Nevada
Infusion
2023 Patient Safety Plan

Purpose

Nevada Infusion has developed a Patient Safety Program in conjunction with the Quality and Performance Improvement Plan and Program in order to provide guidelines for implementation of an integrated patient safety program throughout the facility and to comply with the requirements of the State of Nevada. It is the intent of the leadership of the facility to foster a safe and safety-conscious environment that promotes wellbeing, acknowledges and addresses risks, and encourages interdisciplinary safety and education focusing on process improvement.

Scope

Overall Patient Safety responsibilities in conjunction with the ACHC standards include the following

1. **Improve the accuracy of patient identification.** Improve the accuracy of patient identification. Through the use of two patient identifiers whenever performing procedures, administering medications, taking blood samples or providing treatment or procedures.

2**. Ensure the identification**, reporting, prevention and control of infections, including the role of proper hand hygiene.

3. **Improve the effectiveness of clinical alarms systems**; ie infusion pumps.

4. **Identifying, preventing and correcting errors in the labeling, storing, prescription or administration of medications;** Medication Storage, Dispensing, Labeling, Dispensing Medications.

5. **Ensuring the safe administration** of prescription drugs, pharmaceutical services and other medications .

6. **The identification, investigation and reporting of Sentinel Events** as contained in Nevada Infusion policy, Sentinel Events, and as prescribed by NRS 439.800 and following guidelines established by the Nevada State Health Department's Sentinel Event Registry. The Owner and/or Safety Officer/Director of Professional Services is responsible for the maintenance of Sentinel Event reports.

7. **Patient safety checklists** to improve the health outcomes of patients in the home.

The primary focus of the Patient Safety Program is the patient. The program also addresses the safety of visitors and staff from all clinical and organizational functions. The scope of the Patient Safety Program includes but is not limited to the occurrence of the following:

1. Adverse Drug Reactions
2. Medication Errors and near misses
3. Client complaints/Grievances
4. Chart Auditing (open and closed)
5. Infections (Peripheral, mid, and central line as well as communicable disease)
6. Pre Infusion Labs
7. Sentinel Events
8. Hazardous Condition(s) to include Workplace violence and workplace safety.
9. Cultural Competency awareness through mandated training.

Efforts of the Patient Safety Program is also contained in the safety of the environment of the facility including oversight of

1. Workplace Violence prevention and Training
2. Fire safety training
3. Emergency disaster training
4. Cultural Competency awareness training

Methodology

The Patient Safety Program includes both proactive and responsive components.

Proactive: The proactive patient safety component emphasizes a proactive error reduction and avoidance program. The following topics are reviewed to identify patient safety issues:

1. Medical equipment and medication risk assessment activities

2. Sentinel event alert risk reduction activities

3. Performance improvement indicators (department specific) and monitoring activities

4. Patient Satisfaction reports

5. Medical Record review reports

6. Unusual Occurrence Report trending

Responsive: The facility will utilize information gathered from risk assessments, sentinel event alerts, performance improvement measures, medical record review, and other data in order to track, trend, and respond to patient safety issues. Patient safety related issues are prioritized based on severity.

The following topics reviewed for prospective patient safety issues:
1. Occurrence Report Findings
2. Patient Complaint/Grievance Response
3. Performance Improvement Measures
4. Patient Satisfaction Survey Reports
5. Serious Event Notifications /Sentinel Event Reporting

Quality, Patient Safety and Performance Improvement Committee and Reporting

Patient Safety is the responsibility of all employees. The performance improvement team is multidisciplinary in nature with representatives from facility staff and ownership. Embedded in the performance improvement team are safety issues relevant to the team's focus. Reports from the performance improvement teams are reviewed at minimum quarterly in conjunction with the Quality committee.

In compliance with State of Nevada Regulations, Quality, Patient Safety and Performance Improvement Committee includes at minimum:

(1) The Director of Professional Services and Quality Improvement/Safety Officer (Nurse)

(2) The Pharmacist In Charge

(3) Director of Operations or Operations Manager (in lieu of)

(4) Owner

Patient Safety and Performance Improvement Committee functions include but are not limited to:

1. Review and evaluate internal and external patient safety data from the following sources for opportunities for improvement in the safety of patient care processes:

    a. Patients/Family members

    b. Unusual Occurrence reports

    c. Complaints/Grievances

2. Continually improve processes of care delivery based on data analysis.

3. Develop policies and procedures that result from process improvement activities and corresponding checklists.

4. Continue to conduct an annual risk assessment of patient safety issues/strategies from internal and external reports.

The facility cultivates a non-punitive reporting environment in order to maximize reporting of errors, near misses, adverse outcomes, and sentinel events. Recent studies demonstrated that many errors might be directly related to system and process failures. Disciplinary action is considered if an involved individual takes action to hide the incident, is malicious or untruthful in reporting, when facts and circumstances suggest that the occurrence was deliberate or in reckless disregard to patient and staff safety, or when the individual consistently fails in the detection, reporting or remedies to prevent untoward occurrences. Reporting of patient safety occurrences to an outside agency are completed

when required by regulation or as determined by the Director of Professional Services and Quality Improvement/Safety Officer, the managing pharmacist, or the operations manager.

An annual review of the Patient Safety Plan, appropriate policies, forms, checklists and best practices will be reported to the Patient Safety and Performance Improvement Committee.

Education and training is an important and effective tool in assuring that the Patient Safety Program is clearly understood, particularly error identification and reporting as the basic approaches to Patient Safety. Education and training on patient safety is included in new employee general and department orientation and reviewed annually. Additionally, education is provided to patients and their families about their role in helping to facilitate the safe delivery of care.