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 CAHMC Standard: LD.04.04.05; CHAP Standard: LG.3.I; ACHC 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 OBQM and OBQI 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. Internal systems for reporting system or process failures include incident/variance reporting, root cause analysis and reports to staff and Governing Body as appropriate.

6. External systems for reporting system or process failures will comply with any applicable law or regulation.

7. Responses to unanticipated adverse events include analysis and investigations with potential proactive risk assessments and/or risk reduction activities.

8. Defined support system for staff members who have been involved in a sentinel event includes counseling through the human resources department or the employee assistance program.

9. Leaders will provide an annual report to the Governing Body regarding actions taken to improve patient safety (in response to actual occurrences or proactively) and on process or system failures.

Mountain Crest HOME HEALTH
Above. The best.

STATE OF NEVADA

Annual Safety Program Evaluation: Governing Body Report

Requirement	Expectation	Expectation Met				Corrective Action Taken & Date
		Yes	No	N/A	Comments	
I. Safety	1. Individual assigned to manage.					
	2. Scope of program defined.					
	3. Safety integrated org-wide.					
	4. Procedures to respond to failures.					
	5. Internal & external reporting systems.					
	6. Response to unanticipated adverse events					
	7. If sentinel event occurred, staff support 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	
II. Data Collection	1. Staff perceptions of risks & suggestions for improvement.					
	2. Staff willingness to report unanticipated adverse events.					
	3. Pt perception of care includes: how we can improve safety.					
	4. Hazardous conditions analyzed.					
	5. Environmental safety monitored in office.					
	6. Safety issues communicated to program manager.					

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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

Conclusions: Program is Appropriate: Yes _____ No _____
Program is Adequate: Yes _____ No _____
Program is Effective: Yes _____ No _____
Program is Efficient: Yes _____ No _____

_____ _____
Administrator Signature Date

_____ _____
Governing Body President Signature Date

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 CAMHC Standards: LD.04.04.05, RI.01.02.01; Medicare CoP #s: 484.65(a), (c); CHAP Standard: CQI.2.D.M2; ACHC Standard: HH6-6A.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.
   - 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, (leading to death, permanent harm or severe temporary harm), 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.

- Invasive procedure on the wrong patient, at the wrong site or that is the wrong procedure.
- Unintended retention of a foreign object in a patient after an invasive procedure.
- Abduction of any patient.
- Severe neonatal hyperbilirubinemia (bilirubin greater than 30 milligrams/deciliter).
- Unanticipated death of a full-term infant.

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

4. The Agency will identify and respond appropriately to all sentinel events as defined, including:
   - A formalized team response that stabilizes the patient, discloses the event to the patient and family and provides support for the family as well as staff involved in the event.
   - Notification of leadership.
   - Immediate investigation.
   - Completion of a comprehensive, systematic analysis for identifying the causal and contributory factors.
   - Corrective actions based on casual and/or contributory factors that will lead to sustained improvement.
   - Time line for implementation of corrective actions.
   - Systematic improvement.

5. The Director of Clinical Services and Administrator will initiate a comprehensive systematic analysis of the sentinel event by performing a thorough and credible root cause analysis, which will focus on systems and processes. Appropriate staff, patient's physician and legal counsel will be involved in the root cause analysis.

6. The Agency will create, document and implement risk-reduction activities and corrective action plan. The effectiveness of system and/or process improvements will be measured and analyzed.

7. Sentinel events will be reported to external organizations as required by applicable federal or state law.

8. On an ongoing basis, Agency leaders will monitor published data regarding sentinel events in home care. Such data will be considered for improvement strategies and risk reductions within the Agency.

9. The Agency makes support systems available for staff who have been involved in an adverse or sentinel event through the employee assistance program.