North Vista Hospital DEPARTMENTAL POLICIES AND PROCEDURES				Page(s):	20
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GOVERNING BOARD APPROVAL		Date:		Revised:	03/21, 02/22

INTRODUCTION

North Vista Hospital (NVH) is committed to providing quality healthcare to all patients. The Patient Safety Plan serves as a framework to establish and maintain a safe patient care environment. It expands the organization -wide support for risk management, performance improvement, information management, education, human resources and patient's rights by implementing patient safety standards, measuring and monitoring their effectiveness, and creating a "culture of safety" as part of the overall quality program.

PURPOSE

1. Our goal is to establish a proactive approach to prevent patient injuries and other medical errors in an open and non-punitive environment. The Patient Safety Plan is to assure that a planned, systematic, coordinated approach exists to improve patient safety and reduce risk to patients through an environment that includes.
   - 1.1 Integration of all patient-safety activities both existing and newly created
   - 1.2 Identifies focus of accountability and support within the leadership of the organization
   - 1.3 Involves patients, their families, staff and leaders in the identification and management of actual and potential risks to patient safety as well as opinions, needs and perceptions of risks to patients and suggestions for improving patient safety
   - 1.4 Recognizes acknowledgment of risks to patient safety and medical / healthcare errors
   - 1.5 Initiates actions to reduce these risks
   - 1.6 Internally reports of what has been found and the actions taken
   - 1.7 Focuses on processes and systems rather than individual blame and retribution
   - 1.8 Ongoing proactive reduction in medical / healthcare errors
   - 1.9 Considers patient safety priorities in the design and redesign of all relevant organization processes, functions and services
   - 1.10 Communicates to patients and when appropriate to their families about the outcomes of care, including unanticipated outcomes
   - 1.11 Educates patients and families about their role in helping to facilitate the safe delivery of care
   - 1.12 Ongoing orientation, in-service and other education and training programs to emphasize specific job-related aspects of patient safety to maintain and improve staff competence.

2. The Patient Safety Plan involves all departments and disciplines at all levels of Hospital in establishing the processes and mechanisms that comprise the patient safety activities

through the recognition and acknowledgment of risks, preventive actions to reduce risk, internal reporting and corrective actions taken and fostering a non-punitive environment when errors occurs.

3. Proactive identification and management of potential risks to patient safety have the obvious advantage of *preventing* adverse occurrences, rather than simply *reacting* when they occur. This approach also avoids the barriers to understanding created by hindsight bias and the fear of disclosure, embarrassment, blame, and punishment that can arise in the wake of an actual event.

SCOPE OF ACTIVITIES

1. Hospital recognizes that patients, staff and visitors have the right to a safe environment. Therefore, the organization commits to undertaking a proactive approach to the identification and mitigation of medical errors through the integration into and participation of all components of the hospital into the hospital wide program. This includes Performance Improvement, Risk, Infection Control and Environment of Care (EOC) programs.

2. The Patient Safety Plan promotes the use of internal and external knowledge and experience to identify, analyze, and prevent the occurrence of medical / healthcare errors and identify areas of opportunity to maintain and improve patient safety.

3. Patient safety information will be analyzed from aggregated data reports. These reports will be reported to appropriate hospital and Medical Staff committees and to the Governing Board. The aggregate data will be used to prioritize organization-wide patient safety efforts.

4. The organization also recognizes that despite our best efforts, errors can and will occur. Therefore, it is the intent of the organization to respond quickly, effectively, and appropriately when an error does occur.

5. The organization also recognizes that the patient has the right to be informed of the results of treatment or procedures whenever those results differ significantly from anticipated results.

DEFINITIONS

Error	An unintended act, either of omission or commission, or an act that does not achieve its intended outcome. A failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim. Errors can include problems in practice, products, procedures, and systems.
Patient Safety	The degree to which the risk of an intervention and risk in the care environment are reduced for a patient while under the treatment of a healthcare provider or facility.
Patient Safety Event	Any identified defect, error, medical accident, near miss, sentinel event, medication error, significant procedural variance, or other threat to safety that could result in patient injury.

Medical Accident (Error)	An unintended event in the system of care with actual or potentially negative consequences to the patient. Types of medical errors: ▪ Diagnostic errors (misdiagnoses leading to an incorrect choice of therapy or treatment, failure to use an indicated diagnostic test, misinterpretation of test results, failure to properly act on abnormal test results) ▪ Equipment failures (defibrillator without working batteries, or inadvertent dosing of medications in a short time frame due to IV pumps with valves that are easily dislodged) ▪ Infections (HAI, post-op wound infections) ▪ Blood transfusion-related injuries ▪ Deaths due to seclusion / restraint use
Medical Accident, "near miss"	Any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome. May include a clinical event.
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 be a significant chance of serious adverse outcome.
Root Cause Analysis	A process for identifying the basic or causal factor(s) that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event.
Intensified Analysis	An examination of factors or elements that contribute to undesirable trends in performance to determine where best to focus changes for improvement.
Adverse Drug Event	A patient injury resulting from a medication, either because of a pharmacological reaction to a normal dose or because of a preventable adverse reaction to a drug resulting from an error.
Medication Error	Any preventable event that may cause or lead to inappropriate medication use or patient harm.
Hazardous condition	Any set of circumstances (exclusive of the disease or condition for which the patient is being treated) which significantly increased the likelihood of a serious adverse event.

AUTHORITY/ROLES & RESPONSIBILITY

1. Governing Board

1.1 The Hospital Governing Board has the ultimate authority and responsibility for approving the patient safety program. The Governing Board has delegated the responsibility of implementing an organization-wide patient safety program and creating a "culture of safety" to the leaders and medical staff of the hospital.

2. **Administrator / Chief Nursing Officer (CNO)**

2.1 The Administrator/CNO is responsible for assuring that this program is implemented, supported, and evaluated throughout the organization. As such, the

Administrator/CNO will establish the structures and processes necessary to accomplish this objective. The Administrator/CNO may delegate the day to day implementation and evaluation of this program to an appropriate staff leader who can operationalize this plan such as the Patient Safety Officer who may be supported by the Director/Manager, Performance Improvement.

3. Director/Manager, Performance Improvement, Patient Safety Officer and Infection Control Officer

3.1 The Patient Safety Officer is the Risk Manager at North Vista Hospital. The Patient Safety Officer is responsible for the day to day implementation and evaluation of the processes and activities noted in this program. The Patient Safety Officer will work collaboratively with the Director/Manager of Performance Improvement and the Infection Control Officer in establishing the Patient Safety framework and a culture of patient safety. The leadership including Senior Administration and the Chief of Staff will provide support as needed to assure the Patient Safety Plan is fully implemented and effective in positively impacting patient safety issues.

3.2 Patient Safety Officer Duties Include (As indicated in NRS 439.870):

a. Serve on the Patient Safety Committee (Chair of the Committee)
b. Supervise the reporting of all sentinel events alleged to have occurred at the medical facility, including, without limitation, performing duties required pursuant to NRS 439.835.
c. 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 medical facility.
d. Report to the patient safety committee regarding any action taken in accordance with number 3.2 c.

3.3 Other Duties shall include:

a. Supports Patient Safety Committee by collecting and formulating relevant information to facilitate decision-making activities.
b. Selects at least one high-risk patient safety process for proactive risk assessment (FMEA) at least every 12-18 months. Coordinates the process throughout this period.
c. Presents Patient Safety reports to all departments.
d. Develops, and recommends new policies and procedures for patient safety based on analysis of data from events, and other relevant information.
e. Works in conjunction with the EOC Chair to prioritize risks, review and analyze data and performs risk analysis as needed to address the safety of the patient environment.
f. Maintains the confidentiality and legal privilege, as appropriate, of all data and information.
g. Facilitates patient safety orientation and in-service education programs.
h. Measures and evaluates effectiveness of the patient safety program using the established goals and prepares an annual report for the Governing Board, which includes events related to staffing complement.
i. Assists department directors and administrators in enforcing policies and procedures, standards of care.

4. Directors and Managers

4.1 The leaders of the organization maintain responsibility for proper collection and dissemination of information for continuing education pertaining to the Patient Safety Program to employees.

4.2 The leaders create an environment that encourages prompt error identification and reduction and minimizes blame or retribution against individuals involved in an error or the reporting of an error.

4.3 The leaders provide direction and resources to conduct proactive correction and reversal of conditions and procedures that increase the chance that a patient might be harmed.

4.4 The leaders will collaborate in decision making which effects the development of hospital-wide patient care programs; policies and procedures that describe how patient care needs are met.

4.5 The leaders will assist in the development and implementation of the Hospital Plan for the Provision of Care, Performance Improvement Plan, Patient Safety Plan, Information Management Plan, decision-making structures and processes; and implementation of an effective and continuous program to measure, assess and improve performance and patient safety.

(Directors and Managers defined as those accountable for leadership, planning, organizing, developing, controlling, directing and evaluating care for designated departments – "Provision of Patient Care and Services".)

5. Medical Staff

5.1 The Chief of Staff and Department Chairs of the organized medical staff through the Medical Executive Committee and in collaboration with the leaders of the organization promote and support the patient safety initiatives of Hospital. (Medical staff defined as those physicians who have been granted recognition as members of the medical staff pursuant to the terms of the Medical Staff Bylaws.)

6. Quality Committee

6.1 Quality Management Committee is assigned to oversee Patient Safety Committee at North Vista Hospital. Duties include:

a. Review Patient Safety Dashboard for trends, performance and improvement and make recommendations where necessary.

b. Review, provide input and recommend approval of Patient Safety Plans & evaluations where necessary.

c. Review all sentinel event / root cause analyses and intensified analyses if/as requested by Patient Safety Committee.

d. Review risk assessments and FMEA and make recommendations where necessary.

7. Patient Safety Committee

7.1 The hospital has an organization-wide, integrated patient safety program which operates under the Patient Safety Committee. It is the responsibility of the Patient

Safety Committee to implement a hospital-wide patient safety program. The Patient Safety Committee is chaired by the Patient Safety Officer (Risk Manager) who is tasked to manage the day to day operations of the patient safety program.

7.2 The scope of the patient safety program includes the full range of safety issues, from potential or no-harm errors (sometimes referred to as near misses, close calls, or good catches) to hazardous conditions and sentinel events. All departments, programs, and services within the hospital participate in the patient safety program. As part of the patient safety program, the hospital creates procedures for responding to system or process failures.

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

a. Monitor and document the effectiveness of the patient identification policy.
b. On or before July 1st 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).
c. Receive reports from the patient safety officer pursuant to NRS 439.870.
d. 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.
e. At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the executive or governing body of the facility:
f. 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.
   - The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter).
   - The number and severity of infections that occurred at the facility during the preceding calendar month or quarter.
   - Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
g. Provide regular reports to the Quality Committee.
h. Implement and monitors the National Patient Safety Goals compliance within the facility.

OBJECTIVES AND GOALS FOR THE PATIENT SAFETY PLAN

1. **Goal 1** – Improve the following 3 Patient Safety Culture Domains:
   1.1 Staffing and Work Place 2022 Goal: 54% (scored 48% in 2021)
   Patient Safety Rating 2022 Goal: 65% (scored 31% in 2021)
   Organizational Learning – Continuous Improvement 2022 Goal: 51% (scored 39% in 2021)

2. **Goal 2** – Reduce the cumulative patientfall rate in 2022 from 2021 (2.96)
   2.2 Hospital Wide Performance Improvement Indicator.

3. **Goal 3** – Reduce number of hospital acquired conditions (HACs) in 2022 from

3.1 10 CAUTIs (Catheter -associated urinary tract infection)
3.2 5 CLABSIs (Central line- associated bloodstream infection)
3.3 4 C. Diff (Clostridium difficile) cases
3.4 1 SSI's (Surgical site infections)

COMPONENTS AND METHODLOGY

1. Pursuant to NRS 439.837, a medical facility shall, upon reporting a sentinel event pursuant to NRS 439.835, conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event."

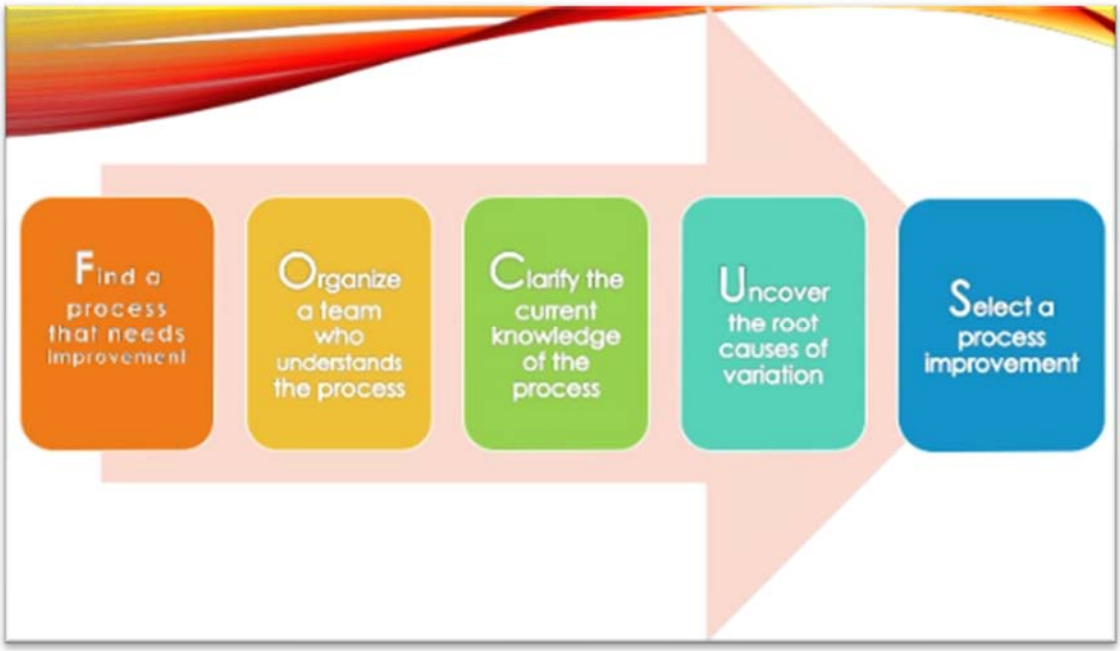
2. North Vista will use Root Cause Analysis (RCA) process to determine the contributing factors and the underlying reasons for the deficiencies or failures. The FOCUS PDCA (Find, Organize, Clarify, Understand, Select, Plan, Do, Check, Act) is the model which North Vista Hospital will use to test the changes.

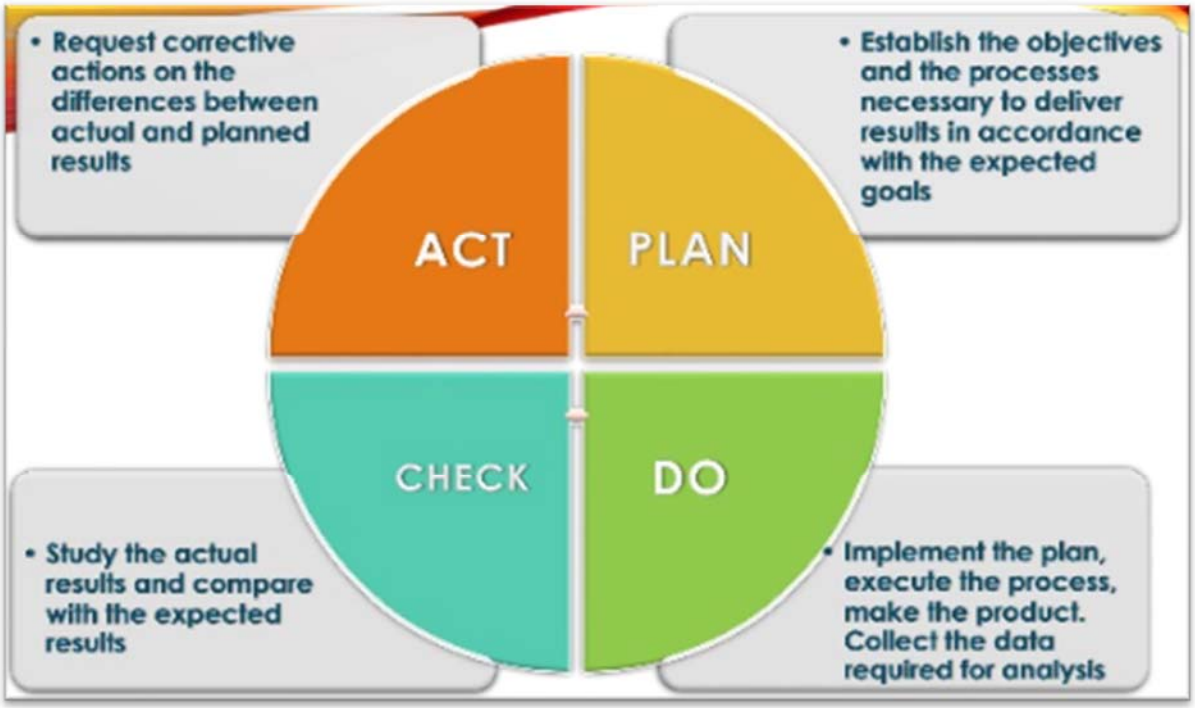
3. **Root Cause Analysis**
   3.1 A Root Cause Analysis (RCA) is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals. Before analyzing the

root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis. The attached forms in Attachment I and II will be utilized to conduct RCAs.

4. **Model for Improvement**

4.1 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.





4.2 This methodology will be accomplished utilizing the RCA forms attached in Attachment I. This methodology is also utilized in the Performance Improvement Plan to select Performance Improvement Indicators for each department.

DATA COLLECTION AND RISK ASSESSMENT

1. In order to reduce the likelihood of patient incidents and negative outcomes, North Vista Hospital will track the frequency and type of patient safety issues and compile them in order to learn from and prevent future negative occurrences. Examples of how the hospital collects and analyzes data is listed below.

1.1 Data Sources

a. Internal
- Risk incident reports with database compilation
- Adverse Drug Events and Adverse Drug Reactions
- Data from patient complaints
- Risk Management and Safety findings
- Compliance findings
- PI and special study findings
- Infectious Disease information
- Operative/Invasive procedures
- Departmental indicators
- Employee surveys (includes perception of risk)

b. External
- Core Measures Indicators
- Accreditation/regulatory deficiencies

- Patient Satisfaction Surveys
- Other Evidence-Based external sources

1.2 Risk Assessment (Failure Mode and Effect Analysis)
An assessment that examines a process in detail including sequencing of events; assesses actual and potential risk, failure, points of vulnerability; and through a logical process, priorities areas for improvement based on the actual or potential patient care impact (criticality).

1.3 Data Analysis
Analysis of collected data will be undertaken to monitor and identify levels of performance, trends or patterns that vary significantly from expected outcomes and the need for possible change/improvement in systems or processes.

1.4 Process Improvement
When undesirable outcomes are identified, the hospital shall involve the personnel, resources, disciplines, and department/services most directly involved with the process to reduce future risk.

1.5 FOCUS PDCA (Plan, Do, Check, Act) methodology for Performance Improvement will be utilized for all performance improvement activities within the facility. This methodology will not be used when conducting RCAs

PATIENT SAFETY CHECKLISTS & PATIENT SAFETY POLICIES

1. Per NRS 439.877, the patient safety plan must include the patient safety checklists and patient safety policies for use by:
   1.1 Providers of healthcare who provide treatment to patients at the facility;
   1.2 Other personnel of the facility who provide treatment or assistance to patients;
   1.3 Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
   1.4 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:
   1.5 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.
   1.6 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.
   1.7 A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
      a. Proper instructions concerning prescription medications;
      b. Instructions concerning aftercare;
      c. Any other instructions concerning his or her care upon discharge; and

d. Any other checklists which may be appropriate to ensure the safety of patients at the facility.

1.8 The patient safety policies must include, without limitation:

a. 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.

b. 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.

c. 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.

CULTURE OF SAFETY SURVEY

1. North Vista Hospital will utilize the Agency of Healthcare and Research Quality (AHRQ) research survey (Culture of Patient Safety Survey) that is intended to measure the ten dimensions of culture pertaining to patient safety:

1.1 Supervisor/manager expectations & actions promoting patient safety
1.2 Organizational learning – continuous improvement
1.3 Teamwork within units
1.4 Communication openness
1.5 Feedback & communications about errors
1.6 Non-punitive response to error
1.7 Staffing effectiveness
1.8 Hospital management support for patient safety
1.9 Teamwork across hospital units
1.10 Hospital handoffs & transitions

The results of the survey will be used by the Patient Safety Committee and/or Quality Committee to enhance the patient safety program at North Vista Hospital.

CONFIDENTIALITY

The proceedings and records of a patient safety committee are subject to the same privilege and protection from discovery as the proceedings and records described in NRS 49.265

PLAN EVALUATION

1. 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 set forth in this section. According to NRS 439.843, on or before March 1st of each year, a copy of the most current patient safety

plan (developed according to NRS 439.865) must be submitted to the Division of Public and Behavioral Health.

2. This plan encompasses many disciplines and activities in addition to those specifically referenced in the plan. The Patient Safety Plan is designed to assist in the integration of these activities, not replace them. Integration should enhance the accountability and impact of the patient safety related activities and collectively provide a comprehensive quality management system for North Vista Hospital.

3. The Patient Safety Plan should be considered a "working" document and an interim product to facilitate the development of a "culture of safety". As such, the plan may be modified as the implementation of the patient safety standards takes place and sections of the plan are incorporated into existing plans, policies, procedures, and protocols.

4. The Patient Safety Plan will be reviewed on an annual basis. Goals shall be identified and prioritized based on internal occurrences and trends, RCA, FMEA, survey results, sentinel events, State and Federal regulations, and other applicable patient safety issues and initiatives.

REFERENCES

Performance Improvement Plan
Infection Prevention and Control Plan
Environment of Care Plan
Plan for Provision and Patient Care Services
Title 40 – Public Health and Safetyhttps://www.leg.state.nv.us/NRS/NRS-439.html

Review/Revised Date:	By:	Description of Change or Location of Change in Document:
02/07/2022	CNO	Under Authorities & Responsibility 3. 3.2 updated NRS 839.870 to 439.870; #4, 4.5 deleted Risk Management Plan and replaced with Patient Safety Plan. Reviewed and approved by P&P as submitted.
02/09/2022	Performance Improvement	Updated objectives and goals for 2022 for the facility based on AHRQ Culture of Patient Safety Survey and HACs from 2021. Corrected a typo in the NRS referenced under Patient Safety Checklists and Patient Safety Policies.

ATTACHMENT I

DETERMINATION OF SEVERITY

Hospital Name:	**Date Identified:**

When Did the Event Occur?		
Date:	**Day of the week:**	**Time:**
Diagnosis:		

What **Type** of **Incident** is this? (See below for definitions)		
☐ **Error**	☐ **Near Miss / Hazardous Condition**	☐ **Sentinel Event**
Explain Error Type (based on definitions below):		

Identified How/Reported by Whom:	**Staff Witnesses:**

Who were the direct/indirect caregivers involved in the event? (use no personal identifiers, job titles only)

Brief Description (No names or other individual identifiers):

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 a serious adverse outcome.

Near Miss:

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

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 outcome.

ORGANIZATION OF THE TEAM

Team Leader:	**Team Meeting Date:**
	Date RCA / IA Completed:

Team Members:	**Job Title:**

Documents/Policies Gathered (include Timeline, Flowchart, etc.):	

UNDERSTAND THE CURRENT PROCESS

What was intended to happen, normally occur? (steps as defined by the policy, procedure)

What went wrong? (Easily identifiable, proximal causes) (Were there any steps in the process that did not occur as intended?)

ROOT CAUSE ANALYSIS

(Checkoff the appropriate sections. This is the ANALYSIS section where you document the drill down of the event. Remove items rows not applicable)

Process	Analysis
☐ **Behavioral Assessment Process:** Was patient's mood/ behavior approp assessed upon admission? Were potential mood/behavior problems identified approp/subsequently monitored? Were referrals made to physicians, Social Work, or Behavioral Health? Are current assmt. tools approp. measurement of mood/behavior?	
☐ **Physical Assessment Process:** Was patient approp. assessed upon admission or prior to their procedure? Was the patient approp. re-assessed throughout their stay? Were assessments done timely and according to policy? If conditions identified, did staff act approp. follow up, referrals, etc.?	
☐ **Patient Identification Process:** Was the patient approp. identified by an ID band or by other means? Are there deficits in the patient identification process that permitted the error to occur? Did the patient have approp. patient identifiers in place (i.e. ID bands, chart labels, etc.)?	
☐ **Patient Observation Procedures:** Was the patient approp. observed/monitored during their stay/procedure? Were conditions present that warranted increased observation/monitoring that were not identified by staff?	
☐ **Care Planning Process:** Was the patient's care planned approp.? Did the patient have a completed History and Physical? Was care deemed to be appropriate as planned? Was the outcome a complication despite appropriate care planning?	
☐ **Continuum of Care:** Was the outcome affected by a breakdown in the continuum of care? Was there a failure to provide adequate information/services from a prior caregiver or other discipline that contributed to the event? Were the appropriate referrals made according to the patient's assessment? Were the appropriate referrals completed?	
☐ **Staffing Levels:** Are staffing levels high enough to meet demand; limitations overtime? Agency/float staff in use? Are staff members approp. matched to assignments? How many continuous hours had the staff/physician involved been working?	
☐ **Orientation and Training Of Staff:** Is ongoing training available regarding the process involved in the event? Are employees oriented to the process involved in the incident? Are staff members aware of reference resources? If event involved a contingent or agency staff member, was orientation and training sufficient for the delivery of patient care?	
☐ **Competency Assessment/Credentialing:** Have staff completed orientation and training on the process involved? Is assessment of employee performance of this procedure part of the employee review process? When was last competency assessment completed? Need to repeat them? What the process involved a "core ability" of the staff member, if so, should competencies be considered? Include omissions in critical thinking and/or performance variance(s) from defined policy, procedure, protocol and guidelines in effect at time.	

☐ **Supervision of Staff:** Are supervisors readily available to both experienced and new staff? Are performance standards made clear? Are staff members observed in the performance of their daily work? Would direct supervision have resulted in a better outcome in this process?	
☐ **Communication with Patient/Family:** Was communication with the patient hindered in any fashion (i.e. a comatose or demented patient)? Was the family or significant other present to assist with the assessment process? Is the patient a reliable historian?	
Process	**Analysis**
☐ **Communication Among Staff Members:** Are instructions clear and precise: evaluation of verbal, written, electronic communication or the lack thereof? Timing factor? Handoff? Are human interactions free of intimidation and embarrassment? Was key information communicated from one caregiver to another as appropriate? Were appropriate referrals made?	
☐ **Availability of Information:** To what degree was all the necessary information available when needed? Accurate? Complete? Unambiguous? Does historical information include all pertinent information needed to facilitate care of the patient? Was the sharing of necessary information hindered due to technological reasons?	
☐ **Adequacy of Technological Support:** Did automation actually contribute to this event? Is the right equipment used for the task at hand? Is the equipment up-to-date? Are resources available to answer the operator's questions about the equipment? Does equipment design play a role in causing problems?	
☐ **Equipment Maintenance/Management:** Is machinery/equipment working properly? Are service guidelines being followed? Is backup equipment on hand? Biomed checks done?	
☐ **Physical Environment:** Current environment meets code? Do noise levels make it difficult for staff to communicate? Was there an environmental risk involved in the event that was not previously identified? Was location a factor in causing the event? Was the facility on any special status at the time (e.g. fire drill, Code Blue, etc.)?Lighting issues?	
☐ **Security Systems and Processes:** Were medications/equipment/supplies needed for the delivery of care secured properly? Were medications/equipment/supplies needed for the delivery of care able to be obtained. Was the safety and security of the patient/staff adequate? Were there deficits or breaches in security that contributed to the event?	
☐ **Control of Medications - Storage/Access:** Are medications stored properly? For example, are dangerous drugs stored away from patient-care units? Is storage set up to eliminate confusion? Is access to medications limited to the appropriate personnel?	
☐ **Labeling of Medications:** Are labels clear and legible? Do similarities in packaging cause confusion? Are labels read at least three times – when picking the medication, preparing the dose, and prior to administration?	

ADDITIONAL QUESTIONS
What uncontrollable external factors influenced this outcome? (Identify any factors the organization cannot change that contributed to a breakdown in the internal process, for example natural disasters).
Were there any other factors that directly influenced this outcome? (List any other factors not yet discussed).
What are the other areas in the organization where this could happen? (Ensure planned actions include addition areas as needed).
What barriers were in place but failed to stop the undesirable outcome? What barriers SHOULD have been place but were not to prevent the undesirable outcome?
What uncontrollable, outside factors directly affected the result?
What human factors were relevant to the outcome? (examples: fatigues, personal problems, in-attentional blindness/ confirmation bias, substance abuse)

Summary	YES	NO
1. Was the event caused by an inappropriate action?		
2. Do policies/procedures exist for the activities/tasks involved?		
3. Do the policies/procedures related to the tasks have sufficient detail?		
4. Do the policies/procedures have sufficient fail-safe mechanisms?		
5. Do the policies/procedures cover tasks in proper sequence?		
6. Did the time of day have an effect on the event?		
7. Did the event occur at shift change?		

What other pertinent issues were identified not already addressed in the minimum scope of investigation as listed above?

CONCLUSIONS

Pertinent Conclusions	
Proximal Cause (s)	
Systemic Deficiencies	

Improvement Opportunities identified: (add rows as needed)	
# 1.	
# 2.	
# 3.	
# 4.	
# 5.	

IONS

ACTION PLAN

*Method Key: **(A)** Policy **(B)** Education **(C)** Audit **(D)** Observation (add rows as needed)

#	Action Plan/Risk Reduction Strategies— Prevent Reoccurrence	*Method				Responsible Party	Target Date
		(A)	(B)	(C)	(D)		
1							
2							
3							
4							

Bibliography: Cite all books and journal articles that were considered in developing this root cause analysis and action plan.

DO NOT WRITE BELOW THIS POINT – RISK MANAGEMENT USE ONLY

Was the analysis completed within forty-five (45) days after determining that the occurrence is a sentinel event?			
☐ **Yes**	☐ **No**	**If NO, Explain:**	

Should this analysis be voluntarily reported to DNV?			
☐ **Yes**	☐ **No**	**Explain:**	

Action	Date

Date discussed in Performance Improvement / Quality Council:	

Performance Improvement Review:

Medical Staff Review:

Legal Services Review:

Final Disposition:	**Date:**

ATTACHMENT II

Minimum Scope of Root Cause Analysis for Specific Types of Sentinel Events

Detailed inquiry into these areas is expected when conducting a root cause analysis for the specified type of sentinel event. Inquiry into areas not checked (or listed) should be conducted as appropriate to the specific event under review.

ANALYSIS AREAS	EVENT TYPE									
	Suicide (24 hr care)	Med. Error	Proced. Cmplic.	Wrong site surg.	Treatmt Delay	Restraint Death	Elopement Death	Assault/ Rape/hom.	Transfusn Death	Infant abduction
Behavioral assessment process*	X					X	X	X		
Physical assessment process	X		X	X	X	X	X			
Patient identification process		X		X					X	
Patient observation procedures	X					X	X	X	X	
Care planning procedures	X		X			X	X			
Continuum of care	X				X	X				
Staffing levels	X	X	X	X	X	X	X	X	X	X
Orientation and training of staff	X	X	X	X	X	X	X	X	X	X
Competency assessment/ credentialing	X	X	X		X	X	X	X	X	X
Supervision of staff		X	X		X	X			X	
Communication with patient/family	X			X	X	X	X			X
Communication among staff members	X	X	X	X	X	X			X	X
Availability of information	X	X	X	X	X	X			X	
Adequacy of technological support		X	X							
Equipment maintenance/ management		X	X			X				
Physical environment	X	X	X				X	X	X	X
Security systems and processes	X						X	X		X
Control of medications: storage/access		X							X	
Labeling of medications		X							X	