrences or other reportable events which affect the health, safety, or welfare of our residents, employees or visitors.

Policy Interpretation and Implementation

1. Our facility will report the following events to appropriate agencies:

    a. Earthquakes, floods, gas explosions, severe fires, power outages or other calamities that damage the facility or threaten the welfare, safety or health of residents, employees or visitors;
    b. An outbreak of any communicable disease;
    c. Poisonings;
    d. Death of a resident, employee or visitor because of unnatural causes (e.g., suicide, homicide, accidents, etc.);
    e. Actual or threatened employee walkouts/strikes, or other curtailment of services, or interruption of essential services (e.g., heating, air conditioning, food, water, linens, sewage or needed medical supplies) provided by the facility;
    f. Inoperable emergency systems, equipment or resident call systems, which if not corrected could readily become life-threatening;
    g. Allegations of abuse, neglect and misappropriation of resident property; and
    h. Other occurrences that interfere with facility operations and affect the welfare, safety, or health of residents, employees or visitors.
    i. Additional reporting as may be required by specific state regulations.

2. Unusual occurrences shall be reported via telephone/fax to appropriate agencies as required by current law and/or regulations within twenty-four (24) hours of such incident or as otherwise required by federal and state regulations.

3. A written report detailing the incident and actions taken by the facility after the event shall be sent or delivered to the state agency (and other appropriate agencies as required by law) as required by federal and state regulations.

4. The administration will keep a copy of written reports on file.

References

OBRA Regulatory Reference Numbers	N/A
Survey Tag Numbers	F600; F602; F603; F606; F607; F943; F689; F836
Related Documents	N/A
Policy Revised	Date: *5/2010 By:* Marquis Companies

Water Temperatures, Safety of

Policy Statement

Tap water in the facility shall be kept within a temperature range to prevent injury of residents.

Policy Interpretation and Implementation

1. Water heaters that service resident rooms, bathrooms, common areas, and tub/shower areas shall be set to temperatures of no more than the maximum allowable temperature per state regulation.

2. Maintenance staff is responsible for checking thermostats and temperature controls in the facility and recording these checks in a maintenance log.

3. Maintenance staff shall conduct periodic tap water temperature checks and record the water temperatures in a safety log.

4. If at any time water temperatures feel excessive to the touch (i.e., hot enough to be painful or cause reddening of the skin after removal of the hand from the water), staff will report this finding to the immediate supervisor.

5. Direct-care staff shall be informed of risk factors for scalding/burns that are more common in the elderly, such as;

   a. Decreased skin thickness;
   b. Decreased skin sensitivity;
   c. Peripheral neuropathy;
   d. Reduced reaction time;
   e. Decreased cognition;
   f. Decreased mobility; and
   g. Decreased communication.

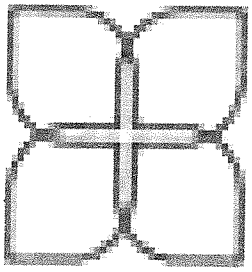
6. The length of exposure to warm or hot water, the amount of skin exposed, and the resident's current condition affect whether or not exposure to certain temperatures will cause scalding or burns. Therefore, ongoing resident observation and assessment during prolonged exposure to warm or hot water will help to determine the safety of the situation.

7. Nursing staff will be educated about signs and symptoms of burns (first, second, and third degree) so that such injuries can be recognized and treated appropriately.

8. If a resident is burned, nursing staff shall follow pertinent first aid and physician notification protocols and report the injury to his or her direct supervisor.

References

OBRA Regulatory Reference Numbers	N/A
Survey Tag Numbers	F689
Related Documents	Safety and Supervision of Residents
Policy Revised	Date: *5/2011 By:* Marquis Companies



MARQUIS PLAZA REGENCY

SAFETY PROGRAM

6021 W. Cheyenne Avenue Las Vegas NV 89108

SAFETY POLICY

When an individual is employed, he or she has a right to expect a proper place in which to work and proper machines and tools with which to do the job, so that energy will be devoted to work without fear of possible harm to health. Only under such circumstances can the relationship between employer and employee be mutually advantageous. It is our desire to provide safe equipment with proper materials and to insist upon safe methods and practices.

Safe working habits on the part of all must be part of our operations. When you have a suggestion on how to reduce injuries or waste, tell your supervisor.

The success of our safety program depends solely on the cooperation, enthusiasm, and effort we all put into it. No job is so important that we cannot take time to do it safely.

Administrator

SAFETY PROGRAM

GOAL:

The goal of the program is to provide safe working conditions for employees and prevent injuries to workers due to unsafe practices and other conditions and at the same time minimize annual Worker Compensation Premiums for the entire corporation.

OBJECTIVES:

The program is aimed at providing a climate where working safely becomes the concern of all employees. It has 3 objectives, none of which can be completely successful without the others:

1. Involve employees in the design and maintenance of a safety program.

2. Reward employees who are successful in working without sustaining on the job injury.

3. Educate employees in the importance of work safety at New Employee Orientation and ongoing in services.

RESPONSIBILITY OF SUPERVISORS

Supervisors have the primary responsibility for our Safety Program and, as representatives of management, are delegated responsibility for carrying out certain objectives as follows:

1. Ensure that a conditional job offer (CJO) and medical review (when indicated) is completed with every new hire (See Appendix A for Safety Forms).

2. Educate new employees on the importance and expectation that they attend a minimum of three Safety Committee Meetings following hire.

3. Set the proper safety example.

4. Assume responsibility for employee safety.

5. Be responsible for a safe work place, personal protective items, storage of materials, and maintenance of equipment.

6. Enforce safety rules.

7. Counsel and train employees in safe work practices.

8. Conduct frequent safety inspections.

9. Investigate and properly report all accidents, in detail.

10. When an accident or incident is reported encourage affected employee(s) to attend the next Safety Committee meeting to participate in prevention planning.

11. See that injured employees receive prompt medical attention.

12. Contribute ideas to management.

13. Conduct new employee safety education on or before the employee begins working.

EMPLOYEE SAFETY RULES AND RESPONSIBILITIES

1. Employees are expected to conduct themselves in a professional manner at all times. Practical jokes or horseplay are forbidden. These acts cause accidents.

2. Report unsafe conditions or work habits to your supervisor. Suggestions are welcome.

3. New employees are expected to attend a minimum of the first 3 Safety Committee Meetings following hire in order to orient themselves to the company/facility Safety Programs, and the first 3 Safety Committee Meetings immediately following any on-the-job injuries to re-orient themselves to the Safety Programs.

4. Report all injuries to your supervisor, immediately. Complete an Incident Report on every injury sustained and turn into your supervisor by the end of the shift in which you are injured.

5. Employees are responsible for their own safety. DO YOUR PART.

6. Conduct work activities in a manner that will not endanger other people, and set an example for other employees.

7. Undertake only those jobs you are authorized to do and that you understand.

8. When making a lift, set feet solidly. Get as close to the object as possible, bend the legs, grip the object firmly, straighten the legs to lift the object comfortably. Do not be a hero. When an object is too heavy or awkward for you, get help. Use a gait belt.

9. Smoking must be confined to designated areas. There are no exceptions.

10. Personal protective equipment must be worn on jobs which require it.

11. Housekeeping is everyone's responsibility. Keep the facility clean and orderly. Clean up and put equipment away.

12. Know the location and use of fire extinguishers. Keep access areas clear.

13. If you are having health problems or feel that there are circumstances which could affect your well-being, mention it to your supervisor.

14. A violation of safety policies or posted safety rules will be cause for disciplinary action. Repeat violations will result in possible suspension or termination at the option of the Administrator.

15. If you are ever in doubt about a safety procedure, consult your supervisor immediately.

NO JOB IS SO URGENT, AND NO WORK SCHEDULE SO RIGID, THAT WE CANNOT TAKE TIME TO WORK SAFELY!

EMPLOYEE EDUCATION

It is the responsibility of the facility to train employees in the performance of their job duties. This includes instruction in the safest techniques to be used.

All new employees should receive orientation in basic safety skills including lifting and bending techniques, resident transfers and hand washing. Special attention should be paid to lifting, bending and transfers as this is the area of highest risk and liability. If possible, have a physical therapist or other professional conduct hands on training.

Ongoing employee education cannot be stressed enough. Other ideas for this continuing education might be safety features held at in-services, bulletin board posters, guest speakers, reminders in the employee bulletin, paycheck stuffers, brochures/handouts, etc.

YOU CAN NEVER OVERDO THE REINFORCEMENT FOR WORKING SAFELY!

FAILURE TO COMPLY WITH EMPLOYEE SAFETY RULES AND RESPONSIBILTIES

Any employee violating the Safety Policy/rules should be counseled immediately. Any infraction should receive disciplinary action in accordance with existing policy.

If the incident is of a serious nature involving resident safety, the Administrator or a designee should conduct an immediate investigation and, if necessary, discharge the employee without issuing the usual warnings.

The Safety Policy must be understood by all employees. For their own and their residents safety, they must understand that the work rules are to be followed. It is suggested employees sign an affidavit such as the one below signifying they have read and understood the rules.

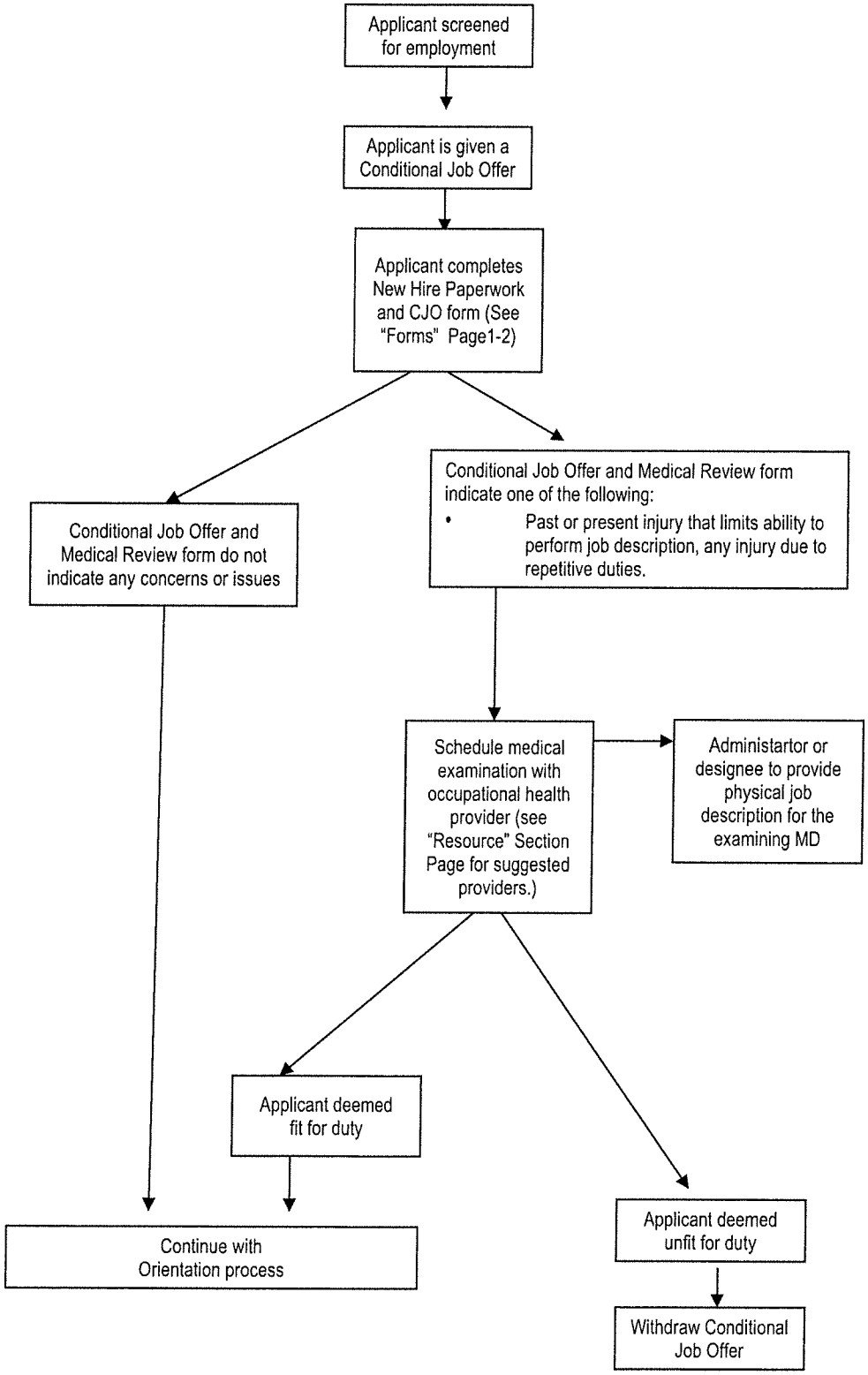
EMPLOYEE ACKNOWLEDGEMENT

*Date*_____

This is to certify that on the above date I received a copy of the Safety Rules and Regulations which I have read. I understand I will be guided by these while employed by this facility.

*Signature*_____

Conditional Job Offer & Medical Review Form Procedure



****Facility is responsible for cost of "Fit For Duty" Exams**

SAFETY COMMITTEE

Goal:

Promote employee awareness of the importance of working safely through employee involvement and interaction by setting and maintaining safety standards for the facility.

Objectives:

1. To assist in the evaluation and improvement of safety and health in the facility.

2. To provide a channel of communication for open discussion of problems that resulted, or could have resulted in an injury or illness;

3. To improve the spirit of cooperation among facility staff members.

Committee Membership:

Membership is recommended to be a minimum of four employees. Half of your members should be managers and half should be line staff. It is not recommended for the administrator to be a committee member.

It is recommended that the committee be composed of the following personnel:

Representative from the following departments:

Nursing
Dietary
Housekeeping and/or Laundry
Maintenance
Activities and/or Social Services

SAFETY COMMITTEE PROTOCOL

All Committee officers are responsible to the Administrator of the facility, as well as the membership of the Safety Committee.

If a member is experiencing difficulty concerning another member, or something pertaining to Safety Committee business, they should first take the problem to an officer of the committee, who in turn will discuss the problem with the remaining officers of the committee, in an effort to resolve it. In the event that a resolution cannot be found, the Chairperson will then consult the Administrator of the facility. If a member feels that the officers of the committee are not addressing the problem in a timely manner, they may then approach the Administrator themselves.

This is not to say that the membership at large cannot approach the Administrator on their own if that is felt to be the only solution, but that an attempt to resolve Committee problems, by the committee, should be the first step.

Acknowledging that nothing pertaining to Committee business is secret to the membership, but that some items need only be known by the officers in the interim between meetings, when all affairs of the committee are made known; it is suggested that topics pertaining to current affairs of the Safety Committee, be made known to the officers before they are made public, or become general knowledge, thereby lessening the opportunity that an officer will be embarrassed publicly due to a lack of knowledge pertaining to those affairs.

The Administrator of the facility will receive a copy of the minutes of each meeting, in a timely manner, from the Chairperson, at which time any new business can be discussed and made known.

It is expected that each member, will come to meetings prepared to discuss business, and that each officer or sub-committee person will be prepared to give a report on that area for which they are responsible.

A code of respectful silence will be maintained during each presentation, with comments or discussion on the subject matter, made only after making a request for the floor. In this way, each member will have the opportunity to voice an idea or opinion and be heard.

When a member of the Safety Committee is unable to attend a meeting, for whatever reason, they will notify the chairperson, as soon as possible, so that an awareness of the absence is known before the meeting.

DUTIES AND RESPONSIBILITIES

Employee Safety

1. Develop directives and programs, and identify standards for employee safety.

2. Design an annual safety inservice program for the education of all employees.

3. Review Incident Reports of all employee injuries for suggestions to correct potential safety hazards. Employees experiencing an on the job accident which necessitates in the filing of an 801 may be asked to attend the next Safety Committee meeting to discuss the accident.

4. Gather and evaluate information which is relevant to employee safety:
   - reports of employee incidents
   - suggestions of employees regarding improvement of employee safety
   - safety inspection reports
   - relevant standards, laws, regulations and safety communications

5. Review and analyze jobs to determine hazards, giving emphasis to those showing high incident occurrence.

6. Make recommendations to administration regarding improvement of employee safety.

Resident Safety

1. Develop directives and programs and identify standards for resident safety.

2. Promote education and training of employees regarding safe resident care practices.

3. Establish a system of reporting resident incidents.

4. Conduct regular periodic inspections throughout the facility.

5. Gather and evaluate information which is relevant to resident safety as directed:
   - resident incident reports
   - suggestions of employees and residents regarding improvement of resident safety
   - safety inspection reports relevant standards, laws, regulations and safety communications.

6. Make recommendations to administration for improvement of resident safety.

7. Coordinate programs with the Facility Infection Control Committee and/or Emergency Response Team (if and when applicable).

Fire Safety (as assigned)

1. Develop directives and programs, and identify standards relating to fire safety.

2. Review and evaluate fire drills, fire incidents, and fire safety inspections of the nursing home.

3. Review and evaluate fire safety inspection reports of the State Fire Marshall.

4. Promote training programs for new and existing personnel.

5. Make recommendations to administration for improvement of fire safety.

Other Emergency Plans (as assigned)

1. Develop and/or review for appropriateness an emergency plan for the facility covering such event as: wind storm, flood, explosion, power outage, etc. (See Facility Emergency Preparedness Manual)

2. Coordinate such plans throughout the facility and with exterior agencies as appropriate.

3. Systematically evaluate and update these plans.

4. Promote training programs for new and existing personnel.

SAFETY COMMITTEE JOB/RESPONSIBILITY DESCRIPTION

CHAIRPERSON: The chairperson shall serve a term of twelve, (12) months, after which the new chairperson will assume the duties, following a majority vote by the membership. If the membership requests that the serving chairperson serve a second, (2), term, and the chairperson consents to this, a majority vote is again needed. A member should only serve two, (2), consecutive terms in office. **Exceptions to this guideline will be reviewed by the Administrator of the facility for necessity.**

The Chairperson is responsible to the Administrator of this facility, and invites said person to all meetings, and/or gives a report of all business discussed. The Chairperson moderates all Safety Committee meetings and hears reports from all Committee members and officers. In the Chairpersons absence, the secretary will chair the meetings

SECRETARY: The secretary serves an elected term of six, (6), months, after which a new person will assume the duties following a majority vote by the membership. The secretary may serve a second, (2), terms, at the request of the membership, and a majority vote of the membership. The secretary may serve only two, (2) consecutive terms, but may be voted into office again after a six, (6) month interval. **Exceptions to this ruling will be reviewed by the Administrator of the facility for necessity.**

The Secretary is responsible to the committee as a whole, but to the Chairman, for job related duties. The Secretary records the minutes of all Safety meetings accurately, and gives copies of said minutes to each Safety Committee member in a timely manner. The Secretary will read the minutes of the previous meeting at each current meeting, and make all corrections and amendments.

The Secretary will serve in place of the Chairperson, at all Committee functions, if the Chairperson should be absent. The Secretary will keep the Chairperson informed of all communication received, relating to the committee, in the interval between meetings. The Secretary will also announce a meeting, to the employees at large, before the start of each meeting. An agenda for the current meeting will be available to the members.

OPTIONAL

TREASURER: The treasurer will be elected to a six (6) month term by the majority of the membership, and may not serve two (2) terms consecutively. After a six (6) month interval, a previous treasurer may be elected again. **Exceptions to this guideline will be reviewed by the Administrator of the facility for necessity.**

The Treasurer will give a report, at each meeting of the membership, of all expenses and moneys earned. A balance of money on hand will also be reported at that time. The Treasurer is responsible for keeping an accurate account of the financial state of the committee and safeguarding the monies entrusted to them, as well as receipts of expenses.

SAFETY COMMITTEE MEETING GUIDELINES

Safety Committee Meetings are to be held at least quarterly, but monthly is preferred. A suggested order of business might be as follows:

1. CALL TO ORDER: Meeting should be called together promptly.

2. ATTENDANCE: Names of persons present should be recorded and members who cannot attend should notify the Chairperson with reasons for absence noted in the minutes.

3. INTRODUCTION OF VISITORS: Name, title and facility or company.

4. MINUTES: Minutes of the previous meeting should be read and corrections made.

5. UNFINISHED BUSINESS: When definite decisions have not been made on previous action items, they should be brought up for reconsideration.

6. REVIEW OF INCIDENT REPORTS: Incident Reports for all employee and resident accidents will be reviewed. Injured workers will not be identifiable to the committee. Accident causes and preventive measures should be discussed to prevent reoccurrence of similar incidents.

7. SAFETY EDUCATION: The Chairperson should obtain speakers, if desired, and prepare an agenda. Subjects should be recorded in the minutes.

8. INSPECTION AND RECOMMENDATIONS: Regular facility inspections will be conducted to note unsafe conditions and work practices and recommendations for corrections included in the minutes. (See "Resource" Section for inspection / walkthrough checklists.)

Minutes will be posted on the employee bulletin board for the review of all employees.

Safety Committee Minutes, Incidents and OSHA Logs must be retained for a period of no less than 5 years.

Prior to a Safety Committee Meeting a "Meeting Notice" should be posted to notify facility staff members. (See "Forms" page 4).

During each Safety Meeting the Secretary or designee will keep Minutes – A suggested format for minutes is included in the "Forms" section page 5.

MONTHLY SAFETY FEATURE AGENDA

(See "Resource" Section – "Education Materials" for Inservices as listed below)

One aid to a successful program is to spotlight a monthly safety feature. Inspections and safety awareness materials should be discussed by the Safety Committee, Administrator and Supervisors.

Long term care industry programs, current facility accident reports, or other activities may suggest subjects to be featured.

The following are possible topics for a 12 month period (do not have to correlate to months noted):

January	Proper lifting techniques	Quarterly Inspection
February	Floors, aisles, and walking surfaces	
March	Machine/equipment hazards	
April	Eye and face protection	Quarterly Inspection
May	Stairs and ramps	
June	Electrical hazards	
July	Combative residents	Quarterly Inspection
August	Housekeeping	
September	Resident transfers	
October	Fire prevention	Quarterly Inspection
November	Stress management	
December	Facility safety inspection	

Electrical Safety for Residents

Policy Statement

The resident will be protected from injury associated with the use of electrical devices, including electrocution, burns and fire.

Policy Interpretation and Implementation

1. Orient the resident to basic electrical safety precautions as part of the admission process, and reinforce the following guidelines with the resident as indicated and/or appropriate:

    a. Ensure that the hands are dry before using an electrical device;
    b. Do not to use electrical devices while standing on a wet floor;
    c. Pull electrical cords out by the plug and never yank the cord;
    d. Report electrical devices if they cause even minor shocks;
    e. Unplug any electrical device that appears to be overheating by smell or touch;
    f. Do not use any electrical device that has been dropped or abused, or if liquid has spilled into it. Wait until it has been checked and declared safe for use; and
    g. Do not use electrical appliances where oxygen is being administered or stored.
    h. Do not use any additional electric adapters/plug ins that have not been approved by facility maintenance director.

2. Inspect electrical outlets, extension cords, power strips, and electrical devices as part of routine fire safety and maintenance inspections.

3. Portable space heaters are not permitted in the facility.

4. Halogen lamps shall be used with caution and away from combustible items in the resident's environment.

5. Extension cords shall not be used as a substitute for adequate wiring in the facility.

6. When extension cords are used, the following precautions must be taken and they must comply with NPFA standards;

    a. Secure extension cords and do not place overhead, under carpets, or where they can cause trips, falls, or overheat;
    b. Connect extension cords to only one device;
    c. Ensure that the type of cord used is appropriate of the size and type of electrical load;
    d. Ensure that cords have proper grounding; and
    e. Inspect regularly for fraying, cuts, or breakage.

7. Power strips shall not be used as a substitute for adequate electrical outlets in the facility. Power strips may be used for a computer, monitor, and printer. Power strips in use must comply with NFPA standards.

8. Power strips shall not be used with medical devices in resident-care areas.

9. When power strips are used, the following precautions must be taken, in addition to must meet NFPA standards;

    a. Install internal ground fault and over-current protection devices;
    b. Secure power strips so that they do not cause trips or falls; and
    c. Use power strips that are adequate for the number and types of devices used.

10. Ground fault circuit interruption devices shall be used in locations near water sources to prevent electrocution of residents and staff.

11. The use of electric blankets and electric heating pads is not allowed.

References	
OBRA Regulatory Reference Numbers	N/A
Survey Tag Numbers	F689
Related Documents	N/A
Policy Revised	Date: *5/2010 By:* Marquis Companies

Hazardous Areas in the Facility

Policy Statement

Hazardous areas in the facility shall be identified with appropriate precautionary signs.

Policy Interpretation and Implementation

1. All hazardous areas are so designated and can be identified on floor plans posted throughout the facility.
2. Hazardous areas, such as power rooms, boiler rooms, oxygen or other flammable liquids storage rooms, etc., are posted with No Smoking signs.
3. Smoking is prohibited in all hazardous areas.
4. The facility's Safety Committee shall recommend measures to ensure that residents cannot access hazardous areas in the facility.
5. The Administrator is responsible for communicating all safety recommendations adopted by the Safety Committee to the appropriate departments within the facility.
6. The Safety Committee shall periodically check for the implementation and integrity of measures intended to prevent residents from entering hazardous areas.

References	
OBRA Regulatory Reference Numbers	N/A
Survey Tag Numbers	F689; F836
Related Documents	N/A
Policy Revised	Date: *5/2010 By:* Marquis Companies

Poison Control

Policy Statement

Poison control information shall be readily available throughout the facility.

Policy Interpretation and Implementation

1. Information about poisoning and poison control, including key contact information, is located at Nursing stations/Medication rooms. This information shall be posted at each nurses' station and/or medication room and other areas of the facility where hazardous and poisonous substances may be used or stored.
2. Antidote information is also available at each nurses' station and/or Medication room.
3. If a resident is suspected of taking poison, nursing staff will notify the Attending Physician and Director of Nursing Services.
4. Administer treatment as ordered by the physician, based on poison control recommendations.
5. Nursing staff will document the resident's condition in the resident's clinical record, and the interventions that were made.
6. Staff will complete an incident report per the appropriate policy.

References	
OBRA Regulatory Reference Numbers	N/A
Survey Tag Numbers	F689
Related Documents	N/A
Policy Revised	Date: *5/2010 By:* Marquis Companies

Proper Use of Side Rails - Level II

Purpose

The purposes of these guidelines are to ensure the safe use of side rails as resident mobility aids and to prohibit the use of side rails as restraints unless necessary to treat a resident's medical symptoms.

Definition

Physical restraints are defined by the Centers for Medicare and Medicaid Services (CMS) as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. (Note: The definition of restraints is based on the functional status of the resident and not on the device, therefore any device that has the effect on the resident of restricting freedom of movement or normal access to one's body could be considered a restraint.)

General Guidelines

1. Side rails are considered a restraint when they are used to limit the resident's freedom of movement (prevent the resident from leaving his/her bed). (Note: The side rails may have the effect of restraining one individual but not another, depending on the individual resident's condition and circumstances.)

2. Side rails are only permissible if they are used to treat a resident's medical symptoms or to assist with mobility and transfer of residents.

3. An assessment will be made to determine the resident's symptoms or reason for using side rails. When used for mobility or transfer, an assessment will include a review of the resident's:

   a. Bed mobility; and
   b. Ability to change position, transfer to and from bed or chair, and to stand and toilet.

4. The use of side rails as an assistive device will be addressed in the resident care plan.

5. Consent for using restrictive devices will be obtained from the resident or resident representative per facility protocol.

6. Less restrictive interventions that may be incorporated in care planning include:

   a. Providing restorative care to enhance abilities to stand safely and to walk;
   b. Providing a trapeze to increase bed mobility;
   c. Providing a bed cane/arc rail to increase bed mobility;
   d. Providing staff monitoring at night with periodic assisted toileting for residents attempting to arise to use the bathroom; and/or
   e. Furnishing visual and verbal reminders to use the call bell for residents who can comprehend this information.

7. Documentation will indicate if less restrictive approaches are not successful, prior to considering the use of side rails.

8. The risks and benefits of side rails will be considered for each resident.

9. Consent for side rail use will be obtained from the resident or resident's representative, after presenting potential benefits and risks. (Note: Federal regulations do not require written consent for using restraints. Signed consent forms do not relieve the facility from meeting the requirements for restraint use, including proper assessment and care planning. While the resident or representative may request a restraint, the facility is responsible for evaluating the appropriateness of that request.)

10. The resident will be checked periodically for safety relative to side rail use.

11. If side rail use is associated with symptoms of distress, such as screaming or agitation, the resident's needs and use of side rails will be reassessed.

12. When side rail usage is appropriate, the facility will assess the space between the mattress and side rails to reduce the risk for entrapment (the amount of safe space may vary, depending on the type of bed and mattress being used).

13. Side rails with padding may be used to prevent resident injury in situations of uncontrollable movement disorders, but are still restraints if they meet the definition of a restraint.

14. Facility staff, in conjunction with the Attending Physician, will assess and document the resident's risk for injury due to neurological disorders or other medical conditions.

References	
MDS (RAPs)	N/A
Survey Tag Numbers	F689; F604

Related Documents	Bed Safety
Risk of Exposure	N/A
Policy Revised	Date: *5/2010 By:* Marquis Companies

Accidents and Incidents - Investigating and Reporting

Policy Statement

All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the Administrator. All accidents and incidents involving residents on or off premises will be investigated and reported to the administrator. Investigations shall be completed within 5 days of the incident.

Policy Interpretation and Implementation

1. The Licensed Nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident. Incident would include, but are not limited to; found on floor, fall, bruise, skin tear, laceration, abrasion, excoriation, pressure ulcer, burn, elopement, resident to resident encounter, etc.

2. The following data, as applicable, shall be included in the resident's electronic clinical record.

   a. The date and time the accident or injury took place;
   b. The nature of the injury/illness (e.g., bruise, fall, nausea, etc.);
   c. The circumstances surrounding the accident or injury;
   d. Where the accident or injury took place;
   e. The injured resident's account of the accident or injury(as able);
   f. The Attending Physician who was notified;
   g. The injured resident's representative who was notified (for residents who are not their own responsible party;
   h. The condition of the injured resident, including his/her vital signs as applicable;
   i. The disposition of the resident (i.e., transferred to hospital, put to bed, sent home, returned to work, etc.);
   j. Any care plan changes made;
   k. Follow-up information;
   l. Other pertinent data as necessary or required; and
   m. The signature and title of the person completing the report.

3. Witnesses and/or those who may have knowledge of the accident or injury will be interviewed as part of the investigation. A summary of the interviews will be included as part of the investigation summary in the clinical record as applicable.

4. The Licensed Nurse and/or the department director or supervisor shall complete the appropriate resident event assessment within the clinical record.

5. For any accident/incident that may meet the definition of potential abuse/neglect, refer to Abuse Investigation policy and procedure.

References	
OBRA Regulatory Reference Numbers	N/A
Survey Tag Numbers	F607; F943; F689
Related Documents	Abuse and Neglect protocols, Assessing falls, elopement assessment, skin and wound assessments, resident to resident assessment.
Policy Revised	Date: *5/2010 By:* Marquis Companies Date: *8/2010 By:* Marquis Companies Date: *5/2011 By:* Marquis Companies Date: *8/2017 By:* Marquis Companies Date: *5/2018 By:* Marquis Companies

Bed Safety

Policy Statement

Our facility shall strive to provide a safe sleeping environment for the resident.

Policy Interpretation and Implementation

1. The resident's sleeping environment shall be maintained by the interdisciplinary team, considering the resident's safety, medical conditions, comfort, and freedom of movement, as well as input from the resident and family regarding previous sleeping habits and bed environment.

2. To try to prevent deaths/injuries from the beds and related equipment (including the frame, mattress, assistive devices, headboard, footboard, and bed accessories), the facility shall promote the following approaches:

a. Inspection by maintenance staff of all beds and related equipment as part of our regular bed safety program to identify risks and problems including potential entrapment risks;
b. Review that gaps within the bed system are within the dimensions established by the FDA (Note: The review shall consider situations that could be caused by the resident's weight, movement or bed position.);
c. Ensure that when bed system components are worn and need to be replaced, components meet manufacturer specifications;
d. Ensure that assistive mobility devices are properly installed using the manufacturer's instructions and other pertinent safety guidance to ensure proper fit (e.g., avoid bowing, ensure proper distance from the headboard and footboard, etc.); and
e. Identify additional safety measures for residents who have been identified as having a higher than usual risk for injury including entrapment (e.g., altered mental status, restlessness, etc.).

3. The facility's education and training activities will include instruction about risk factors for resident injury due to beds, and strategies for reducing risk factors for injury, including entrapment.

4. If assistive devices for bed mobility are used, including but not limited to bed canes/arc rails, there shall be an assessment of the resident, consultation with the Attending Physician if indicated, and input from the resident and/resident representative.

5. The staff shall obtain consent for the use of the assistive device from the resident or the resident's representative prior to their use.

6. After appropriate review and consent as specified above, assistive devices may be used at the resident's request to increase the resident's sense of security (e.g., if he/she has a fear of falling, his/her movement is compromised, or he/she is used to sleeping in a larger bed).

7. Side rails may be used if assessment and consultation with the Attending Physician has determined that they are needed to help manage a medical symptom or condition, or to help the resident reposition or move in bed and transfer, and no other reasonable alternatives can be identified. (See Proper use of Side Rails policy)

8. Side rails shall not be used as protective restraints. Should a protective restraint be used, our facility's protocol for the use of restraints shall be followed.

9. The use of physical restraints on individuals in bed shall be limited to situations where they are needed to treat a resident's medical symptoms, and only after being reviewed by authorized individuals.

10. The staff shall report to the Director of Nursing and Administrator any deaths, serious illnesses and/or injuries resulting from a problem associated with a bed and related equipment including the bed frame, bed assistive device, side rails, and mattresses. The Administrator shall ensure that reports are made to the Food and Drug Administration or other appropriate agencies, in accordance with pertinent laws and regulations including the Safe Medical Devices Act.

References	
OBRA Regulatory Reference Numbers	N/A
Survey Tag Numbers	F689; F908
Related References	See also FDA's Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment; and The Hospital Bed Safety Workgroup's Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings
Policy Revised	Date: *5/2010 By:* Marquis Companies

Proper Use of Side Rails - Level II

Purpose

The purposes of these guidelines are to ensure the safe use of side rails as resident mobility aids and to prohibit the use of side rails as restraints unless necessary to treat a resident's medical symptoms.

Definition

Physical restraints are defined by the Centers for Medicare and Medicaid Services (CMS) as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. (Note: The definition of restraints is based on the functional status of the resident and not on the device, therefore any device that has the effect on the resident of restricting freedom of movement or normal access to one's body could be considered a restraint.)

General Guidelines

1. Side rails are considered a restraint when they are used to limit the resident's freedom of movement (prevent the resident from leaving his/her bed). (Note: The side rails may have the effect of restraining one individual but not another, depending on the individual resident's condition and circumstances.)

2. Side rails are only permissible if they are used to treat a resident's medical symptoms or to assist with mobility and transfer of residents.

3. An assessment will be made to determine the resident's symptoms or reason for using side rails. When used for mobility or transfer, an assessment will include a review of the resident's:

   a. Bed mobility; and
   b. Ability to change position, transfer to and from bed or chair, and to stand and toilet.

4. The use of side rails as an assistive device will be addressed in the resident care plan.

5. Consent for using restrictive devices will be obtained from the resident or resident representative per facility protocol.

6. Less restrictive interventions that may be incorporated in care planning include:

   a. Providing restorative care to enhance abilities to stand safely and to walk;
   b. Providing a trapeze to increase bed mobility;
   c. Providing a bed cane/arc rail to increase bed mobility;
   d. Providing staff monitoring at night with periodic assisted toileting for residents attempting to arise to use the bathroom; and/or
   e. Furnishing visual and verbal reminders to use the call bell for residents who can comprehend this information.

7. Documentation will indicate if less restrictive approaches are not successful, prior to considering the use of side rails.

8. The risks and benefits of side rails will be considered for each resident.

9. Consent for side rail use will be obtained from the resident or resident's representative, after presenting potential benefits and risks. (Note: Federal regulations do not require written consent for using restraints. Signed consent forms do not relieve the facility from meeting the requirements for restraint use, including proper assessment and care planning. While the resident or representative may request a restraint, the facility is responsible for evaluating the appropriateness of that request.)

10. The resident will be checked periodically for safety relative to side rail use.

11. If side rail use is associated with symptoms of distress, such as screaming or agitation, the resident's needs and use of side rails will be reassessed.

12. When side rail usage is appropriate, the facility will assess the space between the mattress and side rails to reduce the risk for entrapment (the amount of safe space may vary, depending on the type of bed and mattress being used).

13. Side rails with padding may be used to prevent resident injury in situations of uncontrollable movement disorders, but are still restraints if they meet the definition of a restraint.

14. Facility staff, in conjunction with the Attending Physician, will assess and document the resident's risk for injury due to neurological disorders or other medical conditions.

References	
MDS (RAPs)	N/A
Survey Tag Numbers	F689; F604

Related Documents	Bed Safety
Risk of Exposure	N/A
Policy Revised	Date: *5/2010 By:* Marquis Companies

OSHA COVID19 - Policies

The policies required based on OSHA ETS regulations are as listed below.

Click on name- link to access.

Respiratory Protection Plan - Marquis

Staff Screening Policy

Visitor Policy

Screening APP protocol: Screening APP protocol

Transmission Based Precautions: COVID-19 https://confluence.marquiscompanies.com/x/f4AxAw

Personal Protective Equipment: Eyewear https://confluence.marquiscompanies.com/x/8IAjAg

Personal Protective Equipment: Gloves https://confluence.marquiscompanies.com/x/_oAjAg

Personal Protective Equipment: Gowns https://confluence.marquiscompanies.com/x/6IAjAg

Administering Medication through a Small Volume (handheld) Nebulizer: https://confluence.marquiscompanies.com/x/E4TgAQ

CPAP/BiPAP Support: https://confluence.marquiscompanies.com/x/54fgAQ

Staff work day/ Break Guidance: https://confluence.marquiscompanies.com/x/FQEDAw

Cleaning and Disinfection of Rooms: https://confluence.marquiscompanies.com/x/AITjAw

Cleaning and Disinfection of Environmental Surfaces: https://confluence.marquiscompanies.com/x/AoTjAw

High Touch Surface Cleaning Log

High Touch Surface cleaning log: https://confluence.marquiscompanies.com/x/BITjAw

Communicable/Contagious Diseases, Employee: https://confluence.marquiscompanies.com/x/dongAQ

Employee Infection and Vaccination Status: https://confluence.marquiscompanies.com/x/mYngAQ

Family and staff communication policy: COVID Communication- Resident/Responsible party and Employees

Employee Return to Work- COVID Positive

Return to work - Post Exposure to COVID

Qualitative Fit Test Procedure- N95Qualitative Fit Test Procedure- N95

Personal Protective Equipment: Respirator Medical Evaluation and Fit Test

Medical Evaluation FIT test form

FIT Test Employee form

Personal Protective Equipment: Using Respirator (N95) (Seal test. Mini Respirator program)

Aerosol Generating Procedures (AGP)

Respirator Donning/Doffing/Seal Check: https://confluence.marquiscompanies.com/x/koTjAw

Safety and Supervision of Residents

Policy Statement

Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities.

Policy Interpretation and Implementation

Facility-Oriented Approach to Safety

1. Our facility-oriented approach to safety addresses risks for groups of residents.

2. Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes; QA&A reviews of safety and incident/accident reports; and a facility-wide commitment to safety at all levels of the organization.

3. When accident hazards are identified, the QA&A/Safety Committee shall evaluate and analyze the cause(s) of the hazards and develop strategies to mitigate or remove the hazards to the extent possible.

4. Employees shall be trained and inserviced on potential accident hazards and how to identify and report accident hazards, and try to prevent avoidable accidents.

5. The QA&A Committee and staff shall monitor interventions to mitigate accident hazards in the facility and modify as necessary.

Resident-Oriented Approach to Safety

1. Our resident-oriented approach to safety addresses safety and accident hazards for individual residents.

2. Staff shall use various sources to identify risk factors for residents, including the information obtained from the medical history, physical exam, observation of the resident, and the MDS.

3. The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for that resident. The care team shall target interventions to reduce the potential for accidents.

4. Implementing interventions to reduce accident risks and hazards shall include the following:

a. communicating specific interventions to all relevant staff;
b. assigning responsibility for carrying out interventions;
c. providing training, as necessary;
d. ensuring that interventions are implemented; and
e. documenting interventions.

5. Monitoring the effectiveness of interventions shall include the following:

a. ensuring that interventions are implemented correctly and consistently;
b. evaluating the effectiveness of interventions;
c. modifying or replacing interventions as needed; and
d. evaluating the effectiveness of new or revised interventions.

Systems Approach to Safety

1. The facility-oriented and resident-oriented approaches to safety are used together to implement a systems approach to safety, which considers the hazards identified in the environment and individual resident risk factors, and then adjusts interventions accordingly.

2. Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment.

3. The type and frequency of resident supervision may vary among residents and over time for the same resident. For example, resident supervision may need to be increased when there are temporary hazards in the environment (such as construction) or if there is a change in the resident's condition.

Resident Risks and Environmental hazards:

1. Due to their complexity and scope, certain resident risk factors and environmental hazards are addressed in dedicated policies and procedures. These risk factors and environmental hazards include:

a. Bed Safety
b. Safe Lifting and Movement of Residents
c. Falls
d. Smoking
e. Unsafe Wandering

f. Poison Control
g. Electrical Safety
h. Water Temperatures

2. Other topics related to resident risk and environmental hazards may be addressed within related policies and procedures (for example, adequate lighting is addressed under the topic of falls).

References	
OBRA Regulatory Reference Numbers	N/A
Survey Tag Numbers	F689, F921
Related Documents	Accidents and Incidents – Investigating and Reporting; Poison Control; Smoking Policy – Residents; Resident-to-Resident Altercations (Resident Rights and Dignity); Falls and Fall Risk, Managing (Falls and Fall Risk); Wandering, Unsafe Resident (Behavior, Mood and Cognition)
Policy Revised	Date: *5/2010 By:* Marquis Companies

QAPI Plan for Sierra Ridge of Northern Nevada

Sierra Ridge of Northern Nevada's mission is to ensure the residents that reside at this facility receive quality care in a safe environment and that the residents are satisfied with their experience during their residency.

The QAPI program will gather data, analyze said data in various methods, track and trend patterns, implement process improvement and plans to improve care for resident/patient services. Data will be pulled from multiple different sources, including but not limited to facility matrix reports, resident council, grievance log, Guardian angel rounds, and staff input. The facility will establish benchmarks in order to measure performance and identify areas that are deficient.

The QAPI committee will meet monthly and committee will be chaired by the facility Administrator. The committee will be composed of at a minimum: Administrator, Director of Nursing, Medical Director or designee (at east quarterly), Pharmacy consultant (at least quarterly), staff development coordinator, and any other individual that the Administrator designates.

When a quality deficiency is identified, the QAPI committee is responsible to oversee the development of appropriate action plans. An appropriate action plan is one that appears to address the underlying cause of the issue comprehensively, at the systems level. A performance improvement project will be chartered for global areas of concern.

The QAPI committee will evaluate its effectiveness a minimum of annually and implement new strategies to ensure that the program is effective.

Patient Safety Plan 6312

LIST OF EMERGENCY CONTACT

1. 911
2. REMSA 775-858-5700
3. WASHOE COUNTY EMERGENCY MANAGEMENT 775-337-5898
4. CATHOLIC CHARITIES EMERGENCY 775-322-7073
5. SPARKS POLICE DEPARTMENT 775-353-2428
6. SPARKS FIRE DEPARTMENT 775-353-2255
7. RENO POLICE DEPARTMENT 775 334-2175
8. RENO FIRE DEPARTMENT 775-534-2300
9. WHEELCHAIR TRANSPORTATION 775-858-5300

COMPREHENSIVE HOSPICE CARE LLC. 3750 S. JONES BLVD. STE 180, LAS VEGAS NV. 89103

COMPREHENSIVE HOSPICE CARE LLC

LAS VEGAS NEVADA

PATIENT SAFETY PLAN

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Safety Management Program

POLICY

Hospice Administrator and staff will implement safety procedures as appropriate. Hospice's safety management plan addresses real and potential threats to the health and safety of patients, staff, others and property.

PURPOSE

To maintain the safety of the environment and equipment which support patient care or services.

REFERENCE

The Joint Commission CAMHC Standard: EC.02.01.01; NPSG: .15.02.01; CHAP Standards: HSLG 1.1, HSRM 1.D; ACHC Standard: HSP7-2A.01, HSP7-4B

RELATED DOCUMENTS

"*Annual Hospice Site Environment Assessment*" form

PROCEDURE

1. Home safety assessments are done on all patients at time of admission that include:
   - Fire hazards from smoking.
   - Oxygen safety, including the presence and functioning of smoke detectors, fire extinguishers and fire safety (exit) plans.
   - Fire safety within the home.
   - Electrical safety.
   - Bathroom safety.
   - Environmental safety.
   - Mobility safety.
   - Equipment usage and safety.
   - Adequate storage and handling of medical gases, drugs and hazardous wastes.

2. A Hospice safety program is established which includes:
   - Emergency operations plan.
   - Fire safety, evacuation plan and maintenance of fire detection systems.
   - Office disaster plan including, but not limited to, a severe weather watch.
   - Equipment safety.
   - Body mechanics.

- Safe storage of office supplies, equipment and hazardous products.
- Controlling access to and from security sensitive areas, e.g., medical records storage.

3. Staff is responsible for giving oral or written education to patients/caregiver(s) at the initial assessment and on an ongoing basis as appropriate. Education will include:
   - Basic home safety (environmental, bathroom, electrical, and mobility).
   - Fire prevention.
   - Security.
   - Utility systems.
   - Managing hazardous materials and wastes.

4. Office equipment safety is ensured through vendor contracts.

5. Manufacturers' written materials are available onsite as a resource.

6. New employees are instructed on office equipment safety during the orientation process.

7. Hospice will conduct an annual environmental site tour to identify hazards, unsafe practices, environmental deficiencies and opportunities for improvement for all Hospice sites.

Staff Personal Safety Education

POLICY

Personal safety for employees is addressed through an educational process available to all staff.

PURPOSE

To ensure personal safety in the work environment.

REFERENCE

The Joint Commission CAMHC Standard: EC.02.02.01; CHAP Standards: HSRM 14.1, HSRM 17.1; ACHC Standard: HSP7-2A.01

PROCEDURE

During new employee orientation and on an ongoing basis, an inservice is provided for all employees that include:

- Safety while making home visits.
- General safety practices.
- Self-defense measures.
- Obtaining an escort.
- Handling unsafe situations.
- Car accident reporting.

Personal Safety in the Community Guidelines

POLICY

Hospice will ensure a safe environment for employees at all times.

PURPOSE

To maximize the personal safety of staff working in the community and home setting.

REFERENCE

The Joint Commission CAMHC Standard: EC.02.01.01; CHAP Standard: HSRM 1.D; ACHC Standard: HSP7-2A.01

PROCEDURE

1. The following precautions will be taken by staff before making visits:
   - Wear name badge and appropriate Hospice uniform that clearly identifies that you are from Hospice.
   - Call patients in advance and alert them to the approximate time of your visit.
   - Request that pets be properly secured before making visits.
   - Keep change on your person for a phone call.
   - Before leaving Hospice, lock your purse in the trunk of your car or cover it with a blanket if it will be visible.
   - Consider use/advantages of a personal cell phone.

2. When traveling by vehicle:
   - Keep your vehicle in good working order with plenty of gas.
   - Consider storing a blanket in your vehicle in the winter and a thermos of cool water in the summer. Keep a snack in the glove compartment.
   - Turn on emergency flashers and wait for the police if you have car trouble.
   - Keep your car locked when parked or driving. Keep windows rolled up if possible.
   - Park in full view of the patient's residence when possible.
   - Know your route. If you get lost, look for a safe place to get additional directions or view your map. If you have a car phone, call for directions.

3. When walking to the patient's home:
   - Have your nursing bag/equipment ready when exiting from the vehicle. Keep one arm free.
   - Walk directly to the patient's residence in a professional manner.
   - Be alert of surroundings – buildings, people and animals.

- Carry car keys in your hand when leaving the patient's residence. (The pointed ends of keys between fingers may make an effective weapon.)

4. Some common sense rules regarding personal safety and defense are:
   - Use common walkways in buildings; avoid isolated stairs.
   - Always knock on the door before entering a patient's home.
   - If a relative or neighbor becomes a safety problem:
     - Make joint visits or arrange for escort services.
     - Schedule visit times when they are not present.
   - Request escort services as appropriate. Consider working in teams of two or obtaining a police escort in high crime areas.
   - Scream or yell "fire"; blow a whistle attached to your key ring.
   - Kick shins, instep or groin; scratch.
   - Use your nursing bag as a defense weapon.
   - **Never** permit an assailant to remove you from the site.

5. When in neighborhoods with questionable safety or drug/gang related problems, make visits in the morning.
   - Some areas may have to be declared unsafe and therefore not serviced by Hospice.

Employee Security and Safety – Managing Undesirable Behavior

POLICY

Employee security and safety for managing patients with undesirable behavior is addressed through an educational process available to all staff.

PURPOSE

To ensure personal safety in the work environment.

REFERENCE

The Joint Commission CAMHC Standard: EC.02.01.01; CHAP Standard: HSRM 1.D; ACHC Standard: HSP7-2A.01

PROCEDURE

1. If a patient, family member and/or caregiver exhibits undesirable behavior to an employee, the employee will confront the person with a statement to stop the behavior. (Direct confrontation is required to alter undesirable behavior.)

2. Employee is to leave the patient's home immediately, if the undesirable behavior should persist.

3. The employee will report the behavior to his/her supervisor as soon as possible. The supervisor will investigate the incident and may need to consult with the patient, caregiver and/or physician regarding the behavior and the effect of the behavior on staff safety.

Hazardous Materials/Waste

POLICY

Hospice will comply with federal/state/local laws and regulations regarding the identification, handling, transportation and disposal of hazardous materials/waste, e.g., Environmental Protection Agency, OSHA and Medical Waste Tracking Act.

PURPOSE

To provide for the safe, appropriate handling of hazardous materials/waste.

REFERENCE

The Joint Commission CAMHC Standard: EC.02.02.01; Medicare CoP #: 418.116; CHAP Standard: HSLG 1.1; ACHC Standards: HSP7-9A.01, HSP7-9A.02

RELATED DOCUMENTS

"*Variance/Incident Report: Patient or Employee*" form

PROCEDURE

1. Hazardous materials/waste includes, but is not limited to:
   - Chemicals.
   - Chemotherapy agents.
   - All materials and wastes that require special handling.
   - Infectious and regulated medical waste, including sharps.

Hazardous materials/waste policy as it pertains to patients

1. Staff will assess the patient's plan of care for the need to address hazardous materials/waste.

2. The patient's home will be assessed for the presence of appropriate supplies and information in the event of an exposure incident, e.g., disposal bags and personal protective equipment for chemotherapy administration, including a chemotherapy spill kit.

3. Hospice staff will communicate the need for hazardous materials/waste supplies to the appropriate company, e.g., to the infusion company for chemotherapy disposal containers.

4. Hospice will implement appropriate work practice controls, engineering controls and personal protective equipment in the provision of patient care.

Hazardous materials/waste as it pertains to Hospice

1. Hospice will assess each site and the activities supported and/or provided by each site for the need to safely handle/dispose of sharps, cytotoxic waste and infectious waste.

2. Hospice will provide the necessary supplies, environment or services to meet any needs identified.

3. Hospice will provide in services to staff upon hire and annually thereafter on all policies/procedures related to the identification, handling, transportation, disposal and exposure to hazardous materials/waste. This includes the Hazard Communication Standard and the Hazardous Chemical Right-To-Know Law.

4. All areas with hazardous materials/waste within Hospice site(s) are identified with the appropriate signs/labels.

5. In the event of exposure to a hazardous material, staff will:
   - Implement immediate action as indicated by the type of hazardous material.
   - Notify the supervisor.
   - Seek follow up care as necessary.
   - Complete a *Variance/Incident Report: Patient or Employee* form.

Hazardous Waste Disposal

POLICY

- All potentially hazardous non-biological waste, including all disposable medical products, is to be discarded into a color coded container before being transported.
- Employees will not transfer waste into another container or sort through the contents of hazardous waste bags.
- All patients are instructed in the appropriate procedure for disposal of medical (hazardous) waste in the home.

PURPOSE

To ensure that hazardous waste is removed from the patient's home, transported and disposed of safely, efficiently and without threat to patients, staff, Hospice or the environment.

REFERENCE

The Joint Commission CAMHC Standard: EC.02.02.01; Medicare CoP#: 418.116; CHAP Standard: HSLG 1.1; ACHC Standards: HSP7-9A.01, HSP7-9A.02

PROCEDURE

1. Hazardous waste is defined as cytotoxic/chemotherapy waste.
2. Gloves will be worn when gathering, transporting or destroying waste which has a chance of having been exposed to hazardous wastes.
3. Containers will not be over filled so that they cannot be easily and tightly closed.
4. All containers will be tightly closed or sealed prior to being taken from the home.
5. If the outside of the container or bag is observed to be punctured or damp from internal leakage, the container will be placed into another container or bag by a gloved employee prior to handling/moving.
6. Spills of hazardous material and waste will be cleaned up immediately utilizing a chemo spill kit with disposal per kit directions.

7. All materials used in the administration of cytotoxic agents are placed in a rigid chemotherapy container, e.g., chemo bags, tubing and syringes. Gloves are worn to prevent possible exposure.

8. When the containers become full, close and secure lid to avoid accidental opening. Company providing chemotherapy should be notified to pick up container and provide replacement.

9. Hazardous waste/biohazard bags and containers will be closed and stored in designated area in the office.

Hazard Communication Program

POLICY

- All employees who work with or may be exposed to hazardous materials under normal working conditions or foreseeable emergencies have the need and "Right-To-Know" what health and physical hazards exist from chemicals found in the workplace.
- The Hazard Communication Program is to be readily accessible to all employees. The written program will be located and available in each site.
- The written program will be reviewed on an annual basis by the Director to ensure a complete and accurate list of chemicals used in the workplace.

PURPOSE

The Department of Labor Occupational Safety and Health Administration (OSHA) has mandated the implementation of a Hazard Communication Standard as stated in 29 CFR 1910, 1200. The purpose of the OSHA Hazard Communication Program is to provide information about chemicals in the workplace and their hazards to all employees. The program will include the following elements:

- Employee training.
- Safety Data Sheets (SDS) or access to SDS via internet or other site.
- Container labeling.
- List of hazardous materials present in the workplace.

REFERENCE

The Joint Commission CAMHC Standard: EC.02.02.01; Medicare CoP #: 418.116; CHAP Standard: HSLG 1.1; ACHC Standards: HSP7-9A.01, HSP7-9A.02

RELATED DOCUMENTS

OSHA Hazard Communication Standard 29 CFR 1910, 1200

CATEGORIES

Skin irritant: chemicals that cause irritation to the skin when the chemical is placed in direct contact with the skin.

Eye irritant: chemicals that cause irritation to the eye when the chemical is placed in direct contact with the surface of the eye.

Oral toxicant: chemicals when swallowed cause irritation or other toxicities.

Dermal toxicant: chemicals that are absorbed into the body through the skin following contact of the chemical with the skin.

Inhalation toxicant: chemicals which are irritating to the lining of the nose, mouth, esophagus or lungs when the chemicals are inhaled. These chemicals may also enter the body through the lungs and exhibit internal toxicities.

LABELING PROCEDURE

1. Containers of hazardous chemicals must be labeled, tagged or marked with the identity of the material and appropriate hazard warnings. Chemical manufacturers, importers and distributors are required to ensure that every container of hazardous chemicals they ship is appropriately labeled. The label must include:
   - Product identifier.
   - Supplier information (name, address and phone number).
   - Signal word (used to indicate the relative level of severity of hazard and alert reader to potential hazard on the label. "Danger" is used for more severe hazards. "Warning" is used for less severe hazards).
   - Pictogram (a symbol plus other graphic elements that is intended to convey specific information about the hazards of a chemical).
   - A hazard statement for each hazard class and category.
   - Precautionary statements.

2. All hazardous chemical containers will be labeled with the identity of the material and appropriate hazard warnings. Unlabeled containers will not be used. Contents of unlabeled containers will be discarded. Labels must be legible and prominently displayed.

3. Hazardous chemicals will remain in the original manufacturer's container until the time of use and will not be transferred into any other container without warning labels. The chemical name stated on the warning label must be identifiable/linkable to the chemicals described in the Safety Data Sheets (SDS).

4. The Director will be notified of any unlabeled containers found.

SAFETY DATA SHEETS (SDS)

1. The role of the SDS is to provide detailed information on each hazardous chemical, including its potential hazard effects, its physical and chemical characteristics and recommendations for appropriate protective measures. Chemical manufacturers and importers are required to develop or obtain a SDS for each hazardous chemical they produce or import. Distributors are responsible for ensuring that their customers are provided a copy of these SDS. Employers must have a SDS for each hazardous chemical in use.

2. Hospice will maintain a list of all hazardous chemicals known to be present using a product identifier that is referenced on the appropriate SDS and the corresponding SDS. A master list will be located in the written program and available from the Director at any time.

3. A SDS for each hazardous chemical will be located in the written program or via internet or other site.

4. The Director is responsible for acquiring and updating SDS. Contact with the chemical manufacturer or vendor will be made if the SDS is not received at the time of shipment.

5. The SDS contains the following information:
   - The chemical identity of the product.
   - Physical and chemical characteristics of the product.
   - Known acute and chronic effects and related health information.
   - Exposure limits.
   - If the chemical is known to be a carcinogen.
   - Emergency and first aid procedures.
   - The identification of the company preparing the SDS.

EMPLOYEE PROTECTION

Skin irritant: rubber or latex gloves are worn to protect the hands from the chemical, according to the information provided on SDS. Gowns and other body coverings that are impervious to the chemical are worn to protect exposed skin from the chemical.

Eye irritant: protective goggles are worn to prevent the chemical from contact with the eyes.

Oral toxicant: eating or drinking is not permitted when handling hazardous chemicals.

Dermal toxicant: rubber or latex gloves, impervious gowns or body coverings, according to the SDS, are worn to prevent the hazardous chemical from direct contact with the skin.

Inhalation toxicant: use hazardous chemicals in a well-ventilated area. Follow specific instructions in SDS for the use of respirators or other protective equipment.

Flammable products: liquids, gases or solids identified as flammable are stored in areas designated for flammable substances only. Flammable chemicals are not stored, delivered nor handled near areas of heat, spark or fire. Follow the instructions for handling of the flammable chemical identified on the SDS.

Detection methods and observations: refer to SDS for each hazardous chemical for specific information on the color, appearance or odor of the product to detect the presence of the chemical in the workplace. Follow the instructions on the SDS for containment of the chemical, clean up and disposal.

EMPLOYEE TRAINING

1. All employees who work with or are potentially exposed to hazardous chemicals will receive initial and annual training on the Hazard Communication Standard and the safe use of those hazardous chemicals. Whenever a new hazard is introduced, additional information and training will be provided.

2. Hazard Communication training will emphasize the following items:
   - Summary of the standard and the written program.
   - Chemicals and physical properties of hazardous materials and methods that can be used to detect the presence or release of chemicals.
   - Physical hazards of chemicals, e.g., potential for fire, explosion, etc.
   - Health hazards, including signs and symptoms of exposure to chemicals and any medical condition known to be aggravated by exposure to the chemical.
   - Procedures to protect against hazards including: personal protective equipment and attire required, proper use; work practices or methods to assure proper use and handling of chemicals; and procedures for emergency response.
   - Work procedures to follow to assure protection when cleaning hazardous chemical spills and leaks.
   - Where SDS are located, how to read and interpret the information on both labels and SDS and how employees may obtain additional information.
   - Documentation of Hazardous Communication training will be maintained in each employee's personnel file.

Variance/Incident Reporting

POLICY

Hospice will establish a consistent documentation and reporting process, in consideration of all federal/state laws and regulations, and define those incidents that require reporting.

PURPOSE

To define the types of incidents/variances to be reported in patients and employees as well as the process for reporting.

REFERENCE

The Joint Commission CAMHC Standards: EC.04.01.01, EC.04.01.03, EC.04.01.05; Medicare CoP#: 418.58c; CHAP Standards: HSLG 1.1, HSRM 1.D; ACHC Standards: HSP6-7A, HSP7-5A.01

RELATED DOCUMENTS

"*Variance/Incident Report: Patient or Employee*" and "*Variance/Incident Reports: Quarterly Data Aggregation*" forms

PROCEDURE

1. Hospice will document and report all incidents (accidents, injuries, safety and security hazards) that deviate from routine Hospice operations and will result in injury or potential harm to a patient/caregiver or Hospice staff. Such incidents may include, but are not limited to:
   - Security incidents involving patients, staff and others in Hospice office or staff in the field.
   - Employee needlesticks with contaminated needles.
   - Equipment and/or medical device failure with resulting injury or harm.
   - Procedure error which results in trauma and/or injury.
   - Untoward outcome, including adverse drug events and reactions.
   - Medication errors.
   - Motor vehicle accidents involving Hospice vehicle or the employee's vehicle while employee is on Hospice business.
   - Any staff accidents that require treatment, lost work days, hospitalization or that identify new safety hazards that were previously unrecognized.
   - Alleged/suspected patient abuse.

- Unexpected patient death not related to the patient's terminal illness within twenty-hour (24) hours of admission.
- Witnessed patient falls.
- Unwitnessed patient falls that require medical intervention.
- Sentinel events.
- Hazardous materials or wastes exposures, spills or other incidents.
- Fire safety management problems, deficiencies and failures.

2. No copies will be made of variance/incident reports and confidentiality of involved individuals will be maintained.

Variance/Incident Reporting

1. A *Variance/Incident Report: Patient or Employee* will be completed on all incidents, as defined in policy, by the staff member involved or the first person to become aware of the incident.

2. The report will be submitted to the immediate supervisor, who is responsible for immediate investigation of the incident and taking any appropriate action.

3. The supervisor will review the *Variance/Incident Report: Patient or Employee* and will document awareness of the incident.

4. The supervisor will assure all applicable federal/state reports/forms are completed, e.g., OSHA 300 Log.

5. The *Variance/Incident Report: Patient or Employee* will be forwarded to the QAPI committee for the purpose of reviewing, analyzing, aggregating, trending and making quality assessment/performance improvement recommendations (see *Variance/Incident Reports: Quarterly Data Aggregation*).

6. Follow up data needed to resolve the incident, e.g., lab reports, physical exams and police reports, will be collected by the supervisor.

7. A file will be maintained of all reported variance/incident reports, as well as any additional data/information pertaining to the *Variance/Incident Report: Patient or Employee*.

ADDITIONAL ACHC REQUIREMENTS

1. Hospice investigates all adverse events, incidents, accidents, variances or unusual occurrences that involve patient care and develops a plan of correction to prevent the same or similar event from occurring again. Events include, but are not limited to:
   - Unexpected death, including suicide of patient.
   - Any act of violence.

- A serious injury.
- Psychological injury.
- Significant adverse drug reaction.
- Significant medication error.
- Other undesirable outcomes.
- Adverse patient care outcomes.
- Patient injury, (witnessed and un-witnessed) including falls.

OSHA 300 Log

POLICY

The Occupational Safety and Health Act (OSHA) of 1970 and 29 CFR Part 1904 require employers to prepare and maintain records of occupational injuries and illnesses. To ensure that Hospice meets the record keeping requirements as stated by OSHA, the OSHA No. 300 Log is utilized. Hospice must report to OSHA:

- All work-related fatalities that occur within 30 days of the work-related incident; within 8 hours.
- All work-related in patient hospitalizations, all amputations and all losses of an eye within 24 hours (if incident occurs within 24 hours of the work-related incident).

PURPOSE

To meet OSHA requirements for reporting, recording and maintaining records of occupational injuries and illnesses.

REFERENCE

The Joint Commission CAMHC Standard: EC.04.01.01; Medicare CoP #: 418.116; CHAP Standard: HSLG 1.1; ACHC Standard: HSP7-5A.01

RELATED DOCUMENTS

Occupational Safety and Health Act of 1970 and 29 CFR Part 1904; www.osha.gov

PROCEDURE

1. The Director is responsible for completing, maintaining and posting the OSHA 300 Log in accordance with OSHA record keeping requirements.

2. All work-related illnesses are recorded on an OSHA form 301 (Injury and Illness Report). Injuries requiring medical treatment (other than first aid) or involve loss of consciousness, restriction of work or motion or transfer to another job are recorded. Medical treatment does not include: one-time treatment and/or subsequent observation of minor scratches, cuts, burns, splinters, etc., which do not ordinarily require medical care even though provided by a physician or registered professional personnel. Exposures to and/or contraction of reportable communicable diseases in the course of work performance are considered reportable on the log. Employee needlestick injuries with contaminated needles must also be recorded on the log. Each injury or illness is recorded within 7 days after learning of the occurrence and maintained for each calendar year.

3. The OSHA 300 Log, 300A and 301 are retained for a 5-year period and available for inspection by employees, former employees and authorized federal and state officials.

4. The *Summary*, a separate form (Form 300A), is posted by February 1 of the following year covered by the form and kept posted until April 30 of that year. The *Summary* is posted even if there are no recorded injuries or illnesses.

5. The OSHA 300 Log may be obtained from the local regional OSHA office.

Security Plan

POLICY

Hospice will ensure a secure environment for employees at all times.

PURPOSE

To maintain staff security.

REFERENCE

The Joint Commission CAMHC Standard: EC.02.01.01; CHAP Standard: HSRM 1.D; ACHC Standard: HSP7-2A.01

PROCEDURE

1. Employees will use designated, secured entrances for entering Hospice's office.

2. All persons entering Hospice's office will be identified.

3. Patients, vendors, sales representatives and others who come to Hospice's office must enter through the designated front door. The receptionist will security-screen all visitors.

4. Visitors are not permitted in any area of Hospice's office other than reception area, unless given permission by Administrator or Director.

5. The potential for workplace violence will be included in staff education, environmental tours and proactive risk assessments, when conducted.

Utility Systems

POLICY

Hospice will maximize patient's utility systems when equipment is used by the patient.

PURPOSE

To identify and decrease potential risks of utility systems failures.

REFERENCE

The Joint Commission CAMHC Standard: EC.02.01.01; CHAP Standard: HDRM 1.D; ACHC Standard: HSP7-2A.01

PROCEDURE

1. Hospice staff will determine if the patient's utility systems are compatible and safe for equipment use during initial and ongoing home safety assessments.

2. Such assessments and reassessments include:
   - Electrical outlets.
   - Space heaters.
   - Electrical cord and use of extension cords: grounding, cord condition, circuit overload and exposure to liquids.
   - Battery condition and charge, e.g., for oxygen concentrators, intravenous pumps and ventilators.
   - Any special electrical requirements for equipment, e.g., ventilators, intravenous pumps and concentrators.
   - Any special power requirements.

Violence in the Workplace Prevention

POLICY

Hospice is committed to providing a safe environment for employees, patients and visitors. Hospice refuses to tolerate violence in the workplace and will take action within its control to prevent violent incidents from occurring. Hospice requires prompt and accurate reporting of all violent incidents, whether or not physical injury has occurred.

PURPOSE

To define violence in the workplace prevention.

REFERENCE

The Joint Commission CAMHC Standard: EC.02.01.01; CHAP Standard: HSRM 1.D; ACHC Standard: HSP7-2A.01

PROCEDURE

1. Hospice will not discriminate against victims of workplace violence. Workplace violence prevention program includes: measures to protect all employees, including supervisors and managers; adherence to work practices that are designed to make the workplace more secure; and not tolerating verbal threats or physical actions that create a security hazard for others in the workplace.

2. Hospice has a zero tolerance for violence in the workplace. An employee is subject to immediate termination for cause. No talk of violence or joking about violence will be tolerated. Hospice defines violence to include physically harming another, shoving, pushing, harassment, intimidation, coercion, brandishing weapons and/or threats or talk of violence.

3. In order to promote a safe workplace, Hospice will limit access to all Hospice property to those with a legitimate business interest.

4. Hospice will not tolerate employees possessing any weapons, including weapons transported in employee vehicles, both inside the workplace and in the parking area. When working outside Hospice's premises, employees are prohibited from carrying or transporting weapons. No carrying of concealed weapons, with or without a valid permit to carry a concealed weapon, is permitted on Hospice property or while performing work as a Hospice employee, unless specifically authorized by Hospice. Weapons include guns, knives, explosives and other potential weapons. Appropriate disciplinary action, up to and including termination, will be taken against any employee who is in violation.

5. As part of the commitment to preventing workplace violence, Hospice provides education for recognition and prevention of violence in the workplace. Training will include:

   - A review and definition of workplace violence.
   - An explanation and description of Hospice's program for recognition and reporting of workplace violence.
   - Training on how to identify potential workplace security hazards, e.g., no lights in the parking area at night, unknown persons loitering outside the building, etc.
   - Review of measures that have been instructed at Hospice to prevent workplace violence.

6. In order to promote a peaceful working environment, Hospice encourages managers, supervisors and employees to enroll in courses to learn more about working with each other. Courses covering communication, problem solving, building effective working relationships, stress management and related or similar course topics are supported by the Director and Administrator.

7. Employees must report any event/incident that may involve a violation of any of Hospice's policies that are designed to provide a safe workplace environment. All events/incidents must be reported as soon as possible to the Director or Administrator.

8. All reports will be investigated and information will be kept confidential. Each incident will be evaluated by Hospice management team. The team will discuss the causes of the incident and will make recommendations on how to revise the workplace violence prevention program to prevent similar incidents from occurring. Revisions of the program will be put in writing and made available to employees.

9. In the event of a major workplace incident that affects, or has the potential to affect, the mental health of Hospice's work force, Hospice may provide initial counseling and support services to employees. As the crisis passes and support systems are put into place for individuals affected by the incident, Hospice will make every effort to return to normal business operations. A reasonable effort will be made to notify employees, patients and others who need to know the status of Hospice's business operations. In cases where direct contact is not possible or practical, an effort will be made to communicate through the news media and other available resources.

SUBJECT: PATIENT SAFETY PLAN	REFERENCE 603
DEPARTMENT: HOSPICE	PAGE: 1 OF: 5
	EFFECTIVE: 1/2/2011
APPROVED BY: NAH BOARD OF TRUSTEES	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.

- 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.

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  - 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.

- 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
  -

- **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

-

- 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.

CARSON TAHOE
HEALTH
Continuing Care Hospital

PATIENT SAFETY PLAN

Carson Tahoe Continuing Care Hospital

2022

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*

Revised: *February 2022*

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

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

CORE VALUES
Putting patients first
Treating everyone with dignity and respect.

I. PURPOSE/ROLE

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

II. FRAMEWORK FOR SAFE, RELIABLE AND EFFECTIVE CARE

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

III. ROLES and RESPONSIBILITIES/COMPOSITION

The Patient Safety Committee shall consist of the System Patient Safety Officer, Infection 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

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, and 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 2022, CTCCH will:
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:

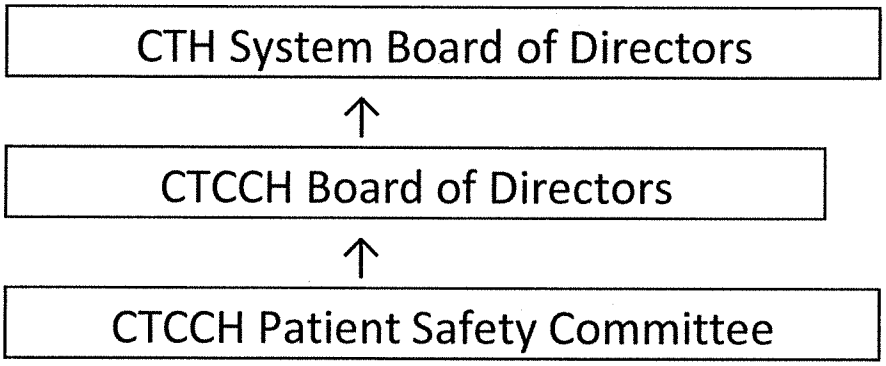
- Serving on the Patient Safety Committee
- Supervising sentinel event reporting to the State
- Conducting mandatory investigations
- Assisting with development of actions taken, tracking progress and loop closure with those involved
- Ensuring notification as appropriate within the medical facility

STRUCTURE

Attachment B depicts the reporting structure.

Attachment B

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 System 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.

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

		Jun-21
Checklist Title	**Checklist Category**	**Department**
Discharge Checklist for nursing	Discharge	Nursing
Discharge Checklist for patient	Discharge	Nursing
Discharge Planning Checklist	Discharge	Nursing
Discharge Checklist	Discharge	Electronic Health Record
CTCCH Admission Criteria Check list	Admission	Nursing - Liaison
Fire Drill Participation	Environment	Housewide
CTCCH Domestic Water Flushing	Environment	CTH Facility Staff/Spruce Engineering
Fire Report	Environment	CTH Facility Staff/Spruce Engineering
Fire Watch Form	Environment	CTH Facility Staff/Spruce Engineering
Life (Fire) Safety Inspection /Healthcare Occupancy	Environment	CTH Facility Staff/Spruce Engineering
CTCCH Rounding Checklist	Environment	CTH Facility Staff/Spruce Engineering/EOC Committee
Patient Room Housekeeping Checklist by area /by shift	Environment	Spruce
Environmental Rounds Performed by Charge RN each shift	Environment	Nursing
Quality Assurance Checklist	Environment	Housekeeping
Unit Department Checklist	Environment	Nursing
CRASH CARTS		
Adult Crash Cart Checklist	Other Safety	Nursing
Refrigerator / Freezer Temperature Record	Other Safety	Nursing/Pharmacy/Dietary
Blanket Warmer Temp Logs	Other Safety	Nursing
Transfer Checklist for Transportation	Other Safety	Housewide
Ventilator Calibration Checklist	Other Safety	Respiratory
Central Line Associated Blood Stream Infection and CAUTI surveillance	Other Safety	Infection Control & Nursing
Emergency Equipment checklist	Other Safety	Nursing Administration/Emergency Preparedness
Hand Hygiene	Other Safety	Infection Control
Infection Control Monitoring during construction	Other Safety	Infection Control
Central Line Insertion	Other Safety	Nursing
Charge Nurse checklist	Other Safety	Nursing
Hand Off Communication sheet Pre-op/OR/PACU	Treatment	Receiving CTH facilities
Magnetic Resonance Imaging History & Assessment	Treatment	Medical Imaging
Medical Imaging Invasive Procedure Checklist	Treatment	Medical Imaging
Non Ionic and/or Ionic Contrast Consent Form	Treatment	Medical Imaging
Foley Catheter Tracking	Treatment	Infection Control & Nursing

List Reviewed and approved by
CTCCH Patient Safety Committee on
June 28, 2021

Carson Tahoe Health System:

PATIENT SAFETY PLAN 2022

DATE: 01/18/2022
VERSION: 1

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.

Intent of Patient Safety Plan

Optimize the patient safety outcomes

Encourage recognition

Reporting

Acknowledgment of risks to patient, visitor and employee safety

Reduce the medical/healthcare errors and /or preventable events

Patient Safety Committee/Program

I. PURPOSE/SCOPE

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.

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

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.

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 for staff.

III. COMMITMENT TO PATIENT SAFETY

Carson Tahoe Health System 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.

IV. MISSION, VISION AND VALUES

In support of our mission, vision, and values, Carson Tahoe Healthcare System Patient Safety

Improvement program promotes:

- Collaboration of healthcare, leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high qualityhealthcare.
- 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 orperformances 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.

All Carson Tahoe Health System staff are required to fully support and participate in this plan, and devote their expertise to the patient safety and healthcare quality improvement process.

The plan 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

V. THE PATIENT SAFETY 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
- 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.1 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 andinfections that occur.
- At least once each calendar quarter 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 (or quarter); The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and
- Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
- Adopt patient safety checklists and patient safety policies as required by NRS 439.877, review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

The 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.

- 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
- Providing emotional support for staff involved in incidents or events, through Human Resources leadership, department supervisors and other resources as appropriate
- 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
- Event 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
    - Hazardous conditions
    - Workplace violence conditions
- 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.

VII. 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 aninvestigation 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."
Carson Tahoe Health System 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 changes.

In 2022, Carson Tahoe Health will:

- Restructure and implement to the entire organization 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

- Create and distribute event trending reports to each department leader to discuss with staff in daily huddle.

- Implement an Action Plan Tracker to increase transparency of SSE
- Utilize the HEAT MAP in daily huddle to identify RCA events for report out by leader

VIII. 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

IX. 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 providersof 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 forapproval 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 safetyplan established to NRS 439.865 must be submitted to the Division of Public and Behavioral Health.

Structure: Appendix A
Checklists: Appendix B

Appendix A:

Patient Safety Reporting Structure

Patient Safety Committee

SARC Huddle Action Plan Follow Up
Falls Committee Quarterly Update
Medication Committee Quarterly Update
Code Blue Committee Quarterly Update
Chest Pain Committee Quarterly Update
Sepsis Committee Quarterly Update
Stroke Designation Committee Quarterly Update
Infection Prevention Committee Quarterly Update
Environment of Care Quarterly Update
Ethics Committee Quarterly Update

Appendix B:

Checklists:

See Attached

Appendix B: Carson Tahoe Regional Medical Center 2022 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

Carson Tahoe Regional Medical Center 2022 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'*sf* 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	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

Carson Tahoe Regional Medical Center 2022 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 Guideline)	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

Centennial Hills Hospital Medical Center

Risk Management/ Patient Safety Plan

Nevada Acute Care Division

Revised 1/2022

A. **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 facility 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 RESPONSIBILITES

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 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:

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: This element outlines the UHS Risk program that lays the foundation for an effective risk management program. The Risk Manager/Director must be seen as a resource to administration, facility, and medical staff. Written plans, goals, and objectives provide a clear vision to meet the purpose of the UHS program. Although the TERM program uses the title, "Risk Manager," this applies equally to Risk Directors.

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

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

Element IV. Patient Safety Initiative: Imperative to a comprehensive RM program is one that focuses on the improvement of patient and staff safety through the creation of an environment that maximizes safety and reduces liability claims exposure. The mechanism used to drive the culture of safety is the Patient Safety 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 cornerstone 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 environmental safety and security programs in the facility serve to protect and preserve both life and property. Areas of safety include licensing, accreditation and state, federal and local safety practices and programs.

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

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

Element IX. Medication Safety Initiative: The medication safety initiative is geared toward preventing and responding to the accidental injury of a patient due to medical care or medical errors during the medication-use process. The mechanism used to drive the culture of safety is the Medication Safety Committee at each facility. The committee proactively assesses risk points at every level of the medication use cycle: procurement, storage, ordering/prescribing, transcription, distribution, preparation, dispensing, administration, documentation, and monitoring.

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.

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 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 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. Patient Safety Priorities, Goals and Objectives for 2022

- **Surgical and Procedural Safety**
  - **Wrong Site Surgery (WSS)**
    - ***Goal***: A 50% reduction in WSS events for 2022. Ultimately, the goal is 0.
  - **Retained Procedural items (RPIs)**
    - ***Goal***: Prevent RPIs- a 50% reduction in RPIs with harm for 2022. Ultimately, the goal for RPIs is 0.

- **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.
  - ***Goal***: Increase the percentage of patients with QBL of 2000 ml who receive transfusions to ≥ 50%.
- **Reduction / elimination of serious harm by utilizing an oxytocin checklist to decrease the percentage of full-term newborns with Apgars less than 6 at 5 minutes and / or requiring NICU admission.**
  - ***Goal:*** Reduce the number of full-term newborns requiring NICU admission by 10%.

- **<u>CLABSI Initiative</u>**
  - ***Goal***: CLABSI will be reduced to less than the CMS national mean Standardized Infection Ratio (SIR: CLABSI 0.692) in 2022.

- **<u>Safe Medication Use</u>**
  - **Smart Infusion Pump High Risk Opioid Event Reduction Initiative.**
    - ***Goal***: Decrease the number of high-risk opioid medication overrides by 50% by December 1, 2022.
    - ***Goal*:** Increase "Guardrails Suite usage to meet UHS and Leapfrog goal of 95% by December 1, 2022.
    - ***Goal:*** Naloxone provision usage will increase to 95% by June 1, 2022.
  - **Anticoagulant Safety in the Perioperative Setting**.
    - ***Goal:*** AHRQ PSI 12 Perioperative Pulmonary Embolism or Deep Vein Thrombosis benchmark is 3.950 per 1000 inpatients. The goal is to monitor this metric to ensure we continue below the benchmark.
    - ***Goal:*** The VTE Advisor will be used to assess the patient's postoperative risk for thromboembolism and documented prophylaxis through the VTE advisor The goal is 80% compliance with "VTE Advisor" usage.

- **<u>Reduce Falls and Falls with Injury</u>**
  - ***Goal***: 10% reduction in the rate of falls in the Acute Care Division by the end of 2022.
  - ***Goal***: 10% reduction in the rate of falls with injury in the Acute Care Division by the end of 2022.

- **<u>Decreasing Hospital Acquired Pressure Injuries</u>**
  - **Goal:** 10% reduction of NPOA rate for all HAPI stages in the Acute Care Division by the end of 2022.

- **<u>Culture of Safety</u>**
  - **Goal**: reduce the number of GHI events (serious safety event rate) for the Acute Care Division by the end of 2022. Ultimately, the goal is 0.

- **Other Identified Goals**
  - **Goal**: ED to increase in Kinder assessment completeness to 90% by Q2 of 2022.
  - **Goal**: 95% compliance for manager event review within 10 days.
  - **Goal**: Improve heparin independent double check documentation by 15%.

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/SOX 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.

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.

- 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):

  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 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

- 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 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
- 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.

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

Desert Springs Hospital Medical Center

Risk Management/ Patient Safety Plan

Nevada Acute Care Division

Revised 1/2022

A. 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 facility 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 RESPONSIBILITES

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 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:

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: This element outlines the UHS Risk program that lays the foundation for an effective risk management program. The Risk Manager/Director must be seen as a resource to administration, facility, and medical staff. Written plans, goals, and objectives provide a clear vision to meet the purpose of the UHS program. Although the TERM program uses the title, "Risk Manager," this applies equally to Risk Directors.

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

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

Element IV. Patient Safety Initiative: Imperative to a comprehensive RM program is one that focuses on the improvement of patient and staff safety through the creation of an environment that maximizes safety and reduces liability claims exposure. The mechanism used to drive the culture of safety is the Patient Safety 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 cornerstone 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 environmental safety and security programs in the facility serve to protect and preserve both life and property. Areas of safety include licensing, accreditation and state, federal and local safety practices and programs.

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

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

Element IX. Medication Safety Initiative: The medication safety initiative is geared toward preventing and responding to the accidental injury of a patient due to medical care or medical errors during the medication-use process. The mechanism used to drive the culture of safety is the Medication Safety Committee at each facility. The committee proactively assesses risk points at every level of the medication use cycle: procurement, storage, ordering/prescribing, transcription, distribution, preparation, dispensing, administration, documentation, and monitoring.

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 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.

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 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 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. Patient Safety Priorities, Goals and Objectives for 2022

- **Surgical and Procedural Safety**
  - **Wrong Site Surgery (WSS)**
    - ***Goal***: A 50% reduction in WSS events for 2022. Ultimately, the goal is 0.
  - **Retained Procedural items (RPIs)**
    - ***Goal***: Prevent RPIs- a 50% reduction in RPIs with harm for 2022. Ultimately, the goal for RPIs is 0.

- **CLABSI Initiative**
  - ***Goal***: CLABSI will be reduced to less than the CMS national mean Standardized Infection Ratio (SIR: CLABSI 0.692) in 2022.

- **Safe Medication Use**
  - **Smart Infusion Pump High Risk Opioid Event Reduction Initiative.**
    - ***Goal***: Decrease the number of high-risk opioid medication overrides by 50% by December 1, 2022.
    - ***Goal*****:** Increase "Guardrails Suite usage to meet UHS and Leapfrog goal of 95% by December 1, 2022.
    - ***Goal:*** Naloxone provision usage will increase to 95% by June 1, 2022.
  - **Anticoagulant Safety in the Perioperative Setting**.
    - ***Goal:*** AHRQ PSI 12 Perioperative Pulmonary Embolism or Deep Vein Thrombosis benchmark is 3.950 per 1000 inpatients. The goal is to decrease the Patient Safety Indicator (PSI) 12 rate by 10% by December 2022.
    - ***Goal:*** The VTE Advisor will be used to assess the patient's postoperative risk for thromboembolism and documented prophylaxis through the VTE advisor The goal is 80% compliance with "VTE Advisor" usage.

- **Reduce Falls and Falls with Injury**

- ***Goal***: 10% reduction in the rate of falls in the Acute Care Division by the end of 2022.
- ***Goal***: 10% reduction in the rate of falls with injury in the Acute Care Division by the end of 2022.

- **Decreasing Hospital Acquired Pressure Injuries**
  - **Goal:** 10% reduction of NPOA rate for all HAPI stages in the Acute Care Division by the end of 2022.

- **Culture of Safety**
  - **Goal**: reduce the number of GHI events (serious safety event rate) for the Acute Care Division by the end of 2022. Ultimately, the goal is 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/SOX 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.

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: 2022
VERSION: 6

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.

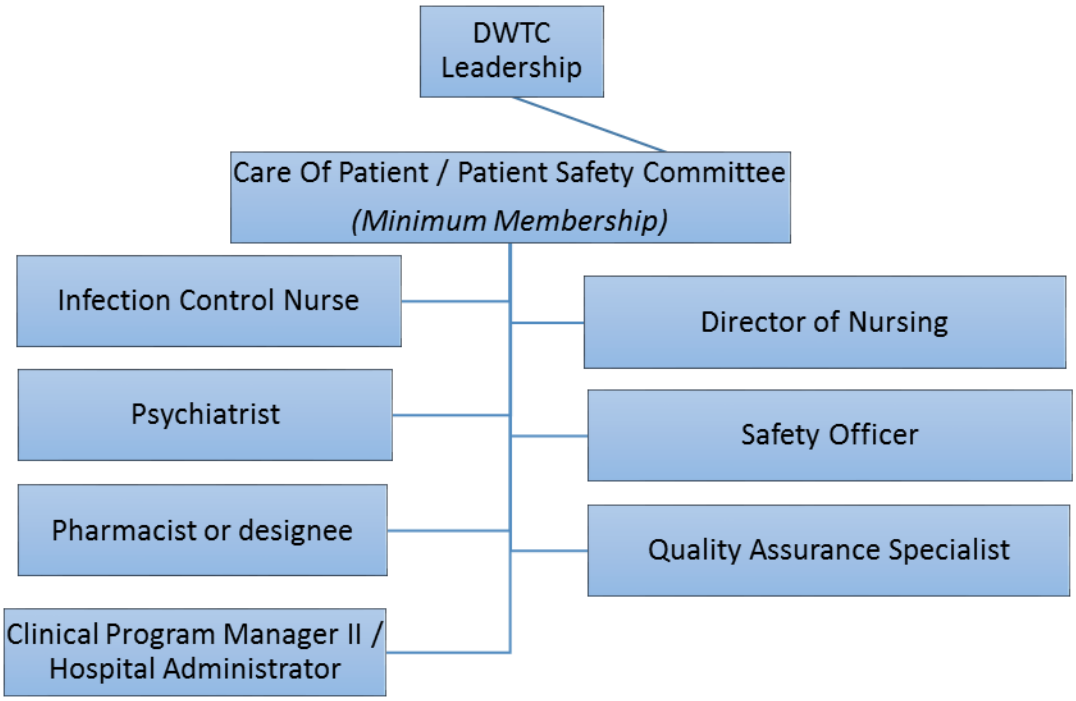
The plan focuses on the process rather than the individual, and recognizes both internal and external customers, as well as facilitates the need of analyzing and improving processes. The core principles of this plan include:

- 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.

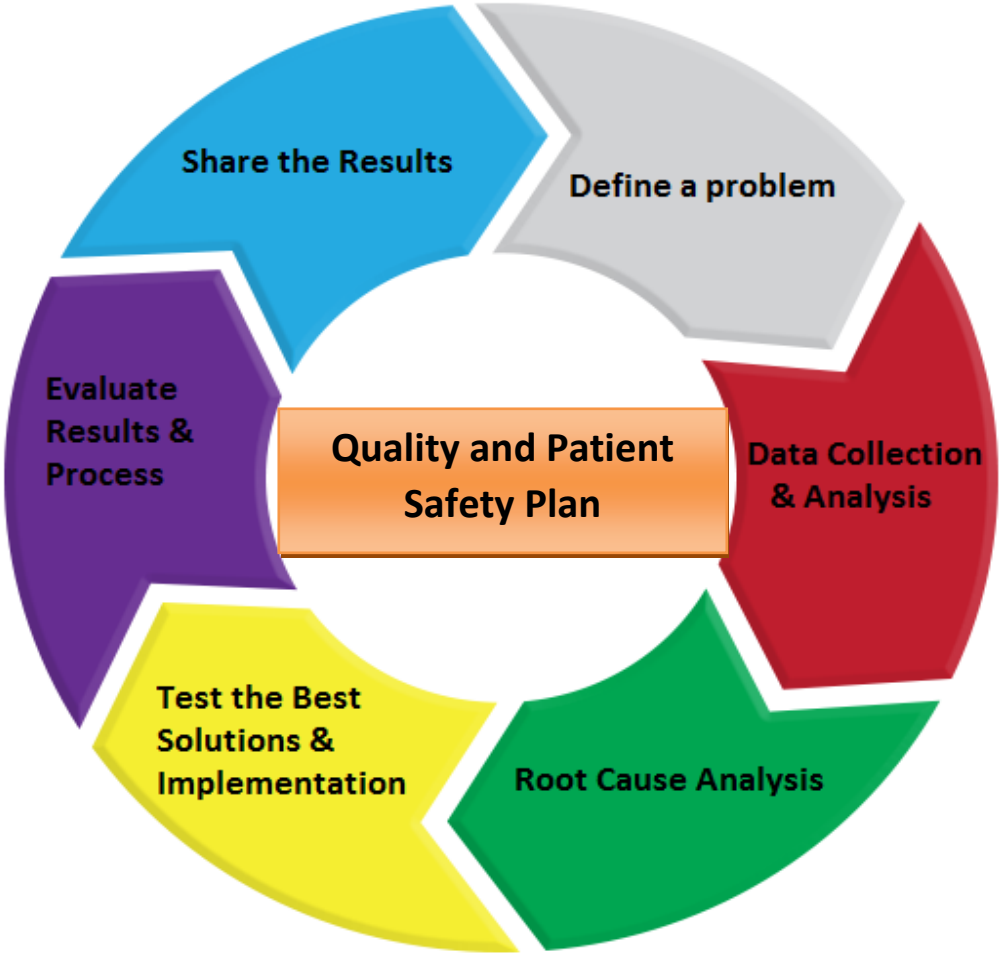
Objectives and Goals of the Quality and Patient Safety Plan

- 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.

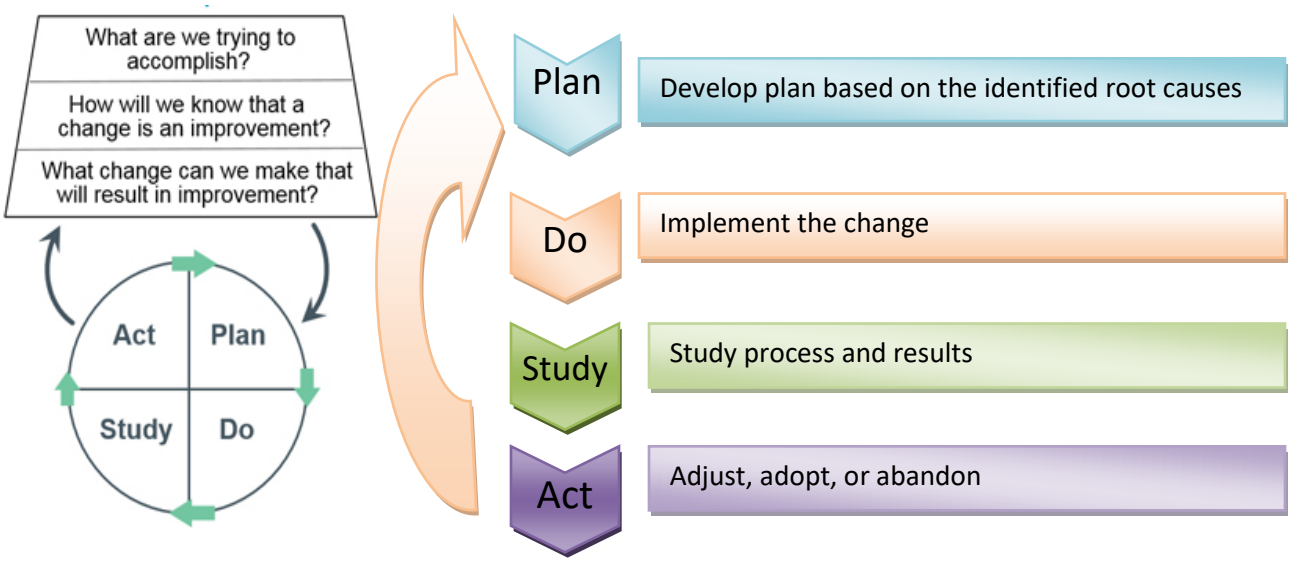
Fishbone Diagram

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

2022

National Patient Safety Goals

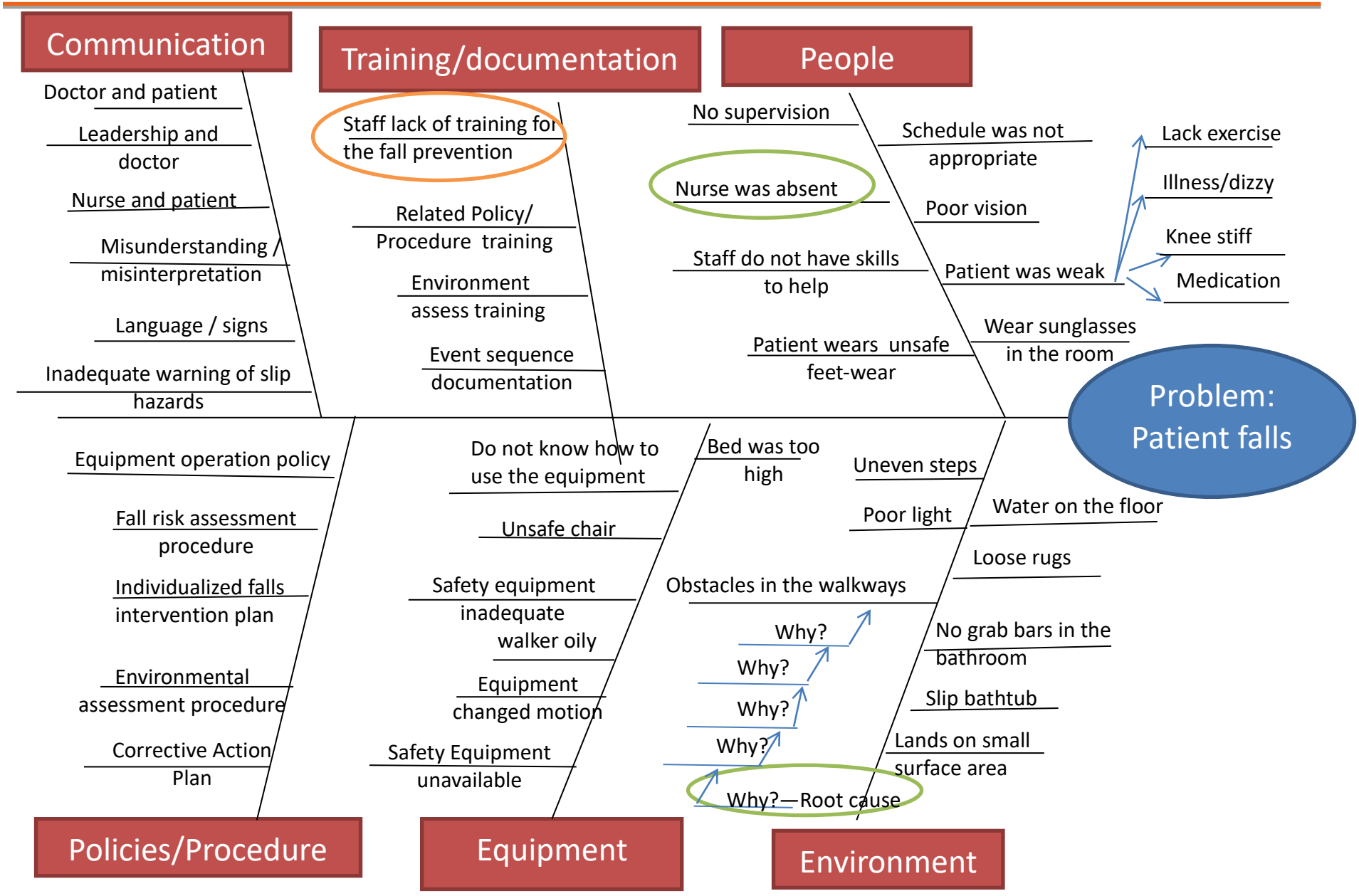
The purpose of the National Patient Safety Goals is to improve patient safety. The goals focus on problems in health care safety and how to solve them.

Identify individuals served correctly	
NPSG.01.01.01	Use at least two ways to identify individuals served. For example, use the individual's name *and* date of birth. This is done to make sure that each individual served gets the correct medicine and treatment.
Use medicines safely	
NPSG.03.06.01	Record and pass along correct information about a individual's medicines. Find out what medicines the individual served is taking. Compare those medicines to new medicines given to the individual served. Give the individual served written information about the medicines they need to take. Tell the individual served it is important to bring their up-to-date list of medicines every time they visit a doctor.
Prevent infection	
NPSG.07.01.01	Use the hand cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization. Set goals for improving hand cleaning. Use the goals to improve hand cleaning.
Identify individuals served safety risks	
NPSG.15.01.01	Reduce the risk for suicide.

The Joint Commission

This is an easy-to-read document. It has been created for the public. The exact language of the goals can be found at www.jointcommission.org.

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 03-21.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_03.2020.docx

Seclusion Monitoring Form S:\DWTC\DWTC FORMS\DWTC 197 Seclusion Monitoring Form 05-20.docx

Peer Review Forms
- S:\DWTC\DWTC FORMS\DWTC 141 - Peer Review - PSYCHIATRIST 03-21.docx
- S:\DWTC\DWTC FORMS\DWTC 141A - Peer Review - PEDIATRICIAN 03-21.docx
- S:\DWTC\DWTC FORMS\DWTC 141C - Peer Review - RN 02-21.docx
- S:\DWTC\DWTC FORMS\DWTC 141D - Peer Review - CLINICIAN - 10-21.docx

Medication Pass Audit S:\DWTC\DWTC FORMS\DWTC 180 Medication Pass Audit 01-21.docx

Medication Variance Investigation
- S:\DWTC\DWTC FORMS\DWTC 142A Medication Variance Report & Investigation Form 08-18.docx
- S:\DWTC\DWTC FORMS\DWTC 142B Medication Variance Error Index 08-18.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 09-20.doc
- S:\DWTC\DWTC FORMS\DWTC 120 C - Medication Room Temperature Log 09-20.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

Appendix D: Checklists (continued)

Environment of Care Monitors

S:\DWTC\DWTC Policies & Procedures\DWTC POLICIES\10.0 - ENVIRONMENT OF CARE\10.50 - ENVIRONMENT OF CARE MONITORS 06-21.docx

Suicide Risk Assessment

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 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
S:\DWTC\DWTC FORMS\COVID -19 TemperatureDailyScreening (CCSD) 08-21.docx
S:\DWTC\DWTC FORMS\DWTC 16 Informed Consent for Routine COVID-19 Testing of Patient 11-21 .docx
S:\DWTC\DWTC FORMS\COVID Testing (Consent and Lab Form) 1-10-2022.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 05-19.docx

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
7.03 Physical Health Assessment
7.04 Nursing Assessment
7.09 Medication Management
7.10 Medication Variances
7.12 Medication Stop Order
7.15 Destruction of Used Needles and Syringes
7.16 Medication Induced Movement Disorder Monitoring
7.18 Pain Management
7.21 Physician Orders
7.22 Psychiatric Evaluation
7.24 Mental Status Examination
7.25 Drug Samples
7.32 Emergency Medical Care / COBRA Packet
7.34 First Aid Nosebleeds
7.35 First Aid for Open Wounds
7.40 Professional Nursing Staff
7.41 Medical Staff
7.50 Vital Signs
7.51 Glucose Monitoring via Glucometer
7.53 Contract Laboratory Services
7.54 Diagnostic Services
7.60 Employee Medical Emergency
7.61 Employee Physical Examinations and TB Tests
7.63 Nursing Care Procedures
7.64 Polypharmacy, High Dose & Off-Label Pharmacotherapy
7.83 Pharmacy Dispensing Procedures
7.85 Critical Test Result Notification
7.86 Medication Reconciliation
7.87 High Alert / LASA / Hazardous Medications
7.88 Shift Report
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
10.02 Influenza Program
10.03 Occupational Exposure to Bloodborne Pathogens
10.04 Infection Control of Ice Machine
10.05 Health Safety Inspection
10.07 Interim Life Safety Measures
10.08 Use of Disposable Gloves During Handling of Foods and Fluids
10.10 Surveillance, Prevention and Control of Infection Guidelines
10.11 Personal Protective Equipment
10.13 Work Practice Controls
10.14 Lice Policy
10.15 Hand Washing
10.16 Tuberculosis Screening for Patients
10.17 Sanitation and Disinfection
10.18 Isolation Techniques
10.19 Nosocomial Detection and Reporting
10.20 Occupational Illness
10.21 Infection Control and Surveillance Plan
10.22 Standard Precautions
10.23 Transmission Based Precautions
10.25 Emergency Preparedness External Disaster
10.40 Maintenance Stand-By for After Hours
10.41 Housekeeping/Maintenance
10.44 Use of State Vehicles
10.46 Non-Smoking/Smoking
10.47 Ordering of Supplies
10.50 Environment of Care Monitors
10.51 Safety Management Plan
10.52 Utility Systems Management Plan
10.53 Security Management Plan
10.54 Hazardous Materials and Waste Management Plan
10.55 Fire Safety Plan (previously Life Safety Management Plan)
10.62 Non-Dairy Beverage Substitutions
10.63 Diets and Food Requisitions
10.64 Meals DWTC
10.66 Nutritional Screening and Assessment
10.68 Dietetic Services Quality Improvement Plan
10.69 Diet Orders
10.70 Wellness Policy
10.73 Nutrition Care Monitoring
10.74 Nutrition Care Manuals and Menu
10.75 Nutrition Education
10.76 Meal Service
10.77 National School Lunch Program
10.81 Incident-Accident Reporting
10.83 Incidents Involving State Vehicles
10.85 Lockout-Tagout System
10.86 Employee Lockers
10.91 911 Emergency Protocol
10.92 Building Security
10.93 Threats / Behavioral Emergencies in the Lobby / Intake Room
10.94 Natural Gas Leak
10.95 Potentially Dangerous Weapons
10.96 Bomb Threats
10.99 Chemical Ingestion by Patient
10.100 Hostage Situation
10.101 CCSD / DWTC Evacuation
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 02-21.docx

Dini-Townsend Hospital

QUALITY AND PATIENT SAFETY PLAN 2022

DATE: 01/27/2022

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

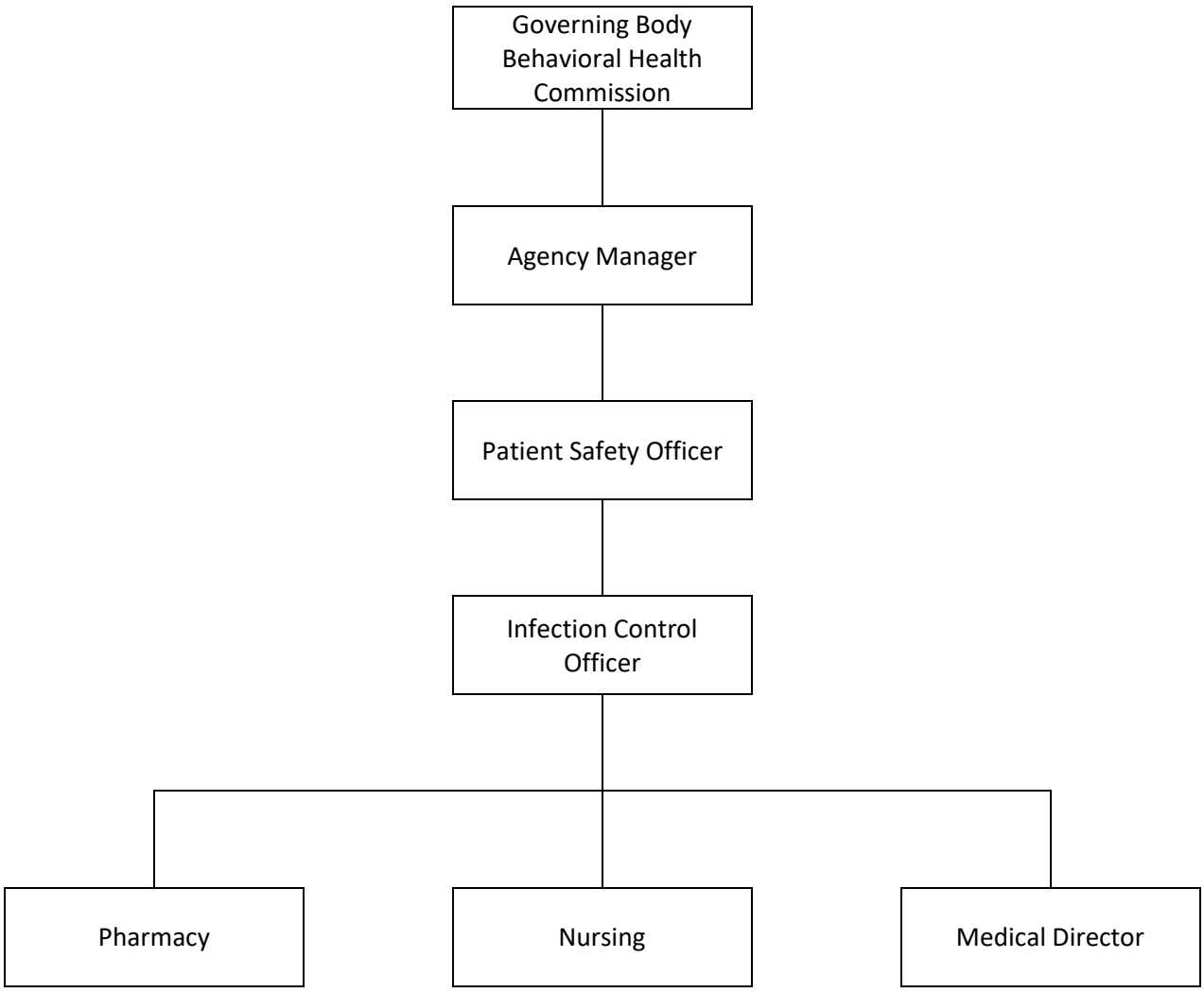
core principles of this plan include:

- 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.

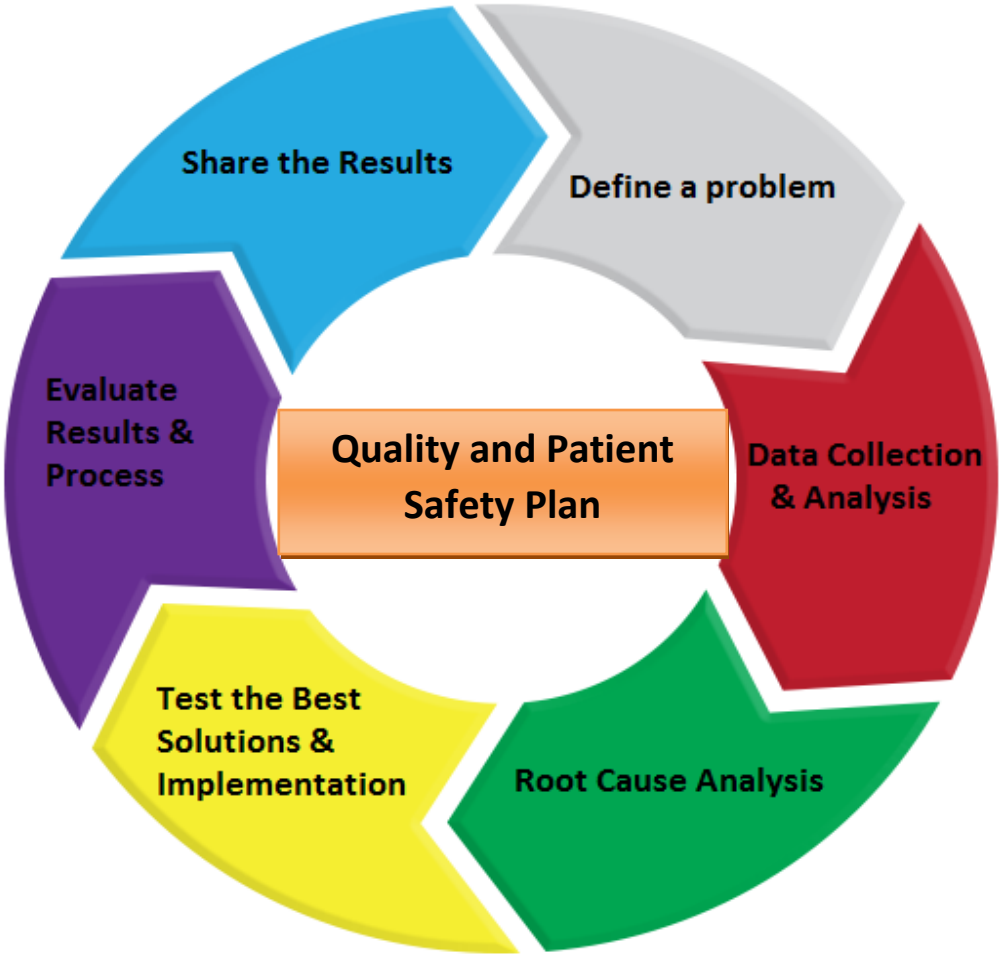
Objectives and Goals of the Quality and Patient Safety Plan

Objective	Goals	Plan	Planned Completion Date	Responsible Party
Reduce seclusion and or restraints by 10 %	Increase the training period for De-escalation (CPI)	• 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	12/31/2022	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.

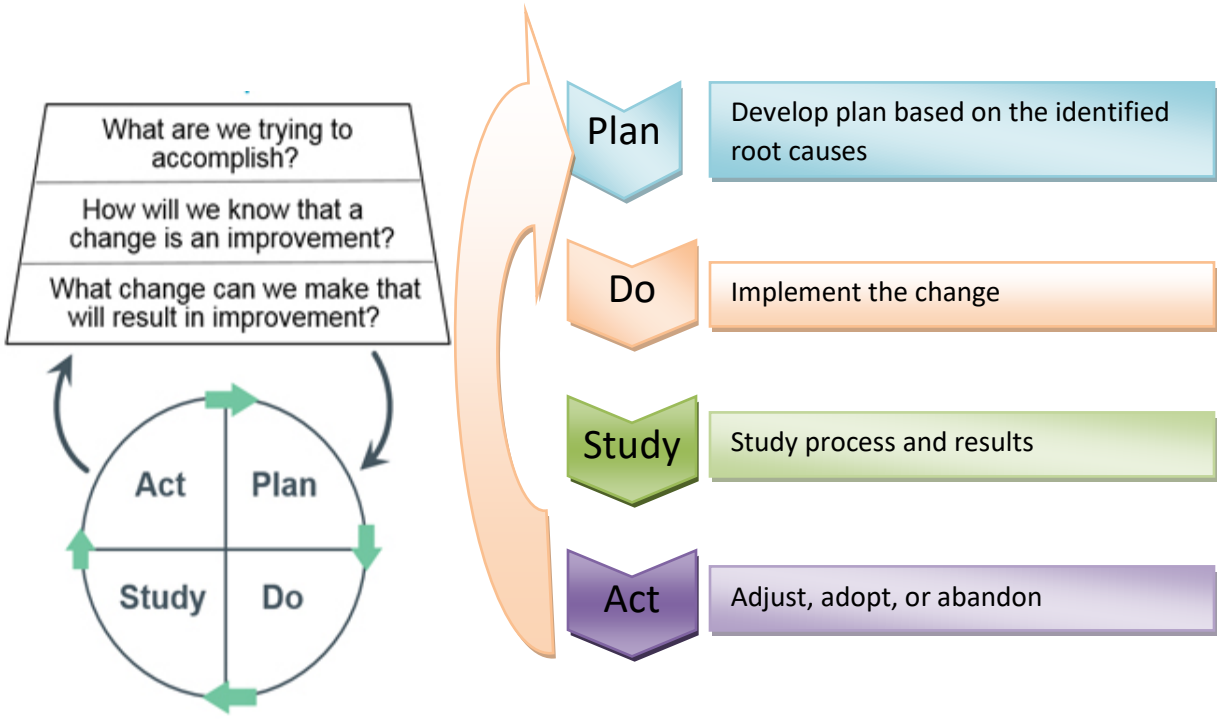
Fishbone Diagram

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_CUR RENT_b.pdf.)

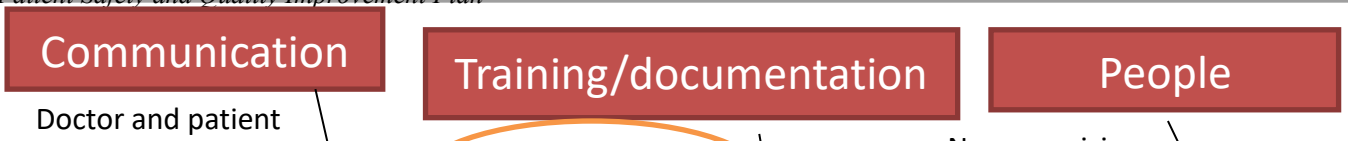
Central Line Associated Bloodstream Infections (CLABSI): Primary bloodstream infections that are associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection.

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 workgroups focused on medication safety, reducing patient falls & hospital acquired pressure ulcers. Revise or develop policies, procedures and protocols.	Establish Patient Safety Council.	

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
- 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.

MERCY HOSPITAL	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

Encompass Health Rehabilitation Hospital of Desert Canyon

Policy#:	Title:	Category:
100	Safety Management Plan	Facility Management
Policy Status:	**Effective Date:**	**Last Reviewed Date:**
Published	03/13/2020	03/12/2021

PURPOSE

The Safety Management Plan describes how the hospital will provide a physical environment free of hazards and manage staff activities to reduce the risk of injuries.

SCOPE

The Safety Management Plan is facility-wide in scope and includes inpatient and outpatient satellites, if any.

RESPONSIBILITY

The Administration of this hospital has appointed the Facilities Management Director as the Safety Officer assigned to coordinate and manage risk assessment and reduction activities and hereby grants the authority for this individual to intervene when conditions immediately threaten life and health in order to minimize potential for harm including but not limited to activation of the Emergency Operations Plan in the absence of the Administrator.

POLICY

The Safety Management Plan includes elements to maintain and supervise the hospital and all grounds and equipment. This is accomplished through established work practices and policies and procedures. Scheduled environmental tours provide an effective method of risk assessment that pro-actively evaluates the impact of the hospital's building, its occupants, and internal physical systems on patient and public safety.

The hospital has established processes (Hospital Incident Reporting - RL Solutions and Worker's Compensation Accident Investigation reporting) for the reporting and investigation of all incidents of property damage, occupational illness and injury's as required by OSHA and posted on the OSHA 300 Log, as well as patient and visitor injury. Response to product safety recalls is also included in the management plan.

The Safety Officer is responsible for collecting and reporting any significant variances identified in the Safety Management Program to the hospital's EOC Committee and Quality Council. These committees include representation from Administration, Nursing Services, Rehabilitation Services, and Support Services.

Hospital staff are trained in the basic components and operation of the hospital's Safety Management Program. Staff training and orientation is conducted upon initial employment during a general orientation session. This orientation and training session includes an introduction to general safety processes. Department Managers perform area-specific training and specific job-related hazards. The need for more training is assessed by reviewing data collected during quarterly environmental tours, surveys, assessments, and reporting activities.

Performance standards are established by policies and procedures, standard work practices, monitoring and inspection activities, emergency and incident reporting procedures that identify when and to whom reports are communicated, and the inspection, preventive maintenance, and testing of safety equipment and systems. Staff safety management knowledge and skill is measured through the monitoring of staff performance, interviews, and direct observation. Safety policies and procedures are available to all staff via a database called Hospital Policy on Demand (HPOD). Policies are practiced, enforced, and reviewed at least annually.

Environmental rounds are conducted on a scheduled basis such that all patient care areas are toured semi-annually and non-patient areas, including grounds are toured at least annually. Tours are scheduled in advance by the Safety Officer who notifies designated staff required to participate in each tour. At a minimum, each tour includes the Safety Officer, Director of Quality, and a manager or supervisor from the department being surveyed. Findings are communicated to responsible parties for any follow-up required and included in quarterly reports to the EOC Committee.

Safety Management Program data is collected from multiple sources including staff input, observation of the physical environment, observation of standard work practices, and internal and external monitoring. The EOC Committee reviews this data on a quarterly basis and ensures that established performance standards are met and maintained.

Quality Improvement

At least one aspect of the program will be monitored on a monthly basis and a report of the results will be forwarded to the EOC Committee and Governing Body on a quarterly basis.

Evaluation

The objective, scope, performance, and effectiveness of the Safety Management Plan are evaluated at least annually by the Environment of Care Committee and findings are reported to Governing Body. Performance indicators are also reviewed annually and considered for change at this time. Changes to improve the plan based on data collection and evaluation, lessons learned from experience, and regulatory compliance standards are communicated to leadership.

PROCEDURE

The table below lists chosen performance indicators for the current year and illustrates sources of data to be included in the analysis of the Safety Management Plan.

Data	Source	Report To
Percentage of Scheduled Environmental Tours Completed	Environmental Rounds Report CMMS Documentation	Safety Officer Surveyed Unit Mgr EOC Committee
Total Number of Reported Occupational Illnesses and Injuries	OSHA 300 Log	Quality Council
Number of Patient Falls – Environment Related	Event Report EOC Tracking Reports	Quality Council EOC/ Patient Safety/ Infection Prevention Committee
Total Number of Safety Incidents– Environment Related	Event Report EOC Tracking Reports	Safety Officer Quality Council

		EOC/ Patient Safety/ Infection Prevention Committee
Number of Product Recalls/Alerts	Product Recall Notices Received	Safety Officer Quality Council EOC/ Patient Safety/ Infection Prevention Committee

Close

Encompass Health Rehabilitation Hospital of Henderson

Policy#:	Title:	Category:
100	Safety Management Plan	Facility Management
Policy Status:	**Effective Date:**	**Last Reviewed Date:**
Published	04/15/2020	03/04/2021

PURPOSE

The Safety Management Plan describes how the hospital will provide a physical environment free of hazards and manage staff activities to reduce the risk of injuries.

SCOPE

The Safety Management Plan is facility-wide in scope and includes inpatient and outpatient satellites, if any.

RESPONSIBILITY

The Administration of this hospital has appointed the FM Director as the Safety Officer assigned to coordinate and manage risk assessment and reduction activities and hereby grants the authority for this individual to intervene when conditions immediately threaten life and health in order to minimize potential for harm including but not limited to activation of the Emergency Operations Plan in the absence of the Administrator.

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The Safety Officer is responsible for collecting and reporting any significant variances identified in the Safety Management Program to the hospital's EOC Committee and Quality Council. These committees include representation from Administration, Nursing Services, Rehabilitation Services, and Support Services.

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Evaluation

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PROCEDURE

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Number of Patient Falls – Environment Related	Incident Report EOC Tracking Reports	Quality Management EOC Committee
Total Number of Safety Incidents– Environment Related	Incident Report EOC Tracking Reports	Safety Officer EOC Committee
Number of Product Recalls/Alerts	Product Recall Notices Received	Quality Management EOC Committee

Close

Encompass Health Rehabilitation Hospital of Las Vegas

Policy#:	Title:	Category:
180	Safety Plan	Plans
Policy Status:	**Effective Date:**	**Last Reviewed Date:**
Published	06/24/2019	03/26/2021

PROCEDURE

PURPOSE:

The purpose of the Patient Safety Program is to improve patient safety and reduce risk to patients, staff and visitors. Recognizing the effective medical/health care error reduction requires an integrated and coordinated approach; Encompass Health Rehabilitation Hospital of Las Vegas has developed an organization-wide safety program. The program supports the creation of an environment in which patients, their families, and organization staff leaders can identify and manage actual and potential risks to patient safety.

OBJECTIVE:

It is the objective of Encompass Health Rehabilitation Hospital of Las Vegas to foster an environment to improve patient safety, establish mechanism to support effective responses to actual occurrences and to be proactive in the reduction of medical/health care errors. Patient safety will be a priority in new design and all relevant organization processes, functions and services.

SCOPE:

The scope of the patient safety program will include compliance with standards identified by external regulatory agencies and accrediting bodies. Program activities will address occurrences ranging from "near misses" to sentinel events with serious adverse outcomes.

DEFINITIONS:

Actual Event-an event occurred that reached the patient or individual (e.g., visitor fall, student injury, etc.).

Near Miss-an event occurred but it did not reach the patient because of chance alone or because of active recovery efforts by caregivers.

Unsafe Condition- circumstances that could cause adverse events (e.g., look-alike medications, confusing equipment, failure to use proper signage when floor is wet).

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

- Severe temporary harm which is defined as critical, potentially life-threatening harm lasting for a limited time with no permanent residual effect, but requires transfer to a higher level of care/monitoring for a prolonged period of time, transfer to a higher level of care for a life-threatening condition, or additional major surgery, procedure, or treatment to resolve the condition. (Hip fractures are always included)
- Permanent harm
- Death

For additional events also considered "sentinel" reference the HealthSouth Sentinel Event policy

PROCEDURES:

A. The responsibility for management of the organization-wide patient safety program is assigned to the Director of Quality/Risk Management and Patient Safety Officer.

1. The Safety Committee and Quality Council will provide interdisciplinary input related to patient, visitor and staff safety.

2. Reports of safety related activities and issues would be presented to Department Managers, Senior Staff,

Medical Staff via the Medical Executive Committee, and the Governing Board. This communication is confidential and for quality assurance purposes only.

B. Staff will report information relating the medical/health care events as outlined in Risk Management Electronic Event Reporting Policy.

1. Staff will be oriented to the Risk Management Policies on hire and through ongoing in-service and other education and training programs.

2. Staff will be oriented to their roles in preventing adverse occurrences as related to their specific job responsibilities and as a part of the organization-wide efforts to improve patient safety.

3. Staff will be oriented to the importance of reporting "near misses," as well as adverse occurrences.

4. Team training to foster an interdisciplinary, collaborative approach to patient care delivery and to reinforce the need and way(s) to report medical/health care errors will be provided as appropriate.

5. The Director of Quality/Risk Management, Department Managers, and Senior Staff are responsible for interacting with staff in a manner that ensures staff do not fear disclosure, embarrassment, blame or punishment for reporting potential or actual events related to patient safety.

6. The Director of Quality/Risk Management, Department Manager and/or Senior Staff member may request the assistance of external resources if a staff member(s) needs support in coping with a sentinel event.

C. Hospital leadership will identify barriers to effective communication among caregivers relative to patient care, redesign the process to eliminate barriers and monitor for effectiveness. Specific attention will be directed to:

1. Process for ensuring accurate, timely, and complete verbal and written communication among care givers and all others involved in utilization of data, and

2. Test results relative to the management of the patient's condition.

D. All patients are entitled to information about all aspects of their health care, including information about clinically relevant unanticipated outcomes of care.

Patients and, when appropriate, their families are informed about the outcomes of care including unanticipated outcomes (i.e. sentinel events, State reportable events). Responsibility for disclosing unanticipated outcomes

outcomes (i.e. sentinel events, State reportable events). Responsibility for disclosing unanticipated outcomes typically rests with the physician or designee who has overall responsibility for the patient's care. However, in some situations, other healthcare professionals may be deemed more appropriate to be responsible for disclosing the outcome. A hospital representative, preferably the Quality/Risk Director, Chief Nursing Officer or the Chief Executive Officer should be present for the initial conversation and any follow-up discussions that may occur with the patient and/or patient's representative.

E. The Director of Quality/Risk Management or designee will respond immediately to notification of significant medical/health events to a patient/visitor or staff member.

1. The Nursing Supervisor or Department Manager will contact the Risk Manager and/or Administrator/Administrator-On-Call to report events.

2. Action(s) will be taken to protect the patient/visitor/staff members as indicated per hospital plans and policies.

3. Factual information will be obtained and preserved for subsequent analysis. Such information is confidential for quality assurance purposes.

F. The facility will review historical risk management, Environment of Care (EOC), Program Improvement (PI) and Human Resources (HR) data for high volume, high risk problem trends in medical and care processes, as well as unanticipated adverse occurrences affecting patients. These will be ranked as:

- A. Unsafe condition (Non-event)
- B1. Near Miss - No Harm/Didn't Reach Patient/Caught by Chance
- B2. Near Miss - No Harm/Didn't Reach Patient b/c of Active Recovery by Caregiver
- C. No Harm – Reached Patient No Monitoring Required
- D. No Harm – Reached Patient Monitoring Required
- E. Harm – Temporary, Intervention Needed
- F. Harm – Temporary, Hospitalization Needed
- G. Harm - Permanent
- H. Harm – Permanent, Intervention Required to Sustain Life
- I. Death

G. The facility will also perform intense analysis consistent with the Root Cause Analysis/Sentinel Event Policies, and reports as required by state, regulatory, and accreditation bodies. The Risk Management designee is responsible for

ensuring compliance with reporting.

H. Emerging needs requiring reprioritizing performance improvement activities may be identified through data collection and assessment, unanticipated adverse occurrences affecting patients, changing regulatory requirements, significant patient and staff needs, changes in the environment of care, or changes in the community. Priority consideration in establishing performance improvement teams is given to:

1. Processes that affect a large percentage of patients.

2. Processes that place patients at risk, if not performed well, if performed when not indicated, or if not performed when indicated.

Processes that have been or are likely to be problem prone.

I. When designing/redesigning processes, Department Managers and staff will:

1. Incorporate information from within the organization and from other organizations about potential risks to patients, including the occurrence of sentinel events in order to minimize risks to patients affected by the new or redesigned process, function or service.

2. Conduct literature searches to obtain evidence based medical and/or care practices to be included in process redesign.

3. Include analysis and or pilot testing to determine whether the proposed design/redesign is an improvement.

J. Hospital leadership will consider the importance of patient safety in:

1. Development of hospital-wide patient care programs, policies and procedures that describe how patients' care needs are assessed and met.

2. Development and implementation of the hospital's plan for the provision of patient care.

3. Decision-making structures and processes.

4. Implementation of an effective and continuous program to measure assesses and improves performance.

5. Development of an interdisciplinary culture that emphasizes cooperation and communication. The leadership role of coaching will be used to promote communication among services, individual staff members

and less formal structures such as quality action teams, performance-improvement teams or members of standing committees.

6. Development of a process to involve the patient, as appropriate to his/her condition, as a partner in helping to facilitate the safe delivery of care.

a. Patients/family members are oriented on admission of the importance of reporting perceived risks and concerns about the patient's care per Patient and Customer Complaint and Grievance Policy.

b. Department Managers and Senior Staff will review Press Ganey Patient Satisfaction Survey questions related to patient safety and develop a corrective action plan to patient/family complaints or suggestions for improving safety as appropriate.

7. The Governing Board will appoint the Director of Quality and Risk Management (DQRM) as the Patient Safety Officer. The Patient Safety Officer/Director's role includes:

- Participating in hazard surveillance, event reporting, reviewing, and the development of patient safety policies and procedures.
- Analyzing and seeking resolution of patient safety issues and works with the appropriate staff to implement recommendations and to monitor patient safety improvement activities.
- Report on findings, recommendations, actions taken, and results of measurements through the hospital quality structure.

K. At least one (1) high-risk process is the subject of ongoing measurement and periodic analysis to determine the degree of variation from intended performance, a minimum of 1 proactive risk assessment every 18 months. The process selected will be based, in part, on the information identifying the most frequently occurring sentinel events and patient safety risk factors.

1. Assess the intended and actual implementation of this process to identify steps in the process where there is, or may be, undesirable variation (i.e. called potential "failure modes").

2. For each identified "failure mode, "identify the possible "effect(s)" and how serious the possible effect on the patient could be (i.e. "criticality "of the effect).

3. For the most critical effects, conduct a root cause analysis to determine the variation (failure mode) leading to that effect occur.

4. Redesign the process and/or underlying systems to minimize the risk of that failure mode to protect patients from the effect of that failure mode.

5. Test and implement the redesigned process.

6. Identify and implement measures of the effectiveness of the redesigned process.

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

L. Hospital leadership will measure and assess the effectiveness of their contributions to improving patient safety. To accomplish these goals, leaders will.

1. Set measurable objectives for improving patient safety.

2. Actively request staff to periodically discuss their opinions, needs, perceptions of risks to patients and suggestions for improving patient safety. The actions taken as a result of this staff input will be reported to the MEC/GB at bi-annually.

3. Review data on staff willingness to report medical/health events.

4. Review data from Press Ganey Patient Satisfaction Survey related to patient safety.

5. Use pre-established, objective process criteria to assess their effectiveness in improving patient safety.

6. Draw conclusions based on their findings and develop and implement improvement in their activities.

7. Evaluate their performance in supporting sustained improvement.

M. The DQRM will report at a minimum quarterly to the Governing Board occurrences of medical/health events and actions to improve patient safety.

Close

Harmon Hospital

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 Hopsital 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). 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

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.
- 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 re**s**ult 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.

- 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.

Goals and Objectives of the Patient Safety Plan

Objective	Goals	Plan	Planned Completion Date	Responsible Party

Components and Methods

- Pursuant to NRS 439.837 and NAC 439.917, within 45 days after reporting a sentinel event pursuant to NRS 439.835, the medical facility shall conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event."

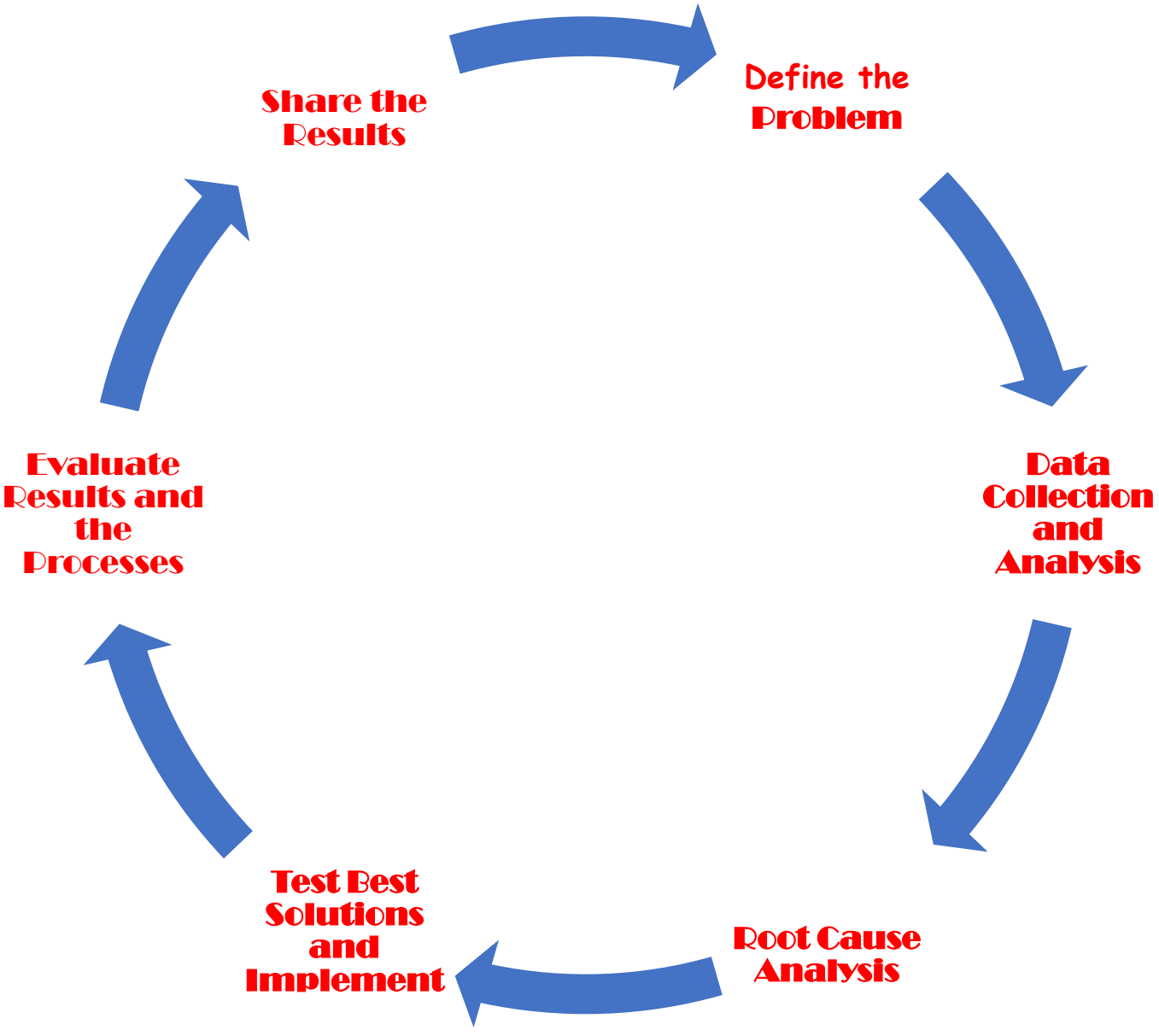
- Harmon Hospital will use RCA process to determine the contributing factors and the underlying reasons for the deficiencies or failures. The Plan-Do-Study-Act (PDSA) is the model, which was developed by the Institute of Health Care Improvement that we will use to test the changes.

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.


Define the Problem
Data Collection and Analysis
Root Cause Analysis
Test Best Solutions and Implement
Evaluate Results and the Processes
Share the Results

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:

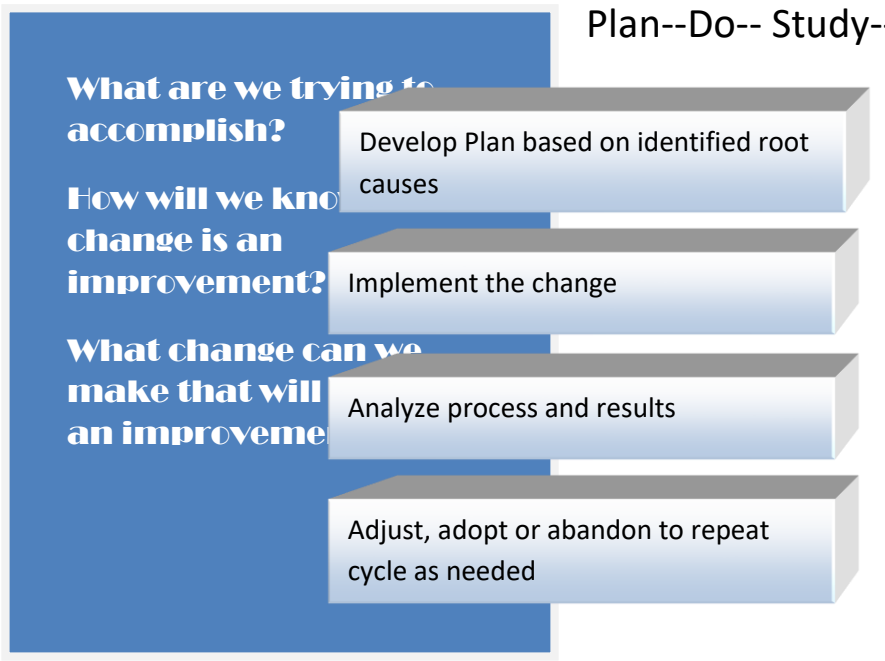
- ✓ people,
- ✓ methods
- ✓ materials,
- ✓ measurements,
- ✓ education,
- ✓ procedures,
- ✓ process,
- ✓ location,
- ✓ environment, etc.

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

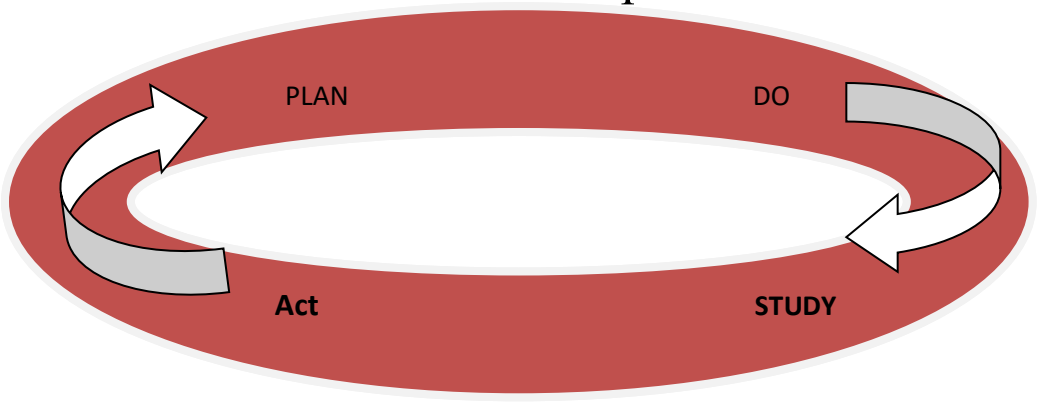
The Model for Improvement is a collaborative and ongoing effort model to improve the product and services quality and process. It provides multi-disciplinary quality team guidance from identifying the root causes; conducting the best tests to assess possible changes, and working in collaboration for 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



Plan--Do-- Study-- Act

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?

- **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: National Health Safety Network

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	Infection Control Policy and Procedures Antibiotic Stewardship Policy and Procedures
5) Interdisciplinary QAPI review (Quality Assessment Performance Improvement)of each department performance and performance improvement plans/goals.	5)Medical Executive Committee review of QAPI reports and Performance Improvement Plans. 6. Governing Board review of Quality and Safety Concerns through Administrative reports	Review of performance improvement plans.

Patient Safety Checklists and Patient Safety Policies

By NRS 439.865, the patient safety plan must include the patient safety checklists and patient safety policies for use by:

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

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

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

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

Henderson Hospital

Risk Management/ Patient Safety Plan

Nevada Acute Care Division

Revised 1/2022

A. **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 facility 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 RESPONSIBILITES

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 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:

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 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.

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:

Element I. Administration of the Risk Management Program: This element outlines the UHS Risk program that lays the foundation for an effective risk management program. The Risk Manager/Director must be seen as a resource to administration, facility, and medical staff. Written plans, goals, and objectives provide a clear vision to meet the purpose of the UHS program. Although the TERM program uses the title, "Risk Manager," this applies equally to Risk Directors.

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

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

Element IV. Patient Safety Initiative: Imperative to a comprehensive RM program is one that focuses on the improvement of patient and staff safety through the creation of an environment that maximizes safety and reduces liability claims exposure. The mechanism used to drive the culture of safety is the Patient Safety 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 cornerstone 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 environmental safety and security programs in the facility serve to protect and preserve both life and property. Areas of safety include licensing, accreditation and state, federal and local safety practices and programs.

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

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

Element IX. Medication Safety Initiative: The medication safety initiative is geared toward preventing and responding to the accidental injury of a patient due to medical care or medical errors during the medication-use process. The mechanism used to drive the culture of safety is the Medication Safety Committee at each facility. The committee proactively assesses risk points at every level of the medication use cycle: procurement, storage, ordering/prescribing, transcription, distribution, preparation, dispensing, administration, documentation, and monitoring.

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 **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 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.

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 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 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. Patient Safety Priorities, Goals and Objectives for 2022

- **Surgical and Procedural Safety**
  - **Wrong Site Surgery (WSS)**
    - ***Goal***: A 50% reduction in WSS events for 2022. Ultimately, the goal is 0.
  - **Retained Procedural items (RPIs)**
    - ***Goal***: Prevent RPIs- a 50% reduction in RPIs with harm for 2022. Ultimately, the goal for RPIs is 0.

- **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.
  - ***Goal***: Increase the percentage of patients with QBL of 2000 ml who receive transfusions to ≥ 50%.
- **Reduction / elimination of serious harm by utilizing an oxytocin checklist to decrease the percentage of full-term newborns with Apgars less than 6 at 5 minutes and / or requiring NICU admission.**
  - ***Goal:*** Reduce the number of full-term newborns requiring NICU admission by 10%.

- **<u>CLABSI Initiative</u>**
  - ***Goal***: CLABSI will be reduced to less than the CMS national mean Standardized Infection Ratio (SIR: CLABSI 0.692) in 2022.

- **<u>Safe Medication Use</u>**
  - **Smart Infusion Pump High Risk Opioid Event Reduction Initiative.**
    - ***Goal***: Decrease the number of high-risk opioid medication overrides by 50% by December 1, 2022.
    - ***Goal*:** Increase "Guardrails Suite usage to meet UHS and Leapfrog goal of 95% by December 1, 2022.
    - ***Goal:*** Naloxone provision usage will increase to 95% by June 1, 2022.
  - **Anticoagulant Safety in the Perioperative Setting**.
    - ***Goal:*** AHRQ PSI 12 Perioperative Pulmonary Embolism or Deep Vein Thrombosis benchmark is 3.950 per 1000 inpatients. The goal is to decrease the Patient Safety Indicator (PSI) 12 rate by 10% by December 2022.
    - ***Goal:*** The VTE Advisor will be used to assess the patient's postoperative risk for thromboembolism and documented prophylaxis through the VTE advisor The goal is 80% compliance with "VTE Advisor" usage.

- **<u>Reduce Falls and Falls with Injury</u>**
  - ***Goal***: 10% reduction in the rate of falls in the Acute Care Division by the end of 2022.
  - ***Goal***: 10% reduction in the rate of falls with injury in the Acute Care Division by the end of 2022.

- **<u>Decreasing Hospital Acquired Pressure Injuries</u>**
  - **Goal:** 10% reduction of NPOA rate for all HAPI stages in the Acute Care Division by the end of 2022.

- **<u>Culture of Safety</u>**
  - **Goal**: reduce the number of GHI events (serious safety event rate) for the Acute Care Division by the end of 2022. Ultimately, the goal is 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/SOX 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

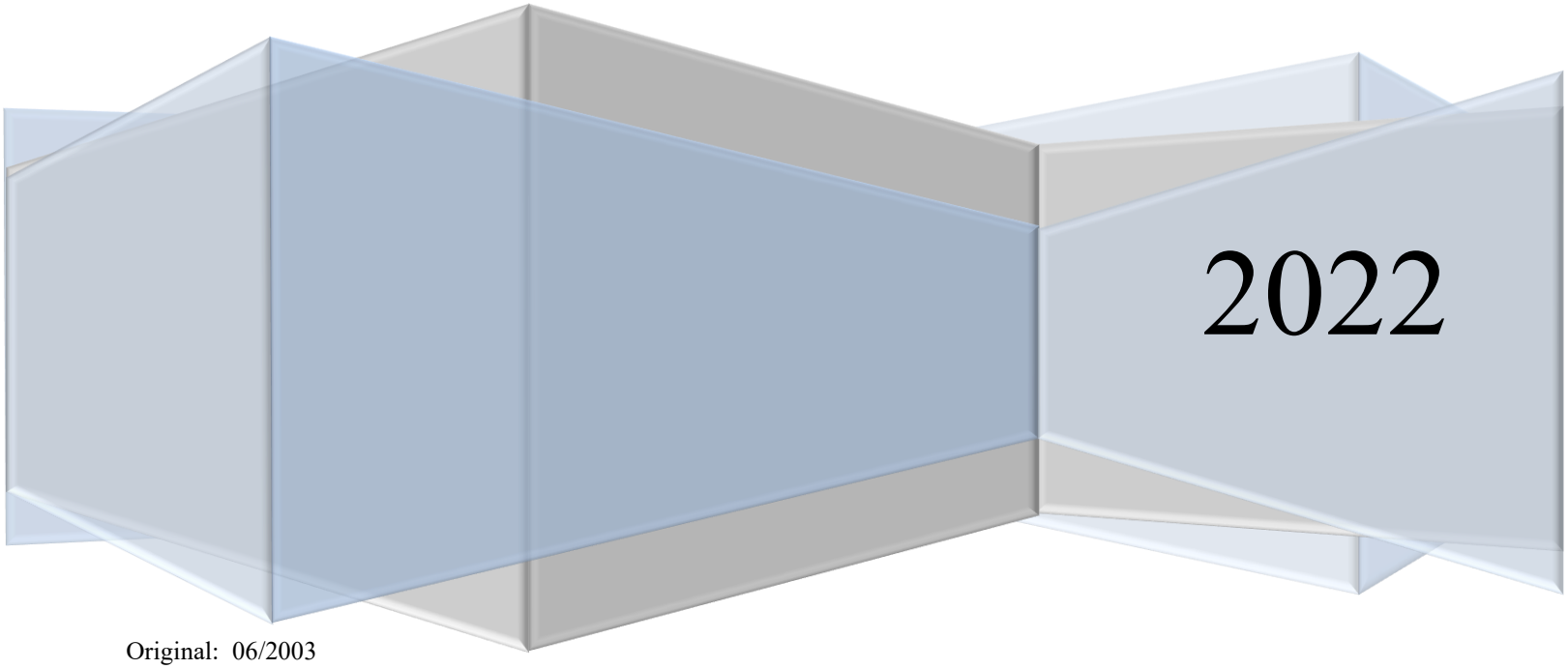
According to NRS 439.865, a medical facility shall submit its patient safety plan to the Governing Board of the facility for approval. After a facility's patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements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

Horizon Specialty Hospitals

Safe Environment Plan

Las Vegas and Henderson



Original: 06/2003
Reviewed/Revised: 12/2009, 3/2010, 1/2011, 1/2012, 1/2013, 2014, 12/2015, 12/2016, 12/2017, 01/2019, 01/2020, 01/2021, 01/2022

HORIZON SPECIALTY HOSPITALS
HENDERSON/LAS VEGAS

DEPARTMENT: Plant Operations/Safety

SUBJECT: Safe Environment Plan - 2022

I PURPOSE

The purpose of the Safe Environment Plan is to provide a programmatic framework to reduce the risk to Horizon Specialty Hospitals. The plan includes processes that are designed to evaluate risks that may adversely affect the life or health of patients, staff and visitors.

Mission:

Horizon Specialty Hospitals are committed to providing medically complex and rehabilitative care in a long-term acute care hospital environment to ensure quality care by using goal directed strategies, safe practices and teamwork to achieve optimal outcomes. The safe environment program is designed to support patient safety and effective care by providing reliable information that allows facility management and staff to make better safety decisions and to evaluate key issues and opportunities for improvement of safety performance.

Consistent with this mission, Horizon Specialty Hospitals have established and provides ongoing support for the safe environment program described in this plan.

II SCOPE

The facility has an Environment of Care Committee (EOC) consisting of a cross representation of the facility's staff. The EOC monitors training and competence of staff and assesses conditions of the physical plant, grounds, and equipment through building inspections, environmental rounds, safety inspections and various performance improvement initiatives. Through review of reliable information, management is able to make the best decisions regarding safety concerns and to evaluate safety performance related to key issues with opportunities for improvement. The EOC monitors and evaluates all safety issues. It takes action and makes recommendations to the facility leadership, including the Administrator/Executive Officer, who is a member of the Governing Board. The EOC may issue assignments to committee members and non-committee staff for follow-up actions/improvements and completion of reports.

III FUNDAMENTALS

A. Safety is information driven. Without appropriate information, accident and incident causing situations cannot be predicted and prevented.

B. Department managers need appropriate information to develop an understanding of safe working conditions and safe work practices within their area of responsibility.

Original: 06/2003
Reviewed/Revised: 12/2009, 3/2010, 1/2011, 1/2012, 1/2013, 2014, 12/2015, 12/2016, 12/2017, 01/2019, 01/2020, 01/2021, 01/2022

C. Safe working conditions and practices are established by using knowledge of safety principles to: educate staff, evaluate existing conditions, design appropriate work environments and purchase appropriate equipment and supplies.

D. The safe environment program establishes processes for identifying, evaluating and alleviating practices or situations that have a potential to harm patients, staff, or visitors or damage to property.

E. The safe environment program establishes processes to reduce the occurrences, the probability and the effects of person-to-person violence.

IV GOALS

A. Comply with accepted standards of safety.

B. Provide a safe, secure and therapeutic environment for patients, staff and visitors.

C. Integrate safety practices into daily operations.

D. Identify opportunities to improve performance.

V ORGANIZATION AND RESPONSIBILITY

A. The Administrator receives regular reports on activities of the safety program from the EOC. The Administrator reviews reports and, as appropriate, communicates safety related concerns about identified issues and regulatory compliance.

B. The Administrator reviews reports and, as necessary, communicates concerns about key issues and regulatory compliance to appropriate departments, services and staff. The administration collaborates with appropriate departments, services and staff to establish operating and capital budgets for the safe environment program.

C. The Safety Officer (SO) has responsibility for identification, collection and analysis of information regarding safety deficiencies, development of plans for improvement, accident and injury prevention and investigation, and emergency response. Training of staff and volunteers is facilitated by the Director of Plant Operations.

D. The EOC coordinates processes within the Environment of Care Standards. Membership on the EOC is by appointment from the Administrator and includes representatives from administration, clinical services and support services. The EOC meets as often as is necessary on a regular basis to receive reports and to conduct reviews of safety issues. Additional meetings may be scheduled at the request of the Safety Officer.

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E. The Administrator authorizes key staff to take immediate and appropriate action in the event of an emergency. An emergency is a situation that poses an immediate threat to life or health, or threatens to damage equipment or buildings.

F. Department managers are responsible for the orientation of new staff members to the department, program and job specific safety procedures.

G. Individual staff members are responsible for learning and following job and task specific procedures for safe operations. Individual staff members are also responsible for learning and using reporting procedures.

VI PROCESSES OF THE SECURITY PROGRAM

A. Risk Assessment

The Horizon Specialty Hospitals Safety officer is responsible for managing the safe environment program risk assessment process. When issues arise the Safety Officer will consult with the Administrator in regard to approval for actions or guidance.

1. Horizon Specialty Hospitals pro-actively performs risk assessments in a manner that allows for comprehensive evaluation of existing aspects of the organization, and the impact of proposed changes. The goal of risk assessment is to reduce the likelihood of future incidents that have the potential for injury, accident, or other loss to patients, staff, visitors and facility assets.

2. Horizon Specialty Hospitals address other environmental considerations when performing risk assessment functions. For example, when planning demolition, construction, or renovation work, the facility conducts a proactive risk assessment using risk criteria to identify hazards that could potentially compromise patient care in occupied areas of the facility buildings.

   Use of the risk assessment process triggers organization linkages with other aspects of the safe environment program. For example, a proposed change may indicate a need to create or revise existing safety policies and procedures; hazard surveillance in the areas affected; safety orientation and education programs; and safety performance improvement monitoring. Horizon Specialty Hospitals' SO is responsible for coordinating the impact of proposed changes with other aspects of the safe environment program.

   Horizon Specialty Hospitals' SO and department managers are responsible for performing follow-up activities on issues, findings, observations or recommendations that result from applying the risk assessment process. Horizon Specialty Hospitals' EOC reviews reports related to the safe environment program risk assessment processes.

Original: 06/2003
Reviewed/Revised: 12/2009, 3/2010, 1/2011, 1/2012, 1/2013, 2014, 12/2015, 12/2016, 12/2017, 01/2019, 01/2020, 01/2021, 01/2022

B. Reporting and Investigating

The safe environment program uses a variety of reporting methods to document activities. The SO, Risk Manager, Chief Nursing Officer/Chief Operations Officer (CNO/COO) and Human Resources Director share responsibility for managing, reporting and investigating incidents.

Reports of patient and visitor incidents/accidents are made using the appropriate forms. These reports are reviewed by the EOC, QAPI and Infection Control. Aggregate information is reviewed by the EOC.

Reports of significant property damage are directed to the SO.

One of the goals of the reporting process is for the responsible manager to receive facility incident reports as soon as practical after an occurrence. This goal is intended to allow appropriate and timely reporting and follow-up activities as needed.

C. Hazard Surveillance

The Director of Plant Operations (DOPO) is responsible for managing the hazard surveillance process including product safety recalls. Hazard surveillance surveys are conducted to evaluate staff knowledge and skill, EOC compliance, observe current practices, assess/evaluate environmental conditions and other risk factors. Results of hazard surveillance activities serve to improve safety policies and procedures, risk assessments, orientation and education programs and staff performance.

Surveys are conducted on a frequency that meets the needs and requirements of the various areas that are surveyed. All inpatient care areas are scheduled for at least two annual hazard surveillance surveys. Non-patient care areas are scheduled for at least one hazard surveillance survey each year. Areas or systems under special circumstances are scheduled for additional surveys as required.

Additional hazard surveillance surveys are performed during the application of Interim Life Safety Measures (ILSM). Hazard surveillance surveys to assure free and unobstructed exiting for construction projects are performed daily.

The EOC is responsible for oversight of the hazard surveillance program. This includes ensuring that the information received includes an analysis of data collected, identification of trends and patterns, risk reduction strategies, corrective action recommended or taken and persons responsible.

Individual department managers are responsible for initiating appropriate action on findings applicable to their scope of authority or responsibility. The SO is responsible for coordinating follow-up activities with individual department managers to ensure each finding is brought to closure.

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D. Environment of Care Committee

The EOC includes selected members of administration, clinical and support services.

The Safety Officer through the EOC is responsible for managing the process of examining safety issues. Effective use of information is dependent on written and verbal reports from a number of different functions within Horizon Specialty Hospital. Reports are used to identify and communicate problems, time-sensitive issues and general information about periodic or structured activities to the EOC. Reports help the EOC to prioritize, develop and approve recommendations for improvement of patient, staff and visitor safety. It is the responsibility of the EOC Chairperson to review the content of reports submitted.

The EOC processes information via a discussion of findings and recommendations outlined in the minutes for each meeting. The minutes also document recommendations the EOC has developed and otherwise approved.

E. Performance Improvement Monitoring

The SO through the EOC has overall responsibility for coordinating the ongoing performance monitoring and the performance improvement monitoring for each of the seven functions associated with Management of the Environment of Care. The SO is responsible for all monitoring associated with the safe environment program.

The intent of establishing performance monitoring is to improve the safe environment program through objective measures of demonstrated performance. **The results of measurement are reported through appropriate channels including the facility's leadership and when appropriate to relevant components of the facility wide patient safety program.** Performance improvement is an important aspect of the Safe Environment Plan. Ongoing performance monitoring serves as an indicator of continued effectiveness of the safe environment program and is a mechanism to identify performance improvement opportunities.

F. Policies and Procedures

The SO has overall responsibility for coordination of the EOC policy and procedure process including coordination with individual department managers.

Individual department, program, and site managers are responsible for their specific safety policy and procedure process. These safety policies and procedures address issues such as: safe operations, use of hazardous equipment or processes and use of personal protective equipment. The SO assists department managers in development of new safety policies and procedures and participates in reviewing existing policies and procedures.

Organization-wide safety policies and procedures are communicated to staff via normal communication channels. Department managers are responsible for distribution of safety policies and procedures and ensuring they are enforced. Each staff member is responsible for knowing and following all safety policies and procedures.

Both facility-wide and departmental, program and site safety policies and procedures are reviewed at least every three years. Additional interim reviews are performed on an as needed basis.

Horizon Specialty Hospital has established a procedure for implementing new policies, procedures and practices. Administrative policy determines the form, structure and organization of all policies, procedures and practices.

G. Safety Officer Appointment

The Administrator is responsible for managing the Safety Officer Appointment process.

The Administrator is responsible for selecting a qualified individual who is capable of overseeing the development, implementation and monitoring of the safe environment program. By appointment, the SO is assigned overall operational responsibly for the safe environment program. The SO is made known to all staff through normal communication channels.

The SO is accountable to the Administrator and is guided by a written duty description. For example, the SO reviews changes in law, regulation and standards; assesses the need to make changes to general safety, procedures, training; and performs other activities essential to the implementation of the safe environment program.

The SO directs the integration of environment of care monitoring and response activities into the hospital-wide patient safety program.

H. Immediate Threat Statement

The Administrator is responsible for managing the process for identifying individual(s) who may intervene whenever conditions pose an immediate threat to life or health or threatens damage to equipment or buildings.

To support this process an Immediate Threat Statement is defined in the Situation Response and Crisis Communication Manual. This policy is intended to define authority and responsibility in situations that pose an immediate threat; to the life or health of patients, staff and visitors; or risk major damage to buildings or property. The goal of the Immediate Threat Statement is to identify and mitigate an immediate threat situation before such situation results in loss and to return the facility to normal conditions as quickly as possible.

Key staffs are empowered to intervene immediately and to take appropriate action(s) to mitigate the effects of such situations. Such delegation of authority enables the facility to implement the policy, swiftly and decisively, on a twenty-four hours a day/seven days a week basis.

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Reviewed/Revised: 12/2009, 3/2010, 1/2011, 1/2012, 1/2013, 2014, 12/2015, 12/2016, 12/2017, 01/2019, 01/2020, 01/2021, 01/2022

The Immediate Threat Statement is approved by the Administrator; is revised as necessary and reviewed at least every three years.

I. Grounds and Equipment

The DOPO is responsible for managing the facilities grounds and external equipment maintenance processes. The Horizon Specialty Hospital provides patient care, treatment or activities outside of facility buildings. There are patient activities conducted outside of facility buildings that require supervision by facility staff.

The DOPO is responsible for scheduling and performing maintenance to facility's grounds and external equipment. DOPO makes regular rounds of various areas to observe and correct conditions and ensure safety of facility's grounds and external equipment.

Facility grounds includes for example: courtyards, shrubs and trees, sidewalks, roadways, parking lots, lighting, signage and fences. External equipment includes for example: electrical switch gear, transfer switches, and fuel storage. The nature of these types of external equipment is such that limited or infrequent preventive maintenance is required. Corrective maintenance is completed on an as needed basis.

J. Annual Evaluation

The SO has overall responsibility for coordinating the annual evaluation of each of the seven functions associated with management of the Environment of Care. The SO is responsible for completing the annual evaluation of the safe environment program. An evaluation of the program's objectives, scope, performance, effectiveness and the Safe Environment Plan is included in each annual evaluation.

In the completion of the annual evaluation, the SO utilizes a variety of source documents such as policy review and evaluation, incident report summaries, risk assessment activities, meeting minutes and statistical information summaries. In addition, other relevant sources of information are used for the annual evaluation, such as results of monitoring studies, reports from accrediting and certification agencies and goals and objectives. The annual evaluation of the security program is used to further develop educational programs, policies, performance monitoring and improvement.

The annual evaluation is reviewed and approved by the EOC. The annual evaluation is then presented to the Performance Improvement Committee, Executive Management Committee, Medical Executive Committee and Governing Board. Minutes or other means of communications from the Governing Board are received, reviewed and acted upon the by the EOC.

VII WORKER SAFETY

The EOC and Infection Control Committee are responsible for identifying activities to reduce the risk of staff/worker injuries.

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Reviewed/Revised: 12/2009, 3/2010, 1/2011, 1/2012, 1/2013, 2014, 12/2015, 12/2016, 12/2017, 01/2019, 01/2020, 01/2021, 01/2022

A. Reporting and Investigating

The safe environment program uses a variety of reporting methods to document activities. The SO, Risk Manager and Human Resource Director share responsibility for managing, reporting and investigating incidents of injuries, occupational illnesses and accidents. Reports are made using the appropriate forms. This information is reviewed by the EOC, QAPI and Infection Control. Aggregate information is reviewed by the EOC.

One of the goals of the reporting process is for the responsible manager to receive facility incident reports as soon as practical after an occurrence. This goal is intended to allow appropriate and timely reporting and follow-up activities as needed.

B. Orientation and Education

The Director of Plant Operations has overall responsibility for organizing the orientation and education program for each of the seven functions associated with Management of the Environment of Care. Department managers are responsible for assuring the safe environment program orientation and education is implemented.

The Director of Plant Operations is responsible for conducting the general orientation program with current information on general safety processes to new staff members as soon as possible but within 30 days of employment. Every new staff member participates in a general orientation program that includes information related to the safe environment program. Critical Environment of Care information is provided prior to staff being allowed to work independently. The Human Resource Department records attendance for each new staff member who completes the general orientation program. Attendance records are maintained in the Education and Human Resource Department.

Each department manager is responsible for providing their new staff members with safe environment orientation specific to their department. The goal of these orientation programs is to provide new staff members with current job specific safety and hazard information.

All staff members of the facility must participate in mandatory continuing education at least once each year, which includes information specific to the safe environment program. This requirement may be satisfied through completion of a self-learning packet or attendance at a regularly scheduled facility-wide continuing education program. The Human Resource and Education Departments maintains records of all completed training.

Various Departments collaborate with the Facilities Department and individual managers, as appropriate, for developing content and supporting material for general and department specific orientation and continuing education programs. The content and supporting materials utilized are reviewed and revised as necessary.

The Human Resource Department reports information on orientation and continuing education data during the reporting period to the EOC.

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VIII SMOKING

Horizon Specialty Hospitals have a policy to reduce the risks to patients who smoke, including possible adverse effects on treatment; risks of passive smoke to others; and risks of fire

Patients, staff and visitors are prohibited from smoking in all facility regulated buildings and campus.

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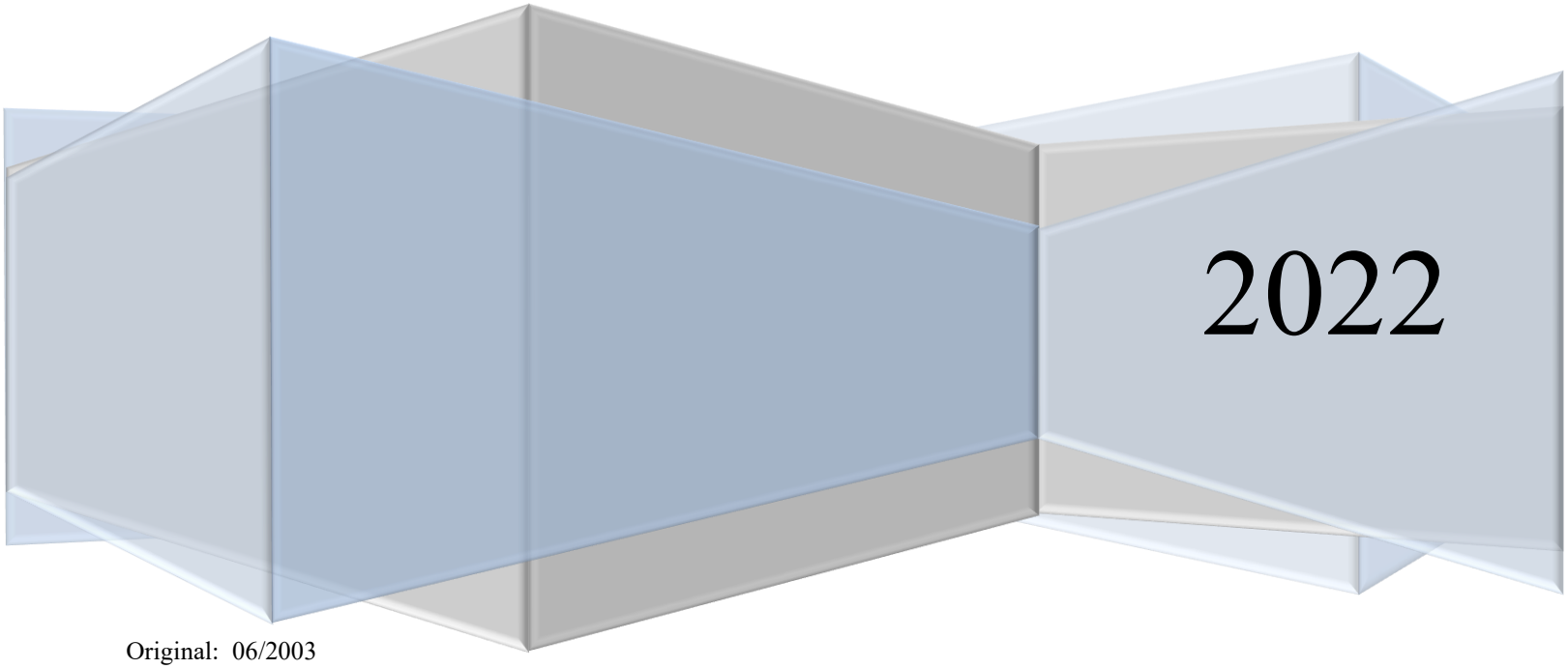
Horizon Specialty Hospitals

Safe Environment Plan

Las Vegas and Henderson



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HORIZON SPECIALTY HOSPITALS
HENDERSON/LAS VEGAS

DEPARTMENT: Plant Operations/Safety

SUBJECT: Safe Environment Plan - 2022

I PURPOSE

The purpose of the Safe Environment Plan is to provide a programmatic framework to reduce the risk to Horizon Specialty Hospitals. The plan includes processes that are designed to evaluate risks that may adversely affect the life or health of patients, staff and visitors.

Mission:

Horizon Specialty Hospitals are committed to providing medically complex and rehabilitative care in a long-term acute care hospital environment to ensure quality care by using goal directed strategies, safe practices and teamwork to achieve optimal outcomes. The safe environment program is designed to support patient safety and effective care by providing reliable information that allows facility management and staff to make better safety decisions and to evaluate key issues and opportunities for improvement of safety performance.

Consistent with this mission, Horizon Specialty Hospitals have established and provides ongoing support for the safe environment program described in this plan.

II SCOPE

The facility has an Environment of Care Committee (EOC) consisting of a cross representation of the facility's staff. The EOC monitors training and competence of staff and assesses conditions of the physical plant, grounds, and equipment through building inspections, environmental rounds, safety inspections and various performance improvement initiatives. Through review of reliable information, management is able to make the best decisions regarding safety concerns and to evaluate safety performance related to key issues with opportunities for improvement. The EOC monitors and evaluates all safety issues. It takes action and makes recommendations to the facility leadership, including the Administrator/Executive Officer, who is a member of the Governing Board. The EOC may issue assignments to committee members and non-committee staff for follow-up actions/improvements and completion of reports.

III FUNDAMENTALS

A. Safety is information driven. Without appropriate information, accident and incident causing situations cannot be predicted and prevented.

B. Department managers need appropriate information to develop an understanding of safe working conditions and safe work practices within their area of responsibility.

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C. Safe working conditions and practices are established by using knowledge of safety principles to: educate staff, evaluate existing conditions, design appropriate work environments and purchase appropriate equipment and supplies.

D. The safe environment program establishes processes for identifying, evaluating and alleviating practices or situations that have a potential to harm patients, staff, or visitors or damage to property.

E. The safe environment program establishes processes to reduce the occurrences, the probability and the effects of person-to-person violence.

IV GOALS

A. Comply with accepted standards of safety.

B. Provide a safe, secure and therapeutic environment for patients, staff and visitors.

C. Integrate safety practices into daily operations.

D. Identify opportunities to improve performance.

V ORGANIZATION AND RESPONSIBILITY

A. The Administrator receives regular reports on activities of the safety program from the EOC. The Administrator reviews reports and, as appropriate, communicates safety related concerns about identified issues and regulatory compliance.

B. The Administrator reviews reports and, as necessary, communicates concerns about key issues and regulatory compliance to appropriate departments, services and staff. The administration collaborates with appropriate departments, services and staff to establish operating and capital budgets for the safe environment program.

C. The Safety Officer (SO) has responsibility for identification, collection and analysis of information regarding safety deficiencies, development of plans for improvement, accident and injury prevention and investigation, and emergency response. Training of staff and volunteers is facilitated by the Director of Plant Operations.

D. The EOC coordinates processes within the Environment of Care Standards. Membership on the EOC is by appointment from the Administrator and includes representatives from administration, clinical services and support services. The EOC meets as often as is necessary on a regular basis to receive reports and to conduct reviews of safety issues. Additional meetings may be scheduled at the request of the Safety Officer.

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E. The Administrator authorizes key staff to take immediate and appropriate action in the event of an emergency. An emergency is a situation that poses an immediate threat to life or health, or threatens to damage equipment or buildings.

F. Department managers are responsible for the orientation of new staff members to the department, program and job specific safety procedures.

G. Individual staff members are responsible for learning and following job and task specific procedures for safe operations. Individual staff members are also responsible for learning and using reporting procedures.

VI PROCESSES OF THE SECURITY PROGRAM

A. Risk Assessment

The Horizon Specialty Hospitals Safety officer is responsible for managing the safe environment program risk assessment process. When issues arise the Safety Officer will consult with the Administrator in regard to approval for actions or guidance.

1. Horizon Specialty Hospitals pro-actively performs risk assessments in a manner that allows for comprehensive evaluation of existing aspects of the organization, and the impact of proposed changes. The goal of risk assessment is to reduce the likelihood of future incidents that have the potential for injury, accident, or other loss to patients, staff, visitors and facility assets.

2. Horizon Specialty Hospitals address other environmental considerations when performing risk assessment functions. For example, when planning demolition, construction, or renovation work, the facility conducts a proactive risk assessment using risk criteria to identify hazards that could potentially compromise patient care in occupied areas of the facility buildings.

   Use of the risk assessment process triggers organization linkages with other aspects of the safe environment program. For example, a proposed change may indicate a need to create or revise existing safety policies and procedures; hazard surveillance in the areas affected; safety orientation and education programs; and safety performance improvement monitoring. Horizon Specialty Hospitals' SO is responsible for coordinating the impact of proposed changes with other aspects of the safe environment program.

   Horizon Specialty Hospitals' SO and department managers are responsible for performing follow-up activities on issues, findings, observations or recommendations that result from applying the risk assessment process. Horizon Specialty Hospitals' EOC reviews reports related to the safe environment program risk assessment processes.

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B. Reporting and Investigating

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Reports of significant property damage are directed to the SO.

One of the goals of the reporting process is for the responsible manager to receive facility incident reports as soon as practical after an occurrence. This goal is intended to allow appropriate and timely reporting and follow-up activities as needed.

C. Hazard Surveillance

The Director of Plant Operations (DOPO) is responsible for managing the hazard surveillance process including product safety recalls. Hazard surveillance surveys are conducted to evaluate staff knowledge and skill, EOC compliance, observe current practices, assess/evaluate environmental conditions and other risk factors. Results of hazard surveillance activities serve to improve safety policies and procedures, risk assessments, orientation and education programs and staff performance.

Surveys are conducted on a frequency that meets the needs and requirements of the various areas that are surveyed. All inpatient care areas are scheduled for at least two annual hazard surveillance surveys. Non-patient care areas are scheduled for at least one hazard surveillance survey each year. Areas or systems under special circumstances are scheduled for additional surveys as required.

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The EOC includes selected members of administration, clinical and support services.

The Safety Officer through the EOC is responsible for managing the process of examining safety issues. Effective use of information is dependent on written and verbal reports from a number of different functions within Horizon Specialty Hospital. Reports are used to identify and communicate problems, time-sensitive issues and general information about periodic or structured activities to the EOC. Reports help the EOC to prioritize, develop and approve recommendations for improvement of patient, staff and visitor safety. It is the responsibility of the EOC Chairperson to review the content of reports submitted.

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The SO through the EOC has overall responsibility for coordinating the ongoing performance monitoring and the performance improvement monitoring for each of the seven functions associated with Management of the Environment of Care. The SO is responsible for all monitoring associated with the safe environment program.

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G. Safety Officer Appointment

The Administrator is responsible for managing the Safety Officer Appointment process.

The Administrator is responsible for selecting a qualified individual who is capable of overseeing the development, implementation and monitoring of the safe environment program. By appointment, the SO is assigned overall operational responsibly for the safe environment program. The SO is made known to all staff through normal communication channels.

The SO is accountable to the Administrator and is guided by a written duty description. For example, the SO reviews changes in law, regulation and standards; assesses the need to make changes to general safety, procedures, training; and performs other activities essential to the implementation of the safe environment program.

The SO directs the integration of environment of care monitoring and response activities into the hospital-wide patient safety program.

H. Immediate Threat Statement

The Administrator is responsible for managing the process for identifying individual(s) who may intervene whenever conditions pose an immediate threat to life or health or threatens damage to equipment or buildings.

To support this process an Immediate Threat Statement is defined in the Situation Response and Crisis Communication Manual. This policy is intended to define authority and responsibility in situations that pose an immediate threat; to the life or health of patients, staff and visitors; or risk major damage to buildings or property. The goal of the Immediate Threat Statement is to identify and mitigate an immediate threat situation before such situation results in loss and to return the facility to normal conditions as quickly as possible.

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The Immediate Threat Statement is approved by the Administrator; is revised as necessary and reviewed at least every three years.

I. Grounds and Equipment

The DOPO is responsible for managing the facilities grounds and external equipment maintenance processes. The Horizon Specialty Hospital provides patient care, treatment or activities outside of facility buildings. There are patient activities conducted outside of facility buildings that require supervision by facility staff.

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Facility grounds includes for example: courtyards, shrubs and trees, sidewalks, roadways, parking lots, lighting, signage and fences. External equipment includes for example: electrical switch gear, transfer switches, and fuel storage. The nature of these types of external equipment is such that limited or infrequent preventive maintenance is required. Corrective maintenance is completed on an as needed basis.

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The SO has overall responsibility for coordinating the annual evaluation of each of the seven functions associated with management of the Environment of Care. The SO is responsible for completing the annual evaluation of the safe environment program. An evaluation of the program's objectives, scope, performance, effectiveness and the Safe Environment Plan is included in each annual evaluation.

In the completion of the annual evaluation, the SO utilizes a variety of source documents such as policy review and evaluation, incident report summaries, risk assessment activities, meeting minutes and statistical information summaries. In addition, other relevant sources of information are used for the annual evaluation, such as results of monitoring studies, reports from accrediting and certification agencies and goals and objectives. The annual evaluation of the security program is used to further develop educational programs, policies, performance monitoring and improvement.

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The EOC and Infection Control Committee are responsible for identifying activities to reduce the risk of staff/worker injuries.

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One of the goals of the reporting process is for the responsible manager to receive facility incident reports as soon as practical after an occurrence. This goal is intended to allow appropriate and timely reporting and follow-up activities as needed.

B. Orientation and Education

The Director of Plant Operations has overall responsibility for organizing the orientation and education program for each of the seven functions associated with Management of the Environment of Care. Department managers are responsible for assuring the safe environment program orientation and education is implemented.

The Director of Plant Operations is responsible for conducting the general orientation program with current information on general safety processes to new staff members as soon as possible but within 30 days of employment. Every new staff member participates in a general orientation program that includes information related to the safe environment program. Critical Environment of Care information is provided prior to staff being allowed to work independently. The Human Resource Department records attendance for each new staff member who completes the general orientation program. Attendance records are maintained in the Education and Human Resource Department.

Each department manager is responsible for providing their new staff members with safe environment orientation specific to their department. The goal of these orientation programs is to provide new staff members with current job specific safety and hazard information.

All staff members of the facility must participate in mandatory continuing education at least once each year, which includes information specific to the safe environment program. This requirement may be satisfied through completion of a self-learning packet or attendance at a regularly scheduled facility-wide continuing education program. The Human Resource and Education Departments maintains records of all completed training.

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The Human Resource Department reports information on orientation and continuing education data during the reporting period to the EOC.

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VIII SMOKING

Horizon Specialty Hospitals have a policy to reduce the risks to patients who smoke, including possible adverse effects on treatment; risks of passive smoke to others; and risks of fire

Patients, staff and visitors are prohibited from smoking in all facility regulated buildings and campus.

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Kindred Hospital Las Vegas Flamingo Campus

PATIENT SAFETY PLAN

DATE: 02/02/22

This plan was created and revised by the Kindred Hospital Las Vegas Flamingo Campus Patient Safety committee/team. Implementation of this plan is intended to optimize the healthcare quality and patient safety outcomes, encourage recognition, reporting, and acknowledgment of risks to patient, visitor, and employee safety, as well as reduce the medical/healthcare errors and /or preventable events.

Patient Safety Committee/Program
Kindred Hospital Las Vegas Flamingo Campus
2250 East Flamingo Road
Las Vegas, Nevada 89119

Jackie Summers
Director of Quality Management
702-936-6337

Al Wazwaz
Chief Executive Officer
702-936-6386

Dan Kunde
Chief Clinical Officer
702-936-6324

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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

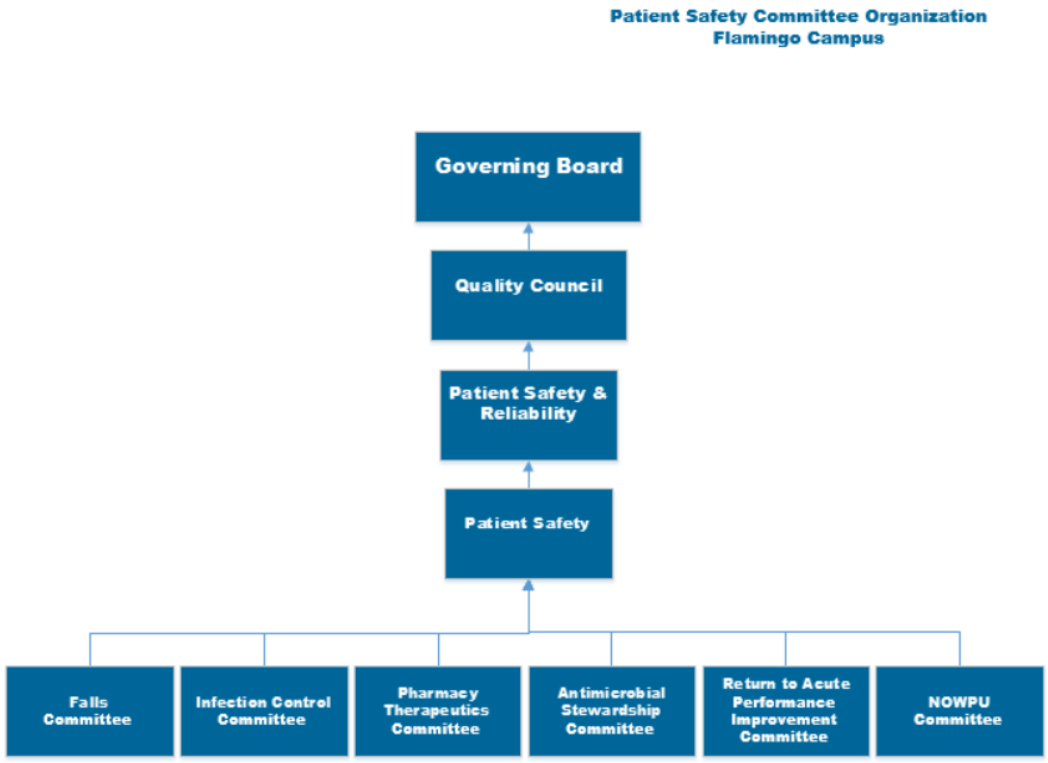
core principles of this plan include:

- 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	GOAL: CLABSI rate to be = or < 1.01 infections per 1,000 central line days 2021 CLABSI Rate: 0.00 as compared to 2020 CLABSI Rate: 0.69	1) Educate and enforce appropriate use of blood culture collection supplies and processes by end of first quarter to confirm reduction in contamination rate. 2) Educate and re-enforce to staff proper blood collection processes and supplies from peripheral and central line sites, including obtaining correct physician's order *3)* Educate and re-enforce to staff 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 and the use of CHG especially for patients who have IV lines and indwelling catheters with assistance from Education Department. Audits conducted monthly *5)* Daily Central line audits to be conducted and coordinated by Nursing Supervisor and Infection Control Preventionist (ICP) or trained designee with oversight by IP. All audits will be submitted to ICP for review. Corrective Action Plans (CAP) will be completed by DNCS	03/31/2022	ICP/CCO
CAUTI Prevention	GOAL: CAUTI rate to be = or < 1.27 infections per 1,000	1) Educate and re-enforce staff compliance to the Urinary Catheter protocol approved by MEC/GB policy	4/30/2022	ICP/DOE/CCO

	indwelling catheter days 2021 CAUTI Rate: 1.00 as compared to 2020 CAUTI Rate: 1.58	2) Reeducate and continue to re-enforce practitioner 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 for competency of urinary catheter insertion for female and male *4)* Daily Urinary catheter maintenance audits will be conducted and coordinated by Nurse supervisor and ICP or trained designee with oversight by ICP. All audits will be submitted to ICP for review. CAP will be completed by DNCS. 5) Implement Remediation process to involve nursing staff in education presentations regarding CAUTI prevention during staff meeting to enhance responsibility and knowledge to decrease occurrences. 6) Work with Education Department to provide an in-services or lunch and learn specific to CAUTI prevention actions at least quarterly		

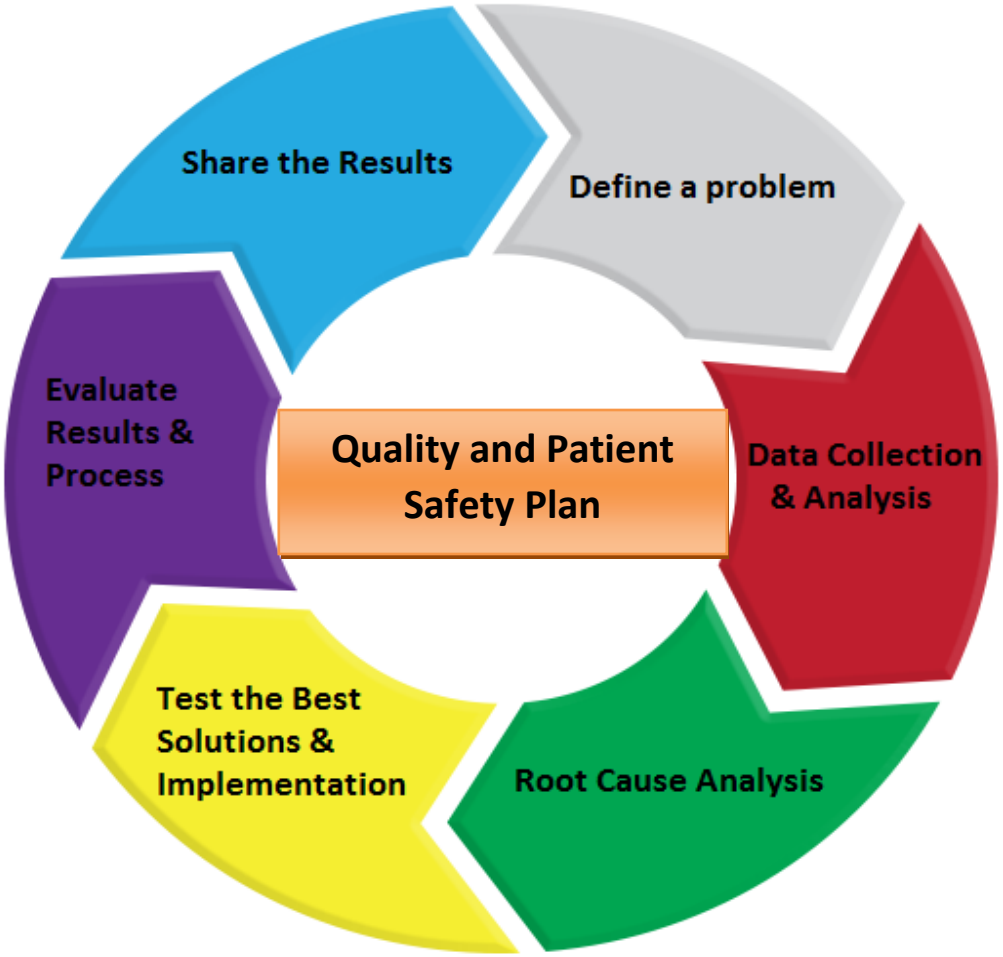
NOWPU Prevention	Reduce NOWPU 10% of 2020 NOWPU Rate of 3.79. 2021 Rate 2.56% which is a 33% decrease.	1) Wound assessment by admitting nurse and verified by the Wound Nurse with wound measurement within 48 hours. 2) Weekly re-assessment by the wound team 3) Braden Scale, Repositioning, Assessment and Wound Education to Patient Family Score 4) Place patient on the appropriate bed surface as well as treatment plan 5) Repositioning Q 2hours 6) RCA done for each event	12/31/22	Wound Care Coordinator/ Chief Clinical Officer
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 - 19 2) Provide CDC, state health department, and other regulatory education to staff and patients/families 3) Audit and report compliance to Patient Safety Committee monthly on 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 5) ADD COVID MANDATE	12/31/2022	ICP/EHN/CCO
Antimicrobial Stewardship	Reduce Antibiotic usage to ≤ 35% of total drug cost 2021 – 19.64% of total drug cost	1) Incorporate the Pharmacist/ICP/ Infectious Disease MD rounding 2) Committee to present/provide antimicrobial education to staff, practitioners and leadership at least annually. Order/dispense/administer and monitor.	12/31/22	Director Pharmacy/ICP/ CCO/ID Medical Director
Fall Reduction	Reduce falls by 10% YTD 2021 2.433	1) Fall risk assessment completed for each patient upon admission, every FRIDAY and with any change of condition or change in medication that increase	12/31/22	DQM/CCO

	which is a 24.5% decrease of from 2020 YTD 3.22	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		
Unplanned Return to Acute Care within 30 days Performance Improvement Team (Market and Medical Staff)	Decrease current RTA rate to goal of 6.59. 2021 RTA rate 9.53% which is significant-ly lower than 2020 rate of 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.

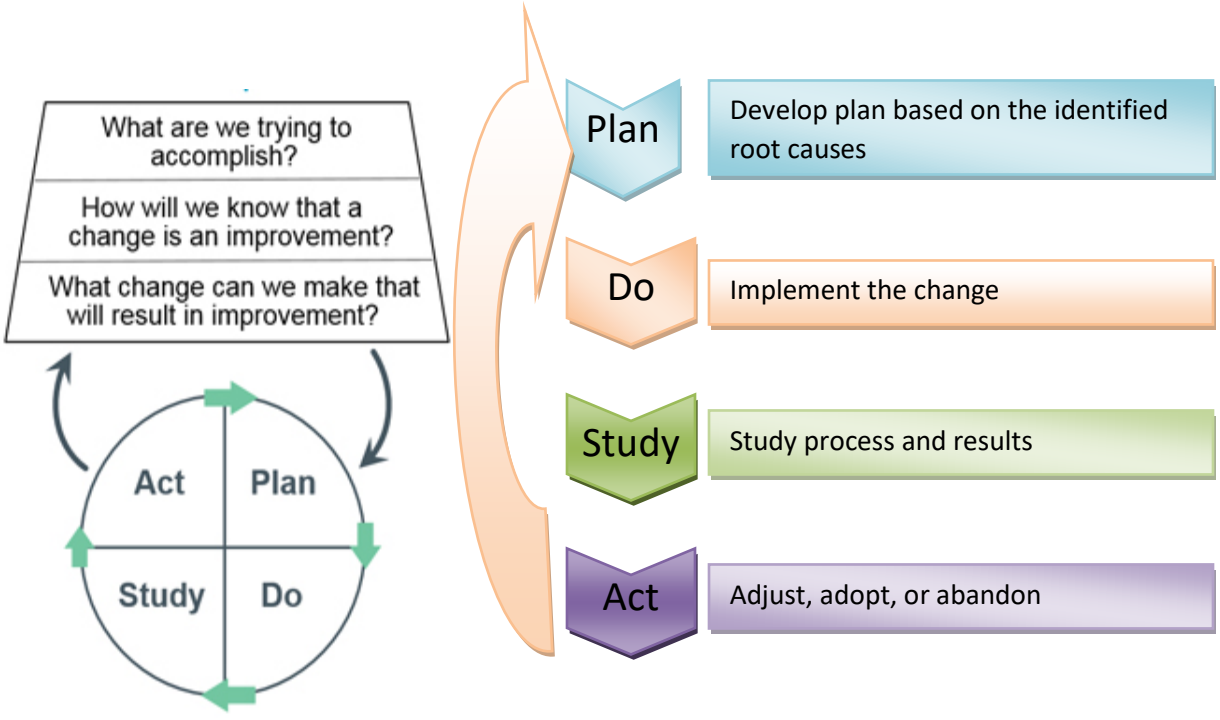
Fishbone Diagram

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 ClearSight Event Reporting System for tracking the incident and sentinel events, NHSN for reporting healthcare infection data, WebIZ for reporting vaccinations, RedCap for reporting sentinel events, and Business Warehouse and Meditech for internal data collection.

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

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

Ongoing Reporting and Review

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

Monthly	Quarterly	Annually
1) Sentinel event monthly report 2) Severity of infection report 3) RCA assessment	1) Sentinel event quarterly report 2) Severity of infection report 3) Review and evaluate the measure of improvement of patient safety 4) Review and evaluate the measurement to prevent and control infections	1) Quality and Patient Safety Plan update 2) Checklists and Policies reviewing and revising

Assessment of the Quality and Patient Safety Plan

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

Patient Safety Checklists and Patient Safety Policies

By NRS 439.865, the patient safety plan must include the patient safety checklists and patient safety policies for use by:

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

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

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

The patient safety policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include, the name and date of birth of the patient.

- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.

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

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

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

The patient safety checklists are listed in Appendix E. (The following links provide some patient safety checklists for your reference— a checklist example is shown in **Appendix E**.)

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

http://www.who.int/patientsafety/implementation/checklists/en/

The patient safety policies are listed in Appendix F. (The following link provides you some patient safety policies for your reference—a policy example is shown in **Appendix F**.)
https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1

Approval of Patient Safety Plan

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

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

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

Reference

- Root Cause Analysis Toolkit http://www.health.state.mn.us/patientsafety/toolkit/
- Quality and Service Improvement Tools http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html
- CQI 101 An Introduction to Continuous Quality Improvement: https://www.coursehero.com/file/13827355/CQI-Overviewppt/
- Quality Improvement http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/
- Root Cause Analysis http://www.patientsafety.va.gov/professionals/onthejob/rca.asp
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2 https://www.jointcommission.org/sentinel_event.aspx
- Hospital Policies https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1

- Checklists to Improve Patient Safety http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf
- Patient Safety Checklists http://www.who.int/patientsafety/implementation/checklists/en/
- Minutes of the Meeting of the Quality and Patient Safety Committee http://www.cookcountyhhs.org/wp-content/uploads/2013/12/09-23-14-QPS-scan-Minutes.pdf
- Title 40 – Public Health and Safety https://www.leg.state.nv.us/NRS/NRS-439.html

Appendix A: Terms and Definitions

Patient Safety: The Agency for Healthcare Research Quality (AHRQ) defines patient safety as "a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events." http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

Sentinel event (NRS 439.830)

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

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

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

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

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

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

Institute for Healthcare Improvement (IHI) defines **medical harm** as "unintended physical injury

resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death."

Facility-Associated Infection: (NRS 439.802)
"Facility-acquired infection" means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

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

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

Medical facility (NRS 439.805)
"Medical facility" means:

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

(Added to NRS by 2002 Special Session, 13)

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

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

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

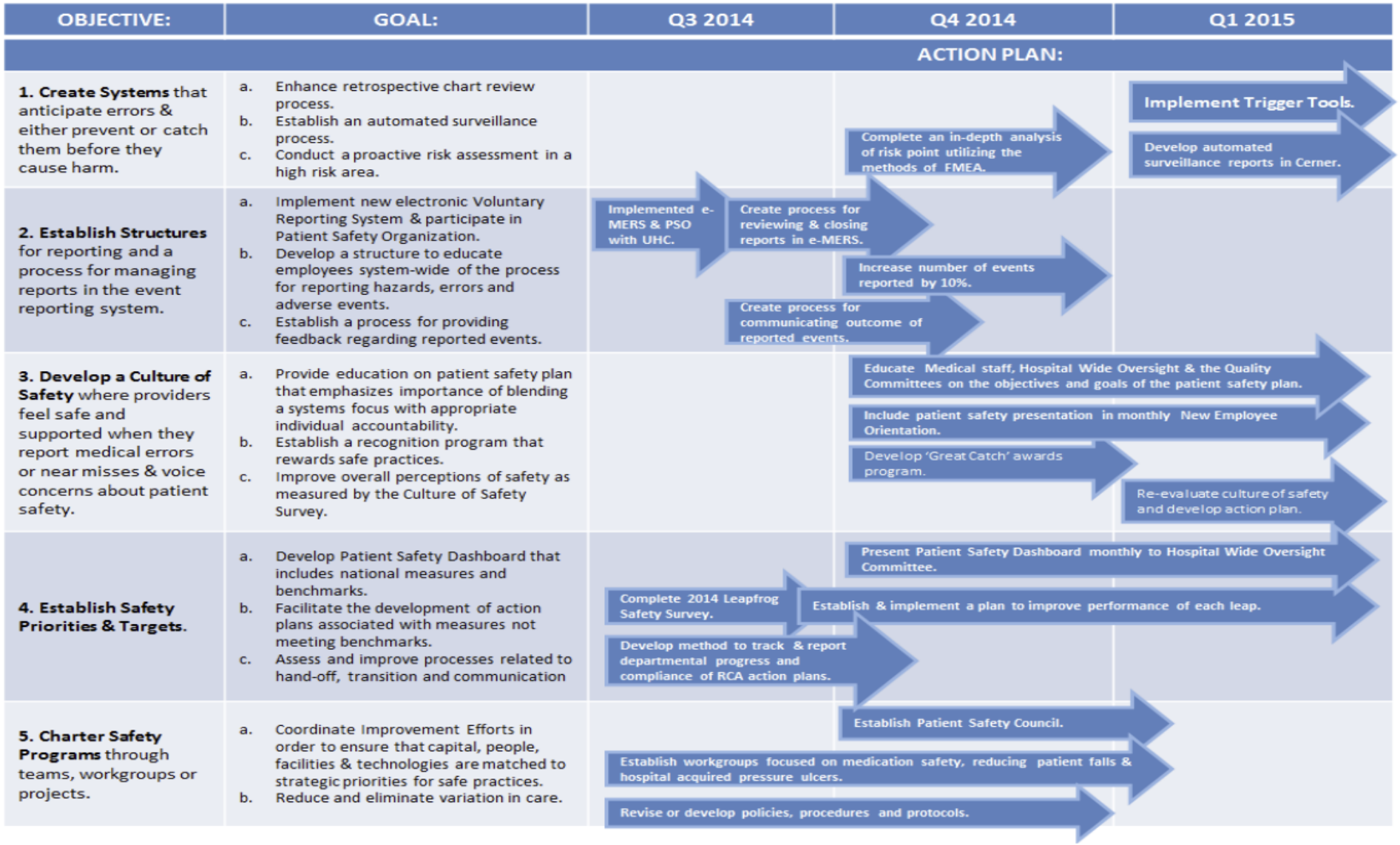
Preventable event: Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Catheter Associated Urinary Tract Infection (CAUTI): A urinary tract infection (UTI) that occurs in a

patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CUR RENT_b.pdf.)

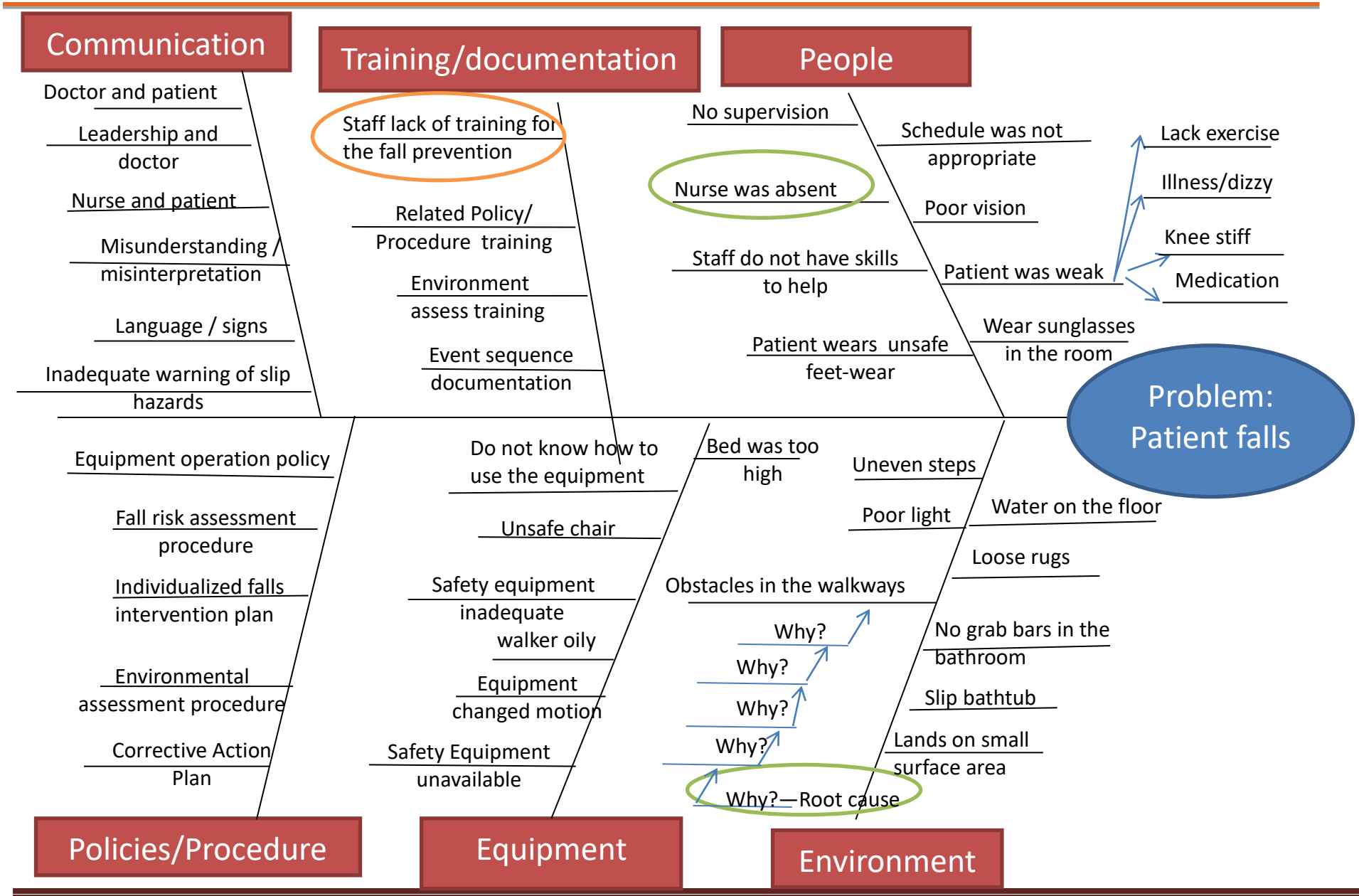
Central Line Associated Bloodstream Infections (CLABSI): Primary bloodstream infections that are associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection.

Appendix B: Patient Safety Goals



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
- 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.

MERCY HOSPITAL	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

1409 E. Lake Mead Blvd. North Las Vegas, NV 89030 North Vista Hospital **DEPARTMENTAL POLICIES AND PROCEDURES**				**Page(s):**	□□
				Saved As:	**Patent Safety Plan** □□□□
Subject:	**Patient Safety Plan** □□□□			**Formulated:**	**Prime-**□□□□
Manual:	**ADMINISTRATIVE MANUAL**			**Reviewed:**	□□□□□□□□□□□□
GOVERNING BOARD APPROVAL		**Date:**	□□□□□□□□□	**Revised:**	□□□□□

INTRODUCTION

North Vista Hospital (NVH) 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.

PURPOSE

1. Our goal is to establish a proactive approach to prevent patient injuries and other medical errors in an open and non-punitive environment. The Patient Safety Plan is to assure that a planned, systematic, coordinated approach exists to improve patient safety and reduce risk to patients through an environment that includes.
   - 1.1 Integration of all patient-safety activities both existing and newly created
   - 1.2 Identifies focus of accountability and support within the leadership of the organization
   - 1.3 Involves patients, their families, staff and leaders in the identification and management of actual and potential risks to patient safety as well as opinions, needs and perceptions of risks to patients and suggestions for improving patient safety
   - 1.4 Recognizes acknowledgment of risks to patient safety and medical / healthcare errors
   - 1.5 Initiates actions to reduce these risks
   - 1.6 Internally reports of what has been found and the actions taken
   - 1.□ Focuses on processes and systems rather than individual blame and retribution
   - 1.□ Ongoing proactive reduction in medical / healthcare errors
   - 1.□ Considers patient safety priorities in the design and redesign of all relevant organization processes, functions and services
   - 1.10 Communicates to patients and when appropriate to their families about the outcomes of care, including unanticipated outcomes
   - 1.11 Educates patients and families about their role in helping to facilitate the safe delivery of care
   - 1.12 Ongoing orientation, in-service and other education and training programs to emphasize specific job-related aspects of patient safety to maintain and improve staff competence.

2. The Patient Safety Plan involves all departments and disciplines at all levels of Hospital in establishing the processes and mechanisms that comprise the patient safety activities

through the recognition and acknowledgment of risks, preventive actions to reduce risk, internal reporting and corrective actions taken and fostering a non-punitive environment when errors occurs.

3. Proactive identification and management of potential risks to patient safety have the obvious advantage of *preventing* adverse occurrences, rather than simply *reacting* when they occur. This approach also avoids the barriers to understanding created by hindsight bias and the fear of disclosure, embarrassment, blame, and punishment that can arise in the wake of an actual event.

SCOPE OF ACTIVITIES

1. Hospital recognizes that patients, staff and visitors have the right to a safe environment. Therefore, the organization commits to undertaking a proactive approach to the identification and mitigation of medical errors through the integration into and participation of all components of the hospital into the hospital wide program. This includes Performance Improvement, Risk, Infection Control and Environment of Care (EOC) programs.

2. 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.

3. Patient safety information will be analyzed from aggregated data reports. These reports will be reported to appropriate hospital and Medical Staff committees and to the Governing Board. The aggregate data will be used to prioritize organization-wide patient safety efforts.

4. 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.

5. 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.

DEFINITIONS

Error	An unintended act, either of omission or commission, or an act that does not achieve its intended outcome. A failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim. Errors can include problems in practice, products, procedures, and systems.
Patient Safety	The degree to which the risk of an intervention and risk in the care environment are reduced for a patient while under the treatment of a healthcare provider or facility.
Patient Safety Event	Any identified defect, error, medical accident, near miss, sentinel event, medication error, significant procedural variance, or other threat to safety that could result in patient injury.

Medical Accident (Error)	An unintended event in the system of care with actual or potentially negative consequences to the patient. Types of medical errors: ▪ Diagnostic errors (misdiagnoses leading to an incorrect choice of therapy or treatment, failure to use an indicated diagnostic test, misinterpretation of test results, failure to properly act on abnormal test results) ▪ Equipment failures (defibrillator without working batteries, or inadvertent dosing of medications in a short time frame due to IV pumps with valves that are easily dislodged) ▪ Infections (HAI, post-op wound infections) ▪ Blood transfusion-related injuries ▪ Deaths due to seclusion / restraint use
Medical Accident "near miss"	Any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome. May include a clinical event.
Sentinel Event	An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would be a significant chance of serious adverse outcome.
Root Cause Analysis	A process for identifying the basic or causal factor(s) that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event.
Intensified Analysis	An examination of factors or elements that contribute to undesirable trends in performance to determine where best to focus changes for improvement.
Adverse Drug Event	A patient injury resulting from a medication, either because of a pharmacological reaction to a normal dose or because of a preventable adverse reaction to a drug resulting from an error.
Medication Error	Any preventable event that may cause or lead to inappropriate medication use or patient harm.
Hazardous condition	Any set of circumstances (exclusive of the disease or condition for which the patient is being treated) which significantly increased the likelihood of a serious adverse event.

AUTHORITY ROLES RESPONSI ILITY

Governing oard

1.1 The Hospital Governing Board has the ultimate authority and responsibility for approving the patient safety program. The Governing Board has delegated the responsibility of implementing an organization-wide patient safety program and creating a "culture of safety" to the leaders and medical staff of the hospital.

2. **Administrator Chief Nursing Officer (CNO)**

2.1 The Administrator/CNO is responsible for assuring that this program is implemented, supported, and evaluated throughout the organization. As such, the

Administrator/CNO will establish the structures and processes necessary to accomplish this objective. The Administrator/CNO may delegate the day to day implementation and evaluation of this program to an appropriate staff leader who can operationalize this plan such as the Patient Safety Officer who may be supported by the Director/Manager, Performance Improvement.

Director Manager Performance Improvement Patient Safety Officer and Infection Control Officer

3.1 The Patient Safety Officer is the Risk Manager at North Vista Hospital. The Patient Safety Officer is responsible for the day to day implementation and evaluation of the processes and activities noted in this program. The Patient Safety Officer will work collaboratively with the Director/Manager of Performance Improvement and the Infection Control Officer in establishing the Patient Safety framework and a culture of patient safety. The leadership including Senior Administration and the Chief of Staff will provide support as needed to assure the Patient Safety Plan is fully implemented and effective in positively impacting patient safety issues.

3.2 Patient Safety Officer Duties Include (As indicated in NRS 43 0):

a. Serve on the Patient Safety Committee (Chair of the Committee)
b. Supervise the reporting of all sentinel events alleged to have occurred at the medical facility, including, without limitation, performing duties required pursuant to NRS 43 35.
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 number 3.2 c.

3.3 Other Duties shall include:

a. Supports Patient Safety Committee by collecting and formulating relevant information to facilitate decision-making activities.
b. Selects at least one high-risk patient safety process for proactive risk assessment (FMEA) at least every 12-1 months. Coordinates the process throughout this period.
c. Presents Patient Safety reports to all departments.
d. Develops, and recommends new policies and procedures for patient safety based on analysis of data from events, and other relevant information.
e. 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.
f. Maintains the confidentiality and legal privilege, as appropriate, of all data and information.
g. Facilitates patient safety orientation and in-service education programs.
h. Measures and evaluates effectiveness of the patient safety program using the established goals and prepares an annual report for the Governing Board, which includes events related to staffing complement.
i. Assists department directors and administrators in enforcing policies and procedures, standards of care.

Directors and Managers

4.1 The leaders of the organization maintain responsibility for proper collection and dissemination of information for continuing education pertaining to the Patient Safety Program to employees.

4.2 The leaders create an environment that encourages prompt error identification and reduction and minimizes blame or retribution against individuals involved in an error or the reporting of an error.

4.3 The leaders provide direction and resources to conduct proactive correction and reversal of conditions and procedures that increase the chance that a patient might be harmed.

4.4 The leaders will collaborate in decision making which effects the development of hospital-wide patient care programs; policies and procedures that describe how patient care needs are met.

4.5 The leaders will assist in the development and implementation of the Hospital Plan for the Provision of Care, Performance Improvement Plan, Patient Safety Plan, Information Management Plan, decision-making structures and processes; and implementation of an effective and continuous program to measure, assess and improve performance and patient safety.

(Directors and Managers defined as those accountable for leadership, planning, organizing, developing, controlling, directing and evaluating care for designated departments – “Provision of Patient Care and Services”.)

Medical Staff

5.1 The Chief of Staff and Department Chairs of the organized medical staff through the Medical Executive Committee and in collaboration with the leaders of the organization promote and support the patient safety initiatives of Hospital. (Medical staff defined as those physicians who have been granted recognition as members of the medical staff pursuant to the terms of the Medical Staff Bylaws.)

Quality Committee

6.1 Quality Management Committee is assigned to oversee Patient Safety Committee at North Vista Hospital. Duties include:

a. Review Patient Safety Dashboard for trends, performance and improvement and make recommendations where necessary.
b. Review, provide input and recommend approval of Patient Safety Plans & evaluations where necessary.
c. Review all sentinel event / root cause analyses and intensified analyses if/as requested by Patient Safety Committee.
d. Review risk assessments and FMEA and make recommendations where necessary.

Patient Safety Committee

.1 The hospital has an organization-wide, integrated patient safety program which operates under the Patient Safety Committee. It is the responsibility of the Patient

Safety Committee to implement a hospital-wide patient safety program. The Patient Safety Committee is chaired by the Patient Safety Officer (Risk Manager) who is tasked to manage the day to day operations of the patient safety program.

□.2 The scope of the patient safety program includes the full range of safety issues, from potential or no-harm errors (sometimes referred to as near misses, close calls, or good catches) to hazardous conditions and sentinel events. All departments, programs, and services within the hospital participate in the patient safety program. As part of the patient safety program, the hospital creates procedures for responding to system or process failures.

□.3 Patient Safety Committee Responsibilities (based on NRS 43□.□□5 and NRS 43□.□□□):

a. Monitor and document the effectiveness of the patient identification policy.
b. On or before July 1st of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to NRS 43□.□□□(4)(b).
c. Receive reports from the patient safety officer pursuant to NRS 43□.□□0.
d. 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.
e. 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:
f. Adopt patient safety checklists and patient safety policies as required by NRS 43□.□□□, review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.
   - The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter).
   - The number and severity of infections that occurred at the facility during the preceding calendar month or quarter.
   - Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
g. Provide regular reports to the Quality Committee.
h. Implement and monitors the National Patient Safety Goals compliance within the facility.

O□□ECTIVES AND GOALS FOR THE PATIENT SAFETY PLAN

1. **Goal** □ – Improve the following 3 Patient Safety Culture Domains:
   1.1 Staffing and Work Pace 2021 Goal: 54□ (scored 4□□ in 2020)
   Patient Safety Rating 2021 Goal: □0□ (scored 65□ in 2020)
   Handoffs & Transitions-2021 Goal: 65□ (scored 60□ in 2020)

□□ **Goal** □ – Reduce the number of patient falls in 2021 from 2020 (25□)
   2.2 Hospital Wide Performance Improvement Indicator.

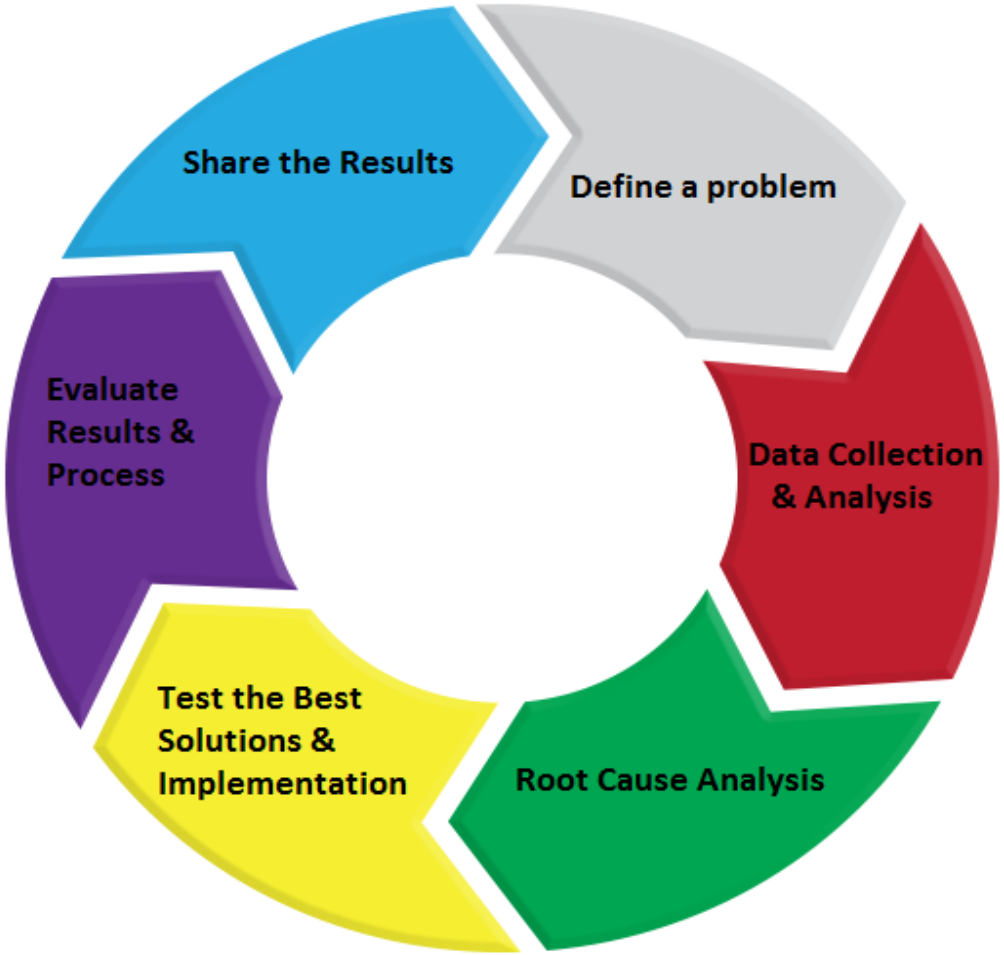
3. **Goal** □ – Reduce number of hospital acquired conditions (HACs) in 2021 from

3.1 14 CAUTIs (Catheter -associated urinary tract infection)
3.2 CLABSIs (Central line- associated bloodstream infection)
3.3 10 C. Diff (Clostridium difficile) cases
3.4 1 SSI's (Surgical site infections)

COMPONENTS AND METHODLOGY

1. Pursuant to NRS 43.033 a medical facility shall, upon reporting a sentinel event pursuant to NRS 43.035, 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."

2. North Vista will use Root Cause Analysis (RCA) process to determine the contributing factors and the underlying reasons for the deficiencies or failures. The FOCUS PDCA (Find, Organize, Clarify, Understand, Select, Plan, Do, Check, Act) is the model which North Vista Hospital will use to test the changes.

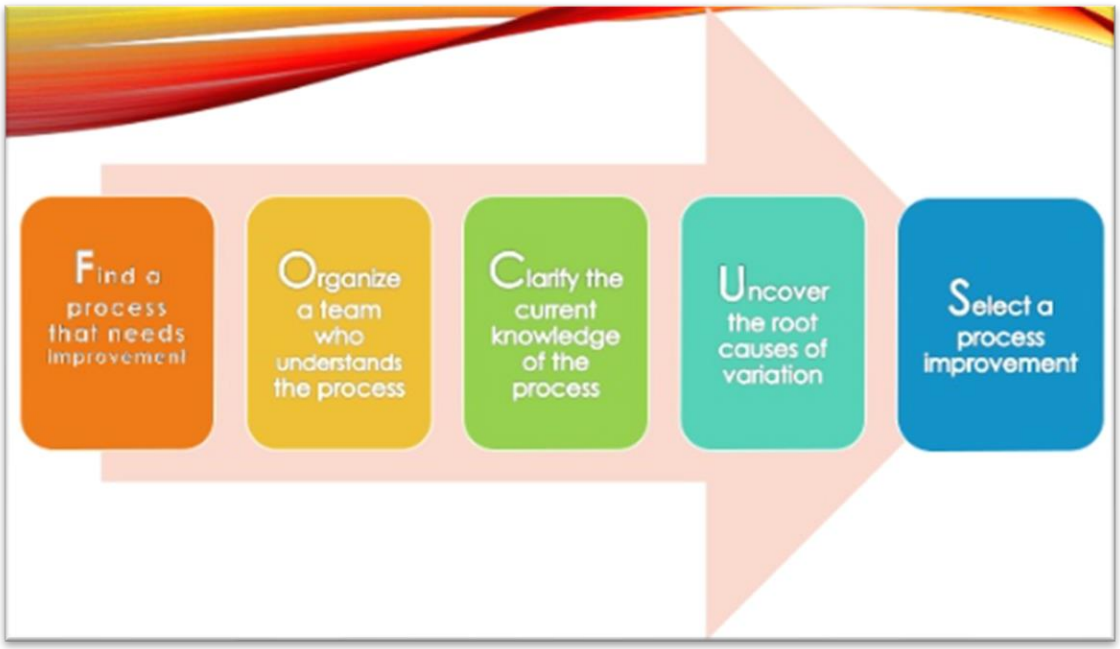


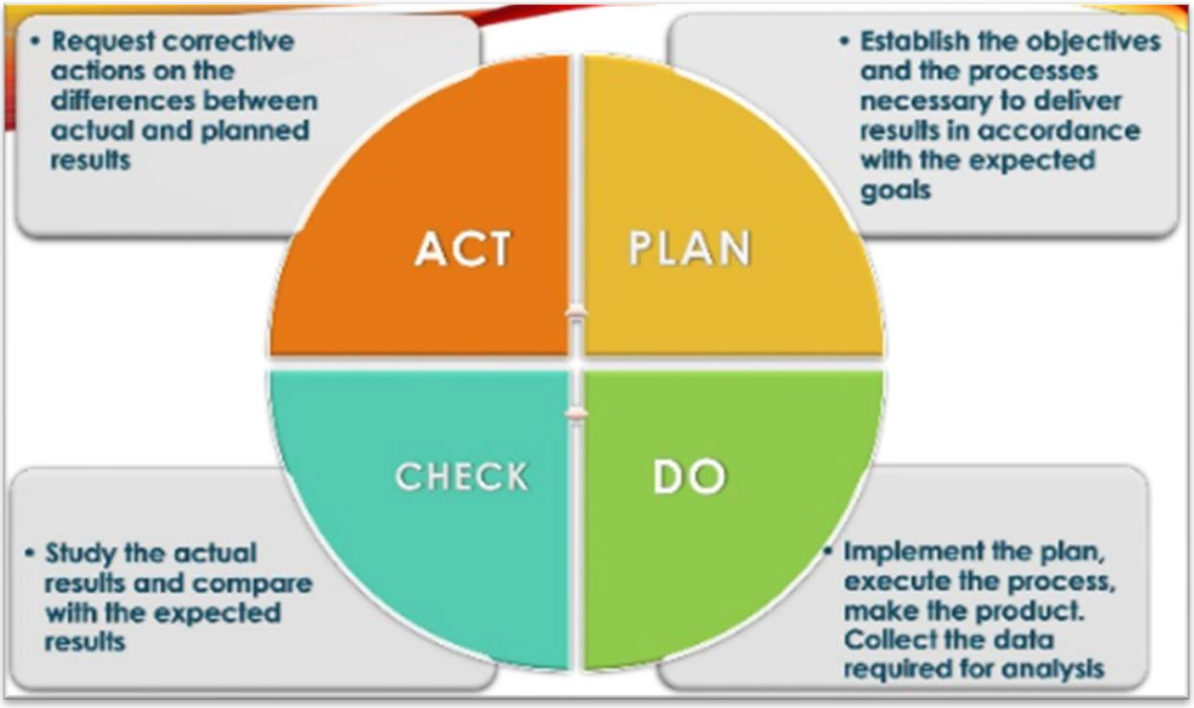
3. **Root Cause Analysis**
   3.1 A Root Cause Analysis (RCA) is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals. Before analyzing the

root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis. The attached forms in Attachment I and II will be utilized to conduct RCAs.

4. **Model for Improvement**

4.1 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.





4.2 This methodology will be accomplished utilizing the RCA forms attached in Attachment I. This methodology is also utilized in the Performance Improvement Plan to select Performance Improvement Indicators for each department.

DATA COLLECTION AND RIS ASSESSMENT

1. In order to reduce the likelihood of patient incidents and negative outcomes, North Vista Hospital will track the frequency and type of patient safety issues and compile them in order to learn from and prevent future negative occurrences. Examples of how the hospital collects and analyzes data is listed below.

1.1 Data Sources

a. Internal

- Risk incident reports with database compilation
- Adverse Drug Events and Adverse Drug Reactions
- Data from patient complaints
- Risk Management and Safety findings
- Compliance findings
- PI and special study findings
- Infectious Disease information
- Operative/Invasive procedures
- Departmental indicators
- Employee surveys (includes perception of risk)

b. External

- Core Measures Indicators
- Accreditation/regulatory deficiencies

- Patient Satisfaction Surveys
- Other Evidence-Based external sources

1.2 Risk Assessment (Failure Mode and Effect Analysis)
An assessment that examines a process in detail including sequencing of events; assesses actual and potential risk, failure, points of vulnerability; and through a logical process, priorities areas for improvement based on the actual or potential patient care impact (criticality).

1.3 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.

1.4 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.

1.5 FOCUS PDCA (Plan, Do, Check, Act) methodology for Performance Improvement will be utilized for all performance improvement activities within the facility. This methodology will not be used when conducting RCAs

PATIENT SAFETY CHEC□LISTS □ PATIENT SAFETY POLICIES

1. By NRS 43□.□65, the patient safety plan must include the patient safety checklists and patient safety policies for use by:
   1.1 Providers of healthcare who provide treatment to patients at the facility;
   1.2 Other personnel of the facility who provide treatment or assistance to patients;
   1.3 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
   1.4 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:
   1.5 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.
   1.6 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.
   1.□ A checklist 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;
      c. Any other instructions concerning his or her care upon discharge; and

d. Any other checklists which may be appropriate to ensure the safety of patients at the facility.

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

CULTURE OF SAFETY SURVEY

1. North Vista Hospital will utilize the Agency of Healthcare and Research Quality (AHRQ) research survey (Culture of Patient Safety Survey) that is intended to measure the ten dimensions of culture pertaining to patient safety:
   1.1 Supervisor/manager expectations & actions promoting patient safety
   1.2 Organizational learning – continuous improvement
   1.3 Teamwork within units
   1.4 Communication openness
   1.5 Feedback & communications about errors
   1.6 Non-punitive response to error
   1. Staffing effectiveness
   1. Hospital management support for patient safety
   1. Teamwork across hospital units
   1.10 Hospital handoffs & transitions

   The results of the survey will be used by the Patient Safety Committee and/or Quality Committee to enhance the patient safety program at North Vista Hospital.

CONFIDENTIALITY

The proceedings and records of a patient safety committee are subject to the same privilege and protection from discovery as the proceedings and records described in NRS 4.265

PLAN EVALUATION

1. According to NRS.43.65, a medical facility shall submit its patient safety plan to the governing board of the facility for approval. After a facility's patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan. The patient safety plan must be reviewed and updated annually in accordance with the requirements set forth in this section. According to NRS 43.43, on or before March 1st of each year, a copy of the most current patient safety

plan (developed according to NRS 43□.□65) must be submitted to the Division of Public and behavioral Health.

2. This plan encompasses many disciplines and activities in addition to those specifically referenced in the plan. The Patient Safety Plan is designed to assist in the integration of these activities, not replace them. Integration should enhance the accountability and impact of the patient safety related activities and collectively provide a comprehensive quality management system for North Vista Hospital.

3. The Patient Safety Plan should be considered a "working" document and an interim product to facilitate the development of a "culture of safety". As such, the plan may be modified as the implementation of the patient safety standards takes place and sections of the plan are incorporated into existing plans, policies, procedures and protocols.

4. The Patient Safety Plan will be reviewed on an annual basis. Goals shall be identified and prioritized based on internal occurrences and trends, RCA, FMEA, survey results, sentinel events, State and Federal regulations, and other applicable patient safety issues and initiatives.

REFERENCES

Performance Improvement Plan
Infection Prevention and Control Plan
Environment of Care Plan
Plan for Provision and Patient Care Services
Title 40 – Public Health and Safetyhttps://www.leg.state.nv.us/NRS/NRS-43□.html

ATTACHMENT I

DETERMINATION OF SEVERITY

Hospital Name:	**Date Identified:**

□ **hen Did the Event Occur**□		
Date:	**Day of the wee**□**:**	**Time:**
Diagnosis:		

What **Type** of **Incident** is this□ (See below for definitions)		
☐ **Error**	☐ **Near Miss** □**Hazardous Condition**	☐ **Sentinel Event**
Explain Error Type (based on definitions below):		

Identified How□**Reported by** □ **hom:**	**Staff** □ **itnesses:**

ho were the direct indirect caregivers involved in the event (use no personal identifiers, job titles only)

rief Description (No names or other individual identifiers):

Definitions:

Error:
An unintended act, either of omission or commission, or an act that does not achieve its intended outcome.

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

Near Miss:
Used to describe any process variation that did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome. Such a near miss falls within the scope of the definition of sentinel event, but outside the scope of those sentinel events that are subject to review by the Joint Commission under its sentinel event policy. Refer to the Sentinel Event Policy for JCAHO reviewable events.

Hazardous Condition:
Any set of circumstances (exclusive of the disease or condition for which the patient is being treated), which significantly increases the likelihood of a serious adverse outcome.

ORGANI ATION OF THE TEAM

Team Leader:	**Team Meeting Date:**
	Date RCA IA Completed:

Team Members:	ob Title:

Documents Policies Gathered (include Timeline Flowchart etc):	

UNDERSTAND THE CURRENT PROCESS

hat was intended to happen normally occur (steps as defined by the policy, procedure)
hat went wrong (Easily identifiable proximal causes) (Were there any steps in the process that did not occur as intended)

ROOT CAUSE ANALYSIS

(Chec□off the appropriate sections□This is the ANALYSIS section where you document the drill down of the event□Remove items rows not applicable)

Process	Analysis
☐ □**ehavioral Assessment Process:** Was patient's mood/ behavior approp assessed upon admission? Were potential mood/behavior problems identified approp/subsequently monitored□Were referrals made to physicians, Social Work, or Behavioral Health□Are current assmt. tools approp. measurement of mood/behavior□	
☐ **Physical Assessment Process:** Was patient approp. assessed upon admission or prior to their procedure□ Was the patient approp. re-assessed throughout their stay□ Were assessments done timely and according to policy□ If conditions identified, did staff act approp. follow up, referrals, etc.□	
☐ **Patient Identification Process:** Was the patient approp. identified by an ID band or by other means□ Are there deficits in the patient identification process that permitted the error to occur□Did the patient have approp. patient identifiers in place (i.e. ID bands, chart labels, etc.)□	
☐ **Patient Observation Procedures:** Was the patient approp. observed/monitored during their stay/procedure□ Were conditions present that warranted increased observation/monitoring that were not identified by staff□	
☐ **Care Planning Process:** Was the patient's care planned approp.? Did the patient have a completed History and Physical□Was care deemed to be appropriate as planned□Was the outcome a complication despite appropriate care planning□	
☐ **Continuum of Care:** Was the outcome affected by a breakdown in the continuum of care□ Was there a failure to provide adequate information/services from a prior caregiver or other discipline that contributed to the event□ Were the appropriate referrals made according to the patient's assessment□ Were the appropriate referrals completed□	
☐ **Staffing Levels:** Are staffing levels high enough to meet demand; limitations overtime□ Agency/float staff in use□Are staff members approp. matched to assignments□How many continuous hours had the staff/physician involved been working□	
☐ **Orientation and Training Of Staff:** Is ongoing training available regarding the process involved in the event□ Are employees oriented to the process involved in the incident□ Are staff members aware of reference resources□If event involved a contingent or agency staff member, was orientation and training sufficient for the delivery of patient care□	
☐ **Competency Assessment□Credentialing:** Have staff completed orientation and training on the process involved□Is assessment of employee performance of this procedure part of the employee review process□When was last competency assessment completed□Need to repeat them? What the process involved a "core ability" of the staff member, if so, should competencies be considered□Include omissions in critical thinking and/or performance variance(s) from defined policy, procedure, protocol and guidelines in effect at time.	

☐ **Supervision of Staff:** Are supervisors readily available to both experienced and new staff□ Are performance standards made clear□ Are staff members observed in the performance of their daily work□ Would direct supervision have resulted in a better outcome in this process□	
☐ **Communication with Patient□Family:** Was communication with the patient hindered in any fashion (i.e. a comatose or demented patient)□ Was the family or significant other present to assist with the assessment process□ Is the patient a reliable historian□	
Process	**Analysis**
☐ **Communication Among Staff Members:** Are instructions clear and precise: evaluation of verbal, written, electronic communication or the lack thereof□ Timing factor□ Handoff□ Are human interactions free of intimidation and embarrassment□ Was key information communicated from one caregiver to another as appropriate□ Were appropriate referrals made□	
☐ **Availability of Information:** To what degree was all the necessary information available when needed□ Accurate□ Complete□ Unambiguous□ Does historical information include all pertinent information needed to facilitate care of the patient□ Was the sharing of necessary information hindered due to technological reasons□	
☐ **Adequacy of Technological Support:** Did automation actually contribute to this event□ Is the right equipment used for the task at hand□ Is the equipment up-to-date□ Are resources available to answer the operator's questions about the equipment□ Does equipment design play a role in causing problems□	
☐ **Equipment Maintenance□Management:** Is machinery/equipment working properly□ Are service guidelines being followed□ Is backup equipment on hand□ Biomed checks done□	
☐ **Physical Environment:** Current environment meets code□ Do noise levels make it difficult for staff to communicate□ Was there an environmental risk involved in the event that was not previously identified□ Was location a factor in causing the event□ Was the facility on any special status at the time (e.g. fire drill, Code Blue, etc.)□Lighting issues□	
☐ **Security Systems and Processes:** Were medications/equipment/supplies needed for the delivery of care secured properly□ Were medications/equipment/supplies needed for the delivery of care able to be obtained. Was the safety and security of the patient/staff adequate□ Were there deficits or breaches in security that contributed to the event□	
☐ **Control of Medications - Storage□Access:** Are medications stored properly□ For example, are dangerous drugs stored away from patient-care units□ Is storage set up to eliminate confusion□ Is access to medications limited to the appropriate personnel□	
☐ **Labeling of Medications:** Are labels clear and legible□ Do similarities in packaging cause confusion□ Are labels read at least three times – when picking the medication, preparing the dose, and prior to administration□	

ADDITIONAL QUESTIONS
□ hat <u>uncontrollable</u> external factors influenced this outcome□ (Identify any factors the organization cannot change that contributed to a breakdown in the internal process, for example natural disasters).
□ ere there any <u>other</u> factors that directly influenced this outcome□ (List any other factors not yet discussed).
□ hat are the <u>other areas</u> in the organization where this could happen□ (Ensure planned actions include addition areas as needed).
□ hat <u>barriers</u> were in place but failed to stop the undesirable outcome□ □ hat <u>barriers SHOULD</u> have been place but were not to prevent the undesirable outcome□
□ hat <u>uncontrollable□outside factors</u> directly affected the result□
□ hat <u>human factors</u> were relevant to the outcome□ (examples: fatigues, personal problems, in-attentional blindness/ confirmation bias, substance abuse)

Summary	YES	NO
1. Was the event caused by an inappropriate action□		
2. Do policies/procedures exist for the activities/tasks involved□		
3. Do the policies/procedures related to the tasks have sufficient detail□		
4. Do the policies/procedures have sufficient fail-safe mechanisms□		
5. Do the policies/procedures cover tasks in proper sequence□		
6. Did the time of day have an effect on the event□		
□. Did the event occur at shift change□		

□ hat other <u>pertinent issues</u> were identified not already addressed in the minimum scope of investigation as listed above□

CONCLUSIONS

Pertinent Conclusions	
Proximal Cause (s)	
Systemic Deficiencies	

Improvement Opportunities identified: (add rows as needed)	
□ □□	
□ □□	
□ □□	
□ □□	
□ □□	

IONS

ACTION PLAN

□Method Key: **(A)** Policy **(□)** Education **(C)** Audit **(D)** Observation (add rows as needed)

□	**Action Plan□Ris□ Reduction Strategies— Prevent Reoccurrence**	**□Method**				**Responsible Party**	**Target Date**
		(A)	**(□)**	**(C)**	**(D)**		
1							
2							
3							
4							

□ibliography: Cite all boo□s and □ournal articles that were considered in developing this root cause analysis and action plan□

DO NOT □ RITE □ELO□ THIS POINT – RIS□ MANAGEMENT USE ONLY

□ as the analysis completed within forty-five (□□) days after determining that the occurrence is a sentinel event□			
☐ **Yes**	☐ **No**	**If NO□ Explain:**	

Should this analysis be voluntarily reported to DNV□			
☐ **Yes**	☐ **No**	**Explain:**	

Action	**Date**

Date discussed in Performance Improvement Quality Council:	

Performance Improvement Review:

Medical Staff Review:

Legal Services Review:

Final Disposition:	**Date:**

ATTACHMENT II

Minimum Scope of Root Cause Analysis for Specific Types of Sentinel Events

Detailed inquiry into these areas is expected when conducting a root cause analysis for the specified type of sentinel event. Inquiry into areas not checked (or listed) should be conducted as appropriate to the specific event under review.

ANALYSIS AREAS	EVENT TYPE									
	Suicide (□□ hr care)	Med□ Error	Proced□ Cmplic□	□ rong site surg□	Treatmt Delay	Restraint Death	Elopement Death	Assault□ Rape□hom□	Transfusn Death	Infant abduction
□ehavioral assessment process□	□					□	□	□		
Physical assessment process	□		□	□	□	□	□			
Patient identification process		□		□					□	
Patient observation procedures	□					□	□	□	□	
Care planning procedures	□		□			□	□			
Continuum of care	□				□	□				
Staffing levels	□	□	□	□	□	□	□	□	□	□
Orientation and training of staff	□	□	□	□	□	□	□	□	□	□
Competency assessment□ credentialing	□	□	□		□	□	□	□	□	□
Supervision of staff		□	□		□	□			□	
Communication with patient□family	□			□	□	□	□			□
Communication among staff members	□	□	□	□	□	□			□	□
Availability of information	□	□	□	□	□	□			□	
Adequacy of technological support		□	□							
Equipment maintenance□ management		□	□			□				
Physical environment	□	□	□				□	□	□	□
Security systems and processes	□						□	□		□
Control of medications: storage□access		□							□	
Labeling of medications		□							□	

Northern Nevada Medical Center

Risk Management/ Patient Safety Plan

Nevada Acute Care Division

Revised 1/2022

A. **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 facility 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 Centers' 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 RESPONSIBILITES

A. Risk Management/Patient Safety Officer

Northern Nevada Medical Center has a designated Risk Director/Manager responsible for patient safety risk identification and reduction for their respective facilities. The

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

The Patient Safety Officer responsibilities based upon NRS 439.870 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: This element outlines the UHS Risk program that lays the foundation for an effective risk management program. The Risk Manager/Director must be seen as a resource to administration, facility, and medical staff. Written plans, goals, and objectives provide a clear vision to meet the purpose of the UHS program. Although the TERM program uses the title, "Risk Manager," this applies equally to Risk Directors.

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

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

Element IV. Patient Safety Initiative: Imperative to a comprehensive RM program is one that focuses on the improvement of patient and staff safety through the creation of an environment that maximizes safety and reduces liability claims exposure. The mechanism used to drive the culture of safety is the Patient Safety 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 cornerstone 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 environmental safety and security programs in the facility serve to protect and preserve both life and property. Areas of safety include licensing, accreditation and state, federal and local safety practices and programs.

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

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

Element IX. Medication Safety Initiative: The medication safety initiative is geared toward preventing and responding to the accidental injury of a patient due to medical care or medical errors during the medication-use process. The mechanism used to drive the culture of safety is the Medication Safety Committee at each facility. The committee proactively assesses risk points at every level of the medication use cycle: procurement, storage, ordering/prescribing, transcription, distribution, preparation, dispensing, administration, documentation, and monitoring.

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 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.

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 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 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. Patient Safety Priorities, Goals and Objectives for 2022

- **Surgical and Procedural Safety**
  - **Wrong Site Surgery (WSS)**
    - ***Goal:*** the goal is 0.
  - **Retained Procedural items (RPIs)**
    - ***Goal***: Prevent RPIs- Ultimately, the goal for RPIs is 0.

- **CLABSI Initiative**

- ***Goal***: CLABSI will be reduced to less than the CMS national mean Standardized Infection Ratio (SIR: CLABSI 0.692) in 2022.

- **Safe Medication Use**
  - **Smart Infusion Pump High Risk Opioid Event Reduction Initiative.**
    - ***Goal***: Decrease the number of high-risk opioid medication overrides by 50% by December 1, 2022.
    - ***Goal*:** Increase "Guardrails Suite usage to meet UHS and Leapfrog goal of 95% by December 1, 2022.
    - ***Goal:*** Naloxone provision usage will increase to 95% by June 1, 2022.
  - **Anticoagulant Safety in the Perioperative Setting**.
    - ***Goal:*** AHRQ PSI 12 Perioperative Pulmonary Embolism or Deep Vein Thrombosis benchmark is 3.950 per 1000 inpatients. The goal is to continue to monitor the Patient Safety Indicator (PSI) 12 rate to December 2022.
    - ***Goal:*** The VTE Advisor will be used to assess the patient's postoperative risk for thromboembolism and documented prophylaxis through the VTE advisor The goal is 80% compliance with "VTE Advisor" usage.

- **Reduce Falls and Falls with Injury**
  - ***Goal***: 10% reduction in the rate of falls in the Acute Care Division by the end of 2022.
  - ***Goal***: 10% reduction in the rate of falls with injury in the Acute Care Division by the end of 2022.

- **Decreasing Hospital Acquired Pressure Injuries**
  - **Goal:** 10% reduction of NPOA rate for all HAPI stages in the Acute Care Division by the end of 2022.

- **Culture of Safety**
  - **Goal**: reduce the number of GHI events (serious safety event rate) for the Acute Care Division by the end of 2022. Ultimately, the goal is 0.

- **Facility Goals**
  - **Goal:** increase Midas events being entered by 10% and department manager/director review within 10 days to be 95%.

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/SOX 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.

PAM Health Specialty Hospital of Las Vegas
2022 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. 2022 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.**
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. 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 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

PAM HEALTH Specialty Hospital
SPARKS
2022 Patient Safety Plan

Purpose

PAM Health 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 2022 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) Health 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 which explain discharge medications, aftercare instructions and other instructions needed to facilitate a safe discharge for each 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.**
9. Cultural Competency awareness through mandated training.

The role of the Patient Safety Program also crosses over into the safety of the environment of the hospital including oversight of the 7 Environment of Care Plans:

1. Safety Management Plan
2. Security Management Plan
3. Life Safety Management Plan /Fire Safety
4. Medical Equipment Plan
5. Emergency Preparedness Plan
6. Hazardous Materials and Waste Management Plan,
7. Utilities – Utilities Management Plan

In collaboration with our Host Hospital Northern Nevada Medical Center (NNMC) Annual Reviews of each of the 7 plans are performed and reported to the Environment of Care Committee/Quality Council and Patient Safety Committee as well as the Medical Executive Committee and the Governing Board of the Hospital.

Methodology

The Patient Safety Program includes both proactive and responsive components.

Proactive: The proactive patient safety component emphasizes a proactive error reduction and avoidance program. The following will be reviewed to proactively identify patient safety issues:

1. Medical equipment and medication risk assessment activities

2. Sentinel event alert risk reduction activities

3. Performance improvement indicators (department specific) and monitoring activities

4. Patient Satisfaction reports

5. Medical Record review reports

6. Staff orientation, evaluation, training, and education **activities to include a Culture of Patient Safety survey to be completed every 18 months.**

7. Failure Mode and Effect analysis (FMEA) activities

8. **Medical Staff Credentialing/Peer to review issues through OPPE and FPPE.**

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) **at PAM Health.**

(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: Medical Staff, 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.

PAM Rehabilitation Hospital of Centennial Hills
Las Vegas, Nevada
2022 Patient Safety Plan

Purpose:

PAM Rehabilitation Hospital of Centennial Hills has developed a Patient Safety Program Plan in collaboration with Quality Assurance Performance Improvement, Infection Control, Pharmacy and Therapeutics, Environment of Care, and Utilization Review committees in order to provide guidelines for implementation of an integrated patient safety program hospital wide and to comply with the requirements for the State of Nevada. In accordance to Hospital Scope of Services, it is the intent of the hospital leadership to foster a safe and safety-conscious environment that promotes wellbeing, acknowledges and addresses risks, and encourages interdisciplinary safety and education focusing on process improvements.

Scope:

Overall Patient Safety responsibilities in conjunction with the 2022 NPSG's include the following:

1. **Accuracy of patient identification**. Improve the accuracy of patient identification through the use of two patient identifiers whenever performing procedures, administering medications and/or blood, obtaining blood or other specimens, or providing treatments.

2. **Staff communication.** Improve staff communication as contained in the *Handoff Communication Guidelines*, located under "Policies and Procedures" on the PAM Health intranet website with focus on SBAR and Patient Hand-off communication.

3. **Medication safety.** Improve the safety using LASA and High Alert Medication as contained in the PAM Health policy, *Medication Safety: High Alert Medications*.

4. **Infection Prevention:** Ensure the identification, reporting, prevention and control of infections, including proper hand hygiene and use of PPE as contained in the PAM Health policies. **The Infection Control Plan** and its addendums (COVID 19), and other polices covering Blood and Body Fluid Exposure, Environmental Disinfection, **Single Use of Drugs and Devices** and the use of Isolations Precautions as contained in the Infection Control and Quality Management policy section.

5. **Patient Safety Risk 1.** Reduce patient falls and injuries. Utilization of the PAM Health policy for *Fall Prevention*. Implement fall prevention as recommended by the Fall Prevention Committee, and analysis of data from the Post Fall Huddle form, and the Post Fall Analysis data collection.

6. **Patient Safety Risk 2.** Reduce the risk of suicide. Per PAM Health policy screening and identification of patients at risk for suicide utilizing the PHQ 2-9 suicide screening tool.

7. **Clinical Alarm Systems:** Improve the effectiveness of clinical alarm systems as contained in the PAM Health policy, *Safety – Alarms Clinical Equipment*.

8. **Preventing and Correcting Errors in Labeling and Storing of Prescription Medications**. Improve medication labeling and storage as contained in the PAM Health policy and in conjunction with Cardinal Health, *Medication Storage, Dispensing Medications – General*, and other policies contained in the Cardinal Pharmacy program.

9. **Safe Administration of Prescription Medications, Controlled Substances and Other Medications.** Ensure safe administration of medication as contained in the PAM Health and Cardinal policy; Administration of Drugs, and other policies contained in the pharmacy section of PAM Health policies.

10. **Identification, Investigation and Report Sentinel Events**. Ensure prompt identification, investigation and reporting of sentinel events, as contained in the PAM Health policy, Sentinel Events, and as prescribed by **NRS 439.800** and following guidelines established by the Nevada State Department of Health's Sentinel Event Registry.

11. **Environment of Care:** Provide oversite of the maintenance of a safe and sanitary environment of care throughout the facility by conducting environmental rounds, infection control rounds, and day-to-day observations by supervisory staff as contained in the PAM Health policies and the **Safety Management Plan**, **Infection Control Plan**, and other policies under Quality Management and Engineering. Ongoing collaboration with EVS and Plant Operations of the host of Hospital (Northern Nevada Medical Center) is in place.

12. **Patient Safety Checklists:** Continued use, adoption and implementation of patient safety checklists to improve health outcomes within the medical facility and to ensure patient safety is constant, consistent, and correct.

Current checklists in use:

- Insertion of PICC lines
- Maintenance of Foley Catheters
- Discharge Checklist
- Respiratory Treatment Competencies
- Wound Care Education
- Physical Therapy Assessment
- Admissions Checklist

- Case Manager Self-Audit Tool

The primary focus of the Patient Safety Program is the Patient; however the program also addresses the safety of visitors and staff. The scope of the Patient Safety Program includes but is not limited to the occurrence of the following:

- Adverse Drugs Reactions
- Falls
- Restraints
- Medication Errors
- Infection
- Near Misses
- Sentinel Events
- Hazardous Conditions (Including Workplace violence)

The Patient Safety Program also includes oversite over the Environment of Care. Currently the Patient Safety Program has oversite of seven (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 Management Plan

Annual review of each of the seven (7) plans are preformed and reported to the Environment of Care Committee, Quality Management Committee, 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 are reviewed proactively to 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, education, and training activities to include a Culture of Patient Safety Survey to be completed every 18 months. Last completed in November 2020
7. Failure Mode and Effects analysis (FMEA) activities (Falls 2020)
8. Medical Staff Credentialing/Peer Review
9. Incident occurrence report tracking and trending

Failure Mode Event Analysis (FEMA) will be conducted at a minimum of every 18 months. The process to be studied each cycle will be determined in collaboration with the medical staff, hospital leadership, and hospital staff.

Information from patient safety organizations such as National Institute for Health, Institute for Safe Medical Practices, and The Joint Commission will be disseminated to the appropriate departments and committees for action and implementation of recommendation if applicable.

Responsive: The hospital will utilize information obtained from risk assessments, sentinel events alerts, performance improvement measures, medical records 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 safety issues:

1. Root Cause Analysis
2. Intensive Assessment and Analysis/FEMA
3. Incident 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 is multi-faceted and responsibility will be shared among individuals, groups, departments, and teams. Each performance improvement team is multidisciplinary and has representatives from hospital and medical staff. Reports from the performance improvement teams are sent to the Quality and Patient Safety Committees, Medical Executive Committee and the Governing Board for review.

In compliance with State of Nevada Regulations, the Patient Safety Committee will be comprised of:

- Patient Safety Officer (annually appointed) by the medical facility.
- At least three (3) providers of health care who treat patients at the medical facility, including, without limitation, at least one member of the medical, nursing, and pharmaceutical staff of the medical facility.
- One member of the executive committee 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
    - Safety Committee
    - Quality/Risk Management
    - Hospital Infection Control

The Patient Safety Committee functions include but are not limited to:

1. Review and evaluate internal and external patient safety data from the following sources for opportunities of 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 as a result from process improvement activities and corresponding checklists.

4. Develop and approve Patient Safety Education for medical and hospital staff.

5. Conduct annual risk assessment of patient safety issues/strategies from internal and external reports.

PAM Rehabilitation Hospital of Centennial Hills believes in a non-punitive environment in order to maximize reporting of near misses, adverse outcomes, and sentinel events as it has been demonstrated that many errors occur as a result of system or process failures.

Disciplinary action may be considered when an individual takes action to hide an incident, is malicious or untruthful in reporting, when facts and circumstances suggest that an error was deliberate or in reckless disregard to patient and/or staff safety, or when the individual consistently fails in 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, 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 successful patient safety program and will be encouraged.

Education and training is an important and effective tool in assuring the Patient Safety program is clearly understood, particularly error identification and reporting and the basic approaches to Patient Safety. Education and training in regards to patient safety is included in new hire general and clinical orientation and is reviewed annually. The Relias Learning Management System is utilized for annual education, and ongoing education needs as identified related to patient safety.

Patient and family education is provided about their roles in promoting and facilitating the safe delivery of care, in partnership with hospital staff and medical providers.

SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES

QUALITY AND PATIENT SAFETY PLAN 2022

Rawson Neal Hospital at Southern Nevada Adult Mental Health Services

DATE: 01/1/2022

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 Rawson Neal Hospital at Southern Nevada Adult Mental Health Services. Implementation of this plan is intended to optimize healthcare quality and patient safety outcomes, and encourage recognition, reporting, acknowledgment and mitigation of risks to patient, visitor, and employee safety. It is focused on reducing 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
702-486-4400

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Commitment to Patient Safety

Rawson Neal Hospital, the civil inpatient Psychiatric Facility of Southern Nevada Adult Mental Health Services, is committed to a comprehensive approach to improving healthcare quality and patient safety. 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, leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high-quality healthcare.
- Honest and open communication to foster trusting and cooperative relationships among healthcare providers, staff members, patients and their families, to ensure accountability for patient safety priorities.
- Responsibility for every healthcare related decision and action.
- 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 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.
- Continuous education of staff and physicians to assure participation of healthcare providers.

Scope and Purpose

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

- Patient safety
- Visitor safety
- Employee safety

All Rawson Neal Hospital staff are required to fully support and participate in this plan and devote their expertise to patient safety and healthcare quality improvement processes.

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 process, rather than the individuals. It emphasizes the importance of analyzing data to be used in improving processes. The core principles of this plan include:

- All staff share the same goal to 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 experiences.
- Customer based including patients, families, and visitors.
- Promote systems thinking.
- Employ well-trained and competent staff to maintain 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.
- Other disciplines and departments within the agency including but not limited to psychology, social services, allied therapy, maintenance, supply and housekeeping, may assign a representative to participate in meetings and other activities of the patient safety committee.

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

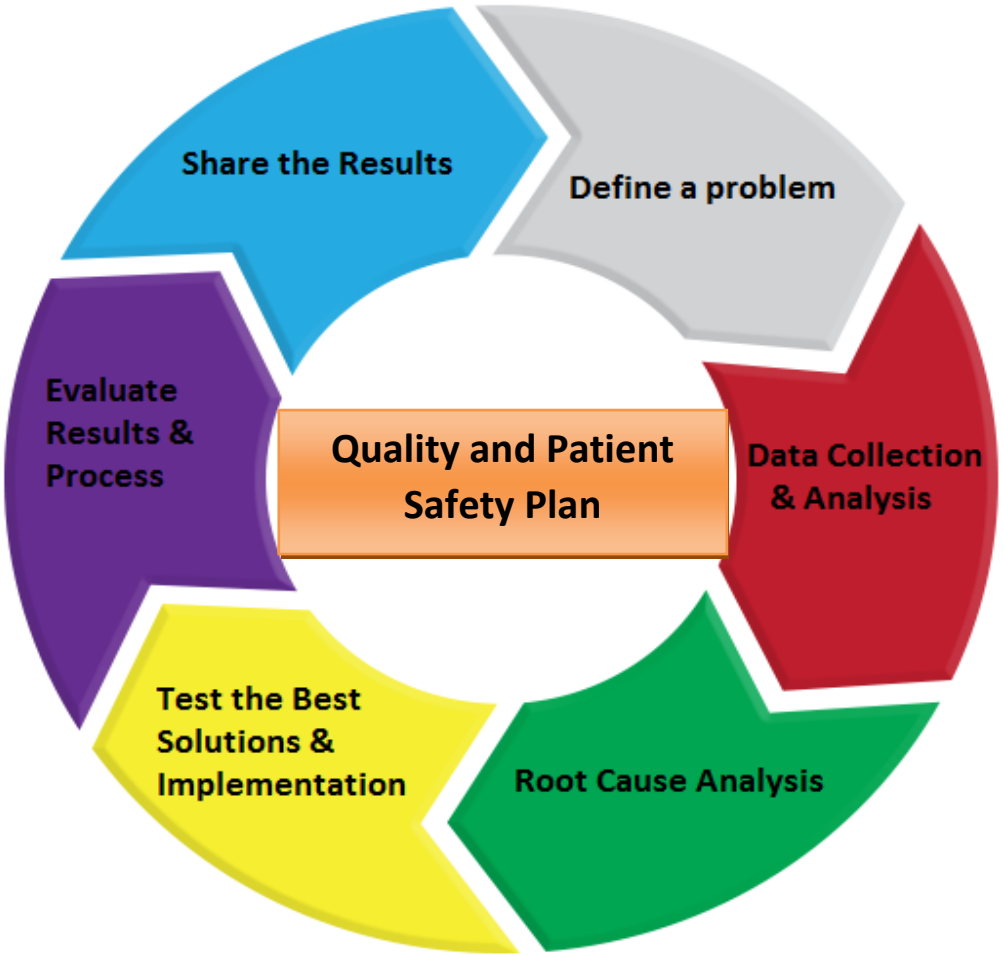
Goals	Objectives	Plan	Planned Completion Date	Responsible Party
Maintain and implement an established Incident Reporting System	To maintain processes that promote the thorough, objective consistent and timely review and analysis of all safety incidents in order to identify corrective actions that can reduce the risk of reoccurrence.	All safety incidents that occur in the facility are documented, reported, analyzed and addressed per established policies and procedures. Any trends identified in Incident Report Tracking are reported, at least monthly, to Executive Leadership and Executive Medical Staff Committees.	Ongoing	Patient Safety Officer Hospital Administration All SNAMHS Staff
Implement regular and ongoing assessments of risks.	To control known and identify potential hazards that can put patients, staff and visitors at risk.	All Rawson Neal Staff are trained in policies and procedures requiring that any identified risks are immediately reported through the appropriate channels and that all steps are to be taken to ensure the safety of patients, staff and visitors. Environmental Rounds will be conducted, at least monthly, by the environmental rounds team comprised of the Facility Safety Officer, Patient Safety Officer, QAPI Director, Infection Control Officer and Housekeeping Supervisor. Any risks identified will be	Ongoing	Facility Manager Patient Safety Officer Hospital Administration All SNAMHS Staff

		reported to Hospital Administration and appropriate individuals who will play key roles in planning for and implementing steps for mitigation. Identified risks and mitigation plans will be discussed during Patient Safety Meeting and/or Environment of Care Committee Meeting as appropriate.		
Root Cause Analysis	To establish a culture of proactively evaluating systems and investigating factors that may have contributed to near miss events and sentinel events.	A root cause analysis will be completed for reported sentinel events or near miss events. RCAs are focused on identifying systems and processes that may have led to the event. The goal is to produce an action plan that identifies strategies that the organization intends to implement to reduce the risk of similar events from occurring in the future.	Ongoing	Patient Safety Officer Hospital Leadership All SNAMHS Staff

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.

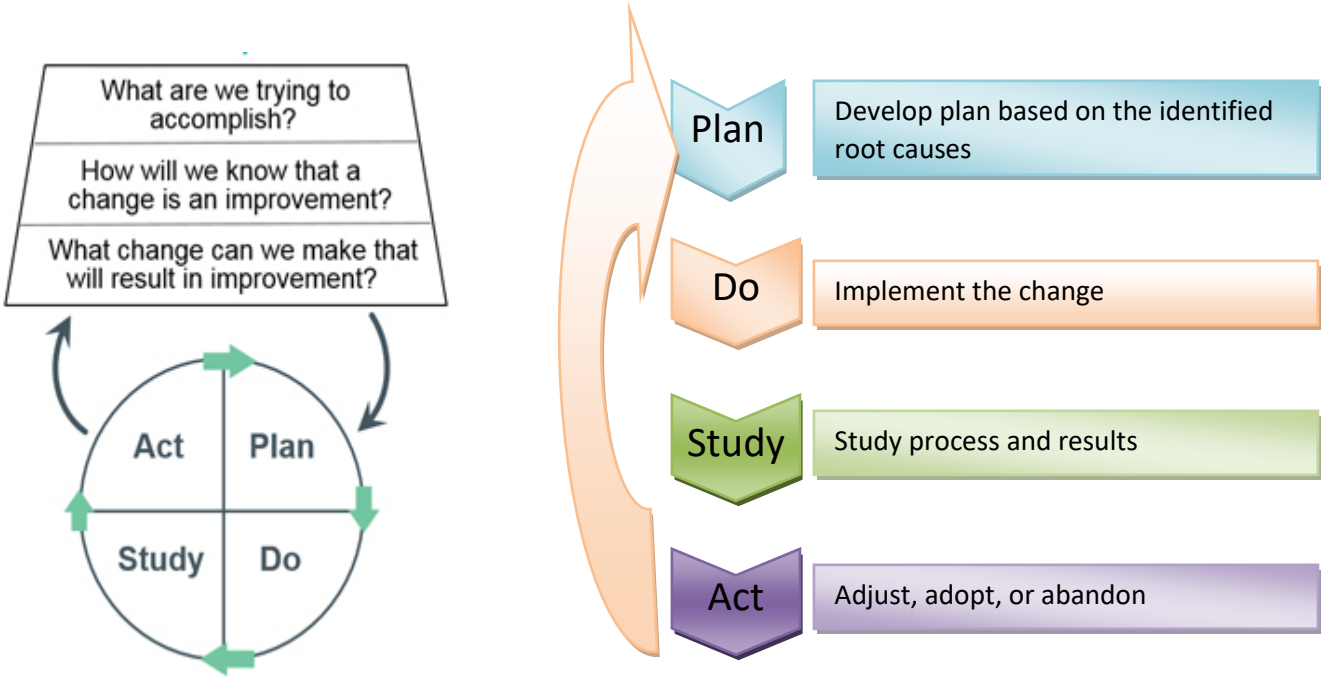
Fishbone Diagram

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 utilizes the electronic medical records system, 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 of each year. 2) Yearly Sentinel Event Report, due March 1 of each year. 2) Yearly AB280 report (Checklists and Policies reviewed and/or revised) due on July 1 of each yera.

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

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 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 patient safety policies are listed in Appendix F.

Approval of Patient Safety Plan

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

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

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

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.)

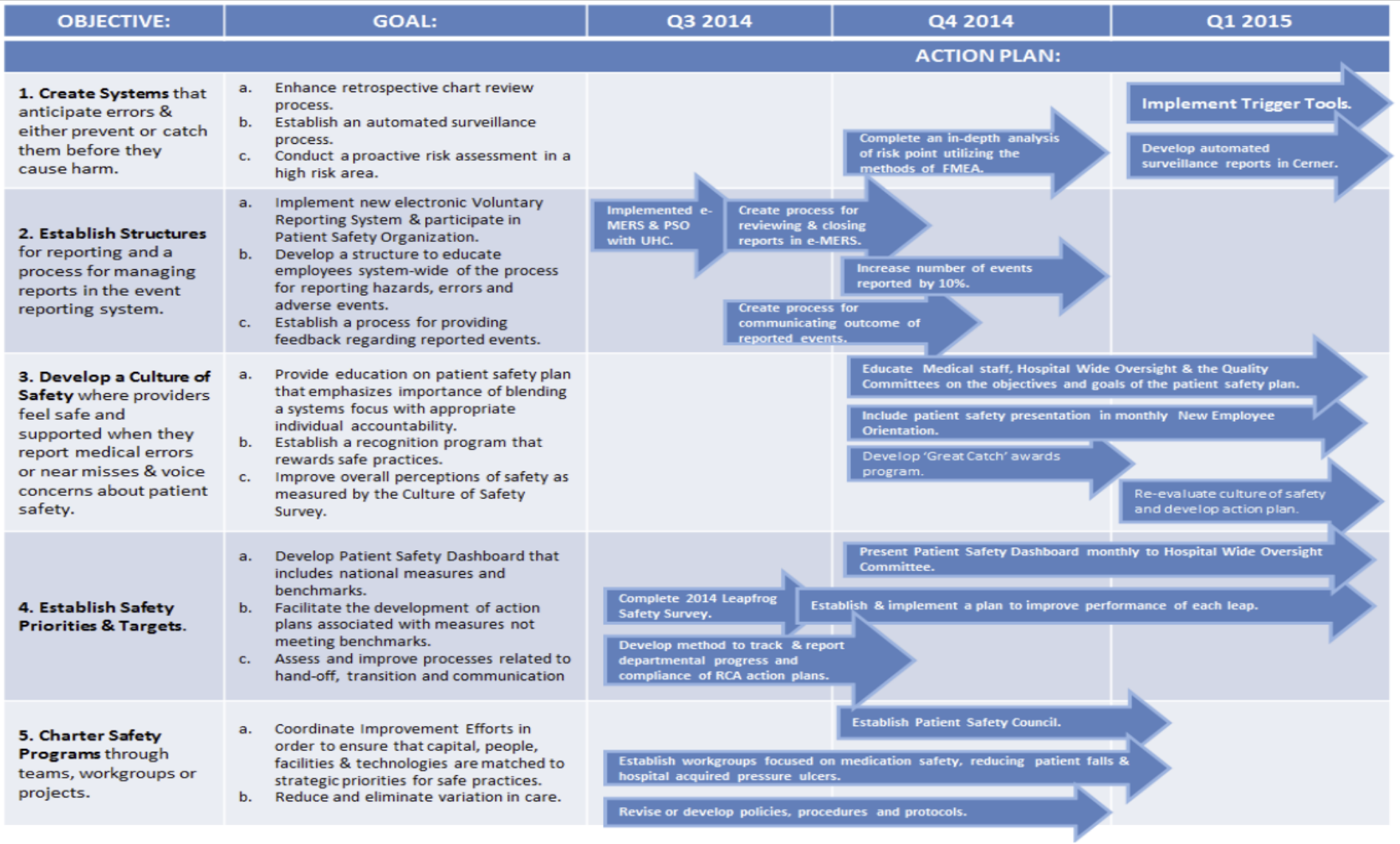
Risk: Possibility of loss or injury. (Merriam-Webster's Online Dictionary, Risk, Available at http://www.merriamwebster.com/dictionary/risk. Last Accessed August 2009.)

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_CUR RENT_b.pdf.)

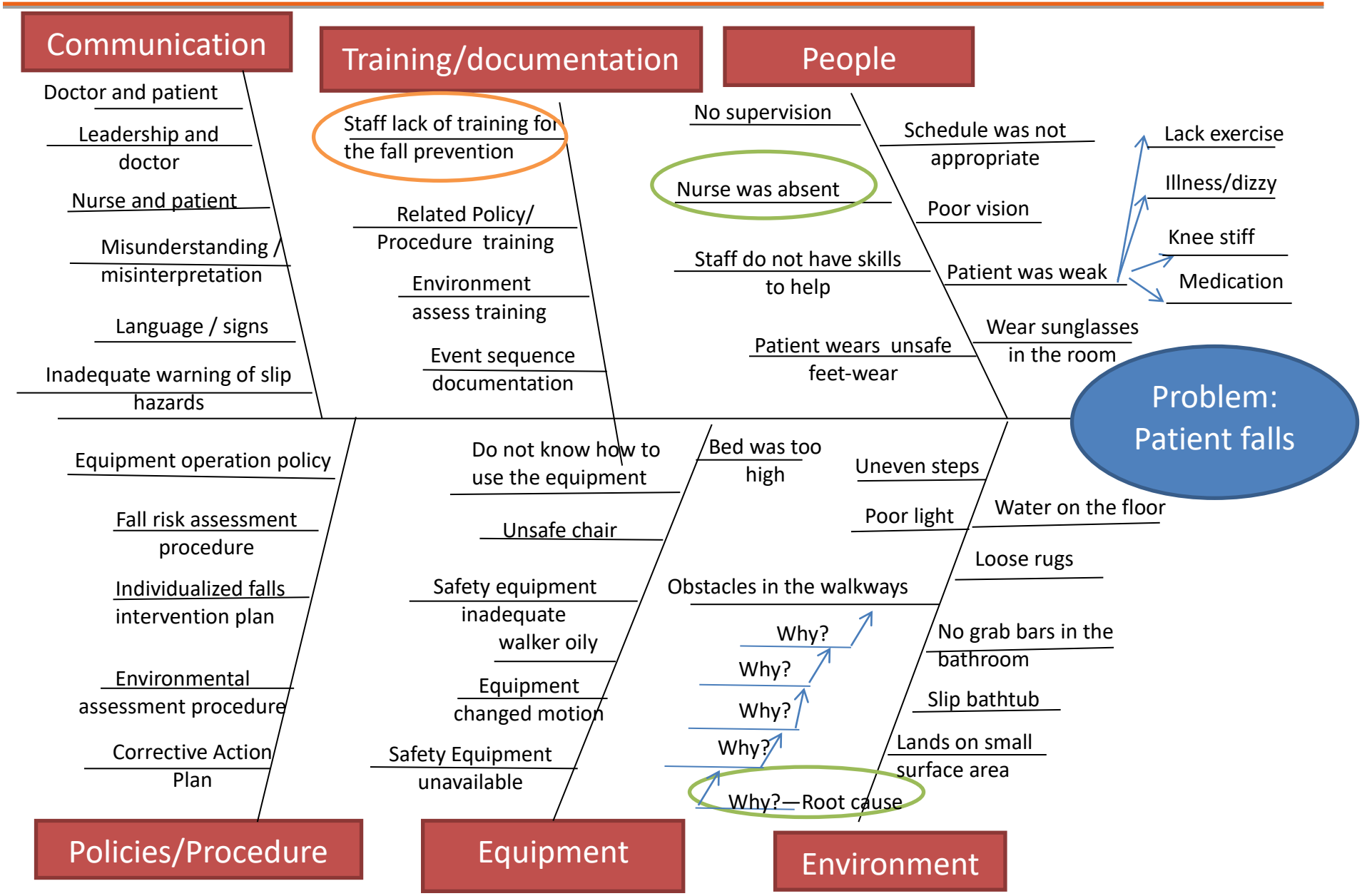
Central Line Associated Bloodstream Infections (CLABSI): Primary bloodstream infections that are associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection.

Appendix B: Patient Safety Goals



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				

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
- 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.

MERCY HOSPITAL	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

RENO BEHAVIORAL
Healthcare Hospital

PERFORMANCE IMPROVEMENT

RISK MANAGEMENT

REVIEW OF 2021

Summary

The primary goals of the organizational Performance Improvement (PI)/Risk Management (RM) are to continually and systematically plan, design, measure, assess and improve performance of critical focus areas, improve healthcare outcomes and reduce and prevent medical/health care errors. To achieve these goals, the plan strives to:

1. Incorporate quality planning throughout the facility

2. Collect data to monitor performance

3. Provide a systematic mechanism for the facility's appropriate individuals, departments and professions to function collaboratively in their efforts toward performance improvement, providing feedback and learning throughout the hospital.

4. Provide for a hospital wide program that assures the facility designs processes (with special emphasis on design of new or revisions in established services) well and systematically measures, assesses and improves its performance to achieve optimal patient health outcomes in a collaborative, cross-departmental, interdisciplinary approach.

Key elements of the program include

- Evaluating hospital performance by gathering and trending data through the ***Hospital Wide Dashboard***
- Evaluating risk and processes through information gathered through the ***Incident Reporting System***
- Evaluating risk and satisfaction through the ***Patient Complaint & Grievance***
- Evaluating patient perception of care through the ***Patient Perception of Care Survey***
- Evaluation of risk and patient safety through the evaluation of
    - Medication Errors
    - Falls
    - Restraints
    - Seclusions
    - Adverse Events
    - Sentinel Events
    - Elopements
    - Mortality

- Performance of monthly quality monitors include various modes of evaluation and measuring by multiple departments.

Review of Quality Monitors from 2021

1. AMA

Target	
≤5% 21,763 inpatient days in 2021 20,809 inpatient days in 2020 (Occurrences/Total Inpatient days *1000)	**2021 Data** **12.4**/272 Occurrences **2020 Data** **11.0**/229 Occurrences

Results: There has been a steady increase over the past few years.

Plan of Action for 2022: Reduce Hospital AMAs

1. Review programming on units for areas of improvement.
   Highest trending unit- Inpatient Detox
2. Staff training on appropriate steps when patient requests to leave AMA.
   Training to be completed via employee attestation and HealthStream
3. Documenting root cause of leaving with attempts for encouraging continued stay.

2. Seclusion and Physical Restraints

Target	
≤5% 21,763 inpatient days in 2021 20,809 inpatient days in 2020 (Occurrences/Total Inpatient days *1000)	**2021 Data** **Rate 14.0**/305 Occurrences **2020 Data** **Rate 22.9**/478 Occurrences

Results: There was a decrease in seclusion and physical restraints for 2021.

Plan of Action for 2022:

1. Promoting alternatives to the use of physical restraints, such as voluntary time out and comfort rooms.
2. To treat Physical restraints as exceptional and extreme practices and as an intervention of last resort.
3. More training for staff in early de-escalation and less restrictive practices.
4. Increasing teamwork and consistency to the way in which staff support the unit therapeutic milieu.
5. Sustaining positive appreciation, to which staff like and enjoy being with patients, affording them respect, compassion and companionship.

Performance Improvement initiatives for 2022:

1. Decrease Physical Restraints and Seclusions
   a. Increase de-escalation methods
   b. Increase staff training and education
   c. Continue training for trauma informed care
   d. Mental Heath Technician Lead training
   e. Train new Crisis Prevention Institute (CPI) instructors to build depth in the training for staff.

2. Increase the return rate and score for the Patient Satisfaction Survey – Inpatient and Outpatient.
   a. Increase understanding on what the patients believe we need to improve on.

3. Decrease AMA discharges
   a. Policy and protocol review
   b. Identify trends of clients leaving AMA

Based on 2021 data, the key priorities for year 2022 will be:

Priority 1:	Priority 2:	Priority 3:
Decrease Physical Restraints and seclusions by 5%.	**Patient Satisfaction Survey: Increase the satisfaction rate by ≥ 5% with a return rate increase by ≥ 10% for Inpatient.** **Satisfaction increased by ≥ 5% with a return rate increase of ≥30% for Outpatient**	**Decrease the number of AMA discharges.**

Renown Acute Services Division

FY22 Quality & Patient Safety Plan

Approved by	Approval dates
Acute Care Quality and Patient Safety Committee (QPSC)	9/8/2021 (send out)
Medical Staff Quality Improvement Committee	9/8/2021 (send out)
System Quality Committee (SQC)	9/13/2021 (send out)
Quality and Professional Affairs Subcommittee of the Board (QPA)	9/21/2021 (in meeting)

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Introduction

In alignment with our mission to make a genuine difference in the health and well-being of the people and communities we serve, we aim to ensure that quality, safety, and service are the standards that differentiate us in the marketplace. We strive to be recognized as an organization that provides highly reliable care as evidenced by a commitment to quality and safety throughout the entire health system from the frontline to the Board. The Renown Acute Division includes Renown Regional Medical Center, South Meadows Medical Center & the Renown Rehabilitation Hospital. This Quality Plan was established to provide structure around quality, safety, regulatory and accreditation for the Acute Care division.

Renown Acute Care Services Quality Program

To ensure that the Quality Program maintains a constant focus and remains aligned with our strategic plan and organizational objectives, program goals and a framework, including four core domains have been identified:

- Reduction of Clinical Variation
- Infrastructure Optimization
- Innovation Investments
- Network Development and Integration

Mission and Vision

Mission

Renown Health makes a genuine difference in the health and well-being of the people and communities we serve. These important words were carefully selected and lay our foundation for future success:

- We make a genuine difference.
- We are about the people and communities we serve.
- We care about health — and not just illness care.

Vision

Renown Health, with our partners, will inspire better health in our communities.

- We inspire being and staying healthy — even as we restore health for those in need.
- We take an active role in community initiatives, with a renewed focus on the underserved.
- We will have many partners because we cannot do it alone.
- We address our community's biggest health needs. Together.

Values

Our values are the words we live by:

- We are caring and compassionate.
- We demonstrate respect and integrity.
- We collaborate with our patients, families, physicians and communities.
- We strive for excellence in all we do.

Program Structure

Scope

1. Renown Health puts quality and patient safety first in every decision.
2. The patient and family are at the center of everything we do.
3. There is information sharing and accountability between Governance and Operations
4. We have a culture of quality improvement that empowers all employees and providers to critically analyze opportunities for process and performance improvement and collaboratively derive solutions for evaluation and implementation.
5. We routinely examine the culture of safety throughout the organization and focus on data-driven improvement at both the system and local levels.
6. We focus on the reduction of variation to improve individual patient outcomes in the context of population health.

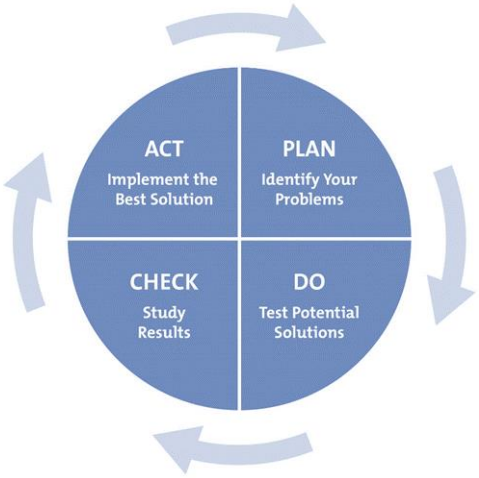
Quality Assurance Performance Improvement (QAPI)

QAPI is the coordinated application of two mutually-reinforcing aspects of a quality management system: Quality Assurance (QA) and Performance Improvement (PI). QAPI takes a systematic, comprehensive, and data-driven approach to maintaining and improving safety and quality, including the monitoring and evaluation of activities and outcomes which address patients of all ages served by Renown Regional Medical Center, Renown South Meadows Medical Center and Renown Rehabilitation Hospital.

Quality Assurance (QA) is on-going and the efforts are both anticipatory and retrospective to ensure that the standards for quality, safety and service outcomes are met and maintained. Renown utilizes both internal and external data sources to measure and assess the quality of care delivered. Data and action plans are presented at the Acute Care Quality & Patient Safety Committee (QPSC) on a regular basis where priorities are established by leadership and outcomes are monitored.

Performance Improvement (PI) is the continuous study and improvement of processes. A key tenet of continuous improvement is use of the Plan, Do, Check, Act (PDCA) Cycle. Once a team has set an aim, established its membership, and developed measures to determine whether a change leads to an improvement, the next step is to test a change in the real work setting. The PDCA

cycle is shorthand for testing a change—by planning it, trying it, observing the results, and acting on what is learned. This is the scientific method, used for action-oriented learning.



Renown Health utilizes the A3 process to provide structure for and documentation of continuous improvement efforts related to public transparency. This process enables key stakeholders to actively collaborate on the purpose, goals, and strategy of a project. It encourages in-depth problem solving throughout the process and adjusting as needed to ensure that the project most accurately meets our objectives. The steps in the process follow the Plan-Do-Check-Act (PDCA) cycle and include:

1. Identify the problem or need
2. Understand the current situation/state
3. Develop the goal statement
4. Perform root cause analysis
5. Brainstorm/determine countermeasures
6. Create a countermeasures implementation plan
7. Check results
8. Update standard work

Public Transparency (CMS Star Ratings & Leapfrog Safety Grades)

Renown Acute Care Services is committed to improving measures selected by both CMS and The Leapfrog Group through engagement of key stakeholders in process improvement. Individual metrics have been assigned to the appropriate operational and/or physician leader. This supports the transparency of data and actionable tactics to drive improvement.

CMS Hospital Quality Initiatives

Hospital Compare is part of the Centers for Medicare & Medicaid Services (CMS) Hospital Quality Initiative. The Hospital Quality Initiative uses a variety of tools to help hospitals improve the

quality of care they deliver. The aim is to help hospitals easily understand performance data and quality information from the patient's perspective.

Renown Health uses Hospital Compare and the Hospital Quality Initiative to help drive quality, safety and service. This system looks at a variety of measures that result in a Star rating for the hospital (1-5). These measures include:

1. Mortality
2. Safety of Care
3. Readmission
4. Patient Experience
5. Effectiveness of Care
6. Timeliness of Care
7. Efficient Use of Medical Imaging

Leapfrog Hospital Grades & Reporting

As a not-for-profit entity the Leapfrog Group promotes safety and quality through data transparency reflecting hospital performance in key areas. Leapfrog rates hospitals through its two main initiatives: The Leapfrog Hospital Survey and the Leapfrog Hospital Safety Grade. Renown Health participates in the Leapfrog program to further improve quality, safety and service.

Patient Safety

The Renown Health Acute Care Division develops patient safety checklists and patient safety policies to continuously improve quality, safety and service. These are reviewed and approved annually by the Acute Care Quality Patient Safety Committee.

Infection Prevention

The Quality and Patient Safety Plan includes an infection control program that carries out the infection control policy. The Renown Health Infection Prevention Plan and Program is established and approved by the Renown Health Infection Control Committee and approved by the Quality and Professional Affairs Subcommittee of the Board (QPA). Regular reports and updates regarding the Infection Prevention Program are provided to the Acute Services Quality and Patient Safety Committee.

Violence Prevention Committee

The Violence Prevention Committee consists of representatives from different multidisciplinary divisions and departments of all major areas of the facility. The safety and health of personnel, patients and visitors is vital to the organization. Acts of physical violence, intimidation and

harassment, which occur on Renown Health properties, are not tolerated. The committee's mission is preventing workplace violence and creating a safe environment for personnel, patients and visitors.

Data Analysis

Changes are occurring in every corner of health care and data is the single most important asset available to drive change, using information from across functional areas of our organization. Data analysis allows for an assessment of past and current performance and provides an objective look at opportunities for continuous improvement. Our Business Intelligence team is dedicated to helping the organization analyze production data from new angles and different viewpoints. Data analytics clearly demonstrate that actions taken at a process or structural level can influence multiple outcomes and improve care delivery.

Service Excellence

An important component of our quality improvement system is vigilant attention to the voice of the customer. Guided by The Service Excellence Plan, the team aims to advocate for the patient experience, enhance the customer journey and also manage and facilitate the resolutions of the complaints and grievances. Additionally, the department maintains service transparency by capturing real-time feedback, raising awareness, and ensuring access to patient experience data.

Culture of Safety

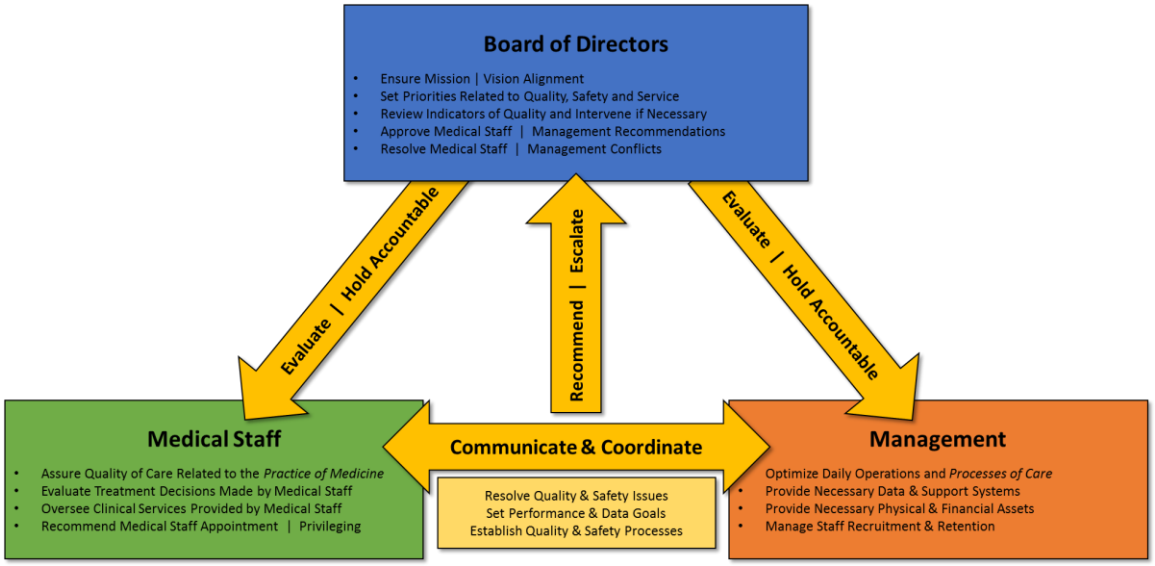
To facilitate the systemic change that is needed to drive transformation all employees must understand their role in the journey. Employee engagement has been consistently and transparently communicated to the entire organization as a key driver of performance. Sustained improvement requires insight into consumer, patient and caregiver needs, as well as, cultural alignment and a commitment to daily execution. Renown Health continues to strive to improve communication and collaboration within its workforce to raise our service levels across the organization and strengthen the cultural environment.

Medical Staff Quality Improvement (MSQI)

The medical staff is integral in the improvement of quality, safety and service. The Medical Staff Quality Improvement or MSQI is responsible for monitoring, reviewing, and reporting on the activities of the medical staff quality program as defined by the Medical Executive Committee (MEC). The critical work of the MSQI is to develop a plan for outcome improvement and monitor performance. The culture must be one of robust engagement, marked by high standards and a willingness to ask hard questions of peers and staff. Essential to its success are data analysis, a commitment to transparency and hearing the voice of the patient.

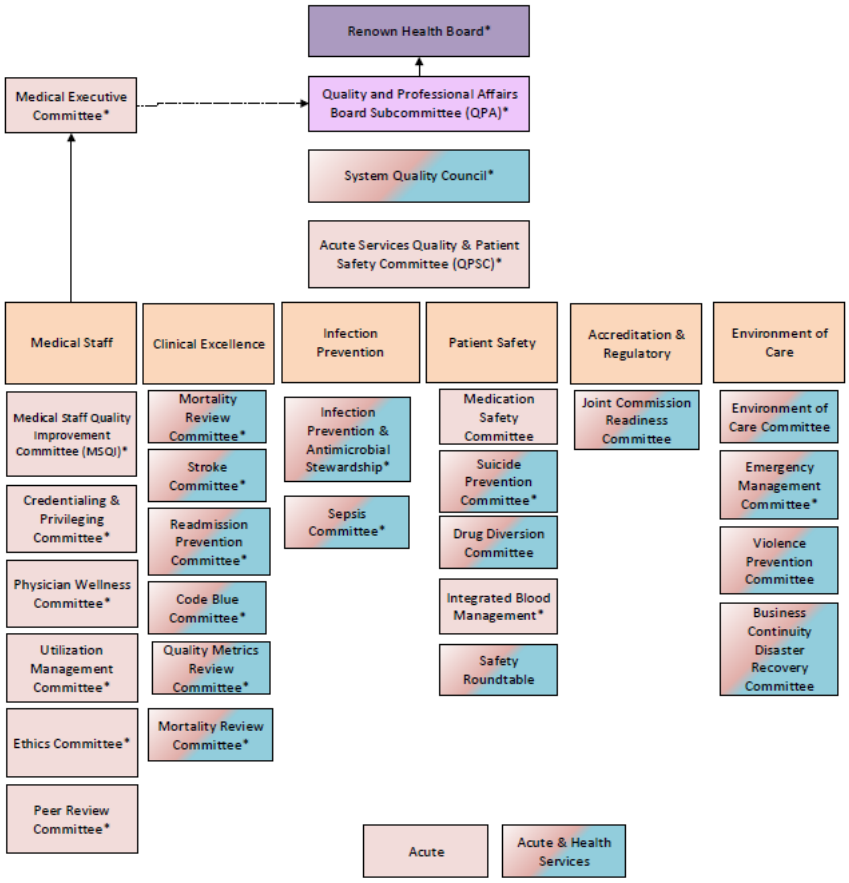
Oversight and Accountability

Renown Health is committed to improving the performance of our health care system. These bodies are responsible for ongoing performance monitoring and assessment to identify organizational quality improvement priorities (see Appendix for additional detail).



In addition to other reporting venues specific to each department and division, data will be presented in the form of dashboards to the Operations Council, Acute Medical Staff Quality Improvement Committee (MSQI), System Quality Council (SQC), Acute Medical Executive Committees (MEC), Acute Quality & Patient Safety Committees (QPSC), and the Quality & Professional Affairs Committee of the Board (QPA) on a monthly basis.

The work of quality and safety is executed through a committee structure with the flexibility to stand up ad-hoc sub-committees and/or task forces to address issues and opportunities as they arise. As noted in the graphic below, many of the committees are cross-divisional allowing for collaboration throughout the health system.



* Indicates Medical Staff Leadership Representation

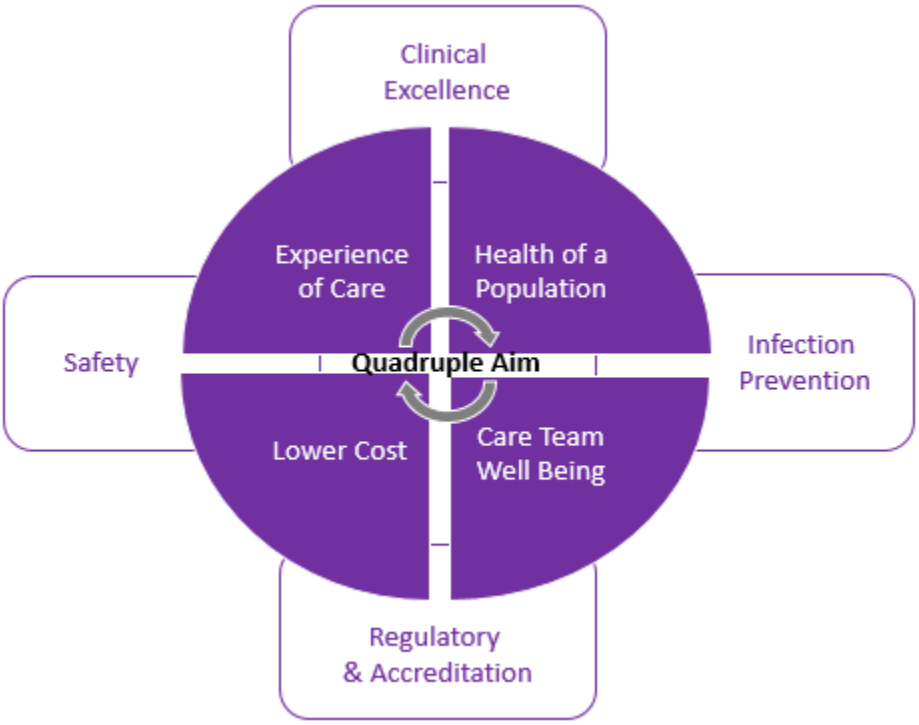
Quality Improvement Resources

The Renown Acute Care Division employs quality coordinators, infection preventionists, a safety program coordinator, an emergency preparedness coordinator and data abstractors who serve as internal resources for performance improvement activities through data analysis, process analysis and redesign and team facilitation throughout the organization. Quality and safety leaders collaborate with operational and medical staff leaders on an ongoing basis to ensure that resources are aligned with activities that will improve the care and experience of patients and clinicians, yield the most improvement in outcomes, and/or impact an area of critical focus related to the health and well-being of the patients and communities we serve.

Annual Work Plan

Multiple sources are used to identify potential improvement projects based on continuous analysis of information which comes to staff and standing committees through either employee, provider, or patient experience surveys, patient safety events, observed needs or problems, member complaints or the evaluation of errors or events.

The final decision on the priority of projects in the annual work plan is made by quality leaders and takes into consideration the organization's strategic plan. In this manner, staff are working on and contributing to a "living work plan", in which objectives, goals and/or activities may require adjustment as needs change based on measurement of effectiveness, business planning or budget constraints. Designated team leaders or subcommittee members report periodically to the either the Quality and Patient Safety Committee or other committees, as appropriate. The categories of focus and aims are:



Accreditation & Regulatory Compliance

SCOPE OF WORK

The goal of Regulatory and Accreditation is to lay the foundation for ongoing compliance and sustained survey readiness. This is achieved through the utilization of tracer methodology, on-going process improvement and education to leadership and staff.

Renown Regional & Renown South Meadows Medical Centers are accredited by The Joint Commission (TJC), an independent not-for-profit organization committed to ensuring safe and effective care is being provided in healthcare organizations.

The Renown Rehabilitation Hospital is accredited by The Commission on Accreditation of Rehabilitation Facilities (CARF). CARF is a nonprofit accreditor of health and human services focused on advancing the quality of services to ensure to best possible outcome.

FY22 Objectives

- Structured Continual Readiness Plan
    - Hospital
    - Inpatient Rehabilitation
- Leadership Boot camp
- Ongoing Surveillance of Regulations
- Integrate Diversity

Clinical Excellence

Scope of Work

Within the acute care setting, the clinical excellence department provides support for several key process improvement initiatives: 1) Quality Management Event Review, 2) Medical Staff Departmental Case Review, and 3) Data Collection & Analysis.

FY22 Objectives

- Reduce Inpatient & 30 Day Mortality - Regional and South Meadows
- Reduce 30 Day All Cause Readmission Rate - Regional and South Meadows
- Decrease Iatrogenic Pneumothorax Rate - Regional and South Meadows
- Decrease Post-Operative PE/DVT Rate- Regional & South Meadows
- Increase Discharge to Community Rate– Rehab
- Decrease Discharge to Acute Rate- Rehab

Tactics

Mortality	Readmissions	Patient Safety Indicators	Rehab
• Collaboration with Clinical Documentation Improvement & Coding • Right level of care • End of life care planning • Multidisciplinary Committee	• Post acute placement • Remote home monitoring • Multidisciplinary Committee	• Collaboration with Clinical Documentation Improvement & Coding • 100% physician review	• Expansion of consulting service to include neurology & pulmonary • Adding neuropsychologist • Establish discharge plan early

Metrics

RRMC Metrics	Description	FY21 Baseline	FY22 Target
Inpatient Mortality O/E	Comparison of observed to expected mortality for Medicare inpatient encounters	1.46	1.15
CABG 30 Day Mortality Rate	Percentage of Medicare patients that expire within 30 days of a previous inpatient admission for CABG.	0%	Maintain below benchmark 2.9%
AMI 30 Day Mortality Rate	Percentage of Medicare patients that expire within 30 days of a previous inpatient admission where the primary diagnosis was AMI.	11.1%	Maintain below benchmark 12.3%
CHF 30 Day Mortality Rate	Percentage of Medicare patients that expire within 30 days of a previous inpatient admission where the primary diagnosis was CHF.	9.09%	Maintain below benchmark 11.2%

Pneumonia 30 Day Mortality Rate	Percentage of Medicare patients that expire within 30 days of a previous inpatient admission where the primary diagnosis was pneumonia.	21.3%	15.3%
COPD 30 Day Mortality Rate	Percentage of Medicare patients that expire within 30 days of a previous inpatient admission where the primary diagnosis was COPD.	7.58%	Maintain below benchmark 8.10%
30 Day All Cause Readmissions	Percentage of non-elective Medicare inpatient readmissions within 30 days of a previous inpatient admission.	11.1%	Maintain below benchmark 15.5%
PSI 06: Iatrogenic Pneumothorax Rate	Iatrogenic pneumothorax cases (secondary diagnosis) per 1,000 surgical and medical discharges for patients ages 18 years and older.	0.43	.25
PSI 12: Perioperative PE/DVT Rate	Perioperative pulmonary embolism or proximal deep vein thrombosis (secondary diagnosis) per 1,000 surgical discharges for patients ages 18 years and older.	2.90	Maintain below benchmark 3.74

SMMC Metrics	Description	FY21 Baseline	FY22 Target
Inpatient Mortality O/E	Comparison of observed to expected mortality for Medicare inpatient encounters	1.16	0.88
30 Day All Cause Readmissions	Percentage of non-elective Medicare inpatient readmissions within 30 days of a previous inpatient admission.	12.4%	Maintain below benchmark 15.5%
CHF 30 Day Mortality Rate	Percentage of Medicare patients that expire within 30 days of a previous inpatient admission where the primary diagnosis was CHF.	9.86%	Maintain below benchmark 11.2%
Pneumonia 30 Day Mortality Rate	Percentage of Medicare patients that expire within 30 days of a previous inpatient admission where the primary diagnosis was pneumonia.	17.17%	15.3%
COPD 30 Day Mortality Rate	Percentage of Medicare patients that expire within 30 days of a previous inpatient admission where the primary diagnosis was COPD.	4.76%	Maintain below benchmark 8.10%
PSI 06: Iatrogenic Pneumothorax Rate	Iatrogenic pneumothorax cases (secondary diagnosis) per 1,000 surgical and medical discharges for patients ages 18 years and older.	0	Maintain below benchmark 0.25
PSI 12: Perioperative PE/DVT Rate	Perioperative pulmonary embolism or proximal deep vein thrombosis (secondary diagnosis) per 1,000 surgical discharges for patients ages 18 years and older.	3.24	Maintain below benchmark 3.74

Rehab Metrics	Description	FY21 Baseline	FY22 Target
Discharge to Acute	Rate of rehab patients requiring transfer to an acute care hospital for greater than 3 midnights.	7.8%	Maintain below

			benchmark 8.3%
Discharge to Community	Rate of patients who are discharged to a CMS defined level of community.	82.6%	83.1%

Patient Safety

Scope of Work

Within the acute care setting, the Infection Prevention and Safety departments provide support for several key safety processes: 1) Prevention of hospital-associated infections and 2) Prevention of serious patient safety events 3) Prevention of violence in the workplace

FY22 OBJECTIVES

- Reduce Colon Surgical Site Infections- Regional
- Reduce Blood Stream Infections (CLABSI & MRSA)
- Reduce Hospital Acquired Injuries
- Reduce Serious Patient Safety Events (Sentinel Events)
- Reduce Workplace Violence Events

Tactics

Hospital Acquired Infections	Hospital Acquired Injuries	Sentinel Events
• Eliminate clinical variation • Monitor bundle compliance • Infection prevention champions	• Fall prevention committee • Fall prevalence rounds monthly	• Safety Roundtable • Root Cause Analysis

Metrics

RRMC Metrics	Description	FY21 Baseline	FY22 Target
Colon Surgical Site Infections	Standardized Infection Ratio(SIR) NHSN	0.785	Maintain Below Benchmark (0.86)
CLABSI	Standardized Infection Ratio(SIR) NHSN	0.784	0.69
MRSA Bloodstream Infections	Standardized Infection Ratio(SIR) NHSN	0.872	0.82
Hospital Acquired Injuries	Falls and trauma per 1,000 patient discharges, CMS HAC reporting	0.469	0.454
Sentinel Event Rate	# of Sentinel Events per 1000 equivalent patient days.	0.08	Decrease by 20%

SMMC Metrics	Description	FY21 Baseline	FY22 Target
Colon Surgical Site Infections	Standardized Infection Ratio-NHSN	1	0

CLABSI	Standardized Infection Ratio(SIR) NHSN	0.825	0.82
MRSA Bloodstream Infections	# of MRSA bloodstream infections	1	0
Hospital Acquired Injuries	Falls and trauma per 1,000 patient discharges, CMS HAC reporting	0	Maintain Below Benchmark (0.454)
Sentinel Event Rate	# of Sentinel Events per 1000 equivalent patient days.	0.13	Decrease by 20%

Rehab Metrics	Description	FY21 Baseline	FY22 Target
CAUTI	Standardized Infection Ratio(SIR) NHSN	0	Maintain ZERO
Falls	# of falls	84	0
Hospital Acquired Pressure Ulcers	# of HAPI's	7	0
Sentinel Event Rate	# of Sentinel Events per 1000 equivalent patient days.	0	Maintain ZERO

Acute Care Metrics	Description	FY21 Baseline	FY22 Target
Workplace Violence Events	# of reported events	132	Decrease by 10%

FY21 Annual Summary

	FY20	FY21	Target	Change
Mortality O/E- Regional	1.38	1.35	1.24	
Mortality O/E- South Meadows	0.67	1.09	1.0	
30 Day All Cause Readmissions- Regional	10.8%	11.1%	15.6%	
30 Day All Cause Readmissions- South Meadows	10.9%	12.4%	15.6%	
PSI 6- Iatrogenic Pneumothorax- Regional	0.82	0.24	0.25	
PSI 6- Iatrogenic Pneumothorax- South Meadows	1.46	0.0	0.25	
PSI 12- Post Op PE/DVT- Regional	3.88	3.11	3.76	
PSI 15- Accidental Puncture & Laceration- Regional	4.20	2.79	1.26	
Foreign Object Retained- Regional	0.12	0.04	0	
Colon Surgical Site Infections-Regional	1.72	0.79	0.89	
Colon Surgical Site Infections-South Meadows	1	0	0	
Catheter Associated Urinary Tract Infections- Regional	0.35	0.39	0.74	
Catheter Associated Urinary Tract Infections- South Meadows	0.78	0.71	0.74	
Falls with Serious Patient Harm- Acute	4	10	0	
Serious Patient Safety Events (Sentinel Events)- Acute	28	32	0	
Rehab: Admit to Referral	5.1	7.0	4.0	

Appendix: Quality Committees

Quality and Professional Affairs Subcommittee of the Board (QPA)

Cadence
Bi-Monthly

Purpose
The Quality & Professional Affairs Committee shall be a standing committee of the Renown Health Concurrent Board of Directors. The primary purpose of the committee shall be to assist the Board of Directors in overseeing:

> (i) medical staff and management's identification and evaluation of the health system's principal aim of building a culture that continuously seeks to foster continuous improvement of integrated health care services, including the health system quality and risk reduction plans and the monitoring of practices employed to manage safe, effective and person centered care across all services, and (ii) the health system's ethics and federal, state and voluntary health regulatory programs.

Function
Quality, safety, and service are responsibilities that extend from the frontline to the Board. In collaboration with the Boards and medical staff, the Renown Health Leadership Team has ultimate accountability for ensuring quality, safety, and service excellence throughout the health system. The Quality & Professional Affairs Committee is responsible for ensuring the priorities of quality, safety, and service are aligned with the strategic priorities of the health system. In addition, responsibilities of committee members include:

- Practicing a culture of openness and transparency and creating shared values, fairness, and ethical practice at all levels throughout the health system.
- Maintaining awareness of emerging quality of care issues, challenges, and opportunities.
- Validating the development of data-driven, patient-focused metrics in clinical outcomes, safety, and patient experience.
- Ensuring medical staff and leadership accountability for program quality and performance.
- Monitoring regulatory adherence across the health system.
- Supporting the organization's participation in deemed status reviews for federally funded reimbursement programs which ensure the link between organizational objectives and national quality and safety standards.
- When necessary, recommending new policies or policy revisions for approval by the Renown Health Board.

Composition
The number of members and the identity of the members of the Quality & Professional Affairs Committee, who, except for the chair, need not be members of the Renown Health Board, shall be determined by appropriate resolutions of the Renown Health Board adopted from time to

time, provided, however, that the following positions serve as ex-officio voting members on the Committee: (i) Renown Regional Medical Center Chief of Staff; and (ii) Renown South Meadows Medical Center Chief of Staff. The Governance & Nominating Committee of the Renown Health Board shall nominate the chair and members of the Quality & Professional Affairs Committee, subject to the consent and approval of the Renown Health Board.

System Quality Council (SQC)

Cadence
Bi-Monthly

Purpose
The purpose of System Quality Council (SQC) is to provide a system-wide quality and safety working group for three Renown quality committees including the respective Acute Care and Health Services Quality and Patient Safety Committees and the Joint Medical Quality and Safety Improvement (MSQI) committee. A critical role for the council is providing both oversight and resolution of unresolved issues of these three committees and escalating those to key executive stakeholders, assigning escalated issue ownership and resolution timeline if possible. The scope of the committee is inclusive of the three reporting quality committees, and as directed by QPA or the CEO of Renown Health. The SQC reports to the Quality and Professional Affairs (QPA) Subcommittee of the Board of Directors.

Function
- Identify opportunities for improvement that translate across the entire health system
- Review current and trending publicly reported data (CMS Stars/Leapfrog/US News and World Report) for the Acute and Health Services Divisions
- Serve as a point of escalation for barriers/delays in resolution of quality issues
- Report to QPA progress on goals/priorities/timelines for quality or safety issues from the JQC
- Evaluate and monitor performance indicators that are benchmarked against top-performing organizations and assist the organization to achieve targets
- When appropriate make recommendations to QPSC and MSQI to facilitate achievement of annual targets
- Reprioritize improvement efforts and network priorities in response to internal or external requirements, changing regulatory demands, new expectations, sentinel events, and new knowledge or information

Membership
CEO, Renown Regional
CEO/Administrator, South Meadows & Rehab Hospital
Chief Medical Officer, Acute Care
Chief Medical Officer, Health Services
Chief Nursing Officer, Acute Care

Chief Nursing Quality Officer, Health Services
Chief Quality Officer, Acute Care
Acute Care Physician Representative
Health Services Physician Representative
Renown Regional Chief of Staff
South Meadows Chief of Staff
MSQI Chairs
Director of Clinical Excellence, Acute
Director of Clinical Excellence, Health Services

Medical Staff Quality Improvement Committee

Cadence
Monthly

Primary Functions
The purpose of the Medical Staff Quality Improvement Committee (MSQI) is to monitor, review, and report on the activities of the medical staff quality program as defined by the Medical Executive Committee (MEC). The MSQI committee reports to the MEC, identifying and prioritizing opportunities for improvement.
The Committee's critical work is to develop a plan for outcome improvement and monitor performance. The Committee's culture must be one of robust engagement, marked by high standards and a willingness to ask hard questions of peers and staff. Essential to its success are data analysis, a commitment to transparency and hearing the voice of the patient.

Responsibilities
- Identify opportunities for improvement through evaluation of quality, safety, experience & outcomes data.
- Understand the medical staff's and administration's approach to and methods of performance improvement;
- Assist the hospital to ensure that important processes and activities to improve performance and patient safety are measured, assessed, and spread systematically across all disciplines throughout the hospital;
- Participate as requested in identifying and managing sentinel events and events that warrant intensive analysis; and
- Participate as requested in the hospital's patient safety program including measuring, analyzing, and managing variation in the processes that affect patient care to help reduce medical/healthcare errors.
- Identify priorities for improvement and collaborate with the Acute Care Quality Department to develop outcome improvement plans utilizing the Plan-Do-Study-Act (PDSA) model.
- Report to the MEC progress related to identified goals/priorities.
- Evaluate and monitor key performance indicators that are benchmarked against top-performing organizations and assist the organization to achieve targets.

- Recommend programs, activities and/or processes to the medical staff(s) to facilitate achievement of annual targets
- Cultivate philosophical and cultural changes required for successful collaboration to improve performance.
- Reprioritize improvement efforts and network priorities in response to internal or external requirements, changing regulatory demands, new expectations, sentinel events, and new knowledge or information.

Membership

Voting Members:

Co-Chairs: Regional Quality Chair
South Meadows Quality Chair
Renown Regional Chief of Staff
South Meadows Chief of Staff
Regional Members- 5
South Meadows Members- 3
Academic Member

Staff:

CEO, Renown Regional
CEO, South Meadows & Rehab
Chief Medical Officer, Acute Care
Chief Nursing Officer, Acute Care
VP of Quality
Director of Clinical Excellence, Acute Care

Acute Quality and Patient Safety Committee

Cadence

Monthly

Primary Function

The Acute Quality and Patient Safety Committee (QPSC) is responsible for ensuring that the mission, vision, and values of Renown Health are achieved through continuous improvement of quality and patient safety. QPSC is responsible for ensuring that the Renown Acute Division provides safe, efficient, effective quality care by evaluating data from numerous sources, including but not limited to serious safety events, sentinel events, event reports, infections prevention and control data, comparative outcome data, accreditation surveys, closed litigation/settlement cases, and culture survey data. The Committee uses these data to set priorities for performance improvement and monitors the effectiveness of these efforts.

Duties and Responsibilities

- Sets goals annually and approves the Quality Improvement and Patient Safety Plan.
- Sets organization-wide priorities for quality improvement and patient safety.
- The QPSC accepts accountability for removing barriers, assigning resources and ensuring implementation and compliance for approved recommendations resulting from analysis of events, data or performance improvement project outcomes.
- Reviews analysis of aggregated, trended data related to quality and patient safety and recommends and monitors actions.
- Recognize and celebrate successful performance improvement efforts and staff actions impacting patient safety.
- Provides regular updates to the System Quality Council (SQC) institutional performance on selected benchmarks, performance improvement projects, compliance with regulatory requirements, and sentinel events.
- The Committee reports to the System Quality Council (SQC) and is responsible to the System's leadership for assuring appropriate oversight for quality and patient safety.

Membership

VP of Quality, Acute Care
Chief Medical Officer, Acute Care
CEO, Renown Regional
CEO/Administrator, South Meadows & Rehab
Chief Nursing Officer, Acute Care
Acute Care Directors

Renown Acute Services Division

FY22 Quality & Patient Safety Plan

Approved by	Approval dates
Acute Care Quality and Patient Safety Committee (QPSC)	9/8/2021 (send out)
Medical Staff Quality Improvement Committee	9/8/2021 (send out)
System Quality Committee (SQC)	9/13/2021 (send out)
Quality and Professional Affairs Subcommittee of the Board (QPA)	9/21/2021 (in meeting)

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Introduction

In alignment with our mission to make a genuine difference in the health and well-being of the people and communities we serve, we aim to ensure that quality, safety, and service are the standards that differentiate us in the marketplace. We strive to be recognized as an organization that provides highly reliable care as evidenced by a commitment to quality and safety throughout the entire health system from the frontline to the Board. The Renown Acute Division includes Renown Regional Medical Center, South Meadows Medical Center & the Renown Rehabilitation Hospital. This Quality Plan was established to provide structure around quality, safety, regulatory and accreditation for the Acute Care division.

Renown Acute Care Services Quality Program

To ensure that the Quality Program maintains a constant focus and remains aligned with our strategic plan and organizational objectives, program goals and a framework, including four core domains have been identified:

- Reduction of Clinical Variation
- Infrastructure Optimization
- Innovation Investments
- Network Development and Integration

Mission and Vision

Mission

Renown Health makes a genuine difference in the health and well-being of the people and communities we serve. These important words were carefully selected and lay our foundation for future success:

- We make a genuine difference.
- We are about the people and communities we serve.
- We care about health — and not just illness care.

Vision

Renown Health, with our partners, will inspire better health in our communities.

- We inspire being and staying healthy — even as we restore health for those in need.
- We take an active role in community initiatives, with a renewed focus on the underserved.
- We will have many partners because we cannot do it alone.
- We address our community's biggest health needs. Together.

Values

Our values are the words we live by:

- We are caring and compassionate.
- We demonstrate respect and integrity.
- We collaborate with our patients, families, physicians and communities.
- We strive for excellence in all we do.

Program Structure

Scope

1. Renown Health puts quality and patient safety first in every decision.
2. The patient and family are at the center of everything we do.
3. There is information sharing and accountability between Governance and Operations
4. We have a culture of quality improvement that empowers all employees and providers to critically analyze opportunities for process and performance improvement and collaboratively derive solutions for evaluation and implementation.
5. We routinely examine the culture of safety throughout the organization and focus on data-driven improvement at both the system and local levels.
6. We focus on the reduction of variation to improve individual patient outcomes in the context of population health.

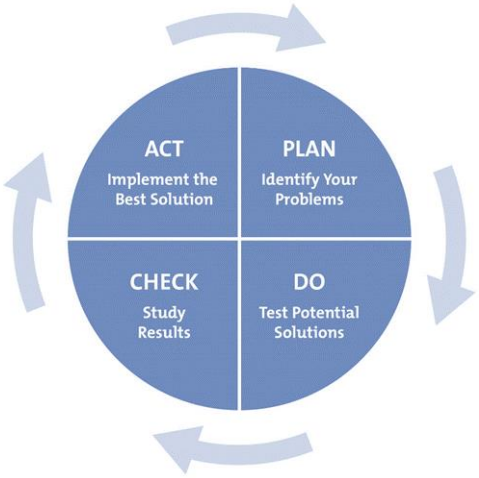
Quality Assurance Performance Improvement (QAPI)

QAPI is the coordinated application of two mutually-reinforcing aspects of a quality management system: Quality Assurance (QA) and Performance Improvement (PI). QAPI takes a systematic, comprehensive, and data-driven approach to maintaining and improving safety and quality, including the monitoring and evaluation of activities and outcomes which address patients of all ages served by Renown Regional Medical Center, Renown South Meadows Medical Center and Renown Rehabilitation Hospital.

Quality Assurance (QA) is on-going and the efforts are both anticipatory and retrospective to ensure that the standards for quality, safety and service outcomes are met and maintained. Renown utilizes both internal and external data sources to measure and assess the quality of care delivered. Data and action plans are presented at the Acute Care Quality & Patient Safety Committee (QPSC) on a regular basis where priorities are established by leadership and outcomes are monitored.

Performance Improvement (PI) is the continuous study and improvement of processes. A key tenet of continuous improvement is use of the Plan, Do, Check, Act (PDCA) Cycle. Once a team has set an aim, established its membership, and developed measures to determine whether a change leads to an improvement, the next step is to test a change in the real work setting. The PDCA

cycle is shorthand for testing a change—by planning it, trying it, observing the results, and acting on what is learned. This is the scientific method, used for action-oriented learning.



Renown Health utilizes the A3 process to provide structure for and documentation of continuous improvement efforts related to public transparency. This process enables key stakeholders to actively collaborate on the purpose, goals, and strategy of a project. It encourages in-depth problem solving throughout the process and adjusting as needed to ensure that the project most accurately meets our objectives. The steps in the process follow the Plan-Do-Check-Act (PDCA) cycle and include:

1. Identify the problem or need
2. Understand the current situation/state
3. Develop the goal statement
4. Perform root cause analysis
5. Brainstorm/determine countermeasures
6. Create a countermeasures implementation plan
7. Check results
8. Update standard work

Public Transparency (CMS Star Ratings & Leapfrog Safety Grades)

Renown Acute Care Services is committed to improving measures selected by both CMS and The Leapfrog Group through engagement of key stakeholders in process improvement. Individual metrics have been assigned to the appropriate operational and/or physician leader. This supports the transparency of data and actionable tactics to drive improvement.

CMS Hospital Quality Initiatives

Hospital Compare is part of the Centers for Medicare & Medicaid Services (CMS) Hospital Quality Initiative. The Hospital Quality Initiative uses a variety of tools to help hospitals improve the

quality of care they deliver. The aim is to help hospitals easily understand performance data and quality information from the patient's perspective.

Renown Health uses Hospital Compare and the Hospital Quality Initiative to help drive quality, safety and service. This system looks at a variety of measures that result in a Star rating for the hospital (1-5). These measures include:

1. Mortality
2. Safety of Care
3. Readmission
4. Patient Experience
5. Effectiveness of Care
6. Timeliness of Care
7. Efficient Use of Medical Imaging

Leapfrog Hospital Grades & Reporting

As a not-for-profit entity the Leapfrog Group promotes safety and quality through data transparency reflecting hospital performance in key areas. Leapfrog rates hospitals through its two main initiatives: The Leapfrog Hospital Survey and the Leapfrog Hospital Safety Grade. Renown Health participates in the Leapfrog program to further improve quality, safety and service.

Patient Safety

The Renown Health Acute Care Division develops patient safety checklists and patient safety policies to continuously improve quality, safety and service. These are reviewed and approved annually by the Acute Care Quality Patient Safety Committee.

Infection Prevention

The Quality and Patient Safety Plan includes an infection control program that carries out the infection control policy. The Renown Health Infection Prevention Plan and Program is established and approved by the Renown Health Infection Control Committee and approved by the Quality and Professional Affairs Subcommittee of the Board (QPA). Regular reports and updates regarding the Infection Prevention Program are provided to the Acute Services Quality and Patient Safety Committee.

Violence Prevention Committee

The Violence Prevention Committee consists of representatives from different multidisciplinary divisions and departments of all major areas of the facility. The safety and health of personnel, patients and visitors is vital to the organization. Acts of physical violence, intimidation and

harassment, which occur on Renown Health properties, are not tolerated. The committee's mission is preventing workplace violence and creating a safe environment for personnel, patients and visitors.

Data Analysis

Changes are occurring in every corner of health care and data is the single most important asset available to drive change, using information from across functional areas of our organization. Data analysis allows for an assessment of past and current performance and provides an objective look at opportunities for continuous improvement. Our Business Intelligence team is dedicated to helping the organization analyze production data from new angles and different viewpoints. Data analytics clearly demonstrate that actions taken at a process or structural level can influence multiple outcomes and improve care delivery.

Service Excellence

An important component of our quality improvement system is vigilant attention to the voice of the customer. Guided by The Service Excellence Plan, the team aims to advocate for the patient experience, enhance the customer journey and also manage and facilitate the resolutions of the complaints and grievances. Additionally, the department maintains service transparency by capturing real-time feedback, raising awareness, and ensuring access to patient experience data.

Culture of Safety

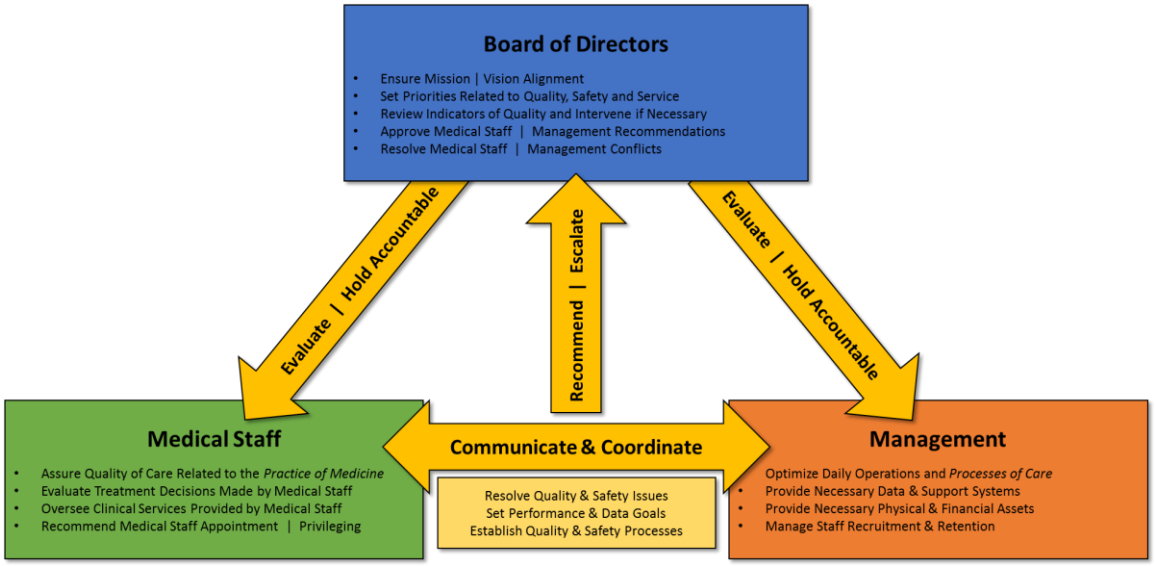
To facilitate the systemic change that is needed to drive transformation all employees must understand their role in the journey. Employee engagement has been consistently and transparently communicated to the entire organization as a key driver of performance. Sustained improvement requires insight into consumer, patient and caregiver needs, as well as, cultural alignment and a commitment to daily execution. Renown Health continues to strive to improve communication and collaboration within its workforce to raise our service levels across the organization and strengthen the cultural environment.

Medical Staff Quality Improvement (MSQI)

The medical staff is integral in the improvement of quality, safety and service. The Medical Staff Quality Improvement or MSQI is responsible for monitoring, reviewing, and reporting on the activities of the medical staff quality program as defined by the Medical Executive Committee (MEC). The critical work of the MSQI is to develop a plan for outcome improvement and monitor performance. The culture must be one of robust engagement, marked by high standards and a willingness to ask hard questions of peers and staff. Essential to its success are data analysis, a commitment to transparency and hearing the voice of the patient.

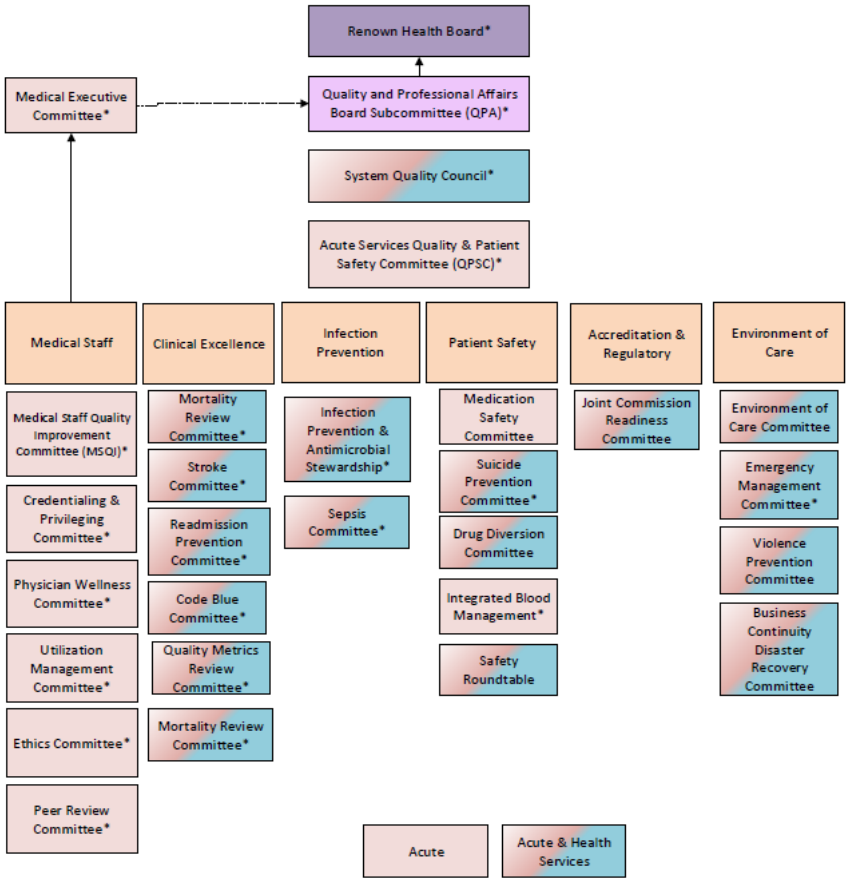
Oversight and Accountability

Renown Health is committed to improving the performance of our health care system. These bodies are responsible for ongoing performance monitoring and assessment to identify organizational quality improvement priorities (see Appendix for additional detail).



In addition to other reporting venues specific to each department and division, data will be presented in the form of dashboards to the Operations Council, Acute Medical Staff Quality Improvement Committee (MSQI), System Quality Council (SQC), Acute Medical Executive Committees (MEC), Acute Quality & Patient Safety Committees (QPSC), and the Quality & Professional Affairs Committee of the Board (QPA) on a monthly basis.

The work of quality and safety is executed through a committee structure with the flexibility to stand up ad-hoc sub-committees and/or task forces to address issues and opportunities as they arise. As noted in the graphic below, many of the committees are cross-divisional allowing for collaboration throughout the health system.



* Indicates Medical Staff Leadership Representation

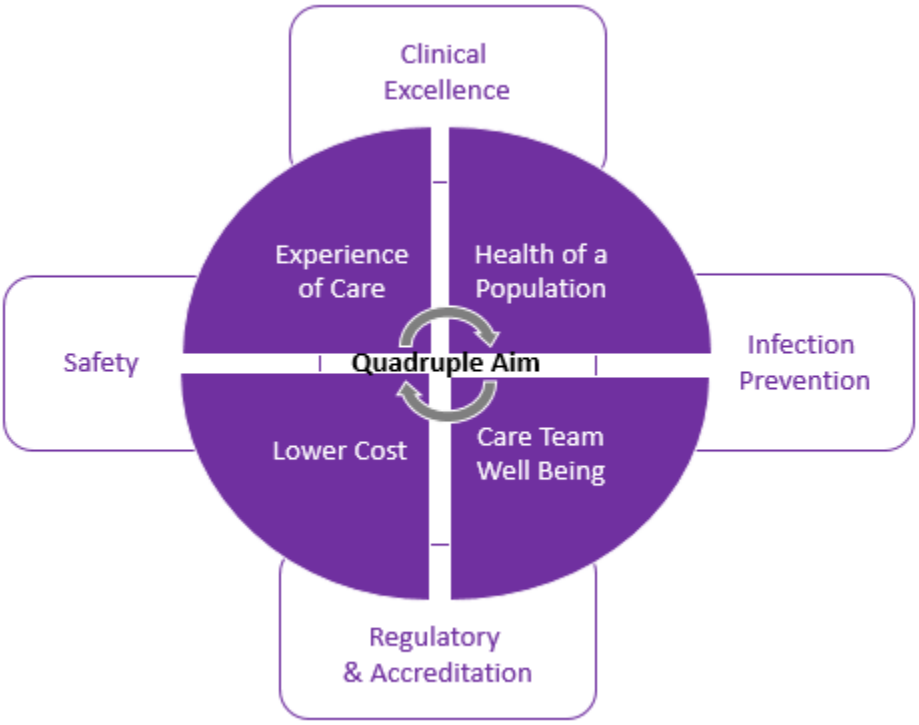
Quality Improvement Resources

The Renown Acute Care Division employs quality coordinators, infection preventionists, a safety program coordinator, an emergency preparedness coordinator and data abstractors who serve as internal resources for performance improvement activities through data analysis, process analysis and redesign and team facilitation throughout the organization. Quality and safety leaders collaborate with operational and medical staff leaders on an ongoing basis to ensure that resources are aligned with activities that will improve the care and experience of patients and clinicians, yield the most improvement in outcomes, and/or impact an area of critical focus related to the health and well-being of the patients and communities we serve.

Annual Work Plan

Multiple sources are used to identify potential improvement projects based on continuous analysis of information which comes to staff and standing committees through either employee, provider, or patient experience surveys, patient safety events, observed needs or problems, member complaints or the evaluation of errors or events.

The final decision on the priority of projects in the annual work plan is made by quality leaders and takes into consideration the organization's strategic plan. In this manner, staff are working on and contributing to a "living work plan", in which objectives, goals and/or activities may require adjustment as needs change based on measurement of effectiveness, business planning or budget constraints. Designated team leaders or subcommittee members report periodically to the either the Quality and Patient Safety Committee or other committees, as appropriate. The categories of focus and aims are:



Accreditation & Regulatory Compliance

SCOPE OF WORK

The goal of Regulatory and Accreditation is to lay the foundation for ongoing compliance and sustained survey readiness. This is achieved through the utilization of tracer methodology, on-going process improvement and education to leadership and staff.

Renown Regional & Renown South Meadows Medical Centers are accredited by The Joint Commission (TJC), an independent not-for-profit organization committed to ensuring safe and effective care is being provided in healthcare organizations.

The Renown Rehabilitation Hospital is accredited by The Commission on Accreditation of Rehabilitation Facilities (CARF). CARF is a nonprofit accreditor of health and human services focused on advancing the quality of services to ensure to best possible outcome.

FY22 Objectives

- Structured Continual Readiness Plan
    - Hospital
    - Inpatient Rehabilitation
- Leadership Boot camp
- Ongoing Surveillance of Regulations
- Integrate Diversity

Clinical Excellence

Scope of Work

Within the acute care setting, the clinical excellence department provides support for several key process improvement initiatives: 1) Quality Management Event Review, 2) Medical Staff Departmental Case Review, and 3) Data Collection & Analysis.

FY22 Objectives

- Reduce Inpatient & 30 Day Mortality - Regional and South Meadows
- Reduce 30 Day All Cause Readmission Rate - Regional and South Meadows
- Decrease Iatrogenic Pneumothorax Rate - Regional and South Meadows
- Decrease Post-Operative PE/DVT Rate- Regional & South Meadows
- Increase Discharge to Community Rate– Rehab
- Decrease Discharge to Acute Rate- Rehab

Tactics

Mortality	Readmissions	Patient Safety Indicators	Rehab
• Collaboration with Clinical Documentation Improvement & Coding • Right level of care • End of life care planning • Multidisciplinary Committee	• Post acute placement • Remote home monitoring • Multidisciplinary Committee	• Collaboration with Clinical Documentation Improvement & Coding • 100% physician review	• Expansion of consulting service to include neurology & pulmonary • Adding neuropsychologist • Establish discharge plan early

Metrics

RRMC Metrics	Description	FY21 Baseline	FY22 Target
Inpatient Mortality O/E	Comparison of observed to expected mortality for Medicare inpatient encounters	1.46	1.15
CABG 30 Day Mortality Rate	Percentage of Medicare patients that expire within 30 days of a previous inpatient admission for CABG.	0%	Maintain below benchmark 2.9%
AMI 30 Day Mortality Rate	Percentage of Medicare patients that expire within 30 days of a previous inpatient admission where the primary diagnosis was AMI.	11.1%	Maintain below benchmark 12.3%
CHF 30 Day Mortality Rate	Percentage of Medicare patients that expire within 30 days of a previous inpatient admission where the primary diagnosis was CHF.	9.09%	Maintain below benchmark 11.2%

Pneumonia 30 Day Mortality Rate	Percentage of Medicare patients that expire within 30 days of a previous inpatient admission where the primary diagnosis was pneumonia.	21.3%	15.3%
COPD 30 Day Mortality Rate	Percentage of Medicare patients that expire within 30 days of a previous inpatient admission where the primary diagnosis was COPD.	7.58%	Maintain below benchmark 8.10%
30 Day All Cause Readmissions	Percentage of non-elective Medicare inpatient readmissions within 30 days of a previous inpatient admission.	11.1%	Maintain below benchmark 15.5%
PSI 06: Iatrogenic Pneumothorax Rate	Iatrogenic pneumothorax cases (secondary diagnosis) per 1,000 surgical and medical discharges for patients ages 18 years and older.	0.43	.25
PSI 12: Perioperative PE/DVT Rate	Perioperative pulmonary embolism or proximal deep vein thrombosis (secondary diagnosis) per 1,000 surgical discharges for patients ages 18 years and older.	2.90	Maintain below benchmark 3.74

SMMC Metrics	Description	FY21 Baseline	FY22 Target
Inpatient Mortality O/E	Comparison of observed to expected mortality for Medicare inpatient encounters	1.16	0.88
30 Day All Cause Readmissions	Percentage of non-elective Medicare inpatient readmissions within 30 days of a previous inpatient admission.	12.4%	Maintain below benchmark 15.5%
CHF 30 Day Mortality Rate	Percentage of Medicare patients that expire within 30 days of a previous inpatient admission where the primary diagnosis was CHF.	9.86%	Maintain below benchmark 11.2%
Pneumonia 30 Day Mortality Rate	Percentage of Medicare patients that expire within 30 days of a previous inpatient admission where the primary diagnosis was pneumonia.	17.17%	15.3%
COPD 30 Day Mortality Rate	Percentage of Medicare patients that expire within 30 days of a previous inpatient admission where the primary diagnosis was COPD.	4.76%	Maintain below benchmark 8.10%
PSI 06: Iatrogenic Pneumothorax Rate	Iatrogenic pneumothorax cases (secondary diagnosis) per 1,000 surgical and medical discharges for patients ages 18 years and older.	0	Maintain below benchmark 0.25
PSI 12: Perioperative PE/DVT Rate	Perioperative pulmonary embolism or proximal deep vein thrombosis (secondary diagnosis) per 1,000 surgical discharges for patients ages 18 years and older.	3.24	Maintain below benchmark 3.74

Rehab Metrics	Description	FY21 Baseline	FY22 Target
Discharge to Acute	Rate of rehab patients requiring transfer to an acute care hospital for greater than 3 midnights.	7.8%	Maintain below

			benchmark 8.3%
Discharge to Community	Rate of patients who are discharged to a CMS defined level of community.	82.6%	83.1%

Patient Safety

Scope of Work

Within the acute care setting, the Infection Prevention and Safety departments provide support for several key safety processes: 1) Prevention of hospital-associated infections and 2) Prevention of serious patient safety events 3) Prevention of violence in the workplace

FY22 OBJECTIVES

- Reduce Colon Surgical Site Infections- Regional
- Reduce Blood Stream Infections (CLABSI & MRSA)
- Reduce Hospital Acquired Injuries
- Reduce Serious Patient Safety Events (Sentinel Events)
- Reduce Workplace Violence Events

Tactics

Hospital Acquired Infections	Hospital Acquired Injuries	Sentinel Events
• Eliminate clinical variation • Monitor bundle compliance • Infection prevention champions	• Fall prevention committee • Fall prevalence rounds monthly	• Safety Roundtable • Root Cause Analysis

Metrics

RRMC Metrics	Description	FY21 Baseline	FY22 Target
Colon Surgical Site Infections	Standardized Infection Ratio(SIR) NHSN	0.785	Maintain Below Benchmark (0.86)
CLABSI	Standardized Infection Ratio(SIR) NHSN	0.784	0.69
MRSA Bloodstream Infections	Standardized Infection Ratio(SIR) NHSN	0.872	0.82
Hospital Acquired Injuries	Falls and trauma per 1,000 patient discharges, CMS HAC reporting	0.469	0.454
Sentinel Event Rate	# of Sentinel Events per 1000 equivalent patient days.	0.08	Decrease by 20%

SMMC Metrics	Description	FY21 Baseline	FY22 Target
Colon Surgical Site Infections	Standardized Infection Ratio-NHSN	1	0

CLABSI	Standardized Infection Ratio(SIR) NHSN	0.825	0.82
MRSA Bloodstream Infections	# of MRSA bloodstream infections	1	0
Hospital Acquired Injuries	Falls and trauma per 1,000 patient discharges, CMS HAC reporting	0	Maintain Below Benchmark (0.454)
Sentinel Event Rate	# of Sentinel Events per 1000 equivalent patient days.	0.13	Decrease by 20%

Rehab Metrics	Description	FY21 Baseline	FY22 Target
CAUTI	Standardized Infection Ratio(SIR) NHSN	0	Maintain ZERO
Falls	# of falls	84	0
Hospital Acquired Pressure Ulcers	# of HAPI's	7	0
Sentinel Event Rate	# of Sentinel Events per 1000 equivalent patient days.	0	Maintain ZERO

Acute Care Metrics	Description	FY21 Baseline	FY22 Target
Workplace Violence Events	# of reported events	132	Decrease by 10%

FY21 Annual Summary

	FY20	FY21	Target	Change
Mortality O/E- Regional	1.38	1.35	1.24	
Mortality O/E- South Meadows	0.67	1.09	1.0	
30 Day All Cause Readmissions- Regional	10.8%	11.1%	15.6%	
30 Day All Cause Readmissions- South Meadows	10.9%	12.4%	15.6%	
PSI 6- Iatrogenic Pneumothorax- Regional	0.82	0.24	0.25	
PSI 6- Iatrogenic Pneumothorax- South Meadows	1.46	0.0	0.25	
PSI 12- Post Op PE/DVT- Regional	3.88	3.11	3.76	
PSI 15- Accidental Puncture & Laceration- Regional	4.20	2.79	1.26	
Foreign Object Retained- Regional	0.12	0.04	0	
Colon Surgical Site Infections-Regional	1.72	0.79	0.89	
Colon Surgical Site Infections-South Meadows	1	0	0	
Catheter Associated Urinary Tract Infections- Regional	0.35	0.39	0.74	
Catheter Associated Urinary Tract Infections- South Meadows	0.78	0.71	0.74	
Falls with Serious Patient Harm- Acute	4	10	0	
Serious Patient Safety Events (Sentinel Events)- Acute	28	32	0	
Rehab: Admit to Referral	5.1	7.0	4.0	

Appendix: Quality Committees

Quality and Professional Affairs Subcommittee of the Board (QPA)

Cadence
Bi-Monthly

Purpose
The Quality & Professional Affairs Committee shall be a standing committee of the Renown Health Concurrent Board of Directors. The primary purpose of the committee shall be to assist the Board of Directors in overseeing:

> (i) medical staff and management's identification and evaluation of the health system's principal aim of building a culture that continuously seeks to foster continuous improvement of integrated health care services, including the health system quality and risk reduction plans and the monitoring of practices employed to manage safe, effective and person centered care across all services, and (ii) the health system's ethics and federal, state and voluntary health regulatory programs.

Function
Quality, safety, and service are responsibilities that extend from the frontline to the Board. In collaboration with the Boards and medical staff, the Renown Health Leadership Team has ultimate accountability for ensuring quality, safety, and service excellence throughout the health system. The Quality & Professional Affairs Committee is responsible for ensuring the priorities of quality, safety, and service are aligned with the strategic priorities of the health system. In addition, responsibilities of committee members include:

- Practicing a culture of openness and transparency and creating shared values, fairness, and ethical practice at all levels throughout the health system.
- Maintaining awareness of emerging quality of care issues, challenges, and opportunities.
- Validating the development of data-driven, patient-focused metrics in clinical outcomes, safety, and patient experience.
- Ensuring medical staff and leadership accountability for program quality and performance.
- Monitoring regulatory adherence across the health system.
- Supporting the organization's participation in deemed status reviews for federally funded reimbursement programs which ensure the link between organizational objectives and national quality and safety standards.
- When necessary, recommending new policies or policy revisions for approval by the Renown Health Board.

Composition
The number of members and the identity of the members of the Quality & Professional Affairs Committee, who, except for the chair, need not be members of the Renown Health Board, shall be determined by appropriate resolutions of the Renown Health Board adopted from time to

time, provided, however, that the following positions serve as ex-officio voting members on the Committee: (i) Renown Regional Medical Center Chief of Staff; and (ii) Renown South Meadows Medical Center Chief of Staff. The Governance & Nominating Committee of the Renown Health Board shall nominate the chair and members of the Quality & Professional Affairs Committee, subject to the consent and approval of the Renown Health Board.

System Quality Council (SQC)

Cadence
Bi-Monthly

Purpose
The purpose of System Quality Council (SQC) is to provide a system-wide quality and safety working group for three Renown quality committees including the respective Acute Care and Health Services Quality and Patient Safety Committees and the Joint Medical Quality and Safety Improvement (MSQI) committee. A critical role for the council is providing both oversight and resolution of unresolved issues of these three committees and escalating those to key executive stakeholders, assigning escalated issue ownership and resolution timeline if possible. The scope of the committee is inclusive of the three reporting quality committees, and as directed by QPA or the CEO of Renown Health. The SQC reports to the Quality and Professional Affairs (QPA) Subcommittee of the Board of Directors.

Function
- Identify opportunities for improvement that translate across the entire health system
- Review current and trending publicly reported data (CMS Stars/Leapfrog/US News and World Report) for the Acute and Health Services Divisions
- Serve as a point of escalation for barriers/delays in resolution of quality issues
- Report to QPA progress on goals/priorities/timelines for quality or safety issues from the JQC
- Evaluate and monitor performance indicators that are benchmarked against top-performing organizations and assist the organization to achieve targets
- When appropriate make recommendations to QPSC and MSQI to facilitate achievement of annual targets
- Reprioritize improvement efforts and network priorities in response to internal or external requirements, changing regulatory demands, new expectations, sentinel events, and new knowledge or information

Membership
CEO, Renown Regional
CEO/Administrator, South Meadows & Rehab Hospital
Chief Medical Officer, Acute Care
Chief Medical Officer, Health Services
Chief Nursing Officer, Acute Care

Chief Nursing Quality Officer, Health Services
Chief Quality Officer, Acute Care
Acute Care Physician Representative
Health Services Physician Representative
Renown Regional Chief of Staff
South Meadows Chief of Staff
MSQI Chairs
Director of Clinical Excellence, Acute
Director of Clinical Excellence, Health Services

Medical Staff Quality Improvement Committee

Cadence
Monthly

Primary Functions
The purpose of the Medical Staff Quality Improvement Committee (MSQI) is to monitor, review, and report on the activities of the medical staff quality program as defined by the Medical Executive Committee (MEC). The MSQI committee reports to the MEC, identifying and prioritizing opportunities for improvement.
The Committee's critical work is to develop a plan for outcome improvement and monitor performance. The Committee's culture must be one of robust engagement, marked by high standards and a willingness to ask hard questions of peers and staff. Essential to its success are data analysis, a commitment to transparency and hearing the voice of the patient.

Responsibilities
- Identify opportunities for improvement through evaluation of quality, safety, experience & outcomes data.
- Understand the medical staff's and administration's approach to and methods of performance improvement;
- Assist the hospital to ensure that important processes and activities to improve performance and patient safety are measured, assessed, and spread systematically across all disciplines throughout the hospital;
- Participate as requested in identifying and managing sentinel events and events that warrant intensive analysis; and
- Participate as requested in the hospital's patient safety program including measuring, analyzing, and managing variation in the processes that affect patient care to help reduce medical/healthcare errors.
- Identify priorities for improvement and collaborate with the Acute Care Quality Department to develop outcome improvement plans utilizing the Plan-Do-Study-Act (PDSA) model.
- Report to the MEC progress related to identified goals/priorities.
- Evaluate and monitor key performance indicators that are benchmarked against top-performing organizations and assist the organization to achieve targets.

- Recommend programs, activities and/or processes to the medical staff(s) to facilitate achievement of annual targets
- Cultivate philosophical and cultural changes required for successful collaboration to improve performance.
- Reprioritize improvement efforts and network priorities in response to internal or external requirements, changing regulatory demands, new expectations, sentinel events, and new knowledge or information.

Membership

Voting Members:

Co-Chairs: Regional Quality Chair
South Meadows Quality Chair
Renown Regional Chief of Staff
South Meadows Chief of Staff
Regional Members- 5
South Meadows Members- 3
Academic Member

Staff:

CEO, Renown Regional
CEO, South Meadows & Rehab
Chief Medical Officer, Acute Care
Chief Nursing Officer, Acute Care
VP of Quality
Director of Clinical Excellence, Acute Care

Acute Quality and Patient Safety Committee

Cadence

Monthly

Primary Function

The Acute Quality and Patient Safety Committee (QPSC) is responsible for ensuring that the mission, vision, and values of Renown Health are achieved through continuous improvement of quality and patient safety. QPSC is responsible for ensuring that the Renown Acute Division provides safe, efficient, effective quality care by evaluating data from numerous sources, including but not limited to serious safety events, sentinel events, event reports, infections prevention and control data, comparative outcome data, accreditation surveys, closed litigation/settlement cases, and culture survey data. The Committee uses these data to set priorities for performance improvement and monitors the effectiveness of these efforts.

Duties and Responsibilities

- Sets goals annually and approves the Quality Improvement and Patient Safety Plan.
- Sets organization-wide priorities for quality improvement and patient safety.
- The QPSC accepts accountability for removing barriers, assigning resources and ensuring implementation and compliance for approved recommendations resulting from analysis of events, data or performance improvement project outcomes.
- Reviews analysis of aggregated, trended data related to quality and patient safety and recommends and monitors actions.
- Recognize and celebrate successful performance improvement efforts and staff actions impacting patient safety.
- Provides regular updates to the System Quality Council (SQC) institutional performance on selected benchmarks, performance improvement projects, compliance with regulatory requirements, and sentinel events.
- The Committee reports to the System Quality Council (SQC) and is responsible to the System's leadership for assuring appropriate oversight for quality and patient safety.

Membership

VP of Quality, Acute Care
Chief Medical Officer, Acute Care
CEO, Renown Regional
CEO/Administrator, South Meadows & Rehab
Chief Nursing Officer, Acute Care
Acute Care Directors

Renown Acute Services Division

FY22 Quality & Patient Safety Plan

Approved by	Approval dates
Acute Care Quality and Patient Safety Committee (QPSC)	9/8/2021 (send out)
Medical Staff Quality Improvement Committee	9/8/2021 (send out)
System Quality Committee (SQC)	9/13/2021 (send out)
Quality and Professional Affairs Subcommittee of the Board (QPA)	9/21/2021 (in meeting)

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Introduction

In alignment with our mission to make a genuine difference in the health and well-being of the people and communities we serve, we aim to ensure that quality, safety, and service are the standards that differentiate us in the marketplace. We strive to be recognized as an organization that provides highly reliable care as evidenced by a commitment to quality and safety throughout the entire health system from the frontline to the Board. The Renown Acute Division includes Renown Regional Medical Center, South Meadows Medical Center & the Renown Rehabilitation Hospital. This Quality Plan was established to provide structure around quality, safety, regulatory and accreditation for the Acute Care division.

Renown Acute Care Services Quality Program

To ensure that the Quality Program maintains a constant focus and remains aligned with our strategic plan and organizational objectives, program goals and a framework, including four core domains have been identified:

- Reduction of Clinical Variation
- Infrastructure Optimization
- Innovation Investments
- Network Development and Integration

Mission and Vision

Mission

Renown Health makes a genuine difference in the health and well-being of the people and communities we serve. These important words were carefully selected and lay our foundation for future success:

- We make a genuine difference.
- We are about the people and communities we serve.
- We care about health — and not just illness care.

Vision

Renown Health, with our partners, will inspire better health in our communities.

- We inspire being and staying healthy — even as we restore health for those in need.
- We take an active role in community initiatives, with a renewed focus on the underserved.
- We will have many partners because we cannot do it alone.
- We address our community's biggest health needs. Together.

Values

Our values are the words we live by:

- We are caring and compassionate.
- We demonstrate respect and integrity.
- We collaborate with our patients, families, physicians and communities.
- We strive for excellence in all we do.

Program Structure

Scope

1. Renown Health puts quality and patient safety first in every decision.
2. The patient and family are at the center of everything we do.
3. There is information sharing and accountability between Governance and Operations
4. We have a culture of quality improvement that empowers all employees and providers to critically analyze opportunities for process and performance improvement and collaboratively derive solutions for evaluation and implementation.
5. We routinely examine the culture of safety throughout the organization and focus on data-driven improvement at both the system and local levels.
6. We focus on the reduction of variation to improve individual patient outcomes in the context of population health.

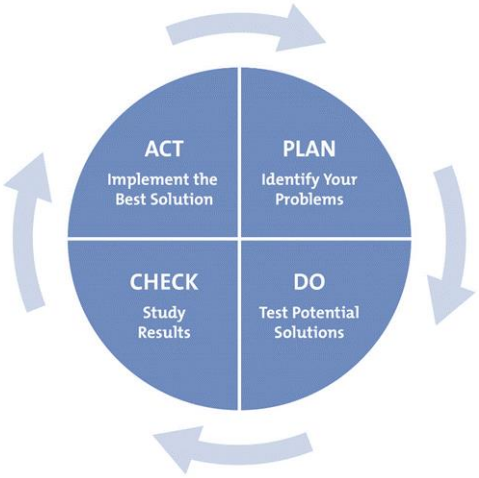
Quality Assurance Performance Improvement (QAPI)

QAPI is the coordinated application of two mutually-reinforcing aspects of a quality management system: Quality Assurance (QA) and Performance Improvement (PI). QAPI takes a systematic, comprehensive, and data-driven approach to maintaining and improving safety and quality, including the monitoring and evaluation of activities and outcomes which address patients of all ages served by Renown Regional Medical Center, Renown South Meadows Medical Center and Renown Rehabilitation Hospital.

Quality Assurance (QA) is on-going and the efforts are both anticipatory and retrospective to ensure that the standards for quality, safety and service outcomes are met and maintained. Renown utilizes both internal and external data sources to measure and assess the quality of care delivered. Data and action plans are presented at the Acute Care Quality & Patient Safety Committee (QPSC) on a regular basis where priorities are established by leadership and outcomes are monitored.

Performance Improvement (PI) is the continuous study and improvement of processes. A key tenet of continuous improvement is use of the Plan, Do, Check, Act (PDCA) Cycle. Once a team has set an aim, established its membership, and developed measures to determine whether a change leads to an improvement, the next step is to test a change in the real work setting. The PDCA

cycle is shorthand for testing a change—by planning it, trying it, observing the results, and acting on what is learned. This is the scientific method, used for action-oriented learning.



Renown Health utilizes the A3 process to provide structure for and documentation of continuous improvement efforts related to public transparency. This process enables key stakeholders to actively collaborate on the purpose, goals, and strategy of a project. It encourages in-depth problem solving throughout the process and adjusting as needed to ensure that the project most accurately meets our objectives. The steps in the process follow the Plan-Do-Check-Act (PDCA) cycle and include:

1. Identify the problem or need
2. Understand the current situation/state
3. Develop the goal statement
4. Perform root cause analysis
5. Brainstorm/determine countermeasures
6. Create a countermeasures implementation plan
7. Check results
8. Update standard work

Public Transparency (CMS Star Ratings & Leapfrog Safety Grades)

Renown Acute Care Services is committed to improving measures selected by both CMS and The Leapfrog Group through engagement of key stakeholders in process improvement. Individual metrics have been assigned to the appropriate operational and/or physician leader. This supports the transparency of data and actionable tactics to drive improvement.

CMS Hospital Quality Initiatives

Hospital Compare is part of the Centers for Medicare & Medicaid Services (CMS) Hospital Quality Initiative. The Hospital Quality Initiative uses a variety of tools to help hospitals improve the

quality of care they deliver. The aim is to help hospitals easily understand performance data and quality information from the patient's perspective.

Renown Health uses Hospital Compare and the Hospital Quality Initiative to help drive quality, safety and service. This system looks at a variety of measures that result in a Star rating for the hospital (1-5). These measures include:

1. Mortality
2. Safety of Care
3. Readmission
4. Patient Experience
5. Effectiveness of Care
6. Timeliness of Care
7. Efficient Use of Medical Imaging

Leapfrog Hospital Grades & Reporting

As a not-for-profit entity the Leapfrog Group promotes safety and quality through data transparency reflecting hospital performance in key areas. Leapfrog rates hospitals through its two main initiatives: The Leapfrog Hospital Survey and the Leapfrog Hospital Safety Grade. Renown Health participates in the Leapfrog program to further improve quality, safety and service.

Patient Safety

The Renown Health Acute Care Division develops patient safety checklists and patient safety policies to continuously improve quality, safety and service. These are reviewed and approved annually by the Acute Care Quality Patient Safety Committee.

Infection Prevention

The Quality and Patient Safety Plan includes an infection control program that carries out the infection control policy. The Renown Health Infection Prevention Plan and Program is established and approved by the Renown Health Infection Control Committee and approved by the Quality and Professional Affairs Subcommittee of the Board (QPA). Regular reports and updates regarding the Infection Prevention Program are provided to the Acute Services Quality and Patient Safety Committee.

Violence Prevention Committee

The Violence Prevention Committee consists of representatives from different multidisciplinary divisions and departments of all major areas of the facility. The safety and health of personnel, patients and visitors is vital to the organization. Acts of physical violence, intimidation and

harassment, which occur on Renown Health properties, are not tolerated. The committee's mission is preventing workplace violence and creating a safe environment for personnel, patients and visitors.

Data Analysis

Changes are occurring in every corner of health care and data is the single most important asset available to drive change, using information from across functional areas of our organization. Data analysis allows for an assessment of past and current performance and provides an objective look at opportunities for continuous improvement. Our Business Intelligence team is dedicated to helping the organization analyze production data from new angles and different viewpoints. Data analytics clearly demonstrate that actions taken at a process or structural level can influence multiple outcomes and improve care delivery.

Service Excellence

An important component of our quality improvement system is vigilant attention to the voice of the customer. Guided by The Service Excellence Plan, the team aims to advocate for the patient experience, enhance the customer journey and also manage and facilitate the resolutions of the complaints and grievances. Additionally, the department maintains service transparency by capturing real-time feedback, raising awareness, and ensuring access to patient experience data.

Culture of Safety

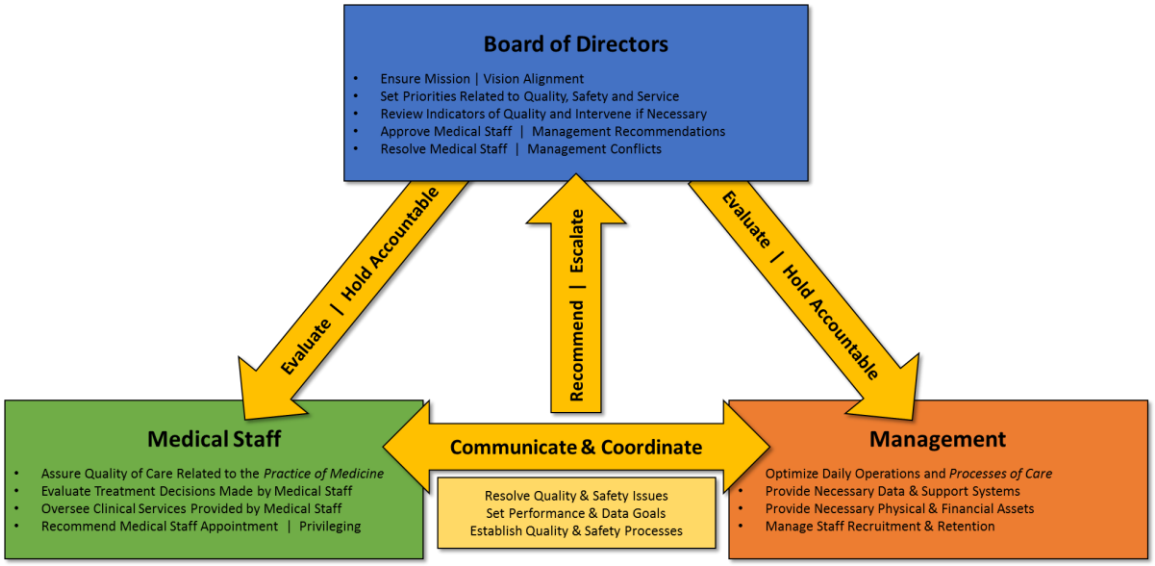
To facilitate the systemic change that is needed to drive transformation all employees must understand their role in the journey. Employee engagement has been consistently and transparently communicated to the entire organization as a key driver of performance. Sustained improvement requires insight into consumer, patient and caregiver needs, as well as, cultural alignment and a commitment to daily execution. Renown Health continues to strive to improve communication and collaboration within its workforce to raise our service levels across the organization and strengthen the cultural environment.

Medical Staff Quality Improvement (MSQI)

The medical staff is integral in the improvement of quality, safety and service. The Medical Staff Quality Improvement or MSQI is responsible for monitoring, reviewing, and reporting on the activities of the medical staff quality program as defined by the Medical Executive Committee (MEC). The critical work of the MSQI is to develop a plan for outcome improvement and monitor performance. The culture must be one of robust engagement, marked by high standards and a willingness to ask hard questions of peers and staff. Essential to its success are data analysis, a commitment to transparency and hearing the voice of the patient.

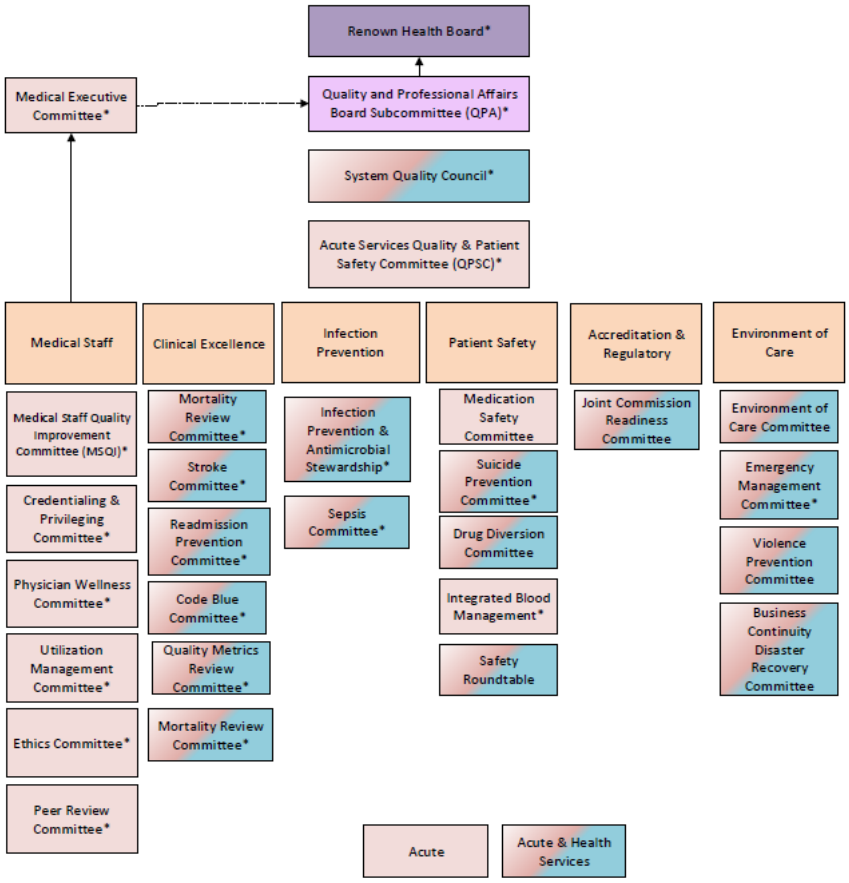
Oversight and Accountability

Renown Health is committed to improving the performance of our health care system. These bodies are responsible for ongoing performance monitoring and assessment to identify organizational quality improvement priorities (see Appendix for additional detail).



In addition to other reporting venues specific to each department and division, data will be presented in the form of dashboards to the Operations Council, Acute Medical Staff Quality Improvement Committee (MSQI), System Quality Council (SQC), Acute Medical Executive Committees (MEC), Acute Quality & Patient Safety Committees (QPSC), and the Quality & Professional Affairs Committee of the Board (QPA) on a monthly basis.

The work of quality and safety is executed through a committee structure with the flexibility to stand up ad-hoc sub-committees and/or task forces to address issues and opportunities as they arise. As noted in the graphic below, many of the committees are cross-divisional allowing for collaboration throughout the health system.



* Indicates Medical Staff Leadership Representation

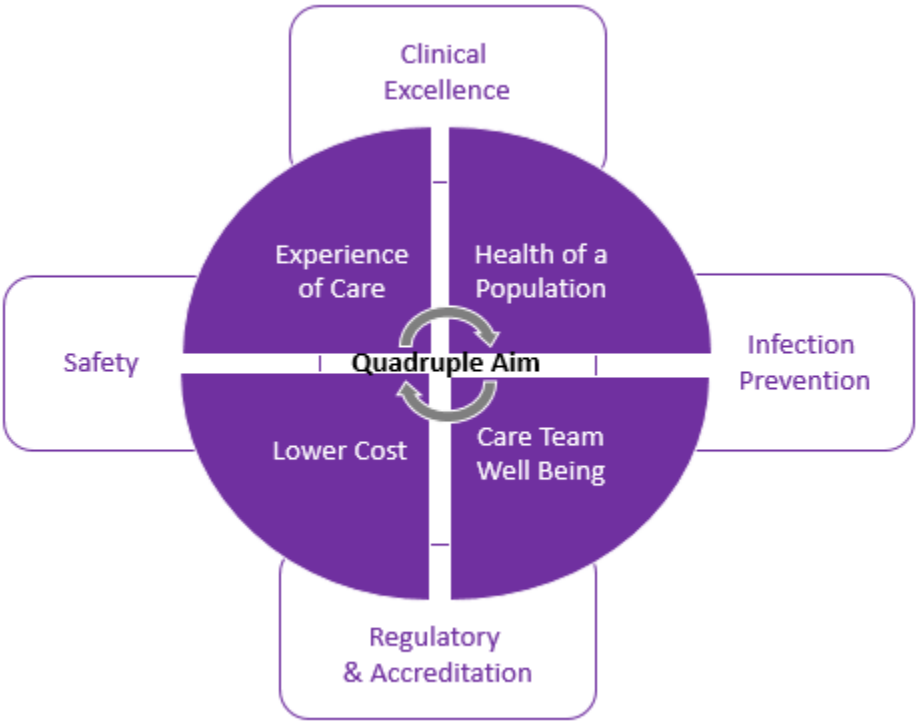
Quality Improvement Resources

The Renown Acute Care Division employs quality coordinators, infection preventionists, a safety program coordinator, an emergency preparedness coordinator and data abstractors who serve as internal resources for performance improvement activities through data analysis, process analysis and redesign and team facilitation throughout the organization. Quality and safety leaders collaborate with operational and medical staff leaders on an ongoing basis to ensure that resources are aligned with activities that will improve the care and experience of patients and clinicians, yield the most improvement in outcomes, and/or impact an area of critical focus related to the health and well-being of the patients and communities we serve.

Annual Work Plan

Multiple sources are used to identify potential improvement projects based on continuous analysis of information which comes to staff and standing committees through either employee, provider, or patient experience surveys, patient safety events, observed needs or problems, member complaints or the evaluation of errors or events.

The final decision on the priority of projects in the annual work plan is made by quality leaders and takes into consideration the organization's strategic plan. In this manner, staff are working on and contributing to a "living work plan", in which objectives, goals and/or activities may require adjustment as needs change based on measurement of effectiveness, business planning or budget constraints. Designated team leaders or subcommittee members report periodically to the either the Quality and Patient Safety Committee or other committees, as appropriate. The categories of focus and aims are:



Accreditation & Regulatory Compliance

SCOPE OF WORK

The goal of Regulatory and Accreditation is to lay the foundation for ongoing compliance and sustained survey readiness. This is achieved through the utilization of tracer methodology, on-going process improvement and education to leadership and staff.

Renown Regional & Renown South Meadows Medical Centers are accredited by The Joint Commission (TJC), an independent not-for-profit organization committed to ensuring safe and effective care is being provided in healthcare organizations.

The Renown Rehabilitation Hospital is accredited by The Commission on Accreditation of Rehabilitation Facilities (CARF). CARF is a nonprofit accreditor of health and human services focused on advancing the quality of services to ensure to best possible outcome.

FY22 Objectives

- Structured Continual Readiness Plan
    - Hospital
    - Inpatient Rehabilitation
- Leadership Boot camp
- Ongoing Surveillance of Regulations
- Integrate Diversity

Clinical Excellence

Scope of Work

Within the acute care setting, the clinical excellence department provides support for several key process improvement initiatives: 1) Quality Management Event Review, 2) Medical Staff Departmental Case Review, and 3) Data Collection & Analysis.

FY22 Objectives

- Reduce Inpatient & 30 Day Mortality - Regional and South Meadows
- Reduce 30 Day All Cause Readmission Rate - Regional and South Meadows
- Decrease Iatrogenic Pneumothorax Rate - Regional and South Meadows
- Decrease Post-Operative PE/DVT Rate- Regional & South Meadows
- Increase Discharge to Community Rate– Rehab
- Decrease Discharge to Acute Rate- Rehab

Tactics

Mortality	Readmissions	Patient Safety Indicators	Rehab
• Collaboration with Clinical Documentation Improvement & Coding • Right level of care • End of life care planning • Multidisciplinary Committee	• Post acute placement • Remote home monitoring • Multidisciplinary Committee	• Collaboration with Clinical Documentation Improvement & Coding • 100% physician review	• Expansion of consulting service to include neurology & pulmonary • Adding neuropsychologist • Establish discharge plan early

Metrics

RRMC Metrics	Description	FY21 Baseline	FY22 Target
Inpatient Mortality O/E	Comparison of observed to expected mortality for Medicare inpatient encounters	1.46	1.15
CABG 30 Day Mortality Rate	Percentage of Medicare patients that expire within 30 days of a previous inpatient admission for CABG.	0%	Maintain below benchmark 2.9%
AMI 30 Day Mortality Rate	Percentage of Medicare patients that expire within 30 days of a previous inpatient admission where the primary diagnosis was AMI.	11.1%	Maintain below benchmark 12.3%
CHF 30 Day Mortality Rate	Percentage of Medicare patients that expire within 30 days of a previous inpatient admission where the primary diagnosis was CHF.	9.09%	Maintain below benchmark 11.2%

Pneumonia 30 Day Mortality Rate	Percentage of Medicare patients that expire within 30 days of a previous inpatient admission where the primary diagnosis was pneumonia.	21.3%	15.3%
COPD 30 Day Mortality Rate	Percentage of Medicare patients that expire within 30 days of a previous inpatient admission where the primary diagnosis was COPD.	7.58%	Maintain below benchmark 8.10%
30 Day All Cause Readmissions	Percentage of non-elective Medicare inpatient readmissions within 30 days of a previous inpatient admission.	11.1%	Maintain below benchmark 15.5%
PSI 06: Iatrogenic Pneumothorax Rate	Iatrogenic pneumothorax cases (secondary diagnosis) per 1,000 surgical and medical discharges for patients ages 18 years and older.	0.43	.25
PSI 12: Perioperative PE/DVT Rate	Perioperative pulmonary embolism or proximal deep vein thrombosis (secondary diagnosis) per 1,000 surgical discharges for patients ages 18 years and older.	2.90	Maintain below benchmark 3.74

SMMC Metrics	Description	FY21 Baseline	FY22 Target
Inpatient Mortality O/E	Comparison of observed to expected mortality for Medicare inpatient encounters	1.16	0.88
30 Day All Cause Readmissions	Percentage of non-elective Medicare inpatient readmissions within 30 days of a previous inpatient admission.	12.4%	Maintain below benchmark 15.5%
CHF 30 Day Mortality Rate	Percentage of Medicare patients that expire within 30 days of a previous inpatient admission where the primary diagnosis was CHF.	9.86%	Maintain below benchmark 11.2%
Pneumonia 30 Day Mortality Rate	Percentage of Medicare patients that expire within 30 days of a previous inpatient admission where the primary diagnosis was pneumonia.	17.17%	15.3%
COPD 30 Day Mortality Rate	Percentage of Medicare patients that expire within 30 days of a previous inpatient admission where the primary diagnosis was COPD.	4.76%	Maintain below benchmark 8.10%
PSI 06: Iatrogenic Pneumothorax Rate	Iatrogenic pneumothorax cases (secondary diagnosis) per 1,000 surgical and medical discharges for patients ages 18 years and older.	0	Maintain below benchmark 0.25
PSI 12: Perioperative PE/DVT Rate	Perioperative pulmonary embolism or proximal deep vein thrombosis (secondary diagnosis) per 1,000 surgical discharges for patients ages 18 years and older.	3.24	Maintain below benchmark 3.74

Rehab Metrics	Description	FY21 Baseline	FY22 Target
Discharge to Acute	Rate of rehab patients requiring transfer to an acute care hospital for greater than 3 midnights.	7.8%	Maintain below

			benchmark 8.3%
Discharge to Community	Rate of patients who are discharged to a CMS defined level of community.	82.6%	83.1%

Patient Safety

Scope of Work

Within the acute care setting, the Infection Prevention and Safety departments provide support for several key safety processes: 1) Prevention of hospital-associated infections and 2) Prevention of serious patient safety events 3) Prevention of violence in the workplace

FY22 OBJECTIVES

- Reduce Colon Surgical Site Infections- Regional
- Reduce Blood Stream Infections (CLABSI & MRSA)
- Reduce Hospital Acquired Injuries
- Reduce Serious Patient Safety Events (Sentinel Events)
- Reduce Workplace Violence Events

Tactics

Hospital Acquired Infections	Hospital Acquired Injuries	Sentinel Events
• Eliminate clinical variation • Monitor bundle compliance • Infection prevention champions	• Fall prevention committee • Fall prevalence rounds monthly	• Safety Roundtable • Root Cause Analysis

Metrics

RRMC Metrics	Description	FY21 Baseline	FY22 Target
Colon Surgical Site Infections	Standardized Infection Ratio(SIR) NHSN	0.785	Maintain Below Benchmark (0.86)
CLABSI	Standardized Infection Ratio(SIR) NHSN	0.784	0.69
MRSA Bloodstream Infections	Standardized Infection Ratio(SIR) NHSN	0.872	0.82
Hospital Acquired Injuries	Falls and trauma per 1,000 patient discharges, CMS HAC reporting	0.469	0.454
Sentinel Event Rate	# of Sentinel Events per 1000 equivalent patient days.	0.08	Decrease by 20%

SMMC Metrics	Description	FY21 Baseline	FY22 Target
Colon Surgical Site Infections	Standardized Infection Ratio-NHSN	1	0

CLABSI	Standardized Infection Ratio(SIR) NHSN	0.825	0.82
MRSA Bloodstream Infections	# of MRSA bloodstream infections	1	0
Hospital Acquired Injuries	Falls and trauma per 1,000 patient discharges, CMS HAC reporting	0	Maintain Below Benchmark (0.454)
Sentinel Event Rate	# of Sentinel Events per 1000 equivalent patient days.	0.13	Decrease by 20%

Rehab Metrics	Description	FY21 Baseline	FY22 Target
CAUTI	Standardized Infection Ratio(SIR) NHSN	0	Maintain ZERO
Falls	# of falls	84	0
Hospital Acquired Pressure Ulcers	# of HAPI's	7	0
Sentinel Event Rate	# of Sentinel Events per 1000 equivalent patient days.	0	Maintain ZERO

Acute Care Metrics	Description	FY21 Baseline	FY22 Target
Workplace Violence Events	# of reported events	132	Decrease by 10%

FY21 Annual Summary

	FY20	FY21	Target	Change
Mortality O/E- Regional	1.38	1.35	1.24	
Mortality O/E- South Meadows	0.67	1.09	1.0	
30 Day All Cause Readmissions- Regional	10.8%	11.1%	15.6%	
30 Day All Cause Readmissions- South Meadows	10.9%	12.4%	15.6%	
PSI 6- Iatrogenic Pneumothorax- Regional	0.82	0.24	0.25	
PSI 6- Iatrogenic Pneumothorax- South Meadows	1.46	0.0	0.25	
PSI 12- Post Op PE/DVT- Regional	3.88	3.11	3.76	
PSI 15- Accidental Puncture & Laceration- Regional	4.20	2.79	1.26	
Foreign Object Retained- Regional	0.12	0.04	0	
Colon Surgical Site Infections-Regional	1.72	0.79	0.89	
Colon Surgical Site Infections-South Meadows	1	0	0	
Catheter Associated Urinary Tract Infections- Regional	0.35	0.39	0.74	
Catheter Associated Urinary Tract Infections- South Meadows	0.78	0.71	0.74	
Falls with Serious Patient Harm- Acute	4	10	0	
Serious Patient Safety Events (Sentinel Events)- Acute	28	32	0	
Rehab: Admit to Referral	5.1	7.0	4.0	

Appendix: Quality Committees

Quality and Professional Affairs Subcommittee of the Board (QPA)

Cadence
Bi-Monthly

Purpose
The Quality & Professional Affairs Committee shall be a standing committee of the Renown Health Concurrent Board of Directors. The primary purpose of the committee shall be to assist the Board of Directors in overseeing:

> (i) medical staff and management's identification and evaluation of the health system's principal aim of building a culture that continuously seeks to foster continuous improvement of integrated health care services, including the health system quality and risk reduction plans and the monitoring of practices employed to manage safe, effective and person centered care across all services, and (ii) the health system's ethics and federal, state and voluntary health regulatory programs.

Function
Quality, safety, and service are responsibilities that extend from the frontline to the Board. In collaboration with the Boards and medical staff, the Renown Health Leadership Team has ultimate accountability for ensuring quality, safety, and service excellence throughout the health system. The Quality & Professional Affairs Committee is responsible for ensuring the priorities of quality, safety, and service are aligned with the strategic priorities of the health system. In addition, responsibilities of committee members include:

- Practicing a culture of openness and transparency and creating shared values, fairness, and ethical practice at all levels throughout the health system.
- Maintaining awareness of emerging quality of care issues, challenges, and opportunities.
- Validating the development of data-driven, patient-focused metrics in clinical outcomes, safety, and patient experience.
- Ensuring medical staff and leadership accountability for program quality and performance.
- Monitoring regulatory adherence across the health system.
- Supporting the organization's participation in deemed status reviews for federally funded reimbursement programs which ensure the link between organizational objectives and national quality and safety standards.
- When necessary, recommending new policies or policy revisions for approval by the Renown Health Board.

Composition
The number of members and the identity of the members of the Quality & Professional Affairs Committee, who, except for the chair, need not be members of the Renown Health Board, shall be determined by appropriate resolutions of the Renown Health Board adopted from time to

time, provided, however, that the following positions serve as ex-officio voting members on the Committee: (i) Renown Regional Medical Center Chief of Staff; and (ii) Renown South Meadows Medical Center Chief of Staff. The Governance & Nominating Committee of the Renown Health Board shall nominate the chair and members of the Quality & Professional Affairs Committee, subject to the consent and approval of the Renown Health Board.

System Quality Council (SQC)

Cadence
Bi-Monthly

Purpose
The purpose of System Quality Council (SQC) is to provide a system-wide quality and safety working group for three Renown quality committees including the respective Acute Care and Health Services Quality and Patient Safety Committees and the Joint Medical Quality and Safety Improvement (MSQI) committee. A critical role for the council is providing both oversight and resolution of unresolved issues of these three committees and escalating those to key executive stakeholders, assigning escalated issue ownership and resolution timeline if possible. The scope of the committee is inclusive of the three reporting quality committees, and as directed by QPA or the CEO of Renown Health. The SQC reports to the Quality and Professional Affairs (QPA) Subcommittee of the Board of Directors.

Function
- Identify opportunities for improvement that translate across the entire health system
- Review current and trending publicly reported data (CMS Stars/Leapfrog/US News and World Report) for the Acute and Health Services Divisions
- Serve as a point of escalation for barriers/delays in resolution of quality issues
- Report to QPA progress on goals/priorities/timelines for quality or safety issues from the JQC
- Evaluate and monitor performance indicators that are benchmarked against top-performing organizations and assist the organization to achieve targets
- When appropriate make recommendations to QPSC and MSQI to facilitate achievement of annual targets
- Reprioritize improvement efforts and network priorities in response to internal or external requirements, changing regulatory demands, new expectations, sentinel events, and new knowledge or information

Membership
CEO, Renown Regional
CEO/Administrator, South Meadows & Rehab Hospital
Chief Medical Officer, Acute Care
Chief Medical Officer, Health Services
Chief Nursing Officer, Acute Care

Chief Nursing Quality Officer, Health Services
Chief Quality Officer, Acute Care
Acute Care Physician Representative
Health Services Physician Representative
Renown Regional Chief of Staff
South Meadows Chief of Staff
MSQI Chairs
Director of Clinical Excellence, Acute
Director of Clinical Excellence, Health Services

Medical Staff Quality Improvement Committee

Cadence
Monthly

Primary Functions
The purpose of the Medical Staff Quality Improvement Committee (MSQI) is to monitor, review, and report on the activities of the medical staff quality program as defined by the Medical Executive Committee (MEC). The MSQI committee reports to the MEC, identifying and prioritizing opportunities for improvement.
The Committee's critical work is to develop a plan for outcome improvement and monitor performance. The Committee's culture must be one of robust engagement, marked by high standards and a willingness to ask hard questions of peers and staff. Essential to its success are data analysis, a commitment to transparency and hearing the voice of the patient.

Responsibilities
- Identify opportunities for improvement through evaluation of quality, safety, experience & outcomes data.
- Understand the medical staff's and administration's approach to and methods of performance improvement;
- Assist the hospital to ensure that important processes and activities to improve performance and patient safety are measured, assessed, and spread systematically across all disciplines throughout the hospital;
- Participate as requested in identifying and managing sentinel events and events that warrant intensive analysis; and
- Participate as requested in the hospital's patient safety program including measuring, analyzing, and managing variation in the processes that affect patient care to help reduce medical/healthcare errors.
- Identify priorities for improvement and collaborate with the Acute Care Quality Department to develop outcome improvement plans utilizing the Plan-Do-Study-Act (PDSA) model.
- Report to the MEC progress related to identified goals/priorities.
- Evaluate and monitor key performance indicators that are benchmarked against top-performing organizations and assist the organization to achieve targets.

- Recommend programs, activities and/or processes to the medical staff(s) to facilitate achievement of annual targets
- Cultivate philosophical and cultural changes required for successful collaboration to improve performance.
- Reprioritize improvement efforts and network priorities in response to internal or external requirements, changing regulatory demands, new expectations, sentinel events, and new knowledge or information.

Membership

Voting Members:

Co-Chairs: Regional Quality Chair
South Meadows Quality Chair
Renown Regional Chief of Staff
South Meadows Chief of Staff
Regional Members- 5
South Meadows Members- 3
Academic Member

Staff:

CEO, Renown Regional
CEO, South Meadows & Rehab
Chief Medical Officer, Acute Care
Chief Nursing Officer, Acute Care
VP of Quality
Director of Clinical Excellence, Acute Care

Acute Quality and Patient Safety Committee

Cadence

Monthly

Primary Function

The Acute Quality and Patient Safety Committee (QPSC) is responsible for ensuring that the mission, vision, and values of Renown Health are achieved through continuous improvement of quality and patient safety. QPSC is responsible for ensuring that the Renown Acute Division provides safe, efficient, effective quality care by evaluating data from numerous sources, including but not limited to serious safety events, sentinel events, event reports, infections prevention and control data, comparative outcome data, accreditation surveys, closed litigation/settlement cases, and culture survey data. The Committee uses these data to set priorities for performance improvement and monitors the effectiveness of these efforts.

Duties and Responsibilities

- Sets goals annually and approves the Quality Improvement and Patient Safety Plan.
- Sets organization-wide priorities for quality improvement and patient safety.
- The QPSC accepts accountability for removing barriers, assigning resources and ensuring implementation and compliance for approved recommendations resulting from analysis of events, data or performance improvement project outcomes.
- Reviews analysis of aggregated, trended data related to quality and patient safety and recommends and monitors actions.
- Recognize and celebrate successful performance improvement efforts and staff actions impacting patient safety.
- Provides regular updates to the System Quality Council (SQC) institutional performance on selected benchmarks, performance improvement projects, compliance with regulatory requirements, and sentinel events.
- The Committee reports to the System Quality Council (SQC) and is responsible to the System's leadership for assuring appropriate oversight for quality and patient safety.

Membership

VP of Quality, Acute Care
Chief Medical Officer, Acute Care
CEO, Renown Regional
CEO/Administrator, South Meadows & Rehab
Chief Nursing Officer, Acute Care
Acute Care Directors

Saint Mary's Regional Medical Center:

PATIENT SAFETY PLAN

DATE: 01/10/2022
VERSION: 01
REBECCA ROLEFF

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.

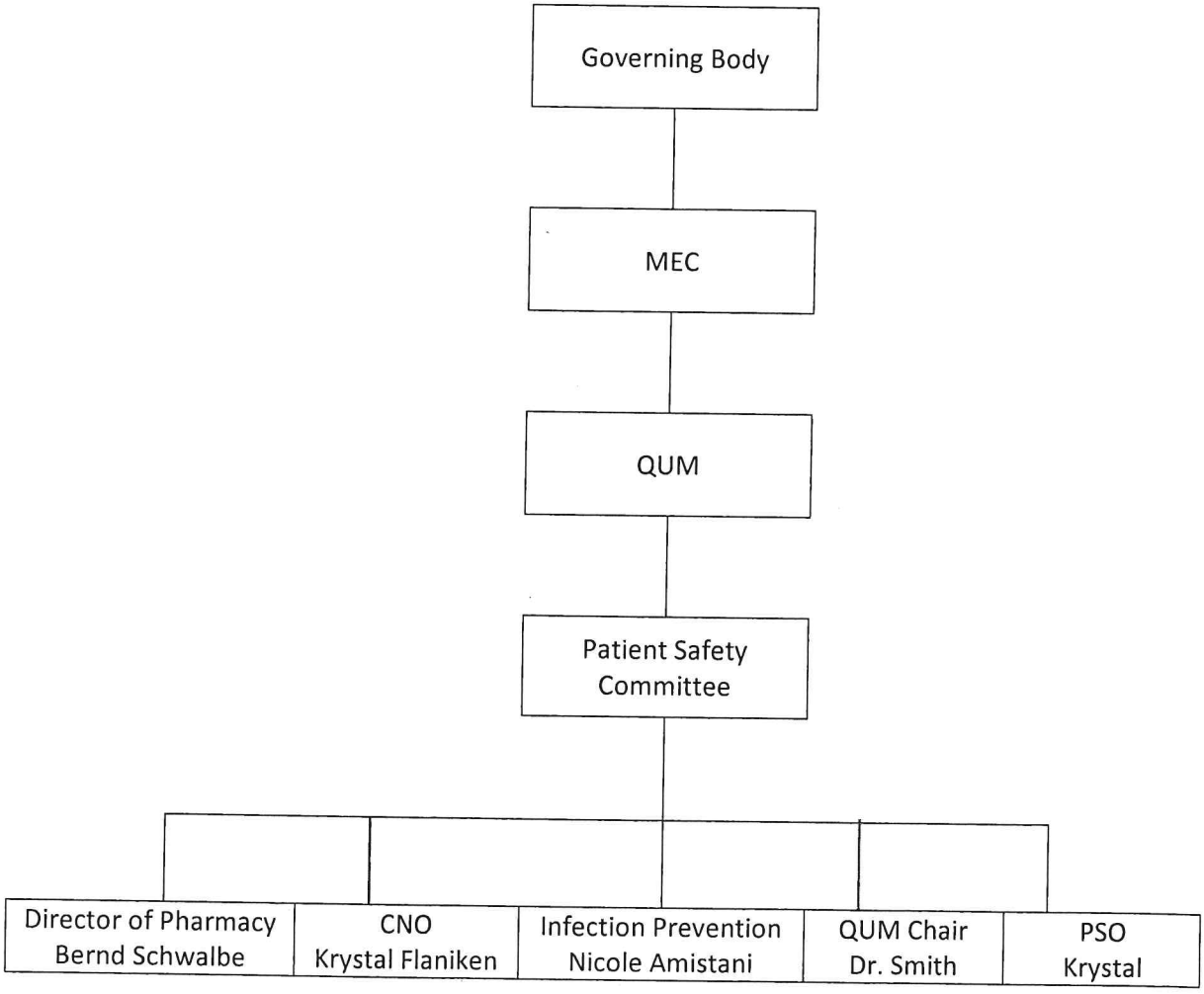
D. The organization also recognizes that despite our best efforts, errors can and will occur. Therefore, it is the intent of the organization to respond quickly, effectively, and appropriately when an error does occur.

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



				Flaniken, CNO

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.
- In addition to the above required members, this is an open committee and all employees are welcome to attend.

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

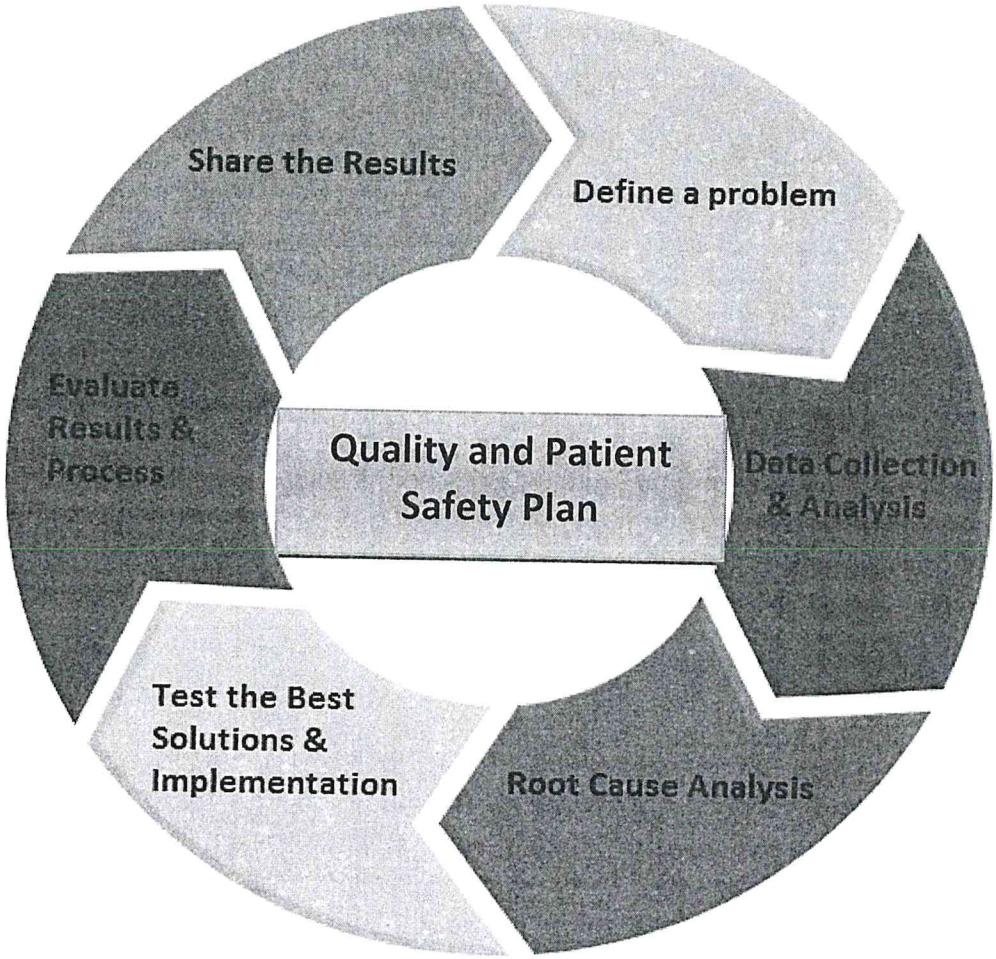
Objective	Goals	Plan	Planned Completion Date	Responsible Party
Improve Medication Reconciliation	Use PDSA tools to create a way to make medication reconciliation timely (within 24hrs) and accurate (dosage, frequency, rout) for home medication information of every patient admission by June of 2022.	Saint 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, 2022	Erin Madewell
Reduce Mislabeled 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, 2022	Chelsea Steverman
Improve response rate of AHRQ Safety Attitude Survey	Improve respondents to 80%	Focus on patient care areas by removing non-clinical departments from denominator	Dec 31, 2022	Erin Madewell

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.

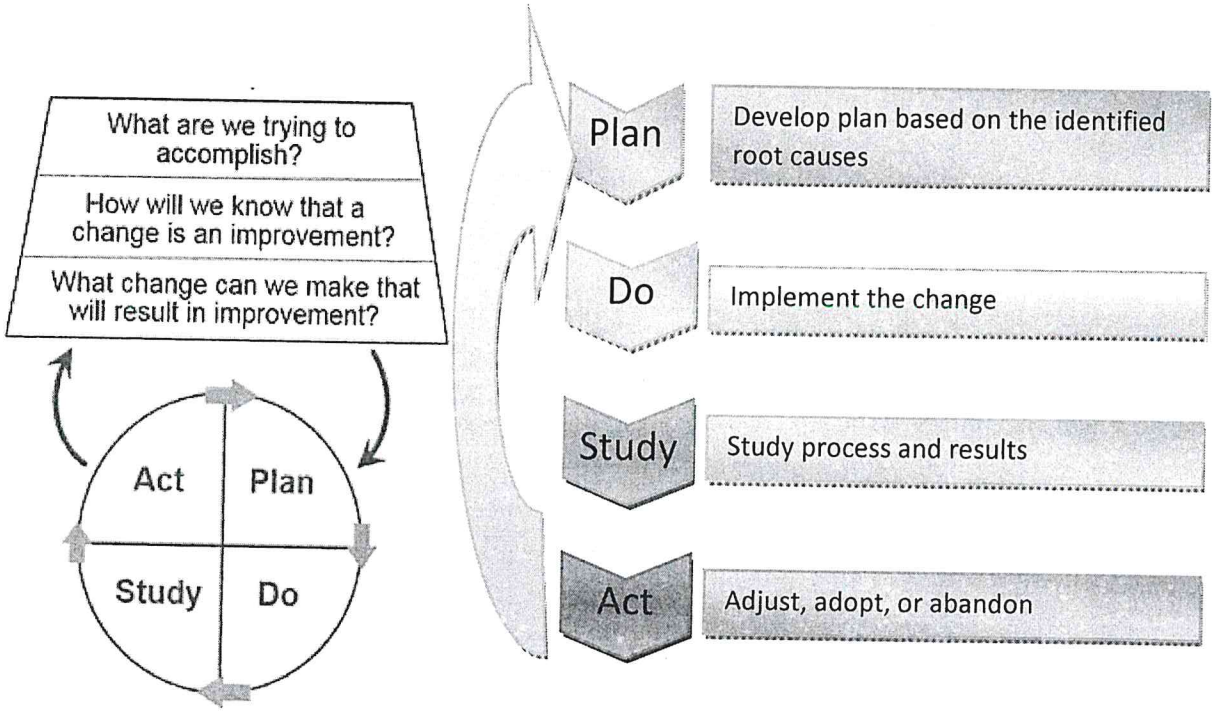
Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

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: 1-11-2022
Chief Nursing Officer / Administrator	Date: 1-11-2022
Chief Executive Officer	Date: 1/11/22
Chairman, QUM Committee	Date: 2/24/22
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.

NPSG.01.03.01

Eliminate transfusion errors related to patient misidentification.

Goal 2 - Improve the effectiveness of communication among caregivers.

NPSG.02.03.01

Report critical results of tests and diagnostic procedures on a timely basis.

Goal 3 - Improve the safety of using medications.

NPSG.03.04.01

Label all medications, medication containers, and other solutions on and off the sterile field in perioperative and other procedural settings.

Note: Medication containers include syringes, medicine cups, and basins.

NPSG.03.05.01

Reduce the likelihood of patient harm associated with the use of anticoagulant therapy.

Note: This requirement applies only to hospitals that provide anticoagulant therapy and/or long-term anticoagulation prophylaxis (for example, atrial fibrillation) where the clinical expectation is that the patient's laboratory values for coagulation will remain outside normal values. This requirement does not apply to routine situations in which short term prophylactic anticoagulation is used for venous thrombo-embolism prevention (for example, related to procedures or hospitalization) and the clinical expectation is that the patient's laboratory values for coagulation will remain within, or close to, normal values.

NPSG.03.06.01

Maintain and communicate accurate patient medication information.

Goal 6 - Reduce the harm associated with clinical alarm systems.

NPSG.06.01.01

Improve the safety of clinical alarm systems.

Goal 7 - Reduce the risk of health care-associated infections.

NPSG.07.01.01

Comply with either the current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines or the current World Health Organization (WHO) hand hygiene guidelines.

NPSG.07.03.01

Implement evidence-based practices to prevent health care-associated infections due to multidrug-resistant organisms in acute care hospitals.

Note: This requirement applies to, but is not limited to, epidemiologically important organisms such as methicillin-resistant staphylococcus aureus (MRSA), clostridium difficile (CDI), vancomycin-resistant enterococci (VRE), and multidrug-resistant gram-negative bacteria.

NPSG.07.04.01

Implement evidence-based practices to prevent central line-associated bloodstream infections.

Note: This requirement covers short- and long-term central venous catheters and peripherally inserted central catheter (PICC) lines.

NPSG.07.05.01

Implement evidence-based practices for preventing surgical site infections.

NPSG.07.06.01

Implement evidence-based practices to prevent indwelling catheter-associated urinary tract infections (CAUTI).

Note: This NPSG is not applicable to pediatric populations. Research resulting in evidence-based practices was conducted with adults, and there is no consensus that these practices apply to children.

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

NPSG.15.01.01

Identify patient at risk for suicide.

1. Conduct a risk assessment that identifies specific patient characteristics and environmental features that may increase or decrease the risk for suicide.
2. Address the patient's immediate safety needs and most appropriate setting for treatment.
3. When a patient at risk for suicide leaves the care of the hospital, provide suicide prevention information (such as a crisis hotline) to the patient and his or her family.

Universal Protocol

Patient Safety Plan

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

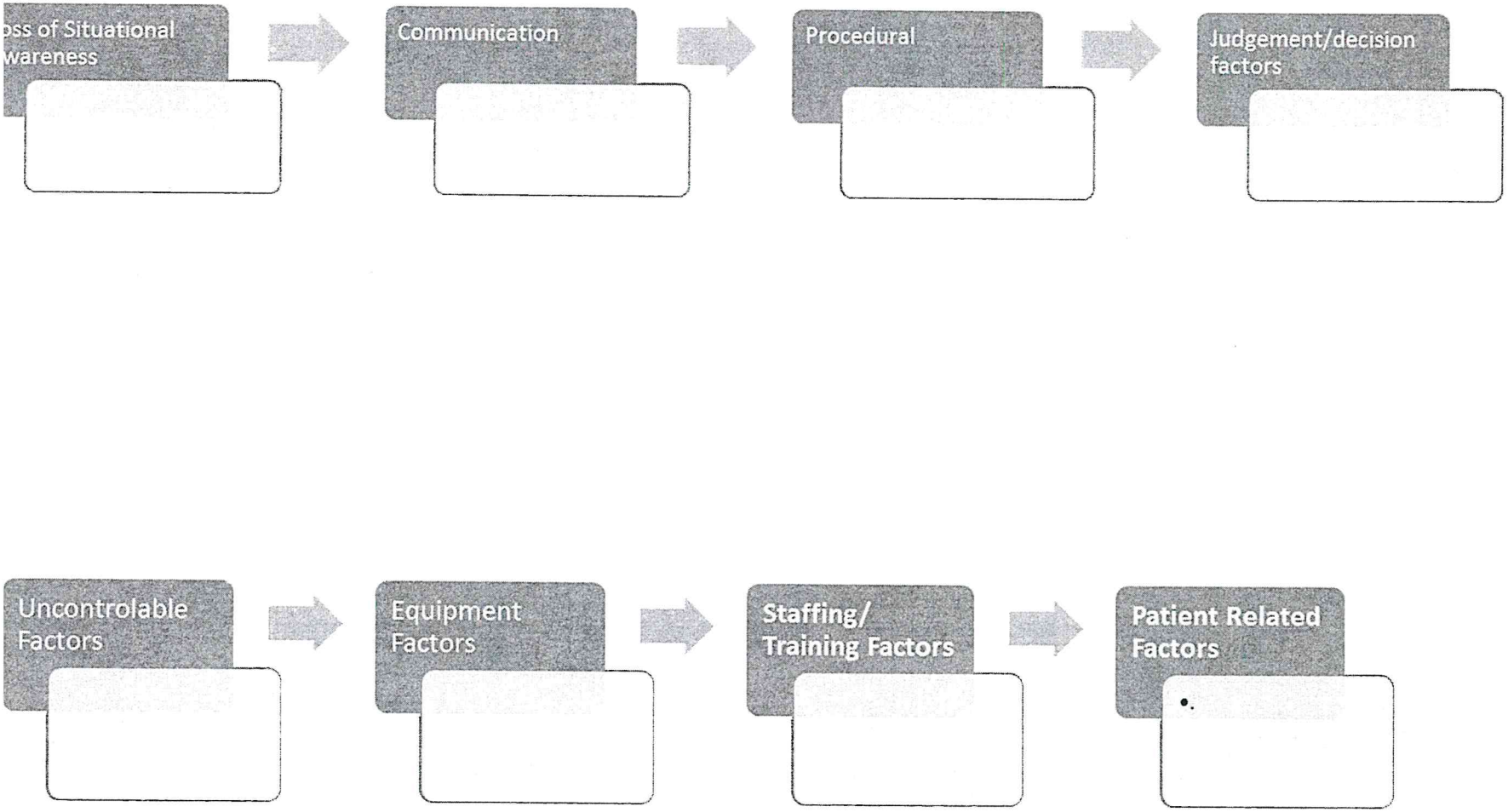
Narrative:

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	

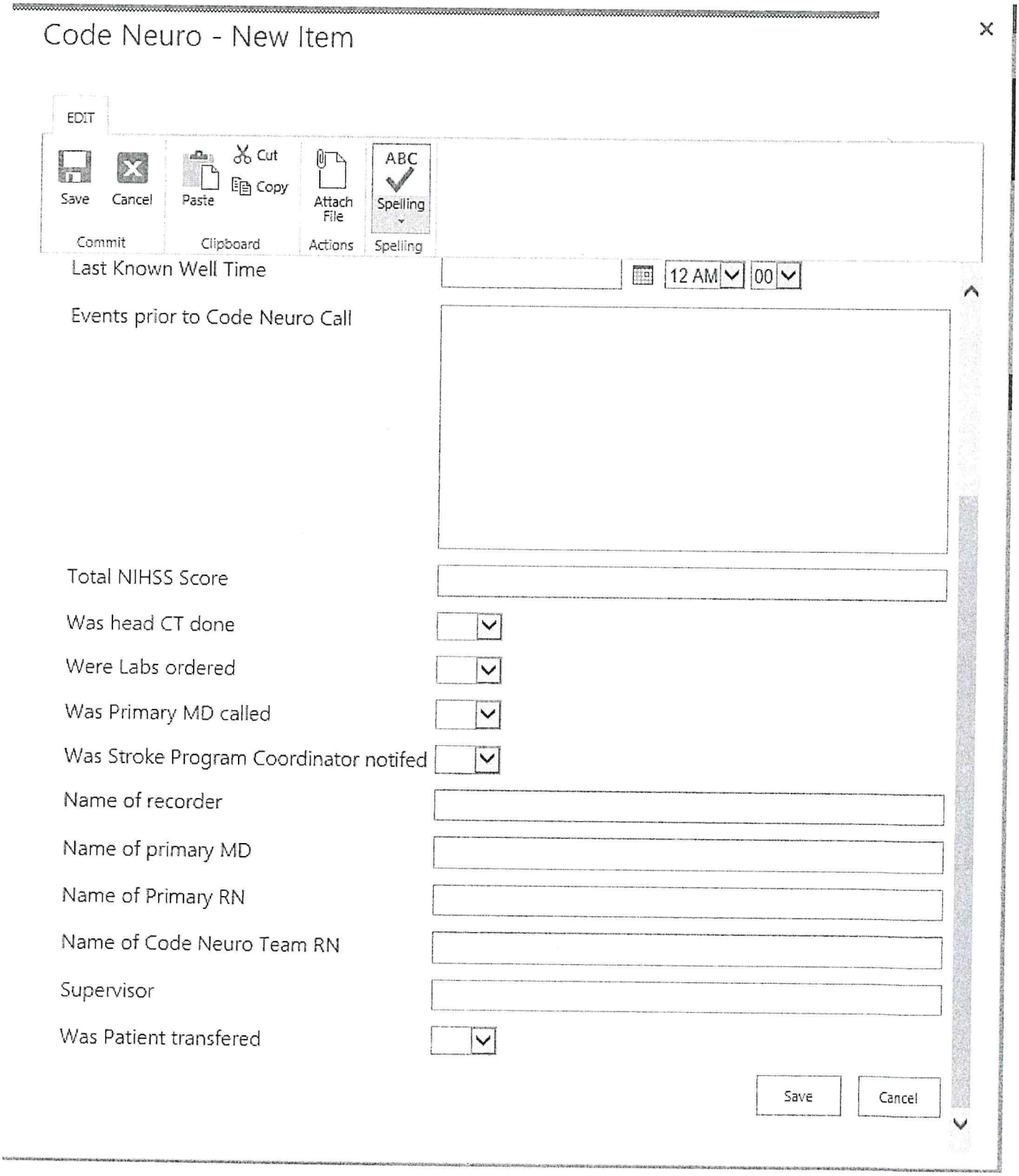
Appendix D-2: PDSA Monthly / Quarterly Progress Report

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



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

Appendix F: Policy Example

Saint Mary's Regional Medical Center	Policy and Procedure	Perioperative Services Labor & Delivery/OR Cath Lab Interventional Radiology
Universal Protocol		

POLICY: Universal Protocol (Procedure Verification, Correct Site Management and Time Out For Invasive Procedures)

All patients undergoing a surgery or invasive procedure are to be considered at risk for the potential of a wrong patient, procedure or wrong site surgery/invasive procedure. The process to prevent wrong patient, wrong procedure and wrong site surgery or invasive procedure includes all required elements of the *Universal Protocol.* To assure that the correct procedure (operative or invasive) is performed on the correct patient and body part or site. Certain patients are considered at higher risk for error such as those undergoing multiple procedures with one or more physicians, those undergoing emergency procedures, or those patients that have unusual characteristics such as a physical deformity or massive obesity.

DEFINITIONS:

Procedure Verification: Includes verification of patient, procedure and site and as applicable, any implants, diagnostic/radiology results, blood, devices and special equipment (as appropriate to the type of surgery or procedure) AND is applicable to all departments performing surgical or invasive procedures, inclusive of bedside procedures.

Invasive Procedure: Any procedure performed which involves a puncture or incision of the skin, or insertion of an instrument or foreign material into the body, including but not limited to percutaneous aspirations, biopsies, cardiac and vascular catheterization, central line placements, epidurals and endoscopies. This policy does not apply to certain routine minor procedures such as peripheral IV line placement, insertion of an NG tube or urinary catheter insertion.

Procedure Room: Any room where a surgical or invasive procedure may occur to include the patient's bedside.

Procedure Personnel: The RN or credentialed personnel who are participating in the invasive procedure

PROCEDURE:

A. General Information

- Procedures NOT within the Scope of the Universal Protocol and this policy:
  - Venipuncture
  - Peripheral intravenous line placement
  - Insertion of nasogastric tube
  - Urinary catheter placement
  - ECT (electroconvulsive therapy)
  - Closed reduction
  - Radiation oncology
  - Lithotripsy (this does have laterality, but the stone is visualized during the procedure)
  - Dialysis (except insertion of the dialysis catheter)

- All other invasive procedures are within the scope of the Universal Protocol and this policy.

- Department staff and physicians participating in a surgical or invasive procedure will actively participate in the Procedure Verification process (to include pre-procedure verification, site marking, and time out) as described in this policy, to assure the correct patient, procedure and site (as applicable) is assessed prior to any surgical or invasive procedure. Staff will document the verification steps in the medical record.

- Anytime there is a discrepancy in the Procedure Verification process, the person discovering the discrepancy will re-verify all the previously completed steps against the surgery schedule, the history and physical, the permit, the patient and notify the physician and department manager. The procedure will not begin until clear verification of the patient, procedure and/or site is completed.

- All actual and "near miss" wrong patient, wrong procedure or wrong site procedures will be reported promptly to the Department Manager or designee and Risk Manager.

B. Pre-Procedure Verification

- Verification of the correct person using two identifiers (patient's name & date of birth), correct site, and correct procedure will occur with the patient/family/legal representative involved, awake and aware, if possible and documented.

- Additionally, persons responsible for scheduling the procedure, completing preadmission testing/assessment and admitting the patient will verify the procedure and site with the physician, physician's office or physician order.

- Pre-procedure verification will occur at the following times:
  - At the time the procedure is scheduled (to include implant information if applicable).
  - At the time of preadmission testing & assessment
  - At the time of admission or entry into the facility for a procedure, whether elective or emergent
  - Before the patient leaves the pre-procedure area (i.e. Same Day Unit or Pre-op Holding) or enters the procedure room

- Anytime the responsibility for care of the patient is transferred to another member of the procedural care team, (including the anesthesia providers), the above information will be communicated during the hand-off

- Additionally, in the pre-procedure area, procedure verification will include the following for patients undergoing a surgical or invasive procedure and be documented. All applicable items will be available in the procedure room/area and matched to the patient:
  - Identification of the procedure scheduled and identified in physician documentation
  - Presence of current, updated and complete History and Physical
  - Consent accurate, complete and signed by patient/representative
  - Provider assessment (MD, Nursing, PA, APN) and pre-anesthesia /procedural sedation assessment completed and documented
  - Marking of the procedure site by the physician prior to the procedure (if applicable)
  - Verification of the correct patient position
  - Availability and documentation of correct and labeled implants, diagnostic/radiology results, blood, devices and special equipment, or special requirements

- Scheduled procedures that involve anatomical sites that have laterality, surface (flexor, extensor), levels or specific digits or lesions, the word(s) left or right or bilateral will be written out fully on the procedure/operating room schedule and on all relevant documentation including the procedural consent or permit.

C. Site Marking

- Site marking is conducted for all procedures involving incision or percutaneous puncture or insertion.

- The marking takes in to consideration anatomical laterality, the surface (flexor, extensor), the level (spine) or specific digit or lesion to be treated.

- In cases where bilateral structures are removed (such as tonsils or ovaries) the site does not need to be marked.

- If one side is definite and the other is possible, only mark the definite site (example: right ovary, possible left ovary, only mark the right side).

- The only exceptions to site marking are:
  - Midline, single organ procedures
  - When both bilateral structures are to be removed.
  - Endoscopies without laterality
  - Procedures when there is no pre-determined site of insertion, such as cardiac catheterization, interventional radiology and amniocentesis.
  - When the use of direct imaging (fluoro x-ray, ultrasound imaging, CT fluoro or MRI imaging) is utilized by a physician present from the time the site is selected through the completion of the procedure. This applies to all cases where the performing physician uses imaging to select and/or navigate and/or complete the procedure.

- The site marking is completed for all procedures involving incision or percutaneous puncture or insertion by the physician or proceduralist performing the procedure prior to the time the patient is moved in to the procedure room/location. The patient/family/legal representative should be involved in the site marking process.

- The physician or proceduralist will identify the patient (using the two patient identifiers) and verify the procedure and site with the patient/family/legal representative.

- In collaboration with the patient or patient's family member, the site will be marked with the initials of the physician performing the procedure using an indelible marker prior to the patient being transferred to the procedure/operating room unless the anatomical site is exempted per policy.

- The site initialed will be made at or adjacent to the incision site, and must be visible after the patient is prepped and draped and positioned in the final position.

- If the procedure involves multiple sides/sites during the same operation, each side and site must be initialed.

- Do not mark any non-operative site(s).

- In limited circumstances, the licensed independent practitioner may delegate site marking to an individual who is permitted by the organization to participate in the procedure, is familiar with the patient, will be present when the procedure is performed, and is either qualified through a medical residency program or is a licensed individual who performs duties requiring collaboration or supervisory agreements with the licensed independent practitioner (i.e., PA, APN).

- For spinal surgery, a two-stage marking process will occur as follows:
    - The general level of the procedure (cervical, thoracic, lumbar, or sacral) will be initialed pre-procedure, along with an indication of the right vs. left if applicable.
    - Intra-operatively, the exact interspace will be precisely marked using the standard intraoperative x-ray.

- The site will not be marked with the letter "X" or the word "No."

- A new marking pen will be used for each patient

- If the patient refuses to be marked, procedural personnel will re-educate the patient regarding the importance of site marking and document. If the patient still declines to be marked, the procedural personnel will notify the physician, document what alternative means was utilized for marking. The patient's refusal to be marked must be resolved between the procedural physician and the patient prior to the invasive procedure.

- If the consent was signed and the patient was marked accordingly, and then it was discovered that the site was incorrect before the incision was made, the procedure can proceed at the discretion of the procedural physician. The procedural personnel as per hospital policy will document an occurrence report.

D. Difficult to Mark Site:

- Sites which are technically difficult or anatomically impossible to mark or minimal access procedures treating a lateralized internal organ, will apply the alternative process below:

- Examples: Arm in cast, ureters through a cystoscope, teeth, or premature infants.

- After verifying with the patient/family/legal representative that the patient identification and procedural information is correct, the procedural personnel will place a patient sticker and the procedural information on an orange band, indicating the 'side' with 'Left' or 'Right'.

- The orange band information will be verified and initialed by the physician, then placed on the patient's ankle. If the patient's anatomy or procedural draping prevents visualization of the band during the time out process then the band will be placed on the patient's wrist.

- The orange band will be removed in the PACU or post-procedure recovery location.

- Teeth. The physician will initial on the dental radiographs or dental diagram each tooth involved in the surgery/procedure. The dental radiograph or diagram will be used during the time-out before the procedure to identify the site during the "time-out".

- Premature Infants: The orange band will be applied as in no. 1 above.

E. Time Out

- The time out is the suspension of all other activities to permit all members of the surgical/ procedural team to focus on active confirmation of the required time out elements. The circulating nurse or technologist will initiate the time out, although any member of the team may do this. These elements include:
    - Correct Patient: Patient identification using the two patient identifiers (patient name & date of birth.
    - Correct Site: Verification/confirmation of procedure site and side as specified on the consent and visualization of site marking that it is correct and agrees with consent
    - Correct Procedure: Accurate procedure and consent form per physician's order.
    - Confirmation of antibiotic administration
    - Consensus with all team members that above information is correct
    - Documentation of the "time out/procedure verification" process

- The procedure will not be initiated until all members agree with all elements included in the time out.

- The time out will be initiated by the procedural personnel after the patient has been prepped and draped and immediately prior to the initiation of the procedure with all team members present in the room or at the bedside.

- Whenever there is more than one procedure performed by separate procedure teams, there will be a time-out completed and documented by the separate procedure teams. The time out will precede each individual procedure.

- If there is any discrepancy among the team members during the time-out, re-verification will occur with a review of the surgical/department procedure schedule, history and physical, procedure consent, radiology films, consultations and any other information available to validate the correct patient, procedure and site.

F. Management Following Discovery of Wrong Patient/ Wrong Site/ Wrong Procedure

- If, after induction of anesthesia, during the course of a surgical/invasive procedure, or after a surgical/ invasive procedure has been completed, it is determined that the procedure being performed or completed is the wrong patient, wrong procedure or at the wrong site, the surgeon/physician and anesthesiologist will:
  - Act in accord with the patient's best interests and to promote the patient's well-being.
  - Record the event accurately in the medical record.

- Procedural personnel will immediately inform the department manager who will immediately notify the Risk Manager per hospital policy.

G. Fire Risk Assessment

- A fire risk assessment shall be done prior to the start of all surgical procedures (Perioperative Areas)
  - Performed before start of procedure
  - All members of the team participating
  - Communicated during the "Time Out"
  - Documented in patient record
  - Fire Risk Assessment Tool:
    - A. Is an alcohol-based prep agent or other flammable solution being used preoperatively?
    - B. Is the surgical procedure being performed above the xiphoid process or in the oropharynx?
    - C. Is open oxygen or nitrous oxide being administered?
    - D. Is an electrosurgical unit, laser, or fiber-optic light being used?
    - E. Are there other possible contributors (i.e. defibrillators, drills, saws, or burrs)?

H. Quality Improvement:

Compliance with the Universal Protocol Policy will be monitored by conducting documentation/observation audits on a monthly basis.

DOCUMENTATION:

Surgical/Procedural Consent

Procedural/Surgical Nursing Record

Preprocedure Safety Checklist

REFERENCE/EVIDENCE BASED PRACTICE:

Prime HealthCare Policy: Universal Protocol: PeriOperative

AORN Position Statement: Preventing Wrong-Patient, Wrong-Site, Wrong-Procedure Events; August 2015

AORN's Fire Safety Tool Kit

The Joint Commission, 2016 National Patient Safety Goals.

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

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

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

AUTHOR/POLICY COORDINATOR:

Tonya Lowry RN, CNOR, Perioperative Clinical Educator

Randy McElreath RN, MSN, Manger Perioperative Services

Krystal Flaniken RN, MSN, Director of Surgical and Perioperative Services

APPROVAL:

Committee Approvals	**Date**
Surgical Services Executive Committee	12/20
Procedural Safety Team	12/20
Committee Approvals	**Date**
Policy Committee	6/20
QUM	6/20
MEC	8/20
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, 2/20,12/20

SOUTHERN HILLS SM
HOSPITAL & MEDICAL CENTER

Patient Safety Plan

Updated: 3/5/18, 2/18/19, 2/18/2020, 4/1/2021, 6/2021
Medical Executive Committee: 3/15/18;3/21/19;3/19/20;6/17/21
Board of Trustee: 3/22/2017, 3/21/18 ;3/27/19;3/25/20;6/23/21

2021 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.
Adverse Event:	A consequence of care that results in an undesired outcome.
CSIP:	THe Clinical Safety Improvement Plan (CSIP) offershospitals the opportunity to voluntarily

	develop and implement specific patient safety initiatives focused on issues identified by the evaluation of close call, adverse events, and current hospital clinical performance metrics. The program aims to reduce incidence of adverse events, reduce patietn harm, and promote the development of competency of patient safety leadership. HCAPSO will guide hospitals in the submission of required program deliverables and will communicate completion results to the facilities
Hazardous condition:	Any set of circumstances (exclusive of the disease or condition in which the patient is being treated), which significantly increases the likelihood of serious adverse outcome.
Healthcare FMEA:	Healthcare Failure Mode and Effects Analysis: A proactive model for addressing potential risks within the organization.
Human Error:	An unintended act, or failure to act, that results in actual or potential patient injury, harm or adverse event in the process of care delivery.
Near miss:	Any process variation that did not affect the patient outcome, but for which a recurrence carries a significant chance of serious adverse outcome.
Non-punitive:	No punishment or disciplinary action imposed for specific error.
Patient injury:	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.
Safety Culture	The safety culture of a hospital is the product of individual and group beliefs, values, attitudes, perceptions, competencies, and patterns of behavior that determine the organization's commitment to quality and patient safety. (TJC)
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; as well as a continuous approach to the improvement of patient safety. Southern Hills Hospital is focused on prevention, not blaming individuals with a just culture approach. Patient safety events are viewed as an opportunity to learn. The Hospital believes in balancing the organization's accountability and the individual's accountability for assuring safe practices and a safe environment to care for patients.

IV. Structure, Roles and Responsibilities

The philosophy guiding the promotion of a culture of patient safety is accountability. To achieve a culture of patient safety the following accountabilities are expected at Southern Hills Hospital:

Role	***Accountability***	***Specific Tasks***
Board of Trustees, with Senior Leadership	Set goals, monitor performance & require accountability.	• Receive regular and thorough reports on patient safety risks, hazards and progress towards performance improvement objectives from the MEC and Quality Care/ 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	• Ensure that an integrated patient safety program is implemented throughout the hospital. • Set performance improvement priorities and identify how the hospital adjusts priorities in response to unusual or urgent events. • Allocate adequate resources for measuring, assessing and improving the hospital's performance and improving patient safety. • Measure and assess the effectiveness of the performance improvement and safety improvement activities. • Monitor implementation for of corrective action of patient safety events. • Ensure remedial activities, identified through analysis of reported patient safety events, are implemented, effective, and do not cause unintended adverse consequences. • Develop a proactive approach to reducing errors. • Encourage an environment of openness & collaboration. • Support a dialogue about outcomes between patients and clinicians including systems to obtain direct feedback from patients regarding performance of the organization • Educate staff about safety. • Support staff and lead by example.

Role	***Accountability***	***Specific Tasks***
Patient Safety Officer/CMO/ Chief of Staff	Lead patient safety initiatives with the medical staff and organizational staff	• Lead an integrated patient safety program. • Serve as the primary point of contact for questions about patient safety, and coordinate patient safety for education and deployment of system changes. • Execute performance improvement priorities and adjusts priorities in response to unusual or urgent events. • Assure effectiveness in measuring, assessing and improving the hospital's performance and improving patient safety. • Lead a proactive approach to reducing errors and make recommendation to reduce patient safety events. • Lead in an environment of openness & collaboration. • Assure dialogue about patient safety issues occurs effectively between patients and clinicians. • Report progress regularly, and educate about patient safety • Support staff and lead by example.
Quality/ Patient Safety Coordinators	Day to day coordination and facilitation of safety initiatives	• Implement operational aspects of the patient safety program throughout the hospital. • Implement proactive patient safety management that assures immediate, appropriate response to unusual or urgent events. • Participate in measuring, assessing and improving the hospital's performance and improving patient safety. • Be accountable for patient safety initiatives and strengthening a culture of safety in day to day practice. • Support an environment of openness & collaboration. • Support a dialogue about patient safety issues between patients and clinicians. • Report progress regularly, and educate about patient safety. • Support staff and lead by example.
Pharmacists	Ensure safe medication usage	• Ensure that authoritative, up-to-date drug information is available in reference form in patient care areas and prescribers' offices. • Periodically examine all drug products stored in patient care areas and procedures on drug storage/distribution to patient care areas. • Minimize the need for nurses to calculate, manipulate, or mix medications. • Establish a pharmacy led interdisciplinary team to spearhead medication safety activities. • Provide leadership to develop safe medication delivery systems.

Role	*Accountability*	*Specific Tasks*
Clinicians & Medical Staff	Monitor, report, & learn.	• Medical staff and other employee job descriptions and competency evaluations incorporate accountability for safety. • Medical staff & employees participate in education on the importance of safety, surveillance, and expectations for reporting safety concerns, beginning with orientation. • Medical staff & employees evaluations include an individual's contributions to safety for the organization. • Medical staff & employees are positively acknowledged for disclosing errors, near-misses, and safety concerns. • Employees and physicians work collaboratively assuring responsibilities of the team to the patients are met, and noticing errors before they cause harm. • Participate in the facility reporting system for PS events, both actual and potential event.
Patients/visitors	Involved partners in prevention.	• Inform doctors and nurses about medications they take, including prescriptions, over-the-counter drugs and dietary supplements. • Ask for written information about possible side effects. • Inform the doctors and nurses about allergies & adverse reactions. • Ask a relative or friend to be an advocate. • Learn about their medical condition by asking their doctor, nurse, and other reliable sources. • Upon hospital discharge, ask doctors for an explanation of the treatment plan to be used at home. • Provide feedback regarding performance of the organization • Report safety concerns through the Patient Safety hotline and other venues available.

V. Mechanisms for Coordination

Southern Hills Hospital Quality Care/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 Qualiry Care/Patient Safety Program. The Patient Safety Officer coordinates activities within the Quality Care/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 of retribution for reporting mistakes.
2. An accessible multifaceted non-punitive, just culture reporting system exists .
3. Errors and accidents are tracked in an attempt to establish trends and patterns, to learn from them and prevent reoccurrence.
4. Healthcare providers participate in reporting and developing improved processes to effectively evaluate errors and near misses.
5. Reporting errors and near misses are a critical component of the 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 (Sodexho 7-Step Cleaning Process)

4. Additional patient safety checklists which may be appropriate to ensure the safety of patients in the facility. These include, but are not limited to the following:
    a. Universal Protocol (Safe Procedural and Surgical Verification)
    b. Central Line Insertion Bundle (Meditech)
    c. Hand Hygiene (Audit)

Proactive Risk Identification and Reduction:

1. Opportunities for improvement regarding patient safety issues and hazardous conditions are identified through trending of actual or potential occurrences involving patients or visitors and/or evidence-based literature (e.g. The Joint Commission Sentinel Event Alerts).
2. When an identified opportunity for improvement is identified, it is analyzed by the involved care providers according to level of severity, frequency of occurrence, potential for harm and liability.
3. At least every 18 months, one high-risk or error-prone process is selected for Failure Mode Effect Analysis (FMEA) process. The underlying systems are examined and modified or redesigned to minimize the risk of the identified failure mode.
4. Trending of adverse events, environmental safety issues, aggregate data collection, and review of intensive assessments are part of the identification and management of risks to safety and are used to prevent reoccurrences.
5. Serious unusual occurrences and sentinel events are reviewed with determination made for intensive assessment and root cause analysis according to the SPAE policy.
6. Near miss events are reviewed and root cause analysis conducted as deemed appropriate.
7. Regular communication about patient safety and risk management is conducted with designated Quality Care Committee, Medical Executive Committee, and the Board of Trustees.
   Disclosure of an adverse event to a patient is in accordance with the SPAE policy.

IX. <u>Reporting Patient Safety Results:</u>

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 2021 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 2021 - Goals

- ☐ 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 4Q20 – 3Q21.
- ☐ Complete and submit all Serious Event Analyses (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 2021
- ☐ Achieve compliance with Clinical Safety Improvement Program (CSIP) initiatives.
- ☐ Implement and monitor action plans from AHRQ Culture of Safety Survey
- ☐ Reduce Hospital Falls by 10%

Spring Valley Hospital and Valley Health Specialty Hospital

Risk Management/ Patient Safety Plan

Nevada Acute Care Division

Revised 1/2022

. Overview

Spring Valley and Valley Health Specialty 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 and Valley Health Specialty** Hospital operates as a Patient Safety Organization to further its commitment in promoting patient safety and assuring that **Spring Valley and Valley Health Specialty** 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 and Valley Health Specialty** 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 and Valley Health Specialty** 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 facility policies. **Spring Valley and Valley Health Specialty** 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 and Valley Health Specialty 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 and Valley Health Specialty 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 RESPONSIBILITES

A. Risk Management/Patient Safety Officer

Spring Valley and Valley Health Specialty 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 and Valley Health Specialty 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 and Valley Health Specialty** 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 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:
Spring Valley and Valley Health Specialty 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 and Valley Health Specialty 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: This element outlines the UHS Risk program that lays the foundation for an effective risk management program. The Risk Manager/Director must be seen as a resource to administration, facility, and medical staff. Written plans, goals, and objectives provide a clear vision to meet the purpose of the UHS program. Although the TERM program uses the title, "Risk Manager," this applies equally to Risk Directors.

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

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

Element IV. Patient Safety Initiative: Imperative to a comprehensive RM program is one that focuses on the improvement of patient and staff safety through the creation of an environment that maximizes safety and reduces liability claims exposure. The mechanism used to drive the culture of safety is the Patient Safety 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 cornerstone 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 environmental safety and security programs in the facility serve to protect and preserve both life and property. Areas of safety include licensing, accreditation and state, federal and local safety practices and programs.

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

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

Element IX. Medication Safety Initiative: The medication safety initiative is geared toward preventing and responding to the accidental injury of a patient due to medical care or medical errors during the medication-use process. The mechanism used to drive the culture of safety is the Medication Safety Committee at each facility. The committee proactively assesses risk points at every level of the medication use cycle: procurement, storage, ordering/prescribing, transcription, distribution, preparation, dispensing, administration, documentation, and monitoring.

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 and Valley Health Specialty** 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.

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 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 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. Patient Safety Priorities, Goals and Objectives for 2022

- **Surgical and Procedural Safety**
  - **Wrong Site Surgery (WSS)**
    - ***Goal***: A 50% reduction in WSS events for 2022. Ultimately, the goal is 0.
  - **Retained Procedural items (RPIs)**
    - ***Goal***: Prevent RPIs- a 50% reduction in RPIs with harm for 2022. Ultimately, the goal for RPIs is 0.

- **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.
  - ***Goal***: Increase the percentage of patients with QBL of 2000 ml who receive transfusions to ≥ 50%.
- **Reduction / elimination of serious harm by utilizing an oxytocin checklist to decrease the percentage of full-term newborns with Apgars less than 6 at 5 minutes and / or requiring NICU admission.**
  - ***Goal:*** Reduce the number of full-term newborns requiring NICU admission by 10%.

- **CLABSI Initiative**
  - ***Goal***: CLABSI will be reduced to less than the CMS national mean Standardized Infection Ratio (SIR: CLABSI 0.692) in 2022.

- **Safe Medication Use**
  - **Smart Infusion Pump High Risk Opioid Event Reduction Initiative.**
    - ***Goal***: Decrease the number of high-risk opioid medication overrides by 50% by December 1, 2022.
    - ***Goal*:** Increase "Guardrails Suite usage to meet UHS and Leapfrog goal of 95% by December 1, 2022.
    - ***Goal:*** Naloxone provision usage will increase to 95% by June 1, 2022.
  - **Anticoagulant Safety in the Perioperative Setting**.
    - ***Goal:*** AHRQ PSI 12 Perioperative Pulmonary Embolism or Deep Vein Thrombosis benchmark is 3.950 per 1000 inpatients. The goal is to decrease the Patient Safety Indicator (PSI) 12 rate by 10% by December 2022. **[NOTE: If your facility is below the benchmark you may delete the 10% reduction goal, but continue to monitor PSI 12.]**
    - ***Goal:*** The VTE Advisor will be used to assess the patient's postoperative risk for thromboembolism and documented prophylaxis through the VTE advisor The goal is 80% compliance with "VTE Advisor" usage.

- **Reduce Falls and Falls with Injury**
  - ***Goal***: 10% reduction in the rate of falls in the Acute Care Division by the end of 2022.
  - ***Goal***: 10% reduction in the rate of falls with injury in the Acute Care Division by the end of 2022.

- **Decreasing Hospital Acquired Pressure Injuries**
  - **Goal:** 10% reduction of NPOA rate for all HAPI stages in the Acute Care Division by the end of 2022.

- **Culture of Safety**

- **Goal**: reduce the number of GHI events (serious safety event rate) for the Acute Care Division by the end of 2022. Ultimately, the goal is 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/SOX 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.

Dignity Health – St. Rose Dominican
Rose de Lima Campus

PATIENT SAFETY/RISK MANAGEMENT PLAN

DATE: 01/2021

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

Patient Safety Committee/Program
St. Rose Dominican – Rose de Lima Campus
102 East Lake Mead Parkway
Henderson, NV 89052
702.616.5552

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Commitment to Patient Safety

Dignity Health – St. Rose Dominican, Rose de Lima is committed to a comprehensive approach to improve 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:

- Inspire trust and 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.
- Commit to the power of working together 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 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, 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, CommonSpirit 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.
- All participants of the PCS have completed the PSO education.

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 the Rose de Lima 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.

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 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.	May 2021
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 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 Privilege 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 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. 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 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 Event Reporting System 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
- FDA: Food and Drug Administration
- ASHRM: American Society for Healthcare Risk Managment

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-ment 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 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/
- CQI 101 An Introduction to Continuous Quality Improvement: https://www.coursehero.com/file/13827355/CQI-Overviewppt/
- Health Resources and Services Administration. HRSA Health Center Program. Health Center Quality Improvement. https://bphc.hrsa.gov/qualityimprovement/index.html
- 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. Division of Public and Behavioral Health of the Department of Health and Human Services. https://www.leg.state.nv.us/NRS/NRS-439.html
- Patient Safety Assessment Tool (PSAT) https://www.paientsafety.va.gov/professionals/onthejob/assessment.asp

Reviewed/Approved:

Patient Safety Committee, January 2021

Quality Care Advisory Committee of the Board, March 19, 2021

Community Board, March 25, 2021

Dignity Health
St. Rose Dominican
San Martín Campus

Dignity Health – St. Rose Dominican

San Martín Campus

Patient Safety & Risk management Plan

2021

Las Vegas, Nevada

Dignity Health.
St. Rose Dominican
San Martín Campus

Patient Safety & Risk management Plan, CY 2021

EFFECTIVE DATE: 1-1-2021	**AUTHORITY: Community Board, Quality Council Advisory Committee, Senior Leadership**
REVIEWED AND APPROVED BY: **Patient Safety Committee : 2-11-2021** **Quality Counsel: 2-11-2021** **Medical Executive Committee: 3-3-2021** **Quality Care Advisory Committee: 3-19-2021** **Community Board: 3-25-2021**	**ACCOUNTABILITY: Senior Leadership, Patient Safety Committee, Quality Management (QM)**
REFERENCES: **Comprehensive Accreditation Manual for Hospitals: The Official Handbook Joint Commission on Accreditation of Healthcare Organizations, 2021** **Nevada Revised Statutes NRS 439.865** **CMS Appendix A – § 482.21 Condition of Participation, Quality Assessment Performance Improvement (Rev. 200, 02-21-20)** **Additional references on page 14**	

This plan was created per and revised by the Dignity Health – St. Rose Dominican Hospital San Martin (SM) campus Patient Safety Officer with review and input from the San Martin's Patient Safety team and Patient Safety Committee in accordance with **NRS 439.865**. 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. St. Rose Dominican San Martin Campus does provide full and equal access for people with disabilities.

Dignity Health.
St. Rose Dominican
San Martín Campus

Patient Safety & Risk management Plan, CY 2021

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.
- 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.

Dignity Health.
St. Rose Dominican
San Martín Campus

Patient Safety & Risk management Plan, CY 2021
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.

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 trends in performance and sentinel events will be analyzed to determine where best to focus changes for improvement.

Data from the following areas will be gathered at and presented for analysis with action plans developed reflective of the findings:

- Initial and ongoing proactive risk assessments

- Facility event reports which will include, those issues reportable to the state of Nevada and those issues that are reviewed for performance improvement, which may include::
    - Patient falls
    - Hospital Acquired Infections
    - Medication events to include delays in administration
    - Adverse drug events
    - Transfusion reactions through laboratory and blood back review
    - Actual and near misses

Patient Safety & Risk management Plan, CY 2021

- Hazardous conditions
- Restraint issues, not reported to the state
- Medical record legibility through peer review
- Perceptions of risks to patients, and suggestions for improving patient safety;
- Identified data trends , Dignity Health Shared Learnings, Others as assigned by various campus committees, Leadership and/or Quality Council and Advisory Committee of the Board (QCAC)
- Dignity Health Shared Learnings; and Others perception of Risk and Patient Safety as defined by 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.
- Establishment; composition; meetings; duties; proceedings and records are privileged.

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 have 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.
- Receive reports from the patient safety officer pursuant to NRS 439.870.
- Establish and evaluate data to identify patient safety performance indicators.
- Select one 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.
- On or before July 1 of each year, submit a report to the Director of the Legislative Counsel Bureau, the 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.

Patient Safety & Risk management Plan, CY 2021

- Review and evaluate the quality of processes carried out by the facility to improve the safety of patients who receive treatment.
- Review and evaluate the quality of processes carried out by the facility to prevent and control infections.
- Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred at the medical facility.

Report committee recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur.

- On a quarterly basis, (NRS 439.875 minimum requirement is annually) report the following to the executive or governing body of the facility regarding:

(1) The number of sentinel events that occurred at the medical facility;
(Previously done as market)
(2The number and severity of infections that occurred; and
(3) Any recommendations to reduce the number and severity of sentinel events and infections

Root Cause Analysis (RCA) Team Responsibilities

- RCA analysis, investigation, and corrective action plan implementations;
- Participation in the RCA meetings and discussions;
- Communicate about only data and facts; and
- Review Quality Department's Performance Improvement Plan

Team Member Responsibilities

Patient Safety Officer Responsibilities (based on NRS 439.870)

The Patient Safety Officer for the San Martin Campus and has responsibility for the following:

Patient Safety & Risk management Plan, CY 2021

- Serve as the Chairperson of the Patient Safety Committee pursuant to NRS 439.875
- Supervise the reporting of all sentinel events alleged to have occurred at the health facility, including, without limitation, performing the duties required pursuant to NRS 439.835.
- Take such action as he/she determines to be necessary to ensure the safety of patients as a result of investigation of any sentinel event alleged to have occurred at the facility.
- Report to the Patient Safety Committee regarding action taken in accordance with the responsibilities above
- Day to day responsibility for the Patient Safety/Risk Management Program at San Martin Campus.
- Monitoring data collected, trended and analyzed at the San Martin campus.

Routine reporting concerning specific trended data and actions taken to improve the quality and safety of patient care.

Infection Control Officer Responsibilities (based on NRS 439.873)

- Serve on the Patient Safety Committee.
- Monitor the occurrences of infections and determine the number and severity of infections.
- Report the number and severity of infections to the Patient Safety Committee. .
- Provides the leadership to prevent and control infections alleged to have occurred at the facility.
- Report Hospital Acquired Infections to NHSN.
- Recommend Best Practice to prevent HAI per CDC guidelines

Patient Safety & Risk management Plan, CY 2021

RCA team leader Responsibilities

- Organize and coordinate the RCA process.

- Assemble a team involved with knowledge of the event.
- 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, and finalized action plan to executive leadership.
- Monitor goals and progress toward completion of the Corrective Action Plan and reports findings to the Patient Safety Committee

Reports findings and results of the Action Plan to the Patient Safety Committee

RCA Facilitator Responsibilities

- Identify RCA participants and coordinate a time, date and location of RCA meeting.
- Inform RCA participants of the process, confidential nature of the review, and Just Culture.
- Explain confidential nature of RCA
- Review event using medical record and any other pertinent materials in preparation for the RCA.
- Provide an agenda and process to be followed during the RCA

Organizational Support Responsibilities: Executive or Governing Body Staff will provide vision and leadership to the Patient Safety and Quality Improvement process;

- Provide vision and leadership to Patient Safety and Quality Improvement and develop and foster a safe learning and improving culture

Patient Safety & Risk management Plan, CY 2021

- Provide oversight to the healthcare quality improvement processes and team
- Senior Leadership will provide the responsibility for implementation of an integrated, organization-wide program, promoting a culture of open communication, ensuring that patient safety issues are given a high priority, and the allocation of appropriate resources to support the committee's functions.
- The Dignity Health St Rose Dominican Board and Senior Leadership have responsibility for the implementation of an integrated organization-wide Patient Safety/Risk Management Program. These responsibilities include:
- Foster an environment in which patients, families, and organizational staff and leaders can identify and manage actual and potential risks to patient safety.
- Establish a culture where communication flows freely regardless of authority gradient.
- Assure that a proactive program for identifying risks to patient safety and reduction of medical/healthcare adverse events is implemented to respond to such events
- Assure that patient safety issues are given high priority when processes, functions or services are designed, redesigned and implemented
- Provide a mechanism to measure, analyze and managed variations in performance of defined processes
- Allocate adequate resources to include personal time, information systems data associated with reducing risk and improving patient safety

Physicians

Physicians are responsible, as participants in the Patient Safety/Risk Management Program for reporting events or near misses and participating on focus teams to reduce identified patient safety risks. Physicians shall participate in RCA's and Case Review Conferences whenever patient care outcomes differ significantly

from anticipated outcomes. The Primary Care Giver, LIP or comparable designee shall explain the outcomes to the patient and when appropriate the family.

Patients/Families/Visitors

Through the Patient's Rights publication, all patients, families and patient representatives (as permitted by the patient), via written communication are encouraged to be active participants in their care and to participate in the development of improved process for improved care, as appropriate.
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 quality projects and regulatory preparation;
- Adherence to Infection prevention measures and the Joint Commission (TJC) National Patient Safety Goals;
- 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;
- Participation in education activities and process implementations; and
- Participate in information needs assessment, staff surveys, and other processes requesting information concerning patient safety and risk management

The Patient Safety Committee convenes monthly in accordance with NRS 439.875 assures the following responsibilities are completed:

Establish and evaluate data to identify patient safety performance indicators;

- Selection of a high-risk patient safety process for proactive risk assessment and improvement on an annual basis;
- Annual review of the Patient Safety Program to ensure its appropriateness of focus and effectiveness of efforts.

Patient Safety & Risk management Plan, CY 2021

- Review and evaluate the Corrective Action Plan for sentinel events and infections
- Report and discuss sentinel events and corrective action which include:
  - Number of sentinel events from previous calendar month (or quarter).(Previously done as market)
  - Number of severe infections that occurred in the facility.
- Patient safety policies and checklists
  - At least annually evaluate Patient Safety policies and checklists for acceptance or revision.

Goals of the Patient Safety/Risk Management - 2021

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
Failure Modes and Effects Analysis (FMEA)	PSC to ensure one FMEA is conducted by Risk Management in CY 2021.	May 2021
Safety Checklists	PSC will receive all new and renewed checklists used that impact patient safety whether directly or indirectly. Submitted annually.	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 and practically 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.

Patient Safety & Risk management Plan, CY 2021

Goal	Plan	Due Date
	Implement action plans to meet federal guidelines consistently.	
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
Implement a High Reliability Organization (HRO)	3-year process. Initiated the process in 2020 – Phase one (1) completed Work with system to accomplish HRO on target date.	2023
Increase event reporting	Re-education concerning the importance of reporting events and near misses	2021
Reduce falls	Redesign and implement a fall program focused at deleting falls on each clinical unit	2021
Reduce Hospital Acquired Conditions (HAC)	Design and implement HAC prevention measures through designated subcommittees that meets regularly to review data monthly and create effective interventions using best practices.	2021

Methods

Proactive Risk Assessment Activities

The Patient Safety/Risk Management Department, in collaboration with the various facility committees will conduct proactive risk assessments to identify hazards/risks that may affect patient safety. These may include, but not limited to the following:

- Patient Safety Risk Assessments;
- Focused assessments; Patient Satisfaction surveys;
- Review employee surveys results to identify safety issues; and
- Infection Prevention Surveillance findings.

Event Reporting

San Martin actively participates in the CHPSO and its Patient Safety Evaluation System for data collection, monitoring, collaboration and evaluation activities. As

Patient Safety & Risk management Plan, CY 2021

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, through documentation, related to the event including physical evidence;
   e. Immediately notify supervisor of the event; and
   f. Submit 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 System.
   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** (Previously done as market) 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. The process can include: Assessment of the intended and actual implementation of processes

- Identification of the possible effects of the undesirable variations
- For critical effects /outcomes complete a RCA
- Redesign the process to minimize risk of variations

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 conducted, collected and documented as Patient Safety Work Product Privilege (PSWPP) to maintain confidentiality as defined in the Federal Regulation.

- San Martin shall respond to all reported potential and actual adverse/sentinel events, will analyze the issue through the RCA process or other process such as the FMEA. (See Sentinel Event policy).
- Minimally, all adverse events will be analyzed utilizing a team of individuals knowledgeable of the event. The following events always elicit an intense analysis:
  - Confirmed transfusion reactions;
  - Significant adverse drug reactions;
  - Hospital acquired infections; and
  - Significant medication events and hazardous conditions
    i. All events meeting the definition of Sentinel Events in the State of Nevada.

Education

A. Staff will receive education through:
   a. General orientation and other education and training programs as needed; Specific Patient Safety/Risk Management Program training including;
      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; and
iv. Event reporting criteria and processes.

B. Physician Education

An overview of the Patient Safety/Risk Management Program will be provided to physicians at the 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.

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 the RCA process to determine the contributing factors and the underlying reasons for the deficiencies or failures. An accepted model of evaluation will be used to evaluate the changes made in the process, to include:

- Define problems based on facts and data
- Develop a root cause analysis action plan framework
- Identify the technique to explore the cause and effect relationship underlying the program
- Once the problems are identified, a Fishbone Diagram is used for analyzing the problem

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 resources will be utilized to include:

- AHRQ: Agency For Healthcare Research & quality
- CDC: Centers for Disease Control and Prevention
- CMS: Centers for Medicare and Medicaid Services
- NQF: National Quality Forum

Patient Safety & Risk management Plan, CY 2021

- 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 3) RCA assessment	1) Severity of Infection report 2) Review and evaluate the measure of improvement of patient safety 3) Review and evaluate the measurement to prevent and control infections	1) Quality and Patient Safety Plan update 2) Checklists and Policies reviewing and revising

Assessment of the Quality and Patient Safety Plan

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

Patient Safety checklist and Patient Safety Policies

By NRS 439.865, the patient safety plan must include the patient safety checklist and patient safety policies for use by:

The patient safety checklist must follow protocols to improve the health outcomes of patients at the facility and must include:

- Checklists related to specific types of treatment. Each checklist must include a requirement to document that the treatment provided was properly ordered by the treating provider.
- Checklists that assure that employees of the organization and contractors who are not employees of the facility follow protocols to assure that room and environment of the patient is sanitary.

Patient Safety & Risk management Plan, CY 2021

- A checklist to be used when discharging a patient which include, verifying that the patient received:
    - Proper instructions concerning prescription medications
    - Instructions concerning his/her care upon discharge
    - Any other checklists which may be appropriate to ensure the safety of the patient at the facility.

The patient safety policies must include:

- A policy for appropriately identifying a patient before treatment using two identifiers
- A policy regarding the nationally recognized standard precautionary protocols, to be observed by providers and protocols relating to hand hygiene.
- A policy to assure compliance with the patient safety checklist and active surveillance for reporting violations, peer to peer communication , video monitoring and audits of sanitation materials
- The patient safety plan must include the Infection Control program and policies.

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, through annual education.

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 & Risk management Plan, CY 2021

Patient Safety Program Reporting and Review

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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 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.

Patient Safety & Risk management Plan, CY 2021

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
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- Title 40 – Public Health and Safety https://www.leg.state.nv.us/NRS/NRS-439.html https://www.leg.state.nv.us/nrs/nrs-439.html

Dignity Health – St. Rose Dominican
Siena Campus

PATIENT SAFETY/RISK MANAGEMENT PLAN

DATE: 01/20211

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

Patient Safety Committee/Program
St. Rose Dominican – Siena Campus
3001 St. Rose Parkway
Henderson, NV 89052
702.616.5552

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Commitment to Patient Safety

Dignity Health St. Rose Dominican, Siena Campus is committed to a comprehensive approach to improve 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:

- Inspire trust and 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.
- Commit to the power of working together 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
- 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, CommonSpirit Health Shared Learnings, etc.
- Others as defined by various campus committees, Leadership and/or Quality Council and Advisory Committee of the Board (QCAC).
- High Reliability Organization (HRO).

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, PSO, 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.
- All participants of the PSC have completed the PSO education.

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 the Siena 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 defined, on-going, proactive program for identifying risks to patient safety and reducing medical/healthcare adverse events is fully implemented and includes responses to actual and potential events;
- Ensure that patient safety issues are given a high priority and addressed when processes, functions or services are designed or redesigned;
- Provide for mechanisms to measure, analyze and manage variation in the performance of defined processes that affect patient safety;
- Allocate adequate resources, including personnel, time, information systems data associated with reducing risk and improving patient safety, and
- Active participation in the Collaborative Healthcare Patient Safety Organization (CHPSO).

Physicians/Licensed Independent Practitioner/Mid-level Practitioners

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/Patient Representatives/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.

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 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.	May 2021
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 Privilege 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 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. 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
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 the iVOS Event Reporting System 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
- FDA: Food and Drug Administration
- ASHRM: American Society for Healthcare Risk Management

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-ment 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 must 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 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/
- CQI 101 An Introduction to Continuous Quality Improvement: https://www.coursehero.com/file/13827355/CQI-Overviewppt/
- Health Resources and Services Administration. HRSA Health Center Program. Health Center Quality Improvement. https://bphc.hrsa.gov/qualityimprovement/index.html
- 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/11-23-20-QPS-scan-Minutes.pdf
- Title 40 – Public Health and Safety. Division of Public and Behavioral health of the Department of Health and Human Services. https://www.leg.state.nv.us/NRS/NRS-439.html
- Patient Safety Assessment Tool (PSAT) https://www.patientsafety.va.gov/professionals/onthejob/assessment.asp

Reviewed/Approved:

Patient Safety Committee, January 2021

Quality Care Advisory Committee of the Board, March 19, 2021

Community Board, March 25, 2021

Summerlin Hospital Medical Center
Las Vegas, NV

Risk Management/ Patient Safety Plan

Nevada Acute Care Division

Revised 1/2022

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 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 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 RESPONSIBILITES

A. Risk Management/Patient Safety Officer

Summerlin Hospital Medical Center has a designated Risk Director 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.

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:
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.

II. Patient Safety Advisories

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

Summerlin Hospital 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: This element outlines the UHS Risk program that lays the foundation for an effective risk management program. The Risk Manager/Director must be seen as a resource to administration, facility, and medical staff. Written plans, goals, and objectives provide a clear vision to meet the purpose of the UHS program. Although the TERM program uses the title, "Risk Manager," this applies equally to Risk Directors.

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

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

Element IV. Patient Safety Initiative: Imperative to a comprehensive RM program is one that focuses on the improvement of patient and staff safety through the creation of an environment that maximizes safety and reduces liability claims exposure. The mechanism used to drive the culture of safety is the Patient Safety 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 cornerstone 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 environmental safety and security programs in the facility serve to protect and preserve both life and property. Areas of safety include licensing, accreditation and state, federal and local safety practices and programs.

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

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

Element IX. Medication Safety Initiative: The medication safety initiative is geared toward preventing and responding to the accidental injury of a patient due to medical care or medical errors during the medication-use process. The mechanism used to drive the culture of safety is the Medication Safety Committee at each facility. The committee proactively assesses risk points at every level of the medication use cycle: procurement, storage, ordering/prescribing, transcription, distribution, preparation, dispensing, administration, documentation, and monitoring.

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 Summerlin 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.

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 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 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 2022

- **Surgical and Procedural Safety**

Wrong Site Surgery (WSS)

2022 Goal(s)

A 50% reduction in Corporate-wide WSS is the goal for 2021. The Hospital-specific goal is 0. Ultimately, the Corporate goal for WSS is 0.

2022 Plan

- Owner: SHMC Leadership
- Data source: MIDAS
- Needed resources: Support from CEO's, COO's, CNO's, and RVPs.
- Frequency of reporting to CPSC: Monthly
- High level plan for improvement implementation:
  - Focus improvement actions for PSO Surgical and Procedural Safety initiatives on
    - Evidence based practices, in particular with **adherence to current policies and procedures**

        - Accountability processes for speak up, escalation, and stop the line
        - Continued involvement of hospital CEOs with follow up of their Gap Analyses, involvement in the revised RCA process for WSS/RPI, and development of consistent rounding by c-suite in the procedural areas
        - Creating an environment conducive to Universal Protocol process
            - Vendor presence and acceptable involvement in procedure
            - Physician provider support of process
            - Accountability for behaviors disruptive to a culture of safety
    -

Retained Procedural items (RPIs)

2022 Goal(s)

A 50% reduction in Corporate-wide RPI is the goal for 2021. The Hospital-specific goal is 0. Ultimately, the Corporate goal for WSS is 0.

2022 Plan

- Owner: SHMC Leadership
- Data source: MIDAS
- Needed resources: Support from CEO's, COO's, CMOs, CNO's, and RVP's.
- Frequency of reporting to CPSC: Monthly
- High level plan for improvement implementation:
    - Focus improvement actions for PSO Surgical and Procedural Safety initiatives on
        - Evidence based practices, in particular with **adherence to current policies and procedures**
        - Accountability processes for speak up, escalation, and stop the line
        - Continued involvement of hospital CEOs with follow up of their Gap Analyses, involvement in the revised RCA process for WSS/RPI, and development of consistent rounding by c-suite in the procedural areas
        - Creating an environment conducive to counting process
            - Vendor presence and acceptable involvement in procedure
            - Physician provider support of process
            - Accountability for behaviors disruptive to a culture of safety
    -

OBHRU

Perinatal Obstetrical Hemorrhage

2022 Goal(s)

In 2020 the percentage of obstetrical patients experiencing blood loss > 2000 ml was 0.88 %, as a result of the increased utilization of QBL the percentage rose to 0.95% in 2021. In advancing the patient safety goals in managing OB hemorrhage outcomes our goal is to increase the percentage of patients with QBL of 2000 ml who receive transfusions to ≥ 50%. Quantification of blood loss will occur at 95% of all deliveries as evidenced by facility results of Healthy Intent/Analytics Hemorrhage report/dashboard.

2022 Plan

- Data source: Healthy Intent/Analytics Hemorrhage dashboard for QBL compliance, Healthy Intent/Analytics Hemorrhage dashboard for assessment of transfusion compared to QBL > 1500 ml and > 2000 ml
- Needed resources: Facility Leadership, Women's Services Leadership; Providers – Obstetricians/Anesthesia/Certified Nurse Midwives; Nurses; Patients; OB Section Medical Director.
- Frequency if reporting to CPSC: Monthly
- High level plan for improvement:

  The measurement for progress / outcomes is as follows:
  - Quantification of blood loss will occur at 95% of all deliveries as evidenced by facility results of Healthy Intent/Analytics Hemorrhage report/dashboard. To be reported to facility Patient Safety Council monthly.
  - Facilities to assess Blood loss of 1000, 1500 and 2000 compared to transfusions utilizing excel tool.
  - Complete debrief on 100% of hemorrhage patients with QBL> 1500 mls.
  - Utilizing the debrief process to track the of percentage of patients transfused with QBL > 1500 ml and QBL > 2000 ml and rationale for not transfusing
  - Submission of post event debrief forms to unit leadership. Unit leadership to report compliance with debrief process to facility patient safety council for patients with blood loss > than 1500 ml. Determination of rationale to not transfuse patients with blood loss great than 1500 ml to be provided to council.

Perinatal Newborn Outcomes Inductions:

2022 GOAL(S)

The reduction/elimination of serious harm by reducing the number of full-term newborns requiring NICU admission by 10%. Reporting period 2/2022 through 1/2023 (Corporate and Hospital goal). Assessment period 1/2022 through 12/2022. The program will begin with the development of a project charter and establishment of a baseline

2022 PLAN

- Owner: Rachel Sheehan
- Data source: Women's Services Oxytocin Dashboard, Midas reports on Apgar Scores < 6 at minutes, and Oxytocin audit results.
- Needed resources: Facility Leadership, Women's Services Leadership; Providers – Obstetricians/Anesthesia/Certified Nurse Midwives; Nurses; Patients; OB Section Medical Director.
- Tools- Women's services oxytocin dashboard, Unique Events Dashboard, Midas Profile Indicator report 1027, Oxytocin checklist audit, oxytocin checklist trend report, Oxytocin medication safety education, and Category II algorithm
- Corporate trending to occur quarterly and to include:
  - Number of facilities completing 5 oxytocin audits per month
  - Trending of Percentage of full-term newborns with Apgar Score less than 6 at 5 min
  - Trending of Percentage of full-term newborn requiring NICU admission: Goal to decrease by 10% from 2021 percentage
  - Newborn Risk Management events trending
- High level plan for improvement:

  The measurement for progress / outcomes is as follows:
  - Quarterly Submission of unique events dashboard
  - Quarterly Submission of monthly oxytocin audit results to corporate OB HRU-utilizing Apgar Score< 6 @ 5 and NICU admissions > 37 weeks

- **CLABSI Initiative**

2022 Goal

CLABSI will both be reduced to less than the CMS national mean Standardized Infection Ratio (0.692) in 2022.

2022 Plan

- Data source: CDC's National Healthcare Safety Network (NHSN)
- Needed resources: Patient Safety leads, RVPs, CEOs, CMOs, CNOs and IPs
- Frequency of reporting to CPSC: Quarterly report of aggregate (SIR)
- High level plan for improvement implementation:
  - Evidence-based prevention bundles ranking interventions using CORE, WISE, SAFE methodology
  - Nurse driven program with support from infection prevention and leadership team
    - Continued partnership between IP and Nursing to drive the initiative forward
  - Reduce device insertions adhering to strict placement criteria
  - Prompt device discontinuation when no longer clinically indicated
  - Daily rounding to promote a culture of accountability
  - Focus on proper technique for device insertion and maintenance
  -

- **Safe Medication Use**
- **Anticoagulation Safety**

2022 GOAL(S)

1. Our goal is to partner with hospitals to help them develop a standardized process at their facility for restarting anticoagulants in the perioperative setting by December 2022.
2. AHRQ PSI 12 Perioperative Pulmonary Embolism or Deep Vein Thrombosis benchmark is 3.950 per 1000 inpatients. Facilities above the benchmark are to meet or decrease their Patient Safety Indicator (PSI) 12 rate by 10% by December 2022 (Corporate and Hospital goal).
3. The VTE Advisor will be used to assess the patient's postoperative risk for thromboembolism and documented prophylaxis through the VTE advisor. The UHS compliance goal is 80% (Corporate and Hospital goal).

2022 PLAN

- Data source: Cerner, MIDAS, UHS Quality PSI Dashboard, UHS VTE Dashboard
- Needed resources: Facility buy-in, PSO guidance, evidence-based recommendations, IS/IT input
- Frequency of reporting to CPSC: Quarterly
- Improvement implementation:
  - Facilities will utilize the UHS Perioperative Anticoagulation Management Guideline published in 2019 as a reference to develop a standardized process for determining the time that the anticoagulant should be restarted a procedure. Target date is June 1, 2022.
  - Each PSI 12 event will have a comprehensive review performed. Elements of the review will be provided.
  -

Smart Infusion Pump

2022 GOAL(S)

1. Each facility will decrease their number of high-risk medication overrides by 50% by December 1, 2022. The CareFusion Executive Summary report will be accessed for hospital specific data. Facilities will be provided with baseline data.
2. Each facility will increase Guardrails Suite usage to meet UHS and Leapfrog goal of 95% by December 1, 2022. The CareFusion Executive Summary report will be accessed for hospital specific data. Facilities will be provided with baseline data.
3. Naloxone provision usage will increase to 95% by June 1, 2022. The Lights On Network will be used to collect naloxone provision data and distributed to the facilities.

2022 PLAN

- Data source: CareFusion Document Delivery System, MIDAS, Lights On Network
- Needed resources: Facility buy-in, PSO guidance, Pharmacy Services & IT assistance, evidence-based team recommendations
- Frequency of reporting to CPSC: Quarterly
- Improvement implementation:
    - Designate individuals to review High-Risk Overrides and Guardrails Suite usage provided in the quarterly CareFusion Executive Summary. Each facility is to track and trend their top 5 high risk overrides and lowest guardrail suite(s) compliance. Determine why auto-programming and guardrails were not used. Track, trend, and report findings to the Medication Safety Committee and document the discussion in the minutes.
    - Hospitals will implement an action plan to determine the cause of manual programming and basic infusion usage and work to eliminate barriers
    - Each facility is to track, trend, and evaluate naloxone administrations in the Medication Safety Committees and document discussion in the minutes.
    - Develop a process to work with providers that do not utilize the naloxone provision in Cerner. Track, trend, and discuss progress in the Medication Safety Committee meeting minutes
    - The Midas Event Reporting System will continue to be utilized for medication errors and adverse drug events related to manual programming of the smart infusion pump. Infusion device errors will be classified in Midas as Medication Event-Administration, Med Event- Infusion Device Operator Error for accuracy in tracking and trending

- **Reduce Falls and Falls with Injury**

2022 Goals

- 10% reduction in rate of falls and rate of falls with injury by end of 2022 (Corporate and Hospital goal. Hospitals with a rate <.05 will have a goal of 0).

2022 Plan

Data source: MIDAS

Needed resources:

- Clinical
    - Standardized, evidence-based Fall Prevention Program
        - Multidisciplinary team
        - Preventative measures
        - Education
        - Debriefing tool

- Information Technology
    - Construct reports and standardized fall debrief tool to support improvement efforts

Frequency of reporting to CPSC: Quarterly
High level plan for improvement:

- UHS Corporate oversight of standardized Fall Prevention Program
    - Fall Prevention Committee at each hospital with multidisciplinary representation and data review
    - Standardized debrief tool used by all hospitals
- Hospital implementation of standardized Fall Prevention Program
    - Data review quarterly at hospital Patient Safety Council
        - Review of number of falls and fall injury rate
        - Use of standardized debrief tool used by hospitals

- **Decreasing Hospital Acquired Pressure Injuries**

2022 GOAL(S)

- 10% overall reduction of not present on admission (NPOA) rate for all HAPI stages in the acute division by end of 2022 (Corporate and Hospital goal).

2022 PLAN

Data source: MIDAS
Needed resources:

- Clinical
    - Standardized, evidenced-based Pressure Injury Reduction Program
        - Multidisciplinary team
        - Preventative measures
        - Education
        - Implement Four Eyes in Four Hours to increase capture of POA wounds
- Information Technology
    - Construct reports to support improvement efforts

Frequency of reporting to CPSC: Quarterly
High level plan for improvement implementation:

- Development of standardized Pressure Injury Reduction program
    - Pressure Injury Prevention multidisciplinary teams within each hospital
    - Performance monitored at Corporate Patient Safety Council
- Hospital implementation of standardized Pressure Injury Reduction program
    - Data review quarterly at hospital Patient Safety Council
        - Review of number of HAPI rate

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/SOX 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.

SUNRISE HOSPITAL & MEDICAL CENTER / SUNRISE CHILDREN'S HOSPITAL Las Vegas, Nevada	**ORG.2404** **Performance Improvement and Patient Safety Plan**
Last Reviewed: (04/2007); 04/2014; 01/2015; 02/2016; 02/2017; 01/2018; 01/2019; 03/2020; 03/2021	**Replaces Policy Dated:** 04/2007; 04/2014; 01/2015; 02/2016; 02/2017; 01/2018
HCA Effective Date: N/A	**Approved by BOT:** 04/2014; 01/2015; 08/2016; 03/2017; 02/2019; 06/2020; 03/2021
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. Performance Improvement priorities identified by leaders.
2. ~~1.~~ Operative or other procedures that place patients at risk of disability or death.
3. ~~2.~~ All significant discrepancies between preoperative and postoperative diagnoses, including pathologic diagnoses.
4. ~~3.~~ Adverse events related to using moderate or deep sedation or anesthesia.
5. ~~4.~~ Use of blood and blood components.
6. ~~5.~~ All reported and confirmed transfusion reactions.
7. The number and location of cardiac arrests
8. ~~6.~~ Resuscitation performance to include outcomes of resuscitation and any transfers to higher level of care post ~~esults of~~ resuscitation.
9. ~~7.~~ Behavior management and treatment.
10. ~~8.~~ Significant medication errors.
11. ~~9.~~ Significant adverse drug reactions.
12. Patient thermal injuries that occur during magnetic resonance imaging exams.
13. Pain assessment and reassessment including interventions and effectiveness.
14. Data requirements as outlined in The Joint Commission Performance Improvement Standards.

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.

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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 serious event analysis (SEA), 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.

American Burn Association (ABA) registry

A. ABA is designed to improve the quality and cost of burn care by collecting and exchanging information on burn injuries and outcomes.

American College of Surgeons National Surgical Quality Improvement Program Pediatrics.

A. ACS NSQIP Pediatric is a surgical quality improvement program specific to pediatric surgery. It is the first multispecialty national database to measure surgical outcomes for pediatrics.
B. ACS NSQIP Pediatric is the nation's first and only risk-adjusted, clinical, outcomes-based program to measure and improve pediatric surgical care.
C. ACS NSQIP Pediatric data powers a preoperative risk calculator tool that allows clinicians to input an individual patient's risk factors—such as age, sex, and ASA class—into a statistical model that calculates the likelihood of various outcomes.

Extracorporeal Life Support Organization (ESLO) Registry

A. ELSO registry provides member institutions with data to improve the quality of care to patients who received Extracorporeal Membrane Oxygenation (ECMO) care.
B. Data submitted by Centers to the Registry includes personally identifiable information: gender, race, nature, and severity of illness, technical details of extracorporeal support used, dates of service, complications, and outcomes.

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

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NRS 439.875 Patient Safety Committee
Joint Commission Requirements for Performance - Performance Improvement Chapter

PERFORMANCE IMPROVEMENT REPORTING STRUCTURE

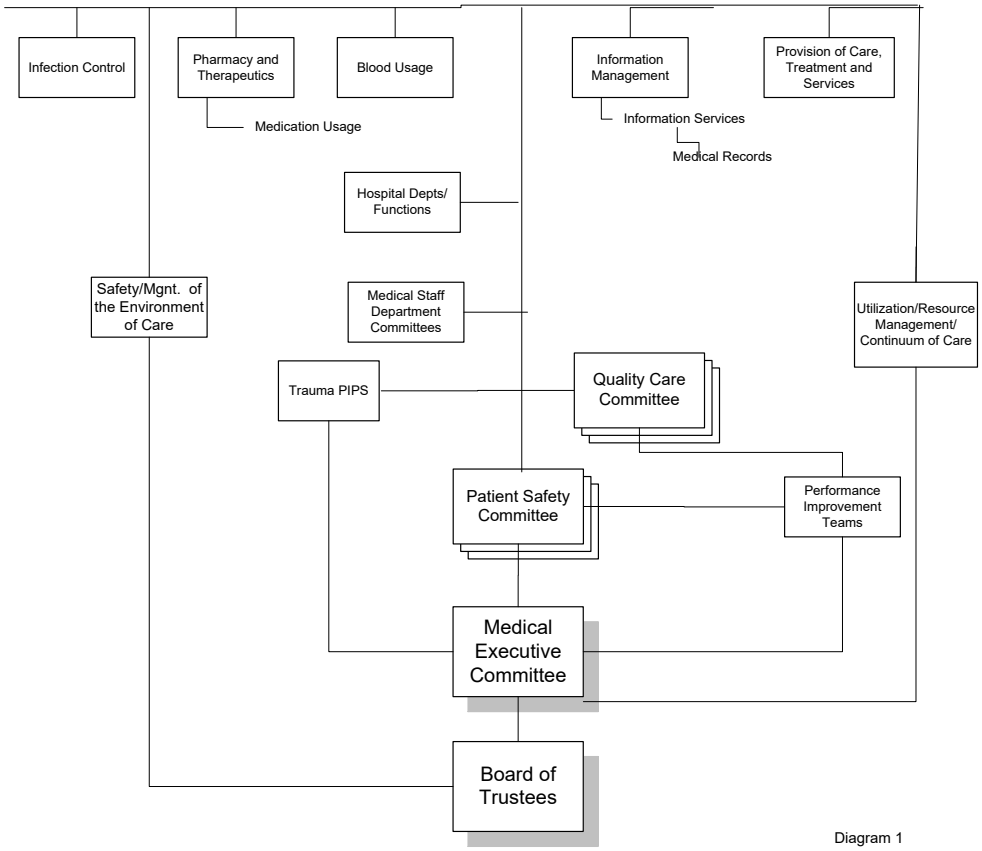
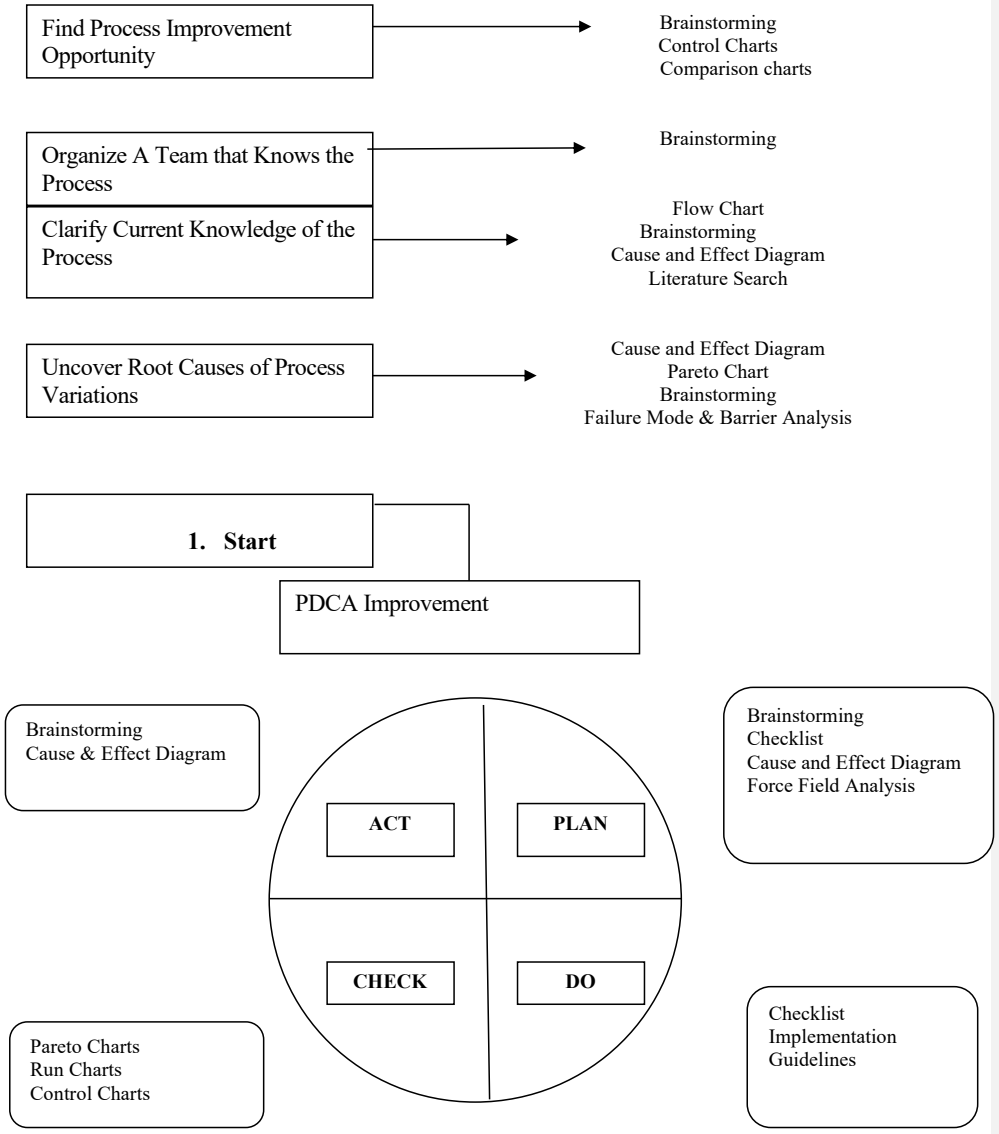


Diagram 1

FOCUS - PDCA


Find Process Improvement Opportunity
Brainstorming
Control Charts
Comparison charts
Organize A Team that Knows the Process
Brainstorming
Clarify Current Knowledge of the Process
Flow Chart
Brainstorming
Cause and Effect Diagram
Literature Search
Uncover Root Causes of Process Variations
Cause and Effect Diagram
Pareto Chart
Brainstorming
Failure Mode & Barrier Analysis
1. Start
PDCA Improvement
Brainstorming
Cause & Effect Diagram
ACT
PLAN
CHECK
DO
Brainstorming
Checklist
Cause and Effect Diagram
Force Field Analysis
Pareto Charts
Run Charts
Control Charts
Checklist
Implementation
Guidelines

	POLICY /GUIDELINE TITLE: Patient Safety Plan 2022
MANUAL: Center for Quality and Patient Safety	**POLICY OWNER:** Patti Stopka
ORIGINATION DATE:	**FINAL APPROVAL DATE:**

SCOPE:

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

- Patient safety
- Visitor safety
- Employee safety

All UMC staff may fully support and participate in this plan, as well as devote their expertise to the patient safety and healthcare quality improvement process.

PURPOSE:

The purpose of the Patient Safety Plan is to address patient safety related concerns, challenges and revise the program to better serve patients and their families/representatives.

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
- Promotion of Just Culture

University Medical Center of Southern Nevada (UMC) is committed to a comprehensive approach to improving healthcare quality and patient safety. Our commitment aligns with our mission, vision, and values to create an environment that supports a dynamic, proactive, and safe culture for patients, family members/representatives, visitors, and employees through continuous learning and improving patient safety policies, procedures, systems, and processes.

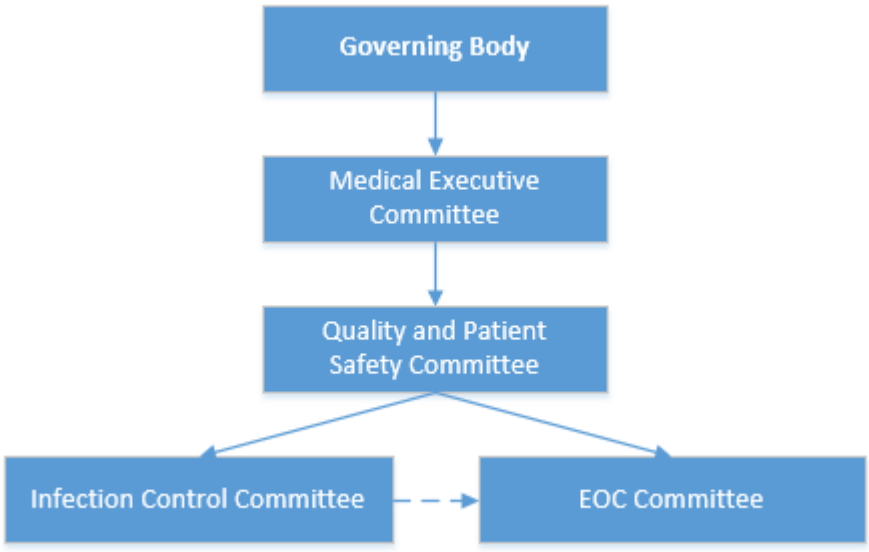
This is achieved through:

- 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 ensure participation of healthcare providers.

POLICY:

In accordance with NRS 439.875, UMC has established a Quality and Patient Safety Committee. The Quality and Patient Safety Committee is responsible to oversee UMC's Patient Safety Program and encompasses: overall patient safety and outcomes, risk management, infection control and environment of care (EOC). As directed by the Board of Governors, the Quality and Patient Safety Committee will serve as the organization's grievance committee.

Hospital Quality and Patient Safety Committee Organization



	POLICY /GUIDELINE TITLE: Patient Safety Plan 2022

Roles and Responsibilities:

Committee:

- In accordance with NRS 439.875, the committee includes the following members:
  - The infection control officer;
  - The patient safety 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;
  - One member of the executive or governing body.

- Committee responsibilities per (NRS 439.875 and NRS 439.877) include, but are not limited to the following:
  - Meet at least monthly;
  - Receive reports from the patient safety officer pursuant to NRS 439.870;
  - Review and evaluate the quality 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 measures carried out by the facility to prevent and control infections;
  - Make recommendations to the executive or governing body 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:
    - (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 policies as required by NRS 439.877, review the checklists and policies annually and revise the checklists and policies as the committee determines necessary.
  - The committee shall also 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 committee's review process.

	POLICY /GUIDELINE TITLE: Patient Safety Plan 2022

Patient Safety Officer: (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 Hospital Quality and Patient Safety Committee;
- Supervise the reporting of all sentinel events alleged to have occurred at UMC, including without limitation, performing the duties required pursuant to NRS 439.835;
- Investigate the occurrence of sentinel events and implement action plans;
- Report to the committee on actions taken to ensure patient safety.

Reporting:

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 a patient safety event report in accordance with the Patient Safety Event Reporting policy and Sentinel Events/Serious Reportable Events policy.
- Department 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 committee.

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:

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 Patient Safety Officer or designee will disclose the event to the patient.

Pursuant to NRS 439.837, upon reporting a sentinel event, UMC 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 (Safety Intelligence)
- Patient and family complaints or grievances
- Risk Management findings
- Morbidity/Mortality reviews
- Infection Control data
- 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

Patient Safety Checklists and Patient Safety Policies:

Patient Safety Checklists must follow protocols and are utilized to improve the health outcomes of patients. Checklists include, without limitation:

- Relationship to specific types of treatment, which include documentation that the treatment provided was properly ordered by the provider of healthcare.
- Assurances that the patient's room and overall environment is sanitary.
- For patient discharges 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 are an extension of the Patient Safety Plan.

Annual Patient Safety Plan and Evaluation:

The Patient Safety Officer reviews and updates the Patient Safety Plan annually. The 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 is submitted through the performance improvement structure and to the Governing Board.

At a minimum, the written report will include 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

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 plan will be maintained within UMC's electronic policy and procedure management system.
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.

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)

	POLICY /GUIDELINE TITLE: Patient Safety Plan 2022

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)

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

Near miss: An event or a situation that did not produce patient harm because it did not reach the patient, either due to chance or to capture before reaching the patient; or it if it did reach the patient, due to robustness of the patient or to timely intervention (AHRQ).

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

REFERENCES:

- 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 Infection Prevention/Control Risk Assessment, Plan and Authority Statement
- UMC policy, Patient Safety Event Reporting
- UMC policy, Patient compliant, grievance and insurance inquiry process
- UMC policy, Just Culture - Response to Safety Events
- UMC policy, Sentinel Events/Serious Reportable

	POLICY /GUIDELINE TITLE: Patient Safety Plan 2022

Review Date:	**By:**	**Description:**
2/2022	Quality/Safety/Regulatory Officer	Revised Committee structure for integration with existing Hospital Quality & Safety Committee; placed on new P/P template.

Valley Hospital Medical Center

Risk Management/ Patient Safety Plan

Nevada Acute Care Division

Revised 1/2022

A. **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 operates as a Patient Safety Organization to further its commitment in promoting patient safety and assuring that 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 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 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 facility policies. 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

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.

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 RESPONSIBILITES

A. Risk Management/Patient Safety Officer

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

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. 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 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:

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.

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: This element outlines the UHS Risk program that lays the foundation for an effective risk management program. The Risk Manager/Director must be seen as a resource to administration, facility, and medical staff. Written plans, goals, and objectives provide a clear vision to meet the purpose of the UHS program. Although the TERM program uses the title, "Risk Manager," this applies equally to Risk Directors.

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

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

Element IV. Patient Safety Initiative: Imperative to a comprehensive RM program is one that focuses on the improvement of patient and staff safety through the creation of an environment that maximizes safety and reduces liability claims exposure. The mechanism used to drive the culture of safety is the Patient Safety 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 cornerstone 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 environmental safety and security programs in the facility serve to protect and preserve both life and property. Areas of safety include licensing, accreditation and state, federal and local safety practices and programs.

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

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

Element IX. Medication Safety Initiative: The medication safety initiative is geared toward preventing and responding to the accidental injury of a patient due to medical care or medical errors during the medication-use process. The mechanism used to drive the culture of safety is the Medication Safety Committee at each facility. The committee proactively assesses risk points at every level of the medication use cycle: procurement, storage, ordering/prescribing, transcription, distribution, preparation, dispensing, administration, documentation, and monitoring.

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'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.

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 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 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. Patient Safety Priorities, Goals and Objectives for 2022

- **Surgical and Procedural Safety**
  - **Wrong Site Surgery (WSS)**
    - ***Goal***: A 50% reduction in WSS events for 2022. Ultimately, the goal is 0.
  - **Retained Procedural items (RPIs)**
    - ***Goal***: Prevent RPIs- a 50% reduction in RPIs with harm for 2022. Ultimately, the goal for RPIs is 0.

- **CLABSI Initiative**

- ***Goal***: CLABSI will be reduced to less than the CMS national mean Standardized Infection Ratio (SIR: CLABSI 0.692) in 2022.

- **Safe Medication Use**
  - **Smart Infusion Pump High Risk Opioid Event Reduction Initiative.**
    - ***Goal***: Decrease the number of high-risk opioid medication overrides by 50% by December 1, 2022.
    - ***Goal*:** Increase "Guardrails Suite usage to meet UHS and Leapfrog goal of 95% by December 1, 2022.
    - ***Goal:*** Naloxone provision usage will increase to 95% by June 1, 2022.
  - **Anticoagulant Safety in the Perioperative Setting**.
    - ***Goal:*** AHRQ PSI 12 Perioperative Pulmonary Embolism or Deep Vein Thrombosis benchmark is 3.950 per 1000 inpatients. The goal is to maintain the Patient Safety Indicator (PSI) 12 rate below the benchmark by December 2022.
    - ***Goal:*** The VTE Advisor will be used to assess the patient's postoperative risk for thromboembolism and documented prophylaxis through the VTE advisor The goal is 80% compliance with "VTE Advisor" usage.

- **Reduce Falls and Falls with Injury**
  - ***Goal***: 10% reduction in the rate of falls in the Acute Care Division by the end of 2022.
  - ***Goal***: 10% reduction in the rate of falls with injury in the Acute Care Division by the end of 2022.

- **Decreasing Hospital Acquired Pressure Injuries**
  - **Goal:** 10% reduction of NPOA rate for all HAPI stages in the Acute Care Division by the end of 2022.

- **Culture of Safety**
  - **Goal**: reduce the number of GHI events (serious safety event rate) for the Acute Care Division by the end of 2022. Ultimately, the goal is 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/SOX 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.

WillowSpringsCenter

A Residential Treatment Center for Children and Adolescents

Risk Management/Patient Safety Plan

2022

Revision Date: 2/2018; 5/2020; 1/2022

1. Overview

   Willow Springs has established a Risk Management/Patient Safety Plan that is supported by Senior Leadership to prevent, reduce, modify and eliminate conditions and practices that may create or cause loss. The safety and wellbeing of patients, personnel and the public is of the highest priority.

   Mission and Vision

   At Willow Springs, we are compassionate, committed and caring people, dedicated to inspire hope, as well as the ability to achieve and celebrate success through the power of relationships developed with children, families, and the communities we support. Willow Springs promotes clinical excellence, an environment of collaboration and trust while maintaining fiscal responsibility and integrity for patients, customers and the communities we serve.

2. Roles and Responsibilities
   A. Risk Management/Patient Safety Officer
      1. Behavioral Health Facilities designate Risk Managers to be responsible for risk identification and risk reduction.
      2. The designated Risk Manager/Director is also the Patient Safety Officer
      3. The Patient Safety Officer responsibilities based on NRS 439.870 includes:
         a. Serve on the patient safety committee.
         b. Supervise the reporting of all sentinel events alleged to have occurred at the medical facility, including, without limitation, performing the duties required pursuant to NRS 439.835.
         c. Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the medical facility.
         d. Report to the patient safety committee regarding any action taken in accordance with paragraph iii.

   B. Infection Prevention Officer
      1. The Infection Prevention Officer's responsibilities based on NRS 439.873 includes:
         a. Shall serve on the patient safety committee.
         b. Shall monitor the occurrences of infections at the medical facility to determine the number and severity of infections.
         c. Shall report to the patient safety committee concerning the number and severity of infections at the medical facility.
         d. Shall take such action as he or she determines is necessary to prevent and control infections alleged to have occurred at the medical facility.
         e. Shall carry out the provisions of the infection control program adopted pursuant to NRS 439.865 and ensure compliance with the program.
      2. Based on NRS 439.865, the patient safety plan must also include an Infection Control Plan/Program that carries out the infection control policy. The policy must consist of:

a. The patient safety checklists and patient safety policies most recently adopted pursuant to NRS 439.877.

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

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

C. Patient Safety Council (PSC)

1. The Patient Safety Council meets monthly and ensures
2. According to NRS 439.875, a medical facility shall establish a patient safety committee.

a. A patient safety committee established pursuant to subsection 1 must be composed of:

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

b. A patient safety committee shall meet at least once each month.

1. A patient safety committee shall meet at least once each month.
2. The Administrator shall adopt regulations prescribing the composition and frequency of meetings of patient safety committees at medical facilities having fewer than 25 employees and contractors.

c. A patient safety committee shall:

1. Receive reports from the patient safety officer pursuant to NRS 439.870.
2. Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred at the medical facility.

3. Review and evaluate the quality of measures carried out by the medical facility to improve the safety of patients who receive treatment at the medical facility.
4. Review and evaluate the quality of measures carried out by the medical facility to prevent and control infections at the medical facility.
5. Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur at the medical facility.
6. At least once each calendar quarter, report to the executive or governing body of the medical facility regarding:
    a. The number of sentinel events that occurred at the medical facility during the preceding calendar quarter;
    b. The number and severity of infections that occurred at the medical facility during the preceding calendar quarter; and
    c. Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
7. Adopt patient safety checklists and patient safety policies as required by NRS 439.877, review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.
8. The proceedings and records of a patient safety committee are subject to the same privilege and protection from discovery as the proceedings and records described in NRS 49.265.

d. Additional Patient Safety Committee Responsibilities, based on NRS 439.877 includes Patient safety checklists and patient safety policies: Adoption by patient safety committee; required provisions; duties of patient safety committee.

1. The patient safety committee established pursuant to NRS 439.875 by a medical facility shall adopt patient safety checklists and patient safety policies for use by:
    a. Providers of health care who provide treatment to patients at the medical facility;
    b. Other personnel of the medical facility who provide treatment or assistance to patients;
    c. Employees of the medical facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
    d. Persons with whom the medical facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients at the facility.

2. The patient safety checklists adopted pursuant to subsection 1 must follow protocols to improve the health outcomes of patients at the medical facility and must include, without limitation:
   a. Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of health care.
   b. Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of health care follow protocols to ensure that the room and environment of the patient is sanitary.
   e. A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
      i. Proper instructions concerning prescription medications;
      ii. Instructions concerning aftercare; and
      iii. Any other instructions concerning his or her care upon discharge.
   f. Any other checklists which may be appropriate to ensure the safety of patients at the medical facility.
3. The patient safety policies adopted pursuant to subsection 1 must include, without limitation:
   a. A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of health care. The personal identifiers may include, without limitation, the name and date of birth of the patient.
   b. A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of health care at the medical facility including, without limitation, protocols relating to hand hygiene.
   c. A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, without limitation, active surveillance. Active surveillance may include, without limitation, a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

4. The patient safety committee shall:
    a. Monitor and document the effectiveness of the patient identification policy adopted pursuant to paragraph (a) of subsection 3.
    b. At least annually, review the patient safety checklists and patient safety policies adopted pursuant to this section and consider any additional patient safety checklists and patient safety policies that may be appropriate for adoption for use at the medical facility.
    c. Revise a patient safety checklist and patient safety policy adopted pursuant to this section as necessary to ensure that the checklist or policy, as applicable, reflects the most current standards in patient safety protocols.
    d. On or before July 1 of each year, submit a report to the Director of the Legislative Counsel Bureau for transmittal to the Legislative Committee on Health Care. The report must include information regarding the development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to paragraph (b).

D. Patient Safety Advisories/Alerts.
    1. Advisories/Alerts are issued to facilities for the purpose of sharing pertinent information regarding a system or event that led to failure. Assessing these systems, can to lead to positive outcome so facilities can reduce the risk and avoid the same or similar outcome.
    2. Each facility should review the advisory and assure that processes are safe and appropriate.

E. TERM Program.
    1. WSC utilizes a risk management program identified as TERM, The Technical Elements Related to the Management of Patient Safety. The TERM document identifies expectations for our facility similar to a standard of care.
    2. Elements of TERM include:
        a. Administration of the RM and Patient Safety Program.
        b. Risk Identification.
        c. Patient Safety Orientation and Education.
        d. Risk Prevention Techniques.
        e. Contract Services.
        f. Risk Profiling.
        g. Patient Safety Council.
        h. Environment of Care.
        i. Claims and Litigation.
        j. Measuring the Effectiveness of the Patient Safety Program.

F. MIDAS.
    1. The entering of the facility's Healthcare Peer Review Reports (HPRs) for patients and non-patients into MIDAS+ as Risk Management Event Entries is the responsibility of the facility Risk Manager. They are entered on a regular basis and the Risk Manager utilizes the system to collect data through the various Risk Management Reports, which are written based on data from the event reports (HPRs) and MIDAS+.

G. ENTERPRISE.
    1. Enterprise is an electronic platform used to enter and track probable claims reports. A PCR is the facility's method of communicating the event and related findings/facts to Corporate Insurance staff.

H. RCA – Root Cause Analysis.
    1. The Root Cause Analysis and Action Plan tool has 24 analysis questions. The framework is intended to provide a template for answering the analysis questions and aid organizing the steps in a root cause analysis. All possibilities and questions should be fully considered in seeking "root cause(s)" and opportunities for risk reduction. Not all questions will apply in every case and there may be findings that emerge during the course of the analysis. For each finding we continue to ask "Why?" and drill down further to uncover why parts of the process occurred or didn't occur when they should have. Significant findings that are not identified as root causes themselves have "roots".
    2. According to NRS 439.837, states that a Mandatory investigation of sentinel event by medical facility:
        a. A medical facility shall, upon reporting a sentinel event pursuant to NRS 439.835, conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event.

I. Risk Management Goals and Objectives 2020:
    1. Demonstrate compliance with the Centers for Disease Control and Prevention (CDC) and compliance with National Patient Safety Goal NPSG.07.01.10, demonstrating our compliance with hand hygiene guidelines."
    2. Monitor infection rates of patients.
    3. Educate new staff and facility adheres to the National Patient Safety Goals to improve patient safety.
    4. Senior leadership conducts audit observation rounds which leads to maintaining patient safety and preventing harm to the patient.
    5. Patient safety orientation and education for all new hires creates risk reducing practices.
    6. Good Catch Program recognizes an event that could have been harmful to a patient, but was prevented. This creates and maintains an environment of non-punitive reporting

J. Approval of Patient Safety Plan.

1. According to NRS 439.865, a medical facility shall submit its patient safety plan to the governing board of the medical facility for approval in accordance with the requirements of this section.
    a. After a medical facility's patient safety plan is approved, the medical facility shall notify all providers of health care who provide treatment to patients at the medical facility of the existence of the plan and of the requirements of the plan. A medical facility shall require compliance with its patient safety plan.
    b. The patient safety plan must be reviewed and updated annually in accordance with the requirements for approval set forth in this section.

References:

https://www.leg.state.nv.us/NRS/NRS-439.html

https://www.cdc.gov/handwashing/index.html

https://www.jointcommission.org/

https://www.jointcommission.org/standards_information/npsgs.aspx

WILLOW SPRINGS CENTER

RISK SAFETY PLAN

Approval Signatures

_____ _____

Governing Board Representative Date

_____ _____

Chairman, Medical Executive Committee Date

_____ _____

Performance Improvement/Risk Director Date

MOUNTAINVIE□ HOSPITAL

PATIENT SAFETY PLAN

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I□ Introduction

Purpose, Scope and Responsibility

- ✓ Purpose:
  - o To define the essential components of the Patient Safety Program at MountainView Hospital, which is committed to ensuring a safe environment and reliable care processes.
  - o To cultivate a culture of patient safety through the ongoing promotion of a safe practices and personal accountability.
- ✓ Scope: Patient safety is everyone's responsibility. To be effective, the plan requires the active involvement of all members of the healthcare team, as well as patients and families. The MountainView Hospital Patient Safety Program covers all activities and functions relating to patient safety at all sites and services within the organization.
- ✓ Responsibility: Leaders, employees, members of the medical staff, students and volunteers are to be familiar with and involved in the Patient Safety Program.

Participation in Patient Safety Organization

- ✓ MountainView Hospital is committed to an organizational environment aimed at improving patient safety and the quality of healthcare provided to the Hospital. To further this objective, the Hospital contracted with HCA Patient Safety Organization, LLC ("HCA PSO, LLC"), a federally certified Patient Safety Organization ("PSO"), to receive assistance in conducting a wide variety of patient safety activities intended to reduce medical errors in a legally protected environment.
  Generally speaking, patient safety work product ("PSWP") is not subject to subpoena or discovery in state or federal court, in administrative proceedings, or pursuant to the Freedom of Information Act ("FOIA"), and cannot be disclosed except as permitted under the Patient Safety and Quality Improvement Act ("PSQIA") and its associated regulations. *(See 42 CFR § 3.204, Privilege of patient safety work product; and 42 CFR § 3.206, Confidentiality of patient safety work product.)*
  The Hospital will be receiving and exchanging patient safety information with the PSO, including event or incident reports and investigations, analytic tools such as root cause analyses, patient safety communications, quality reviews, and other documents aimed at improving patient safety. Documents will be submitted in a standardized format to allow for comparison with like providers. As part of this effort, the Hospital will operate a Patient Safety Evaluation System ("PSES") designed to encourage internal reporting of adverse events, near misses, and unsafe conditions for purposes of reporting to HCA PSO, LLC. The PSES will be the vehicle for collecting, managing, and analyzing information for patient safety purposes. Designated Hospital personnel will collect patient safety information and report it to HCA PSO, LLC on an ongoing basis for analysis and feedback.

Definition of Terms

Accountability:	An obligation or willingness to accept responsibility for one's actions.

Adverse Event:	Event under the control of a provider which has caused harm and requires a new or modified physician order for management of the patient's health care. See Policy RM1□: Sentinel Event for specific event list and RM13: Disclosure of Adverse Events.
CSIP	The Clincial Safety Improvement Plan (CSIP) offers hospitals the opportunity to voluntarily develp and implement specific patient safety initiatives focused on issues identified by the evaluation of close calls, adverse events, and current hospital clinical performance metrics. This program aims to reduce the incidence of adverse events, reduce patient harm, and promote the development of competency of patient safety leadership. HCA PSO will guide hospitals in the submission of required program deliverables and will communicate completion results to the facilities
Hazardous condition:	Any set of circumstances (exclusive of the disease or condition in which the patient is being treated), which significantly increases the likelihood of serious adverse outcome.
Healthcare FMEA:	Healthcare Failure Mode and Effects Analysis: A proactive model for addressing potential risks within the organization.
High Reliability	An environment of "collective mindfulness" in which all staff look for and report small problems or unsafe conditions before they pose a substantial risk to the organization and when they are easy to fix. To achieve this, leadership commitment exists for achieving zero patient harm, a fully functional culture of safety throughout the organization, and the widespread deployment of highly effective process improvement tools (TJC).
Human Error:	An unintended act, or failure to act, that results in actual or potential patient injury, harm or adverse event in the process of care delivery.
Near miss:	Any process variation that did not affect the patient outcome, but for which a recurrence carries a significant chance of serious adverse outcome.
Non-punitive:	No punishment or disciplinary action imposed for specific error.
Patient injury:	Major permanent loss of function, sensory, motor, or intellectual impairment not present at admission, requiring continued treatment or lifestyle change. When "major permanent loss of function" cannot be

	immediately determined, patient injury is not established until either the patient is discharged with continued major loss of function, or two weeks have elapsed with persistent major loss of function, whichever occurs first.
Patient safety event:	All adverse events or potential adverse events that are deemed preventable and Healthcare associated infections as defined by the CDC that are deemed to be preventable.
PSQIA	The Patient Safety and Quality Improvement Act (PSQIA) of 2005, Pub. L. 10□-41, 42 U.S.C. 2□□b-21-b-26 (for which the final rule implementing the regulations became effective on January 1□, 200□), was enacted in response to growing concern about patient safety in the United States and the Institute of Medicine's 1□□□ 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.

Safety Culture: The safety culture of a hospital is the product of individual and group beliefs, values, attitudes, perceptions, competencies, and patterns of behavior that determine the organization's commitment to quality and patient safety. (TJC)

Sentinel Event: A patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in death, permanent harm, and/or severe temporary harm (TJC, 2016). (A permanent loss of function related to the natural course of the patient's illness or underlying condition is not a Sentinel Event.) The State of Nevada defines a sentinel event as an event included in Appendix A of "Serious Reportable Events in Healthcare – 2011 Update: A Consensus Report," published by the National Quality Forum (Nevada Revised Statutes NRS □43□.□30 – effective October 1, 2013).

Sentinel Event Alert Gap Analysis: A model for prioritizing and addressing potential risks related to publish external sentinel or warning alerts.

Unusual Occurrence: Any event or condition not consistent with the normal or usual operation of the hospital or department and which has the potential for causing patient or visitor injury or property damage. (See policies – RM1□: Sentinel Event and RM13: Disclosure of Adverse Events).

II□ Policy

The Board of Trustees delegates responsibility for oversight of the patient safety program to the Patient Safety Committee. The Patient Safety Committee monitors and evaluates the effectiveness of the Patient Safety Program and generates feedback and actions as appropriate. The Patient Safety Committee prepares an annual report to the Quality Council, Medical Executive Committee (MEC), and the Board of Trustees (BOT). The report includes at a minimum, occurrence or trending of patient safety indicators and actions taken in response to actual occurrences as well as proactive assessments of high-risk activities. The Environment of Care Committee oversees non-clinical safety related processes and system issues that affect patients, employees, and visitors in the environment of care.

Risk Management maintains the hospital-wide occurrence reporting system for patients, employees, and visitor occurrences and a referral system for hospital staff and physicians to report potential claims. Risk Management in conjunction with Hospital Quality and Patient Safety Leaders investigate actual and potential safety risk within the organization. They also evaluate occurrences to identify those that may require immediate follow up actions or meet the Sentinel Event, the Safe Medical Device Act, or regulatory agency reporting criteria, including CMS, FDA, OSHA, State of Nevada DHHS, or Joint Commission. Notification is made to Administration, Risk Management, appropriate regulatory and accrediting agencies, equipment manufacturers and other appropriate individuals as necessary.

The Organization ensures timely coordination and dissemination of reporting and data management of patient safety information at the appropriate medical staff/organizational committees for review and discussion.

III□ Culture of Safety

MountainView Hospital is committed to creating a culture of safety by designing or redesigning systems and processes geared to prevent, detect, and minimize the hazards and likelihood of error; as well as a continuous approach to the improvement of patient safety. MountainView Hospital fosters a just culture that is focused on prevention and identifying systemic vulnerabilities that pose a threat to the safety of our patients, staff and the facility. Patient safety events are viewed as an opportunity to learn, not blaming individuals. The Hospital believes in balancing the organization's accountability and the individual's accountability for assuring safe practices and a safe environment to care for patients.

IV□ Structure□Roles and Responsibilities

The philosophy guiding the promotion of a culture of patient safety is accountability. To achieve a culture of patient safety the following accountabilities are expected at MountainView Hospital:

Role	***Accountability***	***Specific Tasks***
Board of Trustees, with Senior Leadership	Set goals, monitor performance & require accountability.	• Receive regular and thorough reports on patient safety risks, hazards and progress towards performance improvement objectives from the MEC and Patient Safety Committee. • Receive regular and thorough briefings regarding the results of culture measurement and performance improvement initiatives • Require multi-cause analysis of errors that lead to injury. • Set performance improvement goals for safety improvement. • Hold hospital leaders accountable for achieving the integrated patient safety agenda. • Receive systematic and regular assessment of resource and budget allocations to key systems (patient safety systems, human resources, quality systems, technology) related to the patient safety agenda.
Administrative (CEO, COO, CNO, VP's, Directors, & Physician Leaders	Set the agenda for the rest of the team	• Ensure that an integrated patient safety program is implemented throughout the hospital. • Set performance improvement priorities and identify how the hospital adjusts priorities in response to unusual or urgent events. • Allocate adequate resources for measuring, assessing and improving the hospital's performance and improving patient safety. • Measure and assess the effectiveness of the performance improvement and safety improvement activities. • Monitor implementation for of corrective action of patient safety events. • Ensure remedial activities, identified through analysis of reported patient safety events, are implemented, effective, and do not cause unintended adverse consequences. • Develop a proactive approach to reducing errors. • Encourage an environment of openness & collaboration. • Support a dialogue about outcomes between patients and clinicians including systems to obtain direct feedback from patients regarding performance of the organization • Educate staff about safety. • Support staff and lead by example.

Role	***Accountability***	***Specific Tasks***
Patient Safety Officer / CMO/Chief of Staff	Lead patient safety initiatives with the medical staff and organizational staff	• Lead an integrated patient safety program. • Serve as the primary point of contact for questions about patient safety, and coordinate patient safety for education and deployment of system changes. • Execute performance improvement priorities and adjusts priorities in response to unusual or urgent events. • Assure effectiveness in measuring, assessing and improving the hospital's performance and improving patient safety. • Lead a proactive approach to reducing errors and make recommendation to reduce patient safety events. • Lead in an environment of openness & collaboration. • Assure dialogue about patient safety issues occurs effectively between patients and clinicians. • Report progress regularly, and educate about patient safety • Support staff and lead by example.
Unit Safety Champions	Day to day coordination and facilitation of safety initiatives	• Implement operational aspects of the patient safety program throughout the hospital. • Implement proactive patient safety management that assures immediate, appropriate response to unusual or urgent events. • Participate in measuring, assessing and improving the hospital's performance and improving patient safety. • Be accountable for patient safety initiatives and strengthening a culture of safety in day to day practice. • Support an environment of openness & collaboration. • Support a dialogue about patient safety issues between patients and clinicians. • Report progress regularly, and educate about patient safety. • Support staff and lead by example.
Pharmacists	Ensure safe medication usage	• Ensure that authoritative, up-to-date drug information is available in reference form in patient care areas and prescribers' offices. • Periodically examine all drug products stored in patient care areas and procedures on drug storage/distribution to patient care areas. • Minimize the need for nurses to calculate, manipulate, or mix medications. • Establish a pharmacy led interdisciplinary team to spearhead medication safety activities. • Provide leadership to develop safe medication delivery systems.

Role	*Accountability*	*Specific Tasks*
Clinicians & Medical Staff	Monitor, report, & learn	• Medical staff and other employee job descriptions and competency evaluations incorporate accountability for safety. • Medical staff & employees participate in education on the importance of safety, surveillance, and expectations for reporting safety concerns, beginning with orientation. • Medical staff & employees evaluations include an individual's contributions to safety for the organization. • Medical staff & employees are positively acknowledged for disclosing errors, near-misses, and safety concerns. • Employees and physicians work collaboratively assuring responsibilities of the team to the patients are met, and noticing errors before they cause harm. • Participate in the facility reporting system for PS events, both actual and potential event.
Patients/visitors	Involved partners in prevention.	• Inform doctors and nurses about medications they take, including prescriptions, over-the-counter drugs and dietary supplements. • Ask for written information about possible side effects. • Inform the doctors and nurses about allergies & adverse reactions. • Ask a relative or friend to be an advocate. • Learn about their medical condition by asking their doctor, nurse, and other reliable sources. • Upon hospital discharge, ask doctors for an explanation of the treatment plan to be used at home. • Provide feedback regarding performance of the organization • Report safety concerns through the Patient Safety hotline and other venues available.

V Mechanisms for Coordination

MountainView Hospital Patient Safety Committee

The MVH Patient Safety Committee (PSC) or equivalent is a multidisciplinary team involving department representatives that meets not less than monthly. The Patient Safety committee or equivalent committee, is comprised of various health care professionals including but not limited to physicians and residents, nurses, pharmacists and administrators, and is chartered to oversee the implementation of the Hospital's Patient Safety Program. The Patient Safety Officer coordinates the PSC. The CEO, CMO, and Chair of Quality Council appoint medical leadership for the PSC.

Structures that support the Patient Safety Committee or equivalent works in conjunction with other safety committees, including but not limited to:

- Medication Safety
- Quality Council
- Environment of Care
- Falls Committee
- Infection Prevention Committee

The PSC reviews and develops implementation strategies for the NPSG's. Strategies include assessing and developing a culture of patient safety, encouraging a non-punitive reporting

environment, developing a best practice infrastructure to foster the design of safety into our systems, and monitoring of systems risks and improvements. The PSC networks with other committees as appropriate per topic to gain consensus (e.g. Quality Council, Infection Prevention, Pharmacy, other). Sentinel Event Alerts and other industry alerts are routed to the appropriate committee or teams to ensure evaluation of current care processes incorporate recommended changes.

The PSC reviews Sentinel Event Alerts, other industry alerts, compliance to The Joint Commission National Patient Safety Goals, State regulatory requirements, adverse events and potential adverse events that are deemed to be preventable, health care associated infections as defined by the CDC that are deemed to be preventable, and assures recommendations are integrated into processes. Additional resources such as national and local professional organizations/associations are monitored for changes in standards and potential risk events. Regular summary reports of progress are reported to the designated Quality Council, Medical Executive Committee, and the Board of Trustees.

The PSC reviews and approves plans to address key organizational concerns, such as Falls, Restraint Reduction, Patient/Family Education, Patient Mobility, Blood and Blood Components, Medication Safety, Adverse Drug Reactions (ADR's), Pressure Ulcer Prevalence, Health Care Associated Infections and Environmental issues updates.

The PSC recommends and provides direction for training on key initiatives and educational strategies related to patient safety.

VI. Communicating with Patients about Safety

It is MountainView Hospital's philosophy that accountability for patient safety is imbedded in a collaborative relationship involving our Board of Trustees, administrative leadership, our medical staff, employees, patients and family.

Patient safety awareness information is posted in public areas throughout the hospital. This information contains basic strategies for patients to assist in assuring their safety. The admission and discharge patient information also contains information on the patient role in safety. Patient Guides are provided to in-patients upon admission, and includes strategies prevent untoward events such as falls, medication errors, and infections while in the hospital. Annually, Patient Safety Awareness Week activities are planned to educate and inform staff, patients and the community. The MountainView Hospital consumer web page also includes access to an electronic version of the Patient Guide. Information and additional resources are provided to assure patient involvement in their care.

Patients or their families may contact the hospital to report patient safety concerns as well as to the State of Nevada Department of Health and Human Services or to the Joint Commission. The hospital's website and other patient materials include information on how to report issues internally as well as to the Joint Commission.

Patients are randomly selected to participate in completing the Patient Experience Survey after discharge, which include questions related to the patient safety experience. These results are reported to the hospital.

VII. Education

1. Staff Education
    - General orientation, on-going in-service and other education and training programs will emphasize specific job-related aspects of patient safety

- Specific Patient Safety Program training at orientation and annually thereafter will include:
    - An overview of the Patient Safety Program
    - Staff's role and responsibilities in the Patient Safety Program
    - Event reporting, including the events requiring reporting and the process for reporting events.
    - Methods to support and foster an interdisciplinary and collaborative approach to the delivery of patient care;
    - Examples of specific job-related aspects of patient safety.

2. Physician Education - An overview of the Patient Safety Program is provided to physicians at time of initial appointment and periodically thereafter that describes the program, emphasizes their role and responsibilities in the program and informs them of the event reporting mechanism and Culture of Safety processes.

3. Organizational Learning: Patient safety is everyone's responsibility. Everyone has a responsibility to report. By reporting concerns, it enables the organization to learn and improve processes, procedures, and systems.

4. Lessons Learned summaries are developed to communicate lessons learned from near misses or actual events. These summaries are shared with the leadership and employees to promote organizational learning and improvement.

VIII Safety Improvement Activities

Prioritization of Patient Safety Activities

Prioritization elements are defined in the annual performance improvement plan and apply to patient safety initiatives. The PSC annual goals are listed at the end of this plan and meet the prioritization elements.

Routine safety-related data collection analysis

- Unusual Occurrence reporting (see policies RM21 Facility Event and Close Call Reporting, RM13: Disclosure of Adverse Events, and SPAE Guidance Policy)
- Medication Error Reporting
- Infection Surveillance
- Culture of Patient Safety Survey
- Environmental Safety Rounds and Assessment
- Patient Experience Survey
- Leadership Walk-around and Tracers
- National Patient Safety Goal Dashboard
- Annual Leapfrog (NQF Safe Practices) Survey
- Sentinel Event Alert Compliance
- Institute for Safe medication Practices (ISMP) and other industry Alerts
- Employee feedback survey

Identification reporting and management of patient safety events

1. To effectively improve processes and systems, health care providers should not be fearful of punishment of retribution for reporting mistakes.
2. An accessible multifaceted non-punitive, just culture reporting system exists .
3. Errors and accidents are tracked in an attempt to establish trends and patterns, to learn from them and prevent reoccurrence.

4. Healthcare providers participate in reporting and developing improved processes to effectively evaluate errors and near misses.
5. Reporting errors and near misses are a critical component of the MountainView Hospital Patient Safety Program.

The Vigilanz Safety Surveillance on-line incident reporting system is a tool for the documentation, investigation, and correction of patient safety issues as described in the organizational policy: RM21 Facility Event and Close Call Reporting. The Director of Risk Management coordinates this process.

Organization or Medical Staff committees refer patient safety issues to the Patient Safety Officer for review at the PSC and corrective action.

NRS □□□□□□□□ – Monitoring and Compliance

Nevada statute NRS 43□.□□□ requires medical facilities to adopt patient safety checklists and patient safety policies. These patient safety checklists are protocols used to improve the outcomes of patients at the hospital to include:

1. Patient Discharge Process (CP120 – Discharge Planning)
2. Patient Identification Process (CP□0 – Patient Identification)
3. Patient room/environment sanitation and cleaning (Sodexo □-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 (CP1□5 – Safe Procedural and Surgical Verification)
    b. Central Line Insertion Bundle (CP131 – Adult Central Line/PICC (Non-Implanted□ Management)

Monitoring and oversight for compliance with these policies and checklists will be the ongoing responsibility of the Patient Safety Committee.

NRS □□□□□□□□ – Infection Control Program

Nevada statute NRS 43□.□65 requires medical facilities have an infection control program to prevent and control infections within the medical facility, as well as an infection control policy. The Hospital's Infection Control Plan is attached as an addendum to the Patient Safety Plan and is reviewed annually. (See Appendix 3 – Infection Prevention and Control Plan)

Proactive Ris□ Identification and Reduction:

1. Opportunities for improvement regarding patient safety issues and hazardous conditions are identified through trending of actual or potential occurrences involving patients or visitors and/or evidence-based literature (e.g. The Joint Commission Sentinel Event Alerts).
2. When an identified opportunity for improvement is identified, it is analyzed by the involved care providers according to level of severity, frequency of occurrence, potential for harm and liability.
3. At least every 1□ months, one high-risk or error-prone process is selected for Failure Mode Effect Analysis (FMEA) process. The underlying systems are examined and modified or redesigned to minimize the risk of the identified failure mode.
4. Trending of adverse events, environmental safety issues, aggregate data collection, and review of intensive assessments are part of the identification and management of risks to safety and are used to prevent reoccurrences.
5. Serious unusual occurrences and sentinel events are reviewed with determination made for intensive assessment and root cause analysis according to the Facility Event and Close Call Reporting and SPAE policies.

6. Near miss events are reviewed and root cause analysis conducted as deemed appropriate.
□. Regular communication about patient safety and risk management is conducted with designated Quality Committee, Medical Executive Committee, and the Board of Trustees. Disclosure of an adverse event to a patient is in accordance with policy. RM13: Disclosure of Adverse Events and the SPAE policy

I□□ Reporting Patient Safety Results:

To the PSC:

The Patient Safety Committee reviews and recommends actions on the following reports:

- Audits on Patient Safety
- National Patient Safety Goals and Safe Practices compliance (including accordance with NRS 43□.□□□)
- Culture of Patient Safety Survey
- Leapfrog Survey

To organization staff and medical staff:

Organizational staff receives patient safety results and information on:

- Lessons Learned summaries
- Culture of Safety Survey
- Patient experience survey results on patient safety components.
- National Patient Safety Goals and Safe Practices compliance (including accordance with NRS 43□.□□□)
- Leapfrog Survey

To executive leadership and □oard of Trustees:

The Board of Trustees and Executive Leadership receives periodic reports on:

- Culture of Safety Survey
- Leapfrog Survey
- Risk Management dashboard
- Patient Safety dashboard

□□ EVALUATION OF CY □□ PSC □Organizational Goals

GOAL	GOAL MET	GOAL NOT MET
Increase participation rate of 2020 AHRQ Patient Safety Survey. Also continue to review implementation and efficacy of 201□ AHRQ action plans.	Goal Met	
Continue to participate in weekly rounding e.g., Patient Safety, Executive Leadership/Nursing leadership safety. This encourages discussion of safety issues and fosters a culture of safety through building respect, trust, and inclusion in the organization.		Due to the management of the COVID-1□ pandemic, this goal was not consistently met. This will continue to be a goal for 2022
Achieve compliance with Clinical Safety Improvement Program initiatives.	Goal met	

Continue developing a Culture of Safety throughout the facility through staff education	Goal met through implementation of 4hr Quality Orientation	
Increase utilization of physician reporting line by 10□	Need to confirm	Due to the management of the COVID-1□ pandemic, this goal was not consistently met.
Implement patient advisory board as well as bioethics committee	This goal was partially met. Bioethics Committee has been implemented	Due to the management of COVID-1□ pandemic, the Patient Advisory Board was not implemented. We will continue to work on Advisory Board development .
Increased number of failure mode & effects analysis conducted.		Due to the management of the COVID-1□ pandemic, this goal was not consistently met.
Improve house wide education. Focus topics to include: COVID lessons learned, falls/pressure ulcer prevention	Continues learning regarding COVID lessons learned was provided. Additional organized education that was also provided includes: Improving Culture of Safety, and Legal Implications of Documentation was provided.	This goal was partially met. Housewide education regarding pressure ulcer prevention was not consistently provided due to management of COVID 1□ pandemic. This will continue to be a goal in 2022.

□I□ CY □□ PSC □Organizational Goals:

1. Adopting HCA core strategies for reducing patient harm and mitigating organizational risk by focusing on clinical focus areas. The goal is to have zero harm events for the following clinical focus areas: Falls (5z-□z), Pressure Ulcers (stage 3-4), and Telemetry monitoring.
2. Improve alignment with HCA Safety Science Strategies. These strategies include:
    a. Achieving compliance with Clinical Safety Improvement Program (CSIP) initiatives.
    b. Enhancing event identification notification and management through Vigilanz Surveillance System. This will include continued house wide education and will be measured by improving overall utilization by 40□; as well reducing patient harm events by 25□ by Q32022.
    c. Improve communication with Facility Safety Huddles (NATE/NASH Technology) by increasing departmental utilization.
3. Enhance building a robust safety learning system through continued learning to frontline staff, Medical Staff and Graduate Medical Education. This includes, but is not limited to storytelling, lessons learned, as well as, providing education on the Great Catch Program.
4. Increase Great Catch recognitions by 20□ by Q32022.
5.
    2. Achieve compliance with 2021 goals that were not met.

□I□ 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.

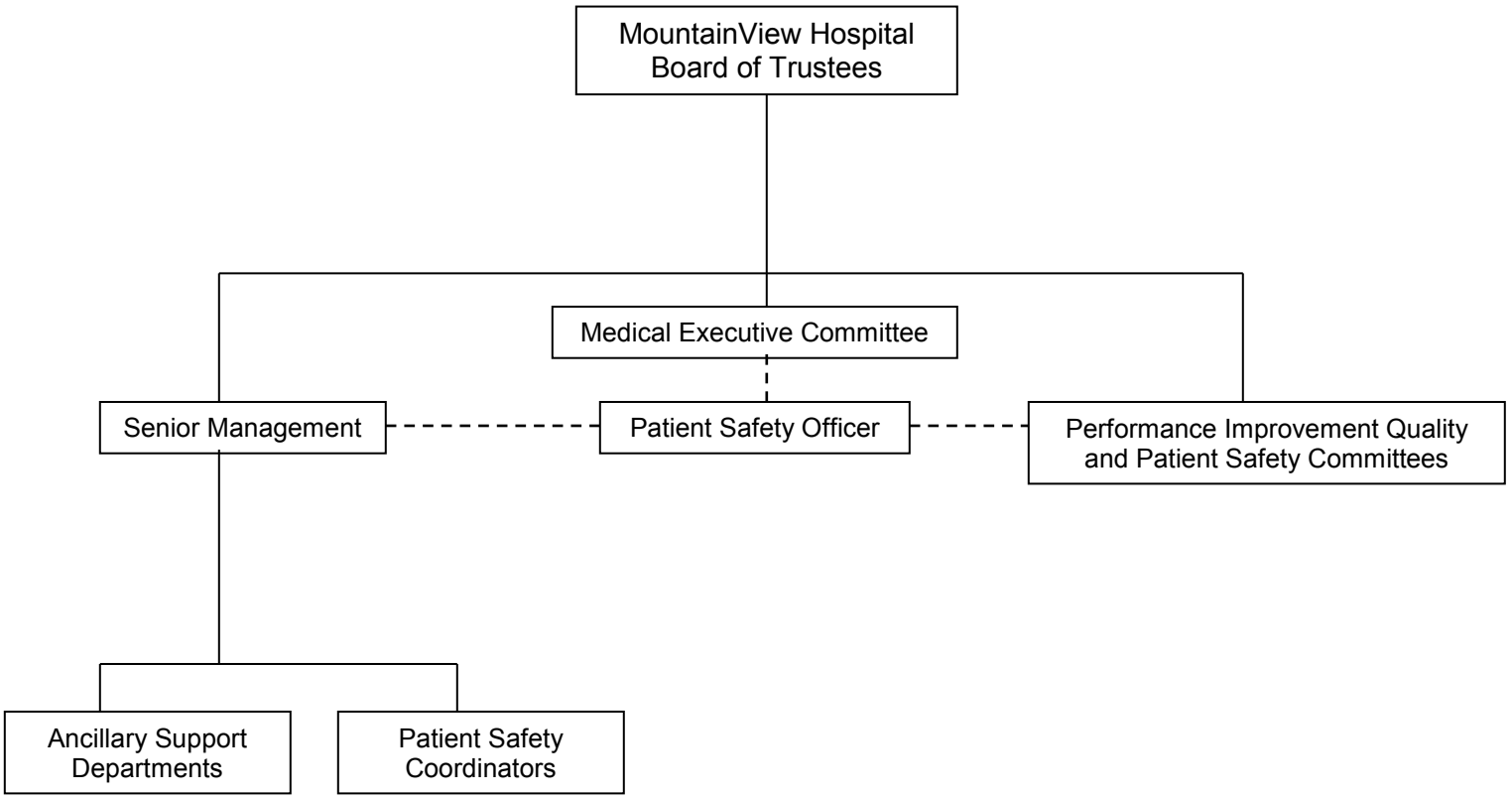
□II□ The MountainView Hospital Patient Safety Program

The components of the patient safety program are outlined in Appendix One.

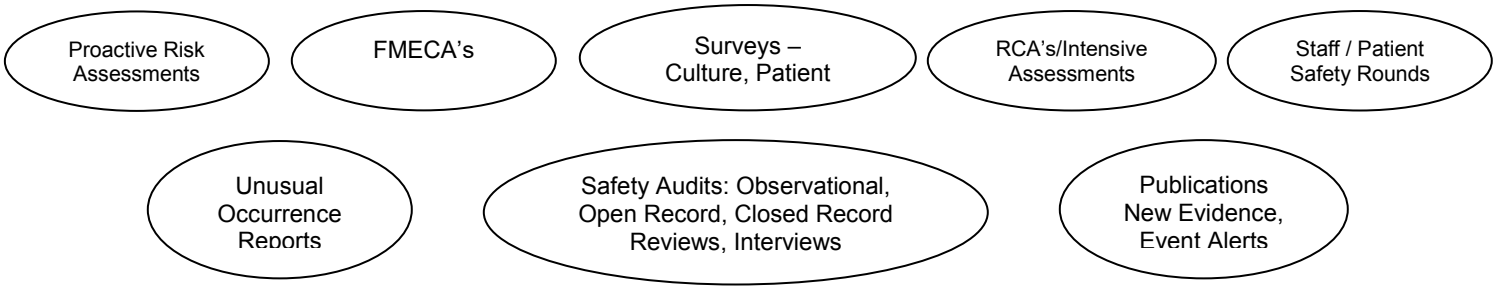
III. References/Authority

- The Joint Commission 2022 NPSG's
- HCA Patient Safety Organization PSO Operating Policy and Procedure
- Federal Register - Department of Health and Human Services 42 CFR Part 3 – Patient Safety and Quality Improvement

Patient Safety Program



Sources of Patient Safety Data



2022 National Patient Safety Goals Overview

The □oint Commission NPSG's	Specific Elements □ ithin □road Goal (Note #'s same as per The □oint Commission's NPSG's for Hospitals)	□ey Content Expert Lin□s to PSC	Audit Methodology (Cross-reference to Patient Safety Dashboard)
□□: Improve the accuracy of patient identification	**A: Use at least two patient identifiers when providing care□treatment or services**		
	A1 Blood draw and other lab specimen collection	Blood Bank Laboratory Nursing	Random observation audits (Quarterly)
	A2 Label containers in presence of patient	Blood Bank Laboratory Nursing	Random observation audits (Quarterly)
	Use distinct methods of identification for newborn patients. Note: Examples of methods to prevent misidentification may include the following: - Distinct naming systems could include using the mother's first and last names and the newborn's gender (for example, "Smith, Judy Girl" or "Smith, Judy Girl A" and "Smith, Judy Girl		
	□: Eliminate Transfusion Errors		

The □oint Commission NPSG's	Specific Elements □ ithin □road Goal (Note #'s same as per The □oint Commission's NPSG's for Hospitals)	□ey Content Expert Lin□s to PSC	Audit Methodology (Cross-reference to Patient Safety Dashboard)
	B1. Blood transfusion process: match blood or blood component to the order; match the patient to the blood or blood component; use a two-person verification process	Blood Bank Laboratory Nursing	Blood Bank Audits (Quarterly)
	B2. Qualified transfusionist part of two-person verification process	Blood Bank Laboratory Nursing	Blood Bank Audits (Quarterly)
	B3. Second qualified individual part of two-person verification process	Blood Bank Laboratory Nursing	Blood Bank Audits (Quarterly)
□□: Improve the effectiveness of communication among caregivers	A. Report critical results of tests and diagnostic procedures on a timely basis.		
	A1. Evaluate the timeliness of reporting the critical results of tests and diagnostic procedures.	Lab Nursing	Random charts and log audits (Quarterly)
□□: Improve the safety of using medications	A. Label all medications, medication containers (for example, syringes, medicine cups, basins), or other solutions on and off the sterile field.	Cardiac Imaging OR Nursing	Random observations and audits, all procedure areas (Quarterly)
	B. Reduce the likelihood of patient harm associated with the use of anticoagulation therapy.	Pharmacy Nursing	Random chart audits (Quarterly)
	C. Maintain and communicate accurate patient medication information.	Pharmacy Nursing	Random chart audits (Quarterly)
□□: Improve the safety of clinical alarm systems□	A. Leaders establish alarm safety as a hospital priority.	Patient Safety Officer / PS Plan	Random observations and audits (Quarterly)

The □oint Commission NPSG's	Specific Elements □ ithin □road Goal (Note #'s same as per The □oint Commission's NPSG's for Hospitals)	□ey Content Expert Lin□s to PSC	Audit Methodology (Cross-reference to Patient Safety Dashboard)
	B. Identify the most important alarm signals to manage.	Patient Safety Committee	Random observations and audits (Quarterly)
	C. Establish policies and procedures for managing alarms as listed above in □B.	Patient Safety Committee	Random observations and audits (Quarterly)
	D. Educate staff and LIP's about the purpose and proper operation of alarm systems for which they are responsible.	Patient Safety Committee	Random observations and audits (Quarterly)
□□: Reduce the ris□ of health care-associated infections	A. Comply with current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines	Infection Prevention Nursing	Random observations (Quarterly)
	B. Implement evidence-based practices to prevent healthcare associated infections due to multiple drug-resistant organisms (MDRO's)	Infection Prevention	MDRO Tracker (Quarterly)
	C. Implement evidence-based practices to prevent central line-associated bloodstream infections (CLABSI's).	Infection Prevention	Targeted Surveillance (Quarterly)
	D. Implement evidence-based practices to prevent surgical site infections (SSI's).	Infection Prevention	Targeted Surveillance (Quarterly)
	E. Implement evidence-based practices to prevent catheter associated urinary tract infections. (CAUTI's)	Infection Prevention	Targeted Surveillance (Quarterly)

The □oint Commission NPSG's	Specific Elements □ ithin □road Goal (Note #'s same as per The □oint Commission's NPSG's for Hospitals)	□ey Content Expert Lin□s to PSC	Audit Methodology (Cross-reference to Patient Safety Dashboard)
□□□: The organization identifies safety ris□s inherent in its patient population	A. The organization identifies patients at risk for suicide. □Applicable to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals.□	Nursing Risk Management	(Structural process) Random chart audits (Quarterly)
Universal Protocol	A. Pre-op verification B. Site marking C. Time-out	Cardiac Medical Imaging Nursing OR	Random observations & chart audits (Quarterly)

Clinical Incident Report Form

Please use this form to report any unexpected patient incidents related to patient care or treatment, even those resulting in no adverse patient outcome. This includes errors, safety hazards, injuries, HIPAA violations or sentinel events. The Clinical Incident Report is to be completed in *addition* to any reporting or investigation required by facility/hospital. Please send completed forms to clinical@trustaff.com

Employee documenting the incident:			
Name:		Title/position:	
Address:		Phone:	
		Email:	

Facility where incident occurred:			
Facility name:		Department unit:	
Facility address:		Date & time of incident:	
Was a facility incident report completed:		☐Yes	☐ No

Incident detail:			
☐ Patient	☐ Employee/staff member	☐ Other (family, vendor)	
Name of affected party:			
Witness(es) to incident:		Witness(es) title:	

Incident summary: Briefly describe the nature and outcome of the incident *(attach separate form if needed)*

Employee acknowledgment:	
Acknowledgement- I acknowledge the facts and circumstances reported above are true and accurate to the best of my knowledge.	☐ Yes
Date:	

FIELD EMPLOYEE MANAGEMENT GUIDELINES

Policy Statement

Progressive discipline policy for how to manage travelers' eligibility for placement with unsuccessful assignments or to address any other issues that could make the traveler ineligible for placement.

It is the company's goal to be fair and consistent, supporting our travelers and our client facilities, minimizing risk to the company, while ensuring both clinical and professional competency.

- **Basic Premise**
  - Offer coaching, counseling and remediation when possible, to improve assignment outcomes.
  - Recognize that there are two-sides to every situation, and we cannot control the working environments of our travelers.
  - Watch for a pattern of behavior/unsuccessful assignments and make employment eligibility decisions accordingly.

- **Quality Assurance Committee**
  - Group designated to review employment eligibility for all travelers being considered for Termination/Do Not Use (DNU) status, due to nature of individual offense, or pattern of unsuccessful assignments.
  - Make recommendations for company policy or guidelines changes based on trends or data collected.

- **Rehire Consideration**
  - To be considered, a compelling reason must exist, and an internal policy must have changed (a traveler would NOT be terminated for the same offense today). All rehire decisions to be made by Quality Assurance Committee. (*Written statement, successful history since termination will be required for all considerations).*

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Unsuccessful Assignments

	Category	Action	Process
	First Offense or 1 of 3 most recent assignments	**Coaching**	Clinical Liaison evaluates for seriousness of offense; places in Suspended status if needed. Once coaching conversation or remediation (if required) completed, Clinical Liaison returns to Active status and clears for placement.
	2 of 3 most recent assignments	**Warning / Probation notice**	Clinical Liaison evaluates for seriousness of offense; places in Suspended status if needed. Warning/notification that next assignment will be Probation; if unable to successfully complete Probation assignment for any reason, Quality Assurance Committee to consider termination/Do Not Use (DNU).
	3 of 4 most recent assignments	**Termination discussion**	Clinical Liaison to take to Quality Assurance committee for termination discussion.
	*Serious offenses **may warrant immediate termination or suspension periods** as well as remediation/training modules.		
	*Consider pre-start cancels in addition to unsuccessful assignments, time between cancel and estimated start date, communication or lack of; consider whether notice given or not (generally 2 weeks, or designated notice required by vendor/facility).		

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Definitions

Term	Definition
Active Status	Eligible for placement without restrictions
Suspended Status	Ineligible for placement for a designated time period related to specific policy or guideline; or, due to severity of previous actions, or for the time period while investigation placement eligibility is still being considered.
Probation Status	Assignment status representing an unsuccessful pattern of assignments; where 2 of the last 3 assignments ended early (cancel or term). Failure to successfully complete probation assignment is grounds for termination and will be considered by Quality Assurance Committee. Successful completion of probation assignment returns traveler back to active status. Additional unsuccessful assignments, where 2 of the last 3 assignments are unsuccessful may result in additional probation assignment or in Termination. All recommendations for termination will be presented to the Quality Assurance Committee for consideration.
Do Not Use (DNU)/Termination	Ineligible for future placement.

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Travel Employee Handbook

Welcome to the trustaff team! This Employee Handbook will serve as your point of reference for any standards, policies, and procedures that trustaff associates are expected to follow. We ask that you read through the handbook and familiarize yourself with the materials. With the publication and distribution of this handbook, we strive to ensure that each new employee receives and understands all necessary information in regards to company policies and procedures, OSHA requirements, The Joint Commission standards, HIPAA regulations, and any other relative guidelines.

We require that you review all materials within 48 hours of beginning your first trustaff assignment, then sign and return copies of the Job Description and the Handbook and Policy Acknowledgement located at the end of this handbook. For your convenience, we have included a checklist of all items required for your continued employment with trustaff. Any delay in receiving all required documents may cause a delay in your assignment until you have completed and returned them. Repeated delays or missing documentation may result in employee discipline, up to and including termination and/or ineligibility for future assignments. trustaff will maintain all documents you submit throughout your employment, and will keep all of your records available to you at all times.

Company Contact Information

Office Hours:	Monday through Friday 9am to 6pm ET
Address:	4675 Cornell Road, Suite 100
	Cincinnati, OH 45241
Phone:	877-880-0346 (office)
	513-659-1267 (On call)
Fax:	888-897-9197

General Policies, Protocols, & Procedures

1.00 Employment at will: Your employment with trustaff is "at-will" meaning you can be terminated at any time and for any reason or for no reason at all, and you can leave at any time and for any reason. This handbook does not constitute a contract for employment.

2.00 Equal Opportunity Employer: trustaff is an equal opportunity employer. trustaff will not discriminate on the basis of race, religion, national origin, sex, age, disability, marital status, genetic information, status as a disabled veteran, or for any other legally protected classification. Information provided on any application or personnel form will not be used for any discriminatory purpose.

3.00 Wage Policies: Whenever possible, trustaff will be consistent with the pay periods and policies of the facility where you are placed. Paydays fall on Friday of each week, assuming that your timecard is received no later than Monday by 12:00 pm Eastern Standard Time. If your timecard is incomplete or late, your paycheck may be delayed until the next pay period, but trustaff will always comply with all applicable laws regarding pay periods.

4.00 Employment Relationship: At all times, trustaff employees are under the supervision of client-approved representatives. trustaff will comply with, and has sole responsibility for, compliance with all applicable federal and state laws and regulations concerning wages, benefits, liability/insurance, and fair employment practices, and any and all other circumstances of the employer/employee relationship.

5.00 Permanent Placement Offers: If at any time you are offered permanent employment with an assigned trustaff client and you wish to accept, there is no fee to yourself, or the client, as long as you have completed at least two (2) consecutive thirteen-week assignments at that facility. Please notify your Recruiter immediately when such an offer is made.

6.00 Resignations/Cancellations: Employees are expected to fulfill the full length of their assignments. If you need to terminate from a position in advance of the end date, please notify your Recruiter immediately so that a replacement can be found in a timely manner. You may be required to pay back any monies paid on your behalf, such as pay advances, housing, etc.

7.00 FMLA: trustaff follows all provisions of the Family Medical Leave Act and all state and local law equivalents. Employees who have worked at trustaff for 12 months and worked at least 1,250 hours over the previous 12 months are eligible to take FMLA leave where trustaff has 50 or more employees within a 75 mile radius. Eligibility is calculated on a rolling 12-month period. Eligible employees may be entitled to up to 12 weeks of unpaid job-protected leave in a 12-month period under the FMLA for the following qualifying reasons:

- To care for the employee's child after birth or placement for adoption or foster care (leave to be completed within one year of the child's birth or placement);
- To care for the employee's spouse, child or parent who has a serious health condition (defined below);
- To care for the employee's own serious health condition; or
- For a qualifying exigency arising out of the fact that the spouse, or a son, daughter, or parent of the employee is on active duty in a foreign country (or has been notified of an impending call or order to active duty) in the Armed Forces.

An eligible employee may also apply for a leave of absence to care for a covered family member who has incurred an injury or illness in the line of duty while on active duty in the Armed Forces if such injury or illness may render the family member medically unfit to perform duties of the member's office, grade, rank or rating. This leave may extend to up to 26 weeks in a single 12-month period for up to five (5) years after he or she leaves military service.

The 12 weeks of FMLA leave may be taken all at once, or if medically necessary, FMLA leave occasioned by a serious health condition may be taken intermittently (in separate blocks of time) or on a reduced leave schedule (reducing the usual number of hours the employee works per workweek or workday). Upon your return from FMLA leave, you will be returned to your same or equivalent position. If you need to take FMLA leave, or if you have any FMLA questions, please contact the HR Department.

7.01 ADA: trustaff complies with all the requirements of the Americans with Disabilities Act and any state or local law regarding qualified individuals with disabilities. If you are a qualified individual with a disability as defined by federal or state law, and need a reasonable accommodation in order to perform your essential job functions, please contact HR. trustaff will engage with you in the interactive process to determine what reasonable accommodations, if any, can be made so that you can perform your essential job functions.

8.00 Harassment: trustaff will not tolerate any harassment of its employees. The term "harassment" includes but is not limited to; slurs, jokes, and verbal or physical misconduct relating to an individual's race, color, sex, religion, national origin, citizenship, age, or disability.

8.01 Sexual Harassment: All employees are allowed the right to work in an environment free from sexual harassment. trustaff will not permit the sexual harassment of any employee, client or candidate by another employee, supervisor, candidate, client, or vendor.

8.02 Sexual Harassment Circumstances: Sexual harassment can occur in a variety of circumstances, including but not limited to the following:

- The victim as well as the harasser may be a woman or a man. The victim does not have to be of the opposite sex.
- The harasser can be the victim's supervisor, an agent of the employer, a supervisor in another area, a peer or co-worker, or a non-employee.
- The victim does not have to be the person harassed but could be anyone affected by the offensive conduct.
- Unlawful sexual harassment may occur without economic injury or loss of employment for the victim.
- The harasser's conduct must be unwelcome.

8.03 Harassment Reporting Protocol: If you believe that you are the victim of harassment you may make your concerns known by directly informing the harasser that the conduct is unwelcome and must stop. You should also immediately inform HR if you believe you have been harassed or if you witness harassment of any kind. Any facts surrounding the offensive conduct or communication should be put in writing when making a complaint. An investigation will be conducted and the proper action will be taken. trustaff will not tolerate retaliation of any kind against anyone reporting harassment in good faith. A determination on the allegation will be made based upon the facts on a case-by-case basis. For more information on this policy, contact HR.

9.00 Authorized Drug and Alcohol Testing: Some of our clients require drug testing as a condition of your placement in their facility. All employees will be provided notice that a screening may be required when discussing the details of accepting an assignment. Employees may be re-tested on an annual basis to maintain current screening results. A failed drug test will result in the termination of your employment.

9.01 Reasonable Suspicion Testing: In addition to our client's request, we may also require an employee to submit to a screening if trustaff has reasonable suspicion that the employee:

- Is under the influence of alcohol or a controlled substance.
- Has violated our policy that prohibits the use, possession, sale, or transfer of illegal drugs or alcohol while working on the premises of our client's facility or operating a vehicle leased to trustaff.
- Has sustained personal injury or caused another employee or client to sustain personal injury.
- Has caused a work related accident by operating machinery, equipment or vehicles; whether assisting or solely operating said equipment.

9.02 Notice of Results: Once the report has been received from the testing lab, trustaff will inform the associate by telephone of the results and if necessary, inform them of their right to request, at his or her own expense, a second confirmatory retest of the original sample. In this case, if the retest does not confirm the original result, no adverse personal action may be taken against the associate based on the initial testing.

9.03 Withdrawal of Job Offer: If an applicant/employee received a positive drug screening result and did not elect a retest, or received a second positive result, offers for placement will be withdrawn and employment will be terminated. A refusal to submit a urine sample for a drug screen will be treated the same as a positive test.

9.04 Confidentiality of Results: All information acquired in the drug and alcohol testing process is private and confidential information that will not be disclosed to any third party individual, other employer, government agency, or private organization without the expressed written consent of the associate/applicant tested, unless the use of such results are necessary to defend trustaff in any cause of action where the results of the test are relevant.

10.00 Records Maintenance: Employees are responsible for maintaining current application, medical, employment, and personnel records with trustaff throughout the duration of their employment.

10.01 Document Expiration & Notification: Those records that require specific scheduled updates during continuous employment with trustaff include:

- Copy of current, valid RN licensure for the state in which employee takes assignments
- Copy of current, valid BLS certification
- Copy of current, valid ACLS, PALS, or NRP/NALS or any skilled certification for those employees working in units that require certification
- Copy of signed and dated physician's statement current within the prior calendar year
- Copy of dated documentation of Tuberculosis screening current within the prior calendar year for a PPD test or current within the two prior calendar years for a chest x-ray [with documentation of a previously positive PPD]

A trustaff Quality Assurance Representative will contact employees prior to expiration of documents to request updates. Any delay beyond an expiration date in providing requested documentation might result in disciplinary action, including but not exclusively, assignment eligibility, employment postponement, or termination.

10.02 Personnel File Non-Expiration Documents: Those records that do not require standard updates, but that may require periodic updates during continuous employment with trustaff, include:

- Application for Employment
- Employment / Work History
- Professional References
- Health Information Privacy & Consent Confidentiality Statement
- Documentation of immunity for Rubella, Rubeola, Mumps, Varicella, and Hepatitis B.
    - Immunity for Rubella, Rubeola, and Mumps may be proven with documentation of MMR vaccination or lab titers results with appropriate antibody level readings
    - Immunity for Varicella may be proven with documentation of Varivax vaccinations OR lab titer results with appropriate antibody level reading

  - Immunity for Hepatitis B may be proven with documentation of Hepatitis B three-step vaccination, lab titer results with appropriate antibody level reading, or a declination statement on receiving the immunization
- W-4 form
- I-9 form with copies of appropriate supplemental documents
- Personnel Record/Payroll Forms
- Policy Consent
- Disclosure & Release
- Permanent Tax Residence Notification
- Job Description
- Competency Testing
- Handbook Acknowledgement

A trustaff Quality Assurance Representative will contact employees prior to and/or during an assignment to request forms and information to complete the employee's personnel file. Any delay in the receipt of required documentation might result in disciplinary action, including but not exclusively, assignment eligibility, employment postponement, or termination.

10.03 Health Information Privacy: With the passage of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), personally identifiable healthcare records came under a new and heightened level of confidentiality. In the regular course of business, trustaff interacts and communicates directly with candidates who may share their personally identifiable information. In turn, we collect, store and process the information electronically and/or manually. With the belief that it is a person's right to have their personal information kept private, trustaff conducts business with respect for and in compliance with all applicable health information privacy laws, including but not limited to HIPAA. We respect our legal obligation to implement privacy procedures and technical security measures to keep personal information private and secure. As we are obligated to give all employees notice of our privacy practices, this statement describes how our staff may use and disclose medical information and how an employee may get access to this information.

10.04 Required Health Information: For employment through trustaff, "health information" includes the following items that we request on behalf of our facility clients:

- Annual physician's statement
- Documentation used to prove immunity to measles, mumps, and rubella [laboratory titers or records of MMR injection(s)]
- Documentation used to prove immunity to varicella [laboratory titer, record of Varivax immunization, or immune by history statement]
- Documentation used to prove immunity to HBV [laboratory titer or record of HBV immunization series] or a declination statement thereof
- Annual tuberculosis screening [PPD test results or chest x-ray reading]
- Pre-employment drug screening
- Any additional requirements based on facility-specific regulations

10.05 Privacy & Disclosure Consent: trustaff representatives cannot use an employee's health information or disclose it to outside parties without written permission. To give written permission, an employee must complete a consent form (Health Information Privacy & Consent Confidentiality Statement) which allows Account Managers and Quality Assurance Representatives to disclose an employee's health information for purposes of submittal to client facilities, of assignment to client

facilities, and continued employment through trustaff. At times, client facilities may request further documentation than the defined "health information" of a candidate's health and immunization records to comply with state or local regulations. In those instances, a trustaff representative will advise an employee of the requirements and request your consent for that additional information be covered under in the same consent form already on file.

10.06 Access to Personal Health Information: An employee may request photocopies of his/her personal health information, an amendment to any incorrect or incomplete information, additional copies of the general notice, or a list of the disclosures made of her/his health information.

10.07 Modifications to Privacy Policy: trustaff reserves the right to change this statement at any time in compliance with federal and state law. If we make any changes, the new policies and protocols will apply to all health information that we already have as well as to such information that we may generate or request in the future. We will send out notices of any changes via mail and post them in our office and on our website.

11.00 Confidentiality: Employees shall use discretion and consideration to ensure that sensitive or confidential information (patient information, client business practices, etc.) not be shared with inappropriate parties.

12.00 Facility-specific Policies & Procedures: Since each facility to which you may travel will have its own set of rules and regulations, we ask that you clarify their policies during orientation at their facility. This inquiry will help you to feel more relaxed and make for an enjoyable assignment, as well as set the standards you have for your assignment at that facility.

13.00 Floating: trustaff believes that all nurses share the same basic skills that all licensed nurses should be able to perform such as: starting IV's, inserting a Foley, administering medications, conducting physical assessments, obtaining medical history on admissions, ambulating, helping with the bathroom, bathing, checking vital signs. Should you be floated to another area outside of the regularly scheduled units, and you are not comfortable or familiar with assuming the role in that area based on the skill set required for that area, we would not expect you to function in that capacity. We would expect you to be available to help with the basic nursing skills that you are competent to perform and/or assist in taking a lighter load of patients (i.e. 2-3 on a MS unit) instead of the full load required by the staff. If at any time during your assignment a client representative requests that you function in a role you believe outside of your capacity or training, contact trustaff personnel immediately.

14.00 Dress Code: The dress code will vary from each facility where you are assigned. We ask that you take into consideration the needs of each facility by maintaining a respectable level of professionalism. If you have not been told of the dress code for a specific facility, request further information. In any questionable or unclear situation, please adhere to the following guidelines:

- Wear clean, pressed, and neat uniforms with white, clean shoes
- Carry appropriate licenses and certifications while on duty
- Maintain standard personal hygiene (i.e., pulling back hair that is shoulder length or longer)
- Maintain professional appearance (i.e., using discretion in the amount of jewelry that is worn)

15.00 Absence Notification: Any absence should be reported to the appropriate supervisor at your assigned facility at least two (2) hours in advance of your scheduled shift. You should record the missed time appropriately on your timecard. Calling off sick may result in your inability to be available for your

hourly guarantee, in which case you will be paid only for hours worked. If you plan to make up hours it must be within that pay period or at the end of your contract, and be approved by your facility supervisor. This policy ensures that the client is not being over billed for your time and that appropriate arrangements have been made with regards to the cost of paying for additional days spent in housing or making travel changes.

16.00 Amenities & Incidentals: trustaff is not responsible for any incidental charges incurred while you are on an assignment. These incidental charges include, but are not limited to, long distance telephone calls, entertainment, meals, dry cleaning, and damages. You may be required to leave a deposit or credit card for such incidentals when checking into your housing.

17.00 Assignment Issues & Concerns: If while on an assignment you experience any difficulties, issues, or concerns, you should first contact your recruiter and discuss the situation immediately. trustaff will address any complaints in a fair and responsible manner. If you have a concern or problem resulting from a misunderstanding or complaints, we encourage you to contact us and discuss the nature of the situation before going to facility personnel. DO NOT WALK-OFF OR LEAVE AN ASSIGNMENT FOR ANY REASON.

17.01 Issues & Concern Escalation: In the circumstance where your recruiter cannot resolve the situation, he/she will then bring it to the attention of the appropriate account manager or other member of management. In the circumstance where you do not feel your Recruiter has dealt with a situation appropriately or completely, please request to speak with a member of management about the situation. DO NOT WALK-OFF OR LEAVE AN ASSIGNMENT FOR ANY REASON.

18.00 Assignment Extensions: Often times a client will request an extension of your assignment at their facility; if you choose to accept their offer please alert your Recruiter immediately so that any changes in accommodations or travel arrangements can be made in a timely manner.

19.00 Customer Service Standard: We want you to feel comfortable and to be equipped with all of the necessary tools to do your work while away from home. If at any time you have questions that you feel have not been answered to your satisfaction, please do not hesitate to contact your Recruiter or any member of the trustaff team.

20.00 Complaints: We value our reputation for holding a highly moral and ethical standard towards our employees and our clients. Each employee is a reflection of trustaff and deserves to be treated with integrity, professionalism, and understanding. We ask that as our representative, each employee avoid activities or situations that would compromise the reputation that each of us has worked so hard to achieve. Complaints about an employee will be required in writing with all appropriate documentation provided accordingly. We will research and discuss the situation with all parties involved and depending on the severity of the incident; an understanding may be reached which could result in:

- Termination of all assignments with trustaff, or
- Termination of placement with that client, or
- An arrangement to resolve the misunderstanding between the client, trustaff, and the employee.

21.00 Job Safety Practices and Procedures: A safe attitude means you recognize and appreciate risks. You are aware of potential accidents *before* they happen and you make sure that they don't! The only person who can keep you safe every day on the job is YOU. trustaff associates have a duty to comply with the following requirements:

- Know the Code of Safe Practices for the general work area and for your job.
- Comply with working conditions, safe work practices and personal protective equipment requirements for your job and/or assigned client facility.
- Report all unsafe conditions or observations of neglect and/or abuse to your unit supervisor immediately.
- Upon arrival at an assignment, ask for a safety guide for the facility, including safety equipment and evacuation procedures.
- Follow all safety and emergency policies and procedures of the facility that you learned in orientation.
- Do not undertake a job that appears to be unsafe or use chemicals without understanding their toxic properties.
- Do not undertake a job until you have received instructions as to what is required for that position.
- Keep cuts and scrapes covered and notify your supervisor if skin rashes, lesions, or dermatitis may prevent you from working with patients or blood and body fluids.
- Attend required facility-specific training and education programs.

21.01 Code of Safe Practices: This code is general in nature and inclusive of many types of business activities.

- All employees will follow these safe practices rules, render every possible aid to safe operations, and report all unsafe conditions or practices to their supervisor.
- Supervisors will insist that employees observe and obey every rule, regulation, and order as it is necessary to the safe conduct of the work, and they will take such action as is necessary to obtain compliance.
- Employees are not permitted to use alcohol and/or drugs in the workplace. Anyone known to be under the influence of alcohol and/or drugs will not be allowed on the job while in that condition and will be subject to disciplinary action.
- No one will knowingly be permitted or required to work while his or her ability or alertness is so impaired by fatigue, illness, or other causes that they might unnecessarily expose that individual or others to injury.
- Employees should be alert to see that all guards and other protective devices are in proper places and adjusted, and will report deficiencies promptly to the supervisor.
- Approved safety shoes will be worn in specified work areas.
- Horseplay and other acts that tend to endanger the safety or well-being of employees are prohibited.
- Work will be well planned and supervised to prevent injuries when working with equipment and handling heavy materials. When lifting objects, employees should bend their knees and use the large muscles of the leg instead of the smaller muscles of the back.
- Employees will not handle or tamper with any electrical equipment, machinery, or air or water lines in a manner not within the scope of their duties.

21.02 Job Safety Considerations: Make these common sense rules a part of your job:

- Maintain good housekeeping by keeping your work area clean and clear.
- Familiarize yourself with all escape exits and the location of any emergency cutoff valves or switches.
- Identify hazards before you start a job or procedure.
- Respect all precautions - don't take chances.

- Ask your clinical manager or senior staff person when you have questions.
- Know in advance what could go wrong, and what to do about it.
- Follow all warnings and instructions.
- Read labels and MSDSs.
- Be aware of your surroundings and others around you.
- Use common sense - practice sensible, safe work habits.
- In case of fire, call the fire department immediately (#911) or notify a supervisor to do so (emergency numbers are posted). Alert all occupants of the building so that a safe, orderly evacuation may take place. If you're working in a client facility, follow their guidelines for announcing a fire emergency. Be aware of the locations and proper operation for fire extinguishers.
- Keep alert and observe all safety signs.
- Never make changes on equipment to bypass safety devices. Do not tamper with controls or switches on any equipment unless you're authorized to do so.
- Lift with your leg muscles, not your back, and have a firm grasp and footing before lifting anything.
- Do not attempt to lift or move anything too heavy. Always ask for assistance if necessary.
- Comply with all posted personal protection equipment (PPE) notices.
- Refrain from using cellular telephones at work since they may interfere with critical equipment.
- Avoid placing carts on both sides of hallways - traffic congestion may lead to accidents.
- Wash your hands before entering and after exiting an examination or procedure room.
- Maintain good health and practice good personal hygiene.

The foregoing list highlights some of the most important and common safety rules for employees. However, this brief list is not intended as a substitute for the educational sections of this handbook or for the separate individual safety plans that our client facilities employ. These key safety rules are merely meant to emphasize some rules that should always be on the minds of any travel healthcare employee. Each client facility will have an infection control and hazard communications plan. Please refer to each facility-specific plan for details.

21.03 Job Injury Incident Reporting: Any injury or illnesses suffered by an employee, even a slight one, must be reported to a trustaff Representative within 24 hours of the incident. If you receive an injury while on the job, follow the steps as outlined below.

- Seek appropriate medical attention and follow the facility-specific injury on the job procedures.
- Contact your Recruiter by phone immediately. If during trustaff business hours, call 877-880-0346 and advise your Recruiter or an Account Manager of the situation.
- Complete a Job Injury Report form and fax it to your Recruiter at 888-897-9197 within 24 hours.
- You may be required to submit to a drug screening. If you refuse, you may forfeit any workers compensation benefits and may be released from employment.
- Follow up with your Recruiter if you lose any work due to the injury.
- Failure to report your injury within 24 hours of the incident could affect your eligibility for benefits.
- If you are exposed to blood or body fluids wash the exposed skin with soap and water. Flush eyes with at least one (1) liter of water. Always notify your unit supervisor of any exposure incident immediately. You must be evaluated and treated immediately. It is important to seek medical attention within two (2) hours of the incident.

If you have questions or concerns regarding incident reporting protocols, please contact your recruiter.

22.00 Joint Commission Certified Agency: trustaff Travel Nurses, LLC is certified by the Joint Commission. Therefore, any quality or safety concerns that have not been addressed by trustaff properly can be directed to the Joint Commission without fear of retribution.

- www.jointcommission.org
- 630.792.5000

23.00 On-Going Performance Evaluations: trustaff will conduct an annual performance evaluation on each active employee. This evaluation will include an administrative and clinical evaluation by at least one client, and an evaluation performed by the Clinical Liaison.

- The evaluations will be performed using the Clinical Client Feedback Form (CCFF) and the Annual Employee Performance Evaluation Form (AEPEF).
- The Clinical Liaison will be responsible for completing the annual performance evaluation. Prior to completing the evaluation he/she will review the client feedback forms to determine if there are any inconsistencies between perceived performance and client feedback, and to provide a realistic assessment of clinical performance.

24.00 Social Media Policy: At trustaff, we understand that social media can be a fun and rewarding way to share your life and opinions with family, friends and co-workers around the world. However, use of social media also presents certain risks and carries with it certain responsibilities. To assist you in making responsible decisions about your use of social media, we have established these guidelines for appropriate use of social media. This policy applies to all associates who work for trustaff Management, Inc., or one of its subsidiary companies or locations in the United States.

24.01 Social Media Guidelines: In the rapidly expanding world of electronic communication, *social media* can mean many things. *Social media* includes all means of communicating or posting information or content of any sort on the Internet, including to your own or someone else's web log or blog, journal or diary, personal web site, social networking or affinity web site, web bulletin board or a chat room, whether or not associated or affiliated with trustaff, as well as any other form of electronic communication. The same principles and guidelines found in trustaff policies and basic beliefs apply to your activities online. Ultimately, you are solely responsible for what you post online. Before creating online content, consider some of the risks and rewards that are involved. Keep in mind that any of your conduct that adversely affects your job performance, the performance of fellow associates or otherwise adversely affects members, customers, suppliers, people who work on behalf of trustaff or trustaff's legitimate business interests may result in disciplinary action up to and including termination. Inappropriate postings that may include discriminatory remarks, harassment, and threats of violence or similar inappropriate or unlawful conduct will not be tolerated and may subject you to disciplinary action up to and including termination.

- **Be respectful:** Always be fair and courteous to fellow employees, customers, members, suppliers or people who work on behalf of trustaff. Nevertheless, if you decide to post complaints or criticism, avoid using statements, photographs, video or audio that reasonably could be viewed as malicious, obscene, threatening or intimidating, that disparage customers, employees, associates or suppliers, or that might constitute harassment or bullying. Examples of such conduct might include offensive posts meant to intentionally harm someone's reputation or posts that could contribute to a hostile work environment on the basis of race, sex, disability, religion or any other status protected by law or company policy.
- **Be honest and accurate:** Make sure you are always honest and accurate when posting information or news, and if you make a mistake, correct it quickly. Be open about any previous

posts you have altered. Remember that the Internet archives almost everything; therefore, even deleted postings can be searched. Never post any information or rumors that you know to be false about trustaff, fellow employees, customers, suppliers, people working on behalf of trustaff or competitors.

- Post only appropriate and respectful content: Maintain the confidentiality of trustaff trade secrets and private or confidential information. Trades secrets may include information regarding the development of systems, processes, products, know-how and technology. Do not post internal reports, policies, procedures or other internal business-related confidential communications.
- Respect financial disclosure laws. It is illegal to communicate or give a "tip" on inside information to others so that they may buy or sell stocks or securities. Such online conduct may also violate the Insider Trading Policy.
- Do not create a link from your blog, website or other social networking site to a trustaff website without identifying yourself as a trustaff employee.
- Express only your personal opinions. Never represent yourself as a spokesperson for trustaff. If trustaff is a subject of the content you are creating, be clear and open about the fact that you are an employee and make it clear that your views do not represent those of trustaff, fellow employees, customers, suppliers or people working on behalf of trustaff. If you do publish a blog or post online related to the work you do or subjects associated with trustaff, make it clear that you are not speaking on behalf of trustaff. It is best to include a disclaimer such as "The postings on this site are my own and do not necessarily reflect the views of trustaff."

- **Using social media at work:** Refrain from using social media while on work time, unless it is work-related as authorized by your manager or consistent with the Company Equipment Policy. Our email system and our company email addresses are intended for business use only and are not to be used for personal reasons during work time.
- **Retaliation is prohibited:** trustaff prohibits taking negative action against any employee for reporting a possible deviation from this policy or for cooperating in an investigation. Any associate who retaliates against another associate for reporting a possible deviation from this policy or for cooperating in an investigation will be subject to disciplinary action, up to and including termination.
- **Media contacts:** Employees should not speak to the media on trustaff's behalf without contacting the Director of Marketing or Chief Operating Officer. All media inquiries should be directed to them.

25.00 Agreement to Arbitrate Claims: While your employment with trustaff is and always remains at-will, by signing the acknowledgment of receipt the Employee Traveler Handbook and/or continuing your employment with trustaff, you and trustaff agree to use binding arbitration, instead of going to court, for any "covered claims" that arise between you and trustaff. "Covered claims" are any legal claims that you might bring against trustaff (and/or its current or former employees, managers, agents, officers, directors, affiliates, and/or customers) or that trustaff might bring against you that arise out of or relate to your employment with trustaff, such as disputes concerning your recruitment, hire, pay, benefits, leaves of absence, accommodation for a disability, workplace treatment (e.g., claims for harassment, discrimination, or retaliation), or termination of employment. Such covered claims include, but are not limited to, claims under the Fair Labor Standards Act, the Equal Pay Act, the Americans With Disabilities Act, the Genetic Information Nondiscrimination Act, the Age Discrimination in Employment Act, Title VII of the Civil Rights Act of 1964 and Section 1981 of the Civil Rights Act of 1866, the Pregnancy Discrimination Act, the Family and Medical Leave Act, the Worker Adjustment Retraining and Notification Act, the Employee Retirement Income Security Act of 1974, the Uniformed Services

Employment and Reemployment Rights Act of 1994, and all comparable state and local laws. **You understand and agree that arbitration is the only forum for resolving covered claims, and that both you and trustaff are waiving the right to a trial before a judge or jury in federal or state court in favor of arbitration.**

- **Claims Not Covered by this Agreement to Arbitrate:** This agreement to arbitrate does not cover claims for workers' compensation or unemployment compensation benefits, claims for emergency or public injunctive relief, or any federal or state-law claims that you cannot legally agree to arbitrate. It also does not limit your right to file or participate in a claim or charge filed with any government agency. Finally, under the National Labor Relations Act, you are not prevented from acting in cooperation with others to challenge this Agreement in any forum, and you will not be retaliated against if you act with others to challenge this Agreement.
- **Waiver of Class and Collective Claims:** You agree that covered claims will only be arbitrated on an individual basis, and that both you and trustaff waive the right to participate in or receive money from any class, collective, or representative proceeding. You may not bring a claim on behalf of other individuals, and any arbitrator hearing your claim may not arbitrate any form of a class, collective, or representative proceeding.
- **Initiating Arbitration:** To arbitrate a claim, you must first send a written demand containing a description of the claim(s) and relief sought to trustaff in order to attempt to informally resolve the claim. If the claim(s) cannot be resolved within thirty (30) days, you must send the description of the claim(s) and relief sought to the American Arbitration Association ("AAA") office closest to where you work or last worked for trustaff. Information about the AAA is available from its website www.adr.org and you may contact them directly at 1-800-778-7879.
- **Time Limitations**: Claims for arbitration must be filed with the AAA within the same legal statute of limitations period (i.e., time limit) that would apply if the claims were filed in court or with a state or federal equal employment opportunity agency.
- **Fees and Costs:** trustaff is responsible for paying any fees and costs unique to the arbitration process arising out of any arbitration proceeding under this Agreement. The employee shall pay a fee to the arbitrator of either the same amount the employee would have to pay if the employee filed a civil action or the maximum filing fee permitted by the Employment Arbitration Rules and Mediation Procedures of the AAA ("AAA Rules"), whichever is less. If you choose to be represented by an attorney, you must pay your own legal fees and costs.
- **Arbitration Proceedings:** Arbitration under this Agreement shall be conducted before a single neutral arbitrator of the AAA. The selection of the arbitrator and the arbitration proceedings will be governed by the applicable rules and procedures of the Employment Arbitration Rules and Mediation Procedures of the AAA ("AAA Rules"), except as provided for in this Agreement. The AAA Rules are available on the AAA's website www.adr.org and you can request a copy from Corporate Human Resources at 866-765-7544. Where there is a conflict between this Agreement and the AAA Rules, this Agreement will govern.
- **Location of Arbitration Hearing:** The arbitration will occur in or near the county in which you are currently employed by trustaff or were most recently employed by trustaff, unless the parties agree to a different location.
- **Decision and Award:** The decision will be in writing, signed by the arbitrator, and issued within 30 days of the close of the hearing or ruling consistent with Rule 12 or 56 of the FRCP. The decision will include a summary of the claims arbitrated and the reasons for the arbitrator's decision. The arbitrator will apply applicable federal law and the laws of the State in which you currently or were most recently employed by trustaff.

- **Confidentiality:** All proceedings under this Agreement are private and confidential, unless a public injunction has been sought or applicable law provides to the contrary.
- **Savings Clause:** If any provision of this Agreement is found to be unenforceable, the remainder of this Agreement will remain intact and be enforceable.
- **Change or Termination of Agreement:** The Agreement may be changed by agreement of the parties in writing with a written or electronic acknowledgement of the parties.
- **Controlling Law:** This Agreement will be governed by the Federal Arbitration Act.

GREEN VALLEY FERTILITY PARTNERS
PATIENT SAFETY AND RISK MANAGEMENT PLAN

I. PURPOSE:

Attention to maintaining and improving patient safety and well being is inherent in Green Valley Fertility Partners (GVFP) commitment to helping patients achieve their goals, safely and effectively in creating a family. In committing ourselves to safeguarding individuals, GFVP must fully understand the processes and systems that are utilized by the organization to deliver patient care. From this deeper understanding, GVFP 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 GVFP commitment to the community it serves.

- Unite GVFP and individuals who work and practice at GVFP 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 GVFP 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 GVFP. Green Valley Fertility Partners leadership and employees must actively embrace and support the patient safety plan in order to achieve the results outlined above.

II. SCOPE:

Green Valley Fertility Partners, 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

GREEN VALLEY FERTILITY PARTNERS
PATIENT SAFETY AND RISK MANAGEMENT PLAN

- Allergic reaction
- Medical Equipment related adverse event
- Technical difficulty with procedure
- Proper indication
- Proper consent
- Current H & P
- Risk Stratification
- Patient Satisfaction
- Pathology Specimen errors
- Time outs
- Patient Education/discharge instructions
- Day of Procedure Cancellations
- Identity Theft/Lack of ID
- Reprocessing errors
- Non-compliant patients with pre-procedure instructions
- Communication with referring providers
- 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
- Responsible adult to accompany patient home
- Patient Identification
- Single use of injection devices

• Fire Prevention and Safety in the Procedure Rooms

Green Valley Fertility Partners recognizes that risk management and patient safety are priorities that include establishing, maintaining and improving the safety of patients and the facility.

III. **STRUCTURE:**

Governing Body

The Governing Body of Green Valley Fertility Partners is comprised the 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, Green Valley Fertility Partners 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 GVFP 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 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

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, Patient Safety Officer, Clinical Manager and Executive Financial Officer. 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.

• 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.

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. Green Valley Fertility Partners encourages all employees to report any errors or work methods that may lead to potential adverse patient outcomes. The GVFP 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.

D. Patient Complaint/Grievance

Complaints can be reported to the Office Manger, Clinical Manager or Medical Director. Employees should report all complaints immediately to their supervisor. Patients should notify the Office Manager. 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.

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 the right procedure.
4. Staff meetings are held to communicate quality improvement and patient safety issues.
5. Ongoing education to staff is provided regarding patient safety issues.
6. Staff education on all disinfectants used throughout the facility.
7. Patient safety checkpoints are added to the pre, intra and post documentation.

VIII. Safety Improvement Activities/Methodologies

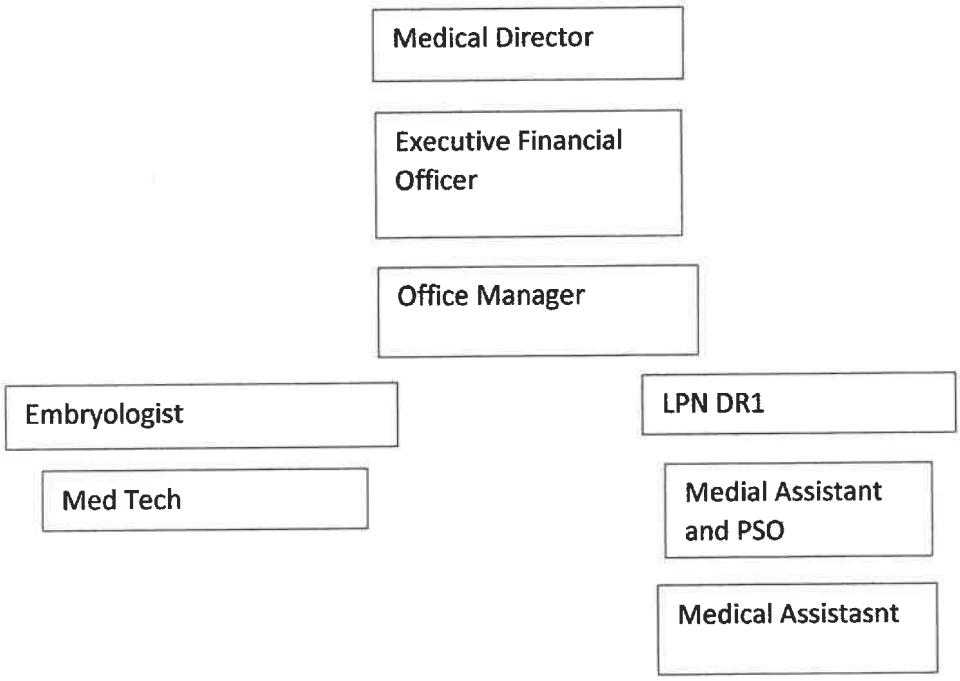
Medication/Pharmacy Surveillance – All matters pertaining to the use of drugs in the office will be monitored on a monthly basis by Clinical Manager.
High Alert Medications – All employees or providers that handle patient medication will follow the procedure for the safe storage and handling of high alert medications. See High Alert Medication Policy.
Infection Surveillance – Infection surveillance will be completed by the Clinical Manager 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 Clinical Manager 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 Hysteroscopy the scope is placed in HLDS, 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 scope is placed in the solution. This is done for each hysteroscopy 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 and physician 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

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 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.

Governing Body



Emergency Procedures

FIRE
THREATS
EVACUATIONS
EMERGENCY CODES

Steinberg Diagnostic
Medical Imaging Centers
"Where Imaging Revolves Around You" SM

□pdated □ arch 2022

□ arch 2022

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Personal Threats
Definition: Any aggressive (physical or verbal) attack that you believe will turn into a violent act that could cause personal injury to yourself or others in the building.

In order to reduce risk to you, we ask that you adhere to the following guidelines should a violent threat be encountered:

Front Desk/ Admitting Area:
1. Announce “code green” and “location” over paging system 3 times or activate Panic Button if the situation is or could be life threatening.
2. Office Manager (or designated Lead), Maintenance, EVS Lead will respond immediately to the area to give assistance in controlling the situation but not to act as Security. If the situation escalates call □-□11/ press Panic button.
3. Office Manager (or designated Lead) or EVS Manager to contact and continue to keep Chief Operating Officer updated on situation as needed.
4. The charge person of that area will be responsible for decision-making and subsequent physician’s orders.
5. Leads gather at “location”. The charge person will communicate information to Leads as needed.
6. Leads disseminate information as needed to employees.

Support/Technical Staff:
1. Stay calm and ensure safety of patients.
2. Reassure patients who may become disturbed by the commotion.
3. Remain in area until situation resolved.
4. If need to leave area avoid situation location

□omb Threats□Fire (□uilding Evacuation)
Upon receipt of a bomb threat immediately:
1. Employee notifies Office Manager (or designated Lead),
2. Employee/Office Manager (or designated Lead), activate panic button or call □-□11.
3. Office Manager (or designated Lead), call all departments and require an immediate evacuation of the building.
4. Office Manager (or designated Lead) to contact Compliance Officer or Chief Operating Officer and continue to keep updating on situation as needed.
5. Communicate as needed appropriate information to Supervisors/Leads.
6. Each Supervisor/Lead will initiate the evacuation procedures for the department and building.
    a) Carry out immediate emergency response.
    b) Clear exits.

c) If fire is in your area, an employee from that area will ensure that all oxygen tanks are shut off
d) A list of patients should be convenient to ensure all are accounted for.
e) One person in each department should be responsible for checking restrooms and ensuring that all doors and windows in the area are closed.
f) Reassure patients who may become disturbed by the commotion.

. Patients will be evacuated first.
. All available personnel should assist patients in other areas as needed then exit
. Remain calm, move quietly and quickly to nearest exit.
10. Assemble at designated evacuation point. Supervisor/Lead immediately conducts a role call for all patients/ personnel for in the area.
11. Supervisor checks in with designated SDMI official at evacuation point to report department's roll call status.
12. EVS or Maintenance is required to make sure employee restrooms are empty.
13. Do not reenter the building until told to do so by Police or SDMI officials.

False Alarms
If there is no emergency announce over the intercom "this is a false alarm, please stay calm". Repeat the announcement every few minutes until the alarm is turned off.

It is extremely important to stay calm and reassure the patients that everything is ok and it is only a false alarm.

uilding Evacuation
In the event the building needs to be evacuated, all employees, patients and guest should evaluate the building as quickly as possible and meet at the following designated safe location:

Administration (Admin- Pea): Exit the building. Walk alongside the sidewalk west towards the covered parking, walk south then east along the covered parking until at SE corner of the employee parking lot area (gravel area), located of the Administration Building.
Anthem (AN- Siena Heights): In the covered parking lot area located behind the building.
lue Diamond (D): Exit building by the employee breakroom and the meeting area is in the SW corner of the employee parking lot.
Centennial Hills (CH): On sidewalk north of the block wall on Hitt Center Court by handicap ramp in the northeast corner of the parking lot.
Craig Road (CR): Exit building by the employee breakroom and meet behind the building under the carport.
Green Valley (GV- Sunset ay): In front of the building along Sunset Way.

Galleria (GA): In the southwest corner of the parking lot by the building sign.
Maryland Par□way (MP): In front of the building on the sidewalk along Maryland Parkway.
Shadow Lane (SL): Under the covered parking on the west side of the building□The side of the building closest to UMC parking lot.
Southwest (S□ - Post Road): In front of the building in the parking lot area near the sign.
Tenaya □ ay (N□ - Northwest): In the employee parking lot area located behind the building.
□ **arehouse:** In front of the building just outside of the parking area.

Disaster Codes

Code Blue	For a person down and needing immediate care.
Code Red	For a Fire
Code Yellow	For a disaster
Code Green	For a person out of control
Code Orange	Patient needs assistance. Doctor needs to evaluate

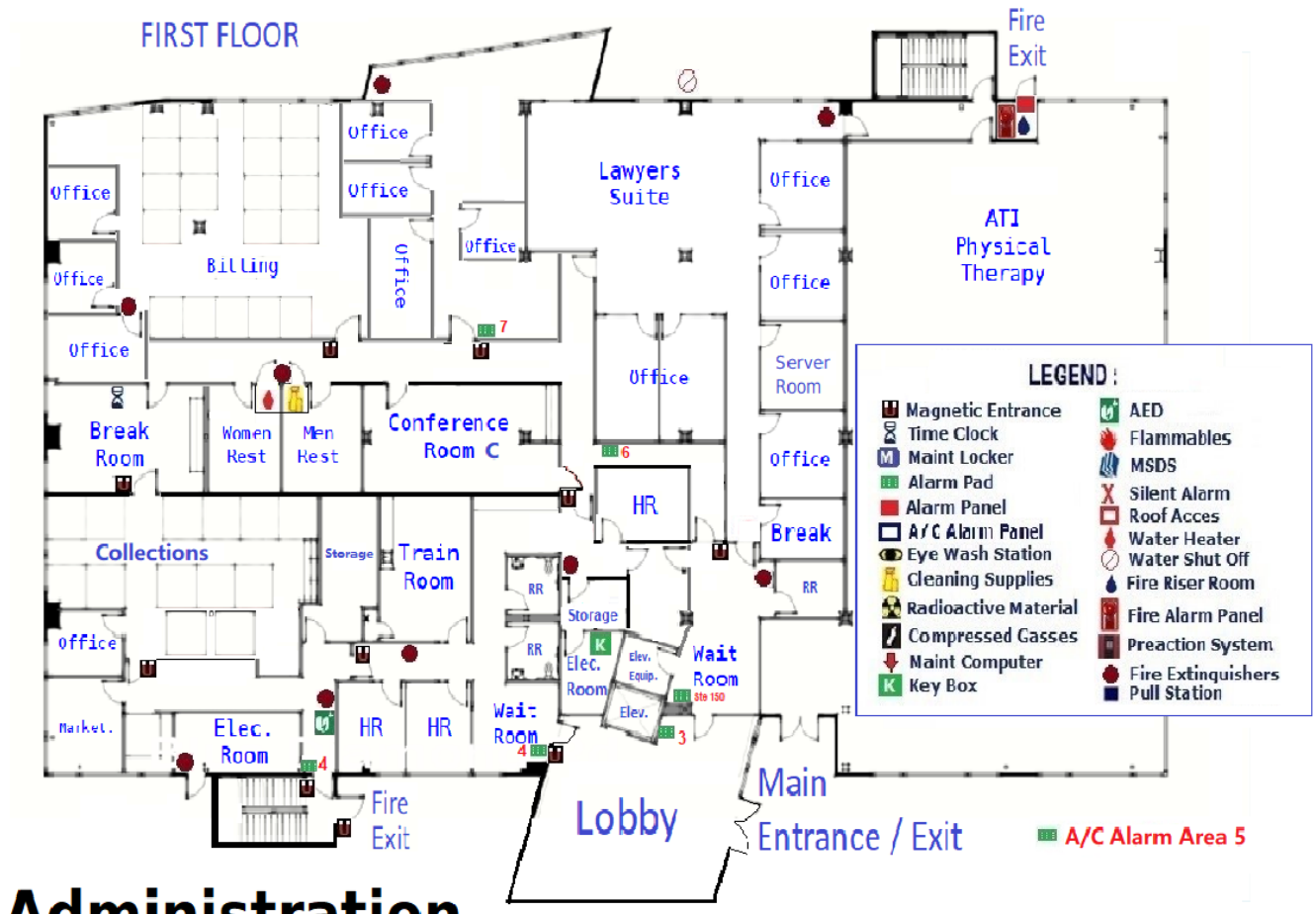
ADMINISTRATION (Admin-Pea□)
□301 Peak Drive Las Vegas, Nevada □□12□

INSTRUCTIONS (ADMIN)
Maintenance Cellular □□□-□□□-□□□□

1. Keys to the fire riser room (fire alarm panel located inside) will be located at the Receptionist desk.

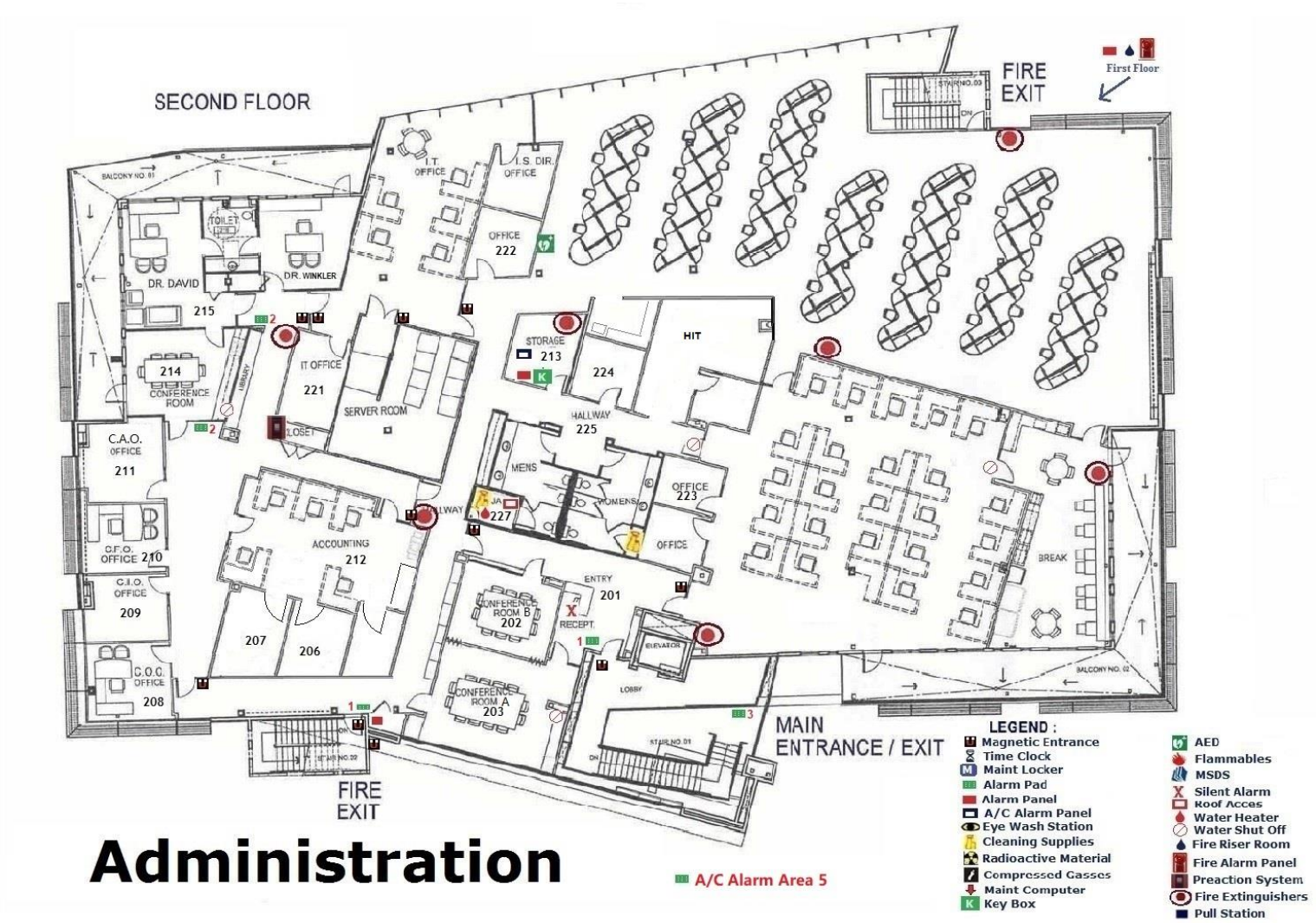
2. Go into the fire alarm panel
   - Located outside at the NE corner of the building (or)
   - Exit emergency exit through Call Center. At bottom of the stairs on outside of stairwell.

3. Read and follow directions on key chain.



Administration

ADMINISTRATION (Admin-Pea□)
Second Floor


SECOND FLOOR
FIRE EXIT
First Floor
I.T. OFFICE
I.S. DIR. OFFICE
OFFICE 222
TOILET
DR. DAVID
DR. WINKLER
215
214 CONFERENCE ROOM
LIBRARY
IT OFFICE 221
SERVER ROOM
CLOSET
STORAGE 213
HIT
224
HALLWAY 225
MENS
WOMENS
OFFICE 223
OFFICE
227
C.A.O. OFFICE 211
C.F.O. OFFICE 210
C.I.O. OFFICE 209
C.O.O. OFFICE 208
ACCOUNTING 212
207
206
CONFERENCE ROOM B 202
ENTRY 201
RECEPT.
ELEVATOR
LOBBY
CONFERENCE ROOM A 203
BREAK
BALCONY NO. 02
MAIN ENTRANCE / EXIT
FIRE EXIT
Administration
A/C Alarm Area 5
LEGEND :
Magnetic Entrance
Time Clock
Maint Locker
Alarm Pad
Alarm Panel
A/C Alarm Panel
Eye Wash Station
Cleaning Supplies
Radioactive Material
Compressed Gasses
Maint Computer
Key Box
AED
Flammables
MSDS
Silent Alarm
Roof Acces
Water Heater
Water Shut Off
Fire Riser Room
Fire Alarm Panel
Preaction System
Fire Extinguishers
Pull Station

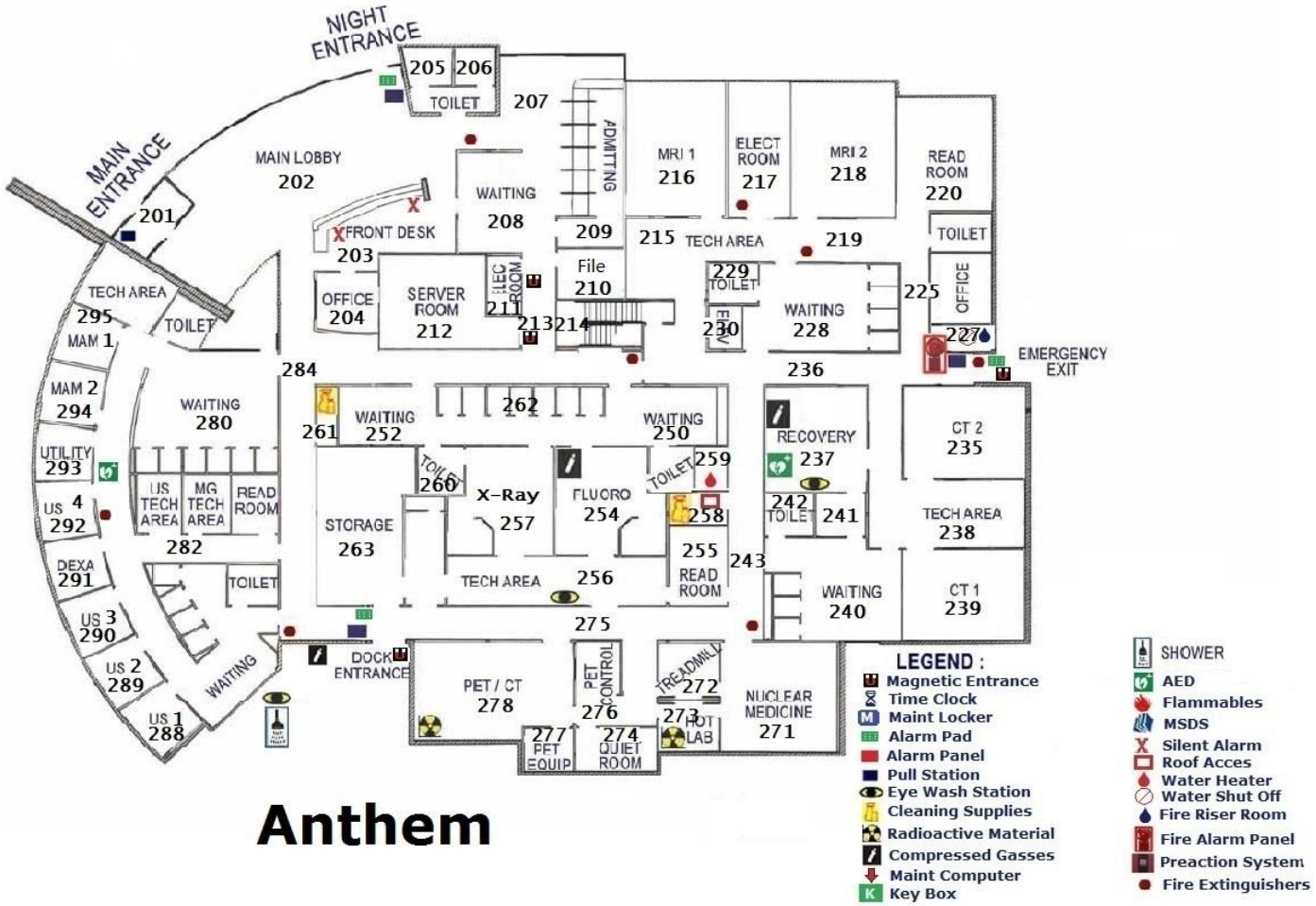
ANTHEM (AN- Siena Heights)

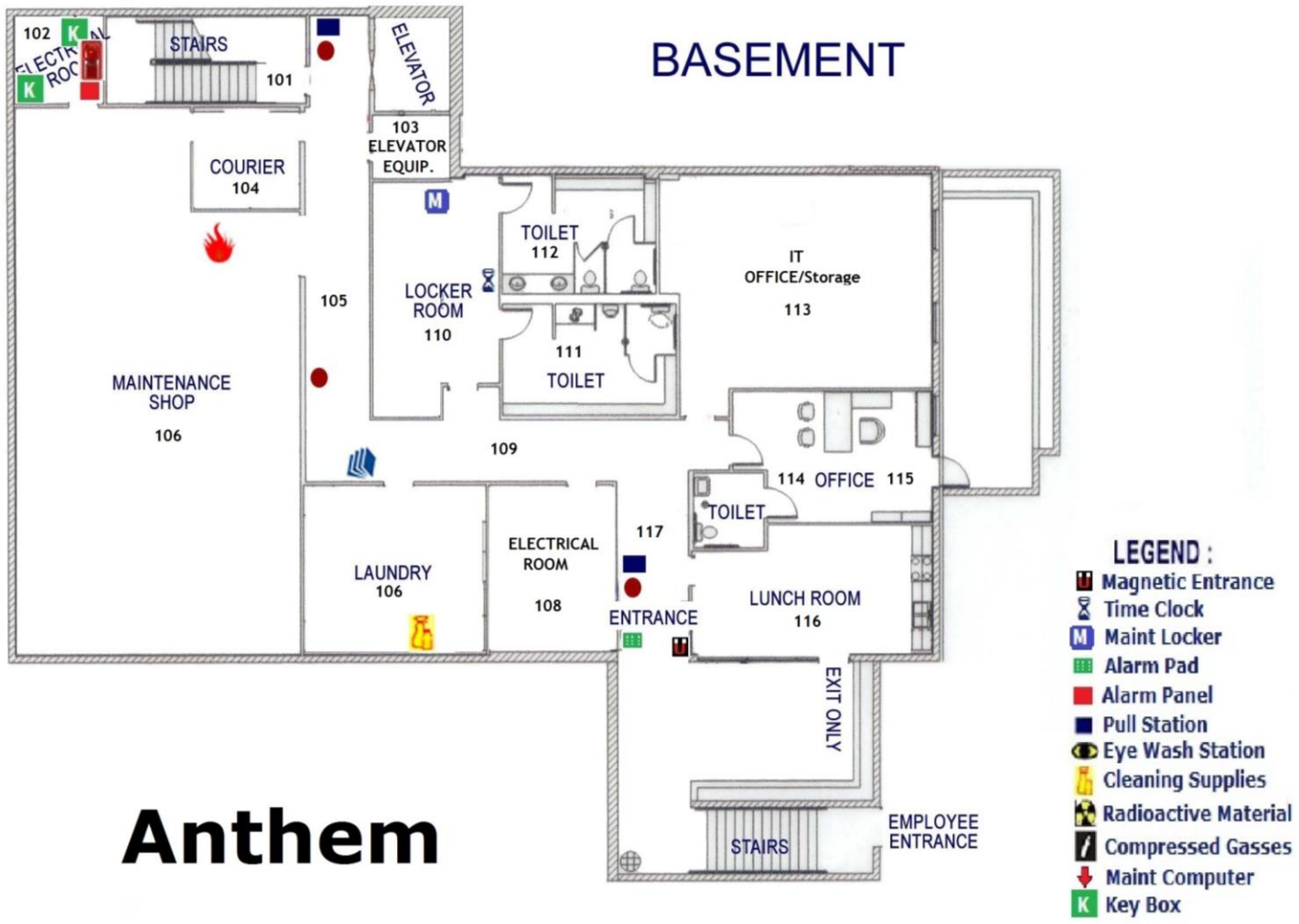
2□50 Siena Heights, Henderson, Nevada □□052

INSTRUCTIONS (AN)

Maintenance Cellular Number □02-4□□-5523

1. Go to the fire alarm panel at the rear door at north end of the building. (Radiologist entrance area- outside the OM Office).
2. Read and follow directions at panel.




BASEMENT
102
STAIRS
101
ELEVATOR
103
ELEVATOR
EQUIP.
COURIER
104
TOILET
112
IT
OFFICE/Storage
113
LOCKER
ROOM
110
105
111
TOILET
MAINTENANCE
SHOP
106
109
114 OFFICE 115
TOILET
117
ELECTRICAL
ROOM
108
LAUNDRY
106
ENTRANCE
LUNCH ROOM
116
EXIT ONLY
EMPLOYEE
ENTRANCE
STAIRS
Anthem
LEGEND :
Magnetic Entrance
Time Clock
Maint Locker
Alarm Pad
Alarm Panel
Pull Station
Eye Wash Station
Cleaning Supplies
Radioactive Material
Compressed Gasses
Maint Computer
Key Box

□lue Diamond (□D)

□□45 Lindell Road Las Vegas, Nevada □□13□

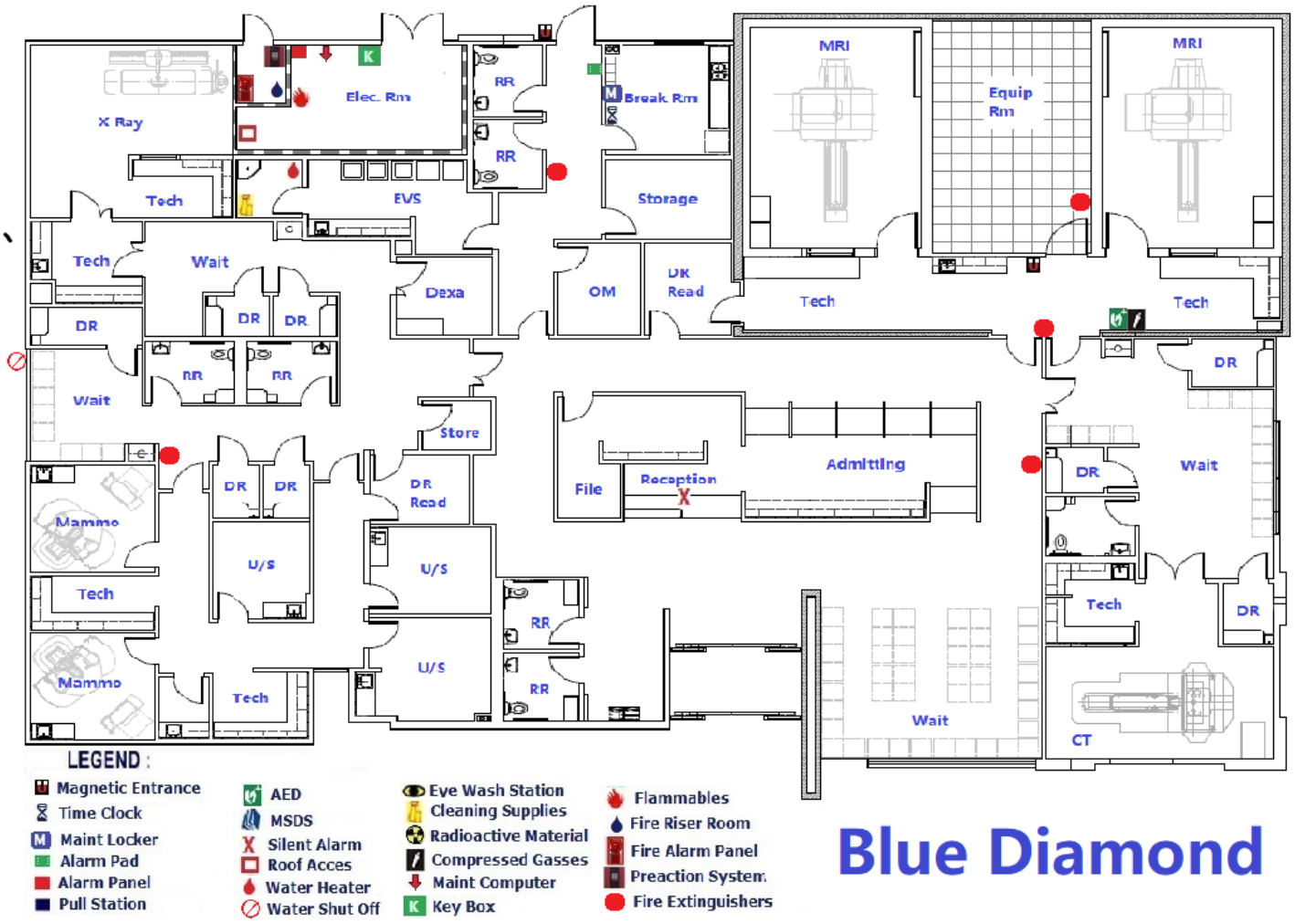
INSTRUCTIONS (□D)

Maintenance Cellular Number □□□-□□□-□□□□

1. □eys to the fire riser room □fire alarm panel located inside□□ill □e located at the Receptionist des□

2. □o to the fire alarm panel located in the □ire Riser Room. □ocated o□tside at □ac□ of □□ilding near electrical room.

3. Read and follo□ directions on □ey chain



CENTENNIAL HILLS (CH)

6□25 N Durango Drive Las Vegas, Nevada □□14□

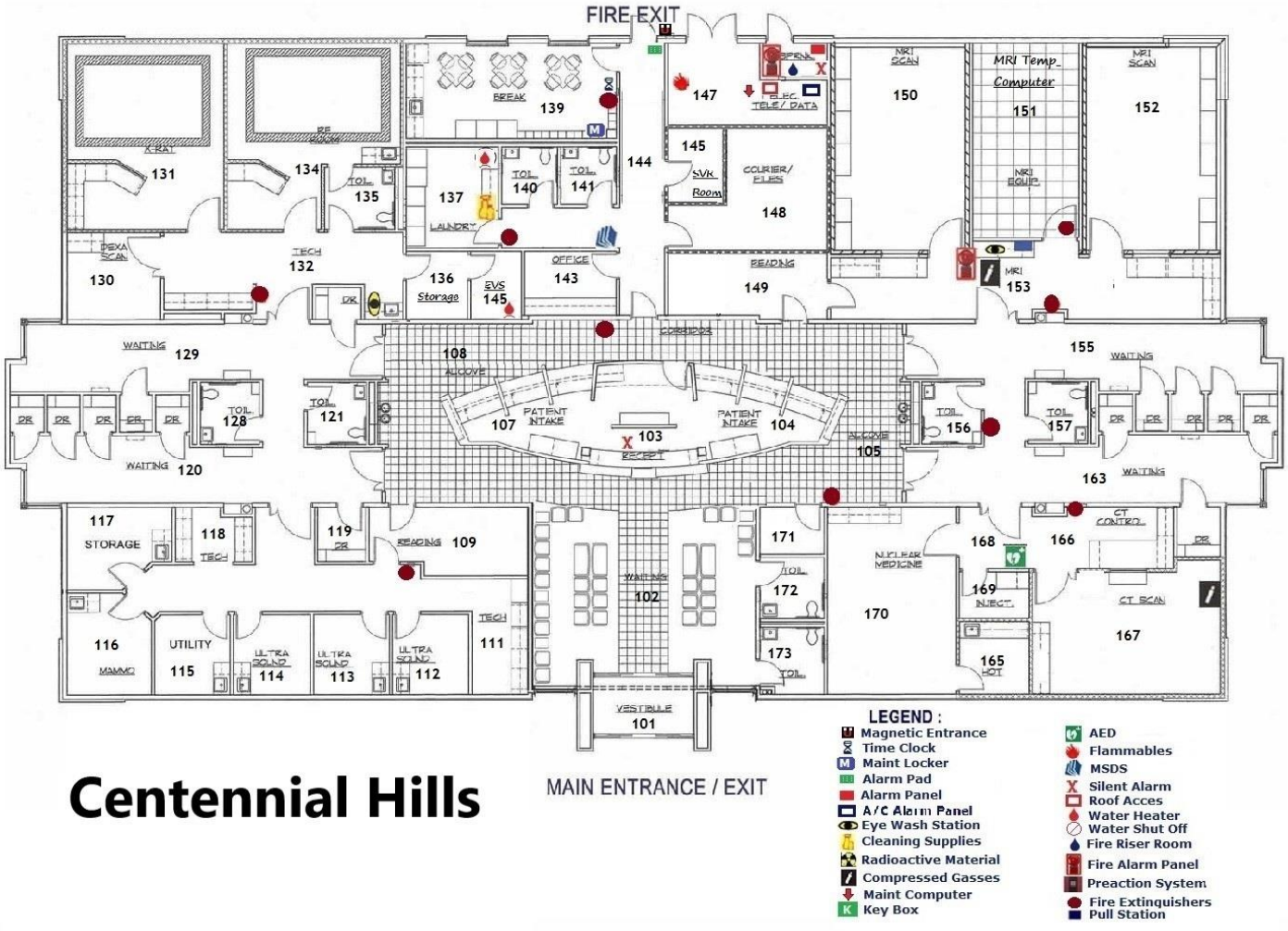
INSTRUCTIONS (CH)

Maintenance Cell □02-5□3□-□□04

1. Keys to the fire riser room (fire alarm panel located inside) will be located at the Receptionist desk.

2. Go to the fire alarm panel located in the Fire Riser Room. Located outside at back of building near electrical room.

3. Read and follow directions on key chain.



□ arch 2022

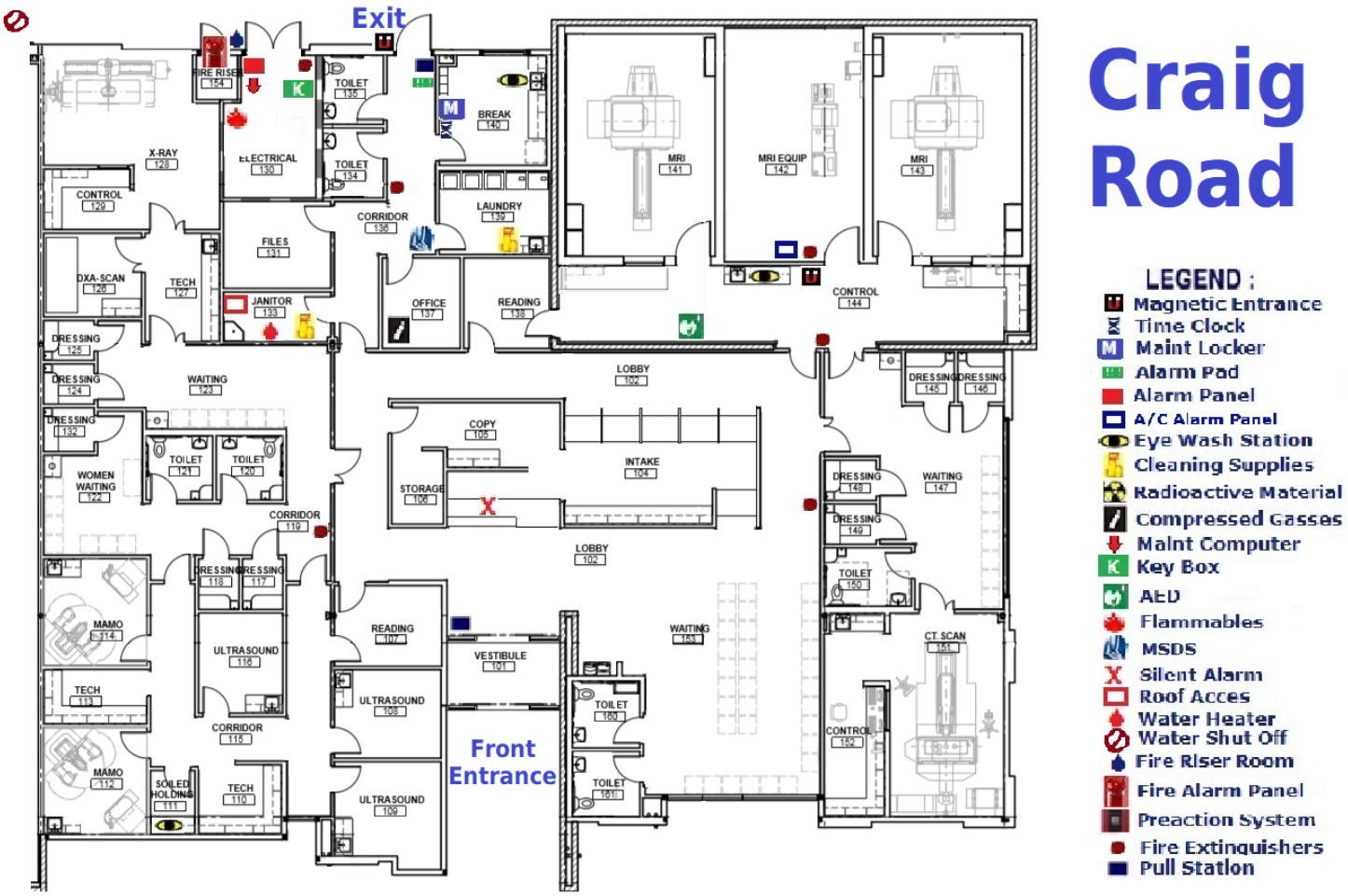
Craig Road (CR)
1650 W. Craig Road North Las Vegas, Nevada □□032

INSTRUCTIONS (CR)
Maintenance Cell □02-521-□2□6

1. □eys to the fire riser room □fire alarm panel located inside□□ill □e located at the Receptionist des□

2. □o to the fire alarm panel located in the □ire Riser Room. □ocated o□tside at □ac□ of □□ilding near electrical room.

3. Read and follo□ directions on □ey chain



□ arch 2022

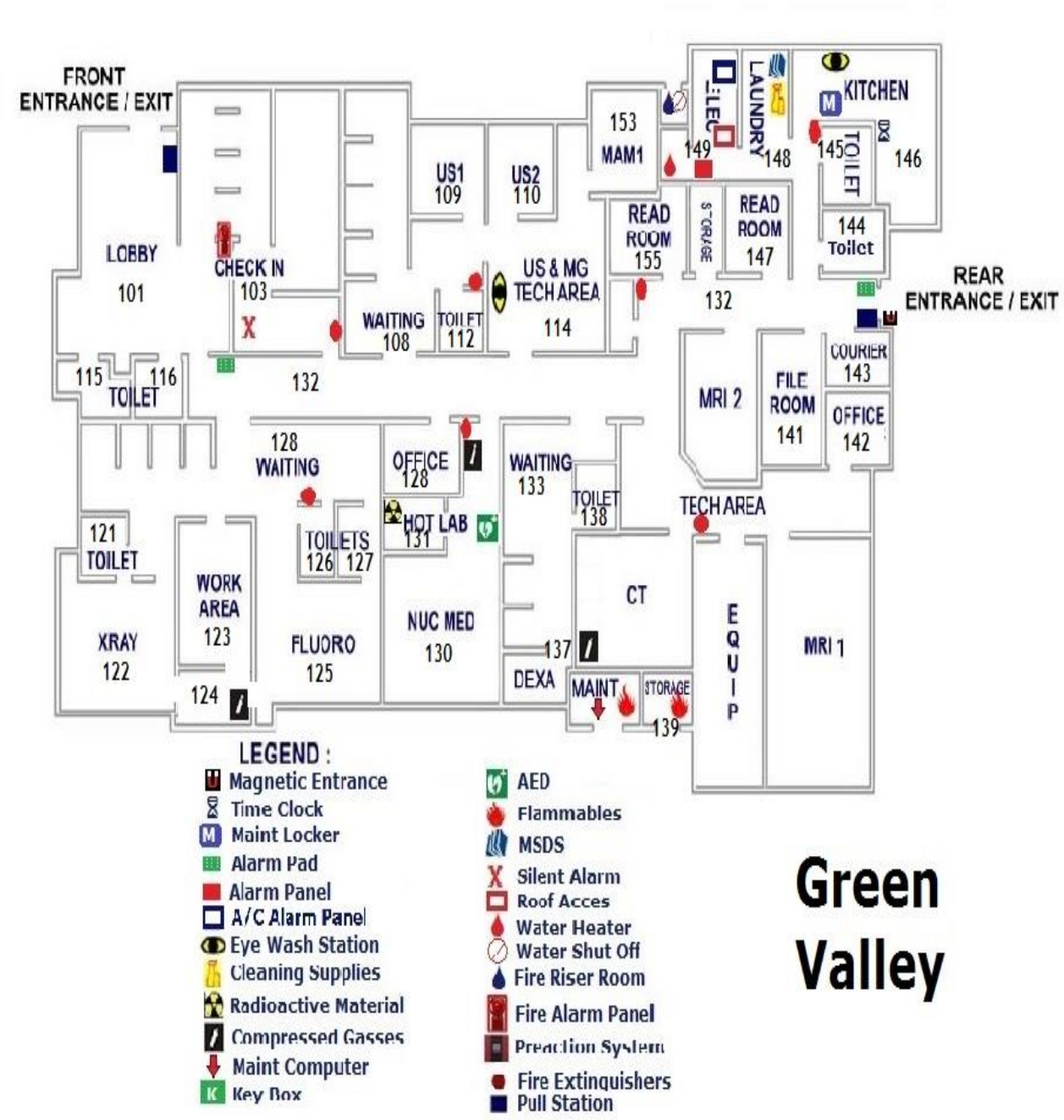
GREEN VALLEY (GV- Sunset)
4 Sunset Way Henderson, Nevada □□014

INSTRUCTIONS (GV)
Maintenance Cell □02-4□□-5523

1. Keys for the fire alarm panel are located at the Receptionist desk.

2. The fire alarm panel is located in the lobby between the Receptionist and Front Desk Admitting area.

3. Read and follow directions on the key chain.



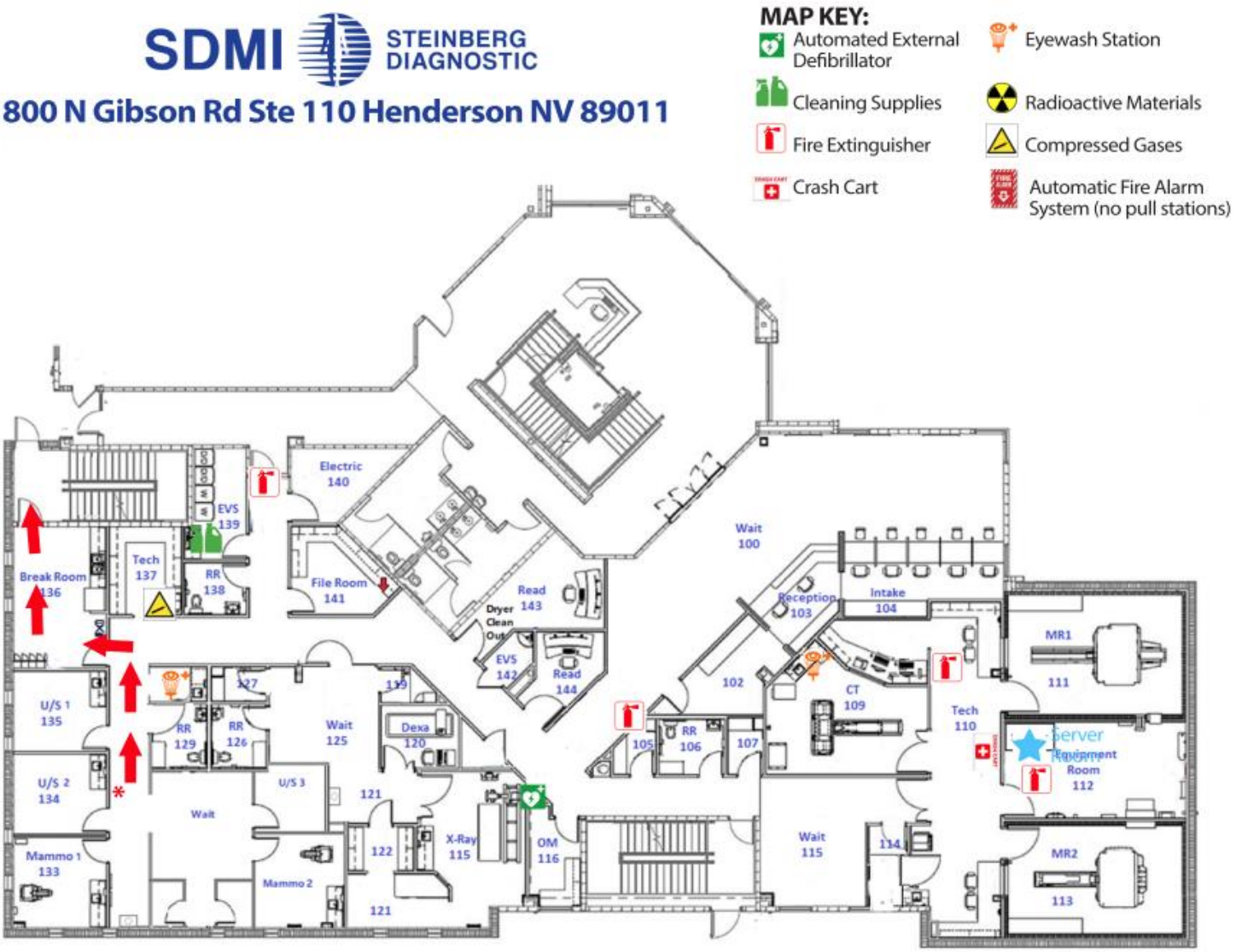
GALLERIA (GA)

□00 Gibson Road Henderson, Nevada □□011

INSTRUCTIONS (GA)

Maintenance Cell □02-4□3-1134

1. Keys to the fire alarm panel are located at the Receptionist desk.
2. Go to the fire alarm panel inside fire riser room opposite MR □2
3. Read and follow directions on the key chain.



□ arch 2022

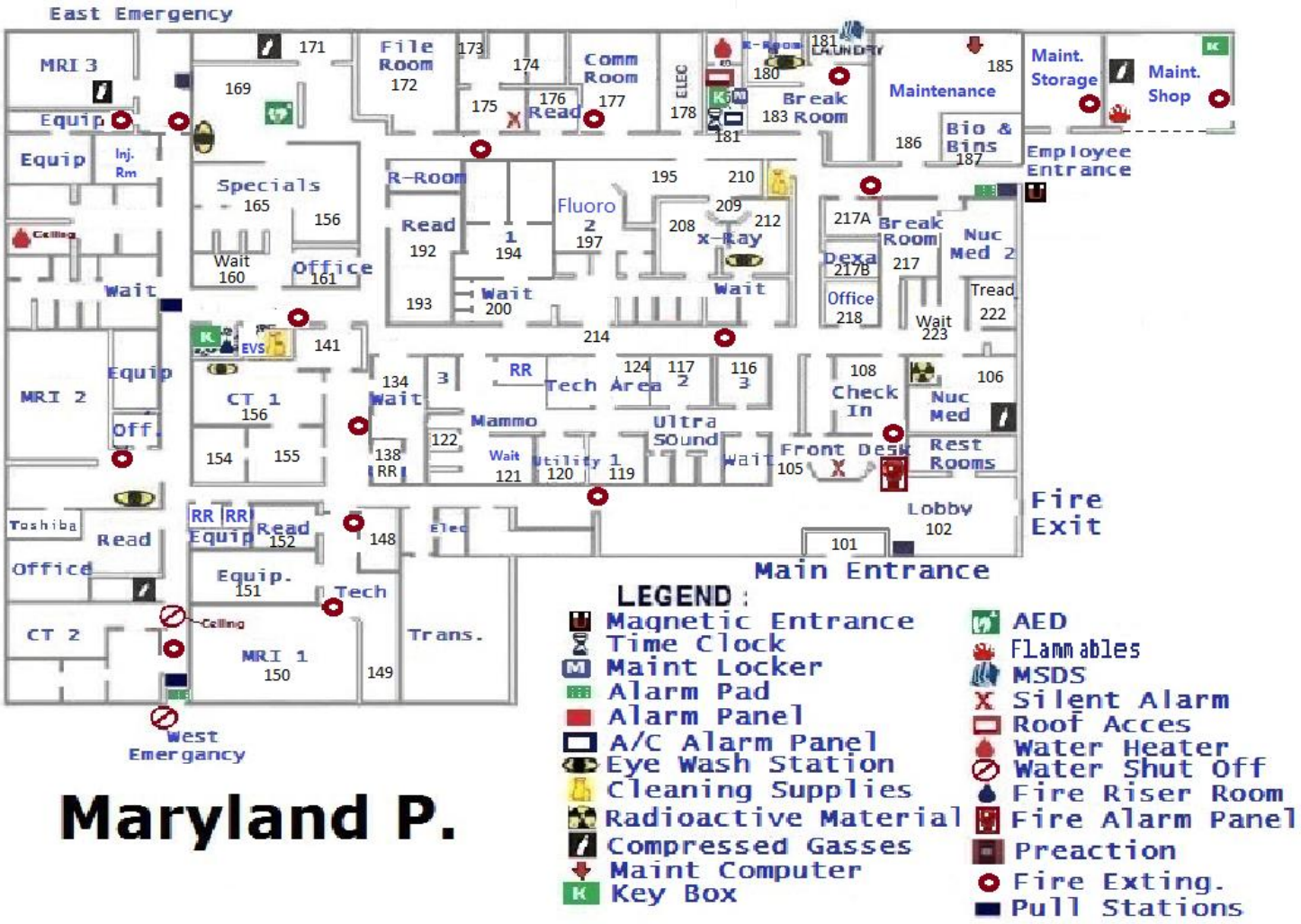
MARYLAND PAR□□ AY (MP)

2□50 S Maryland Parkway Las Vegas, Nevada □□10□

INSTRUCTIONS (MP)

Maintenance Cell □02-□3-1134

1. Keys to the fire alarm panel are located at the Receptionist desk.
2. Go to the fire alarm panel to the left of the Receptionist desk.
3. Read and follow directions on the key chain.



SHADO□ LANE (SL)

□00 Shadow Lane Las Vegas, Nevada □□106

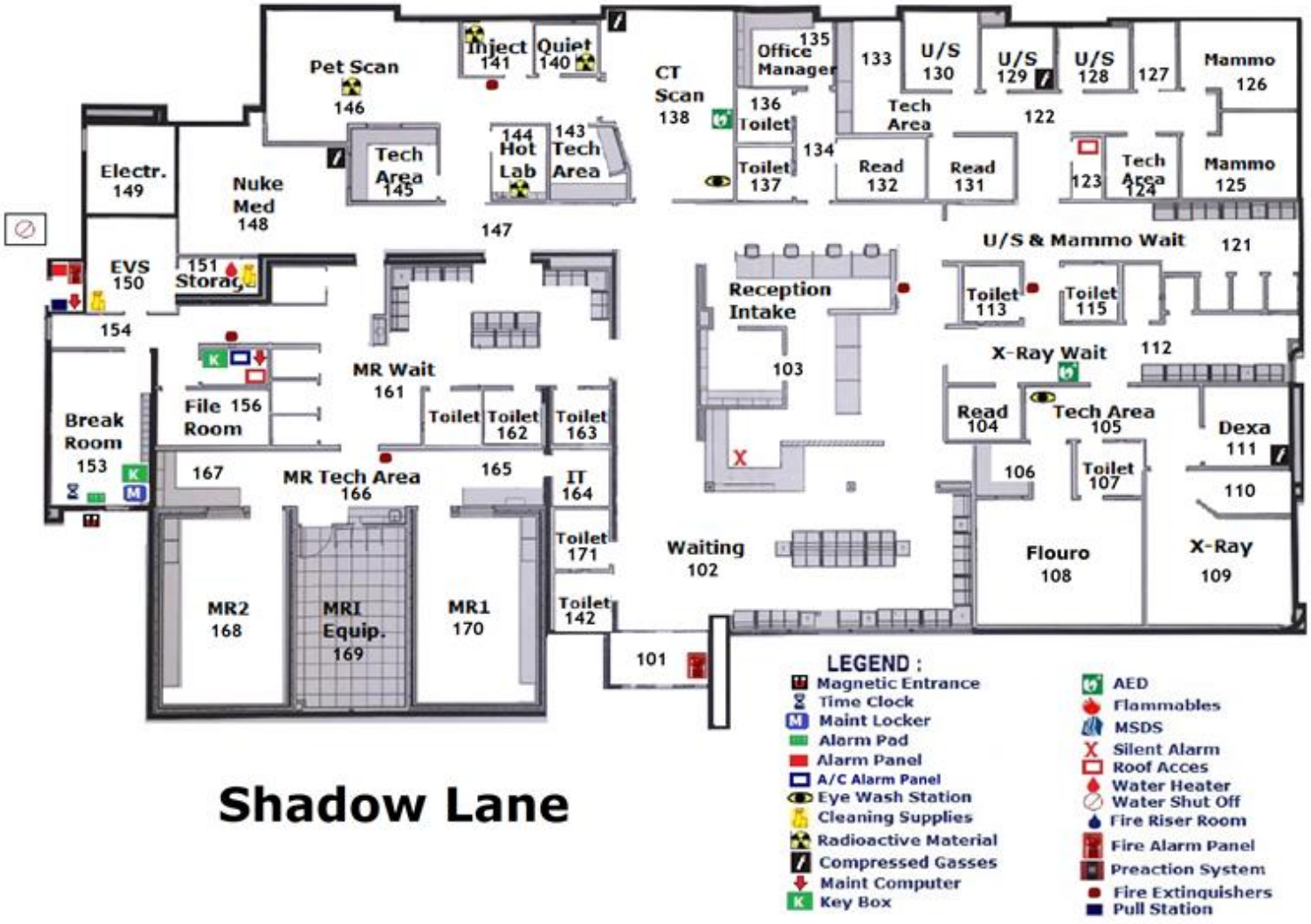
INSTRUCTIONS (SL)

Maintenance Cell □02-521-□2□6

1. Keys to the fire riser room (fire alarm panel located inside) and fire panel in main entrance will be located at the Receptionist desk.

2. Go to either the fire alarm panel located in the main entrance or fire riser room located left of the Maintenance entrance.

3. Read and follow directions on key chain.



□ arch 2022

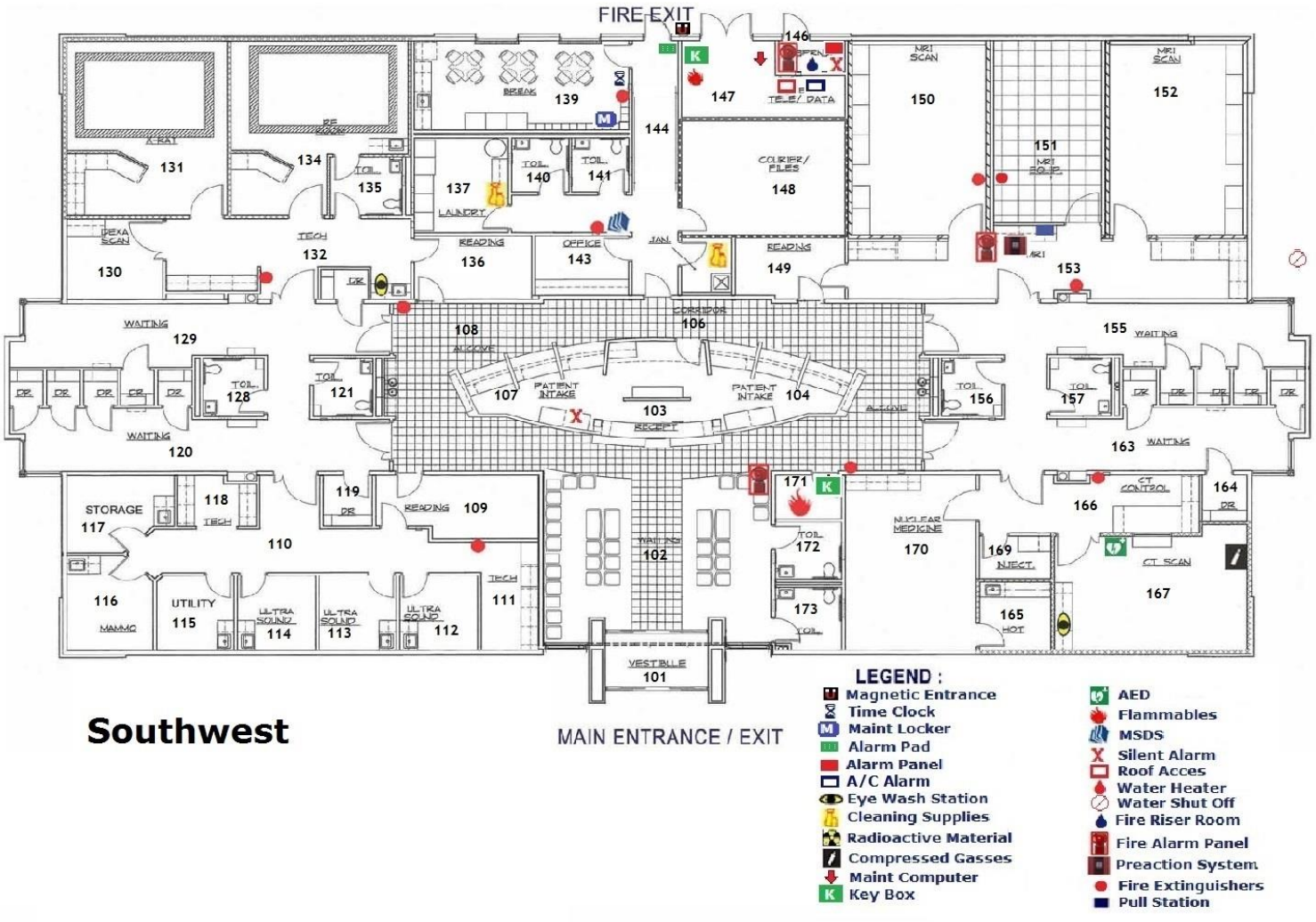
SOUTH□ EST (S□ -Post)

□0□0 W. Post Road Las Vegas, Nevada □□14□

INSTRUCTIONS (S□)

Maintenance Cell □02-□3□-□□04

1. Keys to the fire riser room (fire alarm panel located inside) will be located at the Receptionist desk.
2. Go to the fire alarm panel located in the Fire Riser Room. Located outside at back of building near electrical room.
3. Read and follow directions on key chain



NORTH□ EST (N□ -Tenaya)

2□6□ N. Tenaya Way Las Vegas, Nevada □□12□

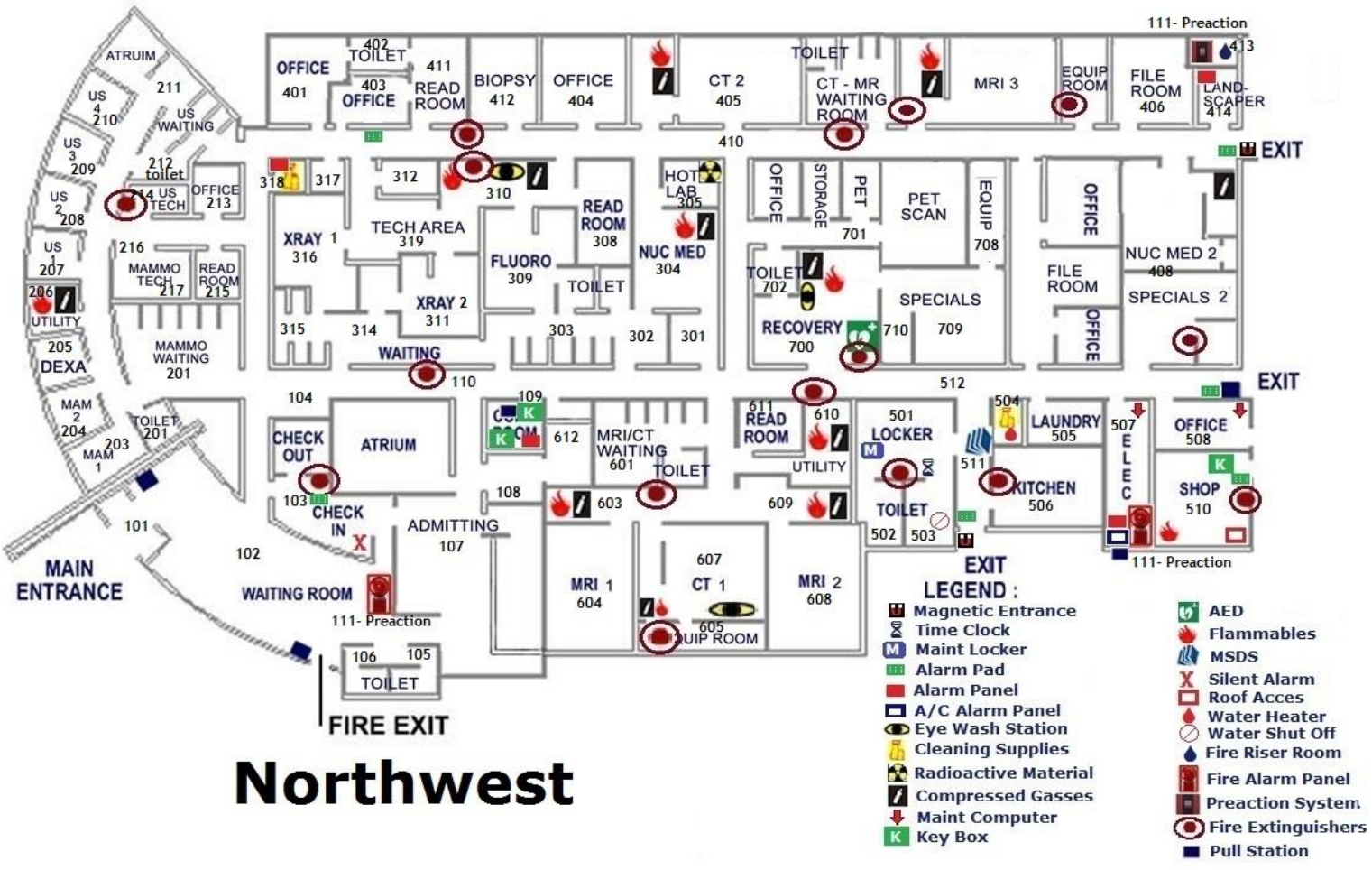
INSTRUCTIONS (N□)

Maintenance Cell □02-4□□-524□

1. Keys to the fire alarm panel will be located at the Receptionist desk.

2. Follow instructions on keys

3. Go to the fire alarm panel located at the right of the Receptionist desk in the lobby.



□ arch 2022

□ AREHOUSE

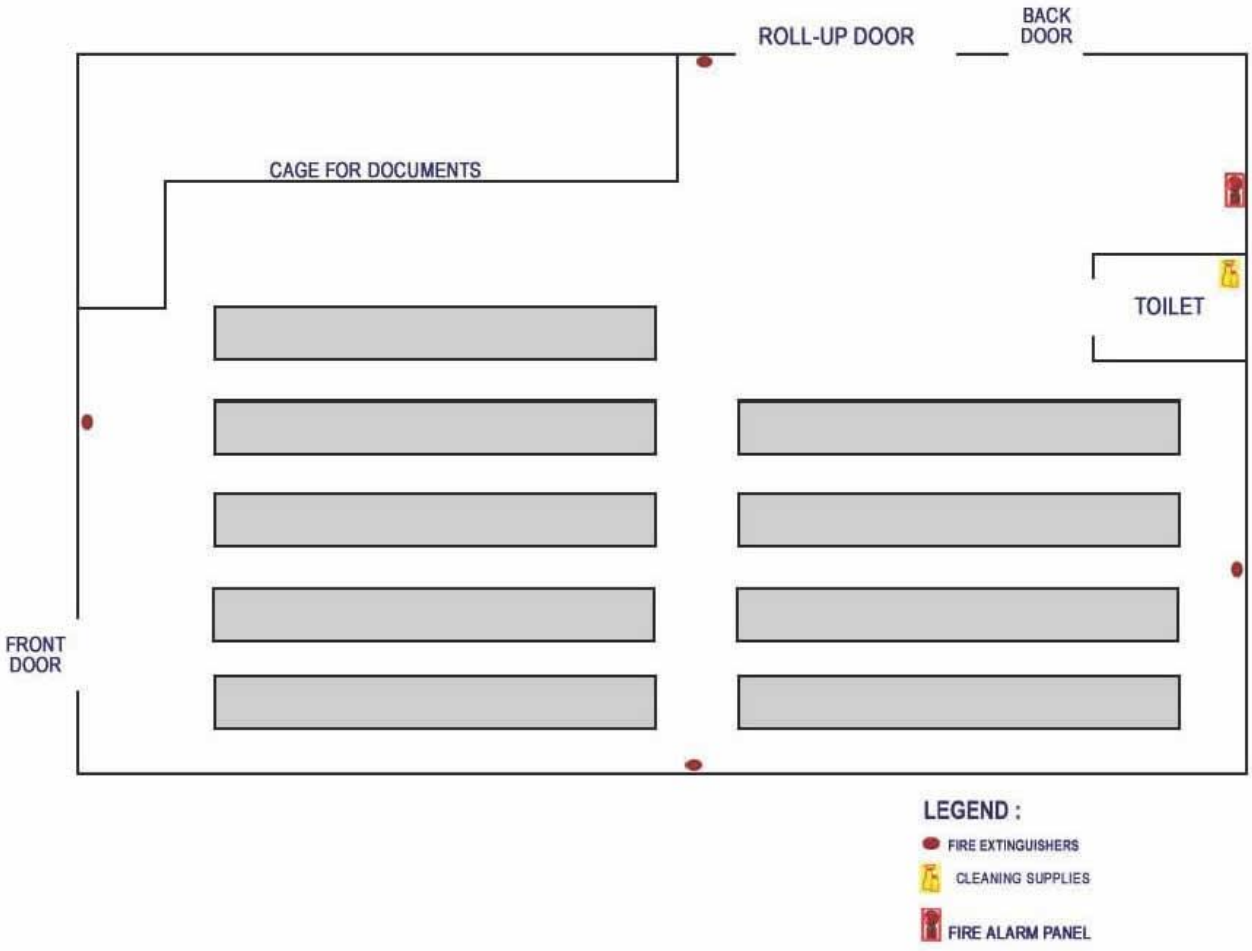
INSTRUCTIONS (□ arehouse)

Maintenance Cell □02-4□□-5523

1. Safely see if there is a fire.

2. In case of fire immediately call □-□11 and confirm fire department has been dispatched.

3. In case of false alarm immediately call Alarmco at □02-3□4-2000 and cancel fire department from being dispatched.



Steinberg Diagnostic
Medical Imaging Centers
"Where Imaging Revolves Around You" SM

SU□□ECT: Fire Plan Responsibilities for Individual Departments	**POLICY NO□** Safety - 10
SCOPE: Organization Wide	**EFFECTIVE:** 1/□□
ISSUED □Y: Chief Human Resource Officer	**REVIE□ ED□REVISED:** □/01, □/03, 5/06, 2/0□, 4/11, 2/1□, 1/2020, 10/2020
APPROVED □Y: COO	**PAGE:** 1 of 2

I□ PURPOSE: To assign responsibility for fire safety/evacuation within each facility.

II□ POLICY: To ensure each department implements an effective plan to safely evacuate all patients and staff while securing the facility and initiating the appropriate fire response procedure.

III□ PROCEDURE: The Office Manager will work with the department supervisors to ensure the following procedure is implemented throughout each facility:

A. One person in each area should be assigned to act as a member of the fire brigade – secure a fire extinguisher at his or her location and be ready to respond if necessary.
B. One person should be assigned to monitor the telephone to answer emergency calls and relay messages.
C. Last person to leave the area should ensure all room doors are closed.
D. Every employee should become familiar with the facility fire plan.
E. In the event of a fire:
    1. Carry out immediate emergency response
    2. Clear exits
    3. If fire is in your area, ensure that all oxygen tanks are shut off
    4. If fire is not in the area, managers should be prepared to use their personnel to assist patients to other area or exit.
    5. Reassure patients who may become disturbed by the commotion
    6. Have someone receive the Fire Department to communicate the nature and location of the emergency.

IV□ DEPARTMENT SUPERVISOR or Designated Representative:

A. Before a fire occurs:

1. Become familiar with the facility fire plan.
2. See that employees in their departments have been instructed as to their respective duties in case of fire.

B. In the event of a fire:
   1. See that these duties are carried out.
   2. Immediately upon hearing the alarm, ensure that all doors and windows in the area are closed.

V MAINTENANCE:

A. Before a fire occurs:
   1. Become familiar with the facility fire plan.
   2. Designate appropriate personnel as members of fire brigade.

B. In the event of a fire:
   1. Carry out immediate emergency response.
   2. Regulate air handling equipment, if system was not shut down by duct alarms.

C. Secure electrical room

Emergency Procedure Acknowledgment

I acknowledge that I have read and understand the Steinberg Diagnostic Medical Imaging Center's Emergency Procedures handout revised March 2022 along with additional policy updates. I am comfortable in performing the duties that are expected of me during an emergency situation.

I acknowledge that the Emergency Procedures contained in this handout are subject to change by SDMI based upon need.

I also understand that this handout is not and was not intended to serve as a contract between SDMI and myself regarding the nature of continued employment or the duration of my employment with SDMI.

I understand that if I desire clarification or elaboration of any emergency procedures, I will talk with my Supervisor, Manager, Maintenance or Human Resources.

□□□□□□□□□□□□□□□□□□□□□□□□□□□□ □□□□□□□□□□□□□□□□□□□□□□□□□□□□

Signature of Employee **Date**

□□□□□□□□□□□□□□□□□□□□□□□□□□□□ □□□□□□□□□□□□□□□□□□□□□□□□□□□□

Printed Name **Department**

Emergency Procedures

FIRE
THREATS
EVACUATIONS
EMERGENCY CODES

Steinberg Diagnostic
Medical Imaging Centers
"Where Imaging Revolves Around You" SM

□pdated □ arch 2022

□ arch 2022

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Instructions/Map

Safety Policy Number □□ Page 20
Fire Plan Responsibilities

Emergency Procedure Ac□nowledgment Page 22

Personal Threats
Definition: Any aggressive (physical or verbal) attack that you believe will turn into a violent act that could cause personal injury to yourself or others in the building.

In order to reduce risk to you, we ask that you adhere to the following guidelines should a violent threat be encountered:

Front Desk/ Admitting Area:
1. Announce “code green” and “location” over paging system 3 times or activate Panic Button if the situation is or could be life threatening.
2. Office Manager (or designated Lead), Maintenance, EVS Lead will respond immediately to the area to give assistance in controlling the situation but not to act as Security. If the situation escalates call □-□11/ press Panic button.
3. Office Manager (or designated Lead) or EVS Manager to contact and continue to keep Chief Operating Officer updated on situation as needed.
4. The charge person of that area will be responsible for decision-making and subsequent physician’s orders.
5. Leads gather at “location”. The charge person will communicate information to Leads as needed.
6. Leads disseminate information as needed to employees.

Support/Technical Staff:
1. Stay calm and ensure safety of patients.
2. Reassure patients who may become disturbed by the commotion.
3. Remain in area until situation resolved.
4. If need to leave area avoid situation location

□omb Threats□Fire (□uilding Evacuation)
Upon receipt of a bomb threat immediately:
1. Employee notifies Office Manager (or designated Lead),
2. Employee/Office Manager (or designated Lead), activate panic button or call □-□11.
3. Office Manager (or designated Lead), call all departments and require an immediate evacuation of the building.
4. Office Manager (or designated Lead) to contact Compliance Officer or Chief Operating Officer and continue to keep updating on situation as needed.
5. Communicate as needed appropriate information to Supervisors/Leads.
6. Each Supervisor/Lead will initiate the evacuation procedures for the department and building.
    a) Carry out immediate emergency response.
    b) Clear exits.

c) If fire is in your area, an employee from that area will ensure that all oxygen tanks are shut off
d) A list of patients should be convenient to ensure all are accounted for.
e) One person in each department should be responsible for checking restrooms and ensuring that all doors and windows in the area are closed.
f) Reassure patients who may become disturbed by the commotion.

. Patients will be evacuated first.
. All available personnel should assist patients in other areas as needed then exit
. Remain calm, move quietly and quickly to nearest exit.
10. Assemble at designated evacuation point. Supervisor/Lead immediately conducts a role call for all patients/ personnel for in the area.
11. Supervisor checks in with designated SDMI official at evacuation point to report department's roll call status.
12. EVS or Maintenance is required to make sure employee restrooms are empty.
13. Do not reenter the building until told to do so by Police or SDMI officials.

False Alarms
If there is no emergency announce over the intercom "this is a false alarm, please stay calm". Repeat the announcement every few minutes until the alarm is turned off.

It is extremely important to stay calm and reassure the patients that everything is ok and it is only a false alarm.

uilding Evacuation
In the event the building needs to be evacuated, all employees, patients and guest should evaluate the building as quickly as possible and meet at the following designated safe location:

Administration (Admin- Pea): Exit the building. Walk alongside the sidewalk west towards the covered parking, walk south then east along the covered parking until at SE corner of the employee parking lot area (gravel area), located of the Administration Building.
Anthem (AN- Siena Heights): In the covered parking lot area located behind the building.
lue Diamond (D): Exit building by the employee breakroom and the meeting area is in the SW corner of the employee parking lot.
Centennial Hills (CH): On sidewalk north of the block wall on Hitt Center Court by handicap ramp in the northeast corner of the parking lot.
Craig Road (CR): Exit building by the employee breakroom and meet behind the building under the carport.
Green Valley (GV- Sunset ay): In front of the building along Sunset Way.

Galleria (GA): In the southwest corner of the parking lot by the building sign.
Maryland Par□way (MP): In front of the building on the sidewalk along Maryland Parkway.
Shadow Lane (SL): Under the covered parking on the west side of the building□The side of the building closest to UMC parking lot.
Southwest (S□ - Post Road): In front of the building in the parking lot area near the sign.
Tenaya □ ay (N□ - Northwest): In the employee parking lot area located behind the building.
□ **arehouse:** In front of the building just outside of the parking area.

Disaster Codes

Code Blue	For a person down and needing immediate care.
Code Red	For a Fire
Code Yellow	For a disaster
Code Green	For a person out of control
Code Orange	Patient needs assistance. Doctor needs to evaluate

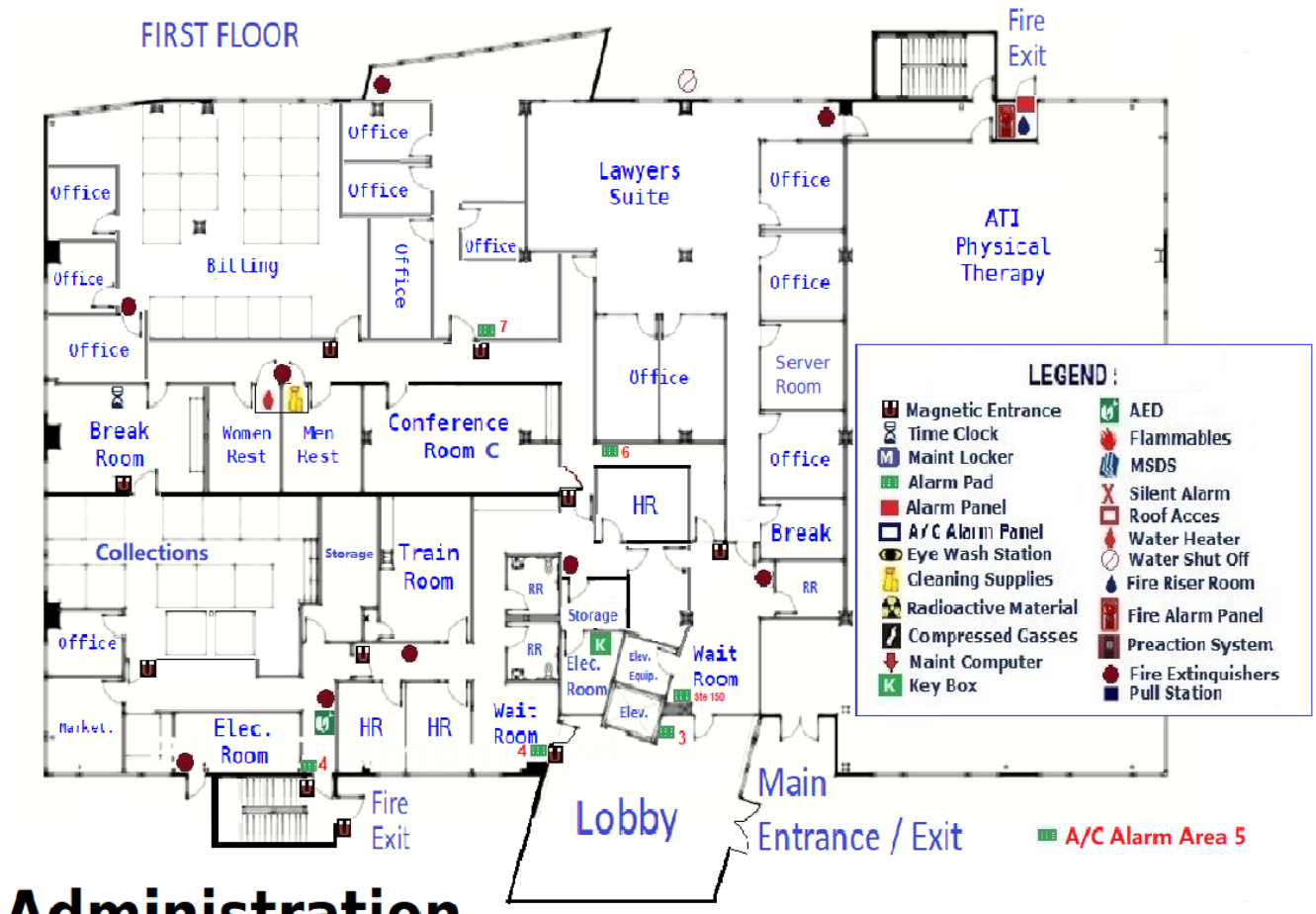
ADMINISTRATION (Admin-Pea□)
□301 Peak Drive Las Vegas, Nevada □□12□

INSTRUCTIONS (ADMIN)
Maintenance Cellular □□□-□□□-□□□□

1. Keys to the fire riser room (fire alarm panel located inside) will be located at the Receptionist desk.

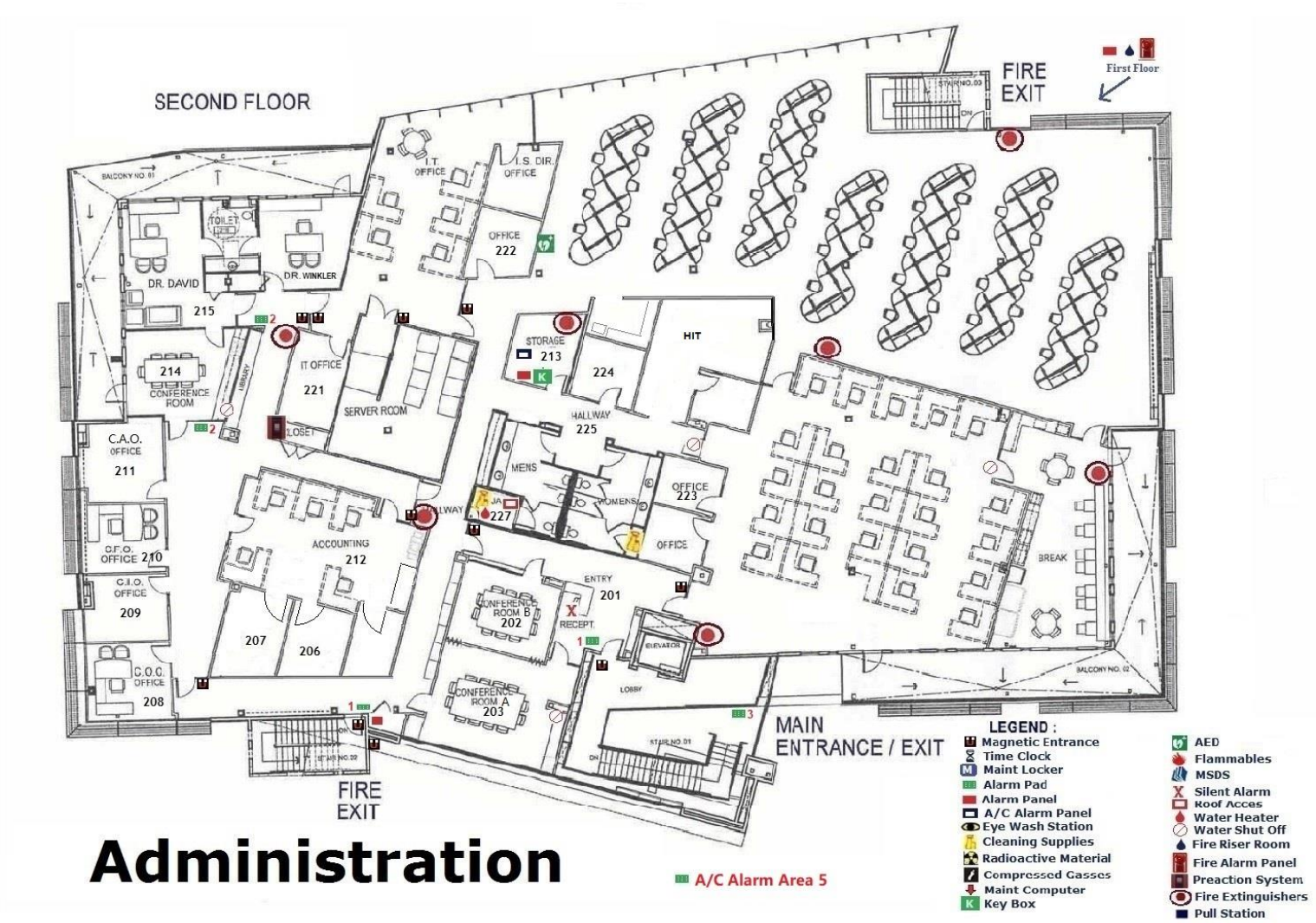
2. Go into the fire alarm panel
   - Located outside at the NE corner of the building (or)
   - Exit emergency exit through Call Center. At bottom of the stairs on outside of stairwell.

3. Read and follow directions on key chain.



Administration

ADMINISTRATION (Admin-Pea□)
Second Floor


SECOND FLOOR
FIRE EXIT
First Floor
I.T. OFFICE
I.S. DIR. OFFICE
OFFICE 222
TOILET
DR. DAVID
DR. WINKLER
215
214 CONFERENCE ROOM
LIBRARY
IT OFFICE 221
SERVER ROOM
CLOSET
STORAGE 213
HIT
224
HALLWAY 225
MENS
WOMENS
OFFICE 223
OFFICE
227
C.A.O. OFFICE 211
C.F.O. OFFICE 210
C.I.O. OFFICE 209
C.O.O. OFFICE 208
ACCOUNTING 212
207
206
CONFERENCE ROOM B 202
ENTRY 201
RECEPT.
ELEVATOR
LOBBY
CONFERENCE ROOM A 203
BREAK
BALCONY NO. 02
MAIN ENTRANCE / EXIT
FIRE EXIT
Administration
A/C Alarm Area 5
LEGEND :
Magnetic Entrance
Time Clock
Maint Locker
Alarm Pad
Alarm Panel
A/C Alarm Panel
Eye Wash Station
Cleaning Supplies
Radioactive Material
Compressed Gasses
Maint Computer
Key Box
AED
Flammables
MSDS
Silent Alarm
Roof Acces
Water Heater
Water Shut Off
Fire Riser Room
Fire Alarm Panel
Preaction System
Fire Extinguishers
Pull Station

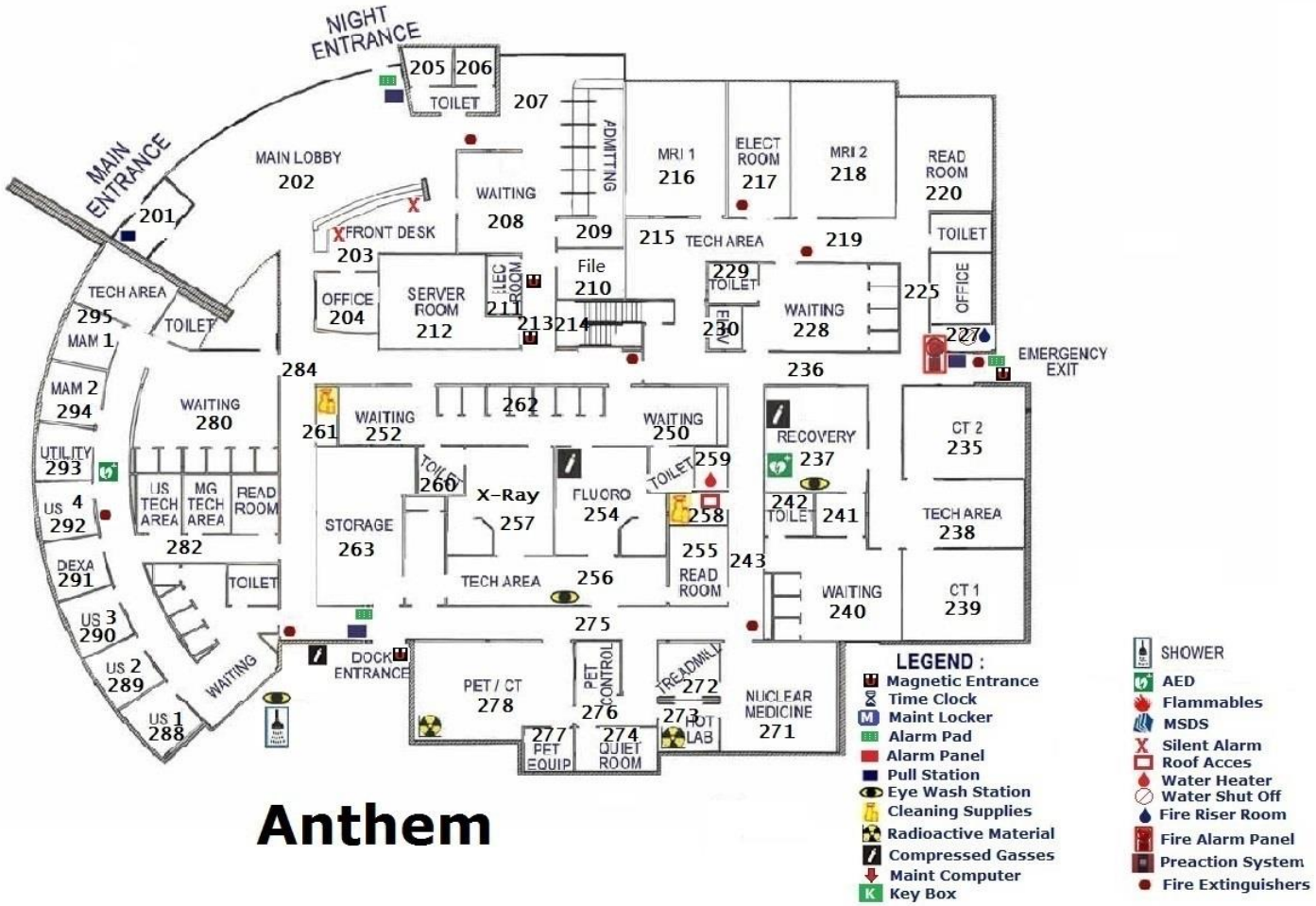
ANTHEM (AN- Siena Heights)

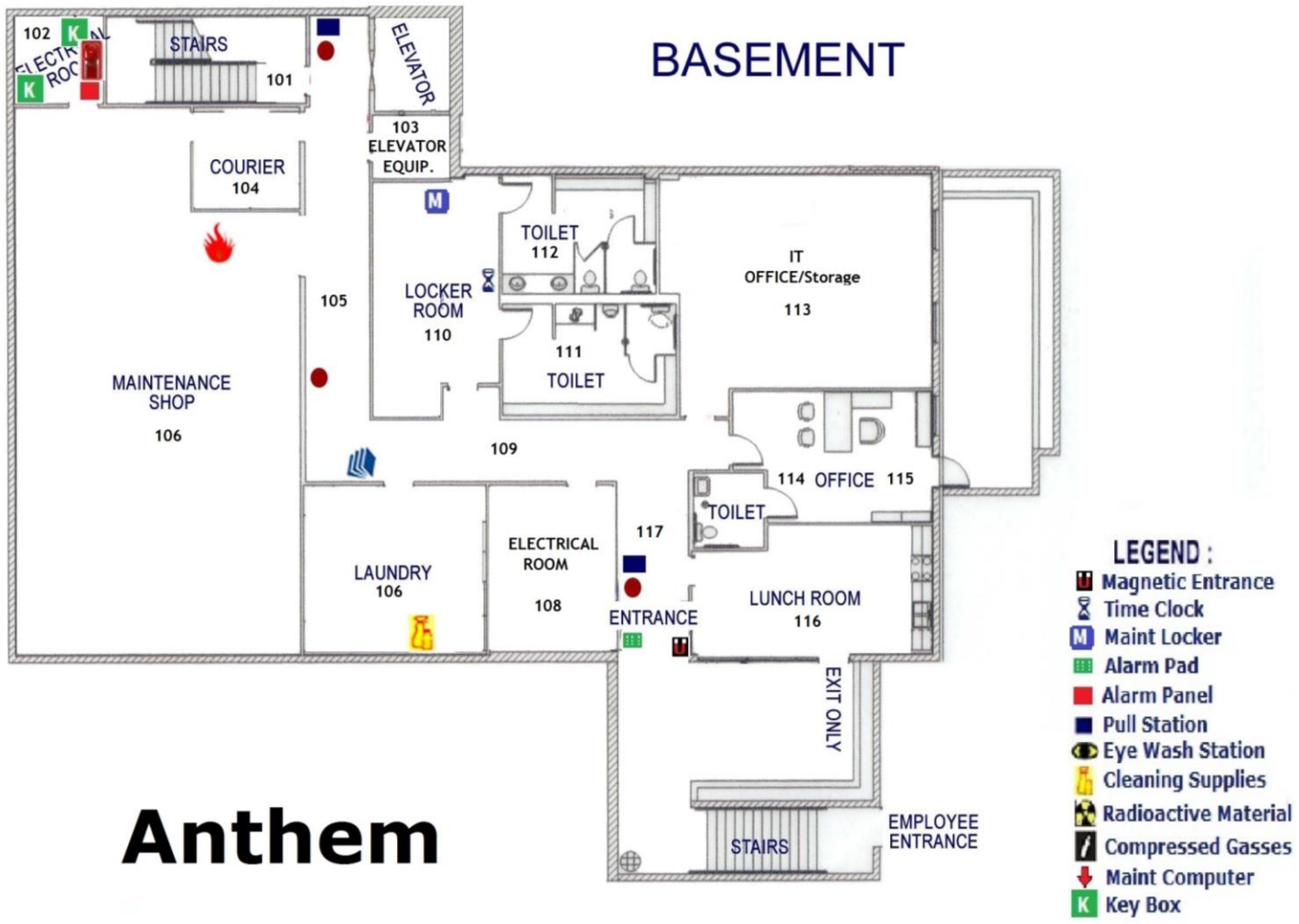
2□50 Siena Heights, Henderson, Nevada □□052

INSTRUCTIONS (AN)

Maintenance Cellular Number □02-4□□-5523

1. Go to the fire alarm panel at the rear door at north end of the building. (Radiologist entrance area- outside the OM Office).
2. Read and follow directions at panel.




BASEMENT
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LOCKER
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114 OFFICE 115
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ENTRANCE
LUNCH ROOM
116
EXIT ONLY
EMPLOYEE
ENTRANCE
STAIRS
Anthem
LEGEND :
Magnetic Entrance
Time Clock
Maint Locker
Alarm Pad
Alarm Panel
Pull Station
Eye Wash Station
Cleaning Supplies
Radioactive Material
Compressed Gasses
Maint Computer
Key Box

□lue Diamond (□D)

□□45 Lindell Road Las Vegas, Nevada □□13□

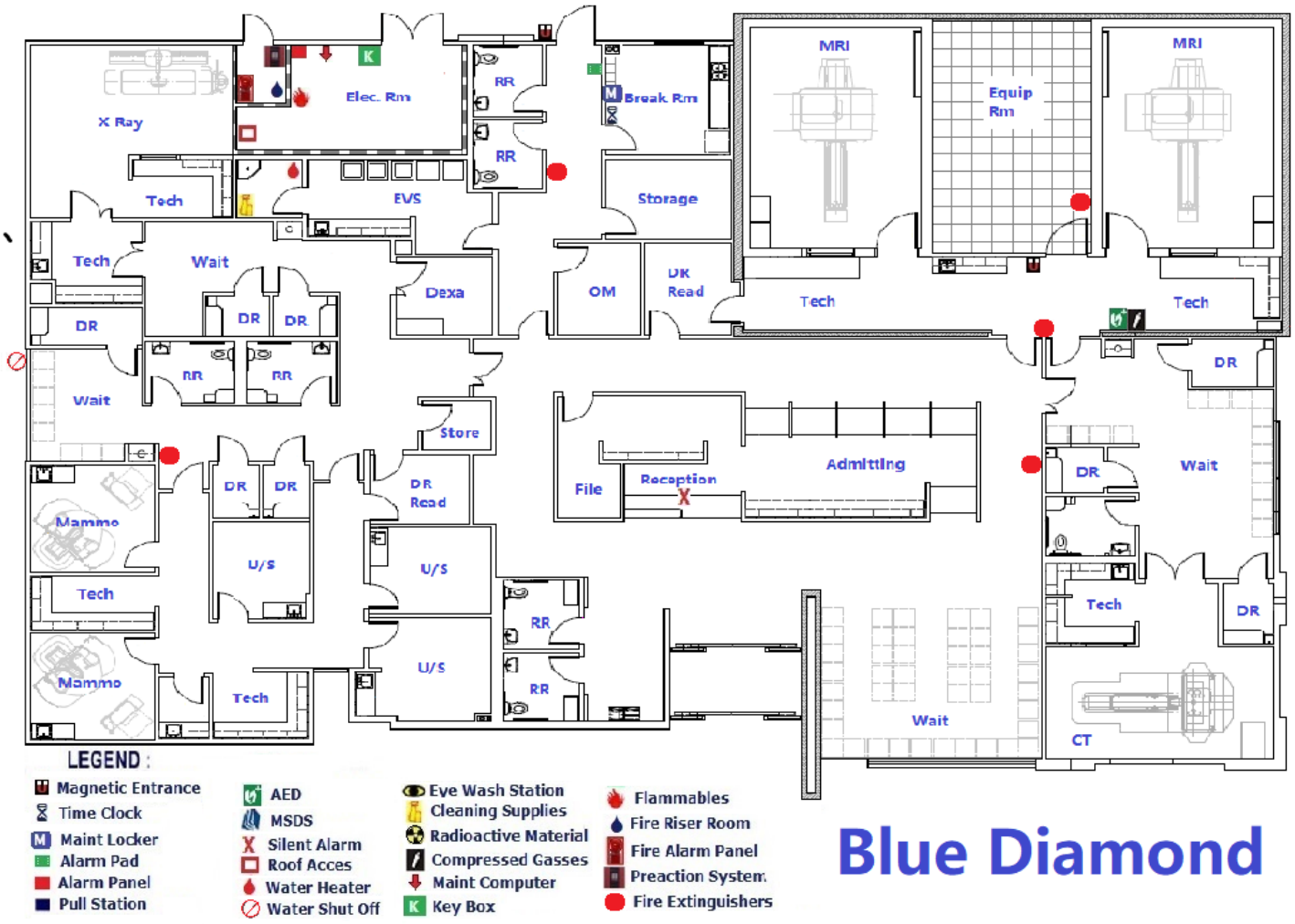
INSTRUCTIONS (□D)

Maintenance Cellular Number □□□-□□□-□□□□

1. □eys to the fire riser room □fire alarm panel located inside□□ill □e located at the Receptionist des□

2. □o to the fire alarm panel located in the □ire Riser Room. □ocated o□tside at □ac□ of □□ilding near electrical room.

3. Read and follo□ directions on □ey chain



CENTENNIAL HILLS (CH)

6□25 N Durango Drive Las Vegas, Nevada □□14□

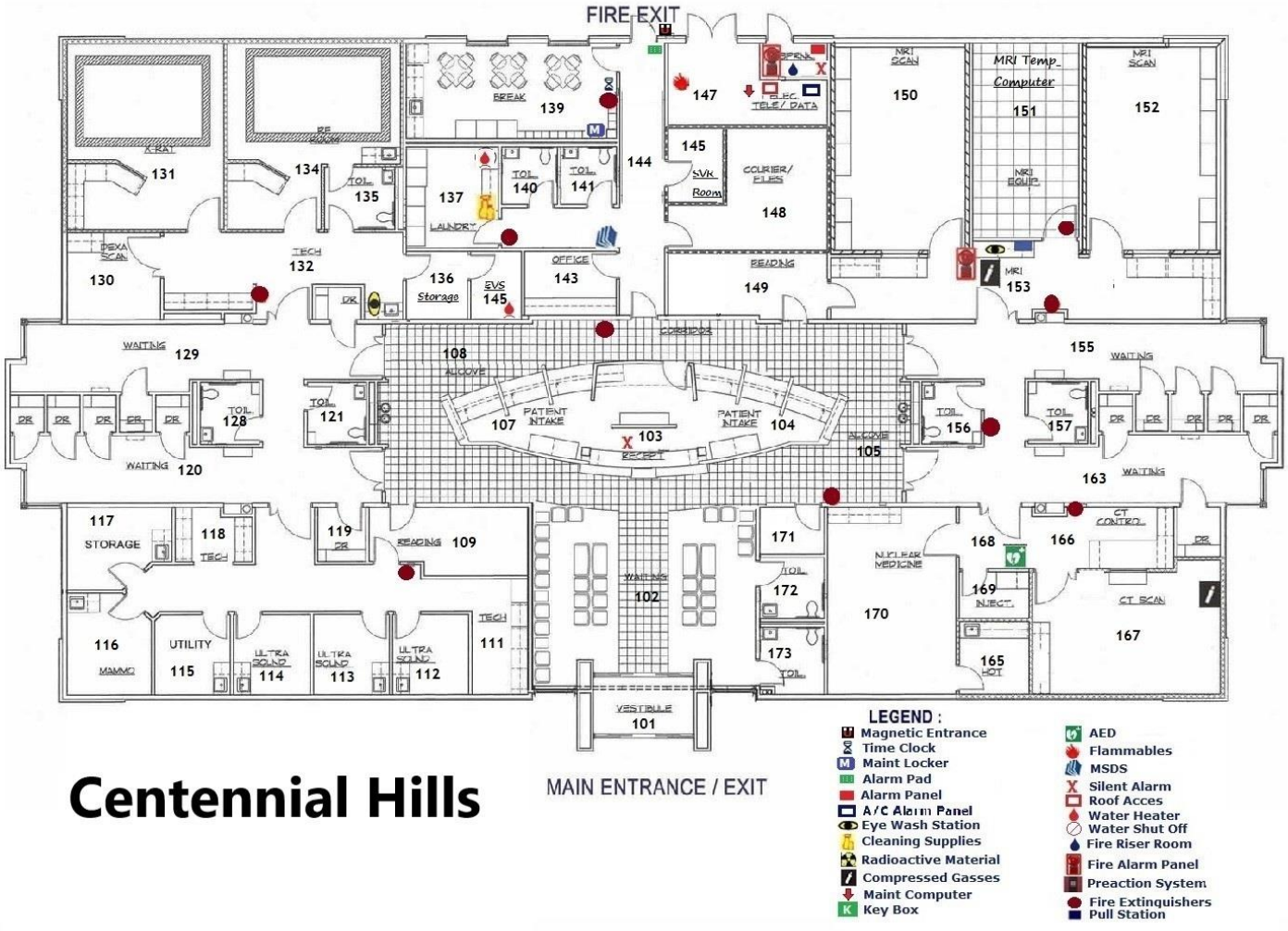
INSTRUCTIONS (CH)

Maintenance Cell □02-5□3□-□□04

1. Keys to the fire riser room (fire alarm panel located inside) will be located at the Receptionist desk.

2. Go to the fire alarm panel located in the Fire Riser Room. Located outside at back of building near electrical room.

3. Read and follow directions on key chain.



□ arch 2022

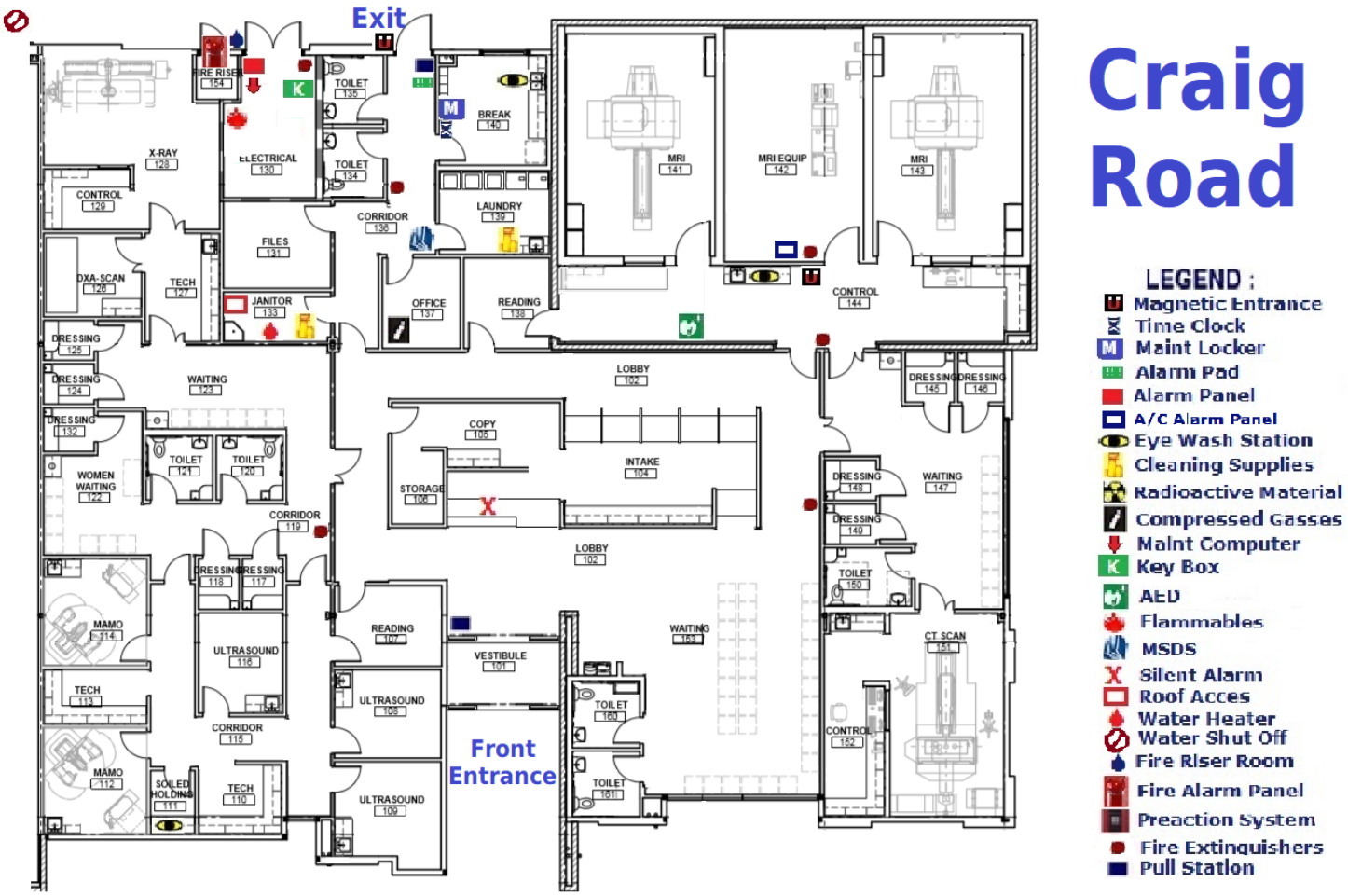
Craig Road (CR)
1650 W. Craig Road North Las Vegas, Nevada □□032

INSTRUCTIONS (CR)
Maintenance Cell □02-521-□2□6

1. □eys to the fire riser room □fire alarm panel located inside□□ill □e located at the Receptionist des□

2. □o to the fire alarm panel located in the □ire Riser Room. □ocated o□tside at □ac□ of □□ilding near electrical room.

3. Read and follo□ directions on □ey chain



□ arch 2022

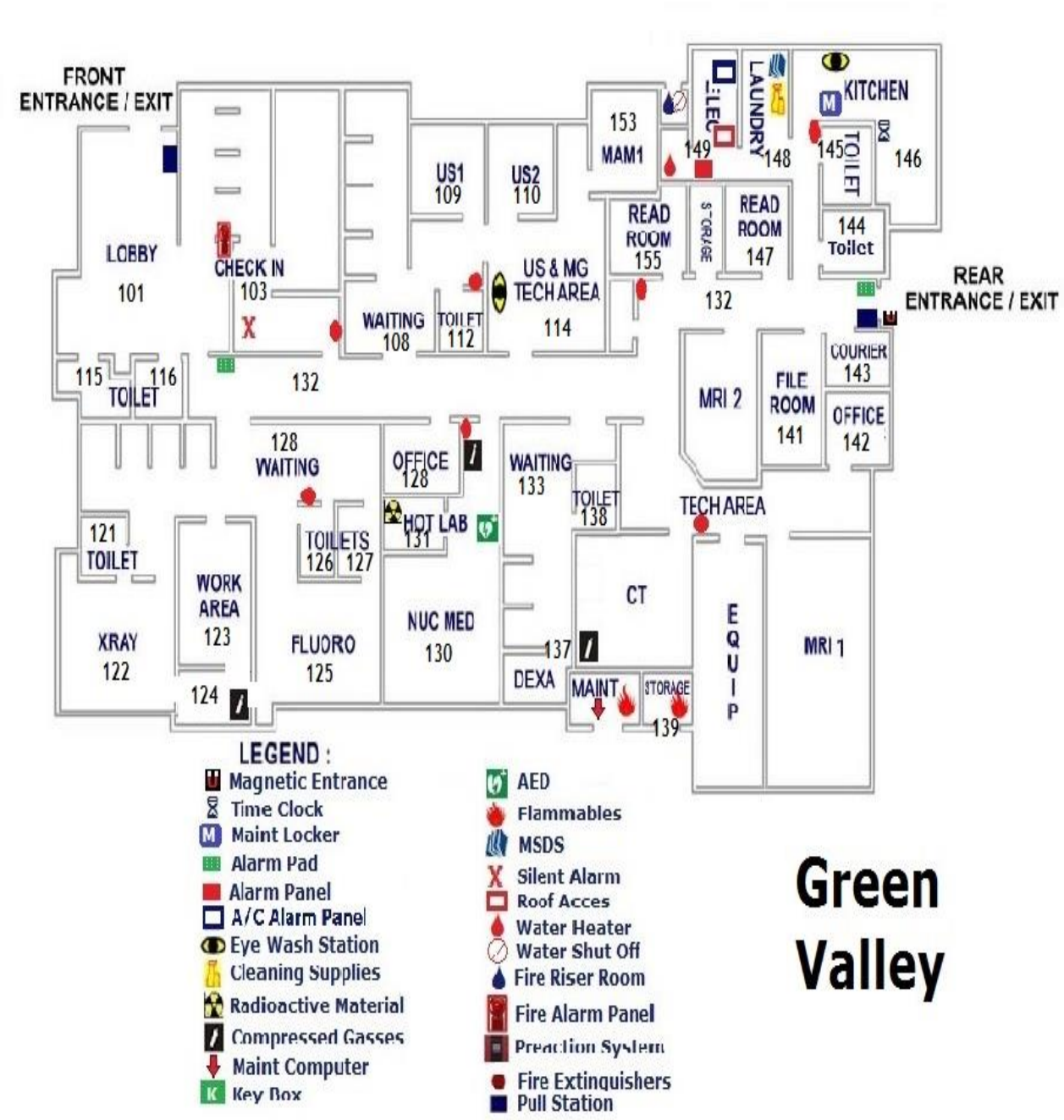
GREEN VALLEY (GV- Sunset)
4 Sunset Way Henderson, Nevada □□014

INSTRUCTIONS (GV)
Maintenance Cell □02-4□□-5523

1. Keys for the fire alarm panel are located at the Receptionist desk.

2. The fire alarm panel is located in the lobby between the Receptionist and Front Desk Admitting area.

3. Read and follow directions on the key chain.



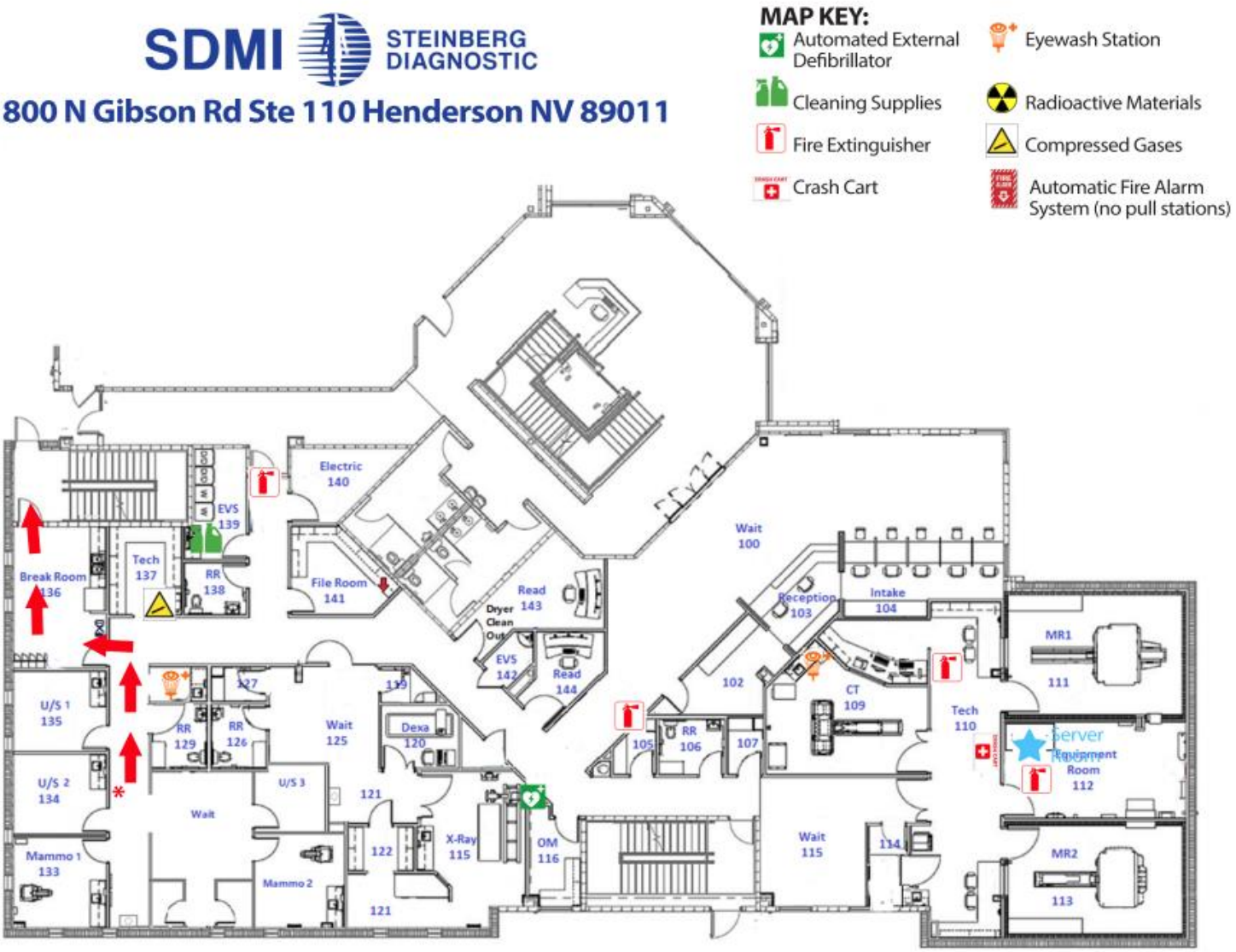
GALLERIA (GA)

□00 Gibson Road Henderson, Nevada □□011

INSTRUCTIONS (GA)

Maintenance Cell □02-4□3-1134

1. Keys to the fire alarm panel are located at the Receptionist desk.
2. Go to the fire alarm panel inside fire riser room opposite MR □2
3. Read and follow directions on the key chain.



□ arch 2022

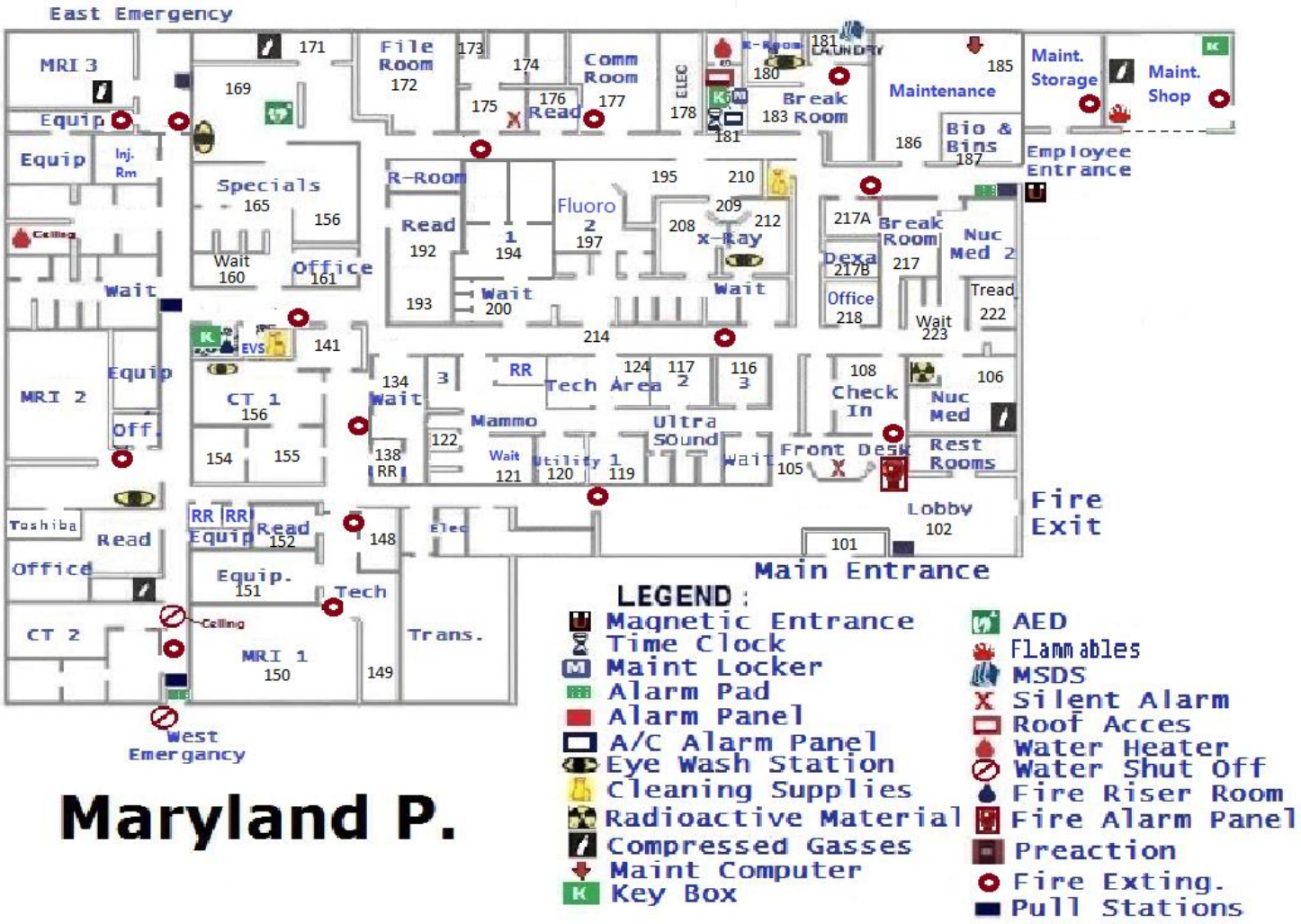
MARYLAND PAR□□ AY (MP)

2□50 S Maryland Parkway Las Vegas, Nevada □□10□

INSTRUCTIONS (MP)

Maintenance Cell □02-□3-1134

1. Keys to the fire alarm panel are located at the Receptionist desk.
2. Go to the fire alarm panel to the left of the Receptionist desk.
3. Read and follow directions on the key chain.



SHADO□ LANE (SL)

□00 Shadow Lane Las Vegas, Nevada □□106

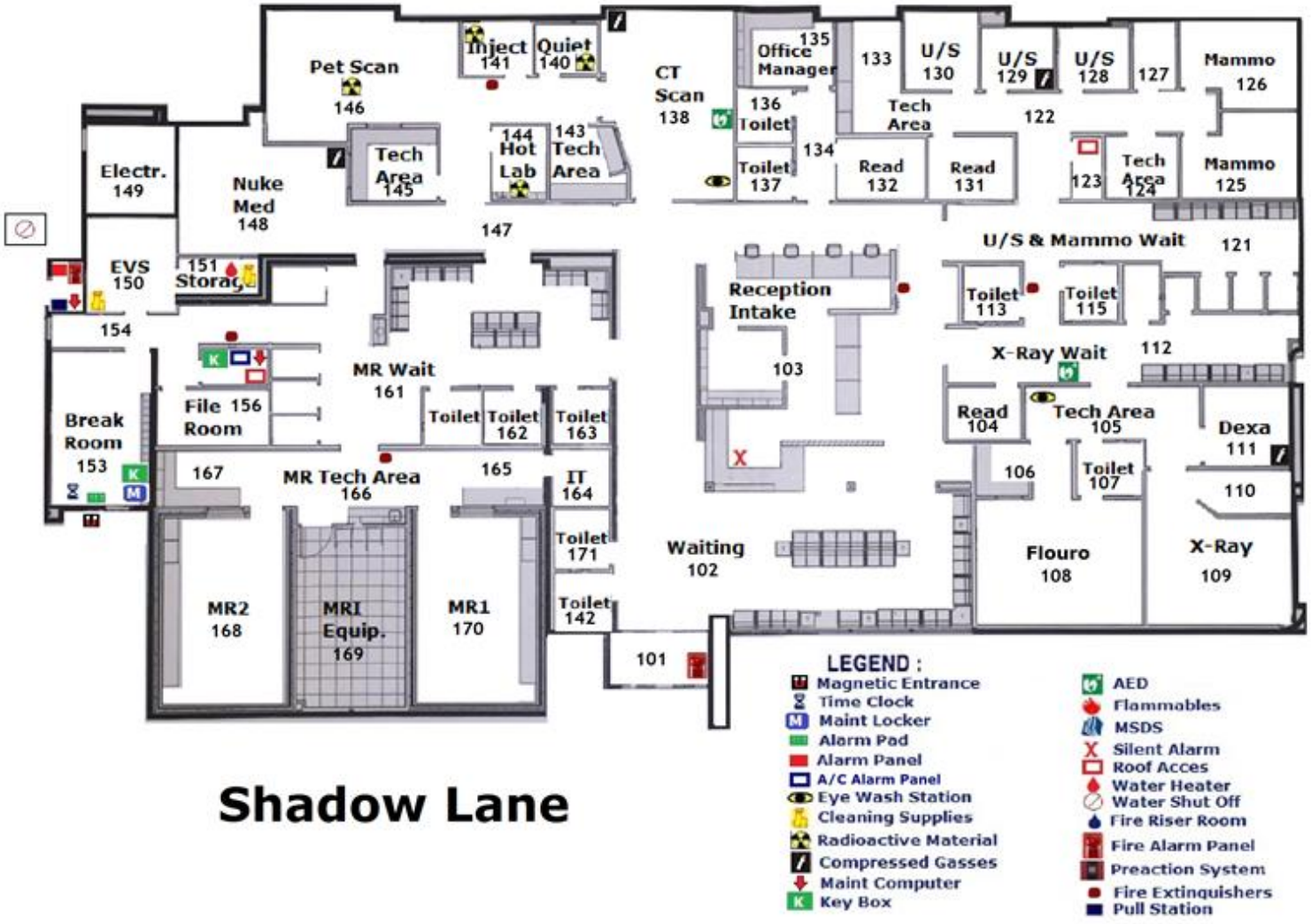
INSTRUCTIONS (SL)

Maintenance Cell □02-521-□2□6

1. Keys to the fire riser room (fire alarm panel located inside) and fire panel in main entrance will be located at the Receptionist desk.

2. Go to either the fire alarm panel located in the main entrance or fire riser room located left of the Maintenance entrance.

3. Read and follow directions on key chain.



□ arch 2022

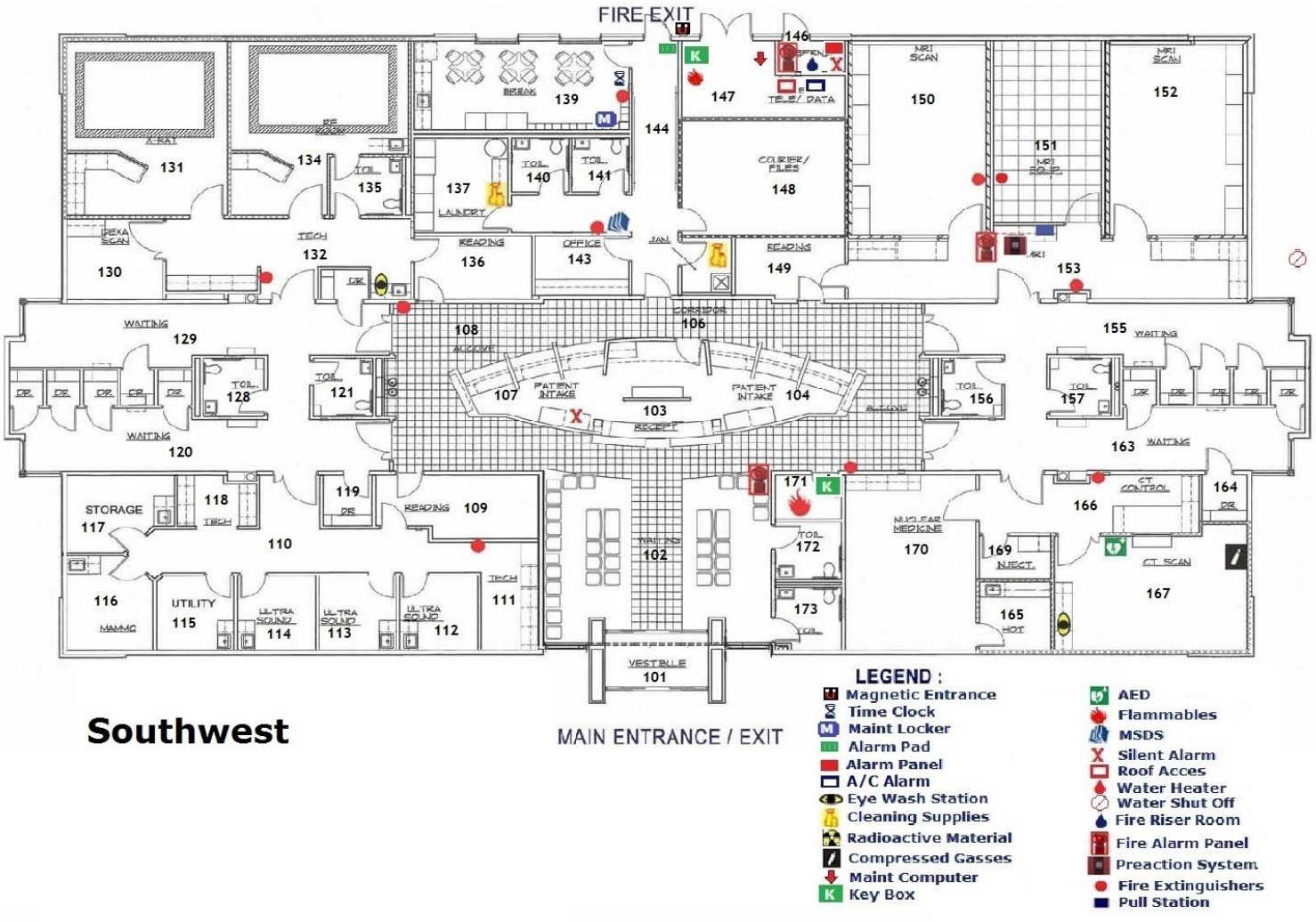
SOUTH□ EST (S□ -Post)

□0□0 W. Post Road Las Vegas, Nevada □□14□

INSTRUCTIONS (S□)

Maintenance Cell □02-□3□-□□04

1. Keys to the fire riser room (fire alarm panel located inside) will be located at the Receptionist desk.
2. Go to the fire alarm panel located in the Fire Riser Room. Located outside at back of building near electrical room.
3. Read and follow directions on key chain



NORTH□ EST (N□ -Tenaya)

2□6□ N. Tenaya Way Las Vegas, Nevada □□12□

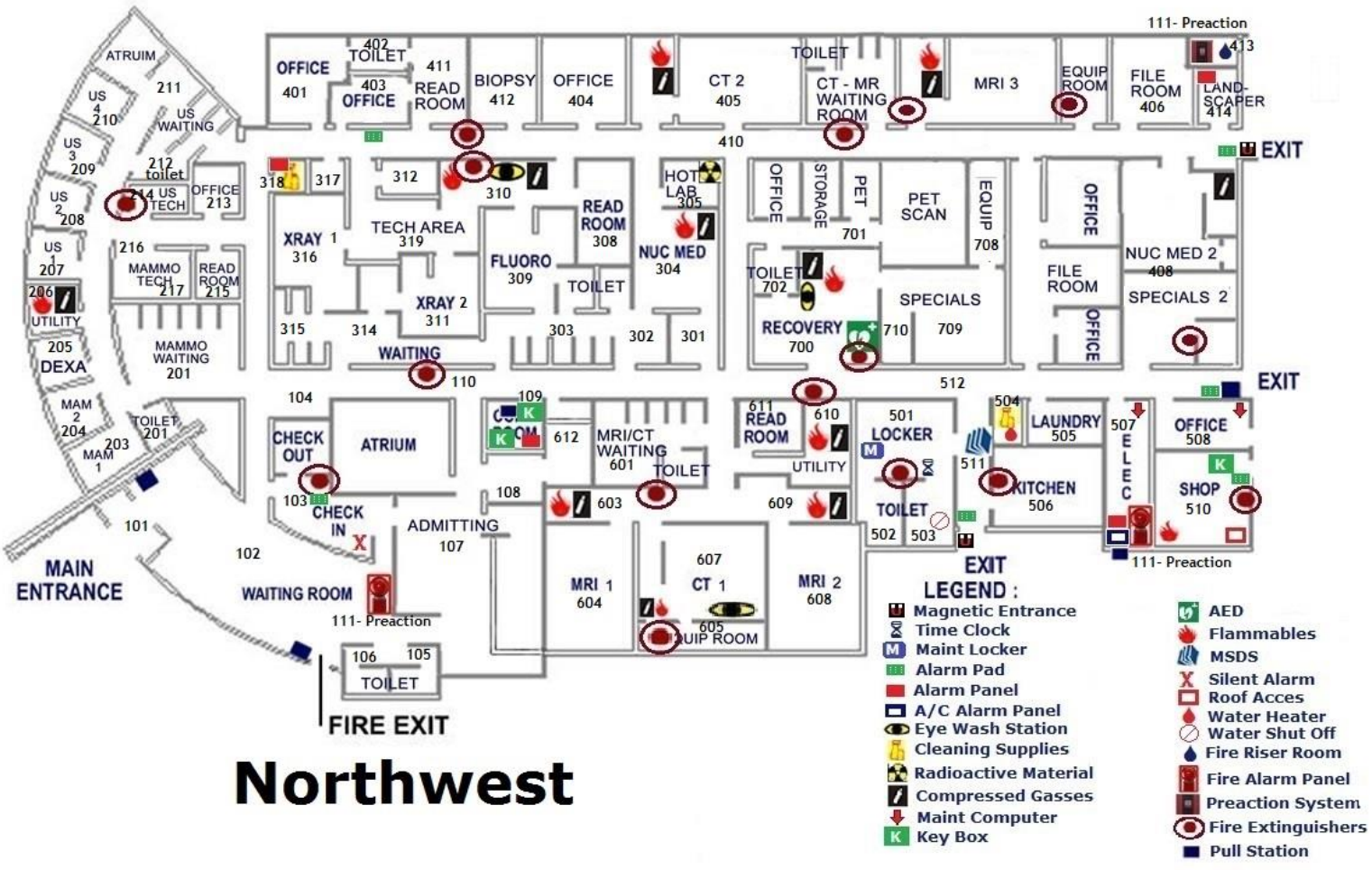
INSTRUCTIONS (N□)

Maintenance Cell □02-4□□-524□

1. Keys to the fire alarm panel will be located at the Receptionist desk.

2. Follow instructions on keys

3. Go to the fire alarm panel located at the right of the Receptionist desk in the lobby.



□ arch 2022

□ AREHOUSE

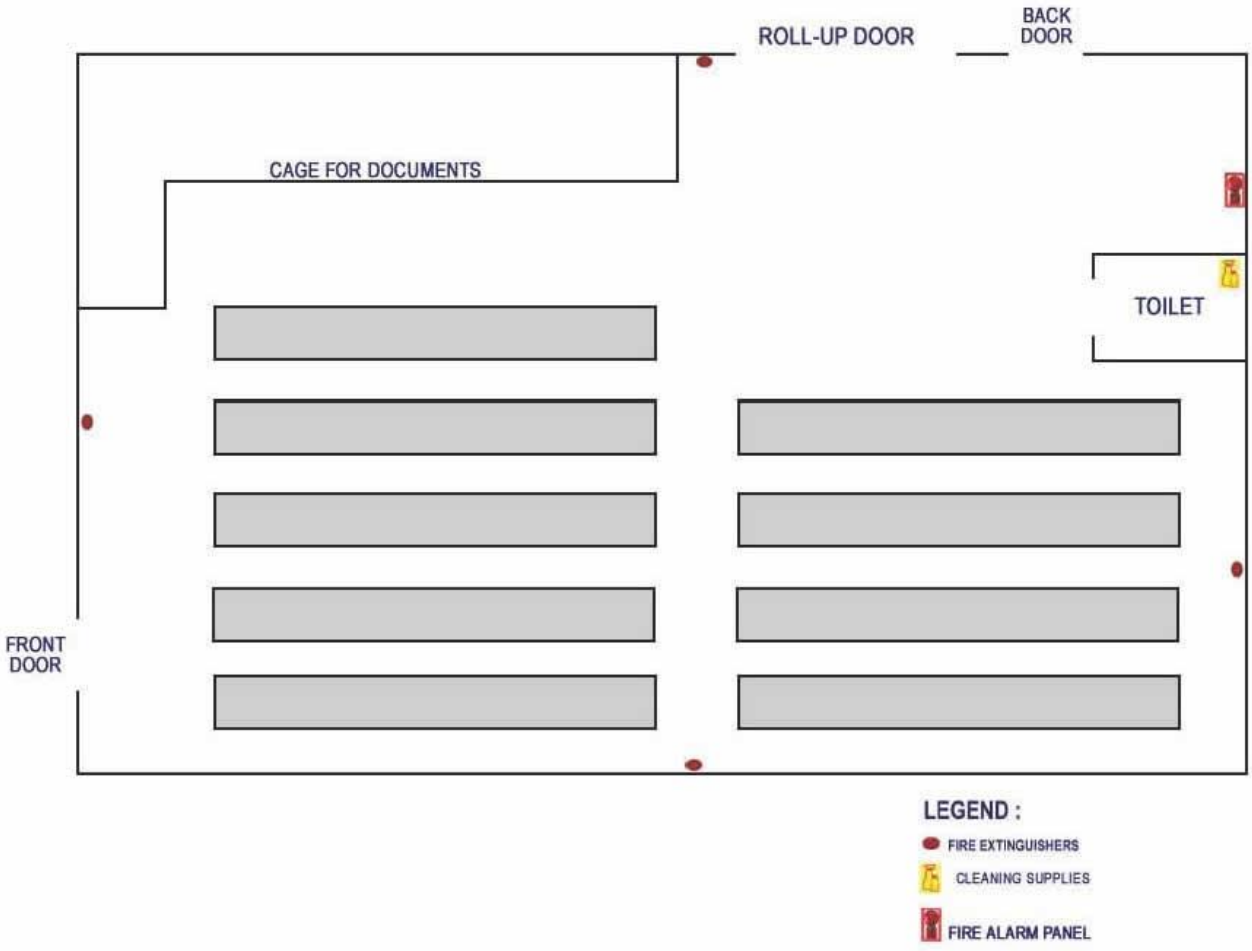
INSTRUCTIONS (□ arehouse)

Maintenance Cell □02-4□□-5523

1. Safely see if there is a fire.

2. In case of fire immediately call □-□11 and confirm fire department has been dispatched.

3. In case of false alarm immediately call Alarmco at □02-3□4-2000 and cancel fire department from being dispatched.



Steinberg Diagnostic
Medical Imaging Centers
"Where Imaging Revolves Around You" SM

SU□□ECT: Fire Plan Responsibilities for Individual Departments	**POLICY NO□** Safety - 10
SCOPE: Organization Wide	**EFFECTIVE:** 1/□□
ISSUED □Y: Chief Human Resource Officer	**REVIE□ ED□REVISED:** □/01, □/03, 5/06, 2/0□, 4/11, 2/1□, 1/2020, 10/2020
APPROVED □Y: COO	**PAGE:** 1 of 2

I□ PURPOSE: To assign responsibility for fire safety/evacuation within each facility.

II□ POLICY: To ensure each department implements an effective plan to safely evacuate all patients and staff while securing the facility and initiating the appropriate fire response procedure.

III□ PROCEDURE: The Office Manager will work with the department supervisors to ensure the following procedure is implemented throughout each facility:

A. One person in each area should be assigned to act as a member of the fire brigade – secure a fire extinguisher at his or her location and be ready to respond if necessary.
B. One person should be assigned to monitor the telephone to answer emergency calls and relay messages.
C. Last person to leave the area should ensure all room doors are closed.
D. Every employee should become familiar with the facility fire plan.
E. In the event of a fire:
    1. Carry out immediate emergency response
    2. Clear exits
    3. If fire is in your area, ensure that all oxygen tanks are shut off
    4. If fire is not in the area, managers should be prepared to use their personnel to assist patients to other area or exit.
    5. Reassure patients who may become disturbed by the commotion
    6. Have someone receive the Fire Department to communicate the nature and location of the emergency.

IV□ DEPARTMENT SUPERVISOR or Designated Representative:

A. Before a fire occurs:

1. Become familiar with the facility fire plan.
2. See that employees in their departments have been instructed as to their respective duties in case of fire.

B. In the event of a fire:
   1. See that these duties are carried out.
   2. Immediately upon hearing the alarm, ensure that all doors and windows in the area are closed.

V MAINTENANCE:

A. Before a fire occurs:
   1. Become familiar with the facility fire plan.
   2. Designate appropriate personnel as members of fire brigade.

B. In the event of a fire:
   1. Carry out immediate emergency response.
   2. Regulate air handling equipment, if system was not shut down by duct alarms.

C. Secure electrical room

Emergency Procedure Acknowledgment

I acknowledge that I have read and understand the Steinberg Diagnostic Medical Imaging Center's Emergency Procedures handout revised March 2022 along with additional policy updates. I am comfortable in performing the duties that are expected of me during an emergency situation.

I acknowledge that the Emergency Procedures contained in this handout are subject to change by SDMI based upon need.

I also understand that this handout is not and was not intended to serve as a contract between SDMI and myself regarding the nature of continued employment or the duration of my employment with SDMI.

I understand that if I desire clarification or elaboration of any emergency procedures, I will talk with my Supervisor, Manager, Maintenance or Human Resources.

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Signature of Employee **Date**

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Printed Name **Department**

Current Status: *Active* **PolicyStat ID:** *9449729*

Origination:	*11/2008*
Last Approved:	*03/2021*
Last Revised:	*03/2021*
Next Review:	*03/2022*
Owner:	*Tamara Saldana: Manager, Clinical Services and Quality*
Policy Area:	*Leadership*
Standards □ Regulations:	*APR.09.01.01 EP 1, LD.02.01.01 EP 1, LD.02.01.01 EP 2, LD.02.01.01 EP 3, LD.02.03.01 EP 1, LD.03.01.01 EP 1, LD.03.07.01 EP 1, LD.03.07.01 EP 2, LD.03.09.01 EP 1, LD.03.09.01 EP 10, LD.03.09.01 EP 11, LD.03.09.01 EP 2, LD.03.09.01 EP 3, LD.03.09.01 EP 4, LD.03.09.01 EP 5, LD.03.09.01 EP 6, LD.03.09.01 EP 8, LD.03.09.01 EP 9, PC.02.03.01*
References:	

CURE 4 THE KIDS FOUNDATION
A Division of Roseman University of Health Sciences

Patient Safety Plan

Purpose:

- The purpose of the organizational Patient Safety Plan at our facility is to improve patient safety and reduce risk to patients through an environment that encourages:
  - Integration of safety priorities into all relevant organization processes, functions and services
  - Recognition and acknowledgment of risks to patient safety and medical/health care errors
  - The initiation of actions to reduce these risks
  - The internal reporting of what has been found and the actions taken
  - A focus on processes and systems, and the reduction of process and system failures through use of failure mode effect analysis
  - Minimization of individual blame or retribution for involvement in a medical/health care error
  - Organizational learning about medical/health care errors
  - Support of the sharing of that knowledge to effect behavioral changes in itself and other health-care 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 our facility. The Patient Safety Plan, developed by the interdisciplinary Environment of Care Committee and approved by the medical staff, Governing Body and administration, outlines the components of the organizational Patient Safety Program.

Procedure:

Scope of Activities:

- The scope of the Patient Safety Plan 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 Environment of Care Committee to prioritize organizational patient safety activity efforts. Types of patient safety or medical/health care errors included in data analysis are:
  - **No Harm Errors** - those unintended acts, either of omission or commission, or acts that do not achieve their intend outcome - that do not result in a physical or psychological negative outcome, or the potential for a negative outcome, for the patient.
  - **Mild-Moderate Adverse Outcome Errors** - those unintended acts, either of omission or commission, or acts that do not achieve their intend outcome, that result in an identified mild to moderate physical or psychological adverse outcome for the patient.
  - **Any Medication Error**
  - **Any Adverse Drug Reaction**
  - **Hazardous Condition** - any set of circumstances, exclusive of the disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious physical or psychological adverse patient outcome.
  - **Sentinel Event** - an unexpected event or occurrence involving death or serious physical or psychological injury or the risk thereof - including any process variation for which a recurrence would carry a significant chance of serious adverse outcome. Serious injury specifically includes loss of limb or function. Sentinel event criteria includes:
    - The event has resulted in an unexpected death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition, or
    - An event is one (1) of the following (even if the outcome was not death or major permanent loss of function unrelated to the natural course of the patient's illness or underlying condition):
      - Abduction of any patient receiving care
      - Infant/child abduction or discharge to the wrong family
      - Rape (by another patient, visitor or staff)
      - Surgery or invasive procedure performed on the incorrect patient or incorrect body part
      - All identified cases of unanticipated death or major permanent loss of function associated with a health care associated infection
  - **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 Plan encompasses the patient population, visitors, volunteers and staff

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(including medical staff). The program addresses maintenance and improvement in patient safety issues in every department throughout the facility. There will be an emphasis on important facility and patient care functions of:

- Ethics, Rights and Responsibilities
- Provision of Care, Treatment and Services
- Medication Management
- Surveillance, Prevention and Control of Infection
- Improving Organization Performance
- Leadership
- Management of the Environment of Care
- Management of Human Resources
- Management of Information

Methodology:

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

All departments within the organization (patient care and non-patient care departments) are responsible to report patient safety occurrences and potential occurrences to the CEO or the Manager of Clinical Services and Quality. This information will then be relayed to the Environment of Care Committee for further evaluation and assessment.

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- Organization-wide Patient Safety Opinion Surveys will be used to determine focus areas for improvement, these surveys will confidential and be conducted at least every three(3) years. Through review of internal data reports and reports from external sources (including, but not limited to, Joint Commission sentinel event report information, occurrence reporting information from state and federal sources and current literature), the Environment of Care Committee will select at least one high-risk safety process for proactive risk assessment annually. All elements of the high-risk safety related process will be described using work tools as necessary (i.e., flowcharts, cause and effect diagrams). The proactive risk assessment will include:
    - Identification of the ways in which the process could break down or fail to perform. This will be done through assessment of the intended and actual implementation of the process to identify the steps in the process where there is, or may be, undesirable variation. Identify the possible effects of the undesirable variation on patients, and how serious the possible effect on the patient could be
    - Prioritizing the potential processes breakdowns or failures
    - For the most critical effects, conduct a root cause analysis to determine why the undesirable variation leading to that effect may occur
    - Redesign the process and/or underlying systems to minimize the risk of that undesirable variation or to protect patients from the effects of that undesirable variation
    - Test and implement the redesigned process
    - Identify and implement measures of the effectiveness of the redesigned process
    - Implement a strategy for maintaining the effectiveness of the redesigned process over time
- Upon identification of a process or system failure and/or medical/health care error, the patient care provider will immediately:
    - Perform necessary healthcare interventions to protect and support the patient's clinical condition.

- As appropriate to the occurrence, perform necessary healthcare interventions to contain the risk to others - example: immediate removal of contaminated IV fluids from floor stock should it be discovered a contaminated lot of fluid solutions was delivered and stocked.
- Contact the patient's attending physician and other physicians, as appropriate, to report the error, carrying out any physician orders as necessary.
- Preserve any information related to the error (including physical information). Examples of preservation of physical information are: Removal and preservation of IV tubing, fluids bags and/or pumps for a patient with a severe drug reaction from IV medication; preservation of medication label for medications administered to the incorrect patient. Preservation of information includes documenting the facts regarding the error on an occurrence report, and in the medical record **as appropriate** to organizational policy and procedure.
- Report the process/system failure or medical/health care error to the staff member's immediate supervisor.
- Submit the incident report to CEO 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 CEO per organizational policy.
- Staff response to process/system failures and/or medical/health care errors is dependent upon the type of error identified:
  - **No Harm Failures or Errors** - (including "no harm" medication errors) - staff will document appropriately in the medical record according to organizational policy, document the circumstances regarding the no harm error on an occurrence report form, submit the form to the Performance Improvement Department and notify their immediate supervisor.
  - **Mild-Moderate Adverse Outcome Failures or Errors** (including medication errors) - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then preserve any physical evidence as appropriate, notify his/her immediate supervisor, document facts appropriately in the medical record and on an occurrence report - submitting the report to the Performance Improvement Department per organizational policy.
    - **Medication Errors** - the staff member identifying a medication error (no harm and mild-moderate harm) will notify the Pharmacy Department of the event.

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

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- Established organizational policy (such as the Sentinel Event Policy) and/or the Environment of Care Committee will determine the organizational response to process/system failures and/or medical/health care errors and occurrences. All sentinel events and near miss occurrences will have a root cause analysis conducted. The determination of the Environment of Care Committee members, based on internal and external data analysis and prioritizing of patient safety criticality, will determine:
  - Further remedial action activities necessary for identified 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. 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 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 Environment of Care Committee regarding the staff member's professional and emotional reconciliation of the sentinel event. The 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 Human Resources Department and/or his or her department supervisor.
  - As part of this organization's culture of safety, any staff member who has concerns about the safety or quality of care provided by the organization may report these concerns to The Joint Commission. The organization supports the staff member's right to report these concerns and will take no disciplinary or retaliatory action against the staff member for reporting the safety or quality of care concern to The Joint Commission.
  - Staff will periodically be queried regarding their willingness to report medical/health care errors.
- The Patient Safety Plan 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.
- Staff will educate patients and their families about their role in helping to facilitate the safe delivery of care. The Environment of Care Committee will request a report from the Information Management Committee on a quarterly basis consisting of random record review verifying compliance with this educational process.
- The Patient Safety Program includes consideration of data obtained from the organizational Information Management Needs Assessment, which includes information regarding barriers to effective communication among caregivers. The Environment of Care Committee will also request a report from the Information Management Team identifying the effectiveness of the organization to provide accurate,

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timely, and complete verbal and written communication among caregivers and all other involved in the utilization of data.

- Patients have access to the compliance hotline number and management to report any concerns or complaints related to patient safety and care. Compliance hotline is posted in exam rooms.
- 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.
    - 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.
    - An annual Environment of Care and Patient Safety report will be posted and sent to staff.

The □oint Commission Standards:

LD.02.01.01- The mission, vision, and goals of the organization support the safety and quality of care, treatment, and services.

EP1: Leaders work together to create the organization's mission, vision, and goals.

EP2: The organization's mission, vision, and goals guide the actions of leaders.

EP3: Leaders communicate the mission, vision, and goals to staff and the population(s) the organization serves.

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LD.02.03.01: Leaders regularly communicate with each other in issues of safety and quality.

EP1: Leaders discuss issues that affect the organization and the population(s) it serves, including the following:
- Performance improvement activities
- Reported safety and quality issues
- Proposed solutions and their impact on the organization's resources
- Reports on key quality measures and safety indicators
- Safety and quality issues specific to the population served
- Input from the population(s) served

APR.09.01.01- The organization notifies the public it serves about how to contact its organization management and The Joint Commission to report concerns about patient safety.

EP1: The organization informs the public it serves about how to contact its management to report concerns about patient safety and quality of care.

LD.03.03.01- Leaders use organization-wide planning to establish structures and processes that focus on safety and quality.

EP1: Planning activities focus on the following:
- Improving patient safety and health care quality
- Supporting a culture of safety and quality
- Adapting to changes in the environment

LD.03.07.01- Leaders establish priorities for performance improvement.

EP1: Performance improvement occurs organization-wide.

EP2: As part of performance improvement, leaders do the following:

- Set priorities for performance improvement activities and patient health outcomes (See also PI.01.01.01, EPs 1 and 2)
- Give priority to high-volume, high-risk, or problem-prone processes for performance improvement activities (See also PI.01.01.01, EPs 3, 5–7, 12, and 13)
- Reprioritize performance improvement activities in response to changes in the internal or external environment

LD.03.09.01- The organization has an organization-wide, integrated patient safety program.

EP1: The leaders implement an organization-wide patient safety program as follows:
- One or more qualified individuals manage the safety program.
- All departments, programs, and services within the organization participate in the safety program.
- The scope of the safety program includes the full range of safety issues, from potential or no-harm errors (sometimes referred to as close calls [“near misses”] or good catches) to hazardous conditions and sentinel events.

EP2: As part of the safety program, the leaders create procedures for responding to system or process failures.

EP3: The leaders provide and encourage the use of systems for blame-free internal reporting of a system or process failure, or the results of a proactive risk assessment.

EP4: The leaders define patient safety event and communicate this definition throughout the organization.

EP5: The organization conducts thorough and credible comprehensive systematic analyses (for example, root cause analyses) in response to sentinel events as described in the "Sentinel Events" (SE) chapter of this manual.

EP6: The leaders make support systems available for staff who have been involved in an adverse or sentinel event.

EP8: To improve safety, the organization analyzes and uses information about system or process failures and, when conducted, the results of proactive risk assessments.

EP9: The leaders disseminate lessons learned from comprehensive systematic analyses (for example, root cause analyses), system or process failures, and the results of proactive risk assessments to all staff who provide services for the specific situation.

EP10: At least once a year, the leaders provide governance with written reports on the following:
- All system or process failures
- The number and type of sentinel events
- Whether the patients and the families were informed of the event
- All actions taken to improve safety, both proactively and in response to actual occurrences

EP11: The leaders encourage external reporting of significant adverse events, including voluntary reporting programs in addition to mandatory programs.

PC.02.03.01- The organization provides patient education and training based on each patient's needs and abilities.

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Attachments

No Attachments

Approval Signatures

Approver	Date
Annette Logan: President and CEO	03/2021
Tamara Saldana: Supervisor, Clinical Services and Quality	03/2021

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GOLDEN MANOR

CRISIS CONTINGENCY
&
EMERGENCY EVACUATION PLAN

Developed for Golden Manor
416 Sysonby Ct.
Reno, NV 89521
Created 03/13/2014

CRISIS CONTINGENCY PLAN

BACKGROUND

GOLDEN MANOR 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)

EMERGENCY EVACUATION PLAN
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BACKGROUND

GOLDEN MANOR, 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 is an ADULT GROUP CARE facility licensed by the Bureau of Health Care and Quality Compliance and is located at 416 Sysonby Ct Reno, Nevada 89521 in the Damonte Ranch are of South Reno.

Although remote, the possibility of an incident, whether externally or internally generated, always exists. GOLDEN MANOR 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	**Description**	**In -charge**
Laundry room Exit doors	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 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
- ✓ Broken water or gas mains in the vicinity of Golden Manor
- ✓ 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 property,
- ✓ Loss of power
- ✓ Bomb Threats (telephonic)

Phase 2 Alert

Structure fires adjacent to the Golden Manor

Utility breaks (gas, water etc.) effecting Golden Manor operations.

Bomb threats (suspect device located on property)

Riot or civil disturbance disruptive to Golden Manor operations

Phase 3 Alert

Any incident requiring the evacuation of all or part of Golden Manor

Any incident requiring implementation of the Emergency Evacuation Plan

Any incident which will, if allowed to continue, have a significant effect on Golden Manor 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.
Leonila Beltejar	**(Owner/Administrator)**	**775-501-4000 (cell)**
Leya Kerr Irugin	**(Manager)**	**775-230-5214 (cell)**
Susan Rosalin	**(Manager)**	**775-737-6335 (cell)**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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. 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."

"OUR CAREGIVER WILL ASSIST YOU FOR A SAFE EVACUATION”

"PLEASE REMAI N 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”

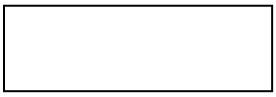
KEY POINTS TO REMEMBER

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.**



GOLDEN MANOR

CRISIS CONTINGENCY
&
EMERGENCY EVACUATION PLAN

Developed for Golden Manor
416 Sysonby Ct.
Reno, NV 89521
Created 03/13/2014

CRISIS CONTINGENCY PLAN

BACKGROUND

GOLDEN MANOR 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)

EMERGENCY EVACUATION PLAN
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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.

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Alternative Exit	**Description**	**In -charge**
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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

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1. The Owner

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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.

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Facility will proceed directly to the assembly area.

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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.

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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.

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- 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.
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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

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EMERGENCY NOTIFICATION PROCEDURES

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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 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
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- ✓ Broken water or gas mains in the vicinity of Golden Manor
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- ✓ Civil disturbances which may overflow into or onto Golden Manor property,
- ✓ Loss of power
- ✓ Bomb Threats (telephonic)

Phase 2 Alert

Structure fires adjacent to the Golden Manor

Utility breaks (gas, water etc.) effecting Golden Manor operations.

Bomb threats (suspect device located on property)

Riot or civil disturbance disruptive to Golden Manor operations

Phase 3 Alert

Any incident requiring the evacuation of all or part of Golden Manor

Any incident requiring implementation of the Emergency Evacuation Plan

Any incident which will, if allowed to continue, have a significant effect on Golden Manor 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.
Leonila Beltejar	**(Owner/Administrator)**	**775-501-4000 (cell)**
Leya Kerr Irugin	**(Manager)**	**775-230-5214 (cell)**
Susan Rosalin	**(Manager)**	**775-737-6335 (cell)**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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. 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."

"OUR CAREGIVER WILL ASSIST YOU FOR A SAFE EVACUATION”

"PLEASE REMAI N 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”

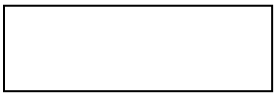
KEY POINTS TO REMEMBER

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.**



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 REMAI N 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.**

West Breezeway
"B" to New Section

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: _____

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.

HOLY CHILD RESIDENTIAL CARE LLC

5828 Tappan Dr. Reno NV 89523
(775)746-8181

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.

HOLY FAMILYHOME CARE

3235 DELNA DRIVE
SPARKS, NEVADA 89431

Staff Reporter

These staff are responsible for filing ANNUAL REPORT & SENTINEL EVENT REPORT.

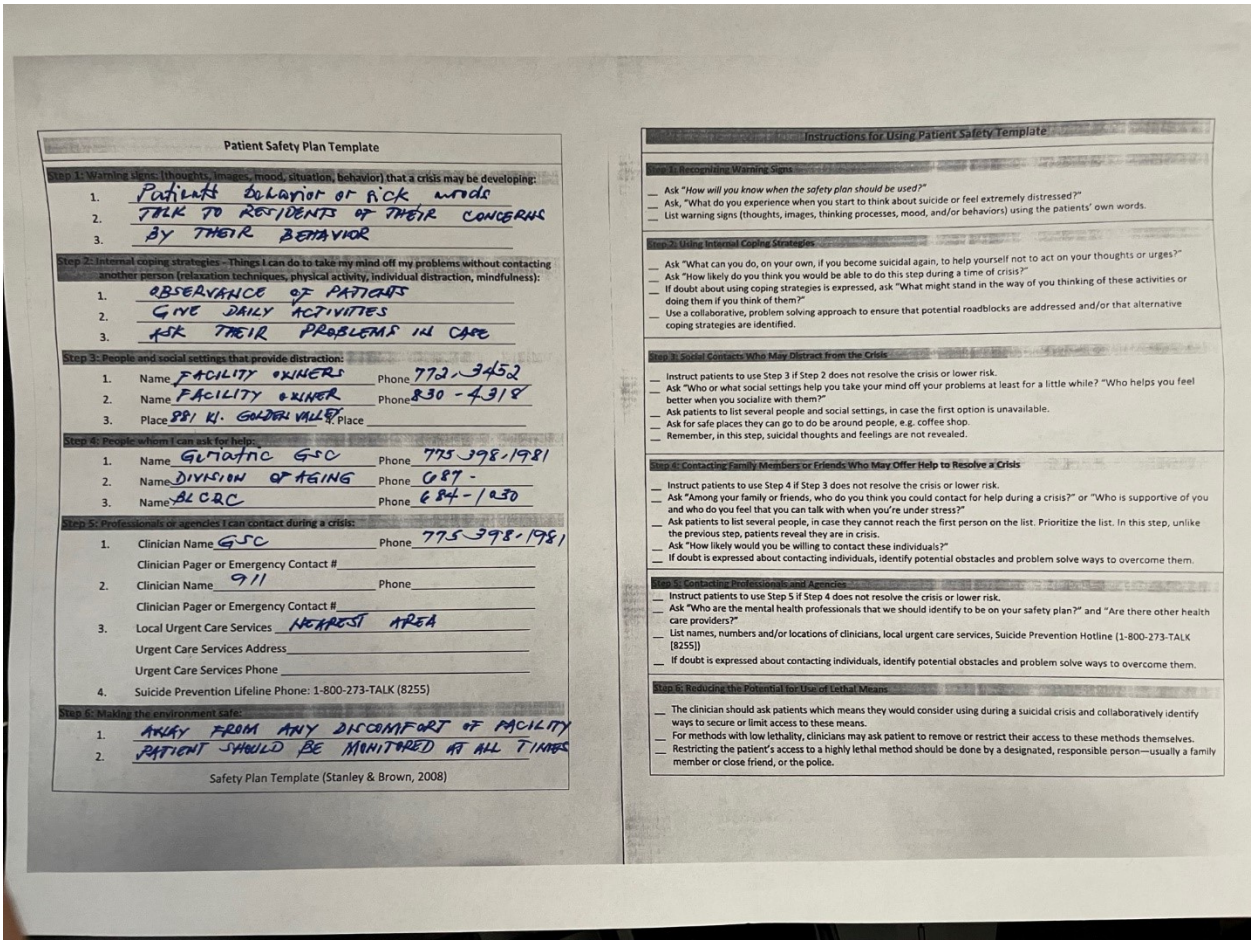
1) Marilou Deang Owner/Caregiver
2) Marie Abogadie Caregiver

Safety Officer

These staff are responsible for performing ROOT CAUSE ANALYSIS and making changes and improvement to prevent occurrence of the same event.

1) Nelia Buendia Facility Administrator
2) Joy Kolaras Caregiver
3) Marilou Deang Owner/Caregiver

Patient Safety Plan 3266



Patient Safety Plan Template

Step 1: Warning signs: (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. Patient behavior or sick words
2. TALK TO RESIDENTS OF THEIR CONCERNS
3. BY THEIR BEHAVIOR

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation techniques, physical activity, individual distraction, mindfulness):

1. OBSERVANCE OF PATIENTS
2. GIVE DAILY ACTIVITIES
3. ASK THEIR PROBLEMS IN CARE

Step 3: People and social settings that provide distraction:

1. Name FACILITY OWNERS Phone 772-3452
2. Name FACILITY OWNER Phone 830-4318
3. Place 881 W. GOLDEN VALLEY Place _____

Step 4: People whom I can ask for help:

1. Name GLMATIC GSC Phone 775 398-1981
2. Name DIVISION OF AGING Phone 687-
3. Name BLCRC Phone 684-1030

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name GSC Phone 775 398-1981
   Clinician Pager or Emergency Contact # _____
2. Clinician Name 911 Phone _____
   Clinician Pager or Emergency Contact # _____
3. Local Urgent Care Services NEAREST AREA
   Urgent Care Services Address _____
   Urgent Care Services Phone _____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

1. AWAY FROM ANY DISCOMFORT OF FACILITY
2. PATIENT SHOULD BE MONITORED AT ALL TIMES

Safety Plan Template (Stanley & Brown, 2008)

Instructions for Using Patient Safety Template

Step 1: Recognizing Warning Signs

- Ask *"How will you know when the safety plan should be used?"*
- Ask, "What do you experience when you start to think about suicide or feel extremely distressed?"
- List warning signs (thoughts, images, thinking processes, mood, and/or behaviors) using the patients' own words.

Step 2: Using Internal Coping Strategies

- Ask "What can you do, on your own, if you become suicidal again, to help yourself not to act on your thoughts or urges?"
- Ask "How likely do you think you would be able to do this step during a time of crisis?"
- If doubt about using coping strategies is expressed, ask "What might stand in the way of you thinking of these activities or doing them if you think of them?"
- Use a collaborative, problem solving approach to ensure that potential roadblocks are addressed and/or that alternative coping strategies are identified.

Step 3: Social Contacts Who May Distract from the Crisis

- Instruct patients to use Step 3 if Step 2 does not resolve the crisis or lower risk.
- Ask "Who or what social settings help you take your mind off your problems at least for a little while? "Who helps you feel better when you socialize with them?"
- Ask patients to list several people and social settings, in case the first option is unavailable.
- Ask for safe places they can go to do be around people, e.g. coffee shop.
- Remember, in this step, suicidal thoughts and feelings are not revealed.

Step 4: Contacting Family Members or Friends Who May Offer Help to Resolve a Crisis

- Instruct patients to use Step 4 if Step 3 does not resolve the crisis or lower risk.
- Ask "Among your family or friends, who do you think you could contact for help during a crisis?" or "Who is supportive of you and who do you feel that you can talk with when you're under stress?"
- Ask patients to list several people, in case they cannot reach the first person on the list. Prioritize the list. In this step, unlike the previous step, patients reveal they are in crisis.
- Ask "How likely would you be willing to contact these individuals?"
- If doubt is expressed about contacting individuals, identify potential obstacles and problem solve ways to overcome them.

Step 5: Contacting Professionals and Agencies

- Instruct patients to use Step 5 if Step 4 does not resolve the crisis or lower risk.
- Ask "Who are the mental health professionals that we should identify to be on your safety plan?" and "Are there other health care providers?"
- List names, numbers and/or locations of clinicians, local urgent care services, Suicide Prevention Hotline (1-800-273-TALK [8255])
- If doubt is expressed about contacting individuals, identify potential obstacles and problem solve ways to overcome them.

Step 6: Reducing the Potential for Use of Lethal Means

- The clinician should ask patients which means they would consider using during a suicidal crisis and collaboratively identify ways to secure or limit access to these means.
- For methods with low lethality, clinicians may ask patient to remove or restrict their access to these methods themselves.
- Restricting the patient's access to a highly lethal method should be done by a designated, responsible person—usually a family member or close friend, or the police.

Patient Safety Plan Template

Step 1: Warning signs: (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies - Things I can do to take my mind off my problems without contacting another person (relaxation techniques, physical activity, individual distraction, mindfulness):

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____ 4. Place _____

Step 4: People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
3. Local Urgent Care Services _____
   Urgent Care Services Address_____
   Urgent Care Services Phone _____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

1. _____
2. _____

Safety Plan Template (Stanley & Brown, 2008)

Instructions for Using Patient Safety Template

Step 1: Recognizing Warning Signs

__ Ask *"How will you know when the safety plan should be used?"*
__ Ask, "What do you experience when you start to think about suicide or feel extremely distressed?"
__ List warning signs (thoughts, images, thinking processes, mood, and/or behaviors) using the patients' own words.

Step 2: Using Internal Coping Strategies

__ Ask "What can you do, on your own, if you become suicidal again, to help yourself not to act on your thoughts or urges?"
__ Ask "How likely do you think you would be able to do this step during a time of crisis?"
__ If doubt about using coping strategies is expressed, ask "What might stand in the way of you thinking of these activities or doing them if you think of them?"
__ Use a collaborative, problem solving approach to ensure that potential roadblocks are addressed and/or that alternative coping strategies are identified.

Step 3: Social Contacts Who May Distract from the Crisis

__ Instruct patients to use Step 3 if Step 2 does not resolve the crisis or lower risk.
__ Ask "Who or what social settings help you take your mind off your problems at least for a little while? "Who helps you feel better when you socialize with them?"
__ Ask patients to list several people and social settings, in case the first option is unavailable.
__ Ask for safe places they can go to do be around people, e.g. coffee shop.
__ Remember, in this step, suicidal thoughts and feelings are not revealed.

Step 4: Contacting Family Members or Friends Who May Offer Help to Resolve a Crisis

__ Instruct patients to use Step 4 if Step 3 does not resolve the crisis or lower risk.
__ Ask "Among your family or friends, who do you think you could contact for help during a crisis?" or "Who is supportive of you and who do you feel that you can talk with when you're under stress?"
__ Ask patients to list several people, in case they cannot reach the first person on the list. Prioritize the list. In this step, unlike the previous step, patients reveal they are in crisis.
__ Ask "How likely would you be willing to contact these individuals?"
__ If doubt is expressed about contacting individuals, identify potential obstacles and problem solve ways to overcome them.

Step 5: Contacting Professionals and Agencies

__ Instruct patients to use Step 5 if Step 4 does not resolve the crisis or lower risk.
__ Ask "Who are the mental health professionals that we should identify to be on your safety plan?" and "Are there other health care providers?"
__ List names, numbers and/or locations of clinicians, local urgent care services, Suicide Prevention Hotline (1-800-273-TALK [8255])
__ If doubt is expressed about contacting individuals, identify potential obstacles and problem solve ways to overcome them.

Step 6: Reducing the Potential for Use of Lethal Means

__ The clinician should ask patients which means they would consider using during a suicidal crisis and collaboratively identify ways to secure or limit access to these means.
__ For methods with low lethality, clinicians may ask patient to remove or restrict their access to these methods themselves.
__ Restricting the patient's access to a highly lethal method should be done by a designated, responsible person—usually a family member or close friend, or the police.

Patient Safety Plan Template

Step 1: Warning signs: (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies - Things I can do to take my mind off my problems without contacting another person (relaxation techniques, physical activity, individual distraction, mindfulness):

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____ 4. Place _____

Step 4: People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
3. Local Urgent Care Services _____
   Urgent Care Services Address_____
   Urgent Care Services Phone _____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

1. _____
2. _____

Safety Plan Template (Stanley & Brown, 2008)

Instructions for Using Patient Safety Template

Step 1: Recognizing Warning Signs

__ Ask *"How will you know when the safety plan should be used?"*
__ Ask, "What do you experience when you start to think about suicide or feel extremely distressed?"
__ List warning signs (thoughts, images, thinking processes, mood, and/or behaviors) using the patients' own words.

Step 2: Using Internal Coping Strategies

__ Ask "What can you do, on your own, if you become suicidal again, to help yourself not to act on your thoughts or urges?"
__ Ask "How likely do you think you would be able to do this step during a time of crisis?"
__ If doubt about using coping strategies is expressed, ask "What might stand in the way of you thinking of these activities or doing them if you think of them?"
__ Use a collaborative, problem solving approach to ensure that potential roadblocks are addressed and/or that alternative coping strategies are identified.

Step 3: Social Contacts Who May Distract from the Crisis

__ Instruct patients to use Step 3 if Step 2 does not resolve the crisis or lower risk.
__ Ask "Who or what social settings help you take your mind off your problems at least for a little while? "Who helps you feel better when you socialize with them?"
__ Ask patients to list several people and social settings, in case the first option is unavailable.
__ Ask for safe places they can go to do be around people, e.g. coffee shop.
__ Remember, in this step, suicidal thoughts and feelings are not revealed.

Step 4: Contacting Family Members or Friends Who May Offer Help to Resolve a Crisis

__ Instruct patients to use Step 4 if Step 3 does not resolve the crisis or lower risk.
__ Ask "Among your family or friends, who do you think you could contact for help during a crisis?" or "Who is supportive of you and who do you feel that you can talk with when you're under stress?"
__ Ask patients to list several people, in case they cannot reach the first person on the list. Prioritize the list. In this step, unlike the previous step, patients reveal they are in crisis.
__ Ask "How likely would you be willing to contact these individuals?"
__ If doubt is expressed about contacting individuals, identify potential obstacles and problem solve ways to overcome them.

Step 5: Contacting Professionals and Agencies

__ Instruct patients to use Step 5 if Step 4 does not resolve the crisis or lower risk.
__ Ask "Who are the mental health professionals that we should identify to be on your safety plan?" and "Are there other health care providers?"
__ List names, numbers and/or locations of clinicians, local urgent care services, Suicide Prevention Hotline (1-800-273-TALK [8255])
__ If doubt is expressed about contacting individuals, identify potential obstacles and problem solve ways to overcome them.

Step 6: Reducing the Potential for Use of Lethal Means

__ The clinician should ask patients which means they would consider using during a suicidal crisis and collaboratively identify ways to secure or limit access to these means.
__ For methods with low lethality, clinicians may ask patient to remove or restrict their access to these methods themselves.
__ Restricting the patient's access to a highly lethal method should be done by a designated, responsible person—usually a family member or close friend, or the police.

Longevity Safety Plan

Step 1: Warning signs: (thoughts, images, mood, situation, behavior) that a crisis may be developing:

- Ask, What do you experience when you start to think about suicide or feel extremely distressed?
- Ask, How will you know when the safety plan should be used?
- List warning signs (thought, images, thinking process, mood, and /or behaviors) using the patients' own words.

Step 2: Internal coping strategies - Things I can do to take my mind off my problems without contacting another person (relaxation techniques, physical activity, individual distraction, mindfulness):

- Ask, What can you do on your own, if you become suicidal again, to help yourself not to act on your thoughts or urges?
- Use a collaborative, problem solving approach to ensure that potential roadblocks are addressed and /or that alternative coping strategies are identified.

Step 3: People and social settings that provide distraction:

1. Sammy Valera RFA (Administrator)- 775-843-9421
2. Juana Saura (Caregiver Coordinator) 775-622-9982

Step 4: People whom I can ask for help:

1. Sammy Valera RFA (Administrator) 775-843-9421
2. Juana Saura (Caregiver Coordinator) 775-622-9982

Step 5: Professionals or agencies I can contact during a crisis:

1. Bureau Of Health Care Quality and Compliance (HCQC) 775-684-1030
2. Washoe County Health District- 775-328-2400
3. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

- Restricting the patient's access to highly lethal method should be done by a designated, responsible person -usually a family member or close friend, or the police
- For methods with low lethality, clinician may ask patient to remove or restrict their access to these methods themselves.

Longevity Safety Plan

Step 1: Warning signs: (thoughts, images, mood, situation, behavior) that a crisis may be developing:

- Ask, What do you experience when you start to think about suicide or feel extremely distressed?
- Ask, How will you know when the safety plan should be used?
- List warning signs (thought, images, thinking process, mood, and /or behaviors) using the patients' own words.

Step 2: Internal coping strategies - Things I can do to take my mind off my problems without contacting another person (relaxation techniques, physical activity, individual distraction, mindfulness):

- Ask, What can you do on your own, if you become suicidal again, to help yourself not to act on your thoughts or urges?
- Use a collaborative, problem solving approach to ensure that potential roadblocks are addressed and /or that alternative coping strategies are identified.

Step 3: People and social settings that provide distraction:

1. Sammy Valera RFA (Administrator)- 775-843-9421
2. Juana Saura (Caregiver Coordinator) 775-622-9982

Step 4: People whom I can ask for help:

1. Sammy Valera RFA (Administrator) 775-843-9421
2. Juana Saura (Caregiver Coordinator) 775-622-9982

Step 5: Professionals or agencies I can contact during a crisis:

1. Bureau Of Health Care Quality and Compliance (HCQC) 775-684-1030
2. Washoe County Health District- 775-328-2400
3. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

- Restricting the patient's access to highly lethal method should be done by a designated, responsible person -usually a family member or close friend, or the police
- For methods with low lethality, clinician may ask patient to remove or restrict their access to these methods themselves.

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.

RESIDENT	Number of falls	Falls resulting in injury	What was injury?	Number of ER visits	Number admitted to the hospital	Wounds	Changes in condition	Admissions	Discharges & Why	Expired	Med errors	Overtime	NOTES
TOTALS													

PROVIDENCE HOME CARE

5325 VISTA LARGA CIRCLE,
RENO NEVADA 89523

RESIDENT SAFETY PLAN

Goals and Objectives:

1) Systematic and objective monitoring and evaluation of reports of injuries, accidents, and Resident's safety issues.
2) Collaboration of owner/administrator, caregivers, State Agencies and other healthcare providers for comprehensive high quality of care.

Fall Safety Plan

a) Provide orientation and get resident familiarized in a new environment upon admission.
b) Obtain Resident's history of fall and assess for risk of fall.
c) Identify devices used by the resident for mobility and implement the use of it.
d) Provide environment that is free from any obstacles for resident's safety.
e) In case of fall, have resident evaluated by medical professional for any injury and report to MD, family, and any agencies involve in resident's care.
f) Continuous staff training and education about fall management.
g) Fill out Serious Occurrence Report and Sentinel Event form and submit to Corresponding agencies.

Elopement Safety Plan

a) Assess Resident's history of elopement, identify risk of elopement.
b) Provide arm band with Resident's name, facility, the facility telephone number and any relevant health issue.
c) Make staff aware of Residents that are risk for elopement.
d) Have Residents picture taken and keep in their file.
e) Report any incident of elopement to the police department.
f) Report incident to MD, family and other health care agencies.
g) Fill out Serious Occurrence Report and Sentinel Event form and submit to the corresponding agencies.

Bed Sore Safety Plan.

a) Assess Resident's skin integrity upon admission.
b) Assess history of skin breakdown.
c) Report to MD any potential skin breakdown for prevention.
d) Provide mattress that promotes circulation per MD.
e) Provide good Nutrition.
f) Educate Resident how to reposition self on bed frequently.
g) For bed fast Resident, reposition every 2-3 hours.
h) Educate staff on bed sore prevention.
i) Report to MD, family and other health care agencies for skin breakdown.
j) Fill out SOR and Sentinel Event form and submit to corresponding agencies.
k) Provide Home Health Care per MD

Sierra Manor Care Home
327 River Flow Dr. Reno, NV 89523

Patient Safety Plan Template

Step 1: Warning signs: (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. Feeling isolated, lonely or without a purpose
2. Poorer memory, thinking, feeling slow, trouble thinking through to make decisions
3. Pain of any type or place in the body

Step 2: Internal coping strategies - Things I can do to take my mind off my problems without contacting another person (relaxation techniques, physical activity, individual distraction, mindfulness):

1. Deep breathing exercise
2. Meditate
3. Go for a walk

Step 3: People and social settings that provide distraction:

1. Name Family Phone
2. Name Friends Phone
3. Place Church 4. Place Senior Center

Step 4: People whom I can ask for help:

1. Name Tamika Miranda - Social Worker Phone 775-687-0824
2. Name Mel Magboo, MD Phone 775-432-6282
3. Name Jie Chen Phone 775-687-0819

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name Brenda - Ombudsman Phone 775-525-1062
   Clinician Pager or Emergency Contact #
2. Clinician Name Older Person's Friendship Hotline Phone 800-971-0016
   Clinician Pager or Emergency Contact #
3. Local Urgent Care Services Renown Urgent Care
   Urgent Care Services Address 4791 Summit Ridge Reno, NV 89523
   Urgent Care Services Phone 775-982-5000
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

1. Discard extra medications or unused/expired medications properly
2. Throw away away noose, razor blades or other means

Safety Plan Template (Stanley & Brown, 2008)

Instructions for Using Patient Safety Template

Step 1: Recognizing Warning Signs

__ Ask "*How will you know when the safety plan should be used?"*
__ Ask, "What do you experience when you start to think about suicide or feel extremely distressed?"
__ List warning signs (thoughts, images, thinking processes, mood, and/or behaviors) using the patients' own words.

Step 2: Using Internal Coping Strategies

__ Ask "What can you do, on your own, if you become suicidal again, to help yourself not to act on your thoughts or urges?"
__ Ask "How likely do you think you would be able to do this step during a time of crisis?"
__ If doubt about using coping strategies is expressed, ask "What might stand in the way of you thinking of these activities or doing them if you think of them?"
__ Use a collaborative, problem solving approach to ensure that potential roadblocks are addressed and/or that alternative coping strategies are identified.

Step 3: Social Contacts Who May Distract from the Crisis

__ Instruct patients to use Step 3 if Step 2 does not resolve the crisis or lower risk.
__ Ask "Who or what social settings help you take your mind off your problems at least for a little while? "Who helps you feel better when you socialize with them?"
__ Ask patients to list several people and social settings, in case the first option is unavailable.
__ Ask for safe places they can go to do be around people, e.g. coffee shop.
__ Remember, in this step, suicidal thoughts and feelings are not revealed.

Step 4: Contacting Family Members or Friends Who May Offer Help to Resolve a Crisis

__ Instruct patients to use Step 4 if Step 3 does not resolve the crisis or lower risk.
__ Ask "Among your family or friends, who do you think you could contact for help during a crisis?" or "Who is supportive of you and who do you feel that you can talk with when you're under stress?"
__ Ask patients to list several people, in case they cannot reach the first person on the list. Prioritize the list. In this step, unlike the previous step, patients reveal they are in crisis.
__ Ask "How likely would you be willing to contact these individuals?"
__ If doubt is expressed about contacting individuals, identify potential obstacles and problem solve ways to overcome them.

Step 5: Contacting Professionals and Agencies

__ Instruct patients to use Step 5 if Step 4 does not resolve the crisis or lower risk.
__ Ask "Who are the mental health professionals that we should identify to be on your safety plan?" and "Are there other health care providers?"
__ List names, numbers and/or locations of clinicians, local urgent care services, Suicide Prevention Hotline (1-800-273-TALK [8255])
__ If doubt is expressed about contacting individuals, identify potential obstacles and problem solve ways to overcome them.

Step 6: Reducing the Potential for Use of Lethal Means

__ The clinician should ask patients which means they would consider using during a suicidal crisis and collaboratively identify ways to secure or limit access to these means.
__ For methods with low lethality, clinicians may ask patient to remove or restrict their access to these methods themselves.
__ Restricting the patient's access to a highly lethal method should be done by a designated, responsible person—usually a family member or close friend, or the police.

SOFIA'S HOME
2612 WABASH CIRCLE
SPARKS, NV 89434

Patient Safety Plan Template

Step 1: Warning signs: (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. FEELING ISOLATED, LONELY OR W/O A PURPOSE
2. POORER MEMORY, THINKING, FEELING SLOW, TROUBLE THINKING THROUGH TO MAKE DECISION
3. PAIN OF ANY TYPE OR PLACE IN THE BODY

Step 2: Internal coping strategies - Things I can do to take my mind off my problems without contacting another person (relaxation techniques, physical activity, individual distraction, mindfulness):

1. DEEP BREATHING EXERCISE
2. MEDITATION
3. GO FOR A WALK

Step 3: People and social settings that provide distraction:

1. Name FAMILY Phone
2. Name FRIEND Phone
3. Place CHURCH 4. Place SENIOR CENTER

Step 4: People whom I can ask for help:

1. Name TAMIKA MIRANDA - SOCIAL WORKER Phone 775 393 9834
2. Name ANDREA RODARTE Phone 775 3981981
3. Name LALA BUENVIASE Phone 775 4323887

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name J. WOODS - OMBUDSMAN Phone 775 687 0818
   Clinician Pager or Emergency Contact #
2. Clinician Name OLDER PERSONS FRIENDSHIP HOTLINE Phone 800 971 601
   Clinician Pager or Emergency Contact #
3. Local Urgent Care Services RENOWN URGENT CARE
   Urgent Care Services Address VISTA COR PRATER WAY SPARKS, NV 89434
   Urgent Care Services Phone 775 982 5000
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

1. DISCARD EXTRA MEDICATIONS OR UNUSED/EXPIRED MEDICATIONS PROPERLY
2. THROW AWAY NOOSE, RAZOR BLADES OR OTHER MEANS

Safety Plan Template (Stanley & Brown, 2008)

Instructions for Using Patient Safety Template

Step 1: Recognizing Warning Signs

__ Ask *"How will you know when the safety plan should be used?"*
__ Ask, "What do you experience when you start to think about suicide or feel extremely distressed?"
__ List warning signs (thoughts, images, thinking processes, mood, and/or behaviors) using the patients' own words.

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__ Ask for safe places they can go to do be around people, e.g. coffee shop.
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__ Restricting the patient's access to a highly lethal method should be done by a designated, responsible person—usually a family member or close friend, or the police.

POLICY AND ROCEDURE SAFETY/MANUAL

SOUTH MEADOWS RESIDENTIAL CARE HOME

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SOUTH MEADOWS MEMORY AND RESIDENTIAL CARE FACILITY

INTRODUCTION

The facility is a beautiful building designed and furnished to support resident's independence. This is their home where they spend most of their life and it should be a place of pride for them.

Our mission is to provide a dignified, caring living environment. To accomplish this goal takes teamwork from all the employees. This mission statement encourages price and ownership. All employees should be looking at the building as a visitor would. When something is wrong or out of place, it is the responsibility of the first person who sees it to make it right. This is true of trash found in the parking lot, in the potted plants, chair cushions to anywhere.

You never get a second chance to make a first impression! One of the key ingredients of a well maintained residence is the impression that new a visitor has when he or she enters the building. If the building is clean and orderly, a visitor will most likely get a feeling that the residents receive proper care. What the senses take in, the mind converts to an impression. The first impression is a lasting one. You have to work very hard to change people's minds if their first impression is not a good one.

The Lobby and Common Areas are the first place that the visitor sees. It should be clean, neat and attractive. The eye should see furniture that is well kept, functioning properly and is placed sensibly to serve a need and allow for safe walkways. The eye should not see cups and glasses, napkins and tissues, and food stuff. The area should be one of relaxed order.

Create a good environment. Make sure the area has only pleasant odors. Eliminate bad odors by finding the cause of the odor and get rid of it. Thoroughly clean the affected area and use a room freshener.

Frequently check the public restrooms. The cleanliness of the restrooms tells visitors about our care. If it is in good shape it shouts our attention to detail, our pride and our ability to handle challenging situations. If it looks neglected, unkempt and is without supplies, it signals problems with management and pride in our building.

Our building should look good, smell good and feel comfortable!

ABUSE, NEGLECT & EXPLOITATION REPORTING & INVESTIGATIONS

The facility is committed to maintaining a safe environment for each resident, visitor and employee. Instances or allegations of abuse, neglect or exploitation should be treated seriously and must be reported to the Executive Director for the supervisor on duty for investigation and appropriate follow up.

ABUSE is defined in Nevada as willful and unjustified infliction of pain, injury or mental anguish on an older person or deprivation of food, shelter, clothing or services which are necessary to maintain the physical or mental health of an older person.

NEGLECT is defined in Nevada as the failure of a person who has assumed legal or contractual responsibility for caring for an older person to provide food, shelter, clothing or services which are necessary to maintain the physical or mental health of the older person.

EXPLOITATION is defined in Nevada as any act taken by a person who has the trust and confidence of an older person or any use of the power of attorney or guardianship of an older person to obtain control, through deception, intimidation or undue influence, over the older person's money, assets or property with the intention of permanently depriving the older person of the ownership, use, benefit or possession of his money, assets or property.

Parties potentially involved: two or more residents; one or more residents, family members and visitors; one or more residents and staff members.

Reporting by Employee: Any employee who witnesses or becomes aware of alleged abuse, neglect or exploitation, should report such incident to Executive Director or supervisor on duty immediately. If the employee feels that appropriate action is not being taken or if the alleged abuse relates to the executive director or the supervisor, the complaint should report directly to the Aging & Disability Services Division.

Documentation by Employee: Any employee who witnesses such an alleged incident must complete the appropriate Incident forms.

RESPONSE TO INCIDENT:

Upon learning of alleged abuse, neglect or exploitation, the supervisor should attempt to take necessary steps to insure that residents are protected from subsequent episodes of abuse, neglect or exploitation while a determination on the matter is pending.

Any person who is harmed during an incident should be provided medical attention, if appropriate. If an incident involves resident on resident contact, both residents should be evaluated for a change of condition. Residents exhibiting aggressive behavior should be considered for continued appropriateness and interventions should be developed to address the behaviors.

Investigations:

Upon receipt of an allegation, the Executive Director should conduct a confidential investigation of the incident in a manner that is least disruptive to the ongoing delivery of services and daily routine of the community. The investigation should be conducted confidentially and in a manner that is least disruptive to the ongoing delivery of services and daily routine of the community.

ABUSE POLICY

POLICY

Every resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to employees, other residents, physicians, consultants, volunteers, family members, legal guardians, friends or other individuals.

Every resident has the right to be free from mistreatment, neglect, and misappropriation of property. This includes the facility's identification of residents, whose personal histories render them at risk for abusing other residents, and development of strategies to prevent occurrences, monitoring for changes that would trigger abusive behavior, and reassessment on a regular basis.

The facility has developed and instituted policies and procedures for screening and training employees in regard to the protection of residents and for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment and misappropriation of property. The purpose is to assure that the facility is doing all that is within its control to prevent occurrences.

The facility will not hire any person with a history of abuse, if that information is known to the facility. The facility reports knowledge of actions by a court of law against an employee that indicates the employee is unfit for duty. The facility reports alleged violations, conduct, and investigation of all alleged violations, to the proper authorities and takes necessary corrective actions.
Abuse is defined as: the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical, emotional or psychological harm, pain or mental anguish.

Abusive Conditions can occur between employee and resident, resident and resident, family to resident, or any combination.

TYPES OF ABUSE

- Physical: Any action that causes actual physical harm. For example, rough handling of a resident.
- Verbal: Using profanity, name calling, cruel teasing
- Negligence: Failing to properly care for a resident in the manner conducive to professional care standards
- Sexual: Touching the resident in an intimate or suggestive manner, making sexual comments or allowing another resident to do so.
- Mental: Any act that makes a resident fearful, feel belittled or to make fun of a resident by mocking, imitating, or ridiculing.
- Corporal Punishment: Physical punishment such as seclusion, restraining or physically inflicting punishment.

DEFINITIONS

1. Neglect: Failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness.
2. Misappropriation of resident property: The deliberate misplacement, exploitation, or wrongful temporary or permanent use of resident's belongings, phone, money, food,

clothing, personal hygiene products, jewelry, magazines, mail, money, or any item or service designated for exclusive use by the resident.
3. Involuntary seclusion: A separation of a resident from other residents or from their room, or confinement to their room against their will.

Emergency or short term monitored separation from other residents is not considered involuntary seclusion and may be permitted if used for limited periods of time as a therapeutic intervention to reduce agitation until a plan of care is made that completely and adequately meets the needs of the residents.

There are three types of seclusion:

1. A special unit which prevents residents from free movement throughout the entire facility to provide specialized care to residents who are cognitively impaired, is NOT considered seclusion in this definition, as long as care and services are provided in accordance with the resident's needs.
2. A resident receiving emergency separation due to temporary behavioral symptoms is NOT considered involuntary seclusion as long as this is the least restrictive approach for the least amount of time and is done for the resident's needs and not staff convenience.
3. A resident confined to the resident room due to contagious illness or conditions is NOT considered involuntary seclusion as long as the care plan and physician orders indicate the contagious condition is the determining factor for the seclusion, and when the contagious condition no longer exists, the resident is released form seclusion.

When a resident is secluded for more than one hour the following must be documented in the resident's medical record:

1. The symptoms leading to the seclusion.
2. The root cause of the symptoms: environment, medication, medical symptom, staff interactions, visitor interactions, etc.
3. Alternative interventions prior to the seclusion.

Following the seclusion, the record must reflect the interventions taken on behalf of the resident: Social Worker intervention, change in environment, improvement in medical symptom, removal of the cause, etc.

If the cause cannot be eliminated, delineate steps taken to teach the resident how to manage the environment, incident and symptoms that lead to the incident. Provide the resident with choices and alternatives to avoid the incident in the future. Include the resident in the plan for managing the incident in the event it occurs in the future; share the plan with family, resident care coordinator and staff.

Monitor and document the outcomes to the lesser restrictive approaches for future incidents.

EMPLOYEE PROCEDURES

- On the initial application for hire, the facility conducts a background check for a history of abuse, neglect, or mistreatment of residents by confirming the status of the applicant with state agencies and former as well as current employers. Additionally a criminal background check is conducted to determine if the applicant has a history containing felony or

misdemeanor convictions. The facility does not employ individuals convicted of abuse, theft or illegal drug involvement.

- All employees attend training during orientation and mandatory annual training related to abuse prevention.
- Training classes include at a minimum:
    - Appropriate interventions to deal with aggressive and catastrophic reactions to residents.
    - Reporting requirements regarding allegations of abuse, without fear of reprisals from any other individual whether they are staff, management, residents or visitors.
    - Recognition of burnout, frustration and stress that may lead to reactions resulting in abusive situations.
    - Definitions of abuse, neglect and misappropriation of resident's property.

PREVENTION

As part of the admission process, residents and family are provided with information regarding how to report suspected abuse.

Employees will be provided with information regarding the process for reporting witnessed abuse.

The Arbors management staff is required to accept all allegations of abuse and conduct a complete investigation including reporting to the proper authorities.

All reports whether from family, residents or staff will be reported immediately to the Executive Director and Resident Care Coordinator.

NO staff member, resident or visitor shall receive reprisals from the reporting of allegations of abuse.

Staff is required to intervene, identify and correct situations where any type of abuse may occur.

After the allegations of abuse are reported to the Resident Care Coordinator and Executive Director, an incident report is completed, and forwarded to the Safety Committee and Quality Improvement Committee.

An analysis is conducted to immediately determine:

- Training level of staff
- Environmental safety
- Appropriate behavior
- Care Plan
- Monitoring of resident's well being
- Safety of resident
- Any injuries sustained by the resident
- Trends or re-occurrences

INVESTIGATION

Any accused staff members will be immediately removed from contact with the resident suspected of being abused and the resident's safety will be protected

- The Executive Director and Resident Care Coordinator will conduct an investigation.
- Other team members may be consulted: Caregiving Staff, Dining Services Manager, Dietary Supervisor, Building Services Coordinator, etc.
- The investigating team will interview all parties concerned: witnesses, the victim, staff and the accused.
- The investigation will proceed and conclude by fact-finding, root cause analysis and comparison of information.
- The results of the investigation will be provided to the proper authorities, Quality Improvement Committee, Attending Physician, Resident and family members of the resident within five days of the reported incident.
- Appropriate steps will be taken to assure the abuse situations do not reoccur in the future.
- The Executive Director and Resident Care Coordinator will report all allegations of abuse, alleged violations and substantiated incidents to the state agency.

The Executive Director or Resident Care Coordinator will report the incident to the licensing board if the facility determines that actions by a court of law against an employee indicate that the individual is unsuited to work in a nursing home.

ABUSE REPORTING

Any incident I which there is suspected abuse; such as defined below, will be thoroughly addressed. Any employee who is found to have abused a resident, visitor or other employee (may) will be terminated. The staff member may be suspended or reassigned pending the outcome of an investigation.

RESIDENT ABUSE

Physical assaults such as hitting, kicking, scratching, pinching, choking, pushing or sexual contact.

Neglect of care, including improper administration of medications, failure to seek appropriate medical care, inadequate change of bedding or clothing, failure to assist with personal grooming.

Denial of meals, clothing or aids to physical functioning such as wheelchairs, walkers, canes, hearing aids and glasses.

Use of derogatory or inappropriate names, phrases or profanity, ridicule, harassment, coercion, threats, cursing, intimidation or sexual exploitation.

Placing unreasonable restrictions on a resident, which violates the resident bill of rights.

Use of restraints except when a resident's actions present an immediate danger to self or others and only until appropriate action is taken by medical, emergency or police personnel.

Financial exploitation, including but not limited to: unreasonable rate increases, borrowing from or loaning money to residents, witnessing wills in which provider is beneficiary, adding provider's names to resident's bank accounts or other personal property without prior approval of resident's family or case manager, inappropriately expending residents' personal funds, co-mingling residents' funds with provider or other residents' funds or becoming a guardian or conservator.

SEXUAL ABUSE

Sexual harassment consists of any unwelcome sexual advances, requests for sexual favors and other physical, verbal or visual conduct based on sex. Any form of sexual intimacy without consent or by force is considered to be sexual abuse.

GUIDELINES

Any incident in which a person is being abused in any way must be reported to the supervisor on duty immediately. If the person is in immediate danger, the staff member discovering the incident must attempt to protect the person if it can be done without worsening the situation.

If the incident is unmanageable, emergency personnel should be called.

The Administrator or Care Coordinator should assume control of the situation as soon as possible.

If the altercation is between two residents, is of minor nature, and there are no injuries, the incident does not need to be reported to state authorities. The incident must however, be documented on an Incident Report Form, a thorough investigation of the precipitating events made and plans for avoiding future incidents developed.

If the same resident repeatedly causes minor altercations, the situation is to be reported to the Administrator to assess the resident's appropriateness to reside in the residence. Attempts will be made to obtain evaluation and treatment from the physician, mental health worker and others who may be effective at stabilizing the behavior. If the resident continues to pose a risk to other residents, the resident will be required to relocate to a more appropriate environment. Arrangements will be made to assure the safety of other residents until the abusive resident is moved.

Any person who is harmed during an abusive incident will receive immediate attention.

If the abusive incident was caused by an employee of the residence, that employee will immediately be put on leave while the incident is investigated. If it is determined that the employee willfully abused a resident, visitor or another employee, the employee will be terminated.

The investigation will be first an internal investigation. If the situation warrants, an independent impartial investigator will be hired. The resident will be assured of protection from further harm or exploitation during and following the investigation.

All abusive incidents perpetrated by an employee will be promptly reported to the appropriate state agencies.

In the event of rape or sexual abuse:

- The suspected offender will not be allowed on the premises. A restraining order will be obtained, if necessary.
- The alleged perpetrator will not be questioned by residence staff.
- The victim will not be questioned about the incident by untrained personnel. The RCC and administrator will provide support and comfort but will strictly follow the direction of the authorities or emergency personnel who will be handling the investigation and treatment.
- Any potential evidence such as bedding or clothing will not be tampered with. It will be untouched until police have examined the area and collected the evidence they feel is necessary. The area will be cleaned when police give approval.
- Discourage the victim from cleaning up before the exam.
- Inform the resident's designated emergency contact and arrange for emotional support for the resident. If no family or friends are available to accompany the resident to the hospital, arranged fro a staff member to go along. This should be a person who the resident trusts and has confidence in.
- Follow up questioning and counseling will be arranged with professionals.
- Protection will be provided to the victim.

ABUSE POLICY AGREEMENT

Employee
Name_____

I have been instructed on and understand the Abuse Policy. I understand that IF I see or suspect abuse, I am to immediately report to my supervisor, the administrator and fill out an incident report. Failure to do so is ground for termination.

I have been given a copy of the Abuse Policy.

_____

Employee Signature
Date

COUMADIN & OTHER ANTICOAGULANTS

POLICY
Residents on Coumadin will receive assistance with necessary monitoring and/or lab tests.

PROCEDURE

1. Med Techs are instructed on signs, symptoms and complications of Coumadin use, and to report these immediately to the physician and to the Care Coordinator.

2. The Care Coordinator conducts an in-service to caregivers on monitoring residents receiving Warfarin (Coumadin) or other anticoagulants.

3. The Care Coordinator makes arrangements for lab draws as required.

4. The Medication Administration Record (MAR)

5. is updated immediately upon receiving the Coumadin dosing change from the prescribing physician.

DEATH OF A RESIDENT

POLICY
S. Meadows Memory and Residential Care Facility Residence will take appropriate action in the event of the death of a resident.

PROCEDURE

- **Call 911.**
  Emergency Medical Services (Paramedics) must be summoned to determine death, unless a Hospice nurse is present at the bedside
- **Do not move the body.**
  - The body may not be moved until the Paramedics arrive. Staff should remain with the body at all times until paramedics arrive.
  - Notify the resident's primary physician and administrator.
- **The coroner must be contacted.**
  Once paramedics have pronounced the body (via communication with the physician or coroner), release of the body must be obtained, allowing for transport to the funeral home of the family's choice.
- **Notify the family.**
  Once the body has been pronounced the family may be told of the death. Frequently the physician will make this phone call. Otherwise, the administrator will notify the family.
- **Prepare the room for visitors if required.**
  Occasionally family or significant other will want to spend a few moments with the resident prior to transport out of the facility. In consideration, tidy the room, remove linens, etc., with objectionable odors and put a chair near the bed. Lights should be turned on to a comfortable level. Insert the resident's dentures (if applicable), close the resident's mouth and eyes.
- **Contact the funeral home.**
  Once coroner release has been obtained, the resident may be removed from the facility. Call the funeral home designated. The resident should remain no longer than two hours in the facility, if possible.
- **Document appropriately.**
- Enter narrative documentation in resident's chart noting:
  - Where was resident found?
  - Body position
  - Condition of surroundings
  - What time was the resident found?
  - By whom?
  - What time was the resident last observed?
  - What was the resident doing at that time?

- What action did you take?
  - Called
  - Notifications

- Did any visitors (family, coroner, etc.) arrive?
  - Transported out of the facility
  - Who transported out?
  - Time
  - Funeral home

DISCHARGE POLICY

POLICY
Discharge from our facility is carried out in a manner to limit transfer upset and to enhance communication.

PROCEDURE
The Care Coordinator coordinates the timing of the discharge with the administrator and receiving facility or new residence.

If ambulance transportation is necessary, it is arranged by the Care Coordinator or designee.

The Med Tech assigns a caregiver to collect and pack resident belongings, as needed.

The resident is dressed in appropriate street clothing if going by car. Gown, pajamas, etc., may be worn if going by ambulance.

The caregiver assigned to the resident ensures hearing aid, dentures, etc., are in place and appropriately accounted for.

The resident's medications are counted and packaged appropriately for transportation.

All treatments and medication given within the last 24 hours are indicated, and passed on to the new facility.

Upon discharge, the Resident Discharge Summary is completed. The information is maintained in the resident's chart.

FALL POLICY & RESPONSE

POLICY
Should a resident experience a fall, staff will provide immediate care and follow through service planning.

PROCEDURE

- Should a resident fall, caregivers are instructed to summon immediate assistance from the Care Coordinator or Med Tech. Caregivers do not move the resident, except to protect against further injury, as in the case of a dangerous environment.
- The Med Tech will perform a brief neurological overview for bleeding or obvious deformities.
- The Med Tech or Care Coordinator assesses range of motion ability.
- The Med Tech or care coordinator may allow the resident to be assisted up to a chair, if:
    - The head did not receive any trauma or injury, nor was struck during the fall;
    - The resident has full range of motion;
    - The resident denies any pain;
    - There was not loss of consciousness;
    - The resident appears alert and oriented to hid/her baseline norm;
    - The resident is able to participate in the process of getting up; and
    - The resident denies a desire for medical transport.

- The physician is contacted for further instructions.
- The nurse instructs caregivers to provide appropriate care and frequent resident checks. Any change in status is reported to the nurse.
- Should the resident have trauma resulting in deformity, exhibit any change in level of consciousness, received obvious head or significant trauma the care coordinator or Med Tech summons emergency medical services (call 911).
- Forty-eight hours after any fall, and the resident remains in or returns to the facility, the Med Tech on each shift will monitor the resident.
- An incident report is completed and given to the administrator.
- The Care Coordinator informs the physician of subsequent falls and instability. Medical intervention, physical therapy, gait analysis is arranged when residents remain a significant risk for falls.

GRIEVANCE POLICY

The facility will assist residents, their representatives, other interested family members, or advocates in filing grievances or complaints when such requests are made.

POLICY:

- Any resident, his or her representative, family member, or advocate may file a grievance or complaint concerning his or her treatment, medical care, behavior of other residents, staff members, theft of property, etc. without fear of reprisal or threat in any form.
- Grievances and complaints must be submitted in writing and signed by the resident or the person filing the grievance or complaint on behalf of the resident.
- The Administrator has delegated the responsibility of grievance and complaint investigation to the appropriate Department Head.
- Upon receipt of a written grievance or complaint, the appropriate department will investigate the allegations and submit a written report of findings to the Administrator.
- The Administrator will review the findings with the person investigating the complaint to determine what corrective actions, if any need to be taken
- The resident, or person filing the grievance or complaint on behalf of the resident, will be informed of the findings of the investigation and the actions that will be taken to correct any identified problems. The Administrator or designee will make such report orally. A written summary of the report will also be provided to the resident, and a copy will be filed in the business office.
- Should the resident not be satisfied with the results of the investigation, or the recommended actions, he or she may file a written complaint to the local ombudsman office or to the state licensing agency. Addresses and telephone numbers of these agencies are posted prominently in the facility.

GRIEVANCE PROCEDURE

One of the best tools for quality improvement is a tool that enables the facility to know the "pulse" in the facility. To have knowledge and the opportunity to impact the conditions is a valuable way to avoid the risk of issues becoming so large that litigation is initiated.

Inform all staff, visitors and residents that the administration is open to all complaints and grievances. Post instructions and grievance forms in a conspicuous place. Encourage staff members to offer them to visitors, families and residents. Allow the complaint to be anonymous or completed with identifying information.

If staff is informed regarding complaints from families or residents, staff should submit the complaint form. The value is in knowing about the complaint so it can be resolved, regardless of the method of reporting the complaint.

REVIEW all complaints as soon as possible. When someone complains, they expect a quick response. Delaying a response will only make the complaint worse, or encourage the complainant to seek additional remedies.

RESOLVE the complaint as soon as possible. Not all complaints are easy to resolve, not all complaints are difficult to resolve. Many complaints are unreasonable because most families do not know how to work

within the framework of the assisted living/memory care environment. Resolve complaints within five days is an adequate time frame for problem resolution, fewer than five days would be ideal.

RESPOND without Resolution. Immediately on receipt of the complaint, acknowledge receipt of the complaint, realizing some complaints are easily remedied, rapid response may resolve them immediately. For those instances where complaints are involved and require investigation, discuss the complaint with the complainant and assure them the investigation will be initiated and concluded to their satisfaction.

MAINTAIN a Complaint Log and a Complaint File. Log every complaint and grievance. Keep record of actions taken regarding the complaint or grievance. These documents are invaluable in the event of future action. Keeping track of who is complaining will be a valuable tool for determining the risk of those who would consider initiating a lawsuit.

It is the goal of The Arbors to provide the best possible care to our residents. This includes promoting independence in all decisions affecting services rendered. Should at any time the resident, family member or visitor feel that our delivery of care is not at its highest potential we ask that you bring this information to the attention of the Care Coordinator or Executive Director. This information can be shared anytime day or night.

Upon request, the Administrator will return to the facility at anytime to correct any apparent problem.

If for any reason you are not pleased with the response given by the Administrator, you may contact the representative from the State Ombudsman Program:

Aging & Disability Services Division; Phone: 775-688-2964

Or, you may wish to contact a representative of the Bureau of Health Care Quality & Compliance

Although either of these agencies will assist you, we encourage you to contact the facility first to correct any apparent problems.

HANDLING A GRIEVANCE

Due to the nature of the services provided in the assisted living environment, complaints are to be expected. While inviting complaints may seem like asking to be the center of a target, it is actually a perfect way to prevent small issues from becoming major events. Every complaint is serious, no matter how insignificant it appears, complaints always contain emotions. Placing blame does nothing to resolve a complaint; resolutions resolve complaints.

Many complaints are based on misunderstanding rather than actual events or results. Turn complaints into opportunities to explain purposes and quality goals of programs and systems. With every complainant be aware of the tone of voice, body language as well as the words used to express what can be done to resolve complaints.

The number and severity of complaints can measure quality of care during any given period of time. Customer service depends on the effectiveness and ability to correctly handle and resolve complaints. Time and communication are essential in managing complaints correctly. The quicker the complaint is dealt with, the quicker, easier and more effective the solution becomes. Regular COMMUNICATION must be established and maintained throughout the process until resolution is reached.

Find the most important complaint first: When a complaint is filed, express understanding (do not admit guilt), and explore ALL concerns. Allow the complainant to reveal all the complaints until the root of the complaints can be discovered.

- Repeat or paraphrase the complaints to verify understanding
- Ask for assistance in prioritizing the complaints and agree which one to tackle first
- Use statements such as:
    - I understand your concern.
    - Your point is well taken.
    - That is a valid question.
    - Can you tell me more about that?
    - How do you feel this happened?
- Apologize without admitting guilt:
    - I am sorry if that is what happened.
    - Please accept my apology for that situation.
- Listen without interrupting or defending.
- Avoid conclusions.
- Never judge.
- Don't place blame.
- Never take a defensive stance.
- Don't start solving the problem until after the conversation is concluded.

Refine the most important complaint first. The purpose of this approach is to make certain the complaint is clear, precise and confined to a specific event and not a general discontentment. Use phrases such as:

- From what you said, it is my understanding that…
- What you are saying is…
- From your perspective you….

Defuse or offer solutions. Solutions can only be offered after an investigation has been completed. The source must be contacted when the investigation is complete, explain the results, and only then offer a solution.

Use statements such as:

- What would be helpful?
- Is that what you are looking for?
- Does that answer your question?
- Is this a workable solution?

GRIEVANCE RESPONSE LETTER

Date

Dear (Responsible Party),

This letter is in response to the complaint issued by (complainant's name) on (date). Your concern is as follows: (Complete description of the complaint).

After a thorough investigation of your concern our findings are: (Description of action taken and facility's position in regard to the complaint).

It is our sincere hope that you understand we have made our best effort to resolve your concern. However if you are not satisfied with the efforts we have made, you have two further possible options. You may contact: (names, positions and phone numbers of the possible contacts).

Sincerely,

(Your Name)

(Your Title)

HOME HEALTH AGENCIES

POLICY
It is the policy of S. Meadows Memory and Residential Care Facility Residence to accommodate the residents with the services of a home health agency as needed.

PROCEDURE
Verify MD order if an agency arrives in the facility. If it is a new agency, it is the responsibility of the administrator to provide clarification of the scope of practice in an assisted living facility (prohibited conditions).

If resident is in need of home health services, the Care Coordinator will get approval from the administrator and contact agency for arrangements.

When home health arrives for initial assessment it is the responsibility of the Care Coordinator to arrange for resident history and complete report to be available for the Home Health nurse. Staff familiar with resident is to be available to nurse for consultation at time of visit, however resident and RN should be provided privacy.

After home health nurse has assessed, and a care plan developed, the nurse, resident and the Care Coordinator shall discuss and clarify interventions. A copy shall be provided, as well as updates, to the Care Coordinator to verify interventions are congruent with regulatory guidelines.

The home health agency is expected to check-in with the S. Meadows Memory and Residential Care staff when arriving at the facility and when leaving.

The visiting nurse should document any significant status change and care plan updates to provide continuity of care and ensure a prohibited condition is not developing. Likewise, the MVR staff shall keep the Home Health nurse apprised of all new orders, medication changes and response to interventions performed by facility staff.

The facility and agency can be a very effective team meeting the needs of the resident. Should the facility have a problem with a particular nurse, the Administrator should be notified so a contact may be made with the Care Coordinator.

A home health nurse shall not provide training nor expect a non-licensed care giver to perform any medical act in a residential care facility. Examples of prohibited acts include, but are not limited to:

- Non-licensed staff filling insulin syringes.
- Dressing changes.
- Irrigation

Should a care plan intervention be questionable, it is the responsibility of the administrator, to verify the action with the licensing evaluator.

IMMUNIZATION

POLICY
All residents will receive immunizations and vaccinations according to physician orders.

PROCEDURE

- The Care Coordinator contacts the resident's physician at the time of admission to obtain a written order for influenza, unless contraindicated.

- All residents without influenza immunization that season are immunized at the appropriate time per physician's orders, unless contraindicated.

- Cost of immunizations shall be borne by the resident.

INFECTION CONTROL LOG

Type of Infection	Onset Date	Site	Infection related to DX	Culture: Yes or No	Organism	Antibiotic	Isolation Yes or No	Nosocomial Yes or No	Trended to other infections? Yes or No

Date:_____

Members of the Infection Control Committee:

_____

_____

INJURY REPORT

Name of Injured Party			Age	Sex
Detail of Injury				
Medical Action Taken				
Triage Priority	1 Life Threatening	2 Severe	3 Moderate	4 Minor
If transported; destination			Time Out	
Transported by				
First aid administered by				
Form completed by			Date	Time

FIRE SAFETY TAG

R – Rescue

A – Alarm

C – Confine

E – Evacuate / Extinguish

FIRE EXTINGUISHER

P – Pull

A – Aim

S – Squeeze

S - Sweep

FIRE DRILL POLICY & PROCEDURE

POLICY

It is the policy of S. Meadows Memory Care Residence to have a written fire plan to be followed in the event of a fire in the facility or in the surrounding area for the care and safety of all residents and employees during emergency situations.

S. Meadows Memory Care Residence will conduct monthly fire drills for staff training. Shift rotation will assure that all employees are trained. Documentation will be made in writing after each fire drill and shall be kept in a permanent facility administration file.

Each staff member is responsible for reviewing the fire and disaster policies to become familiar with their duties in the event of an emergency.

Insure that all employees are properly trained at time of hire in the use and location of fire extinguishers. Annual training is also required.

PROCEDURE

In the event the fire alarm is activated:

- Rescue any residents in immediate danger. Check for visitors in the building.
- Isolate fire by closing doors.
- If a fire is suspected, pull handle of nearest red alarm box. The alarm box alerts the fire department.
- Report the location of fire, inform them of the number of residents and staff in the building.
- In the area designated as the location of the fire, remove those residents to the common dining area opposite the fire location.
- If the fire is controllable (small), attempt to extinguish. Do NOT return inside the residence to do this).
- Evacuation of residents is most important!
- Monitor resident and staff head count.

The is a resident list at the Resident Care office for checking off the names of the residents as they are taken out of the danger area.

DO NOT PANIC, REMAIN CALM, REASSURE THE RESIDENTS

FIRE DRILL

Employee Duties

DAY & PM SHIFTS

When the fire alarm sounds:

- ✓ The person finding the fire SHOULD EVACUATE the RESIDENT in the fire area out to safety.
- ✓ East side Med Tech goes to the annunciator panel outside the front door to IDENTIFY which zone is INDICATED, then check THE ZONE CHART IN THE TIMECLOCK ROOM. THE CHART IS ON THE BOARD AS YOU ENTER THE TIMECLOCK ROOM.
- ✓ All caregivers go the end of the hallway, start evacuating the residents to the appropriate location.
    - o If the fire is in the hallways (ZONES 4 OR 5), bring the residents to the common/dining room area
    - o If the fire is in the middle of the building (ALL ZONES EXCEPT 4 OR 5), take the residents to the atriums.
- ✓ The West side Med Tech is responsible for using the resident list to check out who is accounted for IF RESIDENTS ARE EVACUATED TO THE COMMON AREA.
- ✓ BOTH MED TECHS SHOULD HAVE A CHECK LIST WHEN RESIDENTS ARE EVACUATED TO THE ATRIUMS.
- ✓ Housekeeping and Dietary staff are responsible for making sure that the residents do not leave the common area OR ATRIUMS to return to their rooms. They are also to assist in getting the residents from their rooms to the common area OR ATRIUMS.
- ✓ (STAFF) IS TO BE SURE NO RESIDENTS GO OUTSIDE OR ARE LEFT OUTSIDE DURING A FIRE ALARM.
- ✓ (STAFF) IS TO WATCH THE DOOR WITH A KEYPAD AT THE LOBBY AND THE SIDE GATE WITH A KEYPAD: THESE ARE NOT ARMED DURING A FIRE ALARM.
- ✓ Wellness Director is to secure the medical records and medications. AND, supervise the orderly evacuation to the designated area.

NIGHT SHIFT

- ✓ The person locating the fire should evacuate the person in the room with the fire and those in each room on either side of the fire.
- ✓ The Med Tech will check the annunicator panel and make sure the front door is open.
- ✓ Then call Administrator
- ✓ All other employees are to evacuate the residents to the common area. The Med Tech is responsible for using the resident list to check that all residents are in a safe area or are accounted for

LABS & OUTSIDE MEDICAL SERVICES

POLICY

The resident will receive assistance with arrangements for outside medical services.

PROCEDURE

- ▪ Residents and responsible parties are informed to notify the Care Coordinator or Med Tech of any pending outside medical services.

- The scheduled service is calendared.

- Should the resident not have transportation, the CARE COORDINATOR arranges for with the family to arrange for outside transportation.

- If the resident is unable to be left without an escort, the family must accompany the resident or arrange for an escort.

- It is disclosed to the resident and responsible party upon admission, that off hour unscheduled or ambulance transportation is the financial responsibility of the resident.

- The Med Tech on duty at the time, instructs all labs reporting or transmitting values to directly transmit to the physician. Unlicensed caregivers may not take verbal lab values.

- The Care Coordinator reports abnormal lab values to the physician.

MEDICAL EMERGENCY

POLICY
The resident will receive emergency medical care when needed to prevent further injury or illness.

PROCEDURE

- Caregivers immediately summon the Med Tech or Care Coordinator should a resident exhibit signs and symptoms of a medical emergency.

- The Med Tech or Care Coordinator makes a determination as to the severity of the situation. In the event a nurse is not available, the administrator or caregivers make a determination.

- The facility summons emergency medical services (call 911), when the resident exhibits signs and systems of distress and/or emergency condition. Examples include, but are not limited to:
    - New onset of chest pain;
    - Recurrent chest pain, unrelieved in 15 minutes by previously ordered nitroglycerin given as ordered;
    - Unconsciousness;
    - Fall with deformity, severe pain or head injury;
    - Uncontrolled bleeding;
    - First time seizure;
    - Recurring seizure which last for more than 1 minute;
    - Sudden onset severe pain;
    - Shortness of breath;
    - Sudden lack of muscle control, ability to communicate, drooping facial expression or other signs of stroke;
    - Poisoning;

- Fever which is not lowering despite interventions and fever reducing agents;
- Choking;
- Psychiatric crisis.

An exception is made when the resident is receiving Hospice services. If the Hospice nurse is present
then staff is not required to call 911. However, the nurse must be in full agreement that summoning emergency medical services is not a necessity.

- A non-emergency transport is only used when the resident needs urgent but non-emergency medical care, such as stitches, controlled bleeding, etc.

- The Hospice nurse contacts the family/responsible party, as quickly as possible, once the resident is safely under the care of the paramedics. Unless instructed otherwise by the family/responsible party, this includes anytime, 24-hours a day.

- The nurse or caregivers are not required to obtain permission from the family/responsible party before summoning emergency medical services.

- A staff member remains with the resident until paramedics transport out of the facility.

- A copy of the current MAR is given to the paramedics, along with the Emergency Identification Form.

- The actual medications are retained in the facility.

- The staff person observing the transport out of the facility will note what belongings are going with the resident, such as jewelry, dentures, prosthetic devices, etc.

- A narrative chart entry is made in the resident's chart regarding the circumstances which led up to the call (Data), what care was provided by the staff, including any first aid (Action), as well as the resident's response to the action (Response).

- An Incident Report is completed if the medical emergency is the result of a fall, accident, or other incident requiring the report.

OXYGEN POLICY

POLICY

The Facility provides care to those residents who utilize oxygen by either concentrator or tanks. The facility will send available tanks with the resident if evacuation is indicated.

Should there be a power outage of any type, the caregivers will immediately check on the oxygen-dependent residents. If necessary, the resident will be changed from concentrator use to the portable tank during the duration of the power outage.

PHYSICIAN VISITS

POLICY
The resident will receive assistance in obtaining necessary medical care.

PROCEDURE

- The Med Tech and Care Coordinator are responsible to notify the physician of any medical conditions requiring an office visit.

- The scheduled physician visits are entered on the physician appointment calendar.

- The following accompanies the resident on all physician visits:
  - Physician Visit form.
  - Photocopy of current MAR (originals are never sent).
  - Any other requested documentation.
  - The Physician Visit form is returned to the facility and all orders transcribed by the RCC.

- Family/responsible party may transport the resident to appointments. The Med Tech instructs caregivers to have the resident appropriately dressed and ready for transport.

- Should the resident not have transportation, the Care Coordinator arranges for necessary transportation.

- If a resident is unsafe to be left without an escort, the family must accompany the resident.

- Should the Care Coordinator determine a resident is not stable, safe, or comfortable enough for van/car transportation, arrangements are made for ambulance transport.

- It will be disclosed to the resident/responsible party upon admission, that off-hour, unscheduled, or ambulance transportation is the financial responsibility of the resident.

POISON CONTROL

POLICY

The policy is to take prompt action to minimize any possible side effects that may occur in the event of accidental exposure or ingestion of any poisonous or hazardous substance, i.e., cleaning chemicals, etc.

In the event of any accidental exposure or ingestion of any hazardous or poisonous substance, the Supervisor in Charge or the Executive Director will:

Immediately call the **Poison Control Center at 800-672-1697.**

If possible, the Supervisor will identify the substance in question and save all containers and labels that describe the suspected poisoning agent. Any vomit should also be saved. If the container has poison control instructions, these should be followed immediately.

Send the resident out to the hospital via 911 call. Send a copy of the MSDS sheet that pertains to the agent that was ingested

The Supervisor should then contact the resident's attending physician and advise what has occurred and advise that resident had been sent out to the hospital.

If an employee has ingested the poisonous substance, send them directly to the hospital.

The Administrator must document in the resident's chart:

- Any orders and follow-up from the Poison Control Center and/or physician.
- Notify the attending physician and give report of what has transpired.
- Notify the resident's family or responsible party.

All procedures must be followed relative to filing the Unusual Incident Report. The Bureau of Health Care Quality & Compliance should be notified.

PHYSICIAN ORDER FOR LIFE SUSTAINING TREATMENT
POLST POLICY

POLICY

A POLST order does not direct health professionals working in the facility or any staff member to withhold all emergency care. The resident should receive all medications, treatments and any other care as ordered by the physician, as well as all emergency first aid care as necessary. Any necessary transfer to a higher level of care (acute hospitalization) should take place as necessary.

This policy shall at all times be available for review by the licensing agency and its representatives.

A resident requesting a POLST order be implemented will be directed to obtain the directive from the State with the assistance of their MD. No agent or employee of the facility shall sign, witness or be legally recognized as a surrogate decision maker for the resident's POLST order.

A copy of the POLST order will be placed in the resident's file and in their room. Note: this is confidential information and must not be posted in a conspicuous place for visitors or other residents to see.

A "POLST" sticker or notation will be placed:

- on the outside of the resident's file
- on the resident's medication administration form

A list of all residents with a current valid POLST order will be available in the Med Room office.

In the event of a crisis, emergency medical services should be immediately summoned for the resident. When the emergency medical service personnel arrive they should immediately be presented with the resident's POLST order.

PRE-ADMISSION ASSESSMENT

POLICY

The Administrator and/or Care Coordinator will gather data on each potential resident to determine the need and type of services to be provided.

PROCEDURE

The Care Coordinator meets with the residents and/or family, prior to placement, and to assure assessment is complete and correct.

The Care Coordinator begins the pre-placement meeting with proper introductions and explanations to promote a milieu of trust, comfort, and honesty. Open-ended questions are encouraged. Consent is obtained for the appraisal.

- Explain the purpose of the appraisal is to determine the level and type of services that will be available for the resident at the time of move-in, as well as to meet state licensing requirements. Assure the resident and/or family that honesty and detail regarding care needs is in the best interest of the resident.
- Communicate acceptance by use of proper body posture, nods of understanding and allowing the resident ample opportunity to answer questions.

The Care Coordinator reviews the Physician Report for any prohibited conditions or communicable illness.

- The verification of absence of TB must be evidenced by a negative PPD and verified by an MD or chest x-ray within the last six months read for TB.

The physical assessment will include a review of body system. A skin check is conducted or verification of absence of skin breakdown from the physician.

The medication review will include the following:

- Ask the resident to show you all of the medications currently used. If the medications are not physically present, ask the resident / responsible party to provide a list and dosing of the medications.
- A physician order is obtained prior to admission day, verifying medications and dosing schedule.
- Specifically ask about the use of OTC (Over-The-Counter) medications. Note any preferred OTC medications to ensure physician orders are secured prior to admission.
- When OTC medications are centrally stored, a physician order is required for all routine medications prior to assisting with the medication.
- When the OTC is a PRN and centrally stored, the following must be included in the physician order:
    - Name of drug
    - Strength of drug
    - Dosage
    - Exact time frames between doses
    - Maximum dose in a 24 hour period
    - Symptoms for which the medication is used

Information regarding alcohol consumption is obtained.

Discuss and note any problematic drugs the resident has used in the past.

Care Coordinator communicates immediately with the administrator regarding discovered prohibited health conditions and/or residents significantly at risk. See Chapter 449 requirements related to prohibited health conditions.

UNIVERSAL PRECAUTIONS / INFECTION CONTROL

POLICY

"Universal Precautions" refers to infection control measures that all health care workers must follow with the goal of protecting themselves and residents from disease-producing microorganisms. The concept requires workers to treat all blood and various other bodily fluids as if infected with HIV, hepatitis B virus, and other bloodborne pathogens.

In very rare circumstances, contact with blood or other body fluids can be a means of infection transmission. Thus, universal precautions should be considered an important component of staff and volunteer training and education. All people who work in a healthcare setting must understand the proper precautions to take to prevent the spread of infection.

Following are the basic principles of universal precautions:

Contact with blood must be avoided.

If a resident cuts himself, or sustains a skin tear, staff should be mandate, direct and assure that no one touches the blood. In the administration of first aid, there must be a physical barrier between the person assisting the resident and the blood. Examples of barriers include towels, bandages, or other accessible first aid equipment. Gloves must be readily accessible, and should be provided throughout the facility.

All body fluids (except sweat) should be considered potentials for infection.

Blood is the major risk for transmission of the serious bloodborne infections like HIV and hepatitis B. Contact with urine and stool should be avoided, because other pathogens (such as CMV or diarrhea causative agents) can be spread via these fluids. Saliva and spit, and nasal drainage are major ways respiratory viruses are spread. Tears are not a major source for infection, and sweat is not considered a risk.

Universal Precautions Applies to Everyone

The term "universal precautions" emphasizes that infection control measures apply to everyone. Many persons can harbor infectious agents and be asymptomatic and unaware. Confidentiality mandates that staff may not be aware of an individual's diagnosis. Universal precautions assure that all persons are treated equally.

Specific examples of prevention measures:

Injury involving bleeding: Do not touch the blood; use a barrier to stop the bleeding and cover the injury. Use gloves if first aid is indicated (make sure to inquire about latex allergy first).

Urine or loss of stool or vomit: Do not touch urine, stool, or vomit. Clean up the resident and area as appropriate. If the environment needs cleaning, wear gloves and use a cleaning solution.

Use of restroom: Staff should wash hands with soap for 30 seconds after use of restroom or helping a resident use the restroom.

Resident Hand washing: Residents should wash their hands with warm water and soap prior to each meal, following meals and after using the restroom.

The facility provides annual training for employees about universal precautions and utilization of proper equipment. Such equipment must include: gloves, goggles, gowns, footwear, antibacterial soap, proper handling, disposal and proper handling of residents in isolation.

Knowledge, preparation, and attention to detail can help to ensure a safe environment for residents and staff. Applying basic universal precautions will minimize risks of infection transmission and contribute to the safe environment for everyone.

Glossary of Related Terms

Bloodborne pathogens: pathogenic microorganisms that are present in human blood and cause disease in humans. These pathogens include, but are not limited to, hepatitis B virus and HIV.

Contaminated: the presence or reasonably anticipated presence of blood or other potentially infectious materials on an item or surface.

Contaminated sharps: a contaminated object that can penetrate the skin including needles, scalpels, or broken glass.

Decontamination: using physical or chemical means to remove, inactivate, or destroy bloodborne pathogens on a surface or item until it is no longer capable of transmitting infectious particles and the surface or item is rendered safe for handling, use, or disposal.

Engineered controls: controls (e.g., sharps disposal containers, self and sheathing needles) that isolate or remove the bloodborne pathogen risk from the workplace.

Exposure incident: specific eye, mouth, or other mucous membrane, non-intact skin or arenteral contact with blood or other potentially infectious materials that results from the performance of an employee’s performance.

Occupational exposure: reasonably anticipated skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials that may result from the performance of an employee's duties.

Other potentially infectious materials: The following human body fluids: semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, any body fluid that is visibly contaminated with blood, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids; (2) Any unfixed tissue or organ (other than intact skin) from a human; and (3) HIV-containing cell or tissue cultures, organ cultures, and HIV- or HBV-containing culture medium or other solutions; and blood, organs, or other tissues from experimental animals infected with HIV or HBV.

Parenteral: piercing mucous membranes or the skin barrier through such events as needle sticks, human bites, cuts, and abrasions.

Universal precautions: an approach to infection control whereby all human blood and certain human body fluids are treated as if known to be infectious for HIV, HBV, or other bloodborne pathogens.

Work practice controls: controls that reduce the likelihood of exposure by altering the manner in which a task is performed.

WANDERING POLICY

POLICY

Our policy is to identify residents who walk or wheel about unrestricted and are a threat to leave the facility unattended without the knowledge of the facility staff due to their confusion.

PURPOSE

To ensure the resident's safety utilizing the least restrictive means available.

PROCEDURE

- Obtain information prior to admission regarding any history of wandering or the potential for wandering.
- All instances of wandering or attempted elopement will be recorded in the medical record.
- A plan of care will be developed and implemented with specific approaches and goals for the wanderer.
- The resident's name, picture, and physical description will be placed in the resident chart located at the resident assistant station.
- All staff is responsible for knowing whose name is on the list and be able to recognize the resident and be able to intervene as necessary.

WHEN A RESIDENT IS BELIEVED TO BE MISSING, THE FOLLOWING STEPS WILL BE IMPLEMENTED:

- The Care Coordinator shall be alerted that the resident is missing. The Care Coordinator shall alert all staff. All employees are to report to the resident assistant station. The Care Coordinator will explain the circumstances and designate where each staff person is to search.
- Search the building and grounds thoroughly. Be sure to search the shower room, closets, bathrooms, and entryways.
- If this search is unsuccessful, surrounding streets and yards will be checked. This search should take no longer than 15 minutes.
- Notify the Administrator and the local Police.
- Give the police a description and a current photo of the missing resident.
- The Administrator shall call the family explaining the situation and what is being done to find the resident. Encourage them to assist if they desire.
- When the resident is located, the Administrator will notify all previously contacted persons, notifying of them that the resident has been located.

- Upon return of the resident to the facility, the resident will be assessed for injuries and documented in the resident's medical record.
- A thorough incident report will be filled out by the Care Coordinator and given to the Administrator.
- Administrator will notify the appropriate State personnel.

WANDERING OR MISSING RESIDENT

POLICY

The facility will provide supervision to promote a safe environment for residents as risk for injury due to wandering or elopement behaviors.

KEY POINTS

- Wandering behavior is characterized as "aimless" – appears to have no purpose
- Wandering exhibited by residents who are cognitively impaired can put the resident at risk for harm
- The resident who exhibits aimless movement may "wander" off the unit, into other resident's space, out of the building, or off the facility property
- Whenever a resident leaves facility property, unaccompanied by staff or family members, without notifying the facility staff, an elopement has occurred
- Residents who "elope" from the facility may or may not be cognitively impaired.
- The potential for harm to the resident who wanders or elopes increases with the
- extent of cognitive impairment

WANDERING RESIDENT

- If a resident repeatedly wanders off the premises, the Care Plan should reflect a monitoring schedule to ensure resident safety
- The monitoring schedule is determined according to the resident's wandering pattern
    - Determine the time of day and other conditions that seem to contribute to wandering behavior such as specific events (following family visits); or such as "going to work" or "going home", etc.
    - From the conditions that appear to accompany the behavior, establish a pattern for when and under what conditions the wandering behavior might occur
    - Establish a monitoring system based on the individual resident's pattern for wandering behavior including a method for documentation of the monitoring

MISSING RESIDENT

- On suspicion that a resident is missing, immediately notify the Care Coordinator.
- The supervisor and staff initiate a search throughout the building and grounds
- If resident is not found after searching for 15 minutes:
    - Contact family, administrator on-call, and police immediately
    - Staff assist police and family as needed
    - All staff within the long-term care facility may be called on to assist in the search as necessary
    - Document events
- Each time a resident wanders out of the facility or "elopes" from facility property, an Incident Report form should completed and forwarded to the Administrator.
- The Care Coordinator will be responsible for tracking wandering behavior, identifying residents who may be at risk for harm, and reviewing wandering occurrences.
- The Safety Committee will assist in developing interventions and making recommendations to interdisciplinary care plan committee. A psychological or psychiatric consult may be beneficial in identifying individualized interventions

WANDERING RESIDENT MONITOR

Resident Name: _____ Rm. #: _____ Date:

This resident's location should be visually monitored every 15 minutes on ALL shifts.

Other (Explain)

_____

Enter the appropriate location code next to the time and initial:

Legend					
RR Resident Rm	**SR** Shower Rm	**AR** Activity Rm	**RB** Res Bath	**L** Lobby	DR Dining Rm

6 to 2	CODE	INITIAL	2 to 10	CODE	INITIAL	10 to 6	CODE	INITIAL
6:00AM			2:00PM			10:00PM		
6:15			2:15			10:15		
6:30			2:30			10:30		
6:45			2:45			10:45		
7:00AM			3:00PM			11:00AM		
7:15			3:15			11:15		
7:30			3:30			11:30		
7:45			3:45			11:45		
8:00AM			4:00PM			12:00AM		

8:15			4:15			12:15		
8:30			4:30			12:30		
8:45			4:45			12:45		
9:00AM			5:00PM			1:00AM		
9:15			5:15			1:15		
9:30			5:30			1:30		
9:45			5:45			1:45		
10:00AM			6:00PM			2:00AM		
10:15			6:15			2:15		
10:30			6:30			2:30		
10:45			6:45			2:45		
11:00PM			7:00PM			3:00AM		
11:15			7:15			3:15		
11:30			7:30			3:30		
11:45			7:45			3:45		
12:00PM			8:00PM			4:00AM		
12:15			8:15			4:15		
12:30			8:30			4:30		
12:45			8:45			4:45		
1:00PM			9:00PM			5:00AM		
1:15			9:15			5:15		
1:30			9:30			5:30		
1:45			9:45			5:45		

VISTA ADULT CARE RESIDENT (Patient) SAFETY PLAN

INTRODUCTION

VISTA ADULT CARE has established a strong commitment to Resident Safety and Quality. Our Resident Safety program is designed to align and support our mission, vision and values and our philosophy of resident and family centeredness.

Appropriate policies and procedures have been developed, implemented and evaluated to meet these requirements. The primary focus of this plan is on preventing harm, and promoting the safety of all residents, visitors, volunteers and health care workers.

GUIDING PRINCIPLES

All staff, volunteers, residents, families and their support persons are accountable and have a role to play in residents' safety.

Resident safety is not a "stand alone" program; their accountability is rooted in practice, approach to policy, how we approach and manage adverse events for the purpose of mitigating future risk and continually improving care and service.

Implementation of this plan is dependent on integrating validated safe practices in the facility.

Safety is promoted through organization culture with the goal of developing an environment that is trusting and just for all.

A safe and secure work environment for staff and volunteers contributes to safe resident's care.

OVERVIEW

Vista Adult Care promotes an organizational safety culture that:

- Encourages recognition, reporting, and acknowledgement of risks, near misses, and resident safety events.
- Initiates/monitors actions to reduce the risk of resident safety events.
- Promotes a non-punitive just culture environment for reporting and follow-up of safety events.
- Supports staff who have been involved in a resident safety incident
- Educates staff to ensure participation in the program
- Ensures that all residents/families are informed about the results of care, including unexpected outcomes and safety incidents.
- Ensures that residents/families are aware of safety practices and expectations and feel encouraged to ask for clarification of process or procedure.

SCOPE OF THE PROGRAM

1. Quality indicators of resident's safety:

- Medication incidents
- Facility acquired infections
- Resident's falls
- Use of restraints

- Visitor safety
- Employee safety
- Immunization programs
- Medication Reconciliation at Admission, Transfer and Discharge

2. Data from environmental safety issues such as:

- Product recalls/safety alerts
- Drug recalls/safety alerts
- Product/equipment malfunction
- Air quality
- Disaster planning
- Security incidents
- Workplace violence

3. Data from external sources such as:

- Institute for Safe Medication Practices (ISMP)
- Accreditation in Nevada
- Occupational Safety and Health Administration (OSHA)
- Institute for Healthcare Improvement (IHI)
- Institute for Patient and Family Centered Care (IPFCC)
- National Association of Pharmacy Regulatory Authorities (NAPRA)
- Better Outcomes Registry & Network (BORN)

Key Outcomes:

1. A culture of resident's safety
2. Key stakeholders are engaged
3. Performance is monitored, measured and reported
4. Staff and residents/families impacted by resident safety incidents are supported
5. Resident's Safety is aligned with the Quality Improvement Plan (QIP) and Strategic Plan
6. Systems/procedures are designed to improve reliability and incident prevention.

Responsibility:

It is the responsibility of the Residential Facility Administrator (Evangeline Molino) & Facility Manager (Leoncio Molino) to implement the plan by assigning responsibility for leading resident's safety improvement activities, providing direction, and monitoring progress and outcomes.

Steps:

The next two years (2021-2022) will focus resources, energy and improvement in the following key areas as we continue to build and sustain a culture of resident's safety:

- Medication Reconciliation
- Unit dose medication packaging

- Resident's receiving complete and accurate information at discharge
- Initiatives to meet the needs of the complex, frail, vulnerable residents.

Continue to Monitor:

- Antimicrobial Stewardship
- Hand Hygiene Compliance
- BORN Surveillance

Priority Goals:

As part of the facility's commitment to residents and staff safety, the following goals will be the focus of the 2021-22 fiscal years.

Medication Reconciliation Goal:

To ensure a complete and accurate medication reconciliation (med rec) for all admitted, transferred and discharged residents

MedicationSafety Goal:

To ensure facility and the pharmacy meet the NAPRA standards for all identified medications has been implemented and complete as early as possible.

Hand Hygiene Goal:

To continue to improve hand hygiene compliance, thereby decreasing facility acquired infections, keeping our residents and staff safe. Steps/Action Responsibility Outcomes/Monitoring Timeline Audits will be done on a regular recurring basis by the Infection Control Practitioners (ICP). Hand hygiene rates,

and other infection control indicators, will be posted quarterly on White Boards for staff and public to view Moment 1 (before pt care) audits will be increased on resident's room and posted separately for staff and public to view. Hand hygiene rates will be reviewed monthly and reported to Residential Facility Administrator.

Develop initiatives to meet the needs of the complex, frail and vulnerable residents Goal:

To ensure we meet and exceed the needs of the complex, frail vulnerable patients, preventing or minimizing safety events Steps/Action Responsibility Outcomes/Monitoring Timeline Move to Improve A strategy implemented by Residential Facility Administrator that helps to improve the health and well-being of the people we serve.

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Banner Health

Title: **Banner Health System Quality and Safety Plan**	
Number: 778, **Version**: 19	**Original Date**: 09/19/2002
Effective: 11/04/2021	**Last Review/Revision Date**: 10/8/2021
Next Review Date: 11/1/2023	**Author**: Christina Forman-Goerke (Care Management)
Approved by: Banner Health Board of Directors Quality Committee, Administrative Policy Committee, Chief Clinical Officer, Clinical Leadership Team, Harm Avoidance Team, PolicyTech Administrators	

Discrete Operating Unit/Facility:
Banner Baywood Medical Center
Banner Behavioral Health
Banner Boswell Medical Center
Banner Casa Grande Medical Center
Banner Churchill Community Hospital
Banner Del E Webb Medical Center
Banner Desert Medical Center
Banner Estrella Medical Center
Banner Fort Collins Medical Center
Banner Gateway Medical Center
Banner Goldfield Medical Center
Banner Heart Hospital
Banner Ironwood Medical Center
Banner Lassen Medical Center
Banner Ocotillo Medical Center
Banner Payson Medical Center
Banner Thunderbird Medical Center
Banner—University Medical Center Phoenix
Banner—University Medical Center South
Banner—University Medical Center Tucson
Community Hospital
East Morgan County Hospital
McKee Medical Center
North Colorado Medical Center
Ogallala Community Hospital
Page Hospital
Platte County Memorial Hospital
Sterling Regional Medical Center
Washakie Medical Center
Wyoming Medical Center

Banner Corporate

Ambulatory Services
Banner Health Clinics
Banner Imaging Services
Banner MD Anderson Cancer Center
Banner Surgery Centers
Banner Urgent Care Centers
Occupational Health/Employee Services
Rural Health Clinics

Banner Pharmacy Services

Insurance
Banner Health Network
Banner Plan Administration
University Physicians Health Plans

Research

I. Purpose/Population:

A. The purpose of the Banner Health Quality and Safety Plan is by design to outline Banner Health's commitment and systematic approach to quality and patient safety at all levels of the organization consistent with its Mission, Values, and Purpose. Banner Health's quality goal is to continuously improve and increase reliability of our processes and outcomes for the safety and betterment of our patients and other customers, our providers, our partners, our communities and ourselves.

B. **Population**: All Employees.

C. Mission: Making health care easier, so life can be better.

D. Values:

1. **Customer Obsessed**
   a. Puts the need of the customer and team at the center of decision making
   b. Demonstrates empathy and compassion
   c. Seeks to consistently enhance interactions and experience by exceeding customer and team member expectations
   d. Thinks creatively about solutions and takes ownership
   e. Is passionate about exceptional patient care
2. **Relentless Improvement**:
   a. Takes action that influences and motivates others
   b. Instills positive energy and builds a shared vision and purpose
   c. Ensure that the results of the collective effort aligns with objectives and goals
   d. Uses data to drive streamlined decision making while also considering the impact on our Mission, people and culture
   e. Effectively utilizes the organization's decision-making process and knows when to collaborate, question or empower
3. **Courageously Innovate**
   a. Identifies opportunities to create value by introducing new ideas and driving change
   b. Sees possibilities that don't currently exist
   c. Takes risks and challenges the status quo with the intent to strengthen team and organizational performance
   d. Leverages knowledge and technology to enrich the patient and team member experience and facilitate speed, simplicity, and efficiency
4. **Disciplined Focus**
   a. Is able to assess what is important, balances priorities and creates a clear and effective plan to drive desired outcomes
   b. Uses time management effectively and measures progress
   c. Embodies selflessness by always making the team and our Mission the priority
   d. Is constantly learning, adapting, and paying attention to details
5. **Foster Accountability**
   a. Takes responsibility and ownership for work
   b. Actively resolves problems individually and as part of team
   c. Addresses performance issues with systems and people as opportunities to achieve excellence
   d. Recognizes and reinforces success and establishes processes for sustainability
   e. Maintains a team focus and role models servant-leadership
6. **Continuously Earn Trust**
   a. Fosters strong and authentic relationships in every interaction by demonstrating honesty, respect and assuming positive intent.

b. Actively listens to the needs of others, and follows through on commitments
c. Creates an open culture of communication that honors the truth and values diverse input

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

II. Definitions:

A. Facility – Any Banner Health hospital, ambulatory surgery center, physician/provider office, home health, hospice, skilled nursing facility, clinic, urgent care, imaging center where care is provided which Banner wholly owns or partially owns in which Banner Health is responsible by agreement to provide quality management oversight.

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

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

D. Quality Management – For the purpose of this plan, "Quality Management" includes activities and/or programs such as Quality Assurance, Quality Improvement, Clinical Process Improvement that are designed and implemented to improve the delivery of care and services.

III. Policy:

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

B. Quality Authority/Responsibility
1. Governance.
The Banner Health Board of Directors has the ultimate responsibility and accountability for quality of care and services provided by Banner Health.
a. The Care Management and Quality Committee of the Board and the Clinical Leadership Team serve as the oversight bodies for quality management and have the following duties and delegated responsibilities:
i. Monitor non-financial measures of organizational quality performance.
ii. Ensure use of a systematic approach to quality management and assess ongoing improvement in the quality of services delivered by the corporation.
iii. Review and make recommendations to the Board regarding a system-wide quality plan.
iv. Evaluate and make recommendations to the Board concerning healthcare technologies including, but not limited to, genomics, biotechnology, future clinical services delivery, and therapeutics.
v. Evaluate and make recommendations to the Board with respect to ethical implications relating to the activities and services of the corporation, including quality and clinical innovation.

vi. Review reports regarding the quality of care being provided in respective Facilities.
vii. Perform such other duties and responsibilities as the Board may assign to the Committee from time to time.

b. The Care Management and Quality Committee and the Medical Staff Subcommittee of the Care Management and Quality Committee serve as the oversight bodies for quality management activities pertaining to the acute care hospital medical staffs and have the following duties and delegated responsibilities.
   i. Act for the Board with respect to proposals of management and the local institutions and their medical staffs concerning medical staff policies, patient care policies, and compliance with standards of government and accreditation agencies having jurisdiction over the corporation's institutions as to such policies which require the involvement of the Board of Directors.
   ii. Act for the Board of Directors on matters and activities pertaining to the medical staffs of each local institution operated by the corporation to the extent permitted by law and applicable accreditation standards, including any matter which requires action by the Board of Directors, including the adoption, amendment or repeal of medical staff bylaws, rules and regulations, and medical credentialing criteria.
   iii. Act for the Board of Directors to the extent permitted by law and applicable accreditation standards, and otherwise make recommendations to the Board of Directors on any matter affecting medical staff membership or privileges, including application for appointment to the medical staff; application for reappointment to a medical staff; request for delineated clinical privileges; and denial, curtailment, limitation or revocation of any of the foregoing.
   iv. Review reports regarding the quality of care being provided in respective Facilities.
   v. Perform such other duties and responsibilities as the Board may assign to the Committee from time to time.

c. In some communities, Advisory Boards provide advice and counsel to management and medical staff leadership on a variety of issues, including quality and safety activities and outcomes.

2. Leadership.
   a. Leadership is responsible for setting organizational direction and does this through the establishment of mission, values, and purpose, including annual initiatives. These are turned into actions though the development and execution of the strategic and operational plans that include quality of services and patient safety. Senior leadership communicates organizational direction, reviews and approves plans, provides resources and structure for the execution of the plans, and reviews performance to meet the goals of the plan.
   b. At Banner Health, Care Management provides oversight for improvement of clinical care and patient safety coordinated across the system. The Clinical Leadership Team, a group of Banner Health Leaders representing patient care and supporting functions, makes decisions related to system-wide quality and safety goals and activities to achieve those goals.
   c. Leadership for Facility activities related to quality of services and patient safety is directed by Facility administrative teams working with leaders under the oversight of the Quality Council structure. (See ***Figure 2: Banner Facility Quality and Safety Structure Template***)
   d. Quality Councils are responsible for the oversight of:
      i. Quality Leadership:
         (i) Development and prioritization of Facility quality and patient safety goals and targets in an annual work plan.
         (ii) Facilitation of ongoing quality and patient safety education.
         (iii) Communication of the quality and patient safety commitment, goals, targets and performance.
         (iv) Alignment of policies with quality and patient safety commitment.
         (v) Establishment of an engaged workforce.
      ii. Quality Management:
         (i) Identification of patients and other customer needs.

(ii) Identification of key processes; standardization and simplification.
(iii) Establishment of measures and monitoring.
(iv) Assessment and analysis of processes and outcomes.
(v) Identification of improvement opportunities.

iii. Performance Improvement:
(i) Evaluation and prioritization of improvement opportunities.
(ii) Identification and replication of proven or evidence-based practices.
(iii) Clinical Innovation through the rapid identification and deployment of strategies based on the science of care delivery.
(iv) Allocation of resources for improvement.
(v) Celebration of success.

iv. Evaluation
(i) Evaluation of this plan occurs at the local and system levels. Locally, each Facility reviews its progress towards goals identified in the annual work plan using data that measures clinical, financial, resource utilization, and service performance. To assure sustained improvement, this process includes a review of how improvements have been made and will be maintained. Additionally, leaders evaluate their own performance in supporting sustained improvement. Areas failing to meet targets become areas of focused improvement activities. At the system level, performance information is regularly aggregated for review by leadership and governance.

3. Process Owner/Department Managers.
   a. Process owners, individuals who serve in a leadership role in the performance of a process, are responsible for understanding patient and other customer needs, analyzing the processes used to meet those needs, standardizing and simplifying them to reduce variation and waste, measuring important indicators, and using this data to determine appropriate improvement actions based on the organization's goals.

4. Employees, Contacted Staff and Volunteers.
   a. To assure that the organization meets the needs of its patients and other customers as they interact with nursing and other clinical staff as well as support staff, leadership has committed to developing an engaged workforce (staff, contracted staff and volunteers) who:
      i. Understand job expectations and responsibilities, including service standards;
      ii. Have access to information to determine if patient and other customer needs are being met and understand how to respond quickly to resolve problems;
      iii. Are provided opportunities and skills for meaningful involvement in improving operations;
      iv. Recognize the need to work together to meet patient and other customer needs; and
      v. Know how to identify and report incidents.

5. Medical Staff
   a. Providers fulfill their Medical Staff delegated peer review responsibilities and take a leadership role in quality and patient safety activities. Medical Staff Departments and Committees routinely review clinical performance measures and identify improvement opportunities. Medical Staff leaders partner with administration in the leadership of quality management though routine interaction with administrative leaders and also serve on Quality Councils. In addition, providers serve in various capacities as team members, collaborating with other members of the health care team, to monitor and improve processes.
   b. The Board of Directors has delegated responsibility for review of professional practices to the medical staffs as set forth in the Medical Staff Bylaws. The Medical Executive Committees report on their performance of these responsibilities to the Board through the Medical Staff Subcommittee of the Care Management and Quality Committee of the Banner Health Board.

6. Risk Management
    a. Risk Management conducts activities intended to improve the quality of care and reduce errors and omissions. Risk Management may report trends and concerns relating to individual physicians and allied health providers to the appropriate Medical Staffs to determine whether peer review is warranted. Risk Management may report other trends and concerns to the appropriate subcommittee of the Clinical Leadership Team.

C. Quality Management is initiated as leadership sets organizational direction by planning and developing goals, including quality, patient safety and risk priorities that are based on continuous efforts to understand the needs of those we serve as well as improving current levels of performance, utilizing evidence-based best practices and external benchmarks. Areas identified for improvement and for achievement of the vision are called annual initiatives. Strategic and operational planning processes as well as proactive risk assessment and gap analyses are used to identify desired outcomes and actions to achieve those goals at various levels of the organization. Criteria used for establishing priorities may include, but are not limited to, clinical quality, patient safety, customer and team member satisfaction, strategic direction, financial sustainability, regulatory and accreditation compliance, resource utilization, high volume, high risk, or problem prone areas and external forces.

D. Process owners are expected to identify patient and other customer needs and expectations, understand key processes and safe practices, and establish performance measures for their areas of responsibility. Performance measures encompass different dimensions, including clinical outcomes, patient safety, evidence-based practice, utilization management, and patient satisfaction as well as financial sustainability, and are aligned from the system level (e.g., quarterly patient satisfaction with inpatient care) to the process level (e.g., daily feedback from patients in a nursing unit).

E. Appropriate improvement action is determined by analyzing and interpreting data over time, utilizing principles of variation. Process owners are responsible for standardizing and simplifying processes to increase reliability through the reduction of variation and waste. They are also responsible for proactively recognizing and implementing proven or evidence-based practices for existing processes, using current literature sources, and benchmarking activities internally and externally.

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

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

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

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

J. When current processes are not able to achieve customer expectations and/or established performance goals, new processes and services are designed and implemented utilizing evidence-based and innovative practices. A systematic approach involves multiple departments and disciplines working collaboratively, using information from patients, staff, payers, and others, along with current comparative information/data from other organizations.

K. Data for monitoring the effectiveness and safety of services and the quality of care at each Facility, including clinical outcomes, patient safety, evidence-based practice, utilization management and patient satisfaction, are collected and evaluated on an ongoing basis and reported up to governance for recommendations and actions on at least a quarterly basis.

L. All proceedings, records, and materials related to Quality Assurance/Quality Improvement/Clinical Process Improvement/Quality Management and peer review activities are confidential in accordance with federal and state laws. Meetings will be held in confidence and minutes will be maintained separately. Dedicated portals with restricted access will be created to allow the sharing of confidential information.

M. When performance issues may be related to the performance of a staff member, they will be handled through the appropriate Banner Health Human Resources policies and/or procedures.

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

IV. Procedure/Interventions:

A. N/A

V. Procedural Documentation:

A. N/A

VI. Additional Information:

A. N/A

VII. References:

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

VIII. Other Related Policies/Procedures:

A. Banner Health Annual Initiatives
B. Facility Work Plans
C. Event Reporting (#911)
D. Event Reporting Post-Acute (#7080)
E. Post Discharge Patient Complaint and Grievance (#1341)
F. Peer Review, Medical Staff (#760)

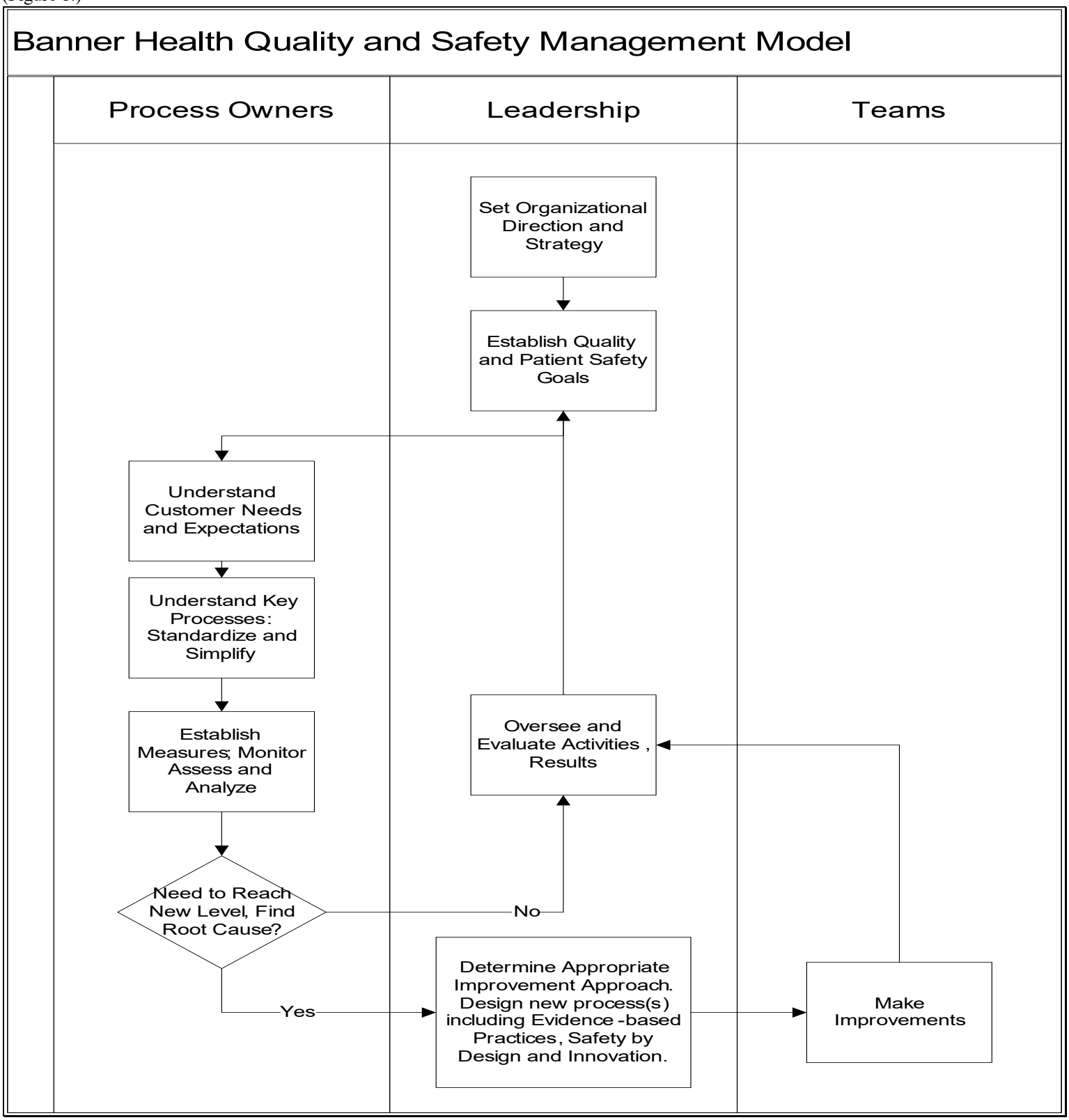
IX. Keywords and Keyword Phrases:

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

X. Appendix:

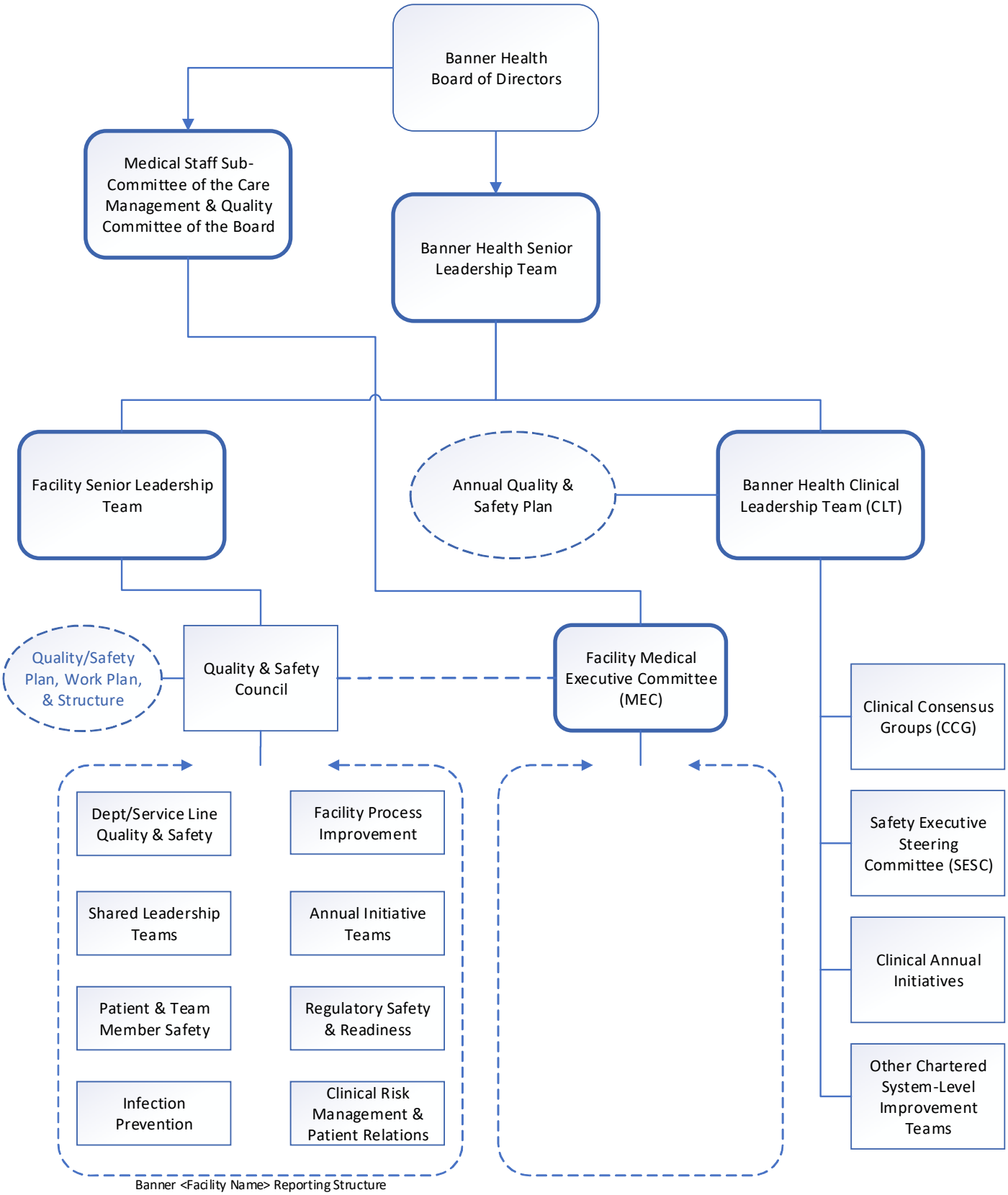
A. Figure 1: Banner Quality and Safety Management Model (See Section III.A: Appendix below)
B. Figure 2: Banner Facility Quality and Safety Structure Template (See Section III.B.2: Appendix below)

(Figure 1.)


Banner Health Quality and Safety Management Model
Process Owners
Leadership
Teams
Set Organizational Direction and Strategy
Establish Quality and Patient Safety Goals
Understand Customer Needs and Expectations
Understand Key Processes: Standardize and Simplify
Establish Measures; Monitor Assess and Analyze
Need to Reach New Level, Find Root Cause?
No
Yes
Oversee and Evaluate Activities , Results
Determine Appropriate Improvement Approach. Design new process(s) including Evidence -based Practices, Safety by Design and Innovation.
Make Improvements

(Figure 2.)

Banner Health <Facility Name> Quality and Safety Structure



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;

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 inappropriate 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 Performance	Surveillance, Prevention and Control of Infection
Leadership	

c. Assures:
   i. All departments have current Safety Manual available on-line
   ii. Emergency Preparedness Quick Reference Guide "Red Book" is available in high traffic areas
   iii. Senior Leaders are FEMA trained (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
   ii. Physician
   iii. Chief Nursing Officer/Patient Safety Officer
   iv. Pharmacy Staff Representative
   v. Human Resources Representative
   vi. Laboratory Representative
   vii. Long Term Care Representative
   viii. Acute Nursing Services Representative
   ix. Purchasing/Central Supply Representative
   x. Environmental Services Representative
   xi. Chief Executive Officer
   xii. Risk Manager
   xiii. Infection Control Nurse
   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;

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

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

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

VIII. Organizational Response

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

2. On an ongoing basis regarding job-related aspects of patient safety.

ii. Education and training will include:
1. The need and method to report medical/health care errors and other safety concerns;
2. Providing the optimal provision of healthcare in an interdisciplinary manner; and
3. An interdisciplinary approach to patient care.

g. Reporting
i. BCH values transparency working together as an organization accountable to the licensing and quality agencies as well as to our patients, staff, medical staff, volunteers and our community
ii. Medical/health care errors and occurrences, including sentinel events, will be reported internally and externally per hospital policy and through the channels established by this plan.
iii. External reporting will be performed in accordance with all state, federal and regulatory body rules, laws and requirements. Refer to House wide policy HWN 135 Reportable Events.
iv. Patient safety reports from the Safety Committee will be submitted to the Medical Executive Committee and the Quality Improvement Committee.
v. The Board of Trustees has the opportunity to review and ask questions during the monthly meeting as the minutes of committees are contained within the Medical Executive Committee minutes for approval by the board.

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, 10/21
	New Date:	Reviewed Date: 8/27/10
Title: Patient Safety Program	8/13/08	Pages 1 of 11 pages

PURPOSE:

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

- A Patient Centered approach to care
- Integration of safety priorities into all relevant organization processes, functions and services
- Recognition and acknowledgment of risks to patient safety and medical/health care errors
- The initiation of actions to reduce these risks
- The internal reporting of what has been found and the actions taken
- A focus on processes and systems, and the reduction of process and system failures.
- Minimization of individual blame or retribution for involvement in a medical/health care error
- Organizational learning about medical/health care errors
- Support of the sharing of that knowledge to effect behavioral changes in itself and other healthcare organizations

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

As we work toward Patient Centered Care, and therefore the maintenance and improvement of patient safety, it is a coordinated and collaborative effort. The approach to optimal patient safety involves all departments and disciplines in establishing the plans, processes and mechanisms that comprise the patient safety activities at Carson Valley Medical Center. The Patient Safety Program is developed by an interdisciplinary Patient Safety Committee and approved by the Governing Body and administration, outlines the components of the organizational Patient Safety Program.

PATIENT SAFETY PROGRAM:

Scope of Activities:

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

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

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

- Any Medication Error resulting in an adverse event

- Any Adverse Drug Reaction

- Any Transfusion Reaction

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

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

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

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

Reporting Requirements NRS 439.835 Appendix A:

1. Surgical or Invasive Procedure Events
   A. Surgery or other invasive procedure performed on the wrong site
   B. Surgery or other invasive procedure performed on the wrong patient
   C. Wrong surgical or other invasive procedure performed on a patient
   D. Unintended retention of a foreign object in a patient after surgery or other invasive procedure

E. Intraoperative or immediately postoperative/post procedure death in an ASA Class 1 patient

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

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

4. Care Management Events
   A. Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)
   B. Patient death or serious injury associated with unsafe administration of blood products
   C. Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting
   D. Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy
   E. Patient death or serious injury associated with a fall while being cared for in a healthcare setting
   F. Any Stage 3, Stage 4, or unstageable pressure ulcers acquired after admission/presentation to a healthcare setting
   G. Artificial insemination with the wrong donor sperm or wrong egg
   H. Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen
   I. Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results

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

6. Radiologic Events

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

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

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

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

- Ethics, Rights and Responsibilities
- Provision of Care, Treatment and Services
- Medication Management
- Surveillance, Prevention and Control of Infection
- Improving Organization Performance
- Leadership
- Management of the Environment of Care
- Management of Human Resources
- Management of Information

Methodology:

The Patient Safety Committee is responsible for the oversight of the Patient Safety Program. The Senior 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, coordinate, 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 Director of Risk/Quality, 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.

<u>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.</u>

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

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

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

- Contact the patient's family/caregivers to report the incident 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 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 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.

- 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. 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.

- 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, and describe the facts of the near miss on an occurrence report.

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 Council 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

Desert View Hospital
Risk Management/
Patient Safety Plan

Revised 1/2022 – Pahrump Nevada

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 a component listed Patient Safety Organization, the UHS Acute Care PSO, to further its commitment in promoting patient safety and assuring that UHS affiliated facilities remain at the forefront in the delivery of safe and effective clinical care. The Member Patient Safety Evaluation System (PSES) is utilized by Desert View Hospital to track safety information, generate Patient Safety Work Product (PSWP) analysis of safety and clinical performance, and promote best practices. The Risk Management/Patient Safety Plan ("Plan") provides the general framework to identify, manage, reduce, and eliminate patient safety risks.

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

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

GENERAL STATEMENTS ON GOALS AND OBJECTIVES

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

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

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

II. Mission and Vision

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

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

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

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

III. ROLES AND RESPONSIBILITES

A. Responsibilities for Patient Safety and Risk Management

Desert View Hospital has a designated Risk Director/Manager responsible for patient safety risk identification and reduction for their respective facilities. Desert View Hospital is required to submit scheduled reports to the Insurance Department describing patient safety risk reduction efforts associated with facility specific risk areas quantified against industry or established benchmarks to assess exposures. Reports are thoroughly reviewed and analyzed by Department risk staff to determine effectiveness and follow-through of identified corrective action plans.

B. Patient Safety

UHSD operates operate the UHS Acute Care PSO, a listed component Patient Safety Organization, to support the patient safety activities at STHS. UHSD and STHS have established Patient Safety Councils (PSCs) to support patient safety activities. Each PSC should ensure that their respective Patient Safety Plan is promoted and executed successfully. STHS has also assembled participants to serve in the Member Workforce and to utilize the Member PSES to generate PSWP and exchange analysis and recommendations with the Acute Care PSO Workforce. The main vehicles for these analytic activities occurring within the Member PSES include the Acute Care Division Corporate Patient Safety Council meetings and the member facility Patient Safety Council meetings. The Member PSES is made up of both electronic and physical spaces for the reporting, storing, and generation of PSWP, including secure SharePoint site, and other electronic databases (including but not limited to Riskonnect (STARS) and AMES/CCD/COE) to maintain and manage PSWP.

I. Desert View Hospital **Patient Safety Council**

Desert View Hospital has a Patient Safety Council (PSC) that meets on a regular basis and at least monthly.

Membership:

The committee core membership consists of 5 Key Members: (CEO, CNO, Physician, Risk, and Quality). The COO, CMO and Regional CMO are discretionary participants as applicable. The required members attend the meetings on a monthly basis. If a required member is absent, the facility makes a suitable replacement with someone that has authority to implement actions identified by the PSC.

Duties and Responsibilities:

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

- Issue Identification: The primary issue is the most important risk issue facing the facility and is determined by reviewing the facility's claims history, claims history

unique to UHS facilities, patient safety concerns, industry claims, and through discussions with the corporate risk staff. Other issues may be related to process and corporate initiatives

- Best Practice: Once identified, the primary issue is dissected to determine its component issues. For each component issue; a best practice is selected. Best practices represent the most appropriate method for performing the delineated process and should not be selected until the council is assured that it is truly the "Best Practice."
- Implementation: Implementation strategies are those methods used to put the best practices into place. Often this includes revising policies, education, newsletters, phone calls, meetings, formal training, etc. Responsible parties and dates for completion are identified to ensure success.
- Monitoring and Accountability: Monitoring is essential to ensure that the strategies identified have been effective. Improvement should be demonstrated statistically whenever possible.

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

II. Patient Safety Advisories

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

Desert View Hospital is required to address the Safety Watch newsletters via their Patient Safety Council, and this is evidenced in their monthly minutes. Responses to the Safety Watch are reviewed for the opportunity to generate a best practice to implement. In addition, Clinical Risk Alerts and Medication Safety Alerts are also formulated to apprise the facility of a specific safety issue that need to be assessed to prevent re-occurrence.

C. TERM Program

The facility has utilized its formalized risk management program identified as TERM, or the Technical Elements of Risk Management. Each element focuses on a separate organizational function and details specific strategies for managing risk in these areas. 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 UHS program. Although the TERM program uses the title "Risk Manager," this applies equally to Risk Directors.

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

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

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

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

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

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

Element VIII: UHS Acute Care Patient Safety Organization (PSO): Facilities will designate key individuals to serve as participants in each Facility's Member Workforce.

Element IX. Medication Safety Initiative: The medication safety initiative is geared toward preventing and responding to the accidental injury of a patient due to medical care or medical errors during the medication-use process. The mechanism used to drive the culture of safety is the Medication Safety Committee at each facility. The committee proactively assesses risk points at every level of the medication use cycle: procurement, storage, ordering/prescribing, transcription, distribution, preparation, dispensing, administration, documentation, and monitoring.

Workforce participants are expected to perform identified patient safety activities on behalf of their Facility and to make regular reports to the Acute Care PSO. Workforce participants will be trained in their responsibilities and must also understand and acknowledge their obligations, including maintaining the confidentiality of PSWP, as required by the Patient Safety and Quality Improvement (PSQIA), and of Protected Health Information, as required by the Health Insurance Portability and Accountability Act (HIPAA) and its regulations, and other federal and state laws.

D. AMES/CCD/COE

The AMES/CCD/COE 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. The facility enters incidents into AMES/CCD/COE through identification of the type of incident and characteristics of the event using risk parameters and outcomes. Additional information and self-analysis can be attributed to a department, physician, or individual, along with further details of the event. This allows the retrieval of information in a variety of ways for additional analysis and review.

E. 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 and corporate staff to identify causation factors associated with any reported event. The system also provides for the entry of details that will describe the event and liability concerns.

Trending of claim information is performed on a scheduled basis to operations leadership that includes metrics that assist in identifying strategies to facilitate risk

reduction efforts. Previous examples of this function include the formation of an OB HRU and Perioperative concepts. Quarterly reports should be provided by the facility's RM to the Governing Board of all claim's activities.

F. Event Notification Site

The Risk Management Department developed the Event Notification Site or ENS, a web-based system that allows for contemporaneous reporting of serious adverse events and key near miss sentinel events to facility and UHSD management. Updates to the event are reported in real-time to all identified facility and corporate stakeholders via the ENS. The corporate risk management staff reviews each ENS to determine its completeness; follow-up is to be completed within 45 days.

G. Root Cause Analysis

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

The Joint Commission's root cause analysis framework and action plan table should be used as reference. It contains analysis questions and guides the organization in the steps of a root cause analysis. Not all the questions apply to all the events or cases.

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

RCA Responsibilities

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

H. MEMBER PATIENT SAFETY EVALUATION SYSTEM (PSES)

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

I. Training and Education

Training is essential to successful implementation of the Patient Safety and TERM program. All facility risk managers undergo extensive orientation and education related

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

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

- Facility specific risk Issues
- Safety Watch newsletters
- AMES/CCD/COE Focus advisories
- Clinical Risk Alerts
- Medication Safety Alerts

IV. Patient Safety Priorities, Goals and Objectives for 2022

- **<u>Surgical and Procedural Safety</u>**
  - **Wrong Site Surgery (WSS)**
    - ***Goal***: A 50% reduction in WSS events for 2022. Ultimately, the goal is 0.
  - **Retained Procedural items (RPIs)**
    - ***Goal***: Prevent RPIs- a 50% reduction in RPIs with harm for 2022. Ultimately, the goal for RPIs is 0.

- **<u>OBHRU</u>**
  - **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.
    - ***Goal***: Increase the percentage of patients with QBL of 2000 ml who receive transfusions to ≥ 50%.
  - **Reduction / elimination of serious harm by utilizing an oxytocin checklist to decrease the percentage of full-term newborns with Apgars less than 6 at 5 minutes and / or requiring NICU admission.**
    - ***Goal:*** Reduce the number of full-term newborns requiring NICU admission by 10%.

- **<u>CLABSI Initiative</u>**
  - ***Goal***: CLABSI will be reduced to less than the CMS national mean Standardized Infection Ratio (SIR: CLABSI 0.692) in 2022.

- **Safe Medication Use**
  - **Smart Infusion Pump High Risk Opioid Event Reduction Initiative.**
    - ***Goal***: Decrease the number of high-risk medication opioid overrides by 50% by December 1, 2022.
    - ***Goal*****:** Increase "Guardrails Suite usage to meet UHS and Leapfrog goal of 95% by December 1, 2022.
    - ***Goal:*** Naloxone provision usage will increase to 95% by June 1, 2022.
  - **Anticoagulant Safety in the Perioperative Setting**.
    - ***Goal:*** AHRQ PSI 12 Perioperative Pulmonary Embolism or Deep Vein Thrombosis benchmark is 3.950 per 1000 inpatients. The goal is to decrease the Patient Safety Indicator (PSI) 12 rate by 10% by December 2022.
    - ***Goal:*** The VTE Advisor will be used to assess the patient's postoperative risk for thromboembolism and documented prophylaxis through the VTE advisor The goal is 80% compliance with "VTE Advisor" usage.

- **Reduce Falls and Falls with Injury**
  - ***Goal***: 10% reduction in the rate of falls in the Acute Care Division by the end of 2022.
  - ***Goal***: 10% reduction in the rate of falls with injury in the Acute Care Division by the end of 2022.

- **Decreasing Hospital Acquired Pressure Injuries**
  - **Goal:** 10% reduction of NPOA rate for all HAPI stages in the Acute Care Division by the end of 2022.

- **Culture of Safety**
  - **Goal**: reduce the number of GHI events (serious safety event rate) for the Acute Care Division by the end of 2022. Ultimately, the goal is 0.

Desert View Hospital 2022 Goals:

- **Safe Medication Use**
- Desert View Hospital will have a medication safety committee with a constructed and approved standardized charter and agenda by June 1, 2022. Monthly meeting minutes to be submitted to PSES site.
- Monitor through AMES/CCD/COE reports, adverse events related to omitted or late medication administration for inpatient/observation patients awaiting bed placement.
- Monitor medication reconciliation for discharged patients within the medical surgical unit. Discharge medication reconciliation compliance is to be performed by hospitalists for 100% of discharged patients.
- Emergency Department, Medical Surgical Unit, Respiratory therapy to achieve a consistent monthly compliance of 90% Bar Code Medication Administration.
- Hospitalists to increase E-prescribe compliance to 100% of all patients for four consecutive quarters for 2022.

V. Monitoring and Accountability

A. Evaluation of TERM Program

Corporate risk management provides site visits to each facility in a variety of ways. Some visits focus solely on a review of risk function and compliance with the TERM program. These evaluations consist of both a core risk and clinical risk review. Each facility is required to submit written corrective action plans for noted deficiencies determined during the TERM visit. All information is shared with senior staff at both the facility and the corporate level and monitored through the facility PSC.

B. Patient Safety Council Coaching

As detailed above, each facility is required to post their monthly reports or minutes that details the work conducted by their Patient Safety Council to the facility PSES site. The representative Corporate Risk Management staff review these minutes and provide detailed feedback to coach the councils on their form and function. Corporate Patient Safety may also provide feedback.

C. Dashboard

The Patient Safety Dashboard 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:

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

- The culture supports the identification and reporting of "Near Miss" events
- The framework advances a "Just Culture" approach to patient safety
- Accountability is promoted when acts of " human error", "at risk", or "reckless behavior" are identified and corrected resulting in a reduction of potential/actual adverse outcomes
- Comparison of trended incident data to include analysis of performance to stated targets, submission of incident data in compliance to SOX stipulations and review of trended data submitted to CPSC for potential action from the corporate leadership team

- Review of annualized and prior year's probable claim reports to determine needs for corporate-based projects designed to improve outcomes in an identified service line;
- Review of educational products distributed for the concluding operating year that were intended to improve outcomes associated with a particular clinical emphasis;
- Review information, analyses, and reports from the Acute Care PSO for integration into the UHS of Delaware Patient Safety Evaluation System.

VII. Confidentiality and Annual Evaluation

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

SUBJECT: PATIENT SAFETY PLAN	REFERENCE #1004
DEPARTMENT: HOSPITALWIDE	PAGE: 1 OF: 12
	EFFECTIVE: 10/2015
APPROVED BY: Board of Hospital Trustees	REVIEWED: 02/07/2019 02/15/2022

PURPOSE:

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

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PATIENT SAFETY PLAN:

- Scope of Activities:
  - The scope of the Patient Safety Plan includes an ongoing proactive risk assessment, using internal and external knowledge and experience, to prevent error occurrence, maintain and improve patient safety.
    - One high-risk process shall be selected at least every 18 months and a proactive risk assessment shall be performed.
  - Patient safety occurrence information from aggregated data reports and individual incident occurrence reports will be reviewed by the Safety/Environment of Care Committee to prioritize organizational patient safety activity efforts. Types of patient safety or medical/health care errors included in data analysis are:
    - No Harm Errors - those unintended acts, either of omission or commission, or acts that do not achieve their intend outcome - that do not result in a physical or psychological negative outcome, or the potential for a negative outcome, for the patient.
    - Mild-Moderate Adverse Outcome Errors - those unintended acts, either of omission or commission, or acts that do not achieve their intend outcome, that result in an identified mild to moderate physical or psychological adverse outcome for the patient.
    - Any Medication Error
    - Any Adverse Drug Reaction
    - Any Transfusion Reaction
    - Hazardous Condition - any set of circumstances, exclusive of the disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious physical or psychological adverse patient outcome.
    - Sentinel Event - an unexpected event or occurrence involving death or serious physical or psychological injury or the risk thereof - including any process variation for which a recurrence would carry a significant chance of serious adverse outcome. Serious injury specifically includes loss of limb or function. Sentinel event criteria includes:

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- The event has resulted in an unexpected death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition, or
- An event is one (1) of the following (even if the outcome was not death or major permanent loss of function unrelated to the natural course of the patient's illness or underlying condition):
  - Suicide of any patient in a setting where the patient receives around-the-clock care, or suicide of a patient within 72 hours of discharge
  - Unanticipated death of full-term infant
  - Abduction of any patient receiving care
  - Infant abduction or discharge to the wrong family
  - Rape (by another patient, visitor or staff)
  - Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities
  - All identified cases of unanticipated death or major permanent loss of function associated with a healthcare associated infection

■ <u>Hospital Acquired Conditions (HACs):</u>

- Serious preventable event - air embolism (never event)
- Serious preventable event - blood incompatibility (never event)
- Catheter-associated urinary tract infections
- Pressure ulcers
- Hospital Acquired Infections

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- ♦ Surgical site infections following certain elective procedures, including certain orthopedic surgeries and bariatric surgery
- ♦ Patient falls (fracture, dislocation, intracranial injury, crushing injury, burn, electric shock)
- ♦ Manifestations of poor control of blood sugar levels, such as diabetic ketoacidosis, hypoglycemic coma
- ♦ Please check the CMS website for the most up-to-date list of preventable conditions (HACs)

- The scope of the Patient Safety Plan encompasses the patient population, visitors, volunteers and staff (including medical staff). The plan addresses maintenance and improvement in patient safety issues in every department throughout the facility. There will be an emphasis on important hospital and patient care functions of:
  - ■ Environment of Care
  - ■ Emergency Management
  - ■ Human Resources
  - ■ Infection Prevention and Control
  - ■ Information Management
  - ■ Leadership

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

- Methodology:
  - The Interdisciplinary Safety/Environment of Care Committee is responsible for the oversight of the Patient Safety Plan. The Safety/Environment of Care Committee Chairperson will have administrative responsibility for the plan, or the Safety/Environment of Care Committee may assign this responsibility to another member of the committee (such as the Performance Improvement Director or Risk Manager).
  - **All departments** within the organization (patient care and non-patient care departments) are responsible to report patient safety occurrences and potential occurrences to the Performance Improvement Director, who will aggregate occurrence information and present a report to the Safety/Environment of Care Committee on a monthly basis. The report will contain aggregated information related to type of occurrence, severity of occurrence, number/type of occurrences per department, occurrence impact on the patient, remedial actions taken, and patient outcome. The Safety/Environment of Care Committee will analyze the report information and determine further patient safety activities as appropriate.

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

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

    - Prioritizing the potential processes breakdowns or failures

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

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

    - Test and implement the redesigned process

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

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

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

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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 - example: immediate removal of contaminated IV fluids from floor stock should it be discovered a contaminated lot of fluid solutions was delivered and stocked.
  - Contact the patient's attending physician and other physicians, as appropriate, to report the error, carrying out any physician orders as necessary.
  - Preserve any information related to the error (including physical information). Examples of preservation of physical information are: Removal and preservation of blood unit for a suspected transfusion reaction; preservation of IV tubing, fluids bags and/or pumps for a patient with a severe drug reaction from IV medication; preservation of medication label for medications administered to the incorrect patient. Preservation of information includes documenting the facts regarding the error on an occurrence report, and in the medical record as appropriate to organizational policy and procedure.
  - Report the process/system failure or medical/health care error to the staff member's immediate supervisor.
  - Submit the occurrence report to the Performance Improvement Department per organizational policy.
- Any individual in any department identifying a process/system failure and/or potential patient safety issue will immediately notify his or her supervisor and document the findings on an occurrence report. The occurrence report will be submitted to the Performance Improvement Department per organizational policy.

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

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

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

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

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

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

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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 Performance Improvement Department per organizational policy.

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

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

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

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

  - Further remedial action activities necessary for identified occurrences

  - Proactive occurrence reduction activities

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

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- An effective Patient Safety Plan cannot exist without optimal reporting of process/system failures and medical/health care errors and occurrences. Therefore, it is the intent of this institution to adopt a non-punitive approach in its management of failures, errors and occurrences. All staff are required to report suspected and identified medical/health care errors, and should do so without the fear of reprisal in relationship to their employment. This organization supports the concept that errors occur due to a breakdown in systems and processes, and will focus on improving systems and processes, rather than disciplining those responsible for errors and occurrences. A focus will be placed on remedial actions to assist rather than punish staff members, with the Safety/Environment of Care Committee and the individual staff member's department 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 or her department supervisor.

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

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

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

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

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

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

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

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

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

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

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

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

    - All system or process failures

    - Number and type of sentinel events

    - If patients and families were informed of the adverse events

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

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

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HUMBOLDT GENERAL HOSPITAL
CRITICAL ACCESS HOSPITAL
118 East Haskell St.
Winnemucca, Nevada 89445

POLICY/PROCEDURE
Revised: Aug 18, 2020

Developed by: Quality Services Director
Revised by: Quality Services director
Department: All Departments

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 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.

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 serous 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 PRINICPLES:

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 stack 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.

TAHOE FOREST HEALTH SYSTEM

Origination Date:	*12/2005*
Last Approved:	*N/A*
Last Revised:	*01/2022*
Next Review:	*1 year after approval*
Department:	*Quality Assurance / Performance Improvement - AQPI*
Applicabilities:	*System*

Patient Safety Plan□AQPI-□□

Ris□:

A Patient Safety Plan is essential to Tahoe Forest Health District 1. to emphasize it's commitment to safe patient care and 2. to clearly outline the goals and elements of that plan. Without a clear patient safety plan, an organization risks not dynamically supporting its goals of safe patient care.

Policy:

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The Tahoe Forest Hospital District (TFHD) Board of Directors makes a commitment to provide for the safe and professional care of all patients, and also to provide for the safety of visitors, employees and health care practitioners. The commitment is made through the provision of this Patient Safety Plan that will identify, evaluate, and take appropriate action to prevent unintended patient care outcomes (adverse events), as well as protect the TFHD's financial resources, tangible assets, personnel and brand. Leadership structures and systems are established to ensure that there is organization-wide awareness of patient safety performance, direct accountability of leaders for that performance and adequate investment in performance improvement abilities, and that actions are taken to ensure safe care of every patient served.

This policy is integrated with a companion policy, Risk Management Plan AQPI-04.

The Tahoe Forest Hospital District endorses the National Quality Forum set of "34 Safe Practices for Better Healthcare." Further, the District ascribes to the tenets and practices of the High Reliability Organization and the Just Culture programs in the investigation of near-misses, adverse events and unexpected/unintended outcomes.

A. SCOPE & APPLICABILITY

1. This is a Health System program empowered and authorized by the Board of Directors of Tahoe Forest Hospital District. Therefore, it applies to all services and sites of care provided by the organization.

B. RECITALS

1. The organization recognizes that a patient has the right to a safe environment, and strives to achieve an error-free healthcare experience. Therefore, the Health System commits to undertaking a proactive approach to the identification and mitigation of unexpected/unintended outcomes.
2. The organization also recognizes that despite best efforts, errors can occur. Therefore, it is the intent of the Health System to respond quickly, effectively and appropriately when an error does occur.

3. The organization also recognizes that the patient has the right to be informed of the results of treatments or procedures whenever those results differ significantly from anticipated results.

C. AUTHORITY & RESPONSIBILITY

1. **Governing □ody**

   a. The Governing Body, through the approval of this document, authorizes a planned and systematic approach to preventing adverse events and implementing a proactive patient safety plan. The Governing Body delegates the implementation and oversight of this program to the Chief Executive Officer (hereinafter referred to as the "Senior Leader") and request that the Medical Staff approve the creation of a Patient Safety Committee. The Medical Staff Quality Committee will serve as the Patient Safety Committee for TFHD and the IVCH Medical Staff Committee will serve as the Patient Safety Committee for IVCH.

2. **Senior Leader**

   a. The Senior Leader is responsible for assuring that this program is implemented and evaluated throughout the organization. As such, the Senior Leader will establish the structures and processes necessary to accomplish this objective. The Senior Leader delegates the day-to-day implementation and evaluation of this program to the Medical Staff Quality Committee and the Management Team.

3. **Medical Staff**

   a. The meetings, records, data gathered and reports generated by the Patient Safety Committee shall be protected by the peer review privilege set forth at California evidence Code Section 115□ relating to medical professional peer review and for the State of Nevada subject to the same privilege and protection from discovery as the proceedings and records described in NRS 4□.265.

   b. The Patient Safety Committee shall take a coordinated and collaborative approach to improving patient safety. The Committee shall seek input from and distribute information to all departments and disciplines in establishing and assessing processes and systems that may impact patient safety in the organization. The Patient Safety Committee shall recognize and reinforce that the members of the Medical Staff are responsible for making medical treatment recommendations for their patients.

4. **Management Team**

   a. The Management Team, through the Director of Quality and Regulations and Patient Safety Officer, is responsible for the day-to-day implementation and evaluation of the processes and activities of this Patient Safety Plan.

5. **Patient Safety Officer (The Patient Safety Officer□s standing committee assignments□chain-of-command and reports□reporting structure are attached as Attachment C)**

   a. The Director of Quality & Regulations or the Quality & Regulations staff designee shall be the Patient Safety Officer for the organization. The Patient Safety Officer shall be accountable directly to the Senior Leader, through the supervision of the Director of Quality and Regulations, and shall participate in the Patient Safety/Medical Staff Quality Committee.

6. **Patient Safety□Medical Staff Quality Committee**

   1. The Patient Safety Committee shall:

      1. Receive reports from the Director of Quality and Regulations and/or the Patient Safety

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Officer

2. Evaluate actions of the Director of Quality and Regulations and/or Patient Safety Officer in connection with all reports of adverse events, near misses or unexpected/unintended outcomes alleged to have occurred
3. Review and evaluate the quality of measures carried out by the organization to improve the safety of patients who receive treatment in the Health System
4. Make recommendations to the executive committee or governing body of the Health System to reduce the number and severity of adverse events that occur
5. Report quarterly, and as requested, to the executive committee and governing body
6. The Patient Safety Committee members shall include, at least, the following individuals:
    1. Director of Quality and Regulations
    2. Members of the Medical Staff
    3. One member of the nursing staff (CNO or designee)
    4. Director of Pharmacy
    5. Medical Director of Quality
    6. Risk Managment/Patient Safety Officer
    7. Chief Operating Officer

D. PROGRAM ELEMENTS, GOALS AND OBJECTIVES

1. Assess patient safety risk, identify threats, prevent occurrence or mitigate frequency and severity of harm when unexpected/unintended outcomes occur
2. Promote a safe environment in the Health Systems to alleviate injuries, damages or losses
3. Foster communication with patients, employees, medical staff and administration when patient safety issues are identified
4. Contribute to performance improvement activities and plans to resolve patient safety issues
5. Participate and/or consult on all patient disclosure conferences regarding unexpected/unintended outcomes utilizing the disclosure checklist
6. Utilize the Beta HEART (healing, empathy, accountability, resolution, trust) principles fostering a culture of safety and transparency including the following:

    a. Administration of the SCORE Culture of Safety survey and sharing of the results utilizing a debrief methodology

    b. Utilizing a formalized process for early identification and rapid response to adverse events integrating human factor/ergonomic analysis and high reliability organization principles

    c. A commitment to honest and transparent communication with patient and families after an adverse event

    d. Staff referral to the Peer Support/Care for the Caregiver program, which is available 24/7

    e. A process for early resolution when harm is deemed a result of inappropriate care or medical error

7. Event investigation includes assessing the environment and securing physical evidence, and utilizes cognitive interview skills of all staff involved and the patient/family as appropriate
8. Designing or Re-designing Processes

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a. When a new process is designed (or an existing process is modified) the organization will use the Patient Safety Officer to obtain information from both internal and external sources on evidence-based methods for reducing medical errors, and incorporate best practices into its design or re-design strategies.

9. Identification of Potential Patient Safety Issues

a. As part of its planning process, the organization regularly reviews the scope and breadth of its services. Attendant to this review is an identification of care processes that, through the occurrence of an error, would have a significant negative impact on the health and well being of the patient. Areas of focus include:

i. Processes identified through a review of the literature

ii. Issues identified during daily safety huddles.

iii. Issues or risks to the organization identified by the Reliability Management Team, a multidisciplinary team of staff and leadership members trained in the principles of High Reliability Organizations. (HRO).

iv. Processes identified through the organization's performance improvement program

v. Processes identified through Safety Risk Management Reports (Event Reporting, AQPI-06) and sentinel events (Sentinel/Adverse Event/Error or Unanticipated Outcome, AQPI-1□06)

vi. Processes identified as the result of findings by regulatory and/or accrediting agencies

vii. The National Quality Forum: "Safe Practices for Better Healthcare – 02/2013 Update"

viii. Adverse events or potential adverse advents as described in HSC 12□□.1 (Attachment A)

ix. Health-care-associated infections (HAI) as defined in the federal CDC National Healthcare Safety Network. (Attachment B)

x. TFHD specific results from the Safe and Reliable Healthcare Safety Culture Survey (SCOR - Safety, Communication, and Organizational Reliability)

10. Performance Related to Patient Safety

a. Once potential issues have been identified, the organization will establish performance measures to address those processes that have been identified as "high risk" to patient safety. In addition, the following will be measured:

i. The perceptions of risk to patients and suggestions for improving care.

a. The level of staff reluctance to report errors in care and staff perceptions of the organization's culture of safety as assessed through an industry-recognized external survey.

ii. Opportunities to reduce errors that reflect system issues are addressed through the organization's performance improvement program.

iii. Opportunities to reduce errors that reflect the performance of the individual care provider are addressed, as appropriate, through the Medical Staff peer review process or through the organization's human resource policy(s) using the practices and tenets of High Reliability Organization.

b. Ensure timely, honest, and transparent communication with the patient and family utilizing the Beta HEART principles that includes:

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i. Assuming responsibility for the event

ii. Expressing empathy and sincerely apologizing for the event

iii. Identifying areas for improvement

iv. Designating an organizational contact who will be responsible for ongoing empathetic and transparent communication

v. Utilizing the multidisciplinary early resolution team and the claims partners to determine fair and reasonable reparation

vi. Developing a restitution plan that includes Administration and Board of Director approval

11. Responding to Errors

    a. The organization is committed to responding to known errors in care or unexpected/unintended outcomes in a manner that supports the rights of the patient, the clinical and emotional needs of the patient, protects the patient and others from any further risk, and preserves information critical to understanding the proximal and – where appropriate – root cause(s) of the error. The organization's response will include disclosure of the incident or error to the patient and/or family (as noted below in 14.a) along with care for the involved caregivers (as noted below in 12.a).

    b. Errors that meet the organization's definition of a potential sentinel event will be subjected to an intensive assessment or root cause analysis using the tenets and practice of High Reliability Organizations. Management of these types of errors is described in *Sentinel/Adverse Event/ Error or Unanticipated Outcome*, AQPI-1□06.

12. Supporting Staff Involved in Errors

    a. Following serious unintentional harm due to systems failures and/or errors that result from human performance failures, the involved caregivers shall receive timely and systematic care which may include: supportive medical/psychological care, treatment that is compassionate, just and respectful and involved staff shall have the opportunity to fully participate in the event investigation, risk identification and mitigation activities that will prevent future events. To that end, the organization has defined processes to provide care for the caregivers: (*Peer Support (Care for the Caregiver*), AGOV-1602)

13. Educating the Patient on Error Prevention

    a. The organization recognizes that the patient is an integral part of the healthcare team. Therefore, patients will be educated about their role and responsibility in preventing medical errors.

14. Informing the Patient of Errors in Care

    a. The organization recognizes that a patient has the right to be informed of results of care that differ significantly from that which was anticipated, known errors and unintended outcomes. Following unanticipated outcomes, including those that are clearly caused by systems failures, the patient, and family as appropriate, will receive timely, transparent and clear communication concerning what is known about the adverse event. Management of disclosure to patients/ families is described in the policy, *Disclosure of Error or Unanticipated Outcome to Patients/ Families*, AQPI-1□0□.

15. Reporting of Medical Errors

    a. The organization has established mechanisms to report the occurrence of medical errors both

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internally and externally.

b. Errors will be reported internally to the appropriate administrative or medical staff entity.

c. Errors will be reported to external agencies in accordance with applicable local, state, and federal law, as well as other regulatory and accreditation requirements. For reporting process, see the Administrative policy, *Sentinel/Adverse Event/Error or Unanticipated Outcome*, AQPI-1□06.

16. Evaluating the Effectiveness of the Program

    1. On an annual basis, the organization will evaluate the effectiveness of the patient safety program. A report on this evaluation will be provided to the Patient Safety/Medical Staff Quality Committee, Medical Staff, Senior Leader(s), and to the Governing Body.

E. Priorities for the 2022 Calendar Year

1. Complete the SCORE Culture of Safety Survey and department specific debriefings to identify survey action plans
2. Focus on organizational wide Beta HEART principle reinforcement through education, Pacesetter articles, Safety First, and electronic email reminders.
3. Utilize implemented surveillance module for case finding for additional safety and quality opportunities
4. Continue quarterly submission of the patient safety data to CHPSO for inclusion in reporting and benchmarking
5. Continue with ongoing Patient Safety education through the Pacesetter Monthly Newsletter, weekly Safety Firsts, email updates, and other educational tools
6. Achieve 5 domain Beta HEART validation in May 2022
□. Achieve a successful triennial unannounced TFH accreditation survey (CDPH GACHLRS)
□. Continued focus on quality and patient/employee safety during the pandemic, following CDC, State, and County Health guidelines
□. Growth and development of TFHD as High Reliability Organization (HRO) with commitment to goal of □ero harm.
10. Event reporting platform upgrade.

Related Policies□Forms:

Sentinel/Adverse Event/Error or Unanticipated Outcome, AQPI-1□06; Event Reporting, AQPI-06; Disclosure of Error or Unanticipated Outcome to Patients/Families, AQPI-1□0□; Peer Support (Care for the Caregiver), AGOV-1602; Risk Management Plan AQPI-04; The National Quality Forum: "Safe Practices for Better Healthcare – 02/2013 Update"

All revision dates: 01/2022, 02/2021, 02/2020, 02/2020, 03/201□, 0□/201□, 02/201□, 12/2016, 03/2014, 02/2014, 11/2013, 10/2013, 01/2012, 01/200□

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Attachments

RM/PSO Standard reports and reporting

Approval Signatures

Step Description	Approver	Date
	Janet VanGelder: Director	pending
	Theresa Crowe: Risk Management/Privacy Officer	01/2022

COPY

MESA VIEW
REGIONAL HOSPITAL

Origination:	*02/2020*
Effective:	*02/2022*
Last Approved:	*02/2022*
Last Revised:	*02/2022*
Next Review:	*02/2023*
Owner:	*Amy Johnson*
Area:	*PT SAFETY - POLICIES*
References:	
Applicability:	*Mesa View Regional Hospital*

□□□□ Patient Safety Plan

PURPOSE

The purpose of the Patient Safety Plan is to provide a systematic, coordinated and continuous approach to the maintenance and improvement of patient safety through the establishment of mechanisms that support effective responses to actual occurrences; ongoing proactive reduction in medical/health care errors; and integration of patient safety priorities into the new design and redesign of all relevant organization processes, functions and services. The goal of the Patient Safety Plan is to provide a safe environment for patients and their families. The approach to optimal patient safety involves multiple departments and disciplines in establishing the plans, processes and mechanisms that comprise the patient safety activities at the Hospital. The purpose includes creating an environment that encourages:

- Recognition and acknowledgment of risks to patient safety and medical/health errors;
- The initiation of actions to reduce these risks;
- The internal reporting of what has been found and the actions taken;
- A focus on processes and systems;
- Minimization of individual blame or retribution for involvement in a medical/healthcare error;
- Organizational learning about medical/healthcare errors;
- Support of the sharing of that knowledge to effect behavioral changes in itself and other health care organizations; and
- Disclosure of the outcomes of care, treatment and services.

The Patient Safety Plan developed by the interdisciplinary Quality Improvement Committee and approved by the Medical Executive Committee, and the Board of Trustees, outlines the components of the organization-wide Patient Safety Program.

SCOPE OF ACTIVITIES

The Patient Safety program is an organization-wide program that includes and integrates all activities within the organization and ECRI PSO. which contributes to the maintenance and improvement of patient safety, healthcare quality and healthcare outcomes.

The scope of the Patient Safety Program involves an ongoing assessment, using internal and external knowledge and experience, to prevent occurrence of errors and to maintain and improve patient safety. Patient safety event information from aggregated data reports and individual event reports will be reviewed by the Quality Improvement Committee and the High Reliability Organization Team to prioritize organizational

patient safety activity efforts.

In addition to internal knowledge and experience, the services and information that the ECRI. offers will be reviewed and evaluated to include:

- Best Practices and Took Kit Development;
- Comparative Analysis of Adverse Event Reported in the Event Reporting System;
- Unsafe Behavior Evaluations;
- Raise safety awareness through the internal publication of anonymized Action Plans from root cause analysis;
- Develop and publish Patient Safety Alerts; and

Patient Safety Event Work Product:

Types of patient safety events, adverse outcomes, or medical/health care errors included in data analysis are:

- Event Reports- those events and outcomes reportable to the Director of Risk Management by an Event Report (Form RM 3301) during downtime or by entering the occurrence into the Event Reporting System include processes and outcomes of care that may result in no harm through serious injury or death. Examples include , but not limited to, falls, medication variances, adverse drug reactions, intravenous therapy variances, procedure variances, procedure complications, patient complaints and AMA and elopement discharges. These may also include near miss events.
- Hemolytic transfusion reactions reported through the transfusion review channels.
- Hazardous Condition – any set of circumstances, exclusive of the disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious physical or psychological adverse patient outcome.
- Serious Safety Event & Sentinel Event: applies to events that have resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition. In addition, there are other event types that are considered sentinel due to the severity of the event even though the outcome was not death or permanent loss of function unrelated to the natural course of the patient's illness or underlying condition.
- Serious Safety Event & Sentinel event criteria and the procedures involved are detailed in the sentinel event and root cause analysis policies and procedures including definitions of near misses, which require a root cause analysis.
- Never Events and Hospital Acquired Conditions including:
  Surgical events:
- Surgery performed on the wrong body part;
- Surgery performed on the wrong patient;
- Wrong surgical procedure performed on a patient;
- Unintended retention of a foreign object in a patient after surgery or other procedure;
- Intraoperative or immediately postoperative death in an American Society of Anesthesiologists Class I patient; or
- Product or device events:
- Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the health care facility;
- Patient death or serious disability associated with the use or function of a device in patient care, in which the device is used for functions other than as intended; or
- Patient death or serious disability associated with intravascular air embolism that occurs while being

cared for in a health care facility e.g., luer connecters are implicated in or contribute to many of these errors because they enable functionality of dissimilar tubes to be connected.

Patient protection events:

- Infant discharged to the wrong person;
- Patient death or serious disability associated with patient elopement (disappearance); or
- Patient suicide or attempted suicide resulting in serious disability, while being cared for in a health care facility

Care management events:

- Patient death or serious disability associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration);
- Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA-incompatible blood or blood products;
- Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a health care facility;
- Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a health care facility;
- Death or serious disability (kernicterus) associated with failure to identify and treat hyperbilirubinemia in neonates;
- Stage 3 or 4 pressure ulcers acquired after admission to a health care facility; or
- Patient death or serious disability due to spinal manipulative therapy

Environmental events:

- Patient death or serious disability associated with an electric shock or electrical cardio-version while being cared for in a health care facility;
- Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances;
- Patient death or serious disability associated with a burn incurred from any source while being cared for in a health care facility;
- Patient death or serious disability associated with a fall while being cared for in a health care facility; or
- Patient death or serious disability associated with the use of restraints or bed rails while being cared for in a health care facility.

Criminal events:

- Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider
- Abduction of a patient of any age;
- Sexual assault on a patient within or on the grounds of the health care facility;
- Death or significant injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of the health care facility; or
- Environment of care significant incidents involving employee, visitor, utility or property damage

Sources of external knowledge and experience include the Sentinel Event Alerts. Published by The Joint Commission, safety alerts published by the Food and Drug Administration, Patient Safety Alerts, adverse outcome and lessons learned from RCA's, information from insurance carriers and other private and public healthcare safety organizations.

The scope of the organization-wide Safety Program encompasses all people including the patient population, visitors, volunteers and staff (including medical staff). The program addresses maintenance and improvement in patient safety issues in every department throughout the facility, as well as employee safety, physical plant and facilities, equipment and supply-related safety issues, among other safety issues. To promote efficiency, there is an Environment of Care Committee, chaired by the Environmental Safety Officer, that addresses employee events and safety, workers compensation, needle sticks and products, visitor Events, hazard surveillance, and the safety management plans. To promote integration, communication and analysis of inter-related issues, there is cross membership between the committees, and both committees report to the Medical Executive Committee and the Board of Trustees. for oversight and further integration of related issues. Physician peer review of medical errors is also conducted at the Medical Executive Committee level (or at their direction).

The Serious Safety Event Rate (SSER) will then be reviewed at least weekly. The SSER should be considered Patient Safety Work Product and will be reported to the following council/committees, Patient Safety, Medical Executive and the Board of Directors. This rate will also be reported to the Patient Safety Committee and the ECRI PSO.

The Quality Improvement Committee is a multidisciplinary body with respresentatives from the Medical Staff, administration and clinical and non-clinical areas. Members may include bt are not limited to: Medical Staff Member, Administrator, Chief Nursing Officer, Director of Quality, and Director of Risk Management.

The meeting frequency should be at least every other month. The organizations' Director of Risk Management will serve as the Patient Safety Officer in most instances.

Procedures

Committee responsibilities:

1. The interdisciplinary Quality Improvement Committee is responsible for the oversight and management of the Patient Safety Program. This includes making recommendations to organization leaders regarding the adequacy of resources allocated to support patient safety activities. The committee will oversee data and analysis in order to prioritize patient safety activities, including, but not limited to patient safety work product, Medication Variances, Infection Surveillance, Safety Surveillance, Staff Perceptions of and suggestions for improving patient safety, Staff willingness to report errors (Employee Surveys), Patient/ Family perceptions of, and suggestions for improving patient safety, and results of any risk assessment surveys by department.
2. The Quality Improvement Committee is responsible to review and approve the organization-wide and departmental patient safety-related policies, procedures and ECRI PSO information. This should include the content of any proactive risk self-assessments prior to data collection, as well as patient/family education regarding their role in helping to facilitate the safe delivery of care.
   All departments within the organization (patient care and non-patient care departments) are responsible to report patient safety occurrences, and potential occurrences to the Director of Risk Management, who will aggregate occurrence information and present a report to the Quality Improvement Committee on a every other month basis. This Patient Safety Work Product report will contain aggregated information related to the cause or nature of the occurrence, severity of occurrence, number/type of occurrences per department, occurrence impact on the patient, improvement actions taken, and patient outcome. The Patient Safety Committee will analyze the report information and determine further patient safety activities as appropriate. Any undesirable patterns or trends in patient safety and sentinel events should be intensively analyzed. Intense analysis involves studying a process to learn in greater detail about how it is performed or how it operates, how it can malfunction, and how errors occur.

3. Patient complaints and concerns or ideas about patient safety should be reported to and evaluated by the Quality Improvement Committee. Patient safety information input regarding employee willingness to report and related information from patient and employee surveys should also be reviewed and evaluated. (Resolution of individual patient complaints is handled by the department director of the involved department and the Director of Risk Management.)
4. The Quality Improvement Committee reviews alerts or guidance from external sources, including TJC, Institute for Safe Medication Practices, the Food and Drug Administration and consider whether their recommendations should and could be implemented at the organization as a proactive measure to reduce patient safety risks.
5. Patient safety occurrences requiring a report to an external agency such the F.D.A., Board of Pharmacy, Center for Medicare Administration, a manufacturer or the state department of health, should also be reported to the Quality Improvement Committee. This report should include an analysis of the occurrence as to underlying causes, any improvement actions recommended and/or taken and, when available, the results of those improvement actions.
6. Through review of internal data reports and reports from external sources (including TJC sentinel event report information, and other sources such as available occurrence reporting information from state and federal sources and current literature), the Quality Improvement Committee will select at least one high-risk safety process for proactive risk assessment annually using a Failure Mode Effects Analysis methodology.

The proactive risk assessment will include:

- Assessment of the intended and actual implementation of the process to identify the steps in the process where there is, or may be, undesirable variation (failure mode). For each identified failure mode, identify the possible effects of the undesirable variation on patients, and how serious the possible effect on the patient could be (criticality);
- For the most critical effects, conduct a root cause analysis to determine why the variation (failure mode) leading to that effect may occur;
- Redesign the process and/or underlying systems to minimize the risk of that failure mode or to protect patients from the effects of that failure mode;
- Test and implement the redesigned process;
- Identify and implement measures of the effectiveness of the redesigned process; and
- Implement a strategy for maintaining the effectiveness of the redesigned process over time.

Organization-wide activities:

1. Education regarding employee responsibilities for patient safety is included in initial and annual orientation programs, both by the Director of Risk Management and department manager. This includes reporting requirements and mechanisms. As appropriate, training which incorporates methods of team training to foster an interdisciplinary, collaborative approach to patient care delivery is provided. The Quality Improvement Committee and other committees may recommend education as a patient safety improvement activity at any time throughout the year. Training on failure mode analysis, effects and criticality analysis should be done for those involved with this risk reduction tool.
2. Patient safety is included as a regular agenda item for at least the clinical and support service departments of the organization. The intent is to foster a culture of "patient safety as job number one", "Safety First". Patient safety is a high priority function in the design and redesign of processes, functions and systems that impact or involve patient care.

3. At any given time, the performance of critical steps in at least one high-risk process is the subject of ongoing measurement and periodic analysis to determine the degree of variation from intended performance.
4. Initiate and comply with TJC National Patient Safety Goals, and/or other regulatory or accrediting standards, by implementing the goals' elements of performance to improve Patient Safety.

Actions upon Error or Event:

Upon identification of a medical/health care error/event, the patient care provider should:

- As appropriate to the occurrence, perform healthcare interventions to contain the risk to the patient or others
- Contact the patient's attending physician and other physicians, as appropriate, to report the error or event, carrying out physician orders as necessary.
- Contact the patient's family, guardian, Power of Attorney or significant other to make aware of the error or event. Refer to the Disclosure of Treatment Outcomes policy.
- Preserve any information (Preservation Checklist) related to the error or event (including physical information). Examples of preservation of physical information are: Removal and preservation of blood unit for a suspected transfusion reaction; preservation of IV tubing, fluids bags and/or pumps for a patient with a severe drug reaction from IV medication; preservation of medication label for medications administered to the incorrect patient. Preservation of information includes documenting the facts regarding the error on an Event Report, and in the medical record ***as appropriate*** to organizational policy and procedure.
- Report the medical/health care error to the staff member's immediate supervisor.
- Submit the Event Report to the Director of Risk Manager per the Patient Safety Evaluation System.

Individuals in any department identifying a potential patient safety issue should notify their supervisor and document the findings on an Event Report. This Patient Safety Work Product includes patient safety near misses. The paper Event Report should be submitted to the Director of Risk Manager. Events that are reported through the on-line Event Reporting System will automatically be sent to the Director of Risk Management

Staff response to medical/health care occurrences is dependent upon the type of occurrence identified:

- Hazardous Condition/Patient Safety Issue - as appropriate, and if possible, staff will contain the hazardous condition or patient safety issue. Staff identifying a hazardous condition or potential patient safety issue should notify their supervisor and document the findings on an Event Report form. The Event Report form will be submitted to the Director of Risk Manager utilizing the online Event Reporting System or paper event report during system downtime. .
- Serious Safety Event & Sentinel Event - staff should perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then follow the organizational Sentinel Event Policy and Procedure. A root cause analysis should be performed for any sentinel event and near miss as defined in the sentinel event policy and procedure.
- Near Miss – staff should report the near miss event to their immediate supervisor, describe the facts of the near miss on an event report and submit the report to the Director of Risk Manager via the on-line Event Reporting System or paper form during system downtime. . A proactive risk assessment may be performed to prevent recurrence if it is determined that a recurrence poses a significant safety risk to future patients. This may be determined by the Director of Risk Manager,the Quality Improvement

Committee and/or High Reliability Organization if there is any disagreement as to risk potential.

An effective Patient Safety Program cannot exist without optimal reporting of medical/health care errors and occurrences. Therefore, it is the intent of this organization to adopt a non-punitive approach in its management of errors and occurrences. All personnel are ***required*** to report suspected and identified medical/health care errors, and should do so without the fear of reprisal in relation to their employment. This organization supports the concept that errors occur due to a breakdown in systems and processes, and will focus on improving systems and processes, rather than disciplining those responsible for errors and occurrences. A focus will be placed on remedial actions to **assist** rather than punish staff members.

Staff Support:

Staff members involved in a sentinel event occurrence will receive support from the Director of Risk Manager regarding the staff member's professional and emotional reconciliation of the sentinel event. The staff member's involvement in the root cause analysis and action plan processes is encouraged, to allow the staff member an active role in process resolution. Additionally, any staff member involved in a sentinel event or other medical/health care error may request and receive supportive personal counseling from the hospital's counseling service available with the employees benefits. The Human Resource Director is to assist the employee in receiving the services necessary to assist the staff member through the crisis.

Disclosure:

Patients, and when appropriate, their families are informed regarding the unanticipated outcomes of care, or when the outcomes differ significantly from the anticipated outcomes. The Quality Improvement Committee will monitor for compliance with this standard through the information management function of record reviews, and through reports from the Patient Safety Officer of evidence found upon individual record review for other risk management purposes. (See also policy regarding disclosure of unanticipated outcomes.)

Communication:

1. Medical/health care errors and occurrences, including sentinel events, will be reported to the ERCI PSO and externally, per hospital policy through the channels established by this plan. External reporting will be performed in accordance with state, federal and regulatory body rules, laws and requirements (i.e., regarding medical devices in accordance with the Safe Medical Devices Act.).
2. An annual report will be compiled by the Quality Improvement Committee and forwarded to the Medical Executive Committee and on to the governing board. This report shall include at least aggregate data regarding patient safety, an analysis thereof (conclusions), recommendations and actions taken to improve patient safety, both in response to actual occurrences and proactively. These reports shall be protected to the extent allowable under the disclosure laws applicable to peer review, Quality Improvement processes, and risk management.
3. The governing board, upon evaluation of received reports (at a minimum, annually), should assess the allocation of resources, the assignment of personnel and their time, the provision of information services and data management processes, and staff training in terms of adequacy of their allocation of human, information, physical and financial resources to support patient safety improvement priorities.

Patient and Family Education:

The organization urges patients and families to get involved in their care. Educational efforts to increase consumer awareness and involvement are supported by the Centers for Medicare and Medicaid Services and TJC as a critical process to improve patient safety. The organization encourages patients and families to:

- Speak up if they have questions or concerns, and if they don't understand, ask again. Encouraging

patients that it is their right to know

- Pay attention to the care received. Making sure you are getting the right treatments and medications by the right health care professionals. Don't assume anything.
- Educate yourself about diagnosis, the medical tests you are undergoing and your treatment plan.
- Ask a trusted family member or friend to be your advocate.
- Know what medications you take and why you take them. Medication errors are the most common health care mistakes.
- And to participate in all decisions about your treatment. You are the center of the health care team.

Attachments

No Attachments

Approval Signatures

Approver	Date
Leslie Woodson	02/2022
Amy Johnson	02/2022

Applicability

Mesa View Regional Hospital

Mt. Grant General Hospital
P.O. Box 1510 ... 200 South "A" Street
Hawthorne, Nevada 89415
(775) 945-2461
FAX (775) 945-2359

March 25, 2022

Nevada State Board of Health
Annual Sentinel Event Reporting

Dear DPBH:

Pursuant to NRS 439.835, which requires patient safety committees in medical facilities to report annually on the facilities review, revision, and usage of patient safety checklists and policies, the following is a summary of Mt. Grant General Hospital's activities during the year 2021.

All checklists and policies were reviewed. There were no new checklists or revisions to current checklists. The Mt Grant General Hospital Patient Safety Program Policy includes the patient safety and policy compliance requirements, attached you will find a report summarizing the specific checklists and policies.

The Patient Safety Committee meets monthly. The membership is comprised of the patient safety officer, safety officer, lab, pharmacy, supply chain, nursing and board member. During the monthly meeting each department reports on specific areas of focus related to patient safety. The committee also defines areas of re-focus or education to the general staff and policy revision or creation supporting the patient safety program.

Please do not hesitate to contact me should you require additional information.

Sincerely,

Denise L Ferguson

Denise L Ferguson
Patient Safety Officer
Mt Grant General Hospital

REPORT TO THE DIRECTOR OF THE LEGISLATIVE COUNSEL BUREAU (LCB) PURSUANT TO NRS 439.835, NRS 439.865, NRS 439.835

Mt Grant General Hospital
200 South A Street, P O Box 1510
Hawthorne, NV 89415
Denise L Ferguson, Patient Safety Officer
dferguson@mgghnv.org 775-341-6117

January 1, 2021 – December 31, 2021

Check Lists Developed Include:	**Revisions**	**Usage**	**Review**
Foley catheter insertion and Maintenance	X	Acute, ER, SNF	12/15/21
Liver biopsy checklist	X	OR	12/15/21
Surgical Safety – Cataract surgery checklist	X	OR	12/15/21
Surgical Safety – Endoscopy check list	X	OR	12/15/21
Surgical Safety – General surgery check list	X	OR	12/15/21
Patient Safety – Pressure ulcer checklist	X	OR	12/15/21
Patient Safety – Discharge checklist	X	Acute	12/15/21
Patient room and environment sanitation checklist	X	Acute/SNF	12/15/21
Patient Safety – Fall Prevention	X	Acute/SNF/ER	12/15/21
Isolation precautions checklist	X	Acute	12/15/21
Patient Safety Policies developed include:	X		
Patient identification before providing treatment	X	Acute, ER, OR, SNF	12/15/21
Hand hygiene nationally recognized protocol	X	Acute, ER, OR, SNF	12/15/21
Compliance with patient safety checklists and policies	X	Acute, ER, OR, SNF	12/15/21
Annual revision and review of checklists and policies by the Patient Safety Committee	X	Acute, ER, OR, SNF	12/15/21
Nationally accepted standards for patient safety and infection control	X	Acute, ER, OR, SNF	12/15/21
Patient notification of infection	X	Acute	12/15/21
Crash cart checks and stocking	X	Acute/ER	12/15/21
Bed Rail Safety Guidelines Check List	X	Acute/SNF	12/15/21
Bed Rail Safety – Resident Assessment Of Need for Side Rails	X	Acute/SNF	12/15/21

X – reviewed with no changes required

Summary of Review	**Total # Developed**	**Total # Revised**	**Total # Reviewed**
Patient Safety Checklists	0	0	10
Patient Safety Policies	0	0	9

Origination:	*06/2002*
Effective:	*06/2021*
Approved:	*06/2021*
Last Revised:	*07/2020*
Next Review:	*06/2022*
Owner:	*Carol Riggio: Director of Quality, Risk and Safety*
Policy Area:	*Leadership*
References:	*439.800, 439.855, 439.860, 439.865, 439.870, 439.875, 439.877, 439.890, CMS CFR §482.21(e)(1), LD.03.01.01, NRS 439.835, TJC LD.04.04.05*
Applicability:	*Northeastern Nevada Regional Hospital*

Patient Safety Plan

SCOPE:

House Wide

PURPOSE:

To build a system for providing safe patient care and for preventing adverse patient outcomes.

DEFINITIONS:

Adverse Event: Harm to a patient as a result of medical care or harm that occurs in a healthcare setting. Although an adverse event often indicates that the care resulted in an undesirable clinical outcome and may involve medical errors, adverse events do not always involve errors, negligence, or poor quality of care and may not always be preventable.

Error: An unintended act, either of omission or commission, or an act that does not achieve its intended outcome.

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

1. Surgical site infections;
2. Ventilator-associated pneumonia;
3. Central line-related bloodstream infections;
4. Urinary tract infections; and
5. Other categories of infections as may be established by the State Board of Health by regulation pursuant to NRS 439.890.

Hazardous Condition: Any set of circumstances (exclusive of the disease or condition for which the patient is

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being treated), which significantly increases the likelihood of a serious adverse outcome.

Failure Mode and Effects Analysis (FMEA): A systematic, proactive method for evaluating a process to identify where and how it might fail, and to assess the relative impact of different failures in order to identify the parts of the process that are most in need of change.

Medical Error: Any event (unanticipated outcome) within the control of a provider that results in harm and requires a new or modified practitioner order for management of the patient's medical care.

"Near Miss": Used to describe any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome. Near misses fall within the scope of the definition of a sentinel event, but outside the scope of those sentinel events that are subject to review by The Joint Commission under its Sentinel Event Policy.

"Sentinel Events": Episodes of care that should never happen in any facility, at any time. Examples include patient abduction, wrong site procedure, and procedure on wrong patient.

Root Cause Analysis: A credible process for identifying the basic or causal factors that underlie variation in performance, including the risk of possible occurrence of a sentinel event.

Hospital Acquired Conditions: Conditions that result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis and could reasonably have been prevented through the application of evidence based guidelines. These include, but are not limited to:

1. Catheter-associated urinary tract infections
2. Central line-associated blood stream infection
3. Hospital acquired infections
4. Surgical site infections

Patient Safety Officer (PSO): The person who is designated as such by a medical facility pursuant to NRS 439.870. Northeastern Nevada Regional Hospital (NNRH) shall designate an officer or employee of the facility to serve as the PSO. The PSO will:

- Supervise reporting of sentinel events
- Serve on the patient safety committee
- Take such actions as he/she determines necessary to insure safety of patient as a result of sentinel event activity
- Report any action taken to Patient Safety Committee
- Work under the direction of the Director of Quality, Risk & Safety

POLICY:

The Safety Plan at NNRH is implemented to provide a collaboratively planned, systematic, organization-wide approach to process design and performance measurement, assessment and improvement of patient safety. With a goal of delivering the safest and highest quality health care to the residents of the community, the plan is designed and organized to support the mission, vision and values of the hospital and LifePoint Healthcare Inc.

In formulating the plan, it is recognized that the implementation of an effective patient safety plan is dependent on a participative management approach, including all organization leaders, the Governing Board, senior management, the Patient Safety Committee, departmental management, and medical staff. We believe

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our plan provides our organization with the mechanisms to achieve patient safety that is expected by our customers and the community we serve.

Senior management is fully committed to the belief that improving patient safety is the most important challenge that we face in the healthcare industry and in our hospital. The purpose of the plan is to develop mechanisms to integrate and coordinate the activities of all of our healthcare staff so that patient safety is the foremost concern at every stage of every process that we conduct. Patient safety is to be the number one priority in the design of new processes, in the evaluation of existing processes and in the re-design of existing processes. The hospital-wide goal is to be proactive in preventing errors and complications.

To accomplish this goal, we are committed to comparing ourselves to national databases, searching for "best practices", studying designs of systems, and always searching for methods of strengthening our existing system designs by adding risk reduction strategies. Senior leaders regularly evaluate the culture of safety and quality using valid and reliable tools and prioritize and implement changes based on such evaluations. All individuals who work in the hospital are able to participate in safety and quality initiatives, either on an individual basis or a team approach. Staff, including the medical staff, is encouraged to discuss any areas of concern that impact patient safety and quality. Relevant literature concerning patient and staff safety is distributed throughout the hospital in the form of flyers, posters, newsletters and through staff meetings. Patients and their family members are encouraged to speak with the hospital staff concerning any safety and quality issues.

PROCEDURE:

INFECTION CONTROL

The patient safety plan works collaboratively with the infection prevention and control plan which is based on a yearly risk assessment carried out by the infection control nurse under the direction of the Infection Control committee. This plan will be developed by a nationally recognized infection control organization as approved by the State Board of Health which may include without limitation, the Association for Professionals in Infection Control and Epidemiology, Inc., The Centers for Disease Control and Prevention (CDC) of the United States Department of Health and Human Services, The World Health Organization, etc.

This facility-specific infection control plan must be developed and reviewed under the supervision of a certified infection preventionist, pursuant to NRS 439.865.

The infection control nurse will be responsible for the implementation of this plan under the approval of the Infection Control committee and Board of Directors.

In the absence of the infection control nurse, the house supervisor or director on call will be responsible for the control of infections at all times.

REPORTING OF PATIENT SAFETY EVENTS

All employees have an affirmative duty to report any occurrence which is not consistent with the routine operation of the hospital and its staff, or the routine care of a particular patient or visitor, or any situation which has potential to cause harm to patients, visitors, or employees. This duty also applies to 'near miss' situations. *Willful failure to report such occurrences may subject the employee to corrective action up to and including termination.*

Patient related occurrences and other abnormal situations will be reported and tracked using an online electronic reporting database developed by **RL Solutions** according to the NNRH Occurrence Report Policy.

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NNRH will follow all statutory, regulatory and licensing agency reporting guidelines and NNRH policies.

A. NRS 439.835 mandates that
    a. Within 24 hours after becoming aware of a sentinel event, an employee of NNRH will notify the PSO of the event.
    b. Within 13 days after receiving notification, the PSO shall report the date, time, and a brief description of the sentinel event to the Health Division using their occurrence reporting form.
    c. If the PSO personally discovers or becomes aware of a sentinel event in the absence of notification by another employee, the PSO shall report the date, time, and a brief description of the sentinel event to the Health Division within 14 days after becoming aware of the sentinel event using their occurrence form.

National Quality Forum List of Serious Reportable Events:

A. Foreign object retained after surgery
B. Wrong surgical procedure performed on a patient
C. Surgery performed on the wrong patient
D. Intraoperative or immediately postoperative death in an ASA Class I patient
E. Death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the healthcare facility
F. Death or disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended
G. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility
H. Infant discharged to the wrong person
I. Patient death or serious disability associated with patient elopement
J. Suicide, or attempted suicide, resulting in serious disability while being card for in a healthcare facility
K. Death or serious disability associated with a medication error
L. Death or serious disability associated with a hemolytic reaction to the administration of ABO/HLA incompatible blood or blood products
M. Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare facility
N. Stage 3 or 4 pressure ulcers not present on admission
O. Death or serious disability due to spinal manipulative therapy
P. Artificial insemination with the wrong donor sperm or wrong egg
Q. Patient death or serious disability associated with an electric shock while being cared for in a healthcare facility
R. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances
S. Patient death or serious disability associated with a burn incurred from any source while being cared for in a healthcare facility

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T. Patient death or serious disability associated with a fall while being cared for in a healthcare facility. This includes but is not limited to fractures, head injuries, and intracranial hemorrhage.

U. Patient death or serious disability associated with the use of restraints or bed rails while being cared for in a healthcare facility

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

W. Abduction of a patient of any age

X. Sexual assault on a patient within or on the grounds of a healthcare facility

Y. Death or significant injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds of a healthcare facility.

NRS439.837 mandates that the facility shall, upon reporting a sentinel event, conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event. A Root Cause Analysis (RCA) will be performed, with all staff involved with the sentinel event, with an ultimate goal of preventing a recurrence.

Once opportunities for improvement are identified, strategies for change can be developed using evidence based practice. Measures are used to determine the effectiveness of the improvement and ongoing feedback is provided to staff, the Patient Safety Committee and Quality Council.

DISCLOSURE OF EVENT TO PATIENT AND/OR FAMILY

When a sentinel event, hospital acquired condition, or an outcome that differs significantly from the anticipated outcome occurs, the patient, and when appropriate, the patient's family or the patient's designee shall be informed as soon as reasonably possible but within 7 days (NRS 439.855). The disclosure of facts of an event should occur after determination of the surrounding facts and after consultation with the Chief Executive Officer (CEO) or designee or Risk Management.

In most instances, disclosure should be handled by the attending physician who has responsibility for the overall care of the patient. The physician or his/her designee should communicate:

- Acknowledgement of the event
- Data known to date
- That a full analysis will take place
- What is currently taking place as a result of the event
- Additional data on an ongoing basis
- Measures taken to prevent recurrence
- Apologize that an event occurred.

PATIENT SAFETY COMMITTEE

The Patient Safety Committee is the interdisciplinary committee designated to manage the organization-wide patient safety program and shall be organized with strict adherence to NRS 439.875.

The Governing Board is responsible for the oversight of the Patient Safety Plan. The Patient Safety Committee functions under the guidance and with the oversight of the CEO and Quality Council, with the PSO, or designee, serving as Chairperson. The meetings, records, data gathered, and reports generated by the Patient Safety Committee are protected by the peer review privilege set forth by the Health Care Quality

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Improvement Act of 1986 (Title IV of Public Law 99-660, as amended, and other applicable Nevada Statutes).

The committee shall be composed of the following members and others as the committee may from time to time add to accomplish specific goals and objectives within the authorized scope of activities outlined herein:

A. Facility Patient Safety Officer
B. Member of the Executive Team representing the Governing Board.
C. Director, Quality, Risk & Safety
D. Nursing representative
E. Medical representative
F. Member representing Pharmacy services
G. Infection Prevention and Control Practitioner

At each monthly meeting, a representative from each of the medical, nursing and pharmaceutical staff, executive team or Governing Board, and the PSO or designee, should be in attendance.

Members of the Patient Safety Committee can be called ad-hoc to assist the PSO in analyzing possible sentinel events or adverse outcomes or assist with any other urgent patient safety matter.

The committee shall operate within the following scope of activities (NRS 439.870):

- Receive reports from the PSO
- Evaluate actions of the PSO in connection with all reports of sentinel events alleged to have occurred in the hospital
- Review and evaluate the quality of measures carried out by the hospital to improve the safety of patients who receive treatment at the hospital
- Review and evaluate the quality of measures carried out by the medical facility to prevent and control infection at NNRH.
- Make recommendations to the Governing Board to reduce the number and severity of sentinel events that occur at the hospital
- Adopt patient safety checklists and patient safety policies according to NRS 439.877 for use by:
    - All providers of health care who provide treatment to patients at the medical facility
    - Other personnel of the medical facility who provide treatment or assistance to patients
    - Employees of the medical facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility
    - Persons with who the medical facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients at the facility
    - Patient safety checklists must follow best practice protocols to improve the health outcome of patients at NNRH according to NRS 439.877 and must include without limitation:
        - Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of health care
        - Checklist to ensure employees and contractors follow protocols to ensure that the room and environment of the patient is sanitary
        - Checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received discharge instructions regarding medication management

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        - Instructions concerning aftercare and any other instructions concerning patient's care after discharge
        - Checklists adopted by NNRH include:
            - Central Line Insertion (with prompt for practitioner order)
            - Universal Protocol and Surgical Site Fire Risk Assessment/Time Out
            - Safe Surgery Checklist
            - Discharge Instructions (prescription medication instructions, aftercare instructions, any other instructions related to discharge such as follow-up appointments)
            - Daily Room Cleaning (room and environment sanitation)
            - CDC Environmental Checklist for Monitoring Terminal Cleaning
            - Pre-Oxytocin Checklist (with prompt for practitioner order)
- In addition, the Patient Safety Committee will adopt and monitor compliance with our policy for the use of two patient identifiers, hand hygiene and any other patient safety checklist and policy adopted pursuant to this section. This may include active surveillance, a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.
- The Patient Safety Committee shall monitor and document the effectiveness of the patient identification policy and at least annually, review the patient safety checklists and patient safety policies adopted and consider any additional patient safety checklist and patient safety policies that may be appropriate for adoption at NNRH.
- On or before July 1st of each year, the committee submits a report to the Director of the Legislative Council Bureau for transmittal to the Legislative Committee on Health Care. The report is to include information regarding the development, revision, and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to paragraph above outlining checklist review (NRS 439.800).
- At least once each calendar quarter, report to the Governing Board or Executive committee regarding:
    - The number of sentinel events that occurred at the hospital during the preceding calendar quarter; and
    - The number and severity of infections that occurred at NNHR during the preceding calendar quarter
    - Any recommendations to reduce the number and severity of sentinel events and infections that occur at the hospital.
- The proceeding and records of a patient safety committee are subject to the same privilege and protection from discovery as the proceeding and records described in NRS 49.265.

REFERENCES:

TJC Standard LD.04.04.05 (2015): Patient Safety Program Components and Governing Body Report

TJC Standard LD.03.01.01 (2015): Patient Safety Culture Regular Evaluation (survey)

CMS CFR §482.21(e)(1): Patient Safety as a component of Performance Improvement Program

Nevada Revised Statutes §439.800 and any implementing Health Division and/or State Board of Health rules and regulations: Patient Safety Plan, Program, Officer and Committee; event reporting, investigation and action plan implementation; and an annual summary of events.

Nevada Revised Statutes §439.860 and any implementing agency rules and regulations pertaining to inadmissibility of report, document or other information compiled or disseminated pursuant to the provisions of §439.800 through §439.890, inclusive, in administrative or legal proceedings.

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Attachments

No Attachments

Approval Signatures

Approver	Date
Alice Allen: CNO	06/2021
Becky Jones: Cardiovascular Services Director	06/2021
Carol Riggio: Director of Quality, Risk and Safety	06/2021

Applicability

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PGH PERSHING GENERAL HOSPITAL & Nursing Home	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 date analyses are:

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

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

    3. Any Medication Error

    4. Any Adverse Drug Reaction

    5. Any Transfusion Reaction

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

    7. Sentinel Event – is defined as an unexpected occurrence, involving facility acquired infection, death or serious physical or psychological injury or the risk thereof, including, without limitation, any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. The term includes loss of limb or function (NRS 439.830). It is called a sentinel event because it signals the need for immediate investigation and response.

        The Mandatory reportable sentinel events include events that have resulted in an unanticipated death or major permanent loss of function.

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

    1. Patient Rights including freedom from abuse/neglect;

    2. Assessment of Patient;

    3. Care of Patients to include special considerations;

    4. Patient/Family and Lay Caregiver Education

    5. Continuum of Care

6. Management of Information

7. Management of Human Resources

8. Management of the Environment of Care

9. Surveillance, Prevention and Control of Infection

2. Methodology:

   a. The 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.

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

PATIENT SAFETY COMMITTEE

	POLICY NO:
SUBJECT: Patient Safety Plan	**PAGE NO: 1 of 8**
	EFFECTIVE: 11/2002
	REVISED:1/2021
CROSS: Medical Staff	**APPROVED:**

POLICY: South Lyon Medical Center Patient Safety Plan

PROCEDURE:

1. The Medical Staff, with the approval of the Governing Board shall develop and implement a Patient Safety Plan to encompass all facets of patient care at South Lyon Medical Center. This includes Acute Care, Long Term Care and Rural Health Clinics.

2. The Medical Staff will appoint and submit to the Governing Board for approval the implementation of a Patient Safety Committee which will comprise at a minimum: a physician, a nurse, pharmacist, governing board member and risk manager. This committee shall:

    a. function under the authority of the Medical Staff
    b. meet monthly
    c. investigate, report and formulate corrective actions related to alleged sentinel events
    d. review medical equipment/devices safety and maintenance inspections
    e. review and recommend actions related to medication events
    f. review and investigate patient care related incident reports
    g. review, investigate and recommend corrective actions for near-miss events
    h. additional tasks as assigned by the Medical Staff

3. The Administrator shall appoint a Patient Safety Officer whose responsibilities are outlined in the position description.

4. The Patient Safety Plan shall include but not limited to the following items:

    I. General:

    a. Patient Safety involves a variety of clinical and administrative activities that health care organizations undertake to identify, evaluate, and reduce the potential for harm to beneficiaries and to improve the quality of health care. Effective medical/health care error reduction requires an integral approach and a supportive environment, in which patients, their families, organization staff and leaders can identify, manage and learn from actual and potential risks.
    b. A successful patient safety program facilitates non-punitive, interdisciplinary approach to decrease unanticipated adverse health care outcomes. The organizational focus is on

continued learning about risks and mitigation strategies and reengineering systems/processes to reduce the chance of human error. South Lyon Medical Center (SLMC) fosters and supports an organizational environment that recognizes and acknowledges potential risks to patient safety and the occurrence of medical/health care errors. The patient safety program encourages medical error reporting in order to identify system or process failures and to enhance improvement strategies.

II. South Lyon Medical Center (SLMC) Patient Safety Program

a. The goal of the SLMC Patient Safety Program is to reduce the chance that the adverse effects of human error will harm patients. By creating and promoting a culture in which staff willingly report actual and near-miss patient safety related events without fear of disciplinary action, SLMC is encouraging these events to be freely identified. Once events have been identified, systems and processes can be analyzed and improved in order to prevent future recurrence. Improved systems and processes result in a safer patient care environment.
b. SLMC Patient Safety Program 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 that on the individual involved in a given patient safety related mishap. This paradigm is very different from that which prevails in the health care community at large. In the patient safety conscious culture, when an error occurs the response is not to ask "who", but rather "why". This new paradigm can exist in light of other organizational expectations associated with risk management, claims management and review of potentially compensable events (PCE) for which the facility may incur financial liability.
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.

WILLIAM BEE RIRIE CRITICAL ACCESS HOSPITAL/RURAL HEALTH CLINIC Ely, Nevada ADMINISTRATION POLICY & PROCEDURES	
Department: Facility Wide	**Program/Manual: Administration**
Policy Subject: Patient Safety Plan	**Section Number: P**
Effective Date: 01/1990	**Revision Date: 9/26/2011, 2/17/2015, 3/14/2018, 12/27/2018**

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 date, evaluate care processes for opportunities to reduce risk and initiate proactive measures
- Report internally and findings and actions taken to reduce risk
- Support sharing of knowledge to effect change
- Supplying support systems to health care workers who are involved in sentinel events.
- Have a sufficient number and mix of individuals to support safe, quality care, treatment, and services.

V. RESPONSIBILITES/DUTIES

It is William Bee Ririe Hospital and Rural Health Clinic's responsibility to designate an officer or employee of the facility to serve as the patient safety officer of the medical facility.

The duties of the designated patient safety officer are:

- To serve as the patient safety officer of WBRH and RHC
- Serve on the Enterprise Safety Committee
- Supervise the reporting of all sentinel events alleged to have occurred at the WBRH and RHC, including, without limitation, performing required pursuant to NRS 439.835
- Duties pursuant to 439.835 are
    a) A person who is employed by WBRH and RHC shall, within 24 hours after becoming aware of a sentinel event that occurred at WBRH and RHC, notify the patient safety officer of the sentinel event.
    b) The patient safety officer shall, within 13 days after receiving notification, report the date, the time and a brief description of the sentinel event to The Health Division and facility representative if that person is different from the patient safety officer.
    c) If the patient safety officer of WBRH and RHC personally discovers or becomes aware, in the absence of notification by another employee, of a sentinel event that occurred at WBRH and RHC, the patient safety officer shall, within 14 days after discovering or becoming aware of the sentinel event report the date, time and brief description event to those listed in b) above.

- Take such action as he or she determine to be necessary to insure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at WBRH and RHC
- Report to the Enterprise safety committee regarding any action taken in accordance to the above paragraph.
- Upon discovery notify the CEO immediately.

The Enterprise Safety Committee shall meet each month

The Patient Safety Plan and any changes thereafter shall be presented to the governing board of WBRH and RHC for approval.

The Patient Safety Plan must include, without limitation, the patient safety checklists and patient safety policies most recently adopted in regards to the patient safety plan.

After the WBRH and RHC's patient safety plan is approved, WBRH and RHC shall notify all providers of health care who provide treatment to patients at WBRH and RHC of the existence of the plan and of the requirements of the plan. WBRH and RHC shall require compliance with the patient safety plan.

The Enterprise safety Committee shall

- Receive reports from the Patient Safety Officer
- Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred at the facility
- Review and evaluate the quality of measures carried out by WBRH and RHC to improve the safety of patients who receive treatment at WBRH and RHC
- Make recommendations to the governing body of WBRH and RHC to reduce the number and severity of sentinel events that occur at WBRH and RHC.

The Enterprise Safety Committee provides a multidisciplinary forum for the collection and analysis of risk to patient safety and the dissemination of information on identified risk for the purpose of improving patient care. It shall review reports on occurrences including near misses to sentinel events. It shall identify those individuals or groups best situated to perform a root cause analysis and develop and implement an action plan for identified issues. It shall review, analyze and disseminate the information it receives, as appropriate, to the designated individuals and/or committees. Is shall provide recommendations concerning identified risks, approve plans for corrective actions and evaluate the implantation of corrective actions taken.

Membership will include: CEO, CNO, CIO, Pharmacist, QIC, Infection Control, Materials Manager, Environmental Safety Officer, Patient Safety Officer, and a Medical Staff Member.

VI. SCOPE

The types of occurrences to be addressed include, but are not limited to, sentinel events, near misses, and actual events related to:

a) Patient safety
b) Adverse drug events (medication errors and adverse drug reactions)
c) Health acquired infections
d) Patient Falls
e) Other patient incidents/unexpected clinical/medical events
f) Unsafe conditions
g) Visitor safety
    - Visitor incidents
h) Employee safety
    - Blood/body fluid exposures
    - Occupational diseases
    - Communicable disease exposures
    - Musculoskeletal injuries
    - Immunization programs
    - Other employee incidents
i) Environmental safety
    - Product recalls
    - Drug recalls
    - Product/equipment malfunction
    - Construction –Infection Control Risk Assessment
    - Water Quality
    - Air Quality
    - Disaster Planning
    - Security incidents
    - Workplace violence

Data from external sources, including but not limited to:

- Centers for Disease Control and Prevention (CDC)
- Joint Commission
- Institute for Healthcare Improvement (IHI)
- Institute for Safe Mediation Practices (ISMP)
- Occupational Safety and Health Administration (OSHA)
- Nevada State Health Division
- Published literature

VII. DEFINITIONS

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

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

- Surgical site infections
- Ventilator-associated pneumonia
- Central line-related bloodstream infections
- Urinary tract infections; and
- Other categories of infections as may be established by the Administrator.

Medical Error is defined as failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim. Medical errors may or may not cause harm.

Serious Error is an error resulting in patient injury including the potential to cause permanent injury or transient but potentially life-threatening harm

Minor Error is an error that does not cause harm or have the potential to do so

Near Miss is an error that could have caused harm but did not reach the patient because it was intercepted.

VIII. STRUCTURE

The authority for the Patient Safety Plan rests with the CEO, CNO, Quality Improvement Coordinator, Patient Safety Officer, and Chief of Medical Staff and has delegate the authority to implement and maintain activities described in this plan to the Enterprise safety committee.

IX. QUALITY REVIEW INFORMATION

To the extent possible, and in the manner consistent with the protection of confidentiality of quality assurance and patient safety data, pertinent information will be shared between the Quality Improvement Program and the Enterprise Safety Program.

In an attempt to protect quality review information from discovery, all quality review documents must be labeled as a Quality Review document. Documents should be in a formal format, handled by a limited number of individuals and secured in the Quality or Risk

Managers Office accessible only to designated individuals. Nevada Revised Statute that protects quality documents is NRS49.265.

X. EDUCATION

Annual Staff and physician/provider education includes but is not limited to the following topics:

- Fire Drills
- Emergency and Disaster Drills
- Workplace violence
- Customer Service
- Creating, implementing, achieving, and maintaining a culture of Enterprise safety
- Risk management and error prevention
- Teamwork

XI. SAFETY IMPROVEMENT ACTIVITIES

Specify Measures Selected for an annual focus; (Examples are listed below)

- Patient satisfaction surveys
- Medical Record review; legible documentation, clear, complete, signed
- Complaints and resolution; to improve care and satisfaction (trends)
- Confidentiality; insure patient and employee information is secure
- Appointments/scheduling process; accessibility to physician
- Informed Consent Policy and Procedure
- Medication management and reconciliation i.e. allergy information current
- Telephone response time to callers
- Occurrence review

Give consideration to measures that facilitate safe practices; (Examples are listed below)

- Involve patients in their health care; consider literacy issues and cultural values, partner with patients in developing and planning their care plan.
- Use a team approach to safety; hold focused safety meetings
- Endorse open, effective communication; identify shared values and attitudes among all members. Interview and/or survey staff for attitudes, perceptions and communication barriers.
- Encourage error reporting to include near miss events. Institute a non-punitive reporting that is confidential and timely.
- Ensure employee and patient information or event reports shared with staff for educational purposes do not identify individuals.
- Facilitate communication skills learning (teamwork)
- Examine physical premises to identify and correct potential hazardous conditions.
- Orient physicians and new employees to risk management and patient safety concepts
- Conduct patient safety rounds

- Provide education and training on high risk processes.

XII. METHODOLOGY

A. Structure
   - Proactive risk prevention strategies
   - Identification of High Risk Areas
   - General Incidences (Patient Injuries)
   - Potential or actual adverse events (medication errors)

B. Method – Establish a process for;
   - Identification, Selection, Prioritization
   - Data Collection and Analyses
   - Development of Actions
   - Implementation
   - Reporting
   - Follow-up

C. Process Improvement – Establish teams/individual staff members to implement processes and to monitor for effectiveness.
   Utilize applicable tools to facilitate improvement; for example
   - PDCA: Plan, Do Check Act with focus on process improvement
   - FMEA: Failure Mode Effect Analysis a systematic process for identifying potential process failures before they occur with the intent to eliminate or minimize risk.
   - RCA: Root Cause Analysis is a retrospective approach to error analysis that identifies what and how the event occurred and why it happened. The focus in on the process and systems not individuals.

XIII. PROGRAM EVALUATION

The Patient Safety Officer will submit monthly a report the Enterprise Safety Committee, Medical Staff and the Board of Directors.

1. Definition of the scope of occurrence including sentinel events, near misses and serious occurrences that occurred at WBRH and RHC during the preceding month including;
   - Employee injuries
   - Potential lawsuits
   - Resolutions
   - Recommendations to the decrease of the number and severity of Sentinel Events

Yearly the Patient Safety Officer will submit to the Enterprise Safety Committee, Medical Staff and the Governing Board the following;

a. Detail of activities that demonstrate the enterprise safety program has a proactive component by identifying the high-risk process selected.
b. Results of the high-risk or error-prone processes selected for ongoing measurement and analysis.
c. A description of how the function of process design that incorporates patient safety has been carried out using specific examples of process design or redesign that include patient safety principles.
d. The results of how input is solicited and participation from patients and families in improving patient safety is obtained.
e. The results of the program that assesses and improves staff willingness to report errors.
f. A description of the examples of ongoing education and training programs that are maintaining and improving staff competence and supporting an interdisciplinary approach to patient care.

Yearly the Enterprise Safety Committee shall;

1. Monitor and document the effectiveness of the patient identification policy.
2. Review the patient safety checklists and patient safety policies adopted and consider any additional patient safety checklists and patient safety policies that may be appropriate for adoption for use at the medical facility.
3. Revise a patient safety checklist and patient safety policy adopted as necessary to ensure that the checklist or policy reflects the most current standards in patient safety protocols.
4. On or before July 1 of each year, submit a report to the Director of the Legislative Counsel Bureau for transmittal to the Legislative Committee on Health Care. This report must contain;
    - Information regarding the development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted.

XIV. NO CRIMAL PENALTY OR CIVIL LIABILITY

No person is subject to any criminal penalty or civil liability for libel, slander or any similar cause of action in tort if the person, without malice;

- Reports sentinel event to a governmental entity with jurisdiction or another appropriate authority.
- Notifies a governmental entity with jurisdiction or another appropriate authority of a sentinel event.
- Transmits information regarding a sentinel event to a governmental entity with jurisdiction or another appropriate authority
- Compiles, prepares or disseminates information regarding a sentinel event to a governmental entity with jurisdiction or another appropriate authority; or

- Performs any other act authorized pursuant to NRS 439.800 to 439.890.

NRS439.860 ANY REPORT, DOCUMENT AND ANY OTHER INFORAMTION COMPILED OR SIDDEMINATED PURSUANT TO THE PROVISIONS OF NRS 439.800 TO 439.890, INCLUSIVE AND SECTION I OF AB 280 IS NOT ADMISSIBLE IN EVIDENCE IN ANY ADMINISTRATIVE OR LEGAL PROCEEDING CONDUCTED IN THE STATE OF NEVADA.

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

Section Title: Facilities And Environment	**Section:** 8
Subject : ADA Compliance Policy	**Policy:** 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.

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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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.

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III. STRUCTURE:

Governing Body

The Governing Body of the Ambulatory Surgical Center of Southern Nevada (ASC of Southern Nevada) is comprised of members including: ASC principal owners, Administrator and Medical Director. The Governing Body assumes full legal responsibility for determining, implementing and monitoring policies so as to provide quality health care in a safe environment and to protect the health and safety of patients and employees. When services are provided through a contract with an outside resource, the Ambulatory Surgical Center of Southern Nevada (ASC of Southern Nevada) will, to the best of its ability, assure that these services are provided in a safe and effective manner. The Governing Body will carry out the following duties and responsibilities either directly or by delegation to committee(s).

The Governing Body oversees this responsibility by:

- Ensuring each patient admitted to the facility is under the care of a physician.
- Ensuring each patient admitted to the facility has had a pre-surgical exam within seven days prior to the date of the procedure.
- Ensuring that a physician is on the premises and is immediately available at all times while patients are in procedure rooms or in the recovery area.
- Maintaining an adequate number of qualified and competent staff to meet the needs of the patients.
- Oversight and accountability for developing a program of quality improvement and risk management appropriate to the specific needs of ASC of Southern Nevada that follow all federal, state and third party regulatory requirements.
- Ensuring that the facility policies and procedures are administered in such a manner that provides health care in a safe environment.

Medical Director

The Medical Director who also serves as the Patient Safety Officer represents the ASC and the medical staff in decision-making processes through direct participation and/or formal referral recommendations. The Medical Director is responsible for determinations as to needed resources when providing services relating to patient care.

The duties of the Medical Director include:

- Oversee and actively participate in the Quality Assurance/Risk Management activities.
- Oversee and actively participate in the Patient Safety Committee
- Participate in the development and have final approval on all service specific policies and procedures associated with patient care.
- Responsible for providing continuing educational in-services for the facility and medical staff in regards to patient care when necessary.
- Active role in evaluating and identifying staffing needs.

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Risk Management/Patient Safety Officer
The Patient Safety Officer will have primary oversight of the facility-wide patient safety program. The Patient Safety Officer will direct others within the facility towards process improvements that will support the reduction of medical/health care errors and other factors that contribute to unexpected adverse patient outcomes.

The duties of the Patient Safety Officer include:

- Notify the liability insurance carrier when adverse or reportable events occur.
- Coordinates the activities of the Patient Safety Committee.
- Investigate patient safety issues, along with the patient safety committee, within the facility.
- Recommend and facilitate change within the organization to improve patient safety based on identified risks.
- Serve as a resource on issues of patient safety.
- Support and encourage error reporting throughout the facility through a non-punitive error reporting system.
- Take such action as he/she determines necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the Governing Body on the occurrence of known medical and health care errors and identified near misses and dangerous conditions within the facility.

Patient Safety Committee
Patient Safety Committee is a part of the Quality Assessment Performance Improvement Committee and is comprised of the Medical Director, Administrator/ Patient Safety Officer, Director of Nursing and the charge. The Patient Safety Committee/Quality Assessment Performance Improvement Committee is responsible to the Governing Body and Administration for the overall operation of the Risk Management and Patient Safety Plan. The Patient Safety Committee meets on a quarterly basis or as needed. Patient Safety Goals will be developed on a yearly basis.

The duties of the Patient Safety Committee include:

- Reviewing and evaluating the quality of patient safety measures.
- Review all adverse outcomes.
- Review incidents
- Making recommendations to eliminate future serious events or incidents.
- Reporting to the Governing Body on a quarterly basis to include the occurrence of medical/health care errors and actions taken to improve patient safety.

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

IV. Definitions

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

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

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

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

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

- Equipment Reprocessing errors not used on patients.

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V. Reporting Mechanisms

To effectively reduce adverse patient outcomes, there must be an environment that supports employees by identifying and learning from errors and system failures. Ambulatory Surgical Center of Southern Nevada (ASC) encourages all employees to report any errors or work methods that may lead to potential adverse patient outcomes. The ASC supports a non-punitive, open communication culture.

A. Non-Punitive Reporting

The facility recognizes that if we are to create a safe environment for our patients and visitors, we must create an environment that is safe for caregivers to report and learn from events and near misses. The facility requires that employees report errors and encourages them to do so.

1. The goal is to identify and track errors in order to continuously improve our systems and to provide the necessary education to prevent reoccurrence.
2. All events, especially those of a clinical nature need to be reported immediately. It is expected that complete disclosure shall occur. Reporting will be in confidence and shall not suffer harassment or retaliation.
3. An employee who knowingly fails to report a clinical error will be subject to disciplinary action.

B. Adverse Event/Incident/Complication/Infection Tracking System

1. All information regarding Complications and Adverse events is collected and documented in the Incident Tracking Report and the Adverse Reactions and Complications Report.
2. The data reviewed that is not consistent with the normal operations of the facility or the anticipated disease/treatment process of the patient is communicated to the Medical Director and or Administrator.
3. The facility's processes will be reviewed to determine methods to prevent reoccurrence, improve quality care and ensure patient and visitor safety.

C. Sentinel Events

When a sentinel event occurs, appropriate individuals are notified and immediate attention investigation is undertaken. The sentinel event policy describes the reporting structure and responsibilities of the designated individuals. A root cause analysis and action plan may be implemented if necessary.

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D. Patient Complaint/Grievance

Complaints can be reported to the Director of Nursing, Administrator or Medical Director. Employees should report all complaints immediately to their supervisor. Patients should notify the Director of Nursing. All complaints will be investigated and a response or corrective action will be made.

VI. Communicating With Patients About Safety

1. Patients Rights and Responsibilities, Advance Directive, Complaint and Grievance Process and Physician Ownership Disclosure shall be explained to the patient at the time the procedure is scheduled via the written copy provided to them.
2. Patients are also provided instructions prior to their procedure.
3. Patient education is provided on safe use of medication regarding their procedure.
4. The day of procedure, the nurse reviews the procedure with the patient and what is involved in the pre and post op care.
5. The nurse verifies the allergies with the patient and medications' confirming that the patient has withheld the anticoagulants, anti-inflammatory and aspirin as ordered by the physician.
6. Verify procedure with patient.
7. Encourage patient to ask questions.
8. If there is a language barrier provide interpretation.
9. Use side rails once patient is in gurney to prevent falls.
10. Make sure the patient uses the call light to ambulate off gurney.
11. Involve patients in Time Outs in procedure room before start of case.
12. Review post-op instructions with patient or family member and verify that the patient understands his/her instructions.
13. Confirm that the patient has an adult to drive them home and does not operate vehicle post procedure if sedation was administered.
14. Confirm that follow-up appointment is communicated with patient if needed.
15. Provide educational pamphlets on diagnosed conditions for patient education.

VII. Staff Education

1. Initial and annual training is provided to all employees on safety in the work environment.
2. Risk Management, Infection Control, Hand Hygiene, Blood Borne Pathogens, Personal Protective Equipment and Safe Injection Practices Training is provided to staff.
3. Educating and following the Time Out Policy to assure that we have the right patient and

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and the right procedure.
4. Importance of verifying color of arm band for the correct patient, correct procedure.
5. Staff meetings are held to communicate quality improvement and patient safety issues.
6. Ongoing education to staff is provided regarding patient safety issues.
7. Staff education on all disinfectants used throughout the facility.
8. Patient safety checkpoints are added to the pre, intra and post documentation.

VIII. Safety Improvement Activities/Methodologies

Medication/Pharmacy Surveillance – All matters pertaining to the use of drugs in the Center will be monitored on a monthly basis by a contracted pharmacist. See service Contracts for facility.

High Alert Medications – All employees or providers that handle patient medication will follow the procedure for the safe storage and handling of high alert medications. See High Alert Medication Policy.

Infection Surveillance – Infection surveillance will be completed by the Director of Nursing, or his/her designee, on a monthly basis or as needed and the findings reviewed with the Patient Safety Committee and staff. Identifying processes that can cause potential risk to patient and visitor safety will be addressed. Recommendations will be communicated to staff members on any new measures to be implemented to ensure patient and visitor safety.

Facility Safety Surveillance – Facility safety surveillance will be done on a monthly basis by a designated employee or as needed to ensure there are no hazardous conditions that would be a safety concern for patients, visitors or employees.

Follow-up Phone Calls to Patients – All patients are called post procedure to document any Complications they may be having or questions they may have.

Patient Satisfaction Survey – Patient Satisfaction surveys are completed on a random number of patients on a monthly basis. The results are communicated to the employees Physicians and the Administrator which function collaboratively to achieve positive patient outcomes when possible.

Monthly Physician Infection Control Reports – Physicians communicate to the Director of

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Nursing any patient that may have developed an infection that was not identified on the Follow-up phone call made by the nurse.

High-Level Disinfectant Solution Checks – Before each endoscope is placed in the automated endoscope reprocessor, the minimum effective concentration is checked to ensure that the active ingredient in the solution still passes the manufacturer's guidelines for reuse before the endoscope is placed in the machine. This is done for each endoscope with all data documented into log books.

Cleaning and Disinfection of Patient Care Equipment – All reusable equipment is classified and processed according to the CDC's guidelines. Employees clean all reusable equipment to ensure the health and safety of our patients.

Safe Injection Practices – All patient care providers follow safe injection practices to prevent patient to patient transmission of bloodborne pathogens. See Safe Injection Practices policy.

Time Outs – Performed with the anesthesia provider, physician and GI Tech before the start of each procedure to verify right patient, right procedure and allergies.

Hospital Transfers – Any patient transferred to the hospital post procedure will have a peer review process performed to recommend areas of improvement if necessary and quality of care.

Cecal Intubation Rates – All physicians are monitored and reported on a monthly basis. Rates are benchmarked against best practices for colonoscopy completion rate. Effective colonoscopists should be able to intubate the cecum in more than 90% of all cases and in more than 95% when the indication is screening and healthy adult.

Withdrawal Time – All physicians are monitored and reported on a monthly basis. Rates are benchmarked against best practice which is more than or equal to 6 minutes.

Physician Peer Review – All physicians are monitored quarterly. Ten charts are reviewed per physician and anesthesia provider. Results are communicated to the Medical Director.

IX. Annual Review of Patient Safety Plan

The Patient Safety Committee is responsible for the annual review of the Patient Safety Plan. Included in this review the committee will set goals for the new year and focus on

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the patient quality indicators that affect patient safety and patient health outcomes. Quality Indicators will be selected throughout the year and QI studies will be implemented to evaluate our current processes. This effort is undertaken so that processes, functions and services can be designed or redesigned to improve patient services or prevent any health risks to patients.

NEVADA ENDOSCOPY MANAGEMENT, INC
GASTROENTEROLOGY CONSULTANTS, LTD
RENO ENDOSCOPY CENTER, LLC
SOUTH MEADOWS ENDOSCOPY CENTER, LLC
CARSON ENDOSCOPY CENTER, LLC

POLICY AND PROCEDURE MANUAL

Policy: **Patient Safety Plan**
Owner: **Center**
Date last updated: 9/2021

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 2019
      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

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

f. Equipment Processing: Cleaning, Disinfection, High Level Disinfection and Sterilization

II. Patient Selection and Screening: Refer also to the Criteria for Scheduling Patients at ASC Policy.

1. To ensure patients are appropriate for the planned procedure in the planned setting patients undergo:
   a. Pre-procedure scheduling evaluation with referral for office visit or consultation as appropriate
   b. Pre-procedure assessment which includes at a minimum:
      i. Review of past medical & surgical history
      ii. Medication reconciliation, review
      iii. Allergy and reaction, review of
      iv. Physical assessment; assessment for communicable diseases
      v. Vital signs

III. Patient Identification: Refer to Patient Identification Policy. Patient identity is verified with at minimum two (2) identifiers at check-in and at multiple points throughout care.

IV. Safe Surgery Checklist: Refer to Safe Surgery Checklist Policy. Patient and procedure are verified immediately prior to procedures.

V. Discharge Teaching: Patients are provided with written discharge instructions which are reviewed with patient and driver, as applicable, prior to discharge. Medications are reconciled prior to discharge if any new medications are ordered. Information specific to diagnosis, as best as known, is given to the patient. Patients are educated about signs and symptoms to report and given a twenty-four (24) hour telephone number to call in event of questions or concerns.

VI. Post Procedure Callbacks: Patients are contacted one (1) to two (2) business days post-procedure for follow up of any concerns and questions regarding discharge instructions.

VII. Pathology follow up: Patients are notified of pathology results and given information and follow up orders as applicable within two (2) weeks.

VIII. Pharmaceutical Services: Refer to Pharmaceutical Services Policy. Safe injection practices are strictly followed. Pharmaceutical services are overseen by a contracting pharmacist on a monthly basis.

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

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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 tacked 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)

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

~~VERSION:~~

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.

~~This plan was created and revised by the_ (facility name) _ 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~~Facility name:~~
2779 W. Horizon Ridge Parkway Suite 140~~Facility Address~~
P 702-589-9250 F 702-589-9257~~Facility contact information~~

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Commitment to Patient Safety

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

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Mission, Vision, and Values

In support of our mission, vision, and values, Coronado Surgery Center ~~(facility name'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 ,~~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 ~~(facility name)~~ 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 ~~(facility name)~~ has developed this Patient Safety plan.

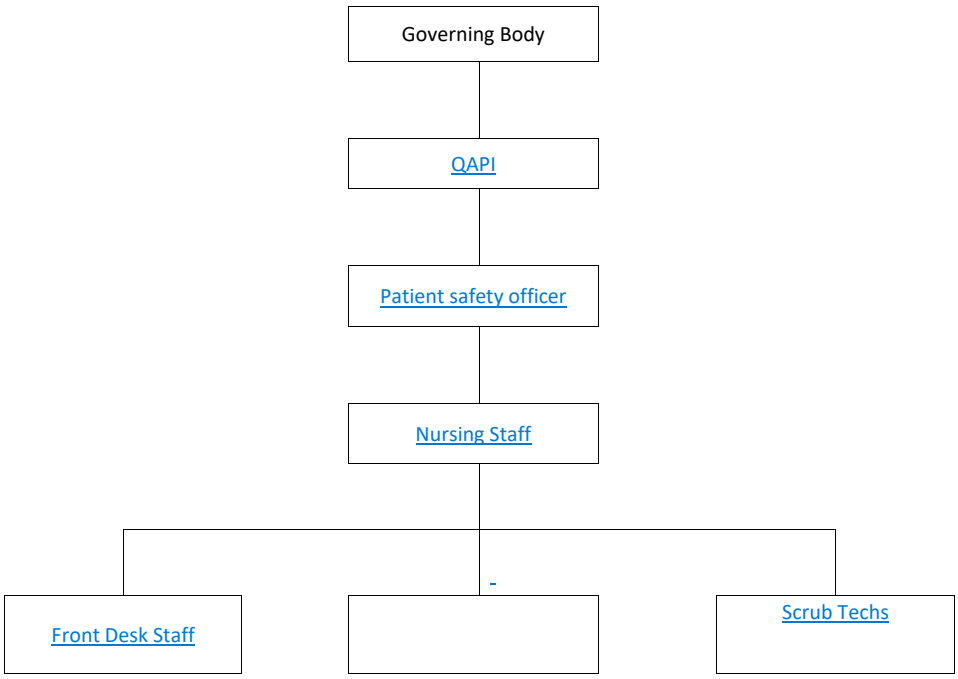
The plan focuses on the process rather than the individual, and recognizes both internal and external customers, as well as facilitates the need of analyzing and improving processes. The core principles of this plan include:

- 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



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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.

Based on NAC 439.920, a medical facility that has fewer than 25 employees and contractors must establish a patient safety committee comprised of:

- The patient safety officer of the medical facility;
- At least two providers of healthcare who treat patients at the medical facility, including but without limitation, one member of the medical staff and one member of the nursing staff of the medical facility; and
- The Chief Executive Officer (CEO) or Chief Financial Officer (CFO) of the medical facility.

The roles and responsibilities are defined below (Please modify them as needed.)

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

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

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

Root Cause Analysis (RCA) Team Responsibilities ~~(please revise as needed)~~

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

Patient Safety Officer Responsibilities (based on NRS 439.870)

- Serve on the patient safety committee.
- Supervise the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to NRS 439.835.
- Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the patient safety committee regarding any action taken in accordance with the responsibilities above.

(Additional responsibilities here if needed)

Infection Control Officer Responsibilities (based on NRS 439.873)

- Serve on the patient safety committee.
- Monitor the occurrences of infections at the facility to determine the number and severity of infections.
- Report to the patient safety committee concerning the number and severity of infections at the facility.
- Take such action as determines is necessary to prevent and control infections alleged to have occurred at the facility.
- Carry out the provisions of the infection control program adopted pursuant to NRS 439.865 and ensure compliance with the program.

(Additional responsibilities here if needed)

RCA team leader Responsibilities ~~(please revise as needed)~~

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

- Provide training, education and direction to create RCA process that incorporate the Patient Safety and Quality Improvement elements.

RCA Facilitator Responsibilities

- 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

~~(Please provide the responsibilities here)~~

Executive or Governing Body Staff Responsibilities ~~(please revise as needed)~~

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

~~(Please provide additional responsibilities here if needed)~~

~~T~~The Patient Safety Committee will meet ~~monthly (or~~ quarterly~~)~~ to accomplish the following:

- Report and discuss sentinel events which include:
  - Number of sentinel events from previous ~~calendar month (~~or quarter~~).~~
  - Number of ~~severe infections~~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

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- 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

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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.

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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."

Coronado Surgery Center ~~(Facility name)~~ will use RCA process to determine the contributing factors and the underlying reasons for the deficiencies or failures. The Plan-Do-Study (check)-Act (PDSA or PDCA) is the model, which was developed by the Institute of Health Care Improvement, that we will use to test the changes.

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Root Cause Analysis

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

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

Root cause analysis and action plan framework table, which was introduced by the Joint Commission. It contains 24 analysis questions. It guides the organization to the steps in a root cause analysis. Not all the

questions apply to all the events or cases. This table can be used individually or with the fishbone diagram.

5 Whys technique will be used ~~i~~at Coronado Surgery Center t~~n (facility name) t~~o 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.

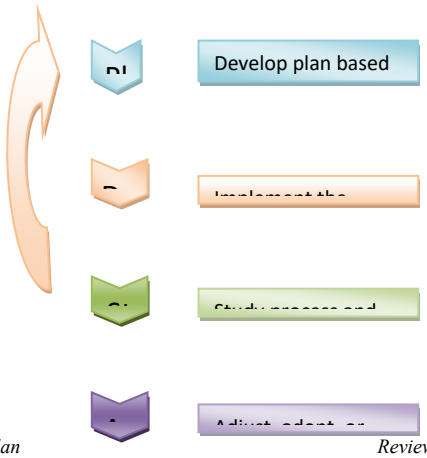
Fishbone Diagram

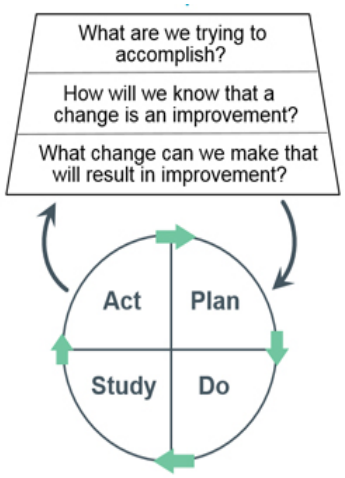
Once the problems are identified, a Fishbone Diagram (Appendix C) will be used for analyzing the problems. You can use the fishbone diagram individually to analyze the root causes or use it with the root cause analysis and action plan framework table.

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 ~~(Facility name)~~ is using ~~(data system name~~Redcaps~~)~~ for tracking the sentinel events, healthcare infection data, and variance ~~(any other database) for~~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 ~~according to~~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~~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 (~~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.

Compliance with ADA at Coronado Surgery Center

A person with a disability can be a person with a mobility or physical disability, sensory (vision or hearing), intellectual, psychiatric, or other mental disability. People with medical conditions such as HIV/AIDS, epilepsy, rheumatoid arthritis, and cancer are also covered under the ADA.

Health care facilities, that provide services to the public are covered by the ADA. The ADA requires that health care entities **provide full and equal access for people with disabilities**. This will be done through: Reasonable Modifications of Policies, Practices, and Procedures, **Effective Communication- making** communication, in all forms easily understood **and physically accessible.**

The term "reasonable modification" is a broad concept that covers every type of disability. Examples are: • Granting an early appointment to a patient with anxiety so that fewer people will be in the office and noise will be minimal. • Allowing a companion to assist a person with a mobility disability with positioning the patient. • For a patient who has low vision or is blind, paperwork can be read aloud and completed by staff. • Allowing additional time to explain care to a patient with an intellectual disability. • Allowing a service dog that has been trained to alert their handler with a seizure disorder at the onset of a seizure to be present in the pre-op area.

Resources on reasonable modifications of policies, practices, and procedures: • The ADA National Network Disability Law Handbook • ADA reasonable modification regulations for state and local governments • ADA public accommodations regulations • Service animals Can be found at https://www.adapacific.org/healthcare#modification-policies-practicesprocedures

The patient safety checklists are listed in Appendix E. ~~(The following links provide some patient safety~~ checklists for your reference— ~~a checklist example is shown in **Appendix E**.)~~

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

http://www.who.int/patientsafety/implementation/checklists/en/

The patient safety policies are listed in Appendix F. (The following link provides you some patient safety policies for your reference—a policy example is shown in **Appendix F**.)
https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1

Approval of Patient Safety Plan

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

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

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

Reference

- Root Cause Analysis Toolkit http://www.health.state.mn.us/patientsafety/toolkit/
- Quality and Service Improvement Tools http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html
- CQI 101 An Introduction to Continuous Quality Improvement: https://www.coursehero.com/file/13827355/CQI-Overviewppt/
- Quality Improvement http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/
- Root Cause Analysis http://www.patientsafety.va.gov/professionals/onthejob/rca.asp
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2 https://www.jointcommission.org/sentinel_event.aspx
- Hospital Policies https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1
- Checklists to Improve Patient Safety http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf
- Patient Safety Checklists http://www.who.int/patientsafety/implementation/checklists/en/
- Minutes of the Meeting of the Quality and Patient Safety Committee http://www.cookcountyhhs.org/wp-content/uploads/2013/12/09-23-14-QPS-scan-Minutes.pdf
- Title 40 – Public Health and Safety https://www.leg.state.nv.us/NRS/NRS-439.html

Appendix A: Terms and Definitions

Patient Safety: The Agency for Healthcare Research Quality (AHRQ) defines patient safety as "a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events." http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

Sentinel event (NRS 439.830)

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

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

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

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

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

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

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

Facility-Associated Infection: (NRS 439.802)

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

- Surgical site infections;
- Ventilator-associated pneumonia;
- Central line-related bloodstream infections;
- Urinary tract infections; and

- Other categories of infections as may be established by the State Board of Health by regulation pursuant to NRS 439.890.

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

Medical facility (NRS 439.805)

"Medical facility" means:

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

(Added to NRS by 2002 Special Session, 13)

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

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

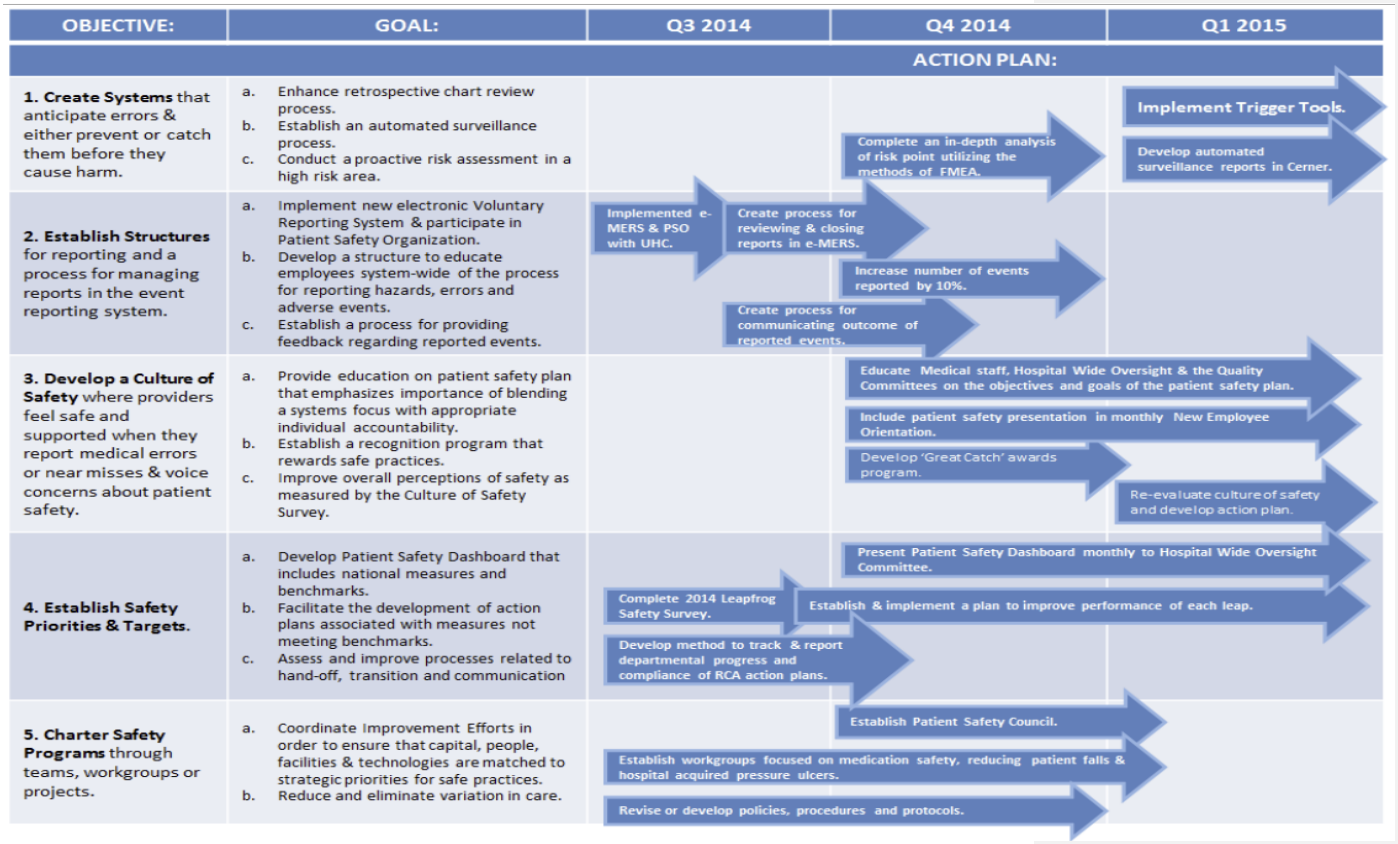
Risk: Possibility of loss or injury. (Merriam-Webster's Online Dictionary, Risk, Available at http://www.merriamwebster.com/dictionary/risk. Last Accessed August 2009.)

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

Catheter Associated Urinary Tract Infection (CAUTI): A urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CUR RENT_b.pdf.)

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

Appendix B: Patient Safety Goals



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, when applicable~~, OT,~~ **MD, RN** ~~**and PharmD**~~				
Include patients, families and caregivers in efforts to prevent falls. Educate regarding fall prevention measures; stay with patient				
Hold post-fall huddles immediately after event; analyze how and why; implement change to prevent other falls				

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

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Appendix F: Policy Example

~~[Reference: Hospital Policies. MERCY Hospital.~~ **Error! Hyperlink reference not valid.**~~]~~

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
- EQuIP5 - 1.5.1 and 1.5.2 Infection Control
- EQuIP5 - Standard 3.2 Criterion 3.2.1 Health and Safety

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

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

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

Objectives:

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

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Coronado Surgery Center MERCY HOSPITAL	~~HOSPITAL~~ POLICY AND INFORMATION MANUAL	
PERSONAL PROTECTIVE ~~EQUIPMENT POLICY~~EQUIPMENT POLICY Page 2 of 2	Date Issued: Date Last Revised: Next Review Date: Approved By:	1/1/2017~~07/01~~ ~~08/14~~ ~~08/17~~ 1/1/2018 Policy Committee

Implementation:

Risk Management
Department Managers, ~~the Occupational Health/~~ Infection Prevention and Control Nurse~~ (OH/IPC Nurse)~~ and ~~Health and~~ Safety Officer~~/ 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~~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

Facility Name:	Policy And Procedure Guideline Name:	Policy Number:
Durango Outpatient Surgery Center	Performance Improvement Plan (Improving Organizational Performance)	PI 100
	Subject Category:	Effective Date: 2008
	Improving Organizational Performance	Revised Date: 12/2020
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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 • 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	1st Quarter	Only cases surgeon preferences not provided
Prevent Surgical Fires	1st Quarter	5% of case volume

Prevent Injury- Prevent Burns	2nd Quarter	5% of case volume
Prevent Injury-Laser Safety	2nd Quarter	5% of case volume
Schedule My First Choice/Handle My First Call	2nd Quarter	Only scheduling calls that went to voicemail
Prevent Infection Hand Hygiene	2nd 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	3rd Quarter	5% of case volume
Prevent Injury- Safe Positioning	3rd	5% of case volume
Prevent Injury- Prevent Falls	4th	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	FIND A PROCESS TO IMPROVE	• Data from customer concerns, staff observation, occurrence reports, Physician input.
O	ORGANIZE A TEAM THAT KNOWS THE PROCESS	• Department/Administrative Level teams. • Quality Management Committee established teams.
C	CLARIFY CURRENT KNOWLEDGE OF PROCESS	• 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	UNDERSTAND CAUSES OF VARIATION	• Data collection/analysis. • Display with graphs, run charts, control chart, histogram, scatter diagram, pareto diagram.
S	SELECT THE PROCESS IMPROVEMENT	• Define the process in simplistic terms. • Examine criteria related to the process. • Present data to leadership for support.
P	PLAN THE IMPROVEMENT AND CONTINUED DATA COLLECTION	• Planning Matrix. • Responsibility Matri. • Who/What/When/Where? EDGE™ Requirement owners.
D	DO THE IMPROVEMENT, DATA COLLECTION AND ANALYSIS	• QM audit tools/EDGE™ DATA. • Discuss in Unit team meeting. • Educate staff on the process.
C	CHECK THE RESULTS AND LESSONS LEARNED FROM THE TEAM EFFORT	• 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**	• **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.**

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

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. The situation doesn't require an immediate solution. Consensus is needed to make the solution work When the problem is a process problem When the process crosses departmental	No need for extensive data-gathering. Quick decision is required. Consensus is not needed. When the problem is a people or performance problem.

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)	1st Quarter	GB
Review of Employee Competency (Form D)	1st Quarter	GB
Review of Human Resource Policies	1st Quarter	GB
Evaluation of Administrator	1st Quarter	GB
Review of Contracts (Form E)	2nd Quarter	MEC/GB
Review the Organizational Chart	2nd Quarter	GB
Review Conflict of Interest & Indemnification Liability	3rd Quarter	GB
Evaluate MEC Performance in PI (Form F)	3rd Quarter	MEC
Evaluate GB Performance (Form G)	3rd 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	3rd Quarter	GB
Review Operating Agreement, Purpose of GB and MEC	4th 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:	Policy And Procedure Guideline Name:	Policy Number:
Durango Outpatient Surgery Center	**Patient Safety + Quality Improvement Program** **(Environment Of Care)**	**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:** **Risk Management Plan**	**Policy Number:** **RM 100**
	Subject Category: **Risk Management**	**Effective Date:** **2008**
		Revised Date: **12/2016, 12/2018, 12/2020**
		Page 1 Of 3

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.

EYE SURGERY CENTER OF NORTHERN NEVADA:

QUALITY AND PATIENT SAFETY PLAN

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

Commitment to Patient Safety

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

Mission, Vision, and Values

In support of our mission, vision, and values, ESCNN Patient Safety and Quality Improvement program promotes:

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

Scope and Purpose

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

- Patient safety
- Visitor safety
- Employee safety

All staff in ESCNN are required to fully support and participate in this plan, and devote their expertise to the patient safety and healthcare quality improvement process.

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

The plan focuses on the process rather than the individual, and recognizes both internal and

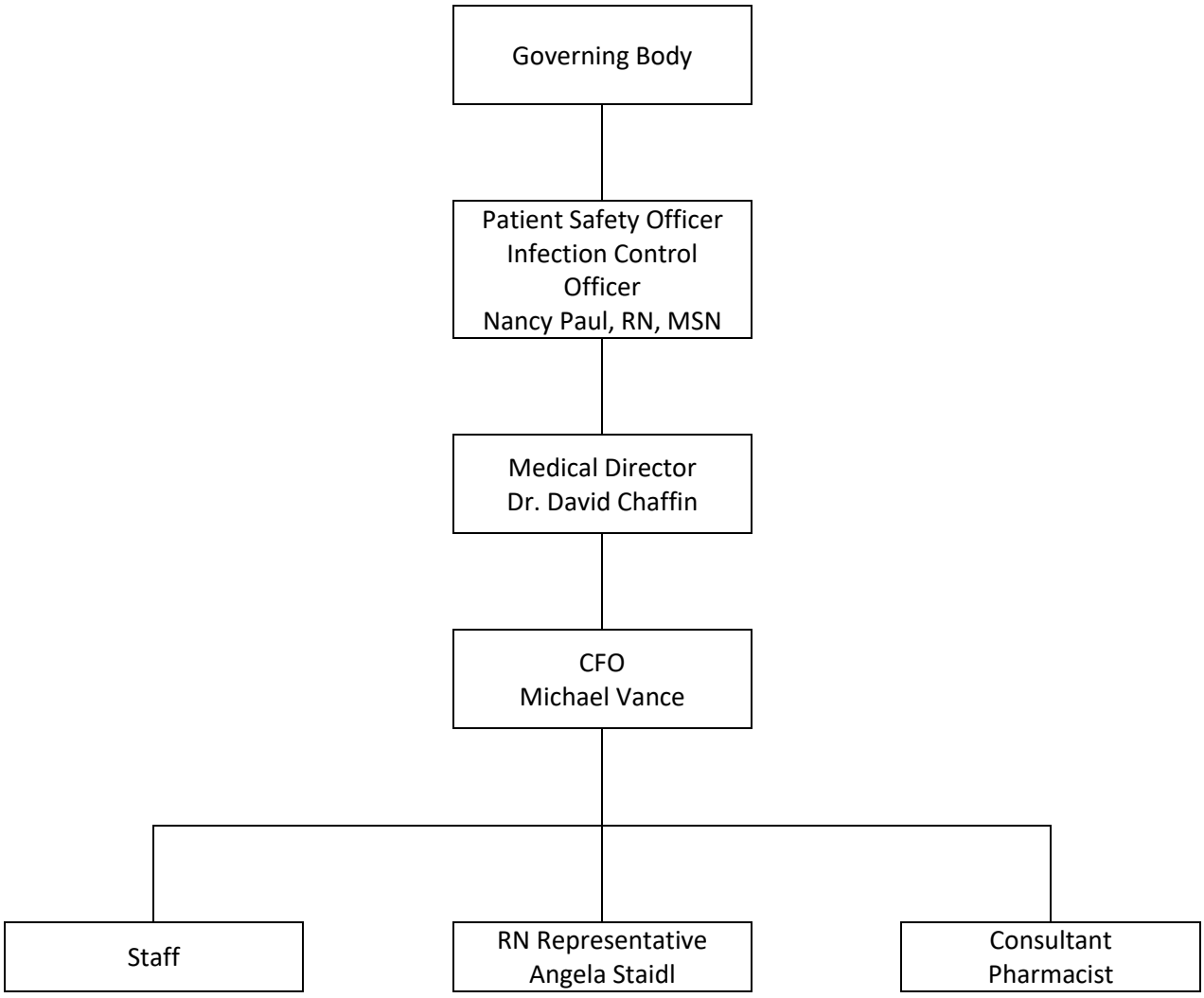
external customers, as well as facilitates the need of analyzing and improving processes.
The core principles of this plan include:

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

Roles and Responsibilities

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

The Patient Safety Committee Organization



Roles and Responsibilities

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

Based on NAC 439.920, a medical facility that has fewer than 25 employees and contractors must establish a patient safety committee comprised of:

- The patient safety officer of the medical facility;
- At least two providers of healthcare who treat patients at the medical facility, including but without limitation, one member of the medical staff and one member of the nursing staff of the medical facility; and
- The Chief Executive Officer (CEO) or Chief Financial Officer (CFO) of the medical facility.

The roles and responsibilities are defined below:

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

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

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

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

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

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

Root Cause Analysis (RCA) :

- Conduct RCA as needed utilizing members of the Patient Safety Committee.
- Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders.
- Make policy changes as needed based on RCA results.

Patient Safety Officer Responsibilities (based on NRS 439.870)

- Serve on the patient safety committee.
- Supervise the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to NRS 439.835.
- Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the patient safety committee regarding any action taken in accordance with the responsibilities above.

Infection Control Officer Responsibilities (based on NRS 439.873)

- Serve on the patient safety committee.
- Monitor the occurrences of infections at the facility to determine the number and severity of infections.
- Report to the patient safety committee concerning the number and severity of infections at the facility.
- Take such action as determines is necessary to prevent and control infections alleged to have occurred at the facility.
- Carry out the provisions of the infection control program adopted pursuant to NRS 439.865 and ensure compliance with the program.

Executive or Governing Body Staff Responsibilities

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

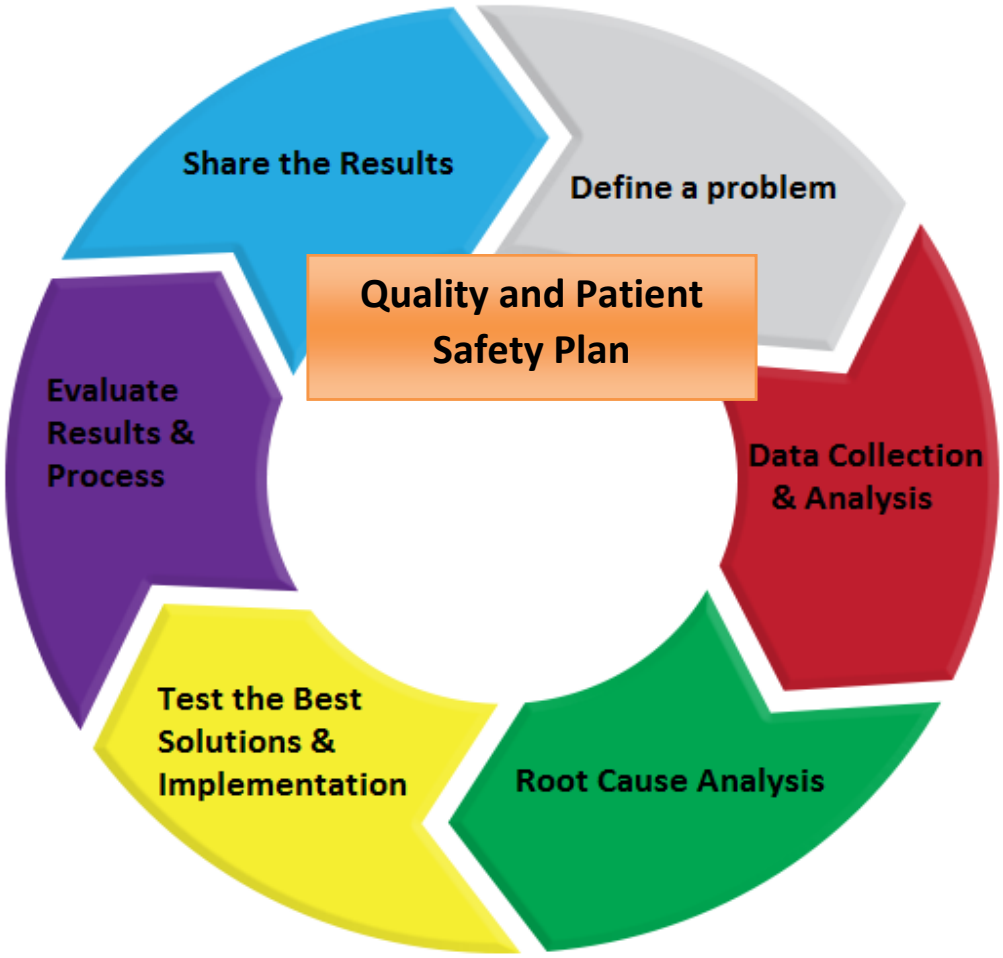
The Patient Safety Committee will meet monthly (or quarterly) to accomplish the following:

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

Components and Methods

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

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



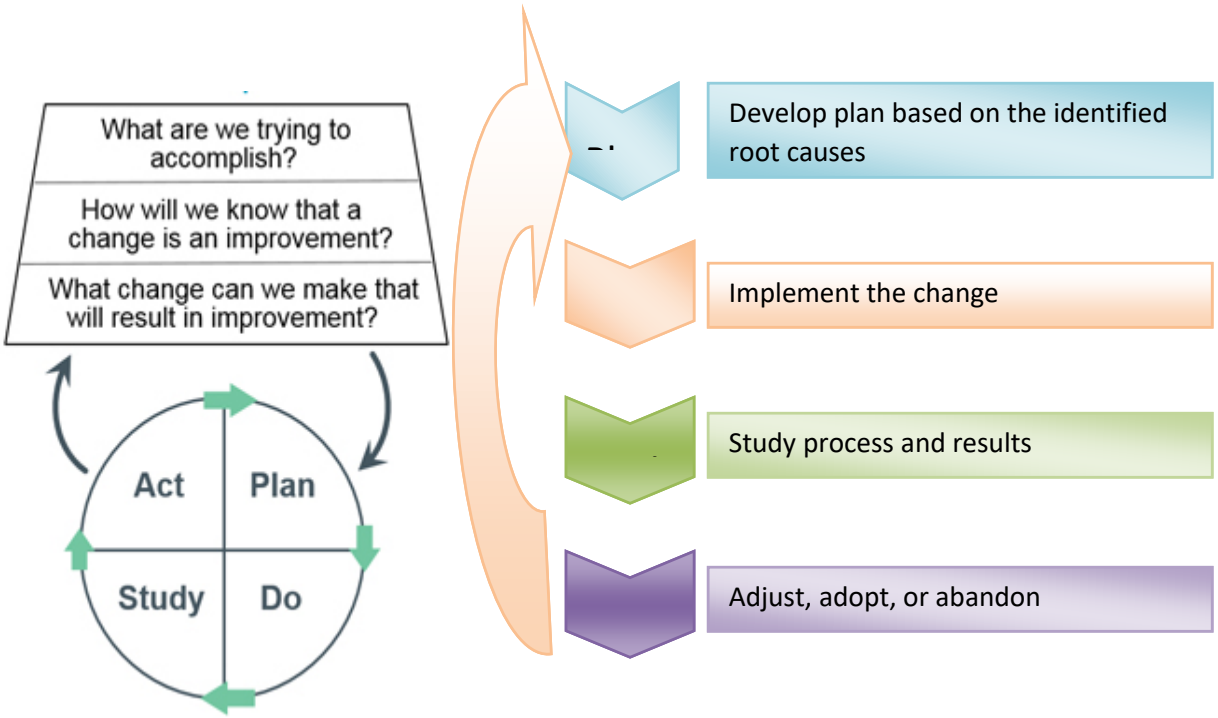
Root Cause Analysis

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

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

Model for Improvement

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



The cycle is defined as follows:

- Plan--collect data and establish appropriate goals. Identify the problem and the possible root causes, and answer the following questions.
  - What is the objective of the test?
  - What are the steps for the test - who, what, when?
  - How will you measure the impact of the test?
  - What is your plan to collect the data needed?
  - What do you predict will happen?

- Do--make changes designed to correct or improve the situation. Use the following questions for the guidance.
  - What were the results of the test?
  - Was the cycle carried out as designed or planned?
  - What did you observe that was unplanned or expected?

- Study -- Study the effect of the changes on the situation. Data should be collected on the new process and compared to the baseline or expected results. Results should be evaluated and by using the following questions as guidance.
  - Did the results match your prediction?
  - What did you learn?
  - What do you need to do next?

- Act--If the result is successful or desirable, standardize the changes and then work on the next prioritized problem or the further improvements. If the outcome is not yet successful, look for different ways to identify the causes or change the testing process.

Data Collection and Reporting

Data should drive any quality and patient safety effort. ESCNN is tracking sentinel events and healthcare infection data.

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

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

Patient Safety Checklists and Patient Safety Policies

By NRS 439.865, the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility.

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

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:

    - Proper instructions concerning prescription medications;
    - Instructions concerning aftercare;
    - Any other instructions concerning his or her care upon discharge.

The patient safety policies must include, without limitation:

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

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

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

Approval of Patient Safety Plan

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

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

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

LIFE SAFETY MANAGEMENT PLAN

I.Scope of Plan

The Desert Orthopaedic Center Surgery Center (DOCSC) administration and governing body are strongly committed to providing a safe and secure environment for patients, visitors, staff and property. The Life Safety Management Plan is the basis for managing the environment of care, including infection control, security, hazardous materials and wastes, emergency preparedness, and utility systems in a fire-safe environment and in accordance with applicable codes and regulations. This plan is reviewed annually.

II.Objectives

DOCSC strives to protect patients, visitors, staff, and property from infection and environmental hazards by meeting the following objectives:

- Prevent and control infections within the facility through the implementation of effective and nationally recognized infection control policies.
- Ensure proper operation of fire detection, alarm, and suppression systems through a program of regular inspection, testing, and maintenance.
- Provide portable fire extinguishers according to established criteria for type, placement, inspection, maintenance, and use.
- Ensure acquisitions such as curtains, furniture, waste baskets, and other equipment meet established fire safety criteria.
- Collect information on staff knowledge and skill during drills.
- Evaluate staff and equipment response during fire and facility emergencies.
- Ensure facility code compliance to identify and correct deficiencies.
- Provide fire safety orientation for new employees and quarterly thereafter.
- Provide for specific roles and responsibilities of personnel at the fire, at areas away from the fire and during evacuation.
- Establish a risk-assessment program that proactively evaluates the building, grounds, equipment, occupants, and internal physical systems and their potential impact on patient and public safety.
- Establish an emergency preparedness program designed to manage the consequences of natural disasters or other emergencies that may disrupt the facility's ability to provide care.

III. Standards of Performance

- All staff complete training in infection control, including aseptic technique and standard precautions, annually.
- Fire drills and education are conducted every quarter
- Staff will know locations of fire extinguishers and alarms
- Evacuation routes are posted in the facility
- Orientation and continuing education of the staff
- Management of hazardous materials and waste
- Bomb Threat drill and education twice a year
- Internal / External disaster at least twice a year

IV. Information Gathering and Reporting

The DOCSC Safety / Quality Improvement Committee is represented by administration, and clinical and business office staff. The committee will meet at least monthly.

Information regarding worker knowledge about life safety and the fire protection system is gathered during fire drills and safety rounds.

Performance improvement and trends are submitted to the Medical Executive Committee and Governing Body.

V. Organizational Roles and Responsibilities

The administrator and department supervisors have direct authority and responsibility for both the safe actions of employees and the safe performance of equipment within their department. Administration and the department supervisors shall:

- Ensure adherence to infection control policies and procedures not limited to, but including, the proper use of required personal protective equipment, aseptic technique, high level disinfection and sterilization.
- Take appropriate disciplinary action when safety rules are violated.
- Take prompt corrective action whenever unsafe working conditions are observed and report them to administration.
- Thoroughly investigate and report all accidents and take appropriate action(s) to prevent re-occurrence. All accidents shall be investigated, including those which do not result in injury or illness.
- Inform employees of the safety committee activities.
- Critique staff response during scheduled fire drills and emergency preparedness drills.
- Assess security and risk and make appropriate adjustments.

Each employee is responsible to practice safety on the job for themselves, patients, visitors, and other employees. Therefore, each employee shall:

- Adhere to infection control policies and procedures not limited to, but including, the proper use of required personal protective equipment, aseptic technique, high level disinfection and sterilization.
- Report unsafe conditions to the department supervisor whenever a safety hazard or unsafe condition is identified.
- Promptly report all injuries and lost days due to work injuries or illness to the department supervisor.
- Use only equipment in safe operating condition. Tag and report defective equipment promptly.
- Respond to emergency situations in accordance with facility policies and procedures.

VI.INDICATORS AND THRESHOLDS

Continuing Safety Education and Training

- All new personnel are oriented to the Safety Management Program. Threshold 100%.
- All personnel participate in continuing safety education and training at least annually. Threshold 100%.

Hazardous Materials and Waste

- Proper storage of hazardous material. Threshold 100%
- Proper waste disposal equipment available. Threshold 100%
- Proper handling of hazardous material. Threshold 100%
- Fire drills conducted quarterly. Threshold 100%

Emergency Preparedness

- Drills are conducted semi-annually. Threshold 100%

Fire Safety

- Fire drills are conducted quarterly. Threshold 100%
- Portable fire extinguishers checked annually. Threshold 100%

Equipment Management

- Scheduled preventive maintenance is performed on patient equipment. Threshold: 100%.

- A summary of equipment problems / failures is immediately reported to the safety committee. Threshold 100%.

Security

- All theft and vandalism is immediately reviewed.

Performance Improvement

- A summary of actions taken by the performance improvement committee is reported quarterly. Threshold 100%

VII.DATA COLLECTION

Quality Indicator data, including patient care and other relevant data regarding furnished services, shall be incorporated. The data are used to monitor the effectiveness and safety of services and quality of care rendered. The data results will help identify opportunities to change and improve patient care. Data sources include:

- Incident Trending Report
- Infection Trending Report
- Patient / family / vendor complaints
- Patient Satisfaction Surveys
- Quality Assurance Committee findings

VIII.EVALUATION OF PLAN ACTIVITIES

DOCSC sets priorities for Quality Improvement activities that

- Focus on high risk, high volume and problem prone areas
- Consider incidence, prevalence and severity of problems in those areas
- Affect health outcomes, patient safety and quality of care

QI activities shall track adverse patient events, examine their causes, and ensure implemented improvements are sustained over time.

DOCSC shall implement preventive strategies throughout the facility, targeting adverse patient events and ensuring all staff members are familiar with the strategies.

IX.CORRECTIVE ACTION

The safety committee and other committees shall implement a corrective action and follow up for each indicator, as warranted.

X.ASSESS ACTIONS AND DOCUMENT IMPROVEMENT

The Safety / Quality Improvement Committee will oversee the effectiveness of corrective action and the progress toward problem solving resolution. The findings, conclusions, recommendations and follow-up will be reported to the medical executive committee and the governing board.

Barton Health

2022 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. 2021 high priorities are reviewed which included tubing misconnections; 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 a controlled substance FMEA. 2022 high priorities are tubing misconnections; improvements to patient identification bands; decreasing alarms, alerts, and notification overload; the development of a neonatal strategic plan; a controlled substance FMEA; the Leapfrog Hospital Survey; culture measurement of patient safety; updating the electronic event reporting and patient relations platforms; the ongoing evaluation and implementation of best practices around the SARs-CoV-2/COVID-19 pandemic; staff resiliency; and assessing and evaluating the new RN graduate program. 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

2022 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 (2021b), 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/Close Call:** Any patient safety event that did not reach the patient (TJC, 2021b).
- **No-Harm Event**: A patient safety event that reached the patient but did not cause harm (TJC, 2021b).
- **Hazardous (unsafe) Condition:** A circumstance, exclusive of the disease or condition for which the patient is being treated, which increases the probability of an adverse event (TJC, 2021b).
- **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.
- **Permanent Harm:** An event or condition that reaches the individual, resulting in any level of harm that permanently alters and/or affects an individual's baseline (TJC, 2021a).
- **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, severe harm (regardless of duration of harm), or permanent harm (regardless of severity of harm (Refer to *Sentinel Event* section below) and is reported to The Joint Commission (TJC, 2021b). 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).
- **Severe harm:** An event or condition that reaches the individual, resulting in life-threatening bodily injury (including pain or disfigurement) that interferes with or results in loss of functional ability or quality of life that requires continuous physiological monitoring or a surgery, invasive procedure, or treatment to resolve the condition (TJC, 2021b).
- **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 though 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 (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 (Throop & Stockmeier, 2011)).

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
- Sexual abuse/assault of any patient while receiving care, treatment, and services while on site at the organization/facility or while under the supervision/care of the organization
- Sexual abuse/ assault of a staff member, licensed independent practitioner, visitor, or vendor while on site at the organization/facility or while providing care/supervision to patients/clients
- Physical assault of any patient (leading to death, permanent harm, or severe temporary harm) while receiving care, treatment, and services while on site at the organization/facility or while under the supervision/care of the organization
- Physical assault (leading to death, permanent harm, or severe temporary harm) of a staff member, licensed independent practitioner, visitor, or vendor while on site at the organization/facility or while providing care/supervision to patients/clients
- Homicide of any patient while receiving care, treatment, and services while on site at the organization/facility or while under the supervision/care of the organization
- Homicide of a staff member, licensed independent practitioner, visitor, or vendor while on site at the organization/facility or while providing care/supervision to patients/clients
- 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 foreign material is inserted 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., cardiac, 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
- Severe neonatal hyperbilirubinemia (bilirubin greater than 30 milligrams/deciliter)

- Prolonged fluoroscopy with cumulative dose greater than 1,500 rads to a single field or any delivery of radiotherapy to the wrong body region or greater than 25% above the 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
- Fall resulting in any of the following: any fracture; surgery, casting, or traction; required consult/management or comfort care for a neurological (e.g., skull fracture, subdural or intracranial hemorrhage) or internal (e.g., rib fracture, small liver laceration) injury; a patient with coagulopathy who receives blood products as a result of the fall; or death or permanent harm as a result of injuries sustained from the fall (not from physiologic events causing the fall)

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 while being cared for in a health facility due to patient actions after admission to the health facility, 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 while being cared for in a facility, 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 a health 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 body part.
   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 disability associated with patient elopement (disappearance).
   3C. Patient suicide, attempted suicide, or self-harm resulting 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 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 significant 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)
- Deep vein thrombosis/pulmonary embolism (excluding pregnant women and children under 21 years of age)
- 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 restrict surgery
  - Orthopedic procedures for spine, neck, shoulder, and elbow
  - Cardiac implantable electronic device (CIED) procedures
- Vascular catheter-associated infection

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. Data analyses of these audits are 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 greater than 90%. Elements below 90% are addressed by the appropriate Department Director/Manager. The Director/Manager formulates an action plan with the goal of improving the affected element score within their department.

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

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

Barton Health uses 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.)
- RCA^2: 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 12/8/2021
Board Quality Committee on 2/3/2022

Section B:

2021 Patient Safety Priority Evaluation

Measures to prevent adverse events associated with misconnecting intravenous, enteral feeding, and epidural lines remained a priority in 2021. A complete conversion to the new ISO standard enteral feeding lines occurred in 2015. Manufacturers are beginning to distribute redesigned neuraxial tubing that cannot be mistakenly interconnected. To ensure compliance with California state law, Neuraxial (NRFit®) connectors with redesigned incompatible connectors will be transitioned to in 2022.

Patient identification is an NPSG and must be performed prior to any patient interaction across Barton Health. In 2021, it was attempted to establish a new patient identification band process for those patients and residents who are required to have a wristband placed. Compatibility challenges among the proposed product systems delayed this transition. This patient safety priority will continue in 2022.

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. Barton Health remained committed in 2021 to evaluating alarms in the clinical settings. Alarm modifications and process changes related to ED central monitors display configurations, pediatric specific care profiles for ED patient monitors, and Hill-Rom bed alarm configurations occurred. Barton Health also purchased a new Wi-Fi enabled medication refrigeration monitoring system and replaced capnography monitors and nasal cannula tubing to reduce nuisance alarms. Alarm fatigue will remain a high priority for Barton Health in 2022.

While Barton was granted a pediatric license through CDPH in 2021, a strategic plan for providing neonatal care in the inpatient setting was also anticipated to be developed. This plan, with multi-disciplinary and collaborative input, focuses 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. The neonatal strategic plan will continue in 2022.

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 continued to evaluate and monitor appropriate staffing levels to ensure patient care needs were met during 2021. This included staffing levels and competencies for any new patient population that presented to Barton Health.

A new FMEA commenced in the fourth quarter to address controlled substances. The overall goal is 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, was completed in 2021. Assessment, analysis, and submission recommendations for each of the survey's sections were completed with key stakeholder involvement. Barton received an 'A' letter grade in fall 2021.

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 culture measurement tool in 2021. Based on the findings, departments held discussions with team members and developed action plans to enhance Barton's patient safety culture.

The electronic patient relations and incident reporting systems were anticipated to be upgraded in 2021. However, acquisition of the event reporting vendor, Verge, by RL Datix and a hand off to different project managers delayed the start of these revisions. The platforms will be redesigned in 2022 with the goals of enhancing usability for end-users, increasing the number of submitted event reports, and improving data utilization.

Finally, Barton Health addressed concerns related to the SARs-CoV-2/COVID-19 pandemic in 2021. Barton Health ensured 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.

Section C:

2022 Patient Safety Priorities

The Patient Safety Plan identifies and defines goals and specific objectives to be accomplished each year. In 2022, Barton Health's high priorities for Patient Safety include tubing misconnections; improvements to patient identification bands; decreasing alarms, alerts, and notification overload; the development of a neonatal strategic plan; a controlled substance FMEA; the Leapfrog Hospital Survey; culture measurement of patient safety through valid and reliable measurement tools; updating the electronic event reporting and patient relations platforms; the ongoing evaluation and implementation of best practices around the SARs-CoV-2/COVID-19 pandemic; and new RN graduate programs.

Measures to prevent adverse events associated with misconnecting intravenous, enteral feeding, and epidural lines will remain a priority in 2022. Barton Health proactively addresses prevention of adverse events associated with misconnecting IV, enteral, and epidural lines through product purchasing and assessment of connector availability throughout the organization as well as through staff education and awareness. As described in the 2021 priority evaluation, neuraxial (NRFit®) connectors with redesigned incompatible connectors will be transitioned at Barton Health in 2022 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, it was attempted to establish a new patient identification band process for those patients and residents who are required to have a wristband placed. Compatibility challenges among the proposed product systems delayed this transition. This patient safety priority will continue in 2022.

Alarms, alerts, and notification overload are 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.

The Leapfrog Hospital Survey, focused on ensuring safe patient care is provided, will be submitted in 2022. Assessment, analysis, and submission recommendations for each of the survey's sections will be completed with key stakeholder involvement.

The controlled substances FMEA will continue to be worked on in 2022. The overall goal will remain to enhance 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 electronic incident reporting system and patient relations module will be upgraded in 2022 as both 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 the platform are to enhance usability for end-users, increase event reporting, and improve data utilization.

Surveys on patient safety culture for the skilled nursing facility and medical offices will be completed in 2022. These help to identify strengths and opportunities that support a culture of safety and high-quality patient care.

A strategic plan for providing neonatal care in the inpatient setting will be developed in 2022. 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.

Barton Health will continue to proactively address concerns related to the SARs-CoV-2/COVID-19 pandemic in 2022. 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. Staff resiliency will be addressed to prevent and assist with professional burnout.

With the national RN staffing shortages, Barton Health initiated hiring new RN graduates to fill vacancies in the nursing division in 2021. 2022 will focus on continuing and improving a high-quality on boarding and educational process to ensure the delivery of safe patient care by these team members.

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Appendix A:

2022 Lake Tahoe Surgery Center
Patient Safety Plan

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

Patient Safety Plan
Lake Tahoe Surgery Center

212 Elks Point Road, Suite #201
Zephyr Cove, NV 89448
(775)588-9188

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Commitment to Patient Safety

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

Mission, Vision, and Values

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

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

Scope and Purpose

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

- Patient safety
- Visitor safety
- Employee safety

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

This plan is action oriented, and solution focused. The purpose of this plan is to address patient safety related concerns, 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.

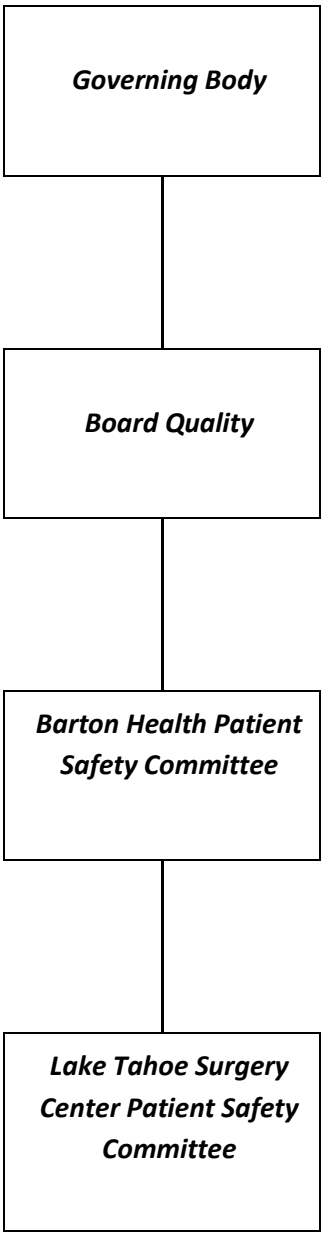
The plan focuses on the process rather than the individual, and recognizes both internal and external customers, as well as facilitates the need of analyzing and improving processes. The core principles of this plan include:

- 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.

Components and Methods

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

Patient Safety Risk Reduction

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

Sentinel Event Alerts

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

Scientific Model Integration

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

- Shewhart cycle or Model for Improvement (Plan, Do, Study, Act –PDSA)
- Failure Mode and Effects Analysis (FMEA)
- Re-engineering (Human factor re-engineering such as signage for High Alert Medications, pop up

alert in Pyxis medication dispensing system, tall man lettering for look-alike sound alike drugs in medication usage process, etc.)

- Rapid Cycle Improvement (Institute of Health Care Improvement [IHI]) Collaborative approach termed the 'Breakthrough Series,' to bring about rapid cycle improvements. Fundamental to the collaborative approach is the acceptance of a model and establishment of infrastructure through which collaborating organizations can identify and prioritize aims for improvement and gain access to the methods, tools, materials etc.)
- RCA^2: 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.

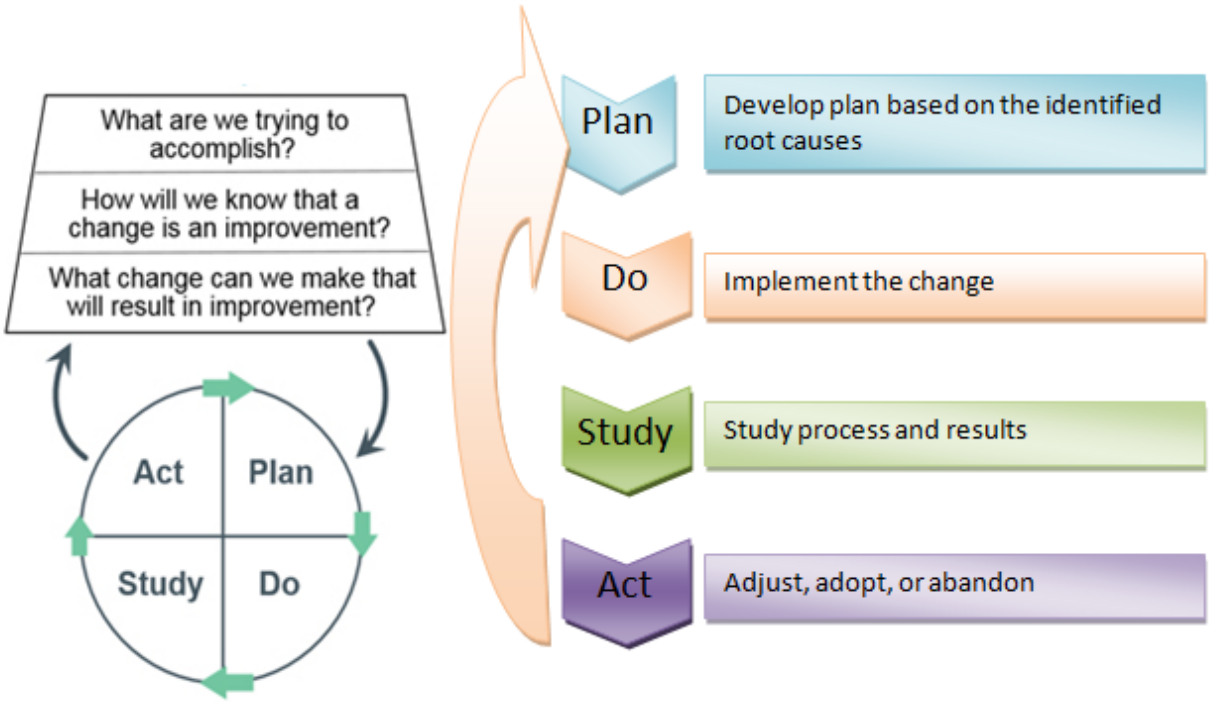
RCA and PI workgroups construct action items and assign them to appropriate individuals for completion. Staff involvement is considered essential since they are the team members on the front line with the most knowledge of the actual day-to-day workings of the processes. Individuals assigned action items 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 Baron 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.

2022 Lake Tahoe Surgery Center Patient Safety Priorities

During 2022, Lake Tahoe Surgery Center will strive to achieve two different priorities to ensure safe patient care. During 2021, the surgical site infection rate was 0.3%. Staff education was provided during the year. In 2022, LTSC would like to maintain a surgical site infection rate of less than 0.5%.

Lake Tahoe Surgery Center had zero never events during 2021. In an effort to reduce the potential for harm, Lake Tahoe Surgery Center will strive to maintain zero harm during 2022. 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. (2021). *Healthcare-associated infections (HAIs).* http://www.cdc.gov/hai/

Nevada Division of Public and Behavioral Health. (2021). *Sentinel event registry.* 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. (2021). *Ambulatory Health Care: 2022 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. (2021). *Root cause analysis.* https://www.patientsafety.va.gov/professionals/onthejob/rca.asp

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

Facility Name:	Policy And Procedure Guideline Name:	Policy Number:
Parkway Surgery Center Henderson, NV	Safety Management Program (Environment Of Care)	SAFE 104
	Subject Category: SAFETY	Effective Date: 12/01/2016
		Revised Date: 12/14/2017, 1/10/19, 02/07/2020; 03/11/2021; 3/4/2022
		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.

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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: 9/2021

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
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      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

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

f. Equipment Processing: Cleaning, Disinfection, High Level Disinfection and Sterilization

II. Patient Selection and Screening: Refer also to the Criteria for Scheduling Patients at ASC Policy.

1. To ensure patients are appropriate for the planned procedure in the planned setting patients undergo:
   a. Pre-procedure scheduling evaluation with referral for office visit or consultation as appropriate
   b. Pre-procedure assessment which includes at a minimum:
      i. Review of past medical & surgical history
      ii. Medication reconciliation, review
      iii. Allergy and reaction, review of
      iv. Physical assessment; assessment for communicable diseases
      v. Vital signs

III. Patient Identification: Refer to Patient Identification Policy. Patient identity is verified with at minimum two (2) identifiers at check-in and at multiple points throughout care.

IV. Safe Surgery Checklist: Refer to Safe Surgery Checklist Policy. Patient and procedure are verified immediately prior to procedures.

V. Discharge Teaching: Patients are provided with written discharge instructions which are reviewed with patient and driver, as applicable, prior to discharge. Medications are reconciled prior to discharge if any new medications are ordered. Information specific to diagnosis, as best as known, is given to the patient. Patients are educated about signs and symptoms to report and given a twenty-four (24) hour telephone number to call in event of questions or concerns.

VI. Post Procedure Callbacks: Patients are contacted one (1) to two (2) business days post-procedure for follow up of any concerns and questions regarding discharge instructions.

VII. Pathology follow up: Patients are notified of pathology results and given information and follow up orders as applicable within two (2) weeks.

VIII. Pharmaceutical Services: Refer to Pharmaceutical Services Policy. Safe injection practices are strictly followed. Pharmaceutical services are overseen by a contracting pharmacist on a monthly basis.

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

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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 tacked 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:
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    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
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- Staff Training Competencies and Logs
- NRS 439.865; 439.877
- CMS §416.54 (Appendix Z)

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□ctivity	O□ner	P□rpose	□ eas□res/□ctions	□oal/Std/□enchmar□	□ata So□rce	□imeline				Res□lts
PROCESS Overview: SHASC will look at Safety, Quality and Performance elements in a systematic way. **-Problem will be defined 1st with focus on the issue, how it affects stakeholders, patients, and overall quality** **-Performance improvement projects must have a method of measurement (how can we look at it objectively with Data?)** **-Collection and Analysis of Data should be mutli-disciplinary as appropriate** **-Execution of changes to address items that emerged during data analysis** **-Measurement of process AFTER changes are made to establish evidence of improvement** **-Strategy for "holding the gains"**										
□ andatory Re□□irements										
□nn□al □ or□ Plan	□□	O□tline the planning□ monitoring and improvement activities for the year	□ or□plan is completed	□ or□plan is revie□ed and approved □y the □□ality Cmte	□ario□s		•			□or□ard to □overning □ody for □pproval. □oard mtg pending □e□2022

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□nn□al Revie□ of Policies and Proced□res	□epartment managers	□ss□re that policy and proced□res are □pdated to reflect c□rrent performance parameters	Policies and Proced□res revie□ed and revised as needed. Staff □ill revie□ policies per mandatory re□□irements and/or changes	□pplica□le policies □pdated □ll mandatory policies revie□ed □y staff □nn□al approval d□e in □ ay	Policy and Proced□res		•			
□mployee □d□cation	□ anagers	Comprehensive training and ed□cation to facilitate and promote the commitment to □□ality of care and service	MEDT RA□NER Program. □pdate SH□SC □□□C□□□ON Plan, □hen needed	100% staff completion □ith at least 80% score		•	•	•	•	EDU Plan to span 4 □□arters

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□ctivity	O□ner	P□rpose	□ eas□res/□ctions	□oal/Std/□enchmar□	□ata So□rce	□imeline				Res□lts
						□ 1	□ 2	□ 3	□ 4	
□ andatory Re□□irements Contin□ed...										
□nn□al □merg □ gmt Plan	□dmin/□□ality	□acility revie□ of ris□s□and concerns for □mergencies	Ris□stratification □ool	Revie□ and send to □overning □ody for approval		•				Pandemic conditions□ evident in assessment□□ plan ad□□sted as s□ch
□ctivity	O□ner	P□rpose	□ eas□res/□ctions	□oal/Std/□enchmar□	□ata So□rce	□imeline				Res□lts
						□ 1	□ 2	□ 3	□ 4	
□□ality/Safety □ndicator □ onitoring										

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□nfections	□nfection control coordinator/ □□	□rac□/trend and analy□e to prevent/minimi□e infections	□nfection rate monthly □□ of infections per total cases□ □ollo□ □p/investigate all patients s□staining post-op infections 1 infection in 2021 1/3114 □.0003□	□o remain □elo□ the standard of 2□	□m□ai reports□ to □e signed off □y all docs. □oli □ □odi to share in the □C. s□rveillance Program	•	•	•	•	

□ctivity	O□ner	P□rpose	□ eas□res/□ctions	□oal/Std/□enchmar□	□ata So□rce	□imeline				Res□lts
						□ 1	□ 2	□ 3	□ 4	
□□ality/Safety □ndicator □ onitoring Contin□ed...										
□ransfers/ Hospital □dmissions	□□/N□rsing Staff	□rac□/trends and analy□e to prevent/minimi□e occ□rrences.	□ onthly □ of any transfers or hospital admission □ithin 72 ho□rs post s□rgery from SH□SC	□ppropriate transfers for cardiac care are good	incident reports□ □ransfer □og □ onthly revie□ □ □□ revie□ □□arterly	•	•	•	•	Cardio has innate ris□for □□. □his is a good thing□if □e can catch things that patients □ere not a□are of and get them treated.

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Patient □□rn	□□/ Safety committee	□rac□/trends and analy□e to prevent/minimi□e occ□rrences.	□onthly % of patients □ith any □□rns from SH□SC 2021 = 0 □□rns	0 patient □□rns	incident reports, □N□R□ OP record	•	•	•	•	□ire Score has □een s□ccessf□l.
Prophylactic IV ABX timing	QI	□rac□/trends and analy□e to prevent infections	□onthly % of any anti□iotics not administered □ithin 1 ho□r at SH□SC	100% compliance 2022: □ight □e good to revie□ and do a QI st□dy on this	S□S Office reporting	•	•	•	•	□mplemented □ t □ased dosing in 2021. □ig □in!
Patient □alls	□□/ Safety	□rac□/trends to analy□e safety ris□s	□onthly % of all patient falls 2021 had 1-2 falls. □visitors)	0 falls	S□S Office reporting, incident reports	•	•	•	•	

□ctivity	O□ner	P□rpose	□eas□res/□ctions	□oal/Std/□enchmar□	□ata So□rce	□imeline				Res□lts
						Q 1	Q 2	Q 3	Q 4	
□□ality/Safety □ndicator □onitoring Contin□ed...										
□ rong site, □rong side, □rong patient, □rong proced□re, □rong implant	□□/ Safety Committee	□rac□/trends for any adverse occ□rrences	% of occ□rrences trac□ed monthly	100% compliance	S□S Office reporting, incident reports	•	•	•	•	□ime O□t □□nctioning □ell

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Patient and □mployee incident reports □ncl□ding near miss incidents□ medication errors and all recalls	□□/ Safety Committee	Prevent any patient/employee incidences incl□ding medication errors and trac□any noted trends	□□arterly revie□ of all incident reports and recalls □y □□P□ committee.	□eep incidents to a minim□m and to properly follo□ thro□gh □ith necessary changes that need to □e made □hen incidents do occ□r	□dverse events□ incident reports	•	•	•	•	SH□SC gets good engagement in reporting events.
Normothermia□ Patients	□□/Safety/N□rsing Staff	Prevent SS□s□ impaired □o□nd healing□adverse cardiac events□ altered dr□g meta□olism□and coag□lopathies	Patients □ill maintain a normothermic temperat□re or ret□rn to 96.8 or higher □ithin 15 min□tes in recovery.	95□ compliance Spot chec□in 2022	P□R record□ S□S Office reporting	•	•	•	•	2021 completed □□st□dy.

□ctivity	O□ner	P□rpose	□ eas□res/□ctions	□oal/Std/□enchmar□	□ata So□rce	□imeline				Res□lts
						□ 1	□ 2	□ 3	□ 4	
□□ality/Safety □ndicator □ onitoring Contin□ed...										

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Patient Satisfaction	□ll staff	□mprove patient satisfaction □ith care received at	Ret□rn rate/overall satisfaction monitored □□arterly	95% e□cellent rating	□rac□ed □y SPH S□rveys					2021 QI st□dy sho□ed great s□ccess. Hold the gains
CO VID □accination	□mpl Health	100% compliance □ith C□ S □andate	P□sh vaccination, and enco□rage □ooster. □olster the CO VID safety meas□res for facility as indicated	100%	Spreadsheet, NHSN Reporting	•	•	•	•	□ e have only 1 e□emption □medical) and the rest are va□d. 😊
Contracted services	□ aterials □ anagement/ □acilities, & □acility □ngineer	□o ass□re that all contracted services are maintaining □□ality standards and follo□ing appropriate g□idelines	□oc□mented evidence of □□ality meas□res □ill □e □ept on file for all contracted services. □hey □ill □e □pdated ann□ally or more often as re□□ired	□oc□mented evidence of □□ality □ill □e □ept on file for 100% of contracted services	Contracts	•	•	•	•	□p to date,
□ctivity	O□ner	P□rpose	□ eas□res/□ctions	□oal/Std/□enchmar□	□ata So□rce	□imeline				Res□lts

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						Q 1	Q 2	Q 3	Q 4	
S□in □ntisepsis St□dy	OR Charge, QA cmte	St□dy s□in prep, and antisepsis int OR	□ata Collection, and choose path□ay, □ased □pon data	TBD	OR team					
QI St□dy Open for ideas										

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Hand□ashing tool	Clinical □ anager	□o ens□re a safe patient and staff environment.	□o give optimal patient care and prevent the spread of diseases □ithin o□r facility.	□oal is to □e 100□ compliant.	Hand□ashing tool					2022 □olster the HH efforts. Compliance/metho d validation□
Radiation Control □osimetry	Radiation Officer	□o □eep patients and staff safe d□ring the □se of radiation e□□ipment	Revie□ policies and proced□res□ □pdate as needed	□oal is have 100□ completion of monthly□ □□arterly and ann□al re□□irements	Radiation control □□ality ass□rance eval□ation□ radiation log	•	•	•	•	Compliant. □anda□er.
□ or□site Safety and Ha□ardo□s □□□ipment □ssessment	□acilities □ngineer	□o maintain a safe □or□ing environment for patients as □ell as staff	Perform assessment and ma□e necessary changes as needed ann□ally	□oal is to have 100□ of safety iss□es that may interfere □ith patient/staff safety corrected in a timely manner	PP□ ha□ard assessment and □ or□site ha□ard assessment	•	•	•	•	□ onthly Safety Ro□nds.
□acility and □nvironment Safety Ro□nd Chec□list	Safety Officer/ □irector of N□rsing	□o maintain a safe □or□ing environment for patients and staff and to ass□re inspection/ □ aintenance is done in a timely manner	Perform Safety ro□nd on a monthly □asis and ta□e necessary action as needed	Reporting of all iss□es□□y □se of the "□irthday card"	□SC □nvironment Safety Ro□nd Chec□list	•	•	•	•	Clinical Ro□nds done monthly

2022 Annual Quality Improvement & Safety Program Work Plan

□mployee/ Patient Health S□rveillance □og	□nfection control officer	□o maintain a safe □or□ing environment for patients as □ell as staff	Perform monthly assessment of sharps in□ries□ comm□nica□le diseases□□□□ □RS□□ imm□ni□ations□and employee/patient illness and in□ry. Oversee the CO□□□ Program	□oal is to have 100□ compliance □ith s□rveillance activities and follo□ C□C g□idelines as appropriate.	□ncident reports□ comm□nica□le disease log□ employee records□patient charts	•	•	•	•	Pandemic Conditions in effect for 2021 and contin□ing in 2022 Recommendations are constantly changing and □eing □pdated.

□□ality □mprovement/Ris□□anagement St□dies

□ctivity	O□ner	P□rpose	□eas□res/□ctions	□oal/Std/□enchmar□	□ata So□rce	□imeline				Res□lts
						□ 1	□ 2	□ 3	□ 4	
□ecrease the amo□nt of patient ref□nds d□e to □p front collection over payments		□o improve □p front collection □□oting and red□ce amo□nt of patient ref□nds d□e to overpayment	□mplement ne□ S□S Office system □ or□□ith □aystar and Clariti to esta□lish a clear process for ins□rance verification and □pfront payments d□e. Re r□n estimate morning of proced□re.	Red□ce amo□nt of patient ref□nds □y 50□ each □□arter						

2022 Annual Quality Improvement & Safety Program Work Plan

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Southwest Medical, Part of Optum Care

PATIENT SAFETY PLAN

MARCH 2022

Southwest Medical™
Part of OptumCare™

The Southwest Medical Patient Safety committee/team created the plan and revises/updates it annually. Implementation of this plan is intended to optimize healthcare quality and patient safety outcomes, encourage recognition, reporting, and acknowledgment of risks to patient, visitor, and employee safety, and reduce the medical/healthcare errors and /or preventable events

Patient Safety Committee/Program
Southwest Medical, Part of Optum Care
Las Vegas, Nevada

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Commitment to Patient Safety

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

Mission, Vision, and Values
In support of our mission, vision and values, Southwest Medical's Patient Safety and Quality Improvement program promotes:

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

Plan Scope and Purpose

The scope of the Patient Safety Committee organizational-wide and includes but is not limited to

- Patient safety
- Visitor safety
- Employee safety

The Committee provides oversight for patient safety activities, infection control activities, initiatives to promote patient safety and monitoring and review of medical/healthcare errors/potential errors involving patients, visitors, SMA staff, students and volunteers

All staff members at Southwest Medical are expected to fully support and participate in this plan and devote their expertise, knowledge, vision, skill, and insight to the patient safety and healthcare quality improvement process

Leadership assumes a role in establishing a culture of safety that minimizes hazards and patient harm by focusing on processes of care. The leaders of the organization are responsible for fostering a culture of safety through personal example by:

- Emphasizing patient safety as an organizational priority
- Providing education to medical and facility staff regarding the commitment to reduction of medical errors
- Supporting proactive reduction in medical/health care errors
- Integrating patient safety priorities into the new design and redesign of all relevant organization processes, functions and services

The purpose of the Patient Safety Plan is:

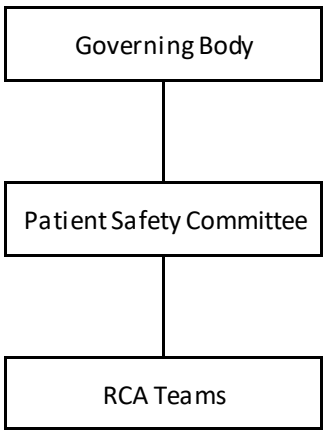
- To address patient safety related concerns and challenges
- To reduce risk
- To respect the dignity of those Southwest Medical serves by assuring a safe environment
- To periodically evaluate and revise the program to better serve patients and their families

Roles and Responsibilities

Southwest Medical created an organization-wide Patent Safety Plan that includes the medical facilities (Surgery Centers) as directed by NRS 439.875 a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plan is promoted and executed successfully

The Southwest Medical Patient Safety Committee

- Is a standing confidential interdisciplinary committee formed to manage the Southwest Medical's Patient Safety Program and Infection Prevention and Control Program through a systematic, coordinated, continuous approach
- Will meet monthly to assure maintenance and improvement of patient safety with the establishment of plans, processes and mechanisms involved in the provision of the patient care
- Will report and discuss events including:
    - Number of sentinel events from previous calendar quarter
    - Number of severe infections from previous calendar quarter
    - Corrective action plans
    - Corrective action plan evaluation
    - Patient safety policies and checklists
- Will monitor and document the effectiveness of the patient safety policy
- Will evaluate patient safety policies and checklists at least annually
- Will revise patient safety policies and checklists as needed
- Will convene a RCA meeting/team as necessary
- Review the RCA process and quality improvement related activities and timelines
- Identify barriers and technical assistance needs for supporting the RCA efforts
- Discuss corrective action process and activities



Patient Safety Committee Membership

In accordance with NRS 439.875, the Patient Safety Committee will include:

- The Patient Safety Officer

- The Infection Prevention and Employee Health Medical Director
- At least three providers of healthcare who treat patients , including but, without limitation, at least one member of the medical, nursing and pharmaceutical staff
- At least one member of the governing body
- The 2022 Committee includes:
    - Medical Director Specialties
    - Medical Director Primary Care
    - Medical Director On Demand Medicine
    - Medial Director Clinical Education Programs
    - Medical Director Surgery Centers
    - Optum Legal
    - Vice President/Operations
    - Chief Nursing Officer
    - RN Vice President/Administrator Surgery Centers
    - RN Associate Vice President On-Demand Medicine and Oncology Programs
    - RN Associate Vice President Specialties
    - Associate Vice President Imaging Services
    - Pharmacy Consultant (PharmD)
    - RN Associate Directors and Managers Surgery Centers
    - RN Associate Directors and Manager Operations
    - RN Manager Clinical Quality (PAD Department)
    - RN Manager Employee Health and Infection Prevention (PAD Department)
    - Infection Prevention/Employee Health Senior Project Coordinator (PAD Department)
    - Optum Regional Safety Manager (PAD Department)

Patient Safety Committee Responsibilities (based on NRS 439.875 and NRS 439.877)
The Patient Safety Committee is a standing confidential interdisciplinary committee formed that manages the Southwest Medical's Patient Safety Program and Infection Prevention and Control Program through a systematic, coordinated, continuous approach

- Evaluating and improving the quality of care rendered by Southwest Medical
- Collecting data and evaluating aggregate data related to individual occurrences in order to utilize performance improvement methodologies to promote patient safety and infection prevention
- Maintaining and improving patient safety with the establishment of plans, processes and mechanisms involved in the provision of the patient care
- Monitoring and documenting the effectiveness of the patient identification policy
- On or before July 1 of each year, submitting a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to NRS 439.877(4)(b)
- Receiving reports from the Patient Safety Officer pursuant to NRS 439.870
- Evaluating actions of the Patient Safety Officer in connection with all reports of potential or actual sentinel events
- Reviewing and evaluating the quality of measures carried out by Southwest Medical to improve the safety of patients who receive treatment
- Reviewing and evaluating the quality of measures carried out by Southwest Medical to prevent and control infections
- Making recommendations to the governing body to reduce the number and severity of sentinel events and infections that occur
    - Report to the Governing Body:
    - The number of sentinel events at the medical facility (Surgery Centers)

  - The number and severity of infections at the medical facility (Surgery Centers)
  - Any recommendations to reduce the number and severity of sentinel events and infections
- Adopting patient safety checklists and patient safety policies as required by NRS 439.877, reviewing checklists and policies annually and revising the checklists and policies as necessary
- Directing root cause analysis teams when indicated
- Providing oversight/direction for Surgery Centers QAPI program and quality studies
- Providing oversight/direction for the Surgery Centers participation in NHSN
- Providing oversight and monitoring for the Optum Practice Health and Safety Clinical Assessment Process

Patient Safety Officer Responsibilities (based on NRS 439.870)

- Chair the Patient Safety Committee
- Supervise the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to NRS 439.835
- Take such action as necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility
- Report to the Patient Safety Committee regarding any action taken in accordance with the responsibilities above
- Promote compliance with patient safety standards and initiatives
- Reinforce expectations of the Patient Safety Plan
- Accept accountability for measurably improving safety and reducing errors
- Liaison with Southwest Medical clinical leadership including surgery center leadership, other quality committees and the Board of Directors

Infection Prevention Officer Responsibilities (based on NRS 439.873)

- Serve on the Patient Safety Committee
- Liaison with Southwest Medical clinical leadership including surgery center leadership, other quality committees and the Board of Directors
- Provide medical direction as indicated (for both patient and employee infection control issues)
- Monitor the occurrences of infections to determine the number and severity of infections
- Report to the Patient Safety Committee concerning the number and severity of infections
- Take such action as necessary to prevent and control infections alleged to have occurred
- Carry out the provisions of the infection control program adopted pursuant to NRS 439.865 and ensure compliance with the program
- Ensure compliance with current infection prevention and control standards
- Direct infection prevention initiatives
- Reinforce expectations of the Infection Control program
- Complete at least four hours of continuing education each year on topics relating to current practices in infection control and prevention

RCA Team/Meeting

Will meet as needed to:

- Define the healthcare issues or potential risks
- Conduct Root Cause Analysis
- Review and analyze data
- Brainstorm issues or the potential risks by using fishbone diagrams or the *5 Whys* technique
- Identify the contributing factors
- Develop Corrective Action Plan
- Identify Plan-Do-Check -Act (PDCA) topics

- Discuss and present possible changes in procedure to improve areas indicated
- Identify strengths and areas that need improvement
- Develop strategies, solutions, and next steps

RCA Team Leader Responsibilities

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

Root Cause Analysis (RCA) Team Responsibilities

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

Governing Body Staff Responsibilities

- Provide vision and leadership to Patient Safety and Quality Improvement process
- Develop and foster a safe learning and improving culture
- Provide oversight to healthcare quality improvement processes and teams
- Plan, discuss and generate patient safety goals and activities

Quality Studies -Process Analysis (Surgery Centers)

The Surgery Centers will complete quality studies each year that include:

1. A statement of the purpose of the QI activity that includes a description of the known or suspected problem and explained significance to the Surgery Center
2. Identification of the performance goal against which Surgery Center will compare current performance
3. Description of the data that will be collected in order to determine the Surgery Center's current performance
4. Evidence of Data Collection
5. Data analysis that describes findings about the frequency, severity and source of issue
6. Comparison of the Surgery Center's current performance against identified performance goal
7. Implementation of corrective action
8. Re-measurement to objectively determine whether corrective actions achieved and sustained improvement
9. Implementation of any additional corrective action to achieve and/or sustain improved performance (and plan for on-going re-measurement)
10. Communication of findings to Surgery Center Leadership, The Patient Safety Committee, the Board of Directors and Surgery Center staff and incorporating findings into educational activities

For quality studies, the Surgery Center(s) may base topic selection on information published by accreditation bodies, National Patient Safety Goals and/or other sources of information including risk management, performance improvement, quality assurance, infection prevention and control, patient/family suggestions/expectations or process outcomes

Surgery Centers' quality studies will focus on redesign or implementation of new processes to incorporate patient safety principles and will place an emphasis on the important facility and patient care functions of:

- Rights of Patients
- Governance
- Administration
- Quality of Care
- Quality Management and Improvement
- Clinical Records and Health Information
- Infection Prevention and Control and Safety
- Facilities and Environment
- Anesthesia Services
- Surgical and Related Services
- Pharmaceutical Services
- Pathology and Medical Laboratory Services
- Diagnostic and Other Imaging Services

Infection Prevention Program

- The purpose of the Infection Control Programs is to prevent and control infections
- The Infection Control Program and the surgery Centers Infection Control Program (SSC and SCT 1600-3 Infection Control Program for Southwest Medical Surgery Center) are components of the Patient Safety Plan
- The Infection Control Programs are based on current guidelines developed by nationally recognized infection control organizations
- The Infection Control Professionals will report regularly on the number and severity of infections that occurred in the prior quarter

Infection Prevention Program – COVID 19

- Southwest Medical implemented risk reduction standards to ensure a safe environment with minimal risk of exposure for all employees, staff, contractors and patients
- Southwest Medical updates infection prevention practices as national standards evolve
- Southwest Medical offers vaccine to all employees and to patients who meet eligibility guidelines
- All patients are screened for COVID symptoms prior to scheduled surgery and on arrival at the Surgery Center
- The Surgery Centers follow infection prevention practices to decrease risk of transmission including surgical mask or better, screening visitors and distancing

Infection Prevention RN

Southwest Medical will maintain at least one Registered Nurse with training and education in infection prevention and control. While supporting the entire organization, the Infection Prevention RN will dedicate specific hours to the Surgery Centers

NHSN

- The medical facilities (Surgery Centers) will participate in the CDC's National Healthcare Surveillance Network
- Infection Prevention staff will report aggregate data and patient follow-up to the Patient Safety Committee at regularly scheduled intervals

Medical/Health Care Event (Incident)

Staff will:

- immediately report the event (incident) to supervisor
- Notify provider and obtain any orders to support the patient's clinical condition
- Initiate an Event (Incident) Report

The supervisor will:

- Communicate the event through appropriate channels to the Patient Safety Officer
- Should this occur during off-hours, the supervisor/designee will leave a voice mail message for the Patient Safety Officer
- Initiate investigation and follow-up actions
- Complete Event (Incident) Report process

The Patient Safety Officer will:

- Follow usual protocols to investigate the error
- Coordinate factual information/investigation for presentation, review and action by the Patient Safety Committee and/or other quality committees as applicable

Identification and Reporting

- SMA Policy 1600-29 (Sentinel Event Policy) and SMA Policy 190-4 (Incident Occurrence Reporting Policy) will describe the mechanism for identification and reporting a Sentinel Event/other medical error
- Southwest Medical will promote an environment that supports staff reporting and will support a Just Culture that focuses on process not individuals

Root Cause Analysis

- The Patient Safety Committee/Patient Safety Officer will provide oversight and direction for any root cause analysis of facility processes conducted for either Sentinel Events or near miss events
- The Patient Safety Officer will act as the liaison to quality committees and the Board of Directors for review/recommendations

Staff Involvement

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

- A non-punitive approach and without fear of reprisal
- Voluntary participation in the root-cause analysis for educational purposes and prevention of further occurrences

Reporting Requirements/Sentinel Event Reporting

- The Patient Safety Officer will direct reporting sentinel events to the Patient Safety Committee
- The Patient Safety Officer will direct reporting of any sentinel event at a medical facility per state of Nevada requirements as defined in NRS (Nevada Revised Statues) and NAC (Nevada Administrative Code)
- The Patient Safety Officer will direct reporting the number of sentinel events and recommendations to reduce the number or severity of sentinel events to the SMA Board of Directors
- The Patient Safety Officer/Committee will provide education and support to providers to ensure providers report the occurrence of a sentinel event resulting from any surgery to the Board within fourteen days after the occurrence of the sentinel event
- The Patient Safety Committee shall evaluate the actions of the Patient Safety Officer in connection with the reporting of sentinel events

- The Patient Safety Committee shall make recommendations to the SMA Board of Directors to reduce the number and severity of sentinel events and infections that occur at the facility

HealthCare Acquired Infections (HAI) Reporting
The Patient Safety Officer/Committee will provide education and support to providers to ensure if a provider identifies a patient with an infection, the provider will notify, within five days or as soon as practicable, the patient or the legal guardian or other person authorized by the patient to receive such information that the patient has an infection

The Patient Safety Officer/Committee will provide education and support to providers so that providers understand the notification may be delayed if the patient does not have a legal guardian, has not authorized any other person to receive such information and:

- Is not capable of understanding the information
- Is not conscious
- In the provider's judgment, the notification is likely to result in the patient harming himself

The Patient Safety Officer/Committee will provide education and support to providers so that providers understand if the notification is delayed, the information must be provided as soon as practicable after:

- The patient is capable of understanding the information
- The patient regains consciousness
- In the judgment of the provider, the patient is not likely to harm himself if informed about the infection
- A legal guardian or other person authorized to receive such information is available

Internal Reporting
The Patient Safety Committee will report internally to provide a comprehensive view of both the clinical and operational safety activity of the organization by submitting Patient Safety Committee minutes/reports to the SMA Board of Directors

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

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

- On or before March 1 of each year, The Patient Safety Committee will submit an annual sentinel event report to the Office of Public Health Informatics and Epidemiology, Bureau of Health Statistics, Planning, Epidemiology and Response, Nevada State Health Division
- The Surgery Centers will participate in the CDC National Healthcare Surveillance Network per State of Nevada NRS and NAC

Annual Report
The Patient Safety Officer will report to the SMA Board of Directors and will include:

- Defining the scope of occurrences including sentinel events, near misses and serious occurrences
- Demonstrating a pro-active component of the patient safety program through selection of high risk or problem prone processes for ongoing measurement and analysis
- Reporting results ongoing measurement and analysis of the high-risk or error-prone processes
- Describing how the function of process design incorporates patient safety using specific examples of process design or redesign that include patient safety principles
- Describing the process for soliciting and obtaining input for improving patient safety from patient/families

- Describing staff willingness to report medical/health care errors
- Describing the procedures for communication with patients/families about adverse events or unanticipated outcomes of care
- Describing examples of ongoing in-service, education and training programs to maintain and improve staff competence and support an interdisciplinary approach to patient care

Medical Facility (Surgery Centers) Reporting Requirements

The Patient Safety Officer/Committee will report to the appropriate licensing Board, within five days, after a change in the privileges of a physician, perfusionist, physician assistant or practitioner of respiratory care that is based on:

- An investigation of the mental, medical or psychological competency of the physician, perfusionist, physician assistant or practitioner of respiratory care
- Suspected or alleged substance abuse in any form by a physician, perfusionist, physician assistant or practitioner of respiratory care

Public Disclosure

The Surgery Centers will provide the name of each physician who performed a surgical procedure at the Surgery Centers, the total number of surgical procedures performed by the physician, reported by type of medical treatment, principal diagnosis, if the information is available, by principle surgical procedure and secondary surgical procedure (SB340)

Objectives Patient Safety Plan

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

Components and Methods

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

Southwest Medical will use RCA process to determine the contributing factors and the underlying reasons for the deficiencies or failures. Southwest Medical will use the Plan-Do-Study (check)-Act (PDSA or PDCA) model, developed by the Institute of Health Care Improvement, to test changes

Root Cause Analysis

- A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals
- Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis
- Root Cause Analysis and action plan framework table was introduced by the Joint Commission. It contains 24 analysis questions. It guides the organization to the steps in a root cause analysis. Not all the questions apply to all the events or cases. This table can be used individually or with the fishbone diagram.

5 Whys technique will be used at Southwest Medical to explore the cause and effect relationship underlay a problem. One can find the root causes by asking "why" no less than five times. This technique can be used individually or as a part of the fishbone diagram.

Fishbone Diagram

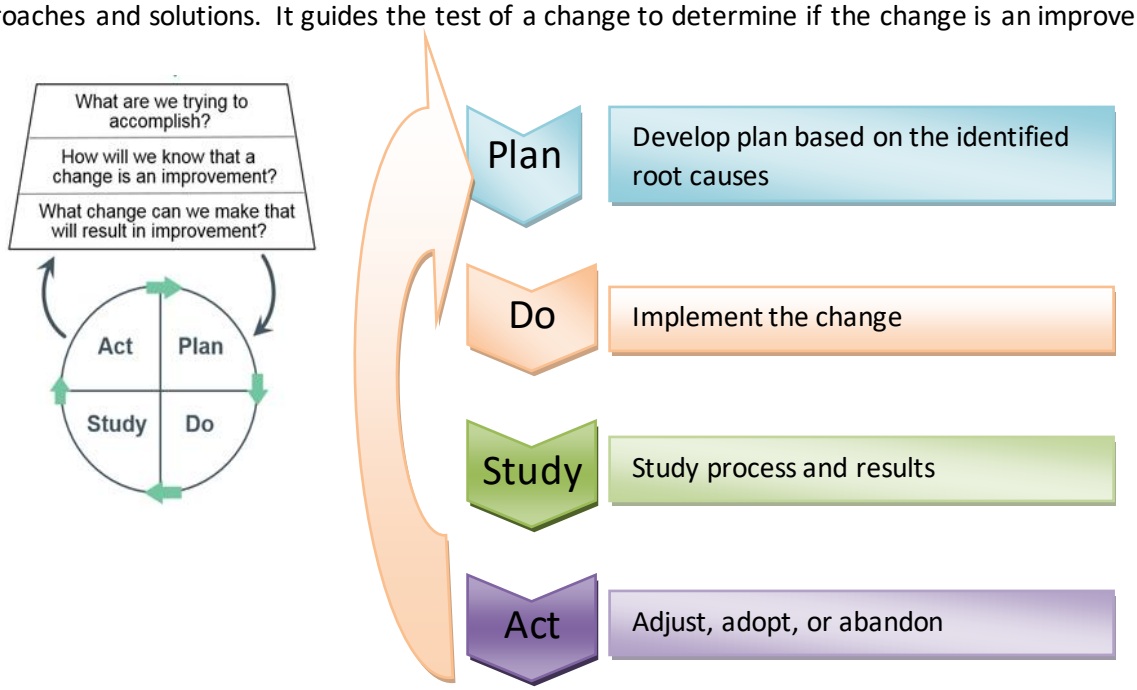
Once the problems are identified, a Fishbone Diagram can be used for analyzing the problems. Southwest Medical can use the fishbone diagram individually to analyze the root causes or can use it with the Root Cause Analysis and action plan framework table

A Fishbone Diagram, also called a Cause-and-Effect diagram, is a useful tool for a team to structurally brainstorm by discovering possible underlying factors or root causes from different major categories for the chosen problems. General categories include: people, methods, materials, measurements, education, procedures, process, location and environment.

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

Model for Improvement

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



The cycle is defined as follows:

- Plan--collect data and establish appropriate goals. Identify the problem and the possible root causes, and answer the following questions:
- Do--make changes designed to correct or improve the situation. Use the following questions for the guidance:
- Study -- Study the effect of the changes on the situation. Data should be collected on the new process and compared to the baseline or expected results. Results should be evaluated and by using the following questions as guidance:
- Act--If the result is successful or desirable, standardize the changes and then work on the next prioritized problem or the further improvements. If the outcome is not yet successful, look for different ways to identify the causes or change the testing process.

Data Collection and Reporting

Data should drive any quality and patient safety effort. Southwest Medial will track sentinel events, healthcare infection data and other internal data collection

External data sources are those data sources which are collected outside the supervisory structure of the case. Southwest Medical may use external data from:

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

Ongoing Reporting and Review

The Patient Safety Committee will review Elements of the Patient Safety Plan at scheduled intervals

Monthly	Quarterly	Annually
1. Sentinel event monthly report 2. Severity of infection report 3. RCA assessments 4. Optum Practice Health and Safety Clinical Compliance and Infection Prevention Clinic Assessments	1. Incidents-including sentinel event quarterly report 2. Severity of infection report 3. Review and evaluate the measure of improvement of patient safety 4. Review and evaluate the measurement to prevent and control infections 5. Quality reports including: • Environment of Care Standards • HLD • Infection Prevention • Sterilization • Pharmacy Standards	1. Quality and Patient Safety Plan update 2. Checklists and Policies reviewing and revising

Assessment of the Quality and Patient Safety Plan

Southwest Medical will review and evaluate the Patient Safety Plan at least annually

Patient Safety Checklists and Patient Safety Policies

By NRS 439.865, the Patient Safety Plan must include the patient safety checklists and patient safety policies for use by:

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

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

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

The patient safety policies must include, without limitation:

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

Based on NRS 439.865, the patient safety plan must also include an infection control program that includes the infection control policy. The policy must consist of:

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

Prevention (CDC), the World Health Organization (WHO) and the Society for Healthcare Epidemiology of America (SHEA)

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

Approval of Patient Safety Plan

According to NRS 439.865, Southwest Medical will submit its Patient Safety Plan to the Governing Board for approval. After the patient safety plan is approved, Southwest Medical will notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan

Southwest Medical will review and update the plan annually in accordance with State of Nevada requirements

Southwest Medical, according to NRS 439.843, will submit the most current copy of the Patient Safety Plan on or before March 1 of each year, to the Division of Public and Behavioral Health

References

- Root Cause Analysis Toolkit http://www.health.state.mn.us/patientsafety/toolkit/
- Quality and Service Improvement Tools http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html
- CQI 101 An Introduction to Continuous Quality Improvement: https://www.coursehero.com/file/13827355/CQI-Overviewppt/
- Quality Improvement http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/
- Root Cause Analysis http://www.patientsafety.va.gov/professionals/onthejob/rca.asp
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2 https://www.jointcommission.org/sentinel_event.aspx
- Hospital Policies https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1
- Checklists to Improve Patient Safety http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf
- Patient Safety Checklists http://www.who.int/patientsafety/implementation/checklists/en/
- Minutes of the Meeting of the Quality and Patient Safety Committee http://www.cookcountyhhs.org/wp-content/uploads/2013/12/09-23-14-QPS-scan-Minutes.pdf
- Title 40 – Public Health and Safety https://www.leg.state.nv.us/NRS/NRS-439.html

Terms and Definitions

Patient Safety
The Agency for Healthcare Research Quality (AHRQ) defines patient safety as "a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events."
http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

Sentinel event (NRS 439.830)

1. Except as otherwise provided in subsection 2, "sentinel event" means an event included in Appendix A of "Serious Reportable Events in Healthcare--2011 Update: A Consensus Report," published by the National Quality Forum
2. If the publication described in subsection 1 is revised, the term "sentinel events" means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:
   January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or
   July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published
3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist

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

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

Facility-Associated Infection: (NRS 439.802)
"Facility-acquired infection" means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections
- Ventilator-associated pneumonia
- Central line-related bloodstream infections
- Urinary tract infections
- Other categories of infections as may be established by the State Board of Health by regulation pursuant to NRS 439.890

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

Medical Facility (NRS 439.805)
"Medical facility" means:

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

(Added to NRS by 2002 Special Session, 13)

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

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

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

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

Catheter Associated Urinary Tract Infections (CAUTI)
A CAUTI is a urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CUR RENT_b.pdf.)

Central Line Associated Bloodstream Infections (CLABSI)
A CLABSI is a primary bloodstream infection that is associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection

Southwest Medical, Part of Optum Care

PATIENT SAFETY PLAN

MARCH 2022

Southwest Medical™
Part of OptumCare™

The Southwest Medical Patient Safety committee/team created the plan and revises/updates it annually. Implementation of this plan is intended to optimize healthcare quality and patient safety outcomes, encourage recognition, reporting, and acknowledgment of risks to patient, visitor, and employee safety, and reduce the medical/healthcare errors and /or preventable events

Patient Safety Committee/Program
Southwest Medical, Part of Optum Care
Las Vegas, Nevada

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Commitment to Patient Safety

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

Mission, Vision, and Values
In support of our mission, vision and values, Southwest Medical's Patient Safety and Quality Improvement program promotes:

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

Plan Scope and Purpose

The scope of the Patient Safety Committee organizational-wide and includes but is not limited to

- Patient safety
- Visitor safety
- Employee safety

The Committee provides oversight for patient safety activities, infection control activities, initiatives to promote patient safety and monitoring and review of medical/healthcare errors/potential errors involving patients, visitors, SMA staff, students and volunteers

All staff members at Southwest Medical are expected to fully support and participate in this plan and devote their expertise, knowledge, vision, skill, and insight to the patient safety and healthcare quality improvement process

Leadership assumes a role in establishing a culture of safety that minimizes hazards and patient harm by focusing on processes of care. The leaders of the organization are responsible for fostering a culture of safety through personal example by:

- Emphasizing patient safety as an organizational priority
- Providing education to medical and facility staff regarding the commitment to reduction of medical errors
- Supporting proactive reduction in medical/health care errors
- Integrating patient safety priorities into the new design and redesign of all relevant organization processes, functions and services

The purpose of the Patient Safety Plan is:

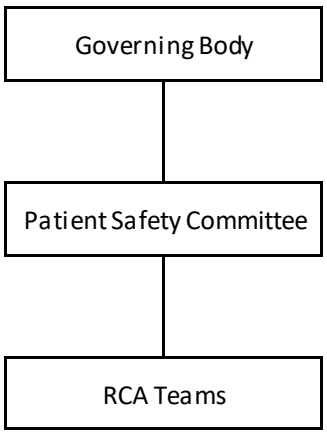
- To address patient safety related concerns and challenges
- To reduce risk
- To respect the dignity of those Southwest Medical serves by assuring a safe environment
- To periodically evaluate and revise the program to better serve patients and their families

Roles and Responsibilities

Southwest Medical created an organization-wide Patent Safety Plan that includes the medical facilities (Surgery Centers) as directed by NRS 439.875 a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plan is promoted and executed successfully

The Southwest Medical Patient Safety Committee

- Is a standing confidential interdisciplinary committee formed to manage the Southwest Medical's Patient Safety Program and Infection Prevention and Control Program through a systematic, coordinated, continuous approach
- Will meet monthly to assure maintenance and improvement of patient safety with the establishment of plans, processes and mechanisms involved in the provision of the patient care
- Will report and discuss events including:
    - Number of sentinel events from previous calendar quarter
    - Number of severe infections from previous calendar quarter
    - Corrective action plans
    - Corrective action plan evaluation
    - Patient safety policies and checklists
- Will monitor and document the effectiveness of the patient safety policy
- Will evaluate patient safety policies and checklists at least annually
- Will revise patient safety policies and checklists as needed
- Will convene a RCA meeting/team as necessary
- Review the RCA process and quality improvement related activities and timelines
- Identify barriers and technical assistance needs for supporting the RCA efforts
- Discuss corrective action process and activities



Patient Safety Committee Membership

In accordance with NRS 439.875, the Patient Safety Committee will include:

- The Patient Safety Officer

- The Infection Prevention and Employee Health Medical Director
- At least three providers of healthcare who treat patients , including but, without limitation, at least one member of the medical, nursing and pharmaceutical staff
- At least one member of the governing body
- The 2022 Committee includes:
    - Medical Director Specialties
    - Medical Director Primary Care
    - Medical Director On Demand Medicine
    - Medial Director Clinical Education Programs
    - Medical Director Surgery Centers
    - Optum Legal
    - Vice President/Operations
    - Chief Nursing Officer
    - RN Vice President/Administrator Surgery Centers
    - RN Associate Vice President On-Demand Medicine and Oncology Programs
    - RN Associate Vice President Specialties
    - Associate Vice President Imaging Services
    - Pharmacy Consultant (PharmD)
    - RN Associate Directors and Managers Surgery Centers
    - RN Associate Directors and Manager Operations
    - RN Manager Clinical Quality (PAD Department)
    - RN Manager Employee Health and Infection Prevention (PAD Department)
    - Infection Prevention/Employee Health Senior Project Coordinator (PAD Department)
    - Optum Regional Safety Manager (PAD Department)

Patient Safety Committee Responsibilities (based on NRS 439.875 and NRS 439.877)
The Patient Safety Committee is a standing confidential interdisciplinary committee formed that manages the Southwest Medical's Patient Safety Program and Infection Prevention and Control Program through a systematic, coordinated, continuous approach

- Evaluating and improving the quality of care rendered by Southwest Medical
- Collecting data and evaluating aggregate data related to individual occurrences in order to utilize performance improvement methodologies to promote patient safety and infection prevention
- Maintaining and improving patient safety with the establishment of plans, processes and mechanisms involved in the provision of the patient care
- Monitoring and documenting the effectiveness of the patient identification policy
- On or before July 1 of each year, submitting a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to NRS 439.877(4)(b)
- Receiving reports from the Patient Safety Officer pursuant to NRS 439.870
- Evaluating actions of the Patient Safety Officer in connection with all reports of potential or actual sentinel events
- Reviewing and evaluating the quality of measures carried out by Southwest Medical to improve the safety of patients who receive treatment
- Reviewing and evaluating the quality of measures carried out by Southwest Medical to prevent and control infections
- Making recommendations to the governing body to reduce the number and severity of sentinel events and infections that occur
    - Report to the Governing Body:
    - The number of sentinel events at the medical facility (Surgery Centers)

  - The number and severity of infections at the medical facility (Surgery Centers)
  - Any recommendations to reduce the number and severity of sentinel events and infections
- Adopting patient safety checklists and patient safety policies as required by NRS 439.877, reviewing checklists and policies annually and revising the checklists and policies as necessary
- Directing root cause analysis teams when indicated
- Providing oversight/direction for Surgery Centers QAPI program and quality studies
- Providing oversight/direction for the Surgery Centers participation in NHSN
- Providing oversight and monitoring for the Optum Practice Health and Safety Clinical Assessment Process

Patient Safety Officer Responsibilities (based on NRS 439.870)

- Chair the Patient Safety Committee
- Supervise the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to NRS 439.835
- Take such action as necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility
- Report to the Patient Safety Committee regarding any action taken in accordance with the responsibilities above
- Promote compliance with patient safety standards and initiatives
- Reinforce expectations of the Patient Safety Plan
- Accept accountability for measurably improving safety and reducing errors
- Liaison with Southwest Medical clinical leadership including surgery center leadership, other quality committees and the Board of Directors

Infection Prevention Officer Responsibilities (based on NRS 439.873)

- Serve on the Patient Safety Committee
- Liaison with Southwest Medical clinical leadership including surgery center leadership, other quality committees and the Board of Directors
- Provide medical direction as indicated (for both patient and employee infection control issues)
- Monitor the occurrences of infections to determine the number and severity of infections
- Report to the Patient Safety Committee concerning the number and severity of infections
- Take such action as necessary to prevent and control infections alleged to have occurred
- Carry out the provisions of the infection control program adopted pursuant to NRS 439.865 and ensure compliance with the program
- Ensure compliance with current infection prevention and control standards
- Direct infection prevention initiatives
- Reinforce expectations of the Infection Control program
- Complete at least four hours of continuing education each year on topics relating to current practices in infection control and prevention

RCA Team/Meeting

Will meet as needed to:

- Define the healthcare issues or potential risks
- Conduct Root Cause Analysis
- Review and analyze data
- Brainstorm issues or the potential risks by using fishbone diagrams or the *5 Whys* technique
- Identify the contributing factors
- Develop Corrective Action Plan
- Identify Plan-Do-Check -Act (PDCA) topics

- Discuss and present possible changes in procedure to improve areas indicated
- Identify strengths and areas that need improvement
- Develop strategies, solutions, and next steps

RCA Team Leader Responsibilities

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

Root Cause Analysis (RCA) Team Responsibilities

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

Governing Body Staff Responsibilities

- Provide vision and leadership to Patient Safety and Quality Improvement process
- Develop and foster a safe learning and improving culture
- Provide oversight to healthcare quality improvement processes and teams
- Plan, discuss and generate patient safety goals and activities

Quality Studies -Process Analysis (Surgery Centers)

The Surgery Centers will complete quality studies each year that include:

1. A statement of the purpose of the QI activity that includes a description of the known or suspected problem and explained significance to the Surgery Center
2. Identification of the performance goal against which Surgery Center will compare current performance
3. Description of the data that will be collected in order to determine the Surgery Center's current performance
4. Evidence of Data Collection
5. Data analysis that describes findings about the frequency, severity and source of issue
6. Comparison of the Surgery Center's current performance against identified performance goal
7. Implementation of corrective action
8. Re-measurement to objectively determine whether corrective actions achieved and sustained improvement
9. Implementation of any additional corrective action to achieve and/or sustain improved performance (and plan for on-going re-measurement)
10. Communication of findings to Surgery Center Leadership, The Patient Safety Committee, the Board of Directors and Surgery Center staff and incorporating findings into educational activities

For quality studies, the Surgery Center(s) may base topic selection on information published by accreditation bodies, National Patient Safety Goals and/or other sources of information including risk management, performance improvement, quality assurance, infection prevention and control, patient/family suggestions/expectations or process outcomes

Surgery Centers' quality studies will focus on redesign or implementation of new processes to incorporate patient safety principles and will place an emphasis on the important facility and patient care functions of:

- Rights of Patients
- Governance
- Administration
- Quality of Care
- Quality Management and Improvement
- Clinical Records and Health Information
- Infection Prevention and Control and Safety
- Facilities and Environment
- Anesthesia Services
- Surgical and Related Services
- Pharmaceutical Services
- Pathology and Medical Laboratory Services
- Diagnostic and Other Imaging Services

Infection Prevention Program

- The purpose of the Infection Control Programs is to prevent and control infections
- The Infection Control Program and the surgery Centers Infection Control Program (SSC and SCT 1600-3 Infection Control Program for Southwest Medical Surgery Center) are components of the Patient Safety Plan
- The Infection Control Programs are based on current guidelines developed by nationally recognized infection control organizations
- The Infection Control Professionals will report regularly on the number and severity of infections that occurred in the prior quarter

Infection Prevention Program – COVID 19

- Southwest Medical implemented risk reduction standards to ensure a safe environment with minimal risk of exposure for all employees, staff, contractors and patients
- Southwest Medical updates infection prevention practices as national standards evolve
- Southwest Medical offers vaccine to all employees and to patients who meet eligibility guidelines
- All patients are screened for COVID symptoms prior to scheduled surgery and on arrival at the Surgery Center
- The Surgery Centers follow infection prevention practices to decrease risk of transmission including surgical mask or better, screening visitors and distancing

Infection Prevention RN

Southwest Medical will maintain at least one Registered Nurse with training and education in infection prevention and control. While supporting the entire organization, the Infection Prevention RN will dedicate specific hours to the Surgery Centers

NHSN

- The medical facilities (Surgery Centers) will participate in the CDC's National Healthcare Surveillance Network
- Infection Prevention staff will report aggregate data and patient follow-up to the Patient Safety Committee at regularly scheduled intervals

Medical/Health Care Event (Incident)

Staff will:

- immediately report the event (incident) to supervisor
- Notify provider and obtain any orders to support the patient's clinical condition
- Initiate an Event (Incident) Report

The supervisor will:

- Communicate the event through appropriate channels to the Patient Safety Officer
- Should this occur during off-hours, the supervisor/designee will leave a voice mail message for the Patient Safety Officer
- Initiate investigation and follow-up actions
- Complete Event (Incident) Report process

The Patient Safety Officer will:

- Follow usual protocols to investigate the error
- Coordinate factual information/investigation for presentation, review and action by the Patient Safety Committee and/or other quality committees as applicable

Identification and Reporting

- SMA Policy 1600-29 (Sentinel Event Policy) and SMA Policy 190-4 (Incident Occurrence Reporting Policy) will describe the mechanism for identification and reporting a Sentinel Event/other medical error
- Southwest Medical will promote an environment that supports staff reporting and will support a Just Culture that focuses on process not individuals

Root Cause Analysis

- The Patient Safety Committee/Patient Safety Officer will provide oversight and direction for any root cause analysis of facility processes conducted for either Sentinel Events or near miss events
- The Patient Safety Officer will act as the liaison to quality committees and the Board of Directors for review/recommendations

Staff Involvement

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

- A non-punitive approach and without fear of reprisal
- Voluntary participation in the root-cause analysis for educational purposes and prevention of further occurrences

Reporting Requirements/Sentinel Event Reporting

- The Patient Safety Officer will direct reporting sentinel events to the Patient Safety Committee
- The Patient Safety Officer will direct reporting of any sentinel event at a medical facility per state of Nevada requirements as defined in NRS (Nevada Revised Statues) and NAC (Nevada Administrative Code)
- The Patient Safety Officer will direct reporting the number of sentinel events and recommendations to reduce the number or severity of sentinel events to the SMA Board of Directors
- The Patient Safety Officer/Committee will provide education and support to providers to ensure providers report the occurrence of a sentinel event resulting from any surgery to the Board within fourteen days after the occurrence of the sentinel event
- The Patient Safety Committee shall evaluate the actions of the Patient Safety Officer in connection with the reporting of sentinel events

- The Patient Safety Committee shall make recommendations to the SMA Board of Directors to reduce the number and severity of sentinel events and infections that occur at the facility

HealthCare Acquired Infections (HAI) Reporting
The Patient Safety Officer/Committee will provide education and support to providers to ensure if a provider identifies a patient with an infection, the provider will notify, within five days or as soon as practicable, the patient or the legal guardian or other person authorized by the patient to receive such information that the patient has an infection

The Patient Safety Officer/Committee will provide education and support to providers so that providers understand the notification may be delayed if the patient does not have a legal guardian, has not authorized any other person to receive such information and:

- Is not capable of understanding the information
- Is not conscious
- In the provider's judgment, the notification is likely to result in the patient harming himself

The Patient Safety Officer/Committee will provide education and support to providers so that providers understand if the notification is delayed, the information must be provided as soon as practicable after:

- The patient is capable of understanding the information
- The patient regains consciousness
- In the judgment of the provider, the patient is not likely to harm himself if informed about the infection
- A legal guardian or other person authorized to receive such information is available

Internal Reporting
The Patient Safety Committee will report internally to provide a comprehensive view of both the clinical and operational safety activity of the organization by submitting Patient Safety Committee minutes/reports to the SMA Board of Directors

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

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

- On or before March 1 of each year, The Patient Safety Committee will submit an annual sentinel event report to the Office of Public Health Informatics and Epidemiology, Bureau of Health Statistics, Planning, Epidemiology and Response, Nevada State Health Division
- The Surgery Centers will participate in the CDC National Healthcare Surveillance Network per State of Nevada NRS and NAC

Annual Report
The Patient Safety Officer will report to the SMA Board of Directors and will include:

- Defining the scope of occurrences including sentinel events, near misses and serious occurrences
- Demonstrating a pro-active component of the patient safety program through selection of high risk or problem prone processes for ongoing measurement and analysis
- Reporting results ongoing measurement and analysis of the high-risk or error-prone processes
- Describing how the function of process design incorporates patient safety using specific examples of process design or redesign that include patient safety principles
- Describing the process for soliciting and obtaining input for improving patient safety from patient/families

- Describing staff willingness to report medical/health care errors
- Describing the procedures for communication with patients/families about adverse events or unanticipated outcomes of care
- Describing examples of ongoing in-service, education and training programs to maintain and improve staff competence and support an interdisciplinary approach to patient care

Medical Facility (Surgery Centers) Reporting Requirements

The Patient Safety Officer/Committee will report to the appropriate licensing Board, within five days, after a change in the privileges of a physician, perfusionist, physician assistant or practitioner of respiratory care that is based on:

- An investigation of the mental, medical or psychological competency of the physician, perfusionist, physician assistant or practitioner of respiratory care
- Suspected or alleged substance abuse in any form by a physician, perfusionist, physician assistant or practitioner of respiratory care

Public Disclosure

The Surgery Centers will provide the name of each physician who performed a surgical procedure at the Surgery Centers, the total number of surgical procedures performed by the physician, reported by type of medical treatment, principal diagnosis, if the information is available, by principle surgical procedure and secondary surgical procedure (SB340)

Objectives Patient Safety Plan

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

Components and Methods

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

Southwest Medical will use RCA process to determine the contributing factors and the underlying reasons for the deficiencies or failures. Southwest Medical will use the Plan-Do-Study (check)-Act (PDSA or PDCA) model, developed by the Institute of Health Care Improvement, to test changes

Root Cause Analysis

- A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals
- Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis
- Root Cause Analysis and action plan framework table was introduced by the Joint Commission. It contains 24 analysis questions. It guides the organization to the steps in a root cause analysis. Not all the questions apply to all the events or cases. This table can be used individually or with the fishbone diagram.

5 Whys technique will be used at Southwest Medical to explore the cause and effect relationship underlay a problem. One can find the root causes by asking "why" no less than five times. This technique can be used individually or as a part of the fishbone diagram.

Fishbone Diagram

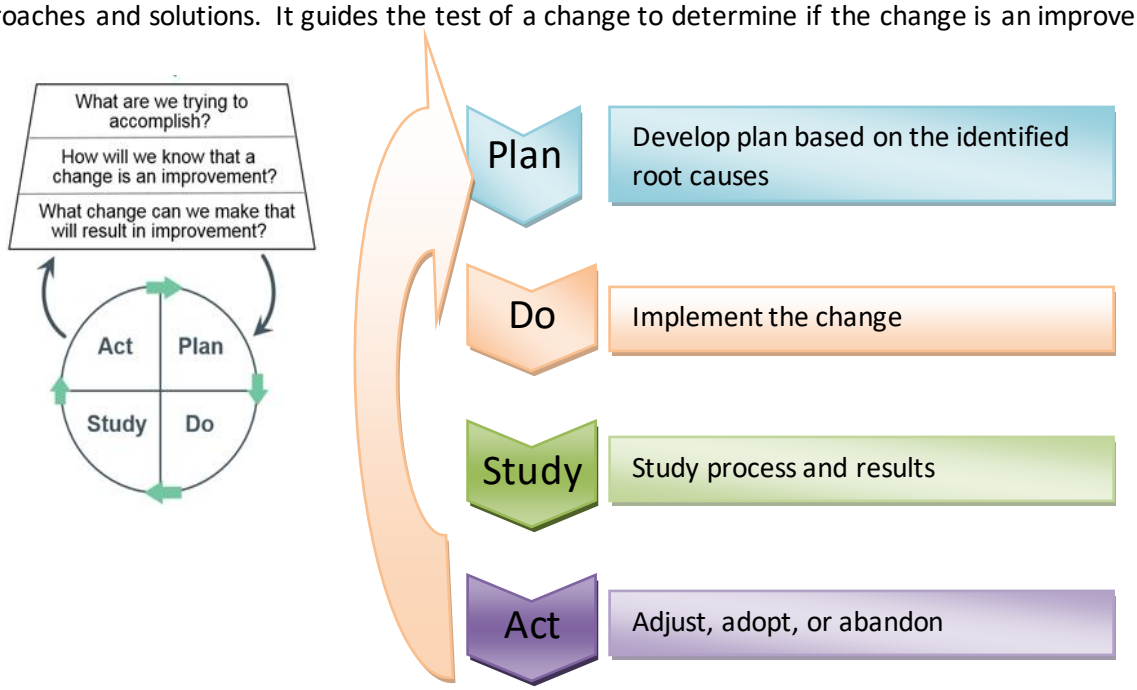
Once the problems are identified, a Fishbone Diagram can be used for analyzing the problems. Southwest Medical can use the fishbone diagram individually to analyze the root causes or can use it with the Root Cause Analysis and action plan framework table

A Fishbone Diagram, also called a Cause-and-Effect diagram, is a useful tool for a team to structurally brainstorm by discovering possible underlying factors or root causes from different major categories for the chosen problems. General categories include: people, methods, materials, measurements, education, procedures, process, location and environment.

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

Model for Improvement

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



The cycle is defined as follows:

- Plan--collect data and establish appropriate goals. Identify the problem and the possible root causes, and answer the following questions:
- Do--make changes designed to correct or improve the situation. Use the following questions for the guidance:
- Study -- Study the effect of the changes on the situation. Data should be collected on the new process and compared to the baseline or expected results. Results should be evaluated and by using the following questions as guidance:
- Act--If the result is successful or desirable, standardize the changes and then work on the next prioritized problem or the further improvements. If the outcome is not yet successful, look for different ways to identify the causes or change the testing process.

Data Collection and Reporting

Data should drive any quality and patient safety effort. Southwest Medial will track sentinel events, healthcare infection data and other internal data collection

External data sources are those data sources which are collected outside the supervisory structure of the case. Southwest Medical may use external data from:

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

Ongoing Reporting and Review

The Patient Safety Committee will review Elements of the Patient Safety Plan at scheduled intervals

Monthly	Quarterly	Annually
1. Sentinel event monthly report 2. Severity of infection report 3. RCA assessments 4. Optum Practice Health and Safety Clinical Compliance and Infection Prevention Clinic Assessments	1. Incidents-including sentinel event quarterly report 2. Severity of infection report 3. Review and evaluate the measure of improvement of patient safety 4. Review and evaluate the measurement to prevent and control infections 5. Quality reports including: • Environment of Care Standards • HLD • Infection Prevention • Sterilization • Pharmacy Standards	1. Quality and Patient Safety Plan update 2. Checklists and Policies reviewing and revising

Assessment of the Quality and Patient Safety Plan

Southwest Medical will review and evaluate the Patient Safety Plan at least annually

Patient Safety Checklists and Patient Safety Policies

By NRS 439.865, the Patient Safety Plan must include the patient safety checklists and patient safety policies for use by:

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

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

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

The patient safety policies must include, without limitation:

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

Based on NRS 439.865, the patient safety plan must also include an infection control program that includes the infection control policy. The policy must consist of:

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

Prevention (CDC), the World Health Organization (WHO) and the Society for Healthcare Epidemiology of America (SHEA)

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

Approval of Patient Safety Plan

According to NRS 439.865, Southwest Medical will submit its Patient Safety Plan to the Governing Board for approval. After the patient safety plan is approved, Southwest Medical will notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan

Southwest Medical will review and update the plan annually in accordance with State of Nevada requirements

Southwest Medical, according to NRS 439.843, will submit the most current copy of the Patient Safety Plan on or before March 1 of each year, to the Division of Public and Behavioral Health

References

- Root Cause Analysis Toolkit http://www.health.state.mn.us/patientsafety/toolkit/
- Quality and Service Improvement Tools http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html
- CQI 101 An Introduction to Continuous Quality Improvement: https://www.coursehero.com/file/13827355/CQI-Overviewppt/
- Quality Improvement http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/
- Root Cause Analysis http://www.patientsafety.va.gov/professionals/onthejob/rca.asp
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2 https://www.jointcommission.org/sentinel_event.aspx
- Hospital Policies https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1
- Checklists to Improve Patient Safety http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf
- Patient Safety Checklists http://www.who.int/patientsafety/implementation/checklists/en/
- Minutes of the Meeting of the Quality and Patient Safety Committee http://www.cookcountyhhs.org/wp-content/uploads/2013/12/09-23-14-QPS-scan-Minutes.pdf
- Title 40 – Public Health and Safety https://www.leg.state.nv.us/NRS/NRS-439.html

Terms and Definitions

Patient Safety
The Agency for Healthcare Research Quality (AHRQ) defines patient safety as "a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events."
http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

Sentinel event (NRS 439.830)

1. Except as otherwise provided in subsection 2, "sentinel event" means an event included in Appendix A of "Serious Reportable Events in Healthcare--2011 Update: A Consensus Report," published by the National Quality Forum
2. If the publication described in subsection 1 is revised, the term "sentinel events" means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:
   January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or
   July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published
3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist

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

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

Facility-Associated Infection: (NRS 439.802)
"Facility-acquired infection" means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections
- Ventilator-associated pneumonia
- Central line-related bloodstream infections
- Urinary tract infections
- Other categories of infections as may be established by the State Board of Health by regulation pursuant to NRS 439.890

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

Medical Facility (NRS 439.805)
"Medical facility" means:

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

(Added to NRS by 2002 Special Session, 13)

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

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

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

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

Catheter Associated Urinary Tract Infections (CAUTI)
A CAUTI is a urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CUR RENT_b.pdf.)

Central Line Associated Bloodstream Infections (CLABSI)
A CLABSI is a primary bloodstream infection that is associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection

Section 2 Fire Safety	Stonecreek Surgery Center, Las Vegas Nevada	
Policy Name: **EVACUATION AUTHORITY AND PROCEDURES**		Page 1 of 1
Approved:	Revised:	

POLICY:

Evacuation of patients from a surgery center is a difficult and time consuming task. Therefore, modern facilities such as Stonecreek Surgery Center are designed to protect patients and staff from the dangers of fire and smoke with minimum relocation. In any fire emergency situation, the persons near the scene must be moved away from an area of immediate danger, but it is not usually necessary to move them a great distance or out of the facility.

Depending on the size, each facility is typically divided into smoke compartments. The fire doors, when closed, separate areas of the facility from others by a fire-and-smoke barrier rated at one to two hours. Usually, movement of patients to the side of the smoke barrier opposite the fire will provide adequate protection.

The decision to evacuate the facility can only be made by the Director of Nursing, the Fire Department or other appropriate civil authorities. Should this decision be made, the evacuation procedures will be implemented per the Comprehensive Emergency Management Plan (CEMP).

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Section 2 Fire Safety	Stonecreek Surgery Center, Las Vegas Nevada	
Policy Name: **FIRE AND DISASTER PLAN**		Page 1 of 1
Approved:	Revised:	

POLICY:

The focus of the fire and disaster plan of Stonecreek Surgery Center is the prevention of fire and disaster to the extent possible and the education of personnel regarding preventive measures and action steps.

Fire risks are identified and minimized, and staff members are prepared to address fire hazards, if necessary. Prioritized risks are identified in a Fire Safety Risk Assessment, which is evaluated and edited as applicable on an annual basis and as needed.

A copy of the Fire Plan should be kept at the reception desk.

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Section 2 Fire Safety	Stonecreek Surgery Center	
Policy Name: **FIRE DRILL PROCEDURES**		Page 1 of 1
Approved:	Revised:	

POLICY:

Fire drills shall be conducted to familiarize personnel with the proper procedures to follow in the event of an actual fire emergency. These drills will be conducted without prior announcement at least once per quarter, per shift, and will include an automatic transmission of signal to the servicing fire department. At least 50% of fire drills shall be unannounced and at least one fire drill will be an operating room fire scenario.

The fire drill will commence when the Director of Nursing hands an employee a small 5" x 8" card, which states something is on fire and that he or she is to commence the drill. The time will immediately be recorded. Staff will have four minutes from this time to complete the first ten (10) indicators. The following exceptions to the fire plan will be made during a drill:

- Patient's rescue/removal from the area may be simulated.
- If the fire is small, fire extinguishers will be brought to the scene, but extinguisher use may be simulated.
- If a fire is large, or a significant smoke hazard is present, facility evacuation may be simulated.

All fire drills will be addressed in a professional manner and as a positive learning experience. The circumstances of the simulated fire should vary to ensure understanding and competency. The safety of the patients, visitors and staff is enhanced by the training of all personnel in proper response to emergency situations.

The person conducting a fire drill will submit a written critique for quarterly Fire/Safety reports.

Fire extinguishers shall be checked monthly to make sure they are properly energized (i.e., the gauge is in the green). If the gauge is in the red, the Director of Nursing shall be notified immediately and the fire extinguisher replaced. Interim Life Safety Measures may be warranted until the replacement fire extinguisher is on site.

<u>Annually</u>

Once a year, the Fire Department will be on-site for review and practice of fire extinguishers, if service is available.

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FIRE DRILL REPORT

Fire Location: _____ Date: _____ Time: _____ Hrs.

Staff present: _____ RACE response time _____ Hrs. Reported by: _____

#	INDICATORS	OBSERVED	NOT OBSERVED	N/A
1	Was automatic fire detector(s) activated? **ANNOUNCE**			
2	Was the signal transmitted and received?			
3	Were victim(s) or potential victim(s) removed from the immediate fire area? (can be simulated) **REMOVE/RESCUE**			
4	Was telephone used to call in the fire location and type? (can be simulated)			
5	Was a pull handle alarm used to report the fire? **ALARM**			
6	Were door(s) closed to the fire area where possible? **CONFINE/CONTAIN**			
7	Were door(s) closed to all rooms along the fire exit passageway (corridor/hall)?			
8	If fire was small, did staff extinguish or attempt to extinguish the fire? (can be simulated) **EXTINGUISH**			
9	If fire was large or a significant smoke hazard was present, did staff prepare to evacuate? (can be simulated) **EVACUATE**			
10	Were all patients, visitors and equipment put behind closed doors?			
11	Was staff prepared to evacuate to (correct direction, designation, etc.)?			
12	Was evacuation to a smoke compartment within the ASC or from the building to outside?			
13	Were indicators #1-10 completed within 4 minutes?			
14	Did staff designate someone to turn off medical gasses?			
15	Did the pull alarm box work?			
16	Did staff know emergency fire procedures?			
17	Were any hall doors wedged open?			
18	Were exit lights visible?			
19	Was any firefighting equipment blocked?			
20	Did automatic fire doors close and latch?			
21	Did automatic smoke doors close?			
22	Were corridors (halls) clear of obstacles?			

List all who participated in this drill:

Areas for Improvement: ❑ N/A

Action Plan: ❑ N/A

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FIRE EXTINGUISHER LOCATIONS

LOCATION	CLASS
Side Exit Hallway – West 1	ABC
Break Room	ABC
IT Room	ABC
PACU	ABC
OR Hallway – North 2	ABC
SPD	ABC
Front Office	ABC

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MONTHLY FIRE EXTINGUISHER CHECKS

To be done at the end of each month. The following items shall be checked on all fire extinguishers at the facility and documented. Initial for each fire extinguisher monthly. If there is a fire extinguisher on site that does not pass the monthly inspection, notify the Clinical Director immediately. Implement Interim Life Safety Measures until corrections or replacements have been completed.

INTERIOR EXTINGUISHERS	EXTERIOR EXTINGUISHERS
• Mounted in an easily accessible place, no debris or material stacked in front of it. • Safety pin is in place and intact. Nothing else should be used in place of the pin. • Label is clear and extinguisher type and instructions can be read easily. • Handle is intact and not bent or broken. • Pressure gauge is in the green and is not damaged or showing "recharge" • Discharge hoses/nozzle is in good shape and not clogged, cracked, or broken • Extinguisher was turned upside down at least three times (shaken)	• Discharge Hose/nozzle is in good shape and not clogged, cracked, or broken • It is mounted in an easily accessible area, with nothing stacked around it. • Safety Pin is in place and not damaged. • Pressure gauge is in the green and not damaged or showing "recharge" • Label is readable and displays the type of extinguisher and the instructions for use. • It is not rusty or has any type of corrosion build up. • Extinguisher was turned upside down at least three times. (Shaken) • The location of the extinguisher is easily identifiable. (signs) • Test conducted in accordance with NFPA 10 - 2010 Edition

FIRE EXTINGUISHER	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Pre-Op/PACU												
West Door												
IT Room												
Breakroom												
Sterile Storage												
Decontamination												
North Exit Door												
Front Office												

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Section 2 Fire Safety	Stonecreek Surgery Center	
Policy Name: **FIRE PREVENTION**		Page 1 of 3
Approved:	Revised:	

POLICY:

The realization that even a minor fire in a health care facility can have serious implications dictates that Stonecreek Surgery Center implement a strong, viable fire prevention program. This program will address the integrity of suppression systems, the elimination or minimization of fire hazards and compliance with fire safety codes and regulations.

Stonecreek Surgery Center was designed to comply with all applicable codes and standards relating to fire prevention, detection and suppression in effect at the time of construction. These features include fire resistant structural materials, wall coverings and floor coverings and a detection/alarm system. These systems are maintained in a manner to ensure proper working conditions and compliance with codes and regulations, which may apply.

Although the facility is structurally fire resistant, care must be taken to prevent the introduction or creation of fire hazards within the facility. There are six areas of concern in the elimination or prevention of fire hazards, which are listed below with general guidelines:

HOUSEKEEPING:

- Ensure all trash is removed on a daily basis and not allowed to accumulate in closets or corners.
- Keep all corridors and fire exits free of any obstruction.
- Storage of any type, at any time, in corridors is prohibited
- Empty boxes or storage cartons will not be allowed to accumulate.
- Trash receptacles, 32 gallons or larger, will be of self-extinguishing or be non-combustible type, bearing the approval markings of Underwriters Laboratories.
- Receptacles larger than 32 gallons shall be stored in one hour hazardous rooms.

ELECTRICAL SAFETY:

- Any actual or suspected electrical problem will be reported immediately.
- Electrical equipment will not be used if damaged or reliability is suspected.

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- All electrical equipment used in the facility will be inspected for safety by the bioengineering consultant prior to being put into service and at required intervals as designated by the manufacturer.

- A detailed inventory of all critical and non-critical medical equipment will be maintained.

- Dust and lint will not be allowed to accumulate on electrical equipment.

- Qualified operators will use electrical equipment only.

SMOKING:

- Stonecreek Surgery Center is a non-smoking facility. This includes use of tobacco and electronic devices.

USE / STORAGE OF OXYGEN:

- Oxygen in itself is a non-flammable gas, but it does support rapid combustion (oxidation).

- Petroleum-based lubricants will not be used on any type of oxygen equipment.

- Cylinders will be stored upright, secured to prevent falling and separate from any other flammable gasses or liquids.

- Smoking is prohibited where oxygen is used or stored.

- Actual or suspected leaks in the oxygen distribution system will be reported immediately.

STORAGE OF MATERIALS AND SUPPLIES:

- All storage areas will be kept neat and orderly.

- No storage is permitted above a horizontal plane eighteen inches below the lowest point of a sprinkler head.

- Doors will be kept closed when storage rooms are unoccupied.

- A clear path will be maintained at all times.

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- No material or storage units will be located where they conceal or hinder access to fire alarm pull stations or fire extinguisher.

EDUCATION:

- The staff, including operating licensed independent practitioners and anesthesia providers, will be educated on how to control heat sources and manage fuels.

- Guidelines to minimize oxygen concentration under drapes include:

    - Question the need for 100% O_2 for open delivery on the face
    - Use air or FiO_2 30% for open delivery
    - Minimize O_2 and N_2O buildup beneath surgical drapes; tent drapes to dissipate gases
    - Use an incise drape to isolate head and neck incisions from O_2 and alcohol vapors
    - Do not drape patient until all flammable preps have fully dried
    - Coat facial hair near the surgical site with water-soluble surgical lubricating jelly to make it nonflammable

Source: ECRI, 5200 Butler Pike, Plymouth Meeting, PA info@ecri.org

Stonecreek Surgery Center is subject to periodic inspections by the Fire Department, State Department of Health, Medicare and other regulatory bodies. These inspections are conducted to ensure compliance with local and state fire codes and to aid the facility in improvement of its fire prevention efforts. These inspections should be viewed positively and every effort made to cooperate with the inspectors. The Director of Nursing of the facility will accompany all inspectors and will take action as directed by the Governing Body to ensure the facility corrects any discrepancies or implements policies suggested by the inspecting authority.

Stonecreek Surgery Center will strive for continued compliance with applicable codes and prevention of hazardous conditions, employing periodic surveillance inspections conducted by the performance improvement subcommittee. Reports of these inspections will be submitted to the Governing Body for review and corrective action, as required.

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Section 2 Fire Safety	Stonecreek Surgery Center	
Policy Name: **FIRE RESPONSE PLAN**		Page 1 of 2
Approved:	Revised:	

POLICY:

Rapid and effective response in the first few minutes of a fire is of paramount importance to ensure the safety of patients, visitors and staff and to minimize damage and interruption of service. There are five basic procedures, which, when employed in order, should achieve the greatest degree of personal safety and minimum amount of property damage. These steps are:

Announce
Remove or **R**escue
Alarm
Confine or **C**ontain
Evacuate or **E**xtinguish

ANNOUNCE:

The personnel at the scene will notify the receptionist. The location, type and extent of the fire will be given along with the name of the person calling. The receptionist will overhead page three times **"CODE RED"** and **"(LOCATION)".**

REMOVE / RESCUE:

Personal safety in a fire emergency is of utmost importance. Every reasonable attempt to move patients, visitors and staff away from an area of immediate danger must be performed as rapidly as possible. The following guidelines apply to this procedure:

- Do not risk your own life or serious injury when attempting a rescue.
- Do not attempt to move or reach through flames.
- Keep in a low, crouched or crawling position when in areas of smoke.
- Do not move patients any further than necessary to ensure their safety.
- Do not allow yourself to become trapped between the fire and a means of escape.

Do not move patients any further than necessary to ensure their safety. This may be to a protected area, different smoke compartment, within the facility or it may be an evacuation from the building.

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ALARM:

As soon as the safety of the people in the vicinity of the fire is secured and the fire is confined, the Fire Department summoned. The automatic fire detection system may perform this function, but its reliability, as with any electro-mechanical system, cannot be guaranteed to be perfect. In addition, call 911 to give the location of the fire.

CONFINE / CONTAIN:

Smoke and toxic gases given off during a fire are the primary cause of death in structural fires. Efforts must be taken to minimize both the spread of the fire and the smoke. The facility is designed to minimize this hazard and provide safe areas of refuge and egress. Containment of the fire and smoke to the smallest area possible is to be initiated immediately after the rescue process is completed. Guidelines for containment are:

- Close the door to the room or area in which the fire occurs and close all doors in the facility.
- Ensure the smoke barrier doors in the corridor are closed.
- Do not reopen any doors unless absolutely necessary.
- Do not, under any circumstances, open a door that is hot or warm to the touch. The heat felt through the door indicates the fire on the other side has grown past the point of fighting except by professional firefighters.

EVACUATE / EXTINGUISH:

The final step in responding to a fire emergency is evacuation or extinguishment. Portable fire extinguishers will be used on small fires. A large fire, or one that is spreading rapidly, will be confined and left for the Fire Department to fight.

The staff personnel on the scene will attempt to extinguish the fire pending the arrival of the Fire Department, if it is safe and reasonable to do so. Upon arrival of the Fire Department, the ranking officer will assume complete charge of the situation. Staff will assist the Fire Department only if requested to do so.

All fires extinguished or un-extinguished, insignificant or major must be reported to the Director of Nursing so proper reports may be made to the Fire Department.

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Stonecreek Surgery Center will insert a diagram of the fire exit routes pertaining to their building.

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Section 2 Fire Safety	Stonecreek Surgery Center	
Policy Name: **FIRE WATCH PLAN**		Page 1 of 2
Approved:	Revised:	

POLICY:

A Fire Watch is required when the fire alarm system or the fire protection system, such as sprinklers, is inoperative for any four hours in a 24-hour period. The Safety Officer will conduct the Fire Watch tour at least hourly.

PURPOSE:

The purpose of the Fire Watch is to supplement the existing fire detection and response systems and to provide additional compensatory activity to assure the safety of patients, visitors, and staff. The Fire Watch will identify and report hazards and corrective action and will document their findings and activity. Regular reports of the activity and findings will be provided to the QAPI Committee and to appropriate governmental agencies on a periodic basis.

PROCEDURE:

- The fire department (or other emergency response group) and insurance company, if required, are notified, and the time of this notification is documented.
- A Fire Watch inspection tour will be made hourly throughout the affected areas and documented on the Fire Watch checklist.
- Each item identified will be documented on the inspection form as exceptions, and the appropriate responsible party will be informed for correction.
- Items identified will be corrected as quickly as possible by notifying the appropriate individual to correct.
- Open items will be reviewed by the Safety Officer to allow ongoing evaluation of the problems and documentation of the corrective activity completed.
- Items that are not corrected or cleared in a timely fashion will be assessed for Interim Life Safety Measures and brought to the attention of the appropriate individual or administrative management for further action.

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DOCUMENTATION:

- The status of items identified in the Fire Watch Checklist will be documented and followed-up as necessary.
- The name of the person contacted during the follow-up will be documented
- The Fire Watch Checklist will become part of the record of the project.
- On a periodic basis, open issues will be printed and provided to the Safety Officer for evaluation.
- Open issues will be sorted by responsible individuals, and lists of the open issues for which that person is responsible will be sent to them. They are then requested to provide status reports for those open items.

Checklist

The Fire Watch checklist will be evaluated at least annually to assure that the appropriate elements are on the list.

Training

- Staff need to verify with their local fire department for requirements for training. If no requirement is established, the training will include:
    - Purpose of the Fire Watch
    - The key elements on the checklist to be observed
    - The documentation process, including notification and recording the data
    - The areas including routes to be taken and the specific elements to be included in the observations
    - The person(s) who will be notified of identified problems and deficiencies
    - The person(s) who will be responsible for the fire watch process and with whom to check if there are questions
- Staff in the affected areas will be trained on their fire response procedures during the duration of the fire watch upon the areas being affected. Annual training will be conducted for staff on fire response procedures.

(Please Note: For full text and any exceptions, refer to NFPA 101-2000: 9.6.1.8 and 9.7.6.1. See also LS.01.01.01, EP 3.)

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FIRE WATCH CHECKLIST

Date:	**Start Time:**
Shift: 1 2 3	**Finish Time:**
Conducted by:	**Job Title:**

Item	Conditions	Yes	No	N/A	Contact
1	There is no fire, smoke, or a smell of smoke, or other evidence of a fire or incipient fire.				
2	Fire alarm pull stations, smoke detectors, or heat detectors are not blocked, obstructed, or rendered inaccessible.				
3	Fire alarm pull stations, smoke or heat detectors, bells or other fire alarm elements are not damaged or broken.				
4	Fire extinguishers are not blocked, or obstructed, or rendered unavailable for immediate use.				
5	Fire extinguishers are not damaged, missing, or have been inspected for the month.				
6	Fire or smoke doors are not blocked or obstructed by materials, equipment, or wedging.				
7	Fire or smoke doors are not damaged, broken, or unable to close fully, or latch appropriately.				
8	Exit lights or illumination of the corridor is not burned out or not operating properly.				
9	Exit path is not blocked or obstructed. Exit stairs do not contain any material, or supplies, or debris.				
10	Exit door at bottom of stair is not obstructed, nonfunctional, or unable to easily open.				
11	Exit stairs lighting is operational; areas of the stair are not dark and is visible.				
12	Corridors do have supplies, equipment, trash, debris, or other materials obstructing any part of corridor.				
13	Trash, debris or other combustible materials are not stored in rooms or areas adjacent to the corridor.				
14	Construction materials or equipment storage do not obstruct the corridor, exit path, stairs, or other use areas.				
15	There are no potential ignition sources (i.e., watch for arcing or exposed electrical wiring)				
16	There is no evidence of smoking within the area.				
17	There are no breaks, leaks, or damage to the standpipe and sprinkler system; ensure that there are no obstructions at the FD connection and fire hydrants.				
16	There are holes in walls, floors, or fire separations, or other visible changes in the building fire construction exist that could cause injury or risk to patients or staff.				
Other					
Other					

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FIRE WATCH FOLLOW-UP ON IDENTIFIED CONDITIONS

Item Number	Condition Identified	Contact Notified	Date Cleared

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POLICY:

Portable fire extinguishers, when properly used in the early stages of a fire, are extremely effective and can prevent a small controllable fire from becoming a major problem resulting in extensive property damage, injury or fatalities. All employees of Stonecreek Surgery Center will make themselves familiar with the Fire Safety Plan, the location and proper use of extinguishers in and near the work area.

Fires are classified by the type of fuel involved as listed below:

Class A	Ordinary Combustibles (wood, paper, rags, trash, etc.)
Class B	Flammable Liquids (gasoline, oil, etc.)
Class C	Electrical (fires in or around electrical equipment)
Class D	Burning Metals (not applicable to this facility)

For a fire to sustain itself, it must have three elements: fuel, heat and oxygen (air). The removal of any of these will cause the fire to extinguish. Portable fire extinguishers are designed to eliminate one or more of these elements.

USE OF PORTABLE FIRE EXTINGUISHER:

Fire extinguishers are classified by the type of fire they are designed to suppress. The chart below shows the different types of extinguishers and class/classes of fires for which they are intended.

Pressurized Water	Class A only
Carbon Dioxide	Class B or C
Dry Chemical	Class A, B or C
Halon	Class A, B or C

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The proper use of an extinguisher can best be remembered by using the PASS System.

P = **Pull** the safety pin
A = **Aim** the nozzle at the base of the fire
S = **Squeeze** the handle to discharge the extinguishing agent
S = **Sweep** the nozzle or hose side-to-side at the base of the flame

There are several guidelines and precautions to follow when using a portable fire extinguisher:

- Keep space between you and the fire and always have a safe escape route.
- Never use an extinguisher to fight a fire above your head.
- Do not return a discharged extinguisher to its cabinet or bracket. It must be recharged before being returned.
- Familiarize yourself with the locations and operation of the fire extinguishers before an emergency occurs.
- Do not attempt to fight a large fire with a portable fire extinguisher.

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SUN VALLEY
SURGERY CENTER

Sun Valley Surgery Center

QUALITY AND PATIENT SAFETY PLAN

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

Patient Safety Committee/Program
Facility name: Sun Valley Surgery Center
4090 N. Martin Luther King Blvd.
N. Las Vegas, NV 89032
P (702) 489-5460
F (877) 752-9402

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Commitment to Patient Safety

Sun Valley 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, Sun Valley 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 Sun Valley 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, Sun Valley Surgery Center has developed this Patient Safety Plan.

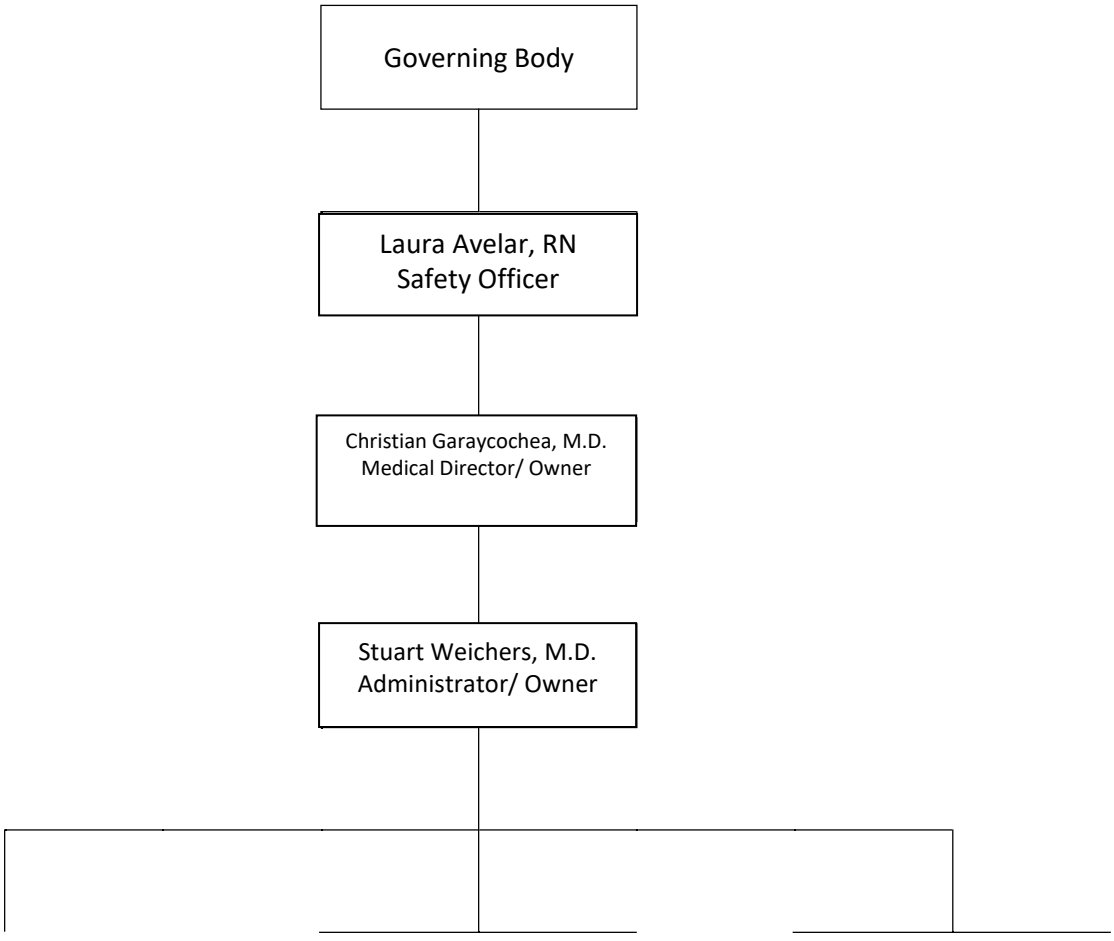
The plan focuses on the process rather than the individual, and recognizes both internal and external customers, as well as facilitates the need of analyzing and improving processes. The core principles of this plan include:

- 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



Clinical Staff RN, CRNA, Surgical Tech, Instrument Tech, Surgical Runner	Administrative Staff Business Director, Medical Billing, Receptionist, Credentialing	Rendering Physicians Dental Assistant

Roles and Responsibilities

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

Based on NAC 439.920, a medical facility that has fewer than 25 employees and contractors must establish a patient safety committee comprised of:

- The patient safety officer of the medical facility;
- At least two providers of healthcare who treat patients at the medical facility, including but without limitation, one member of the medical staff and one member of the nursing staff of the medical facility; and
- The Chief Executive Officer (CEO) or Chief Financial Officer (CFO) of the medical facility.

The roles and responsibilities are defined below (Please modify them as needed.)

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

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

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

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

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

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

Root Cause Analysis (RCA) Team Responsibilities (please revise as needed)

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

Patient Safety Officer Responsibilities (based on NRS 439.870)

- Serve on the patient safety committee.
- Supervise the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to NRS 439.835.
- Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the patient safety committee regarding any action taken in accordance with the responsibilities above.

Infection Control Officer Responsibilities (based on NRS 439.873)

- Serve on the patient safety committee.
- Monitor the occurrences of infections at the facility to determine the number and severity of infections.
- Report to the patient safety committee concerning the number and severity of infections at the facility.
- Take such action as determines is necessary to prevent and control infections alleged to have occurred at the facility.
- Carry out the provisions of the infection control program adopted pursuant to NRS 439.865 and ensure compliance with the program.

(Additional responsibilities here if needed)

RCA team leader Responsibilities (please revise as needed)

- Organize and coordinate the RCA process.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA, and corrective action plan implementation process.

- Communicate the progress of the investigation, institutional barriers, and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.
- Provide training, education and direction to create RCA process that incorporate the Patient Safety and Quality Improvement elements.

RCA Facilitator Responsibilities
(Please provide the responsibilities here)

Executive or Governing Body Staff Responsibilities (please revise as needed)

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

(Please provide additional responsibilities here if needed)

The Patient Safety Committee will meet monthly (or quarterly) to accomplish the following:

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

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

- Define the healthcare issues or potential risks.
- Conduct Root Cause Analysis
  - Reviewing and analyzing the data.
  - Reviewing the RCA process and quality improvement related activities and timelines.
  - Brainstorming issues or the potential risks by using the fishbone diagrams.
  - Identify the contributing factors and conduct the Root Cause Analysis.
- Conduct Corrective Action Plan
  - Identifying the Plan-Do-Study-Act (PDSA) topics.
  - Discussing corrective action process and activities.
  - Discussing and presenting possible changes in procedure to improve areas indicated.
  - Identifying strengths and areas that need improvement.
  - Developing strategies, solutions, and steps to take next.
- Identify barriers and technical assistance needs for supporting the RCA efforts.

A meeting agenda and minutes noting follow-up tasks will be kept.

Objectives and Goals of the Quality and Patient Safety Plan

Objective	Goals	Plan	Planned Completion Date	Responsible Party

Components and Methods

Pursuant to NRS 439.837 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."

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

Root Cause Analysis

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

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

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

5 Whys technique will be used in Sun Valley 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.

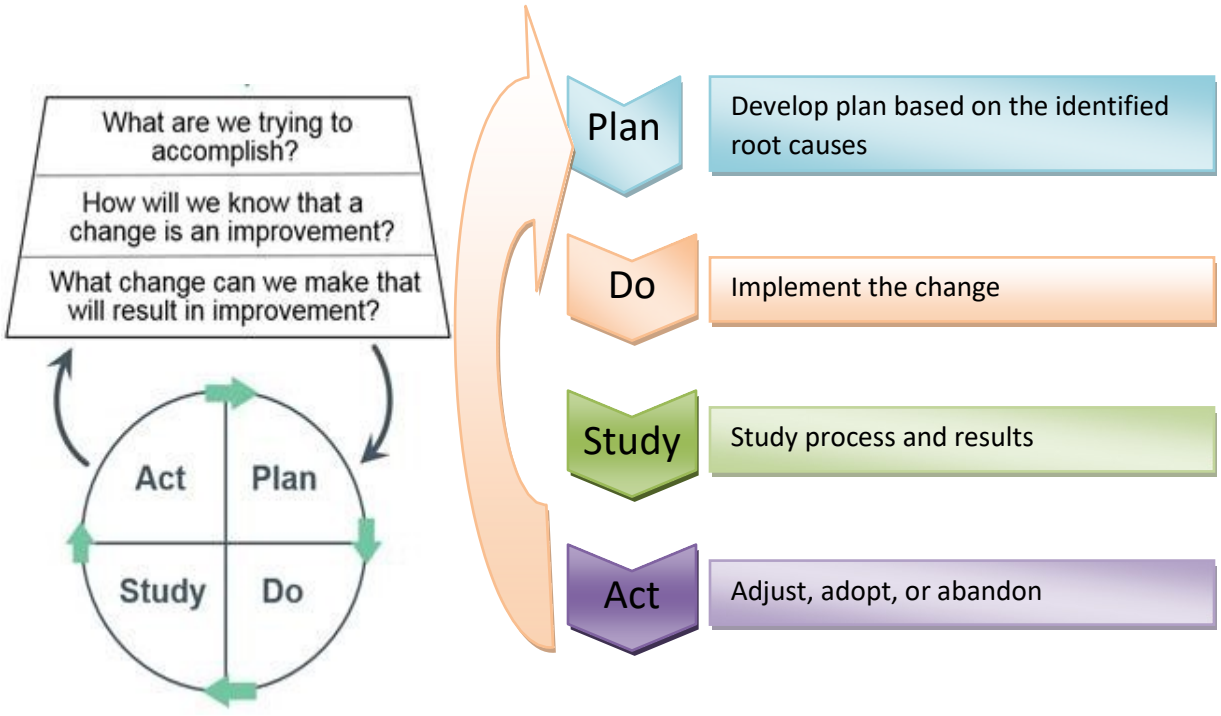
Fishbone Diagram

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 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. Sun Valley Surgery Center is using (data system names) for tracking the sentinel events, healthcare infection data, and (any other database) for internal data collection.

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

- AHRQ: Agency for Healthcare Research & Quality
- CDC: Centers for Disease Control and Prevention
- CMS: Centers for Medicare & Medicaid Services
- NQF: National Quality Forum
- NHSN: National Healthcare Safety Network
- AAAHC: Accreditation Association for Ambulatory Health Care

Ongoing Reporting and Review

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

Monthly	Quarterly	Annually
1) Sentinel event monthly report 2) Severity of infection report 3) RCA assessment	1) Sentinel event quarterly report 2) Severity of infection report 3) Review and evaluate the measure of improvement of patient safety 4) Review and evaluate the measurement to prevent and control infections	1) Quality and Patient Safety Plan update 2) Checklists and Policies reviewing and revising

Assessment of the Quality and Patient Safety Plan

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

Patient Safety Checklists and Patient Safety Policies

By NRS 439.865, the patient safety plan must include the patient safety checklists and patient safety policies for use by:

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

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

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

The patient safety policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include, the name and date of birth of the patient.

- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.

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

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

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

The patient safety checklists are listed in Appendix E. (The following links provide some patient safety checklists for your reference— a checklist example is shown in **Appendix E**.)

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

http://www.who.int/patientsafety/implementation/checklists/en/

The patient safety policies are listed in Appendix F. (The following link provides you some patient safety policies for your reference—a policy example is shown in **Appendix F**.)
https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1

Approval of Patient Safety Plan

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

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

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

Reference

- Root Cause Analysis Toolkit http://www.health.state.mn.us/patientsafety/toolkit/
- Quality and Service Improvement Tools http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html
- CQI 101 An Introduction to Continuous Quality Improvement: https://www.coursehero.com/file/13827355/CQI-Overviewppt/
- Quality Improvement http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/
- Root Cause Analysis http://www.patientsafety.va.gov/professionals/onthejob/rca.asp
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2 https://www.jointcommission.org/sentinel_event.aspx
- Hospital Policies https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1
- Checklists to Improve Patient Safety http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf
- Patient Safety Checklists http://www.who.int/patientsafety/implementation/checklists/en/
- Minutes of the Meeting of the Quality and Patient Safety Committee http://www.cookcountyhhs.org/wp-content/uploads/2013/12/09-23-14-QPS-scan-Minutes.pdf
- Title 40 – Public Health and Safety https://www.leg.state.nv.us/NRS/NRS-439.html

Appendix A: Terms and Definitions

Patient Safety: The Agency for Healthcare Research Quality (AHRQ) defines patient safety as "a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events." http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

Sentinel event (NRS 439.830)

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

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

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

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

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

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

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

Facility-Associated Infection: (NRS 439.802)

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

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

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

Medical facility (NRS 439.805)

"Medical facility" means:

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

(Added to NRS by 2002 Special Session, 13)

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

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

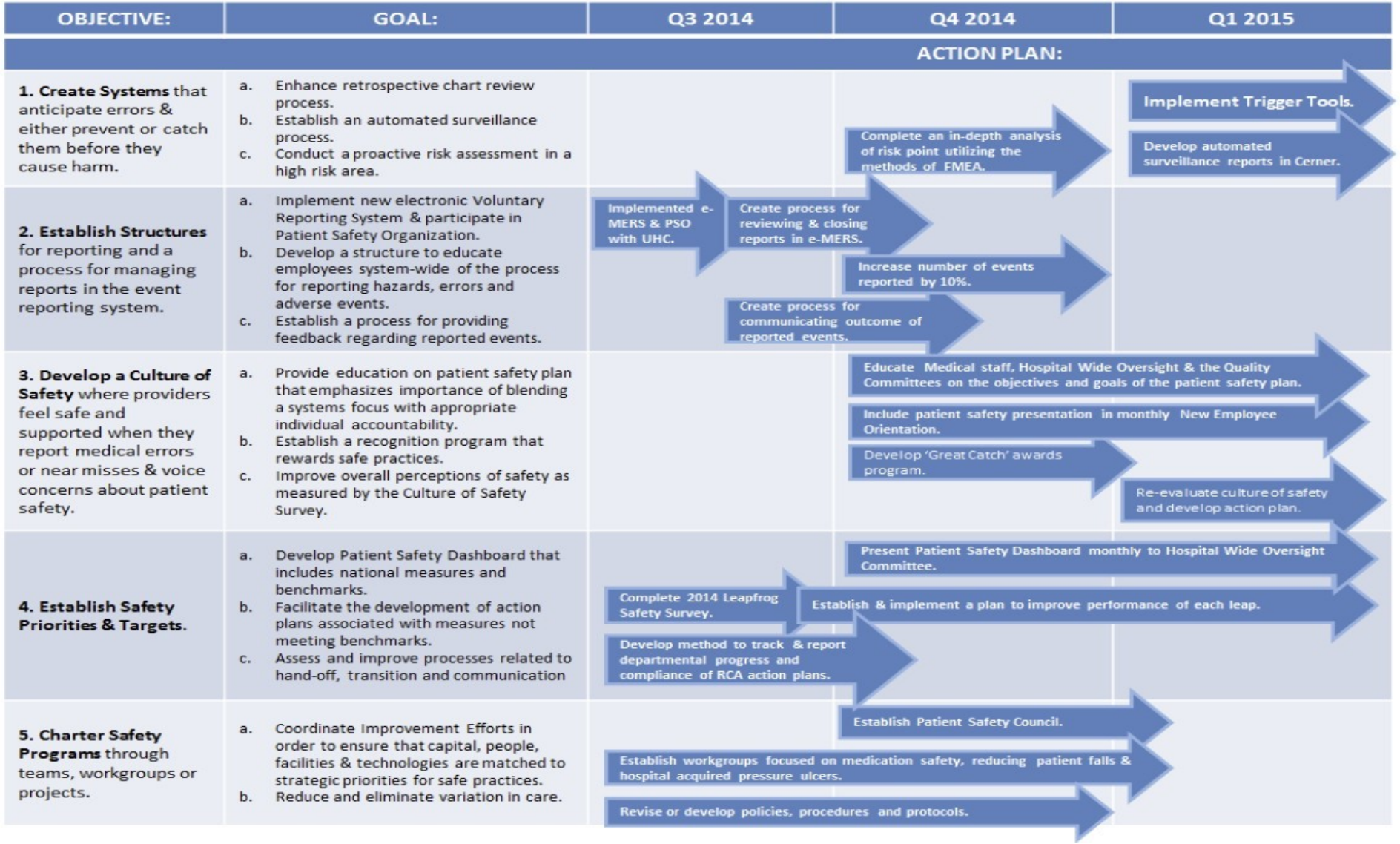
Risk: Possibility of loss or injury. (Merriam-Webster's Online Dictionary, Risk, Available at http://www.merriamwebster.com/dictionary/risk. Last Accessed August 2009.)

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

Catheter Associated Urinary Tract Infection (CAUTI): A urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CUR RENT_b.pdf.)

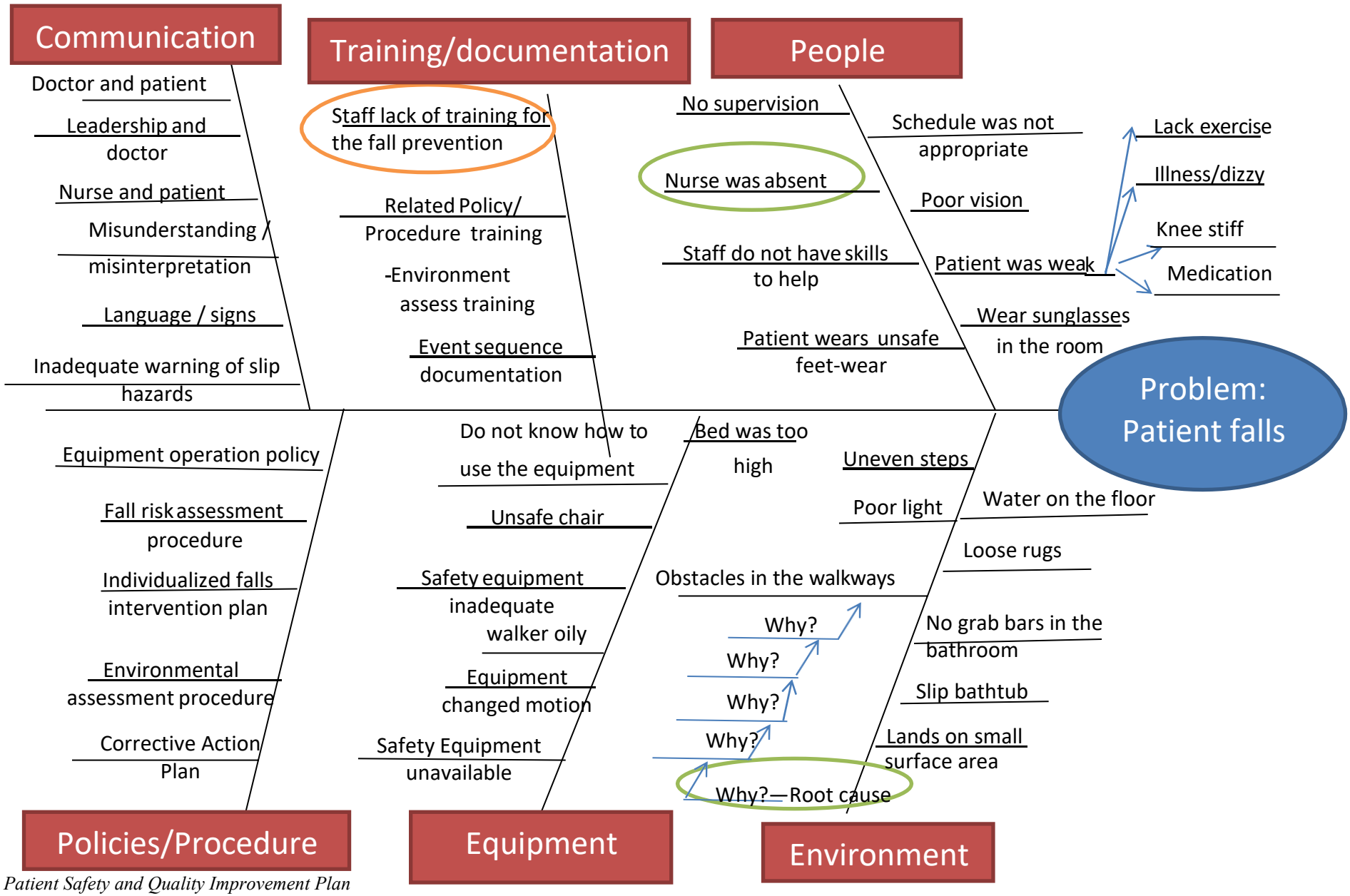
Central Line Associated Bloodstream Infections (CLABSI): Primary bloodstream infections that are associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection.

Appendix B: Patient Safety Goals



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
- 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.

MERCY HOSPITAL	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

SUBJECT: PATIENT SAFETY PLAN	REFERENCE #1067
	PAGE: 1 OF: 8
	EFFECTIVE: 04/01/19
APPROVED BY: Board of Managers	REVISED:

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 adverse outcome. Serious injury specifically includes loss of limb or function. Sentinel event criteria includes:

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- ♦ 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
  - Management of the Environment of Care

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- 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;

  - Test and implement the redesigned process;

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- 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.
- 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

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- 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.

  - 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.

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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 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 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.

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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.

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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, 3-21**

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, 3-21**

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
☒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: Medication Management Plan

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 provided 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.

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 place 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.

c. If employees incur exposure of their skin or mucous membranes to blood or other potentially infectious materials, those areas shall be washed or flushed with water as appropriate, as soon as feasible following contact.

3. Work Practice Controls:

a. In work areas where there is a reasonable likelihood of exposure to blood or other potentially infectious materials or where body fluid specimens are handled, employees are not to eat, drink, smoke, apply cosmetics or lip balm, or handle contact lenses

b. Food and drink will not be stored in refrigerators, freezers, shelves, cabinets, or on countertops or bench tops where blood or other potentially infectious materials are present

c. All procedures involving blood or other potentially infectious materials will be performed in such a manner as to minimize splashing, spraying, spattering, and generation of droplets of these substances.

d. Mouth pipetting/suctioning of blood or other potentially infectious materials is prohibited.

e. Specimens of blood or other potentially infectious materials will be placed in a container, which prevents leakage during collection, handling, processing, storage, transport, or shipping. The container used for this purpose will be labeled or color-coded in accordance with the requirements of the OSHA standard. The SCOR does not have any specimens that could puncture a primary container. If the outside of the specimen container becomes contaminated, the container will be placed within a secondary container which prevents leakage during the handling, processing, storage, transport, or shipping of the specimen. Requisition slips will be attached to the outside of the secondary container.

f. The surgeon and the assisting scrub technician use extreme caution when passing sharps between each other. In certain surgical procedures, the surgeon may or may not operate under the use of a microscope and is unable to look away to obtain instruments, including sharps, from the scrub technician. Thus, the passing of sharps in a covered state or in a holding container is unsafe in these specific situations. The sharps will be passed to the surgeon by the scrub technician, who will hold the handle of the sharps with the sharp edge pointed down and under his/her hand and never toward the surgeon. The position of the scrub technician's hand will be in the pronated position as the sharp is placed into the surgeon's hand. The scrub technician will then release the sharp after the

surgeon obtains the sharp and remove his/her hand down and away from the sharp. The surgeon will pass the sharp back to the scrub technician in the same 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 tuberculosidal 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 peructaneous injury must be disposed of in appropriate sharps container.
c. Protective coverings used to cover surfaces must be removed s 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 tuberculosidal or microbacterial viral disinfectant.
g. Biohazard signs must be placed on containers of regulated medical waste, containing blood or OPIM and other containers used to store or transport contaminated materials.
h. Contaminated Equipment to be serviced: Unless SCOR demonstrates decontamination of the equipment or portions of the equipment is not feasible, equipment which may become contaminated with blood or other potentially infectious materials will be examined prior to servicing or shipping and a readily observable tag or label will be attached to the equipment stating which portions remain contaminated. SCOR will ensure that this information is conveyed to all affected employees, the servicing representative, and/or the manufacturer, as appropriate, and prior to handling, servicing, or shipping so that appropriate precautions will be taken.

i. All buckets, bins, cans, and similar receptacles intended for reuse which have a reasonable likelihood for becoming contaminated with blood or other potentially infectious materials will be inspected and decontaminated on a weekly basis and cleaned and decontaminated immediately as soon as feasible upon visible contamination.

6. Personal Protective Equipment (PPE):
    a. Employees must use appropriate PPE and precautions to prevent skin and mucous membrane contact with any blood or any body fluid.
    b. Training will be provided to each employee as to the appropriate selection, location, use, and disposal of PPE during their clinical orientation.
    c. The type of PPE available to employees are as follows: Gloves, gowns, masks, goggle, eye shields, foot protection, head protection.
    d. Each employee is instructed to critically review their work responsibilities to make informed decisions or recommendations regarding appropriate use of PPE.

e. When there is an occupational exposure, the SCOR will provide, at no cost to the employee, appropriate personal protective equipment. Personal protective equipment will be chosen based on the anticipated exposure to blood or other potentially infectious material. Personal protective equipment will be considered "appropriate" only if it does not permit blood or other potentially infectious materials to pass through to or reach the employee's surgical attire, undergarments, skin, eyes, mouth, or other mucous membranes under normal conditions of use and for the duration of time that the protective equipment is used. The SCOR will ensure that appropriate PPE in the appropriate sizes are readily accessible at the SCOR in the respective changing areas for employees, at the nursing and patient care areas, and in the surgical suites.

1. Gloves: Gloves will be worn when it can be reasonably anticipated that the employee may have hand contact with blood, body fluids, or OPIM, mucous membranes, non-intact skin, when performing vascular access procedures, when the employee has cuts, scratches, or other breaks in his or her skin, and when handling or touching contaminated items or surfaces. Wash hands immediately after removing gloves. Never wash or decontaminate disposable gloves for reuse. Replace gloves if torn, punctured, contaminated, or their ability to function as their barriers are compromised.
2. Masks, Eye Protection, and Face Shields. Masks in combination with eye protection devices, such as goggles or glasses with solid side shields, or chin-length face shields, will be worn whenever splashes, spray, spatter, or droplets of blood or other potentially infectious materials may be generated and eye, nose, or mouth contamination can be reasonable anticipated.
3. Gowns, Aprons, or Other Protective Body Clothing. Appropriate protective clothing such as, but not limited to, gowns, aprons, clinic jackets, or similar outer garments will be worn in occupational exposure situations. The type and characteristics will depend upon the task and degree of exposure anticipated.

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

f. Resuscitation bags or other ventilation devices should be available in areas where resuscitation is anticipated.

g. Alternative gloves/PPE will be provided to employees who are sensitive or allergic to the gloves normally provided.

h. All non-disposable PPE will be maintained, cleaned, and disposed of by SCOR.

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

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

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

7. Hepatitis B Vaccination:

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

8. Post Exposure Evaluations:

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

1. Post Exposure Evaluation Procedures:
   A. First aid. Clean/rinse exposed area.
   B. Report incident to supervisor.
   C. Supervisor to ask source patient to be tested.
   D. Employee to be evaluated and or treated within 2 hour window as recommended by CDC, or as soon as possible by the designated workman compensation health care provider.
   E. Post exposure prophylaxis (PEP) will be addressed at the designated health care provider, which the employee is referred to.
   F. Evaluations by the designated health care provider at date of injury, 6, 12, 24 weeks or as ordered by the health care provider..

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

2. Workers compensation steps:
   a) Depending on severity of injury:
      i) Provide access to care/transportation to hospital or clinic
   b) Take a statement from the injured worker and any witnesses
   c) Provide injured worker with information on carrier

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 Termination Date	05/15/2020 05/15/2021
Policy Number Employer's FEIN	WC 47-81-713-00 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

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, 3-21**

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 solutio 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	**				

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

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.

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

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
- ☐ CSF
- ☐ Pericardial
- ☐ Peritoneal
- ☐ Pleural
- ☐ Semen
- ☐ Synovial
- ☐ Vaginal fluid
- ☐ Saliva
- ☐ Sputum
- ☐ Tears
- ☐ Urine
- ☐ Feces/stool
- ☐ Other (Specify): _____

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)

☐ Superficial, surface scratch ☐ Deep puncture or wound

☐ Moderate, penetrated skin ☐ Unknown

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

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

Hollow-bore needle

☐ Arterial blood collection device ☐ Biopsy needle ☐ Bone marrow needle

☐ Hypodermic needle, attached to syringe ☐ Hypodermic needle, attached to IV tubing ☐ Unattached hypodermic needle

☐ IV catheter – central line ☐ IV catheter – peripheral line ☐ Huber needle

☐ Prefilled cartridge syringe ☐ IV stylet ☐ Spinal or epidural needle

☐ Hemodialysis needle ☐ Dental aspirating syringe w/ needle ☐ Vacuum tube holder/needle

☐ Winged-steel (Butterfly™ type) needle ☐ Hollow-bore needle, type unknown ☐ Other hollow-bore needle

Suture needle

☐ Suture needle

Other solid sharps

☐ Bone cutter ☐ Bur ☐ Electrocautery device

☐ Elevator ☐ Explorer ☐ Extraction forceps

☐ File ☐ Lancet ☐ Microtome blade

☐ Pin ☐ Razor ☐ Retractor

☐ Rod (orthopedic) ☐ Scaler/curette ☐ Scalpel blade

☐ Scissors ☐ Tenaculum ☐ Trocar

☐ Wire

Glass

☐ Capillary tube ☐ Blood collection tube ☐ Medication ampule/vial/bottle

☐ Pipette ☐ Slide ☐ Specimen/test/vacuum tube

Plastic

☐ Capillary tube ☐ Blood collection tube ☐ Specimen/test/vacuum tube

Non-sharp safety device

☐ Blood culture adapter ☐ Catheter securement device ☐ IV delivery system

☐ Other known device (specify): _____

4. Manufacturer and Model: _____

Exposure to Blood/Body Fluids

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.

- ☐ Bluntable needle, sharp
- ☐ Hinged guard/shield
- ☐ Retractable needle/sharp
- ☐ Sliding/gliding guard/shield
- ☐ Needle/sharp ejector
- ☐ Mylar wrapping/plastic
- ☐ Other safety feature (specify):_____
- ☐ Unknown safety mechanism

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

- ☐ Before activation of the safety feature was appropriate
- ☐ During activation of the safety feature
- ☐ Safety feature improperly activated
- ☐ Safety feature failed, after activation
- ☐ Safety feature not activated
- ☐ Other (specify): _____

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

- ☐ Before use of the item
- ☐ During use of the item
- ☐ After use of the item before disposal
- ☐ During or after disposal
- ☐ Unknown

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

Obtaining a blood specimen percutaneously

- ☐ Performing phlebotomy
- ☐ Performing arterial puncture
- ☐ Performing a fingerstick
- ☐ Other blood-sampling procedure (specify): _____

Giving a percutaneous injection

- ☐ Giving an IM injection
- ☐ Giving a SC injection
- ☐ Placing a skin test (e.g., tuberculin, allergy, etc.)

Performing a line related procedure

- ☐ Inserting or withdrawing a catheter
- ☐ Obtaining a blood sample from a central or peripheral I.V. line or port
- ☐ Injecting into a line or port
- ☐ Connecting an I.V. line

Performing surgery/autopsy/other invasive procedure

- ☐ Suturing
- ☐ Incising
- ☐ Palpating/exploring
- ☐ Specify procedure: _____

Performing a dental procedure

- ☐ Hygiene (prophylaxis)
- ☐ Restoration (amalgam composite, crown)
- ☐ Root canal
- ☐ Periodontal surgery
- ☐ Oral surgery
- ☐ Simple extraction
- ☐ Surgical extraction

Handling a specimen

- ☐ Transferring BBF into a specimen container
- ☐ Processing specimen

Other

- ☐ Other diagnostic procedure (e.g., thoracentesis)
- ☐ Other (specify): _____
- ☐ Unknown

Exposure to Blood/Body Fluids

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

- ☐ Cleaning room
- ☐ Collecting/transporting waste
- ☐ Decontamination/processing used equipment
- ☐ Disassembling device/equipment
- ☐ Handling equipment
- ☐ Opening/breaking glass container (e.g., ampule)
- ☐ Performing procedure
- ☐ Placing sharp in container
- ☐ Recapping
- ☐ Transferring/passing/receiving device
- ☐ 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)

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

Exposure to Blood/Body Fluids

Section III – Mucous Membrane and/or Skin Exposure

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

- ☐ Small (<1 tsp or 5cc)
- ☐ Moderate (>1 tsp and up to ¼ cup, or 6-50 cc)
- ☐ Large (> ¼ cup or 50cc)
- ☐ Unknown

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

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

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

- ☐ Face shield
- ☐ Gloves
- ☐ Goggles
- ☐ Gown
- ☐ Mask/respirator
- ☐ Other (specify): _____
- ☐ No barriers

Section IV – Bite

1. Wound description: (Check one)

- ☐ No spontaneous bleeding
- ☐ Spontaneous bleeding
- ☐ Tissue avulsed
- ☐ Unknown

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

- ☐ During dental procedure
- ☐ During oral examination
- ☐ Providing oral hygiene
- ☐ Providing non-oral care to patient
- ☐ Assault by patient
- ☐ Other (specify): _____
- ☐ Unknown

Exposure to Blood/Body Fluids

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 ☐ Other symptomatic HIV, not AIDS

☐ AIDS ☐ HIV infection, no symptoms

☐ Acute HIV illness ☐ Unknown

2. Is the source patient taking anti-retroviral drugs? ☐ Y ☐ N ☐ U

2a. If yes, indicate drug(s): _____ _____ _____ _____ _____ _____

3. Most recent CD4 count: _____mm^3 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

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		Label	
_____	____/____/____	_____	____/____/____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Comments

Attachment E

SOURCE PATIENT-POST EXPOSURE CONSENT FOR TESTING

I understand that a Surgery Center of Reno's employee has accidentally been exposed to my blood/body fluid.

In order to comply with Federal regulations and to properly advise our Surgery Center of Reno's employee on the most appropriate treatment, we are asking for permission to test your blood for HIV, Hepatitis B, and Hepatitis C.

I furthermore give consent to disclose the results of my testing to the exposed employee under the protocol of the Surgery Center of Reno's Bloodborne Pathogens Exposure Control Plan. I have had a chance to ask questions about the testing and my questions have been answered. I understand that the testing will be confidential and will be done without charge to me and these results will be available to me if I choose to ask for the results.

_____ _____

Signature of patient/guardian Date/Time

_____ _____

Signature of Witness Date/Time

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 Witness

Date	Site	Lot	Exp	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: _____

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 that 30 percent of the EPS nameplate kW rating.
3)If the engine cannot be operated until the water temperature and the oil pressure have stabilized and then the test shall be terminated before the 30 minute time period expires.

Maintenance Requirements Annual Load Bank Testing

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

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

Maintenance Requirement 36 Month Load Bank Testing

Section 8.4.9 Level 1 EPSS shall be tested for the duration of its as-assigned class (see Section 4.2), for at least 4 hours, at least once within every 36 months.
Section 8.4.9.1 The load shall be the EPSS system load running at the of the test. The test shall be initiated by opening all switches or breakers supplying normal power to the EPSS

Maintenance Requirements Time Delays

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

Time Delays should be set as follows:
On start: 1 second minimum
Transfer to emergency: no minimum
Return to normal: 5 minutes minimum
Shutdown: 5 minutes minimum
Transfer switches shall be operated monthly (8.4.6

Maintenance Requirements

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

Transfer Time

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

Fire Extinguisher

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

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

PATIENT LABEL

BRIEF DESCRIPTION **(Attach additional sheet, if needed)**

_____

_____

_____

_____

_____

_____

_____

Patient/Family aware of incident?_ Yes ____ No _____

_____

A. LOCATION OF INCIDENT:_____

Type of Incident (Check only one that most applies)

B. FALLS

☐ Slip/fall ☐ Found on floor ☐ Other

C. MEDICATION VARIANCE

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

D. TREATMENT OR PROCEDURE VARIANCE

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

E. INFECTION SURGERY CENTER

☐ Infection/Nosocomial confirmed

F. EQUIPMENT/PRODUCT-RELATED INCIDENT

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

LOT # _____

EQUIPMENT TYPE:_____ **MODEL #:**_____

MANUFACTURER:_____ **SERIAL #:**_____

G. MISCELLANEOUS

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

H. MEDICAL TREATMENT

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

Physician Name: _____

☐ Notified **Date:** _____ **Time:** _____

Address:_____

_____

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

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

J. RELATED FACTORS (check all that apply)

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

K SEVERITY LEVEL

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

WITNESSES

Name: _____ Name: _____

EMPLOYEE PREPARING REPORT

Name _____ Date/Time: _____ Title: _____

L. HOW COULD THIS EVENT HAVE BEEN PREVENTED?

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

Signature: _____ Title: _____

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

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

- ☐ No action at this time
- ☐ Physician review
- ☐ Instruction/Education
- ☐ Action/Recommendation
- ☐ Discuss in QI
- ☐ Notify Risk Management

Statistics: ☐ Infection ☐ Complication

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, 3-21**

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:

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.

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.

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

☐ Pre-Op Staff	☒ All Employees	☒ Clinical Managers
☐ Post-Op Staff	☐ All Clinical Staff	☒ Medical Director
☐ PACU Staff	☐ All Business Office Staff	☒ Administrator
☒ Director of Nursing		

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 determined areas of patient care that may need to be addressed to reduce the gaps from benchmarking norms. Both internal and external benchmarks are evaluated and utilized in QI activities.

Risk Management:
The QI Plan includes a 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	

West Las Vegas Surgery Center, LLC
d/b/a Valley View Surgery Center
1330 S. Valley View Blvd
Las Vegas, NV 89102-1865
Ph 702.675.4600
Fax 702.675.4604

February 28,2022

Valley View Surgery Center's Patient Safety Plan, 2021

VALLEY VIEW SURGERY CENTER

Chapter: 5.3.1. and Chapter 7, II.A.2.a
Policy: Quality Management and Improvement
Subject: The Patient Safety Prevention Plan
Effective: 07/12 **Revision/Reviewed Date: 02/19, 02/20, 12/21**

,
This plan was created and revised by VVSC's 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 employ safety, as well as reduce the medical/healthcare errors and/or preventable events.

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Commitment to Patient Safety:
VVSC is committed to a comprehensive approach to improving 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, and visitors, through continuous learning and improving patient safety policies, systems, and processes.

The National Patient Safety Goals for Ambulatory Healthcare will outline the patient safety goals for VVSC. The patient safety goals are:

- Improve the accuracy of patient identification
- Improve the safety of using medications
- Reduce the likelihood if patient harm associated with the use of anticoagulant therapy
- Maintain and communicate accurate patient medication information through medication reconciliation.
- Reduce the risk of healthcare associated infections
- Prevent Wrong site, wrong procedure, and wrong person surgery

VVSC has implemented the Safety plan to prevent sentinel events from occurring by implementing the "Near Miss "reporting system. A "Near Miss" is defined as an event or situation that could have resulted in an accident, injury or illness, but did not, either by chance or timely intervention. The "Near Miss" reporting system will identify medication, surgical, equipment and other "Near Miss" occurrences.

A "Near Miss" may be related to close calls relating to medications, procedures, equipment, communication (example- handoffs).

A culture of safety is promoted at VVSC. The staff are encouraged to report any situation that may result in ham to a patient by using the "Near Miss Report". The information from the form will initiate a root cause analysis to improve the patient safety at VVSC.

Mission, Vision, and Values:
In support of our mission, vision, and values, VVSC Patient Safety and Risk Management Plan promotes:

- Prevention of sentinel events through the monitoring of "near misses"
- 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 VVSC.
- 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 VVSC-wide which includes but is not limited to:

- Patient safety
- Visitor safety

All staff in VVSC is 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, VVSC 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, land 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 NSR 429.875, a medical facility shall establish a Patient & Employee Safety Committee (PSC). The PSC should ensure that Risk Management and Patient Safety Plan is promoted and executed successfully.

The Patient Safety Committee Organization:

- Governing Board (GB)
- Medical Executive Committee (MEC) which is the PSC.
- Pharmaceutical and Therapeutic Committee that meets monthly as part of the Patient Safety Committee.
- Staff members of the PSC Sub-Committee for data collection for the PSC.

Roles and Responsibilities:

- In accordance with NRS 439.875, a patient safety committee at VVSC is composed of:
  - The infection control officer of VVSC
  - The patient safety officer of VVSC is the Infection Control Officer
  - At least three providers of healthcare who treat patients at VVSC, including but, without limitation, at least one member of the medical, nursing, and pharmaceutical staff (Consultant Pharmacist) of VVSC
  - One member of MEC or GB of VVSC

The roles and responsibilities are defined below:

Patient Safety Committee Responsibilities (based on NRS 49.875 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 connect with all reports of sentinel events alleged to have occurred.
- Review and evaluated the quality of measures carried out by VVSC to improve the safety of patients who receive treatment.
- Review and evaluate the quality of measures carried out by VVSC to prevent and control infections.
- Make recommendations to the MEC and GB of VVSC to reduce the number and severity of sentinel events and infections that occur.
- At least once each month, the Pharmaceutical and Therapeutic (P&T) Committee meets as part of the PSC. The P&T submits a report to the MEC that meets each calendar quarter. The MEC will review and as needed will make revisions or adds before submitting report to the GB. The report is regarding:
  (1) The number of sentinel events that occurred at VVSC during the preceding calendar months and in summary quarterly;

(2) The number and severity of infections that occurred at VVSC during the preceding calendar months and in summary quarterly;
(3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at VVSC.
(4) The number of near miss types as outlined by the World Health Organization (WHO)

- 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 (fishbone/Ishikawa diagrams), investigation, and corrective action plan implementations.
- Participates in the RCA meetings and discussions.
- Communicate honestly and openly about only data and facts to staff members involved in RCA and their supervisors/charge.

RCA team leader Responsibilities: (to be performed by the Patient Safety Officer):

- Develop a reporting culture by establishing trust by adopting a just culture in eliminating the fear of punishment.
- Accountability
- Identifying unsafe conditions
- Strengthening systems and assessment
- Organize and coordinate the RCA process.
- Assemble and encourage a supportive and proactive team members.
- 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.

Patient Safety Officer Responsibilities:

- Serve on the patient safety committee.
- Supervise the reporting of all sentinel events alleged to have occurred at VVSC, 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 VVSC.
- Report to the patient safety committee regarding any action taken in accordance with the responsibilities above.

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 (CD C), the World
- Health Organization (WHO) and the Society for Healthcare Epidemiology of America (SHEA); and
- VVSC-specific infection control developed under the supervision of an Infection Control Nurse who has undergone Infection Control education, preferably from a nationally recognized infection control organization, for the prevention and control of infection

Infection Control Officer Responsibilities (based on NRS 439.873):

- Serve on the PSC.
- Monitor the occurrences of infections at VVSC to determine the number and severity of infections.
- Report to the PSC concerning the number and severity of infections at VVSC.
- Take such action as determined is necessary to prevent and control infections alleged to have occurred at VVSC.
- Carry out the provisions of the infection control program adopted pursuant to NRS 439.865 and ensure compliance with the program.

GB Responsibilities:

- Provides vision and leadership to Patient Safety and Quality Improvement process and develop foster a safe learning and improving culture.
- Provides oversight to the healthcare quality improvement processes and teams.
- Plan, discuss, and generate VVSC's patient safety goals and activities, in conjunction with the patient safety action plans.

The PSC will meet monthly at the Pharmaceutical and Therapeutic Meeting and quarterly to accomplish the following:

- Report and discuss near miss events which include:

- Number of near misses from previous calendar months and summary for the quarter.
- Number of severe infections that occurred in VVSC.

- Corrective Action Plan for the near miss occurrences and infections
  - Evaluate the corrective action plan to improve on root cause of the problem
- Patient safety/employee policies and checklists
  - At lease annually evaluate patient safety/employee policies and checklists
  - Revise the patient/employee safety policies and checklists as needed.
  - Monitor and document the effectiveness of the patient/employee safety policy.

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

- Define healthcare issues or potential risks.
- Conduct RCA
  - Reviewing and analyzing the data.
  - Reviewing the RCA process and quality improvement related activities and timeliness.
  - Brainstorming issues or the potential risks by using the fishbone diagrams.
  - Identify the contributing factors and conduct the RCA.
- Conduct Corrective Action Plan
  - Discussing corrective action process and activities to correct the root cause.
  - 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 Goal of the Risk Management and Patient Safety Plan

- Objectives:
  - Establish a reporting culture
  - To learn from close calls and hazardous conditions
  - To prevent sentinel events from happening
  - To improve patient safety by implementing root cause analysis and revised policies and procedures to close the safety gap
  - To use patient safety checklists to implement and audit patient and employee safety practices and interventions.
  - To promote process improvement and increase patient safety.
  - VVSC staff will use patient safety checklists 100% of the time while caring for patient perioperatively.
  - Plan: Oversight for near miss, risk with possibility of loss or injury, preventable events, patient safety concern(s), and other mandatory reporting.

- Planned Completion Date: Annually evaluate the status of the plan
- Responsible Party: Patient Safety Committee

Sentinel Events- Reporting- See Risk Management Plan
Pursuant to NRS 439.837 and NAC 439.917, within 45 days after reporting a sentinel event pursuant to NRS 439.835, VVSC will conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event.

Root Cause Analysis for Identifying Special Cause
An RCA is a process for identifying the root causes of the problems(s). It focuses on the system that generated the error instead of individuals. Processes, procedures and systems cause most medical mistakes and errors, not people. The goal is to eliminate mistakes and errors by changing the process.

RCA 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 an RCA. Not all the questions apply to all the events or cases. This table can be used individually or with the fishbone diagram.

5 Whys will be used in VVSC to explore the cause-and-effect relationship underlay of 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. The major causes in the fishbone diagrams are processes, machines, materials, measurements, people, environment. For each cause ask why five times to arrive at the root cause of the problem.

Methodology for Reducing Errors
The use of the Quality Improvement methodology Focus, Improve, Sustain and Honor (FISH) will be used: **F**ocus will define the error/defect/problem, and analyze the root cause. **I**mprove: Implement the root cause countermeasures/checklists. **S**ustain: Monitor for re-occurring near misses. **H**onor will review, recognize and refocus.

Preventing Errors by Implementing 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 VVSC who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, the environment cleaning services of VVSC; 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 VVSC and must include, without limitation:

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

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.

Data Collection and Reporting:
The data will be collected on near miss forms and analyzed by the Risk Manager.
The types and number of near misses and actions implemented will be reported to the Patient Safety Committee and to the MEC.

Ongoing Reporting of Near Misses and Safety Plan Review:

- Monthly to the Patient/Employee Safety Committee

- Quarterly to the MEC
- Annual Review of the Patient Safety Plan/Checklists/Policies

Assessment of the Patient Safety Plan:
It is critical for VVSC to spend time each year assessing the effectiveness of its Safety Plan in its achievement of its desired goal(s) and objectives. The MEC will undertake this assessment and report to the GB. The report will outline the accomplishments and shortcomings of the Plan along with factors that influenced the performance of the Plan.

The Patient Safety Assessment Tool (PSAT) from the VA National Center for Patient Safety is used as a reference.

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. The Patient Safety plan include the data from one or several of the following:

- WHO: World Health Organization
- 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
- AAAHC Accreditation for Ambulatory Health Care, Inc.

Appendix A References

- Retrieved 02.11.19 http://dpbh.nv.gov/Programs/SER/dta/Publications/Sentinel_Events_Registry_(SER)___-Publications/ Quality and Patient Safety Plan Template, *Patient Safety Plan Template*
- The World Health Organization (WHO) -Near Misses and Their Importance for Improving Patient Safety) June 2014
- Root Cause Analysis Toolkit http://www.health.state.mn.us/patientsafety/toolkit/
- Quality and Service Improvement Tools- Six Sigma Instructor Guide Jay Arthur 2003
- CQI 101 An Introduction to Continuous Quality Improvement: https://www.coursehero.com!file/13827355/CQI-Overviewppt/
- Quality Improvement http://www.hrsa.gov/guality/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/l
- Checklists to Improve Patient Safety http://www.hpoe.org/Reports-HPOE/CkLists **PatientSafety.pdf**
- **Patient Safety Checklists http://www.who.int/patientsafety/implementation/checklists/en/**
- Minutes of the Meeting of the Quality and Patient Safety Committee http://www.cookcountyhhs.org/wp-content/uploads/2013/12/09-23-14-QPS-scan-Minutes.pdf
- Title 40 - Public Health and Safety https://www.leg.state.nv.us/NRS/NRS-439.html

Terms and Definitions

Patient Safety: The Agency for Healthcare Research Quality (AHRQ) defines patient safety as

"a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery." Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events."
http:www.ahrg.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 449.012and 449.0151;
- An obstetric center, as that term is defined in NRS 449.0151and 449.0155;
- A surgical center for ambulatory patients, as that term is defined in NRS 449.0151and 449.019; and
- An independent center for emergency medical care, as that term is defined in NRS 449.013and 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.)

Close call-unsafe acts or conditions -errors, procedure violations or hazards-t that could have seriously harmed a patient but did not because they were identified, reported and addressed and eliminated.

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.)

Reference: Chapter 5.3.1. *Quality and Patient Safety Plan, Sentinel Events*

Appendix B National Safety Goals

Appendix C - WHO Near Miss Types

Near Miss Report

Ear Nose and Throat Surgery Center:

QUALITY AND PATIENT SAFETY PLAN

DATE: 01/1/2020
VERSION: 01

This plan was created and revised by the Ear Nose and Throat Surgery Center _ Quality Improvement and Patient Safety committee/team. Implementation of this plan is intended to optimize the healthcare quality and patient safety outcomes, encourage recognition, reporting, and acknowledgment of risks to patient, visitor, and employee safety, as well as reduce the medical/healthcare errors and /or preventable events.

Quality Improvement and Patient Safety Committee/Program
Ear Nose and Throat Surgery Center:
8840 W. Sunset Rd. Suite B, Las Vegas, NV 89148
702-209-3377

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Commitment to Patient Safety

Ear Nose and Throat Surgery Center LLC is committed to a comprehensive approach to improving healthcare quality and patient safety by aligning with our Mission, Vision, and Values, creating an environment that supports a dynamic, proactive, and safe culture for patients, family members, visitors, and employees, through continuous learning and improving patient safety policies, systems, and processes, developed, reviewed approved and monitored by the Governing Body.

Mission, Vision, and Values

In support of our mission, vision, and values, Ear Nose and Throat Surgery Center LLC Patient Safety and Quality Improvement program promotes:

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

Scope and Purpose

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

- Patient safety
- Visitor safety
- Employee safety

All staff in Ear Nose and Throat Surgery Center are required to fully support and participate in this plan, and devote their expertise to the patient safety and healthcare quality improvement process.

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

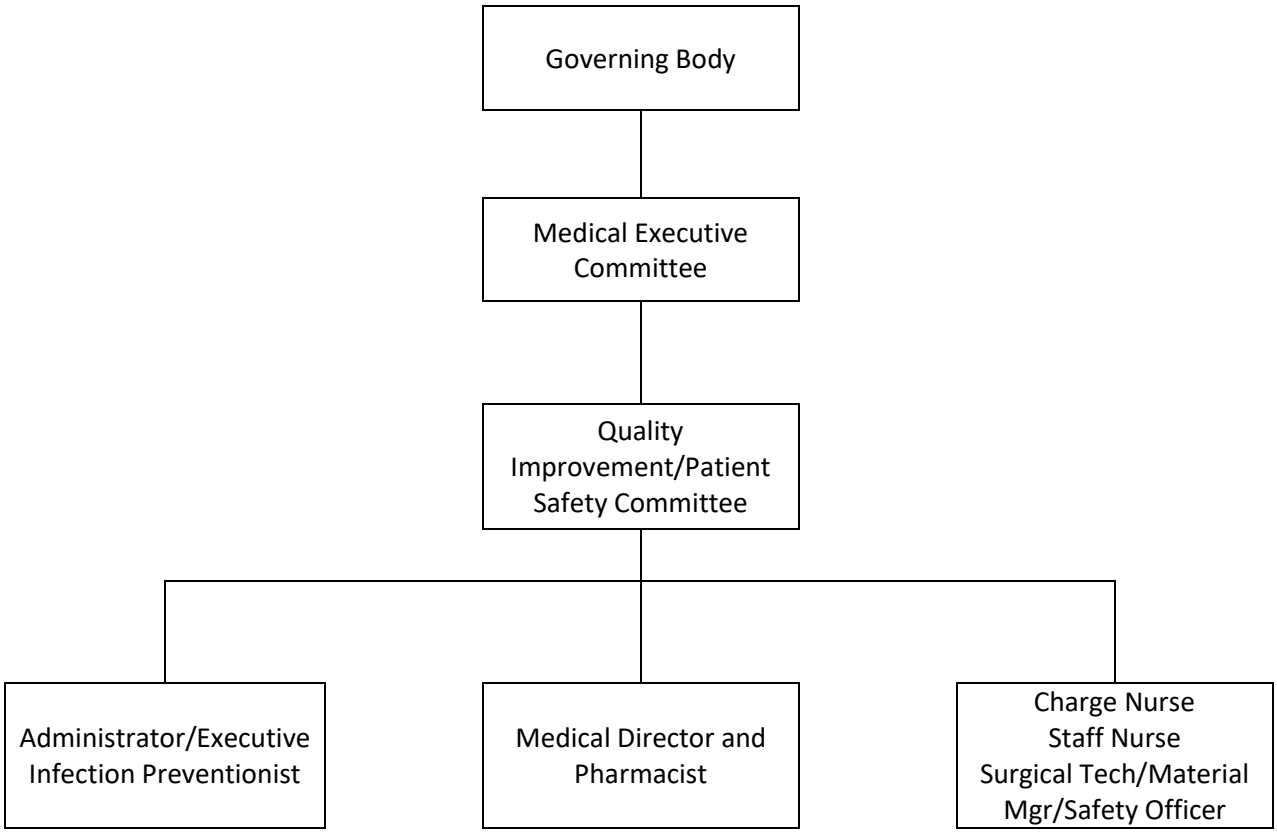
The plan focuses on the process rather than the individual, and recognizes both internal and external customers, as well as facilitates the need of analyzing and improving processes. The core principles of this plan include:

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

Roles and Responsibilities

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

The Patient Safety Committee Organization



Roles and Responsibilities

- In accordance with NRS 439.875, a patient safety committee must be comprised of:

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

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

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

Root Cause Analysis (RCA) Team Responsibilities

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

Patient Safety Officer Responsibilities (based on NRS 439.870)

- Serve on the patient safety committee.

- Supervise the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to NRS 439.835.
- Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the patient safety committee regarding any action taken in accordance with the responsibilities above.
- Monitors and reports to the Quality Improvement/Patient Safety Committee safety statistics.

Infection Control Officer Responsibilities (based on NRS 439.873)

- Serve on the patient safety committee.
- Monitor the occurrences of infections at the facility to determine the number and severity of infections.
- Report to the patient safety committee concerning the number and severity of infections at the facility.
- Take such action as determines is necessary to prevent and control infections alleged to have occurred at the facility.
- Carry out the provisions of the infection control program adopted pursuant to NRS 439.865 and ensure compliance with the program.

RCA team leader/Facilitator Responsibilities

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

Executive or Governing Body Staff Responsibilities

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

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

- Report and discuss sentinel events which include:
  - Number of sentinel events from previous calendar month.
  - Number of severe infections that occurred in the facility.

- Corrective Action Plan for the sentinel events and infections
  - Evaluate the corrective action plan.
- Patient safety policies and checklists
  - At least annually evaluate Patient Safety policies and checklists
  - Revise the patient safety policies and checklists as needed.
  - Monitor and document the effectiveness of the patient safety policy.

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

- Define the healthcare issues or potential risks.
- Conduct Root Cause Analysis
  - Reviewing and analyzing the data.
  - Reviewing the RCA process and quality improvement related activities and timelines.
  - Brainstorming issues or the potential risks by using the fishbone diagrams.
  - Identify the contributing factors and conduct the Root Cause Analysis.
- Conduct Corrective Action Plan
  - Identifying the Plan-Do-Study-Act (PDSA) topics.
  - Discussing corrective action process and activities.
  - Discussing and presenting possible changes in procedure to improve areas indicated.
  - Identifying strengths and areas that need improvement.
  - Developing strategies, solutions, and steps to take next.
- Identify barriers and technical assistance needs for supporting the RCA efforts.

A meeting agenda and minutes noting follow-up tasks will be kept.

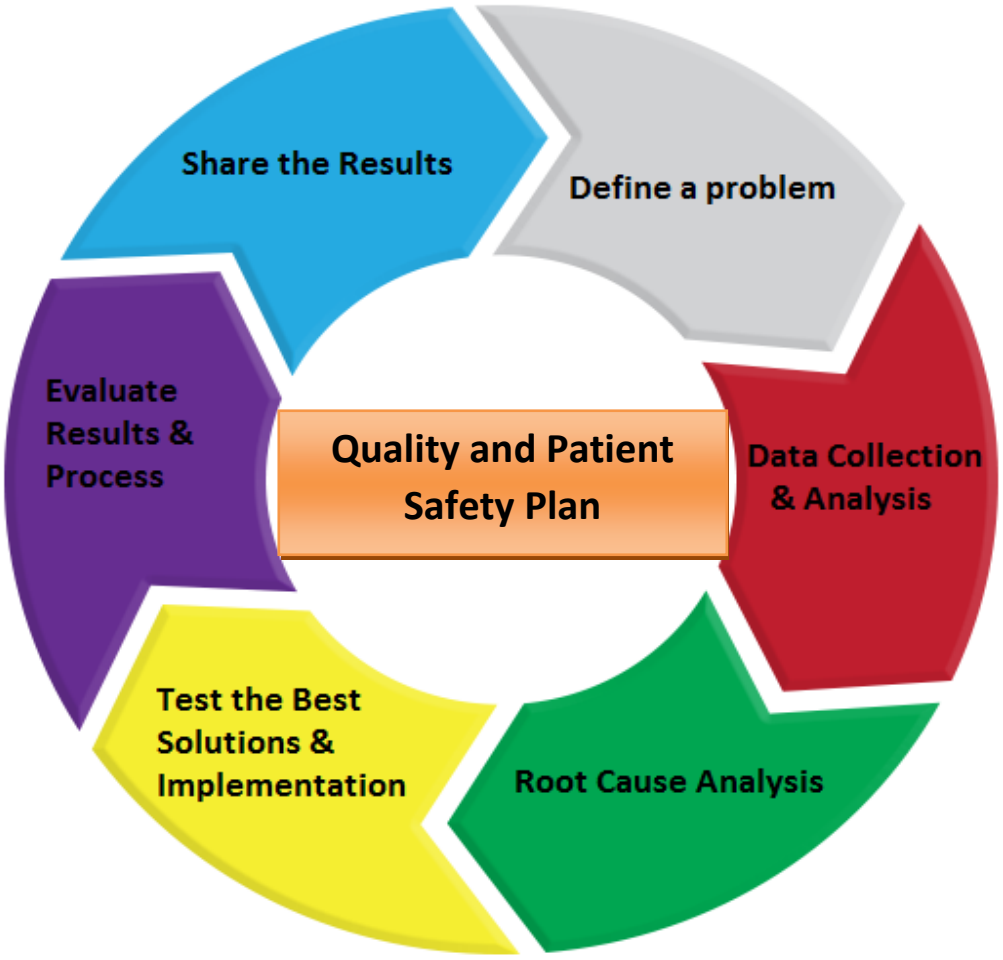
Objectives and Goals of the Quality and Patient Safety Plan

Objective	Plan	Planned Completion Date	Responsible Party
See Objectives in Quality Improvement Plan 2020			

Components and Methods

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

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



Root Cause Analysis

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

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

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

5 Whys technique will be used in Ear Nose and Throat Surgery Center to explore the cause and effect relationship underlay a problem. One can find the root causes by asking "why" no less than five times. This technique can be used individually or as a part of the fishbone diagram.

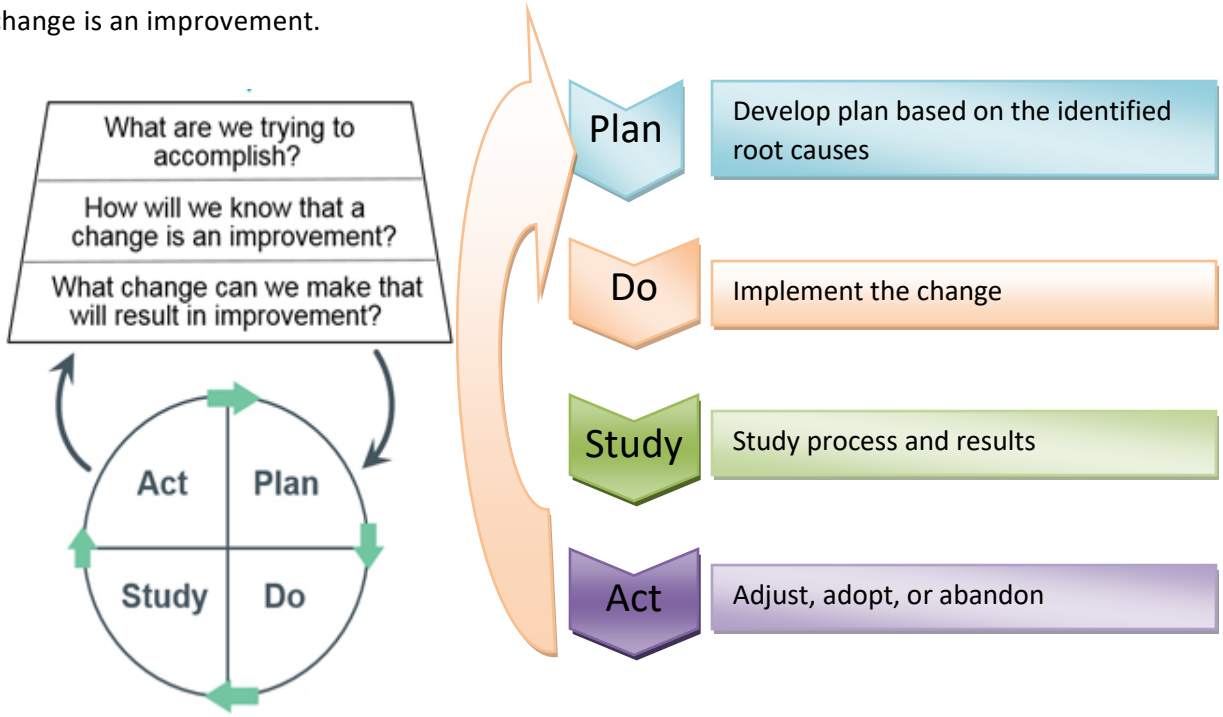
Fishbone Diagram

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

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

Model for Improvement

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



The cycle is defined as follows:

- Plan--collect data and establish appropriate goals. Identify the problem and the possible root causes, and answer the following questions.
  - What is the objective of the test?
  - What are the steps for the test - who, what, when?
  - How will you measure the impact of the test?
  - What is your plan to collect the data needed?
  - What do you predict will happen?

- Do--make changes designed to correct or improve the situation. Use the following questions for the guidance.
  - What were the results of the test?
  - Was the cycle carried out as designed or planned?
  - What did you observe that was unplanned or expected?

- Study -- Study the effect of the changes on the situation. Data should be collected on the new process and compared to the baseline or expected results. Results should be evaluated and by using the following questions as guidance.
  - Did the results match your prediction?
  - What did you learn?
  - What do you need to do next?

- Act--If the result is successful or desirable, standardize the changes and then work on the next prioritized problem or the further improvements. If the outcome is not yet successful, look for different ways to identify the causes or change the testing process.

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

Data Collection and Reporting

Data should drive any quality and patient safety effort. (Facility name) is using (data system names) for tracking the sentinel events, healthcare infection data, and (any other database) for internal data collection.

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

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

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 or person with training and/or experience making them effective in this role.

The patient safety checklists are listed in Appendix E. (The following links provide some patient safety checklists for your reference— a checklist example is shown in **Appendix E**.)

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

http://www.who.int/patientsafety/implementation/checklists/en/

The patient safety policies are listed in Appendix F. (The following link provides you some patient safety policies for your reference—a policy example is shown in **Appendix F**.)
https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1

Approval of Patient Safety Plan

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

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

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

Reference

- Root Cause Analysis Toolkit http://www.health.state.mn.us/patientsafety/toolkit/
- Quality and Service Improvement Tools http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html
- CQI 101 An Introduction to Continuous Quality Improvement: https://www.coursehero.com/file/13827355/CQI-Overviewppt/
- Quality Improvement http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/
- Root Cause Analysis http://www.patientsafety.va.gov/professionals/onthejob/rca.asp
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2 https://www.jointcommission.org/sentinel_event.aspx
- Hospital Policies https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1
- Checklists to Improve Patient Safety http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf
- Patient Safety Checklists http://www.who.int/patientsafety/implementation/checklists/en/
- Minutes of the Meeting of the Quality and Patient Safety Committee http://www.cookcountyhhs.org/wp-content/uploads/2013/12/09-23-14-QPS-scan-Minutes.pdf
- Title 40 – Public Health and Safety https://www.leg.state.nv.us/NRS/NRS-439.html

Appendix A: Terms and Definitions

Patient Safety: The Agency for Healthcare Research Quality (AHRQ) defines patient safety as "a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events." http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

Sentinel event (NRS 439.830)

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

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

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

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

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

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

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

Facility-Associated Infection: (NRS 439.802)

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

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

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

Medical facility (NRS 439.805)

"Medical facility" means:

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

(Added to NRS by 2002 Special Session, 13)

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

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

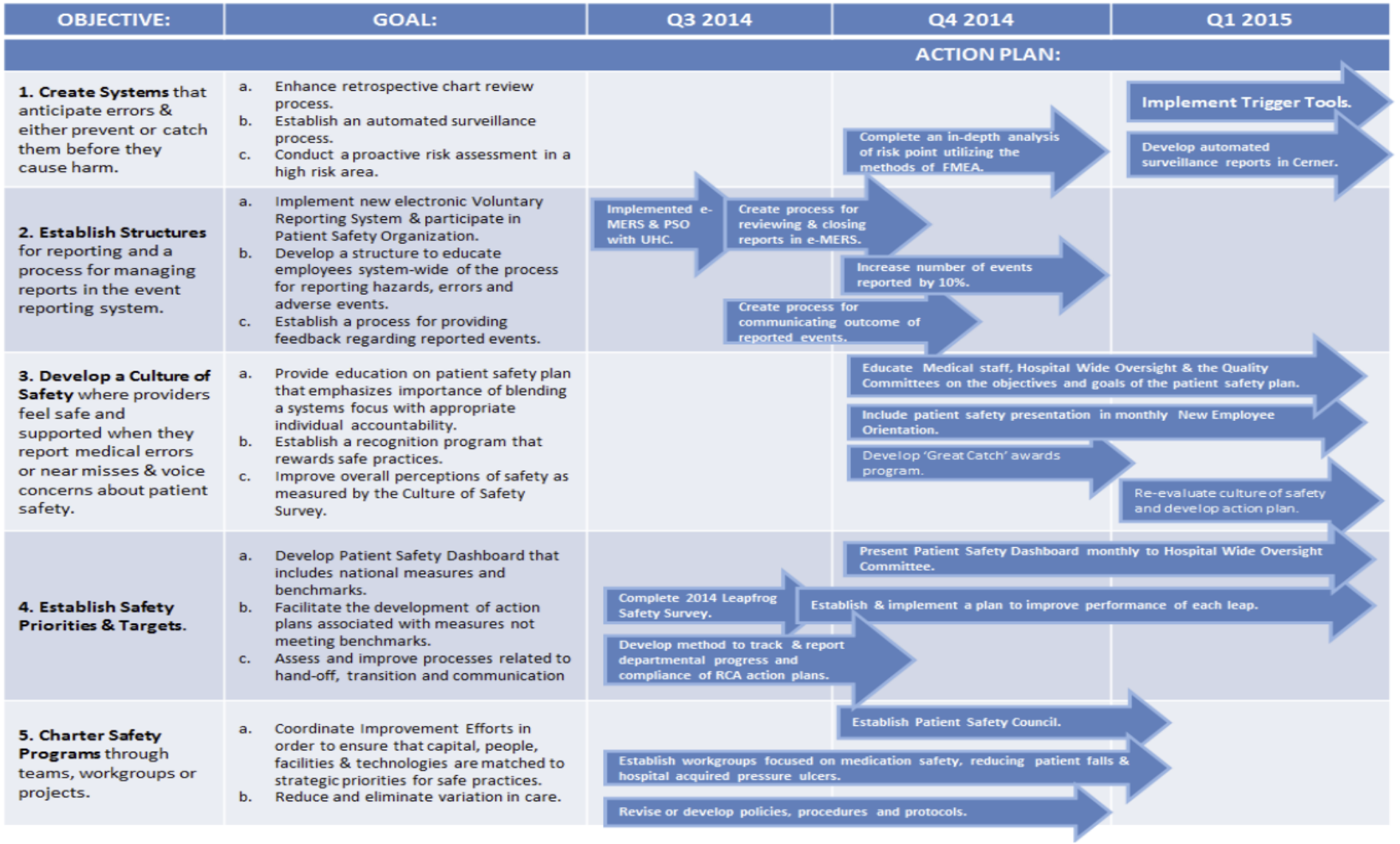
Risk: Possibility of loss or injury. (Merriam-Webster's Online Dictionary, Risk, Available at http://www.merriamwebster.com/dictionary/risk. Last Accessed August 2009.)

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

Catheter Associated Urinary Tract Infection (CAUTI): A urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CUR RENT_b.pdf.)

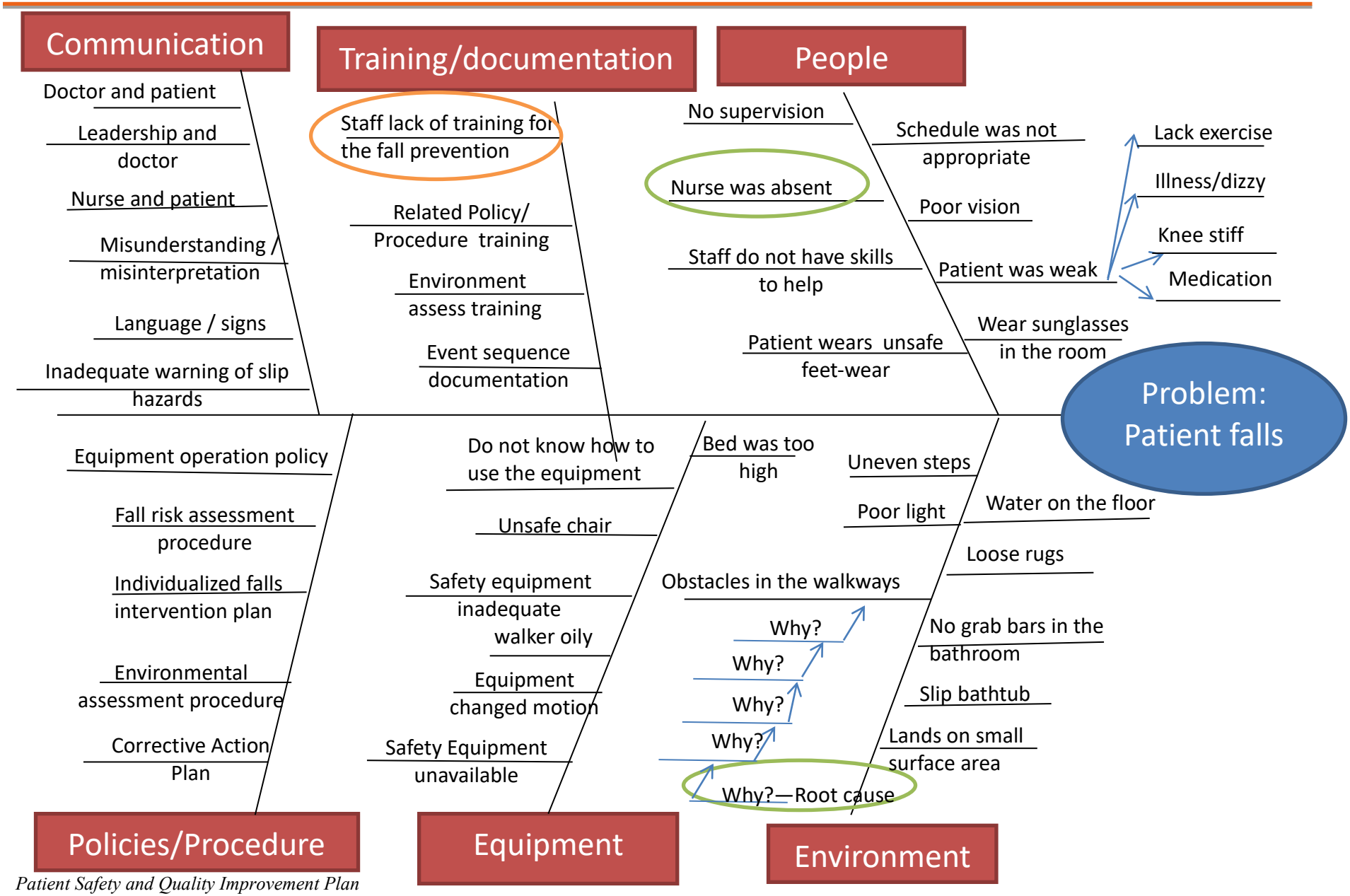
Central Line Associated Bloodstream Infections (CLABSI): Primary bloodstream infections that are associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection.

Appendix B: Patient Safety Goals



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
- 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:

MERCY HOSPITAL	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

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

Implementation:

Risk Management
Department Managers, the Occupational Health/ Infection Prevention and Control Nurse (OH/IPC Nurse) and Health and Safety/ Infection Control Representatives (HSIC reps) will in consultation with staff:

Ensure PPE requirements are identified when carrying out risk assessments of activities;

- Regularly review the risk assessment of activities if substances or work processes change;
- Identify the most suitable type of PPE that is required;
- Ensure PPE is available to those who need it;
- Inform staff of the risks involved in their work and why PPE is required;
- Monitor compliance.

Process

Manager's Responsibilities

Must ensure that:

- PPE requirements are considered when risks are assessed;
- Suitable PPE is provided and made accessible to employees;
- PPE is properly stored, maintained, cleaned repaired and replaced when necessary;
- Adequate information and training is provided to those who require PPE;
- PPE is properly used;
- Use of PPE is monitored and reviewed.

Employee's Responsibilities All employees must
ensure that:

- They use PPE whenever it is required;
- Attend and comply with training, instruction and information;
- Check the condition of their PPE;
- Store, clean and maintain their PPE;
- Report losses, defects or other problems with PPE to their manager.

Evaluation:

- Staff health and safety orientation
- Environmental audits
- Incident reports