POLICY:

Stonecreek Surgery Center will institute and administer a comprehensive and continuous Patient Safety Program for all patients to improve patient safety and reduce risk to patients through an environment that encourages:

- Recognition of risks to patient safety and medical/health care errors
- Actions to reduce these risks
- Internal reporting of incidents and potential incidents and actions taken
- Focus on processes and systems rather than individual blame

PURPOSE:

The Patient Safety Program provides a systematic, coordinated and continuous approach to maintenance and improvement of patient safety by using established mechanisms to support responses to actual occurrences, have an ongoing proactive plan to reduce medical/health errors, and integrate patient safety as a high priority in all relevant organizational processes and services.

RESPONSIBILITY:

As with patient care, it is a coordinated and collaborative effort of the entire organization to maintain and improve patient safety.

The Governing Body approves the data-driven Patient Safety Program and ensures the program reflects the complexity of the facility's organization and services, including those services furnished under contract or arrangement and focuses on the prevention and reduction of medical/health errors and adverse effects.

ROLES:

Safety Officer:
MD:
RN:
CEO or CFO:

The RN Clinical Director is responsible for the management of the Patient Safety Program by:

- Coordinating all patient safety activities
- Facilitating assessment and appropriate responses to reportable events
- Monitoring Root Cause Analysis and resulting action plans
- Serving as a liaison among the departments to assure facility wide integration of the Patient Safety Program.

Each individual employee within the organization acts as a patient advocate for safety and is responsible to report patient safety occurrences and potential occurrences to the QAPI Coordinator and the Clinical Director, who will aggregate the occurrence information and report to the Governing Body.

PROGRAM:

The scope of the Patient Safety Program includes an ongoing assessment 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 to prioritize organizational patient safety efforts.

Types of Patient Safety or Medical/Health Care Errors:

- No Harm Errors – those unintended 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.
- Mild-Moderate Adverse Outcome Errors – 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.
- 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 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 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):
    - Suicide of a patient.
    - The sexual assault of a patient during treatment or while the patient was on the premises of the facility.
    - A hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities.
    - Medication error resulting in a patient's unanticipated death or major permanent loss of bodily function in circumstances unrelated to the natural course of the illness or underlying condition of the patient.
    - A surgical procedure on the wrong patient or on the wrong body part of a patient.
    - A foreign object accidentally left in a patient during a procedure.
    - A patient death or serious disability associated with the use or function of a device designed for patient care that is used or functions other than as intended.
    - 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.

<u>What to Do When a Patient Safety Error Occurs</u>

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 supply 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, piggyback fluid 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 incident occurrence report to the QAPI Committee per organizational policy.

Internal Reporting Of the Error/Event

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 incident occurrence report form, submit the form to the QAPI 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 responsible for the patient, carrying out any necessary physician orders. Staff will then preserve any physical evidence as appropriate, notify their immediate supervisor, document facts in

the medical record and on an incident occurrence report, submitting the report to the QAPI Committee per policy.

- **Adverse Drug Reaction** – staff will perform any necessary clinical interventions to support and protect the patient and notify the physician responsible for the patient, carrying out any necessary physician orders. Staff will then preserve any physical evidence as appropriate, notify their immediate supervisor, document facts appropriately in the medical record and on an incident occurrence report, submitting the report to QAPI Committee 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 their supervisor and document the findings on an incident occurrence report which is then submitted to QAPI Committee

- **Sentinel Event** – staff will perform any necessary clinical interventions to support and protect the patient and notify the physician responsible for the patient, carrying out any necessary physician orders. Staff will then follow the organizational Sentinel Event Policy and Procedure, which includes a root cause analysis and action plan.

- **Near Miss** – staff will report the near miss event to their immediate supervisor, describe the facts of the near miss on an occurrence report and submit the report to QAPI Committee.

- It is the intent of this facility to adopt a non-punitive approach in its management of errors and occurrences. All personnel are <u>required</u> 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 individual staff member's supervisor determining the appropriate course of action to prevent error recurrence.

Root Cause Analysis

- All sentinel events will have a root cause analysis conducted to examine the cause and effect of the event through an impartial process

- A Root Cause Analysis is an interdisciplinary review process for identifying the basic or contributing causal factors that underlie a variation in performance associated with an adverse event or reportable patient safety event. It focuses primarily on systems and processes, includes an analysis of underlying cause and effect, progresses from special causes in clinical processes to common causes in organizational processes, and identifies potential improvements in processes or systems.

- The QAPI Committee is responsible for conducting the root cause analysis. It will be completed within 45 days of becoming aware of one of the reportable events. They will encourage the staff members' involvement in the root cause analysis and action plan processes, to allow the staff member an active role in process resolution.

A written Root Cause Analysis and "Action Plan" will be created which includes specific measures to correctly identify problems or areas of concern, identify strategies for implementing system improvements; and also includes outcome measures to indicate the effectiveness of system improvements in reducing, controlling or eliminating identified problem areas. The action plan must specifically address responsibility for implementation and oversight, time frames for implementation, and the strategy for measuring the effectiveness of the actions.

- The CMS, *A Guide for Performing Root Cause Analysis* format may be used

- Results of the entire Root Cause Analysis will be presented to the Governing Body/MEC for evaluation.

Communication of Action Plans and Root Cause Analysis

- Action Plans related to a Root Cause Analysis will be shared with the entire staff upon Completion by the QAPI Committee. Possible recommendations to

update or change policy and procedures may be presented to the staff, management and Governing Body to improve patient safety.

- Staff will educate patients and their families about their role in helping to facilitate the safe delivery of care. There will be a random record review verifying compliance with this educational process.

- Root Cause Analysis Action Plan will be made available to the state health department representatives during onsite reviews.

Reporting Obligations

- Medical/Health care errors and occurrences, including sentinel events, will be reported internally and externally, 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 Program Staff Education/Training

- 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 errors results from multiple factors. Flawed systems or processed can combine with active failures by caregivers in the clinical setting to produce accidents and errors. Some contributing factors are:
  - Inadequate communication among team members
  - Incomplete review of patient health records and diagnostic studies
  - Traditional hierarchical and autocratic cultures
  - Patient – related decisions made only by physicians
  - Unclear instructions

- Confusing packaging of medications and supplies
- Time pressures and constraints, Multi-tasking
- Failure to include the patient and family members in assessment and decision-making

- Staff will be trained about error reduction, which requires the commitment of all members of the health care team. Besides correcting the identified factors above, the following individual and facility changes will be focused on:
  - Reduce reliance on memory by using checklists and protocols.
  - Standardize processes as much as possible for procedures and other activities.
  - Focus on the safety aspects of products during the selection and evaluation process.
  - Promote safety related clinical competency.
  - Educate employees about the potential for errors and how to avoid them.
  - Creating a "Culture of Safety" whereby there is a change of environment from blaming individuals for errors to one in which errors are treated as opportunities to improve systems. This is accomplished by:
    - establishing a sense of trust among team members;
    - dissemination and verifying receipt of information to all levels of staff and management;
    - developing and supporting a proactive approach rather than a reactive approach;
    - making a sincere commitment to affirming safety as the first priority.

- Patient Safety Program meetings will be incorporated into the QAPI Program and conducted to review any incident occurrence reports and review any new patient safety recommendations or alerts. The Patient Safety Committee will meet as a part of the QAPI meeting.

PATIENT SAFETY GOALS

The Governing Body of Stonecreek surgery center is committed to providing its patients with the safest environment within the control of the organization. This facility will incorporate The Joint Commission's National Patient Safety Goals as a part of the overall Safety Program.

- Goal 1: **Improve the accuracy of patient identification.**

- Use at least two patient identifiers when providing care, treatment or services, including during medication, blood or blood component administration, and when collecting blood samples and other specimens for clinical testing.
- Label containers used for blood and other specimens in the presence of the patient.
- Eliminate transfusion errors related to patient misidentification.

- Goal 2: **Improve the safety of using medications.**

  - In perioperative settings both on and off the sterile field, label medications and solutions that are not immediately administered.
  - Label any medication or solution when it is transferred from the original packaging to another container.
  - Immediately discard any medication or solution found unlabeled.
  - Maintain and communicate accurate patient medication information.
  - Obtain and/or update information on current patient medications.
  - Provide the patient with written information on the medications to be taken upon discharge.

- Goal 3: **Reduce the risk of health care-associated infections**.

  - 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.
  - Implement evidence-based practices for preventing surgical site infections.

- **Universal Protocol for Preventing Wrong Site, Wrong Procedure and Wrong Person Surgery**

  - Create and use a preoperative verification process, such as a checklist, to confirm that appropriate documents (e.g., medical records, imaging studies) are available.
  - Implement a process to mark the surgical site, and involve the patient in the marking process.
  - Conduct a TIME OUT immediately before starting the procedure.

The National Quality Forum's (NQF) new report, *Safe Practices for Better Healthcare,* lists best practices that experts agree would significantly improve patient safety. Some

of the practices that will be incorporated in Stonecreek surgery center's safety plan include, but are not limited to:

- Create a culture of safety by establishing policies on issues such as prioritizing and analyzing patient safety events and training staff in teamwork-based problem solving skills.
- Specify a protocol to ensure that you have adequate nursing care based on your patient mix and nurse experience.
- Record and read back verbal orders to the prescriber immediately.
- Use only abbreviations and doses that the organization has standardized.
- Prepare patient care summaries from original source documents, not from memory.
- Transmit care information, such as order changes or diagnostic information, on time and in an understandable format to all providers who may need the information to care for a patient.
- Ask patients or legal surrogates to repeat what providers explained to them about informed consent.
- Prominently display patient's preferences for life-sustaining treatment in their charts.
- Standardize protocols for preventing wrong-site or wrong-patient procedures by using a pre-surgical checklist and establishing a process to mark the operative site.
- Evaluate preoperative patients for the risk of surgical site infection and implement appropriate preventive measures such as antibiotic prophylaxis.
- Use a hygienic hand rub or wash your hands with disinfectant soap before and after contact with patients or objects immediately around them.
- Keep the medication preparation area clean, orderly, well lit and free of clutter, distraction and noise.

- Use standard methods for labeling, packaging and storing medications.
- Identify all "high-alert" drugs, such as chemotherapy agents, anticoagulants, insulin or narcotics.

In the day to day operations of Stonecreek surgery center, the workplace will be designed in order to comply with the above, and:

- Optimize the work environment for safety by keeping workloads within an acceptable range.
- Increase feedback by making staff aware of responses to reported errors.
- Train for teamwork by training workers to be interdependent as well as independent.

- Drive out fear by publicly rewarding reports of error and establishing confidential reporting of errors.
- Obtain leadership commitment by decreasing competition and increasing cooperation among the staff.
- Improve direct communication (e.g., repeat verbal orders verbatim).