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Owner	Ryan Fredrickson: Director of Quality/Risk/Safety
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Patient Safety Plan

SCOPE:

House Wide

PURPOSE:

To build a system for providing safe patient care and for preventing adverse patient outcomes.

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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.

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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 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

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2. Central line-associated blood stream infection
3. Hospital acquired infections
4. Surgical site infections

Patient Safety Officer (PSO): The person who is designated as such by a medical facility pursuant to NRS 439.870. Northeastern Nevada Regional Hospital (NNRH) shall designate an officer or employee of the facility to serve as the PSO. The PSO will:

- Supervise reporting of sentinel events
- Serve on the patient safety committee
- Take such actions as he/she determines necessary to insure safety of patient as a result of sentinel event activity
- Report any action taken to Patient Safety Committee
- Work under the direction of the Director of Quality, Risk & Safety

POLICY:

The Safety Plan at NNRH is implemented to provide a collaboratively planned, systematic, organization-wide approach to process design and performance measurement, assessment and improvement of patient safety. With a goal of delivering the safest and highest quality health care to the residents of the community, the plan is designed and organized to support the mission, vision and values of the hospital and LifePoint Healthcare Inc.

In formulating the plan, it is recognized that the implementation of an effective patient safety plan is dependent on a participative management approach, including all organization leaders, the Governing Board, senior management, the Patient Safety Committee, departmental management, and medical staff. We believe our plan provides our organization with the mechanisms to achieve patient safety that is expected by our customers and the community we serve.

Senior management is fully committed to the belief that improving patient safety is the most important challenge that we face in the healthcare industry and in our hospital. The purpose of the plan is to develop mechanisms to integrate and coordinate the activities of all of our healthcare staff so that patient safety is the foremost concern at every stage of every process that we conduct. Patient safety is to be the number one priority in the design of new processes, in the evaluation of existing processes and in the re-design of existing processes. The hospital-wide goal is to be proactive in preventing errors and complications.

To accomplish this goal, we are committed to comparing ourselves to national databases, searching for "best practices", studying designs of systems, and always searching for methods of strengthening our existing system designs by adding risk reduction strategies. Senior leaders regularly evaluate the culture of safety and quality using valid and reliable tools and prioritize and implement changes based on such evaluations. All individuals who work in the hospital are able to participate in safety and quality initiatives, either on an individual basis or a team approach. Staff, including the medical staff, is encouraged to discuss any areas of concern that impact patient safety and quality. Relevant literature concerning patient and staff safety is distributed throughout the hospital in the form of flyers, posters,

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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.

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REPORTING OF PATIENT SAFETY EVENTS

All employees have an affirmative duty to report any occurrence which is not consistent with the routine operation of the hospital and its staff, or the routine care of a particular patient or visitor, or any situation which has potential to cause harm to patients, visitors, or employees. This duty also applies to 'near miss' situations. *Willful failure to report such occurrences may subject the employee to corrective action up to and including termination.*

Patient related occurrences and other abnormal situations will be reported and tracked using an online electronic reporting database developed by **RL Solutions** according to the NNRH Occurrence Report Policy.

NNRH will follow all statutory, regulatory and licensing agency reporting guidelines and NNRH policies.

A. NRS 439.835 mandates that
    a. Within 24 hours after becoming aware of a sentinel event, an employee of NNRH will notify the PSO of the event.
    b. Within 13 days after receiving notification, the PSO shall report the date, time, and a brief description of the sentinel event to the Health Division using their occurrence reporting form.
    c. If the PSO personally discovers or becomes aware of a sentinel event in the absence of notification by another employee, the PSO shall report the date, time, and a brief description of the sentinel event to the Health Division within 14 days after becoming aware of the sentinel event using their occurrence form.

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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
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

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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.

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PATIENT SAFETY COMMITTEE

The Patient Safety Committee is the interdisciplinary committee designated to manage the organization-wide patient safety program and shall be organized with strict adherence to NRS 439.875.

The Governing Board is responsible for the oversight of the Patient Safety Plan. The Patient Safety Committee functions under the guidance and with the oversight of the CEO and Quality Council, with the PSO, or designee, serving as Chairperson. The meetings, records, data gathered, and reports generated by the Patient Safety Committee are protected by the peer review privilege set forth by the Health Care Quality Improvement Act of 1986 (Title IV of Public Law 99-660, as amended, and other applicable Nevada Statutes).

The committee shall be composed of the following members and others as the committee may from

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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

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include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of health care

- Checklist to ensure employees and contractors follow protocols to ensure that the room and environment of the patient is sanitary
- Checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received discharge instructions regarding medication management
- Instructions concerning aftercare and any other instructions concerning patient's care after discharge
- Checklists adopted by NNRH include:
    - Central Line Insertion (with prompt for practitioner order)
    - Universal Protocol and Surgical Site Fire Risk Assessment/Time Out
    - Safe Surgery Checklist
    - Discharge Instructions (prescription medication instructions, aftercare instructions, any other instructions related to discharge such as follow-up appointments)
    - Daily Room Cleaning (room and environment sanitation)
    - CDC Environmental Checklist for Monitoring Terminal Cleaning
    - Pre-Oxytocin Checklist (with prompt for practitioner order)

- In addition, the Patient Safety Committee will adopt and monitor compliance with our policy for the use of two patient identifiers, hand hygiene and any other patient safety checklist and policy adopted pursuant to this section. This may include active surveillance, a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.
- The Patient Safety Committee shall monitor and document the effectiveness of the patient identification policy and at least annually, review the patient safety checklists and patient safety policies adopted and consider any additional patient safety checklist and patient safety policies that may be appropriate for adoption at NNRH.
- On or before July 1st of each year, the committee submits a report to the Director of the Legislative Council Bureau for transmittal to the Legislative Committee on Health Care. The report is to include information regarding the development, revision, and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to paragraph above outlining checklist review (NRS 439.800).
- At least once each calendar quarter, report to the Governing Board 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

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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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Approval Signatures

Step Description	Approver	Date
	Becky Jones: CNO	08/2022
QRM Director	Carol Riggio: Director of Quality, Risk and Safety [BJ]	08/2022

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