Harmon Hospital

Patient Safety Plan

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Appendix I

Commitment to Patient Safety

Harmon Hospital is committed to a comprehensive approach to improving healthcare quality and patient safety by aligning with our Mission, Vision, and Values, creating an environment that supports a dynamic, proactive, and safe culture for patients, family members, visitors, and employees, through continuous learning and improving patient safety policies, systems, and processes.

Mission, Vision, and Values

In support of our mission, vision, and values, Harmon Hospital's Patient Safety function as part of the Quality Assessment Quality Improvement program promotes:

- Collaboration of healthcare, 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 and 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.
- Responsibility for every healthcare related decision and action.
- 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 participation of healthcare providers.

Scope and Purpose

The scope of this Quality and Patient Safety Plan is organizational-wide/hospital-wide/agency-wide which includes but is not limited to

- Patient safety
- Visitor safety
- Employee safety

All staff in Harmon Hospital are required to fully support and participate in this plan, and devote their expertise to the patient safety and healthcare quality improvement process.
This plan is action oriented and solution focused. The purpose of this plan is to address patient safety related concerns, challenges and revise the program to better serve the patients and their families. To this end, Harmon Hopsital has developed this Patient Safety Plan.
The plan focuses on the process rather than the individual, and recognizes both internal and external customers, as well as facilitates the need of analyzing and improving processes. The core principles of this plan include:

- All staff have the same goal and contribute their knowledge, vision, skill, and insight to improve the process of the Patient Safety Plan.
- Decisions will be based on data and facts, and staff will be encouraged to learn from the experiences.
- Customer based including patients, families, and visitors.
- Promote systems thinking.
- Employ well-trained and competent staff maintaining high healthcare quality.

Roles and Responsibilities

According to NRS 439.875, a medical facility shall establish a Patient Safety Committee (PSC). This Committee should ensure that the Patient Safety Plan is promoted and executed successfully. The Patient Safety Function is incorporated into the Quality Assessment Performance Improvement Committee (QAPI)

The Patient Safety Function Organization

Roles and Responsibilities

In accordance with NRS 439.875, a patient safety committee must be comprised of:

- The infection control officer of the medical facility;
- The patient safety officer of the medical facility, if he or she is not designated as the infection control officer;
- 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; and
- One member of the executive or governing body of the medical facility.
- The Chief Executive Officer (CEO) or Chief Financial Officer (CFO) of the medical facility.

Patient Safety Committee Responsibilities (based on NRS 439.875 and NRS 439.877)

- Monitor and document the effectiveness of the patient identification policy.
- **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)(b).
- 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.
- Review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- Review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least once each calendar report to the executive or governing body of the facility regarding:
  - ✓ The number of sentinel events that occurred at the medical facility during the preceding calendar month

R (2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and

(3) 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.

Root Cause Analysis (RCA) Team Responsibilities

- Root Cause interviews,
- analysis,
- investigation, and
- corrective action plan implementations
- Participates in the RCA meetings and discussions.
- Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders.

Patient Safety Officer Responsibilities (based on NRS 439.870)

- Serve on the QAPI meeting for the patient function.
- Supervise 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.
- Take such 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 patient safety function of the QAPI committee regarding any action taken in accordance with the responsibilities above.

Infection Control Officer Responsibilities (based on NRS 439.873)

- Serve on the QAPI Committee and report on infections and practices impacting patient safety.
- Monitor the occurrences of infections at the facility to determine the number and severity of infections.
- Report to the QAPI committee concerning the number and severity of infections at the facility.
- Take such action as determines is necessary to prevent and control infections alleged to have occurred at the facility.
- Carry out the provisions of the infection control program adopted pursuant to NRS 439.865 and ensure compliance with the program.

RCA team leader 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.
- Provide training, education and direction to create RCA processes that incorporate the Patient Safety and Quality Improvement elements.

Executive or Governing Body Staff Responsibilities

- Provide vision and leadership to Patient Safety and Quality Improvement process, and
- Develop and foster a safe learning and improving culture.
- Provides oversight to the healthcare quality improvement processes and teams.
- Plan, discuss, and generate the organization patient safety goals and activities, in conjunction with the patient safety action plans

The Quality Assessment and Performance Improvement Committee (including the Patient Safety function) will meet monthly to accomplish the following:

- Report and discuss sentinel events which include:
  - ✓ Number of sentinel events from previous calendar month.
  - ✓ Number of severe infections that occurred in the facility.
  - ✓ Corrective Action Plan for the sentinel events and infections
  - ✓ Evaluate the corrective action plan.
- Patient safety policies and checklists
- At least annually evaluate Patient Safety policies and checklists
- Revise the patient safety policies and checklists as needed.
- Monitor and document the effectiveness of the patient safety policy.

A RCA Team and meeting will meet as needed to accomplish the following:

- Define the healthcare issues or potential risks.
- Conduct Root Cause Analysis
  - ✓ Reviewing and analyzing the data.
  - ✓ Reviewing the RCA process and quality improvement related activities and timelines.
  - ✓ Brainstorming issues or the potential risks by using the fishbone diagrams.
  - ✓ Identify the contributing factors and conduct the Root Cause

- A meeting agenda and minutes noting follow-up tasks will be kept.

Goals and Objectives of the Patient Safety Plan

Objective	Goals	Plan	Planned Completion Date	Responsible Party

Components and Methods

- Pursuant to NRS 439.837 and NAC 439.917, within 45 days after reporting a sentinel event pursuant to NRS 439.835, the medical facility shall 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."

- Harmon Hospital will use RCA process to determine the contributing factors and the underlying reasons for the deficiencies or failures. The Plan-Do-Study-Act (PDSA) is the model, which was developed by the Institute of Health Care Improvement that we will use to test the changes.

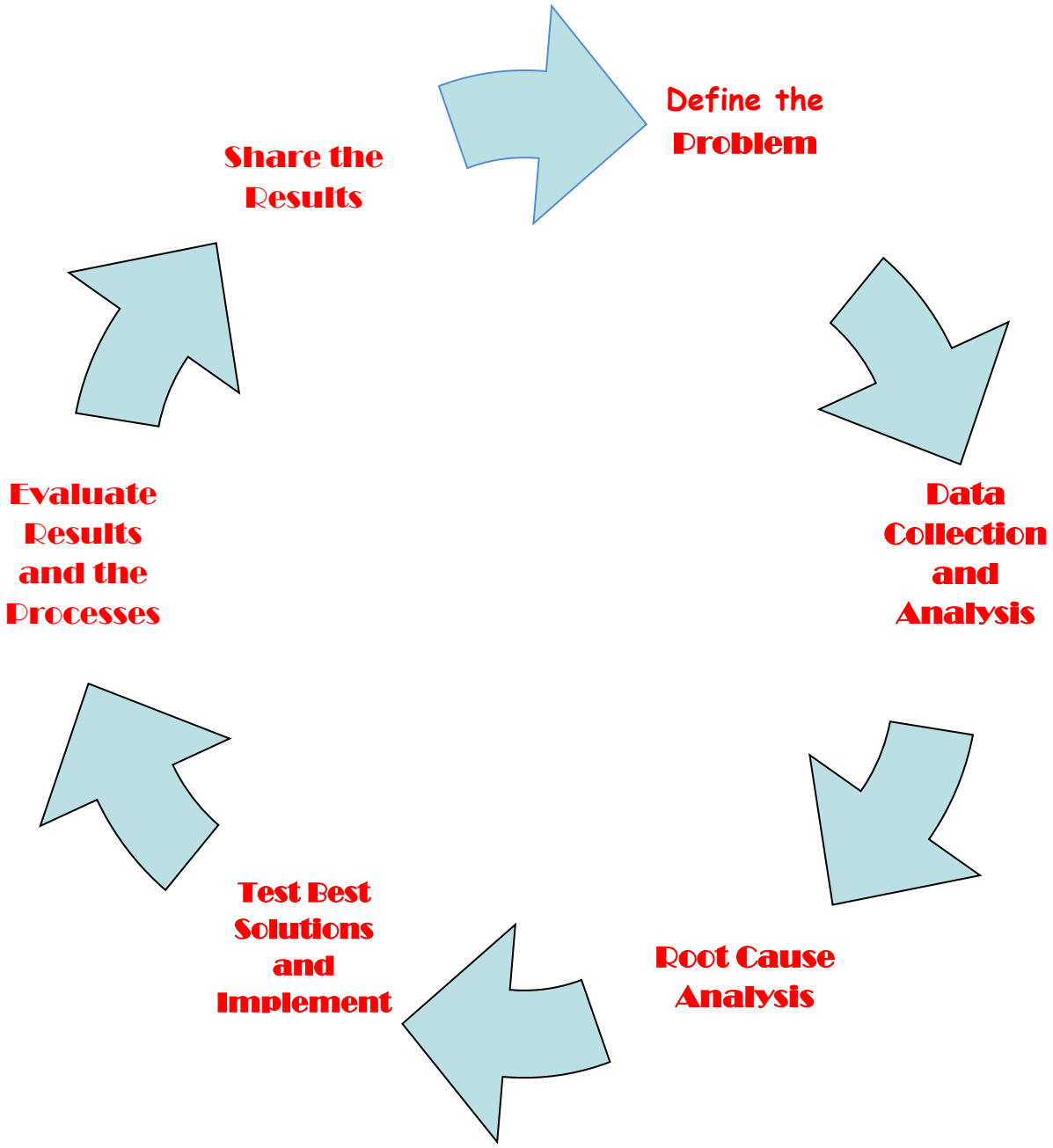
Root Cause Analysis

- 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.

- **Root cause analysis and action plan framework table**
  - ✓ It guides the organization to the steps in a root cause analysis.
  - ✓ Not all the questions apply to all the events or cases.
  - ✓ This table can be used individually or with the fishbone diagram.

- **5 Whys**
  - ✓ Technique will be used by Harmon Hospital to explore the cause and effect relationship underlay a problem.
  - ✓ One can find the root causes by asking "why" no less than five times.
  - ✓ This technique can be used individually or as a part of the fishbone diagram.

RCA Improvement Process



Fishbone Diagram

Once the problems are identified, a Fishbone Diagram (Appendix C) will be used for analyzing the problems. You can use the fishbone diagram individually to analyze the root causes, or use it with the root cause analysis and action plan framework table.

A Fishbone Diagram, also called a Cause-and-Effect diagram, is a useful tool for a team to structurally brainstorm by discovering possible underlying factors or root causes from different major categories for the chosen problems. General categories used include:

- ✓ people,
- ✓ methods
- ✓ materials,
- ✓ measurements,
- ✓ education,
- ✓ procedures,
- ✓ process,
- ✓ location,
- ✓ environment, etc.

RCA team members will brainstorm and ask multiple times, "why did this happen?" for each cause until all ideas are exhausted. The highest priority root causes will be chosen for PDSA topics. Once all the categories are established on the fishbone diagram, 5 Why's technique also can be used to drill down the problem and find the root causes.

Model for Improvement

The Model for Improvement is a collaborative and ongoing effort model to improve the product and services quality and process. It provides multi-disciplinary quality team guidance from identifying the root causes; conducting the best tests to assess possible changes, and working in collaboration for implementation of the new approaches and solutions. It guides the test of a change to determine;

- ✓ if the change is an improvement.
- ✓ Adjust, adopt, or abandon
- ✓ Study process and results
- ✓ Implement the change
- ✓ Develop plan based on the identified root causes

What are we trying to accomplish?

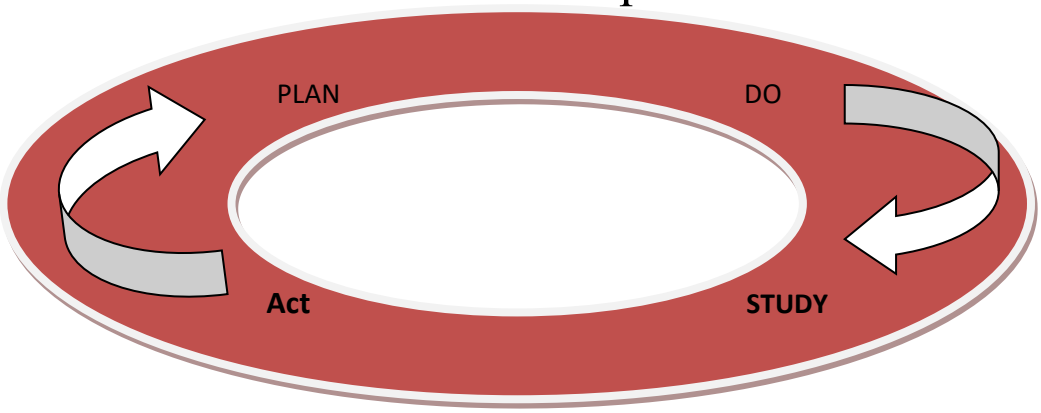
How will we know a change is an improvement?

What change can we make that will result in an improvement?

Plan--Do-- Study-- Act

Plan	Develop Plan based on identified root causes
Do	Implement the change
Study	Analyze process and results
Act	Adjust, adopt or abandon to repeat cycle as needed

Cycle continues until maximum improvement is achieved



The cycle is defined as follows:

- **Plan**--Collect data and establish appropriate goals. Identify the problem and the possible root causes, and answer the following questions.
  - ✓ What is the objective of the test?
  - ✓ What are the steps for the test - who, what, when?
  - ✓ How will you measure the impact of the test?
  - ✓ What is your plan to collect the data needed?
  - ✓ What do you predict will happen?

- **Do-**
  - ✓ Make changes designed to correct or improve the situation.
  - ✓ Use the following questions for the guidance.
    - What were the results of the test?
    - Was the cycle carried out as designed or planned?
    - What did you observe that was unplanned or expected?

- **Study** –
  - ✓ Study the effect of the changes on the situation.
    - Data should be collected on the new process and compared to the baseline or expected results.
    - Results should be evaluated by using the following questions as guidance.
  - ✓ Did the results match your prediction?
  - ✓ What did you learn?
  - ✓ What do you need to do next?

- **Act**—
  - ✓ If the result is successful or desirable, standardize the changes
  - ✓ Then work on the next prioritized problem or the further improvements.
  - ✓ If the outcome is not yet successful, look for different ways to identify the causes or
  - ✓ Change the testing process.

Data Collection and Reporting

Data should drive any quality and patient safety effort. Harmon Hospital is using a Fundamental LTC corporate database for tracking the sentinel events and other incidents such as falls, hospital acquired pressure ulcers and medication variations for internal data collection.

External data sources are those data sources which are collected outside the supervisory structure of the case. External data which will be utilized for Quality and Patient Safety plan include the data from:

- AHRQ: Agency for Healthcare Research & Quality
- CDC: Centers for Disease Control and Prevention
- CMS: Centers for Medicare & Medicaid Services
- NQF: National Quality Forum
- NHSN:

Ongoing Reporting and Review Data points such as the following will be reviewed according to the schedule prescribed:

Monthly	Quarterly	Annually
1) Sentinel event monthly report	1) Sentinel event quarterly report	1) Quality and Patient Safety Plan update
2) Severity of infection report	2) Severity of infection report	2) Checklists
3) RCA assessment	3) Review and evaluate the measure of improvement of patient safety	3) Policies reviewing and revising
4) Infection reports	4) Review and evaluate the measurement to prevent and control infections	

Patient Safety Checklists and Patient Safety Policies

By NRS 439.865, the patient safety plan must include the patient safety checklists and patient safety policies 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; a
- 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.

- 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.

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.

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.

References

- ✓ Root Cause Analysis Toolkit http://www.health.state.mn.us/patientsafety/toolkit/
- ✓ Quality and Service Improvement Tools http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html
- ✓ CQI 101 An Introduction to Continuous Quality Improvement: https://www.coursehero.com/file/13827355/CQI-Overviewppt/
- ✓ Quality Improvement http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/
- ✓ Root Cause Analysis http://www.patientsafety.va.gov/professionals/onthejob/rca.asp
- ✓ Patient Safety Systems Chapter, Sentinel Event Policy and RCA2 https://www.jointcommission.org/sentinel_event.aspx
- ✓ Hospital Policies https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1
- ✓ Checklists to Improve Patient Safety http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf
- ✓ Patient Safety Checklists http://www.who.int/patientsafety/implementation/checklists/en/
- ✓ Minutes of the Meeting of the Quality and Patient Safety Committee http://www.cookcountyhhs.org/wp-content/uploads/2013/12/09-23-14-QPS-scan-Minutes.pdf
- ✓ Title 40 – Public Health and Safety https://www.leg.state.nv.us/NRS/NRS-439.html

APPENDIX A

DEFINITIONS

Sentinel Event

1. Except as otherwise provided in subsection 2, "sentinel event" means an event included in Appendix A of "Serious Reportable Events in Healthcare--2011 Update: A Consensus Report," published by the National Quality Forum.

2. If the publication described in subsection 1 is revised, the term "sentinel events" means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:

(a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or

(b) July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published.

** If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.

(Added to NRS by 2002 Special Session, 13; A 2005, 599; 2013, 217)

Medical Harm

Institute for Healthcare Improvement (IHI) defines **medical harm** as "unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death."

Facility-Associated Infection: (NRS 439.802)

- "Facility-acquired infection" means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:
  - ✓ Surgical site infections;
  - ✓ Ventilator-associated pneumonia;
  - ✓ Central line-related bloodstream infections;
  - ✓ Urinary tract infections; and
  - ✓ Other categories of infections as may be established by the State Board of Health by regulation pursuant to NRS 439.890.

  (Added to NRS by 2005, 599; A 2009, 553)

Medical facility (NRS 439.805) Medical facility" means:

- A hospital, as that term is defined in NRS 449.012 and 449.0151;
- An obstetric center, as that term is defined in NRS 449.0151 and 449.0155;
- A surgical center for ambulatory patients, as that term is defined in NRS 449.0151 and 449.019; and
- An independent center for emergency medical care, as that term is defined in NRS 449.013 and 449.0151.

(Added to NRS by 2002 Special Session, 13)

Near miss:

- An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Mandatory reporting:

- Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985;254(6):796-800.)

Risk:

- Possibility of loss or injury. (Merriam-Webster's Online Dictionary, Risk, Available at http://www.merriamwebster.com/dictionary/risk. Last Accessed August 2009.)

Appendix B PDSA

Plan-Do-Study-Act

WORKSHEET

PDSA WORKSHEET
Harmon Hospital

TOPIC:		
PERSON COMPLETING WORK SHEET		Date:
Telephone:	e-mail	Quarter:
QAPI Committee Members		
Medical Director		
Physician Member		
Physician Member		
CEO		
DQM-Patient Safety Officer		
Infection Control Officer		
Facility Safety Officer		
Team Members:		

AIM: Describe the Overall Goal team wishes to achieve

Plan

1. List the tasks needed to set up this test of change

2. Predict what will happen when the test is carried out

3. List the steps to develop the test-who what and when

Steps	By whom	By when	Desired outcome

DO: (Describe what actually happened when you ran the test including any problems and unexpected findings)

STUDY: (Describe what you learned and did you meet your measurement role?)

Did you meet measurement goal? Explain:	Summarize what was learned: success, failure, inintended consequences etc.

Act: (Describe what you concluded from this cycle)

Based on what your learned, Pleas indicate the action to be considered.	Describe what modifications to the plan will be made for the next cycle based on what you have learned
☐ Adapt: modify changes and repeat the PDSA cycle	
☐ Adopt: standardize and expand changes throughout org.	
☐ Abandon: change approach and repeat PDSA cycle	
☐ Other:	

APPENDIX C
Patient Safety Goals

Patient Safety Goals Objectives and Action Plan				
Goal	Objectives	QTR 1	QTR 2	QTR 3
Safety and Quality method for improvement educations for all staff	✓ Utilize Institute of Healthcare Improvement free online training ▪ On Demand: An Introduction to the Model for Improvement ▪ On Demand: Building Skills in Data Collection and Understanding Variation ▪ On Demand: Using Run and Control Charts to Understand Variation ▪ On Demand: Improvement Skills to Empower Front-Line Nurses			
Design systems/processes to anticipate errors and prevent or identify them before they cause harm	✓ Conduct proactive risk assessment areas identified as high risk ✓ Utilize retrospective chart review to identify areas of concern ✓ Establish an automatic surveillance process			
Establish structures for reporting events and a process for managing reports in the event reporting system	✓ Educate and train staff to utilized incident reporting process for all events with potential for patient harm ✓ Establish standardized reports based on events that occurred as well as near missed ✓ Evaluate the potential and actual harm caused by these events. ✓ Develop processes to prevent actual and potential harm			

Goal	Objectives	QTR 1	QTR 2	QTR 3
Develop a culture of safety within the organization	✓ Ensure staff feels safe and supported when they report medical errors/ near misses or when they voice concern about patient safety ✓ Conduct a Culture of Safety Survey with all staff ✓ Identify key areas for improvement based on the Culture of Safety Survey			
Establish Safety Priorities and benchmarks	✓ Establish a Patient Safety Dashboard with national measures and benchmarks ✓ Facilitate the development of action plans for safety measures not meeting benchmarks			
Improve all levels of communication and particularly with handoff and transition patient information	✓ Ensure a standardized process for handoff communication at change of shift ✓ Utilize checklists for key transition processes such as RTA and Discharge ✓ Educate staff on key measures to improve communication such as Huddles and post event assessments			
Initiate Monitoring process for National Patient safety goals	✓ Focus on the following 5 until solidly in place: • Two identifiers • Critical value management • Suicide assessment • Hand washing, PPE • Fall prevention			

Appendix D Leadership Policy for Patient Safety

PURPOSE

To establish guidelines and processes supporting a comprehensive, effective, organization-wide Patient Safety Program designed to improve patient safety by preventing medical/healthcare errors and reducing risks to patients.

POLICY

The Patient Safety Program is a coordinated and systematic approach to create an information infrastructure and build a better evidence base for patient safety critical to reducing medical/healthcare errors and improving patient safety. The program meets the requirements of Patient Safety Standard, and integrates with the Quality Assessment and Performance Improvement (QAPI) Plan and the Sentinel Event Policy, and is endorsed by the medical staff and Leadership.

Patient Safety Program:

Harmon Hospital is committed to making the safety of all patients, employees, physicians and visitors a leadership priority for organizational performance improvement. The Patient Safety Program is an integral part of the QAPI Plan that includes processes to:

- Establish and maintain a just culture of safety throughout the hospital;
- Promote safety by recognizing and reducing risks and hazardous conditions that result in medical/healthcare errors and patient injury;
- Support a strong internal non-punitive reporting mechanism;
- Facilitate the rapid redesign of unsafe care processes and systems in response to actual and potential adverse events;
- Support ongoing proactive efforts through implementation of known safe practices;
- Promote communication and coordination among individuals and departments to minimize risk to patients;
- Support sharing of knowledge to effect behavior change and organizational improvement to reduce risk and improve patient safety;
- Support notification of patients and when appropriate, their family, of unplanned outcomes;
- Establish a data collection system to monitor performance of new or revised processes including patient, family, and staff input, needs, perceptions of risk to patients, and suggestions for improvement.

Organizational Culture:

An organizational culture has been established by the leaders that support the effective reduction of medical/health care errors and other factors that contribute to unintended adverse patient outcomes. This culture is based on the principles of organization-wide cooperation and communication and encourages:

- The recognition and acknowledgement that preventing errors and improving safety for patients requires a systems approach in order to modify the conditions that contribute to errors;
- A focus on processes and systems;
- Minimization of individual blame or retribution for involvement in a medical/health care error;
- The internal reporting of what has been found and the actions taken to reduce risk; and
- Organizational learning about medical/health care to effect behavioral changes in order to improve patient safety.

The organizational culture is also reflective of Harmon Hospital's Philosophy, which supports the patient's right to be informed about the outcomes of their care, including unanticipated outcomes.

An effective Patient Safety Program cannot exist without optimal reporting of actual or potential medical/healthcare errors and occurrences. Therefore, it is the intent of Harmon Hospital to adopt a just, non-punitive approach in its management of errors and occurrences. All personnel will report suspected or actual medical/healthcare errors and may do so without fear of reprisal.

Scope of Activities:

The Patient Safety Program at Harmon Hospital is an organization-wide program that includes not only facility staff and medical staff, but is inclusive of patients, family and visitors. The Patient Safety program supports and encourages the active participation of each person in order to have an effective program.

When processes, functions or services are designed or redesigned, information internal and external to the organization regarding potential risks to patient safety will be considered and where appropriate, utilized to minimize the risk to patients affected by the new or redesigned process, function or service.

Undesirable patterns or trends in performance and sentinel events will be intensively analyzed to determine where best to focus changes for improvement. Intensive analysis will be initiated when:

- Levels of performance, patterns, or trends vary significantly and undesirably from those expected;
- Performance varies significantly and undesirably from that of other organizations;
- Performance varies significantly and undesirably from recognized standards; or
- When a sentinel event has occurred.

Minimally, data from the following areas will be analyzed and action plans developed reflective of the findings:

- Initial risk assessment
- On-going proactive risk assessments utilizing internal and external resources
- Aggregate event report reflective of all medical/healthcare errors, with and without adverse outcomes, including but not limited to:
- Medication errors, to include delays in administration
- Adverse drug reactions
- Transfusion reactions
- Patient falls
- Sentinel events, actual and near misses
- Hazardous conditions
- Restraint issues
- Medical record legibility issues
- Patient/family/staff opinions, needs, perceptions of risks to patients, and suggestions for improving patient safety
- Others as defined by Harmon Hospital

Leadership:

Hospital leadership has overall responsibility for the implementation of an integrated, organization-wide Patient Safety Program. These responsibilities include the following:

- Fostering an environment in which patients, their families and organization staff and leaders can identify and manage actual and potential risks to patient safety through personal example and the provision of resources to establish proactive mechanisms to reduce risk.
- Establishing a culture in which communication flows freely regardless of authority gradient;
- Ensuring that a defined, on-going, proactive program for identifying risks to patient safety and reducing medical/health care errors is fully implemented and includes responses to actual and potential events, as well as addresses two high risk processes for proactive intensive assessment based on internal data and information published in JCAHO Sentinel Event Alerts and other literature sources;
- Ensuring that patient safety issues are given a high priority and addressed when processes, functions or services are designed or redesigned;
- Providing for mechanisms to measure, analyze and manage variations in the performance of defined processes that affect patient safety;
- Allocating adequate resources, including personnel, time, information systems, data management support and staff training to support the performance improvement processes associated with reducing risk and improving patient safety; and
- Annually evaluating the patient safety plan for its effectiveness in reducing risk and improving patient safety.

Patient Safety Coordinator:

The Risk Manager has been designated the *Patient Safety Coordinator* and as such, has the administrative responsibility for the Program. Specific responsibilities include:

- Day to day responsibility for the ***Patient Safety Program***
- Along with the Safety Officer, collection, trending and analysis of data
- Quarterly reporting of trended data and actions taken to improve the quality and safety of patient care to the Patient Safety Committee and senior leadership
- Working with Patient Safety Committee to achieve the goals of the Patient Safety Program

Patient Safety Committee:

The Patient Safety Committee, in collaboration with the chair of the committee and the Patient Safety Coordinator, has oversight responsibility to ensure that the responsibilities and functions outlined in this program are carried forward throughout the organization. The following responsibilities are assigned:

- Serve as champions of the Patient Safety Program within the organization;
- Establish and evaluate data to identify patient safety performance indicators;
- Evaluate other sources of patient safety data utilizing internal and external resources including, but not limited to, risk assessments, sentinel event report/alert information, and event reporting information from a variety of available resources including the event reporting system;
- Selection of at least two high-risk patient safety processes (one related to medication errors and one related to mistake management) for proactive risk assessment and improvement annually; and
- Annual review of the Patient Safety Program to ensure its appropriateness of focus and effectiveness of efforts.

Physicians:

Physicians are responsible, as participants in the patient safety program, for reporting errors or near misses, and participating on teams to reduce identified patient safety risks. Whenever patient care outcomes differ significantly

from the anticipated outcomes, the primary care provider and/or responsible licensed independent practitioner (or comparable designee), shall clearly explain these outcomes to the patient, and when appropriate, the family.

Patients/Families/Visitors:

Patients and families are responsible for:

- Providing, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to the patient's health;
- Reporting perceived risks in their care and unexpected changes in the patient's condition to the responsible practitioner;
- Asking questions when they do not understand what they have been told about the patient's care or what they are expected to do.

Patients and visitors will be provided with educational materials explaining these expectations and their role in reducing risk and improving patient safety at the time of admission. Some patients may also be included in the process to obtain their opinions, needs, perceptions of risks to patients and their suggestions for improving patient care.

Hospital Departments and Staff:

Hospital departments and staff have the following responsibilities:

- Active participation in the Patient Safety Program;
- Participation in all education activities and process implementation;
- As appropriate, the provision of accurate, timely and complete verbal and written communication among care givers, including test results relevant to the management of the patient's condition, and to all others involved in the utilization of data; and
- Participation in the information needs assessment, staff surveys and other processes that request information regarding the Patient Safety Program.
- Participate in the measurement activities for process and outcomes which will be utilized for data driven decisions and improve quality of care and services.

PROCEDURE

1. Proactive Risk Assessment Activities

1.1. The Risk Manager, in collaboration with the Patient Safety Committee, will conduct proactive risk assessments to identify hazards/risks that may affect patient safety. Risk assessment activities will include, but not be limited to the following:

1.1.1. An initial patient safety risk assessment evaluating known high risk processes/procedures that have associated risks;

1.1.2. On-going risk assessments based on internal and external data, including sentinel event alerts;

1.1.2.1. Focused risk assessments as determined by the Patient Safety Committee, senior leadership and/or Quality Council

1.1.2.2. Selection of patient safety process improvements and risk reduction activities utilizing the priority setting criteria of Gerald Champion RMC.

1.1.2.3. The information needs assessment conducted by Harmon Hospital will include identification of barriers to effective communication among caregivers.

1.1.2.4. Patient satisfaction surveys will include a question determining how the patient/family thinks the facility can improve patient safety. Results from this question shall be analyzed and responded to in a manner that supports risk reduction.

1.1.2.5. Staff surveys will be conducted to assess for staff opinions, needs, perceptions of risks to patients and suggestions for improving patient safety as well as the staff's willingness to report medical/health care errors.

1.2. Risk assessment activity results will be aggregated and analyzed. Appropriate action plans will be developed in response to the results with the goal of reducing the actual, potential or perceived risk to patient safety.

2. Event Reporting

2.1. When an unplanned event occurs, the patient care provider will do the following:

2.1.1. Perform the necessary healthcare interventions to support the patient's clinical condition

2.1.2. Perform the necessary interventions to contain the risks to others

2.1.3. Notify the patient's attending physician

2.1.4. Preserve any information related to the event including physical evidence.

2.1.5. Preservation of the information includes the documentation of facts regarding the event or complication of event on the Event Reporting form and in the medical record

2.1.6. Notify immediate supervisor of the event

2.1.7. Submit the Event Report form to the medical center's Risk Manager

2.2. Identification of potential unsafe condition that may affect patient safety:

2.2.1. Individuals identifying such a condition will immediately report such to their supervisor, and document on the Event Report form

2.2.2. Take the necessary actions to ensure that any potential risks to patient care and safety are mitigated

2.2.3. Submit the Event Report form to the medical center's Risk Manager

3. Event Monitoring/Risk Assessment Analysis, Action Planning and Intervention

3.1. Patient safety related event reporting data within the scope of the Patient Safety Program and all risk assessment results will be aggregated and presented to the Executive Safety Committee for analysis quarterly. Based on the analysis of this data, any actual or potential sentinel events and other internal and external data including JCAHO Sentinel Event Alerts and other current literature, proactive action plans will be developed to include the following:

3.1.1. Assessment of the intended and actual implementation of processes to identify the steps in where there is, or may be, undesirable variation;
3.1.2. Identification of the possible effects of the undesirable variations on patients and how serious the effect or outcome on the patient might be;
3.1.3. For critical effects/outcomes, a root cause analysis will be conducted to determine why the variation leading to the effect may occur;
3.1.4. Redesign of the process and/or underlying systems to minimize the risk of that variation or to protect patients from the effects of the variation;
3.1.5. Test and implement the redesign process;
3.1.6. Identification and implementation of measures of the effectiveness of the redesigned process;
3.1.7. Implementation of a strategy for maintaining the effectiveness of the process over time.

4. Response to Reported Adverse/Sentinel Events

4.1. Harmon Hospital shall respond to all reported potential and actual adverse/sentinel events as described in the sentinel event policy.
4.2. Minimally, all significant adverse events will be analyzed utilizing a team of individuals to conduct a root cause analysis and/or a failure mode and effects analysis, implement an action plan to reduce further risk to patients and establish measures of effectiveness as described above in Section III A.
4.2.1. The following events always elicit an intense analysis:
4.2.1.1. Confirmed transfusion reactions;
4.2.1.2. Significant adverse drug reactions;
4.2.1.3. Significant medication errors and hazardous conditions;
4.2.1.4. Major discrepancies, or patterns of discrepancies, between preoperative and postoperative (including pathologic) diagnoses, including those identified during the pathologic review of specimens removed during surgical or invasive procedures; and
4.2.1.5. Significant adverse events associated with anesthesia use.
4.2.2. A root cause analysis is performed when a sentinel event occurs.

4.3. Staff involved in an adverse/sentinel event shall be treated with respect and dignity.

4.3.1. A non-punitive approach shall be taken in order to facilitate changes in systems and processes to prevent further risk to patient safety, as well as promote future reporting by other staff.

4.3.2. Involved staff should be involved in the root cause analysis process.

4.3.3. The department manager will provide on-going support to the staff member as needed.

4.3.4. Whenever necessary, Employee Assistance Programs will be offered as support to the involved employee.

4.4. Harmon Hospital will notify patients and/or family members, when appropriate, of unplanned outcomes.
Staff will follow the policy and procedure on "Disclosure of Unanticipated Adverse Outcomes to Patients/Families."

5. Facility Education

5.1. Staff Education

5.1.1. General orientation, on-going in-service and other education and training programs will emphasize specific job-related aspects of patient safety.

5.1.2. Specific Patient Safety Program training at orientation and annually thereafter will include:

5.1.2.1. An overview of the Patient Safety Program

5.1.2.2. Staff's role and responsibilities in the Patient Safety Program

5.1.2.3. Event reporting, including the events requiring reporting and the process for reporting events.

5.1.2.4. Methods to support and foster an interdisciplinary and collaborative approach to the delivery of patient care;

5.1.2.5. Examples of specific job-related aspects of patient safety.

5.1.3. Staff participating at a higher level of the Patient Safety Program will receive appropriate training necessary to understand and complete their assigned responsibilities.

5.2. Physician Education

5.2.1. An overview of the Patient Safety Program will be provided to physicians at time of initial appointment and periodically thereafter that describes the program, emphasizes their role and responsibilities in the program and informs them of the event reporting mechanism.

5.2.2. Specific physicians may receive additional training to support their involvement at a higher level in the Patient Safety Program.

6. Patient Safety Program Reporting and Review

6.1. Patient Safety related data and information reports will be provided at least quarterly to the Patient Safety Committee.

6.2. A summary report of data, other internal and external information, as well as all actions taken by the Patient Safety Committee and/or specific patient safety related teams will be submitted to the Quality Council, Quality and Utilization Management Committee the Medical Executive Committee and Governing Board.

6.3. Annually, the Patient Safety Program will be evaluated for effectiveness and the program updated to reflect the results of risk assessments of patients, families and staff. The review shall include a summary of the occurrence of medical/health care errors and actions taken to improve patient safety, both in response to actual occurrences and proactive efforts.

6.3.1. The review will be approved by Patient Safety Committee, Medical Staff Executive Committee

6.3.2. Will be submitted to the governing body for review and approval.

REFERENCES:

Conditions of Participation- (CMS) Standards
The Joint Commission Standards
Sentinel Event Policy

Addendum A
Patient Safety Policy and Procedure
Definitions

Error: An unintended act, either of omission or commission, or an act that does not achieve its intended 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 risk thereof" includes any process variation for which a recurrence would carry a significant chance of serious adverse outcome.

Near Miss: Used to describe any process variation which did not affect the outcome, but for which recurrence carries a significant chance of a serious adverse outcome. Such a near miss falls within the scope of the definition of a sentinel event, but outside the scope of those sentinel events that are subject to review by the Joint Commission under its Sentinel event Policy.

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 adverse event.

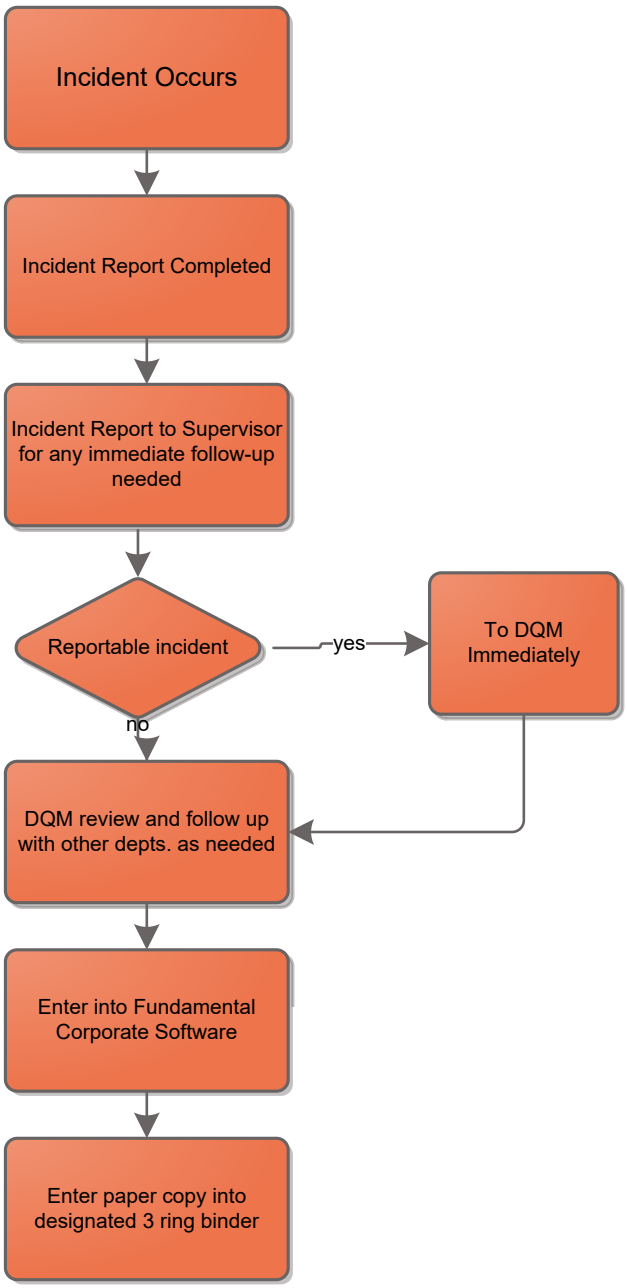
APPENDIX

INCIDENT REPORTING

Incident Report Process (Non-Medication incident)

1. Incident is identified by Hospital staff
2. Incident report is completed
3. Incident Report is given to Nursing Supervisor for immediate review and follow up as needed.
4. Any additional assessment and investigation is completed and documented. Supporting documentation is attached to the Incident Report.
5. After incident information and follow up Completed the information and incident report is given to the Director of Quality Management (DQM).
6. DQM reviews for any immediate actions/notifications including interface with other departments involved.
7. DQM gives incident report to Patient Advocate for entering into Fundamental incident reporting software on Fundamental site.
8. Patient Advocate enters the Incident into the Incident Reporting Module.
9. Patient Advocate then has the paper copy of the incident with supporting documentation filled in 3 ring binders for maintaining incident reports.
10. Incidents are filed in binder by date. The binder is kept in the DQM office when filing is completed.
11. Reports are maintained on site for 3 years and then filed and sent to Iron Mountain for a total of 7 years.

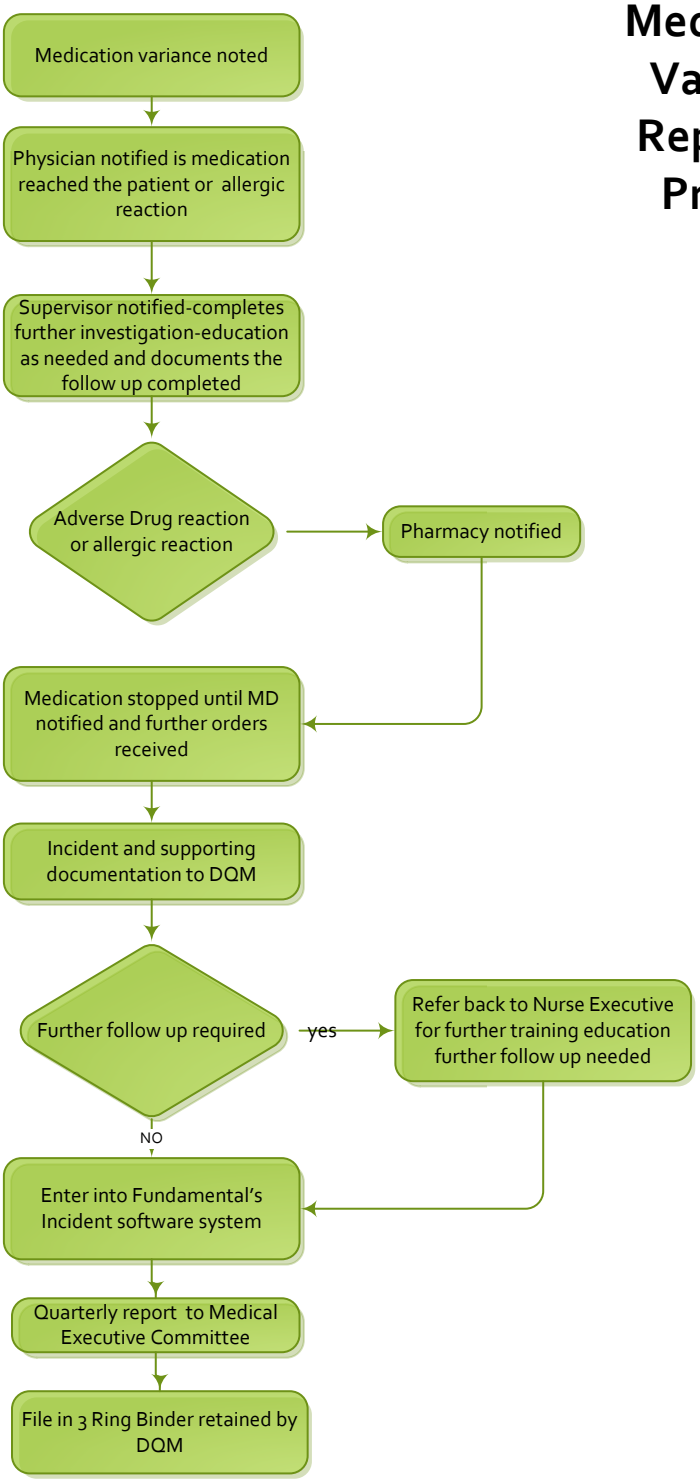
Incident Process Flow Chart



Incident Reporting Process
Medication Variances

1. Medication Variation is noted. (error, transcription error, medication not available, adverse drug reaction, etc.)
2. Individual noting the error completes the incident report.
3. Physician notified of medication error (only if wrong medication reached the patient, route, reached the patient or an obvious allergic reaction)
4. If the medication error reached the patient the physician notifies the patient, guardian or Power of Attorney of the error and any impact this had on the patient. This interaction must be documented in the patient's medical record.
5. Nursing Supervisor notified.
6. Nursing Supervisor investigates the medication variation issue and ensures all required follow up is completed.
7. Nursing Supervisor documents all and follow-up in a report to the nurse executive.
8. Staff education is completed at the time of the incident with the nurses involved. (Nursing Supervisor). Nurse Executive may do further education or further follow –up as appropriate at a later date.
9. Pharmacy is notified promptly for Adverse Drug Reactions and or allergic reactions.
10. Incident Report and all supporting investigative data are sent to the Director of Quality Management (DQM).
11. DQM will review medication variation, investigation and follow-up. Notifies the Nurse Executive if more follow-up or further investigation is needed.
12. DQM or designee enters the medication error into the Fundamental Corporate Software program.
13. Medication variations are reported to the Pharmacy and Therapeutics function at the Medical Executive Committee Quarterly.

Medication Variance Reporting Process



Appendix

Checklist and Action Plan for Safety

Process Change	In Place	Not done	Will adopt	Responsible-By when
Conduct Fall Risk Injury Assessment upon admission	✓			
Reassess risk daily and when change in condition occurs	✓			
Implement patient specific interventions to prevent falls/injuries	✓		improve	Nursing Educator Mar 2023
Communicate risk across the team, handoff forms, visual cues, huddles	✓		improve	Nursing Services Mar 2023
Rounds every 1-2 hrs for high-risk patients, address needs, (e.g. 4 Ps – pain- potty –position change pressure relief- personal needs) Combine w/ other tasks	✓		improve	Nursing Educator Mar 2023
Individualize interventions,. Use non-skid floor mats, float heels, hip protectors, individualized toileting schedule, adjust rounds to patient needs	✓			
Medication Review by pharmacy, avoid unnecessary hypnotics, sedatives				Pharmacy Department On-going
Multidiscipline input for falls	✓			On-going
Prevention measures from PT, OT, MD, RN, Pharm D	✓			Patient Safety Committee Review On-going
Include patients and families in efforts to prevent falls/injury. Educate regarding fall/injury prevention measures, stay with patient	✓			
Hold post-fall huddles immediately after falls, analyze how and why, implement changes in intervention to prevent further falls	✓		improve	Nursing Services/Nursing Educator

Reference: Checklist to Improve Patient Safety. June 2013 Health Research & Educational Trust

Action Plan for Improvement

Improvement item	Findings	Actions to be taken	Responsible - timeframe
Communicate risk across the team, handoff forms, visual cues, huddles	Information is communicated but forms would increase quality and accuracy of reports. Patient specific visual cues in place Huddles are not consistently conducted immediately post fall-no form utilized for consistent review. Analysis forms but are not conducted by team.	1. Fall investigation documentation reviewed by Nursing Management and Administration 2. Cues for staff on fall safety	Nursing Services Mar 2023
Rounds every 1-2 hrs for high-risk patients, address needs, (e.g. 4 Ps –pain- potty – position change pressure relief- personal needs) Combine w/ other tasks	Inconsistency in timeliness and consistency with 4 Ps	1. Reeducate to rounds process 2. Re-implement process 3. Measure and report compliance	Nurse Educator Mar 2023
Develop daily routine of activites out of bed, sensory stimulation, strengthening, and restorative services in highly monitored environment for high fall risk patients.	DayHab program	1. Re-start dayhab program for inpatient services for high fall risk patients. 2. Maintain social distancing and infection control procedures in program	Nursing Services

Compliance Checklist

Organization: _____ Department/Unit: _____
Date of Review: _____ Reviewer: _____

Environment of Care [CAH, HAP, NCC]

✔ **N/A**

☐ ☐ All equipment on one side of hall
☐ ☐ No equipment plugged in within hallways
☐ ☐ Nothing parked in hall longer than 30 minutes
☐ ☐ Top of linen cart covered; solid bottom on cart
☐ ☐ Nothing other than linen on linen carts

Clean Utility or Storage Room [AHC, CAH, HAP, NCC, OBS]

✔ **N/A**

☐ ☐ Oxygen tanks upright, in holder, full and empty tanks separated with signage
☐ ☐ Top of linen cart covered when not in use; solid bottom on cart
☐ ☐ Door to hall closed (not propped open)

Soiled/Dirty Utility Holding Room [AHC, BHC, CAH, HAP, NCC, OBS, OME]

✔ **N/A**

☐ ☐ Biohazard trash contained
☐ ☐ Nothing under sink

Housekeeping and Security [AHC, BHC, CAH, HAP, NCC, OBS]

✔ **N/A**

☐ ☐ Trash contained
☐ ☐ Drawers locked, as appropriate

Crash Cart [AHC, CAH, HAP, NCC, OBS]

✔ **N/A**

☐ ☐ Daily checklist completed
☐ ☐ No clutter on top
☐ ☐ Locked (including extra locks secured)
☐ ☐ No expired medications or supplies noted

Medication Carts/Storage Areas [AHC, BHC, CAH, HAP, NCC, OBS, OME]

✔ **N/A**

☐ ☐ No open single-use vials; all discarded after use
☐ ☐ Opened multidose vials dated
☐ ☐ MAR/eMAR closed when not in use
☐ ☐ Pill crushers/splitters cleaned
☐ ☐ All doors/drawers locked when unused

Medication Refrigerator/Freezer [AHC, BHC, CAH, HAP, NCC, OBS, OME]

✔ **N/A**

☐ ☐ Temperature checks completed; response to variances recorded

☐ ☐ Opened multidose vials dated
☐ ☐ Discharged patient medications managed
☐ ☐ No expired medications

Medications/Solutions [AHC, BHC, CAH, HAP, NCC, OBS, OME]

✔ **N/A**
☐ ☐ No unsecured medications, sharps, or syringes
☐ ☐ No expired medications or solutions
☐ ☐ No predrawn syringes

Point-of-Care Glucose Meters [AHC, BHC, CAH, HAP, NCC, OME]

✔ **N/A**
☐ ☐ Cleaned
☐ ☐ Controls and strips dated when opened
☐ ☐ QC performed, per manufacturer's guidelines

Patient Care [AHC, CAH, HAP, NCC, OBS]

✔ **N/A**
☐ ☐ All patients wearing correct ID band
☐ ☐ Fall-risk patients wearing bracelets; signage up
☐ ☐ Any nonambulatory patients (on gurneys or in wheelchairs) in hall covered with dignity
☐ ☐ Trays and snacks delivered
☐ ☐ Call lights functional and within patient reach
☐ ☐ Alarms answered
☐ ☐ Confirmed confidentiality of medical records
☐ ☐ Isolation precautions implemented if ordered
☐ ☐ Reviewed hand hygiene policy with staff and ensured sanitizer dispensers are full
☐ ☐ Reminded staff to perform time-out for any invasive procedures
☐ ☐ Reviewed medication administration with staff

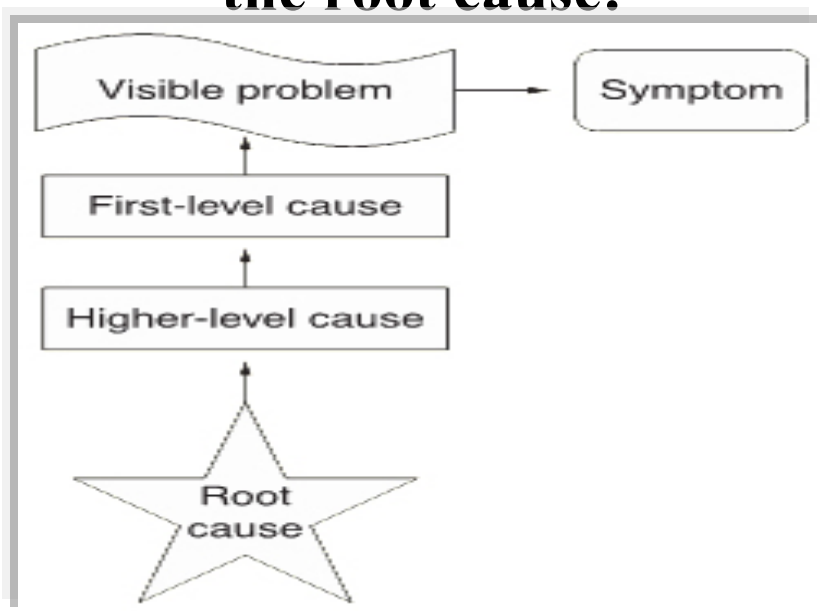
Chart Review (New Admits) [CAH, HAP, NCC]

✔ **N/A**
☐ ☐ Home medication record completed
☐ ☐ Administration database completed
☐ ☐ TO/VO/critical value documentation completed

Appendix 1

ROOT CAUSE ANALYSIS

The highest-level cause of a problem is called the root cause:



The root cause is "the evil at the bottom" that sets in motion the entire cause-and-effect chain causing the problem(s) and or adverse outcome.
Some root cause analysis approaches are geared more toward identifying true root causes than others; some are more general problem-solving techniques, while others simply offer support for the core activity of root cause
At the start of your fact finding team meeting list the sequence of events (flowchart) as they happened that lead to the problem, issues, or Sentinel Event.
If there is a defined procedure for the process that resulted in an adverse outcome list the sequence of steps in the approved procedure.
Compare the actual sequence of events to the steps outlined in the procedure. Identify any areas in the event sequence where approved procedure was not followed.
These areas may become the basis to develop a Cause and Effect Diagram to identify Root Cause.
Root causes analysis using the Cause and Effect methods.

Define the issue by its impact to overall goals. People often disagree over how to define the problem. You can get alignment when the problem is defined by the impact to the goals.

Why did it happen?

Break the problem down into a visual map. Using a Cause and Effect Diagram to provide a thorough explanation revealing all of the causes required to produce the problem.

What will be done?

Prevent or mitigate any negative impact to the goals by selecting the best solutions. Effective solutions should make a change to how people execute work process.

Better Communication, Better Analysis

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The Sequence of Events identifies areas needing more investigation.
The Cause and Effect Diagram creates a visual dialogue, making it easier to communicate what's known and what needs a little more digging.
People can see how all of the pieces fit together to produce a particular incident.
The better an organization gets at explaining its problems, the better it becomes at finding smart solutions.

How to Use the Cause and Effect (Fishbone) Tool for Root Cause Analysis

Overview:
Root cause analysis is a structured team process that assists in identifying underlying factors or causes of an adverse event or near-miss. Understanding the contributing factors or causes of a system failure can help develop actions that sustain the correction.
A cause and effect diagram, often called a "fishbone" diagram, can help in brainstorming to identify possible causes of a problem and in sorting ideas into useful categories. A fishbone diagram is a visual way to look at cause and effect. It is a more structured approach than some other tools available for brainstorming causes of a problem (e.g., the Five Whys tool). The problem or effect is displayed at the head or mouth of the fish. Possible contributing causes are listed on the smaller "bones" under various cause categories. A fishbone diagram can be helpful in identifying possible causes for a problem that might not otherwise be considered by directing the team to look at the categories and think of alternative causes. Include team members who have personal knowledge of the processes and systems involved in the problem or event to be investigated.

Directions:
The team using the fishbone diagram tool should carry out the steps listed below.
● Agree on the problem statement (also referred to as the effect). This is written at the mouth of the "fish." Be as clear and specific as you can about the problem. Beware of defining the problem in terms of a solution (e.g., we need more of something).
● Agree on the major categories of causes of the problem (written as branches from the main arrow). Major categories often include: equipment or supply factors, environmental factors, rules/policy/procedure factors, and people/staff factors.
● Brainstorm all the possible causes of the problem. Ask "Why does this happen?" As each idea is given, the facilitator writes the causal factor as a branch from the appropriate category (places it on the fishbone diagram). Causes can be written in several places if they relate to several categories.
● Again asks "Why does this happen?" about each cause. Write sub-causes branching off the cause branches.
● Continues to ask "Why?" and generate deeper levels of causes and continue organizing them under related causes or categories. This will help you to identify and then address root causes to prevent future problems.

Tips:
● Use the fishbone diagram tool to keep the team focused on the causes of the problem, rather than the symptoms.
● Consider drawing your fish on a flip chart or large dry erase board.
● Make sure to leave enough space between the major categories on the diagram so that you can add minor detailed causes later.
● When you are brainstorming causes, consider having team members write each cause on sticky notes, going around the group asking each person for one cause. Continue going through the rounds, getting more causes, until all ideas are exhausted.

● Encourage each person to participate in the brainstorming activity and to voice their own opinions.
● Note that the “five-whys” technique is often used in conjunction with the fishbone diagram – keep asking why until you get to the root cause.
● To help identify the root causes from all the ideas generated, consider a multi-voting technique such as having each team member identify the top three root causes. Ask each team member to place three tally marks or colored sticky dots on the fishbone next to what they believe are the root causes that could potentially be addressed.

Examples:
Here is an example of the start of a fishbone diagram that shows sample categories to consider, along with some sample causes.
Here is an example of a completed fishbone diagram, showing information entered for each of the four categories agreed upon by this team. Note, as each category is explored, teams may not always identify problems in each of the categories.
Facts gathered during preliminary investigation:
● Time of fall: change of shift from days to evenings
● Location of fall: resident’s bathroom
● Witnesses: resident and aide
● Background: the plan of care stipulated that the resident was to be transferred with two staff members, or with one staff member using a sit-to-stand lift.
● Information from interviews: the resident was anxious and needing to use the bathroom urgently. The aide was helping the resident transfer from her wheelchair to the toilet, without using a lift, and the resident fell, sustaining an injury. The aide stated she did not use the lift because the battery was being recharged, and there was no extra battery available. The aide stated she understood that the resident could be transferred with assist of one.

With this information, the team proceeded to use the fishbone diagram to better understand the causes of the event.
The value of using the fishbone diagram is to dig deeper, to go beyond the initial incident report, to better understand what in the organization’s systems and processes are causing the problem, so they can be addressed.

In this example, the root causes of the fall are:
● There is no process in place to ensure that every lift in the building always has a working battery. (One battery for the lift on this unit is no longer working, and the other battery was being recharged.)
● There is no process in place to ensure timely communication of new care information to the aides. (New transfer information had not yet been conveyed to the aide. The aide’s “care card” still indicated transfer with assist of one for this resident.)

The root causes of the event are the underlying process and system problems that allowed the contributing factors to culminate in a harmful event. As this example illustrates, there can be more than one root cause. Once you have identified root causes and contributing factors, you will then need to address each root cause and contributing factor as appropriate.

- **Root Causes are Identified**
- **Develop Action Plan for each Root Cause.**
- **Identify a Goal for each Root Cause.**
- **List the Steps needed to accomplish the Goal.**
- **What Resources are needed to complete the action steps?**
- **Who is Responsible for the Goal's steps?**
- **What is the anticipated Timeframe for completion?**
- **How will you Measure the effectiveness of the action steps?**

Planning is preparatory to action. Analytically at least, planning must be separated from implementation so that the major policy decisions can be taken and their implications understood prior to action

8 Steps to Develop a Plan for Action

1 Express your solution as a series of goals
Having agreed on a root cause to a particular problem within your organization, you first need to define that solution in terms of a goal. For example, each goal could be expressed as follows: "For us to ....., we would need to ....." Record each goal at the top of a whiteboard or sheet of paper

2 Generate a list of Actions for each goal
Use brainstorming to compile a list of actions to achieve a particular goal and record these below the goal. Arrange this list of suggested actions in sequential order. Include training and education, P&P changes, approvals.

3 Prepare a timeline
Beginning with a time point labeled "now" and ending with a point labeled "goal achieved", build a timeline on which you allocate dates by which you intend to complete each of the sequential actions listed under a particular goal. It is important that you get both sequence and timing right if you are to reach "goal achieved" effectively.

4 Allocate resources
Financial, physical and human resources must be allocated to each action step. If resources are limited, or fall short of requirements at any stage, it may be necessary to return to an earlier step and revise the action plan.

5 Identify possible problems
Consider all of the things that could go wrong in the process of achieving a particular goal. List these problems and identify causes and suitable actions to resolve them. If necessary, these actions might need to be added to appropriate slots in the timeline

6 Develop strategies for monitoring progress
List ways in which progress of the action plan can be monitored. These monitoring stages should also be included on the timeline.

7 Assign tasks
Take each point on the timeline in turn and ask : "Who will do what, by the date set, to bring about the specified action? Allocate these tasks to appropriate individuals or teams.

8 Implement the plan
Translate all your information to a clean copy, listing the actions required, the person responsible for a particular task, and when that task is to be completed. Having now finalized the plan for action in specific terms, this information can now be made available to all involved.

Corrective Action Plan			
Root Cause:			
Goal:			
Potential Obstacles:			
Action Steps	**Required Resources**	**Projected timeframes**	**Responsible**
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Corrective Action Plan			
Root Cause:			
Goal:			
Potential Obstacles:			
Action Steps	**Required Resources**	**Projected timeframes**	
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Executive Summary Report

Brief incident description: **Incident date:** **Incident type:** **Actual effect on patient and/or service:** **Actual severity of incident:**
Level of investigation conducted
Involvement and support of the patient and/or relatives
Detection of the incident
Care and service delivery problems
Contributory factors
Root causes
Lessons learned
Recommendations

Arrangements for sharing learning
Outcome of Measurement

_____ _____ _____

Name Title Date

Root Cause Analysis Investigation Report

Incident Investigation Title:	
Incident Date:	
Incident Number:	
Author(s) and Job Titles	
Investigation Report Date:	

Complete Report Below (include action plan and data collection tools)

FINDINGS:

Chronology of events

Chronology (timeline) of events	
Date & Time	**Event**

Detection of incident

Notable practice

Care and service delivery problems

Contributory factors

Root causes

Lessons learned

CONCLUSIONS:

Recommendations

Arrangements for Shared Learning

Distribution List

Appendices

Data Collection

Measure of Success Indicators	How data collected	By Whom	Timeframe	Follow up

Appendix

LINK TO SENTINEL EVENT REGISTRY TOOLKIT.
Use Control /enter while holding cursor over title below.

Access to the complete manual for using the registry and Redcap.

The Sentinel Event Registry Toolkit