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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

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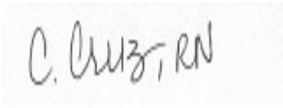

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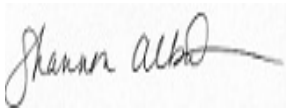

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