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Subject: VIII - **Patient Safety Plan**
Policy #: 7.6.17

I. PURPOSE:

The purpose of the Patient Safety Plan is to outline the process for implementing a patient safety program at Riverside Regional Medical Center Peninsula Surgery Western Nevada Surgical Center (WNSC) that supports the proactive reduction of medical / health care errors as well as an effective response to actual occurrences.

II. POLICY:

It is the policy of Riverside Regional Medical CenterPeninsula SurgeryWestern Nevada Surgical Center to promote the reduction of risks to patients through an integrated and coordinated organization-wide approach. The Board of Directors Governing Body is committed to providing the resources, delegating responsibility, and acting on reports to provide a systematic program designed to effectively reduce errors and other factors that lead to unanticipated adverse patient outcomes.

Administration shall provide an environment in which patients, their families, facility staff, managers and physicians are encouraged to identify, report and manage both actual and potential risks to patient safety. The program shall be non-punitive in nature, focusing on processes, procedures and systems rather than individuals.

III. SCOPE:

This policy applies to all Riverside Health System facilities and components. (However, internal structural variations within individual facilities may necessitate changes in review and reporting mechanisms) The objectives include:

A. To recognize risks to patient safety and sources of medical/health care errors and to initiate actions to proactively reduce these risks;
B. To encourage learning about errors and share this knowledge to improve patient safety ;
C. To encourage internal reporting of errors and issues;
D. To focus on the improvement of processes and systems associated with medical/health care errors; and
E. To minimize individual blame or retribution for involvement in a medical / health care error.
F. To review and implement the Patient Safety goals as promulgated by JCAHO
   - Improve the accuracy of patient identification
   - Improve the effectiveness of communication among caregivers

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- Improve the safety of using high-alert medications
- Eliminate wrong-site, wrong-patient and wrong-procedure surgery
- Improve the safety of infusion pumps
- Improve the effectiveness of clinical alarm systems
- Be ADA compliant

IV. AUTHORITY & RESPONSIBILITY:

A. Board of Directors – The Board of Directors of Riverside Regional Medical Center Peninsula Surgery Centers, L.L.C.Governing Body – The Governing Body of WNSC has the ultimate responsibility for patient safety. To fulfill the commitment to patient safety, the board delegates

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the responsibility for identifying, analyzing and managing patient safety activities to administration, management, supervisors, medical staff and employees. The Board Governing Body recognizes that proactive management of patient safety is a continuous, ongoing process; therefore they will provide the necessary resources to carry out this philosophy. Through the development of strategic initiatives, the Board Governing Body provides direction for the organization's improvement activities. Monthly rReports from the Quality CouncilUtilization Review/Quality Improvement Committee provide the Board with a means of evaluating the organization's effectiveness in reducing risks to patient safety. The Board reviews and evaluates the Quality Council's annual report, which addresses the prior year's patient safety program activities and uses the information for developing the next year's initiatives.

B. Administration and Managers – Administration and managers are responsible for supporting the Patient Safety Plan and the risk reduction efforts of the organization. These efforts are given a high priority, especially when processes are designed or redesigned. To support these activities the organization will provide:
- Adequate resources;
- Staff to participate in risk reduction activities;
- Adequate time for staff to participate;
- Adequate information systems and data management systems; and
- Staff education regarding risk reduction strategies.

C. Medical Staff -The Medical Staff is involved in patient safety activities by participation in various Medical Staff and Medical Center committees including, but not limited to, the Quality Council, Clinical Review/Performance Improvement Committees, Pharmacy and Therapeutics Committee and the Infection Control Committee. They provide support and oversight for organization-wide performance improvement and patient safety activities by assisting with the identification of priorities for improvement, assuring physician

input, developing action plans as appropriate, and communicating all relevant information to the full Medical staff. Reports from the various Medical Staff committees are submitted to the Medical Executive Committee and the Quality Councilthe Utilization/Quality Improvement Committee. on a regular basis.

D. Committees

1.Quality Council – The Quality Council oversees, coordinates, and directs the performance improvement activities at Riverside Regional Medical CenterPeninsula Surgery Center, including activities involved in the identification, analysis and improvement of risks to patient safety. The Quality Council delegates to the Medical Staff and Riverside Regional Medical Center departments, respective standing committees and other ad hoc committees, the authority to provide effective mechanisms to monitor and evaluate the quality and appropriateness of patient care outcomes.

Regarding patient safety, the Quality Council is responsible for coordinating activities that will result in the reduction of medical/health care errors. This is accomplished through a proactive risk assessment process and through the use of available information regarding sentinel events and other medical/health care errors known to occur in other organizations.

a.Proactive Risk Assessment

1)At least one high-risk process will be identified by the Quality Council annually to undergo a proactive risk assessment. The process to be selected will be based on information identified through literature review and/or information published by JCAHO in *Sentinel Event Alerts* identifying the most frequently occurring sentinel events.

2) The process is assessed to identify steps that may cause undesirable variations.

3)For each identified variation, the possible effects, including the seriousness of the effects, on the patient are identified.

4)For the effects on the patient that are determined to be critical, a root cause analysis is conducted to determine why the effect may occur.

5) The process will then be redesigned to reduce the risk of these variations occurring or to protect the patient from the effects.

6)The redesigned process will be tested and then implemented. Performance measures will be developed and implemented to measure the effectiveness of the new process.

7)Strategies for maintaining the effectiveness of the redesigned process over time will be implemented.

b. Literature Based Information

1)Information contained in *Sentinel Event Alerts* (Patient Safety Goals) and/or obtained from other sources will be forwarded by the Performance Improvement Department to the Quality

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Council, department managers, other appropriate committees or individuals for their review and consideration.

2)The Council will recommend actions to be taken and will delegate the actions to existing committees, the appropriate department or process owners, or will sanction the formation of a Quality Improvement team.

3)Outcomes related to these actions will be reported to the Quality Council and are documented in the Council's minutes.

2.Root Cause Analysis Committee – The Root Cause Analysis Committee addresses Sentinel Events and near misses (see definitions below and Sentinel Event Policy #704.00). Risk reduction activities are identified, interventions implemented and reviews are conducted to assess the effectiveness of the interventions. Reports are submitted to the Quality Council on a regular basis.

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3.Safety Committee – The Safety Committee provides the mechanism to monitor and evaluate patient safety related to environmental issues. These issues could include but are not limited to:

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a.Patient Falls;
b.Medical Equipment (SMDA); and
c.Hazardous conditions (Defined as 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 adverse outcome.).

Reports are submitted to the Quality Council on a regular basis at least quarterly.

E. Employees and Volunteers – The role of the individual employee and volunteer is critical to the success of a patient safety initiative. Patient safety is everyone's responsibility. All employees and volunteers must believe that every patient care process can be improved and feel empowered to fix and prevent problems, as well as contribute to improvement efforts. Any employee, medical staff member or volunteer may make a suggestion for a patient safety initiative through their department manager or the Quality Choice programsupervisor.

Refer to the Performance Improvement Policy for further delineation of the integration of patient safety with Performance Improvement.

V. MEDICAL/HEALTH CARE ERROR AND NEAR MISS REPORTING

A. Definitions:

- Error – an unintended act, either of omission or commission, or an act that does not achieve its intended outcome.
- Near Miss - used to describe any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome

- Sentinel Event – an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.

B. In response to a medical/health care error, appropriate steps will be taken in the care of the patient to minimize negative outcomes. Any appropriate steps that would decrease the possibility of the error occurring again, or that would protect others from the risk, will be implemented immediately.

C. The physician or his/her designee will clearly explain the outcome of any treatments or procedures to the patient and/or family members as soon after the incident as is possible and appropriate whenever those outcomes differ significantly from the anticipated outcomes.

D. When a medical/health care error occurs that has caused harm to a patient, staff members will immediately notify the manager of the departmentAdministrator. The manager Administrator is then responsible for investigating the incident and notifying the appropriate organizational leaders including the risk manager and administration.

E. When a medical/health care error or near miss occurs, a staff member involved in

F. in the occurrence will complete an Incident Report and Follow-Up. the occurrence will complete a Quality Care Control Report (QCCR) as described in the Medical Center's policy: Incident Report and Follow-up (#604.00).

F. The manager Nurse of the department where the error or near miss occurred will begin the preliminary analysis. All information obtained during the analysis will be reported to Risk Management and/or the appropriate committeethe Administrator. the preliminary analysis. All information obtained during the analysis will be reported to the Administrator.

G.G. Care will be taken at the time that an error or near miss occurs to preserve any information or evidence that may be helpful in the analysis of the error. information or evidence that may be helpful in the analysis of the error.

H. H. The QCCR will be forwarded to the Risk Management Department for review. Depending on the type of medical /health care error, the issue will be forwarded to Administration for assignment to the appropriate committee for further review and action planning.

I.Depending on the nature and severity of the medical/health care error, the appropriate external authorities (such as the Food and Drug Administration (FDA), National Institute Occupational Safety Administration (NIOSA), United States Pharmocopea (USP), Nevada Department of Health) will be notified of the

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error. The Administrator will discuss the details of each case with appropriate staff to determine what authorities need to be notified.

I. appropriate external authorities (such as the Food and Drug Administration (FDA), National Institute Occupational Safety Administration (NIOSA), United States Pharmocopea (USP), Virginia Department Mental Health/Mental Retardation Services and the VirginiaNevada Department of Health) will be notified of the error. The Risk ManagerAdministrator will discuss the details of each case with appropriate administrators staff to determine what authorities need to be notified.

J.When a medical/health care error is determined to fall within the definition of a sentinel event as defined in the "Sentinel Event" policy, then a root cause analysis will be completed within 45 days of the determination as a Sentinel Event.

K.Staff involved in a serious medical/health care error or sentinel event may need additional support. As appropriate, the department manager will facilitate contacting the Employee Assistance Program (EAP).

Data related to medical/health care errors, near misses and sentinel events will be aggregated-, analyzed across the organization to identify patterns and trends and appropriate action implemented.

VI. Western Nevada Surgical Center does not use any latex containing supplies at the facility.
- Any patient identified with a latex allergy will be identified on their wristband and the front of the patient chart

VI.VII. NEW AND REVISED PROCESSES

Patient safety is given high priority at Riverside Regional Medical CenterPeninsula Surgery at Western Nevada Surgical Center. Patient safety considerations must be an integral part of the development of new policies, procedures, systems and services. When existing policies, procedures, systems and services are revised and re-evaluated, patient safety considerations will be addressed.

VII. STAFF EDUCATION

Patient safety will be included in the orientation program for all new employees, both at the facility level and the department specific level. Annual review and updated information will be presented as part of the mandatory annual safety training.

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20On-going education regarding *Sentinel Event Alerts* will be provided as appropriate to the facility, department and job class. Department managers may provide specific education annually as appropriate for their specific needs.