Valley Hospital Medical Center

Risk Management/ Patient Safety Plan

Nevada Acute Care Division

I. Overview

Valley Hospital Medical Center ("VHMC") 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. VHMC operates as a Patient Safety Organization to further its commitment in promoting patient safety and assuring that VHMC remains at the forefront in the delivery of safe and effective clinical care. The Member Patient Safety Evaluation System (PSES) is utilized by VHMC 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 extends to facilities in which VHMC is responsible for oversight—Elite Medical Center and The ER at Desert Springs.

The Plan identifies the mechanisms to continually assess and improve the patient safety systems at VHMC. 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. VHMC 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

VHMC'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.

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

III. Roles and Responsibilities

A. Risk Management/Patient Safety Officer

VHMC 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. VHMC 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

VHMC 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. VHMC 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 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:
VHMC'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 and /or patient safety 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 corporate risk and patient safety 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:
  i. The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter).
  ii. The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and
  iii. 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 Corporate Patient Safety Council, claims reporting, Safety Watch Newsletters, The Joint Commission (Sentinel Event Alerts) and others, HRUs and from the TERM evaluation or other surveys, or 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.

VHMC 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.

D. TERM Program

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

Element I. Administration of the Risk Management Program: The tenets outlined in Element 1 lay the foundation for an effective risk management program. The Risk Manager/Director must be seen as a resource to administration, facility, and medical staff. Written plans, goals, and objectives provide a clear vision to meet the purpose of the 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): Facilities will designate key individuals to serve as participants in each Facility's Member Workforce. 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.

E. 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.

F. 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 RM to the Governing Board of all claims' activities.

G. 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.

H. 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.

I. 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.

J. 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.

K. 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.

L. 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. VHMC's Patient Safety Priorities, Goals and Objectives for 2023

A. The Corporate Patient Safety Council Goals for 2023 will include:

- **Culture of Safety**
  - ***Goal***: reduce the number of GHI events (serious safety event rate) for the Acute Care Division by the end of 2023. Ultimately, the goal is 0.
- **Surgical and Procedural Safety**

  Wrong Site Surgery (WSS)
  - ***Goal***: A 50% reduction in WSS events for 2023. Ultimately, the goal is 0.

  Retained Procedural items (RPIs)
  - ***Goal***: Prevent RPIs- a 50% reduction in RPIs with harm for 2023. Ultimately, the goal for RPIs is 0.

B. The Corporate Patient Safety Council will monitor the following metrics for 2023:

- **Reduce Falls and Falls with Injury**
  - ***Goal***: 10% reduction in the inpatient rate of falls in the Acute Care Division by the end of 2023—**1.39**.
  - ***Goal***: 10% reduction in the rate of falls with harm in the Acute Care Division by the end of 2023—**2.7%.**
- **Decreasing Hospital Acquired Pressure Injuries**
  - ***Goal*:** 10% reduction of NPOA rate for all HAPI stages in the Acute Care Division by the end of 2023—**1.169**.
- **Safe Medication Use**

  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 the end of 2023—**5.769**.
  - ***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>Smart Infusion Pump High Risk Event Reduction Initiative</u>**
    - ***Goal***: Decrease the number of high-risk medication overrides by 50% by the end of 2023.
    - ***Goal*:** Increase "Guardrails Suite" usage to 95% by the end of 2023.
- **<u>Infection Initiative</u>**
    - ***Goal***: CLABSI will be reduced to less than the CMS national mean Standardized Infection Ratio (SIR: CLABSI 0.814) in 2023.

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.

VI. 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.

VII. Approval of Patient Safety Plan

According to NRS 439.865, a medical facility shall submit its patient safety plan to the Governing Board of the facility for approval. After a facility's patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan.
The Patient Safety Plan must be reviewed and **updated annually** in accordance with the requirements for approval set forth in this section.

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.