Carson Tahoe Health System:

CTH PATIENT SAFETY PLAN

2023

February 2023

Carson Tahoe Health (CTH) 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, quality assurance performance improvement (QAPI), 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 safety program.

PURPOSE:

The purpose of this annual plan is to describe the components of the Patient Safety Program at Carson Tahoe Health for the purpose of improving and enhancing the health and safety of patients and employees in addition to reducing preventable patient safety events. The components are outlined in the following sections:

A. Patient Safety Program Scope and Purpose
B. Patient Safety Plan Annual Goals and Objectives
C. Patient Safety Program Organizational Structure & Responsibilities
D. Patient Safety Program Resources
E. Patient Safety Problem Identification, Notification & Resolution Process
F. Patient Safety Program Hospital Staff & Medical Staff Education
G. Patient Safety Program Patient & Community Education

POLICY:

1. The Patient Safety Plan is reviewed annually by the Patient Safety Committee and will include measurable objectives to meet Carson Tahoe Health's Annual Patient Safety Goals.

2. The Patient Safety Plan is approved by the Quality Management Committee, Medical Executive Committee, and the System Board of Directors Committee.

3. The Board of Directors delegates the responsibility for Carson Tahoe Health Patient Safety to the Medical Executive Committee and the Quality Management Committee.

4. 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.

5. According to NRS 439.843, on or before March 1 of each year, a copy of themost current patient safety plan established to NRS 439.865 must be submitted to the Division of Public and Behavioral Health.

6. Carson Tahoe Health leadership, with the Patient Safety Committee, routinely evaluates and reports to the Quality Management Committee, the Board Directors Committee, and the Board of Trustees the overall effectiveness of the Patient Safety Plan.

7. Hospital staff immediately reports an unusual occurrence and/or unexpected event that may affect patient safety and/or quality of patient care. (Refer to Sentinel Event Review Process, and the Event Reporting Policies)

8. Medical Staff officers, committees or sections identified in the Bylaws may access the event reporting system to identify situations that put patient safety and/or quality of patient care at risk.

9. 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.

PATIENT SAFETY PROGRAM:

A. Patient Safety Program Scope and Purpose

Carson Tahoe Health's mission is to enhance the health and well-being of the communities we serve. This includes a commitment to provide safe and high quality health care to all patients we serve.

The commitment to improving patient safety spans all services and levels of care. The Carson Tahoe Health's Patient Safety Program is an organization-wide program and encompasses all administrative, medical staff, nursing, and support activities.

The purpose of the Patient Safety Program is:

- To improve patient safety and reduce patient harm throughout the organization (CTH).
- To ensure that the Carson Tahoe Health Board of Directors, Medical Staff, Leadership and Staff consistently evaluate, monitor, improve, and document patient safety activities.
- To provide a mechanism to assist the organization (CTH) in accomplishing its strategic goals and objectives relative to the quality and safety of patient care.
- To assure that a planned, systematic and coordinated approach exist to improve patient safety and reduce risk to patients through a mechanism that encourages reporting of actual and potential adverse events, errors and near misses; and an environment that promotes a culture of safety.
- To minimize blame or retribution against staff involved in patient safety incidents and to emphasize identification of system and design flaws (the "how" of events/errors) and not on individuals (the "who" of events/errors).
- To ensure the Patient Safety Plan is integrated into the Quality Plan and into the organization's (CTH) strategic vision.

- To provide a meaningful monitoring tool for patient safety (scorecard/dashboard)

- To carry out a system of risk management and patient safety through early event identification (both actual and potential), assessment and resolution as it relates to clinical operations, business operations, and regulatory compliance.

B. Patient Safety Plan Annual Goals and Objectives

The overall purpose of the Plan/Program is to create a safe environment for patients/visitors/staff. To achieve this purpose, the program strives to meet or exceed the annual Patient Safety Goals and Objectives. (See Appendix B)

C. Patient Safety Program Organizational Structure & Responsibilities

Carson Tahoe Health's operational structure is aligned to meet the function of the Patient Safety Program. (See Appendix C) The goals and objectives of the Patient Safety Program are integrated into the functions of each of the following organizational / operational groups:

Board of Trustees (CTRH) and System Board of Directors (CTHS) Committees

It is the ultimate responsibility of the Hospital Board of Directors to ensure the quality and safe patient care throughout the organization. Key responsibilities of the governing board regarding Patient Safety are seen in activities such as:

- Critically examines organization (CTH) and medical staff processes to assure high standards
- Evaluates the practice of its Medical Staff members
- Reviews the Medical Staff Bylaws, Rules and Regulations
- Monitors the adequacy and appropriateness of Medical Staff processes
- Delegates oversight of patient care to the Medical Staff Per Nevada law
- Approves the Patient Safety Plan
- Reviews organization-wide performance on key indicators including sentinel/never events, and holds the Board, senior management, mid-level management and physician leadership, and frontline caregivers directly accountable for results.

Medical Executive Committee (MEC)

As delegated by the System Board of Directors, the Medical Executive Committee is responsible for Patient Safety. The key responsibilities of the MEC for Patient Safety include:

- Approves the Patient Safety Plan and provides subsequent recommendations for approval to the Board.
- Identifies opportunities to improve patient care, patient safety, and the hospital's performance. This responsibility is shared with the ELT and the QMC.

- Reviews Patient Safety activities and set priorities (in collaboration with Senior Leadership) for the Patient Safety Program.

Executive Leadership Team (ELT)

Executive Leadership Team responsibilities pertaining to Patient Safety include:

- Incorporates Patient Safety function into the Organization Strategic Plan.
- Reviews and approves the Patient Safety Plan as appropriate.
- Fosters a culture of safety in which staff is encouraged to identify and communicate opportunities for improvement, report patient safety risks, disclose significant process/ protocol variances ("near misses"), and participate in performance improvement activities.
- Ensures that processes are in place for communicating relevant Patient Safety information throughout the hospital
- Identifies opportunities to improve Patient Safety. This responsibility is shared with the MEC and the QMC.
- Allocates sufficient resources needed to improving Patient Safety, including training as and when appropriate.
- Evaluates the culture of safety and quality every two (2) years using valid and reliable tools and uses the results to create a culture of safety and quality.

Quality Management Committee (QMC)

Responsibilities of the QMC include, but are not limited to the following activities:

- Review relevant Patient Safety data and identify opportunities to improve Patient Safety. This responsibility is shared with the MEC, ELT, and Patient Safety Committee.
- Provides direction for addressing Patient Safety issues and monitors implementation of corrective Patient Safety events.
- Reviews actions plans resulting from teams for intensive assessment of adverse events and/or RCA (sentinel event or near misses).
- Reviews and evaluates reports regarding the progress and effectiveness of Patient Safety improvement activities.
- Ensures that Patient Safety is incorporated in the design of processes, functions, and services.
- Make recommendations to eliminate future Patient Safety events.

Patient Safety Committee

- Oversees key Patient safety activities which include approving, prioritizing, and operationalizing the plan.
- Reviews and evaluates Patient Safety Plan annually and provides its subsequent recommendation(s) for approval to the Quality Management, MEC, ELT and the Board as appropriate.

- Manages the flow of information to ensure follow up and organizational learning including the reporting system for reporting of Patient Safety events by health care practitioners, employees, patients and visitors.
- Champions patient safety and assures compliance with patient safety initiatives.
- Recommends education and monitoring plans for CIHQ Targeted Quality & Safety Practices.
- Works together with Risk Management and Medication Safety Team to review reported errors and near miss and recommends action plans to for patient safety improvements.
- Reviews Sentinel Event Alert and recommends plans for process improvement and compliance.
- Promotes patient safety awareness throughout the organization (CTH).
- Oversee the completion of a proactive risk assessment as appropriate at 18 month intervals.
- Reports activities to QMC and ELT as appropriate.

Medical Staff Leadership

The Medical Staff supports Patient Safety through the following:

- Incorporates hospital patient safety goals into various section, committee and department meetings as appropriate.
- Participates in educational and other collaborative activities (Proactive Risk Assessment, RCA, and PI etc.).

Hospital Leadership/Staff

To achieve the goal of delivering safe, high quality care, employees are given the empowerment with responsibility and authority to actively participate in the Carson Tahoe Health's Patient Safety Program.

CTH uses frontline department level resources, or "quality/safety champions (such as Unit Based Council, Nursing Practice Council, and Education Council)" to support additional education, raise awareness, and to provide feedback on patient safety issues and the effectiveness of our patient safety program. Accurate, Analyzed, and Timely data as requested by the Organization Patient Safety Program.

D. Patient Safety Program Resources

Designated resources are provided to assist the organization to meet the goals and objectives of the Patient Safety Program and to facilitate the implementation of the Patient Safety Plan.

The Quality Management, Risk Management, Nursing and other appropriate ancillary services are the primary sources of support for patient safety improvement activities within Carson Tahoe Health. These departments include data analysis, project managers and registered nurses, to assist with the integration of data management, clinical processes, and patient outcomes. The Organization ELT & Patient Safety Officer are the designees for

Carson Tahoe Health and are responsible for the coordination and implementation of the Patient Safety Plan.
Other major support areas for patient safety include CTH Infection Prevention & Control, Clinical Nurse Specialists/Educators, Risk Management, system & Patient Safety Committee, Medical Staff, and Executive Management.

Carson Tahoe Health is committed to providing psychological support to staff involved in serious patient safety events or critical/sentinel events. Sources of support include:

- Human Resources
- Employee Assistance Program
- Clinical Social Work Department
- Chaplain
- Rights and Ethics Committee
- Quality Management Committee

E. Patient Safety Problem Identification, Notification & Resolution Process

When a situation occurs that may risk patient safety, CTH staff immediately reports an unusual occurrence and/or unexpected event using any of the following reporting mechanisms:

- Event Report
- Notification to department Manager/Supervisor/Director
- Notification to Patient Safety Officer
- Notification to Compliance/Risk
- Notification to Quality Management

When a situation arises that requires immediate response to a patient safety event, the staff takes appropriate action to prevent further harm to patient, communicates with the physician, patient and/or patient's family and immediately notifies the Nursing/Administrative Supervisor, Risk Management and Patient Safety Officer.

Carson Tahoe Health also conducts proactive Patient Safety risk reduction measures, which include identifying high risk processes and use of the Proactive Risk Assessment.

Once a Patient Safety issue is identified, it is evaluated, prioritized, managed and resolved through the Hospital's organizational structure for Patient Safety/Quality Improvement. (Refer to the Quality Performance Improvement Plan for details of the process.)

F. Patient Safety Program Hospital Staff & Medical Staff Education

Carson Tahoe Health communicates patient safety information throughout the organization. Examples of communication methods include:

- Posters in key locations
- Employee and Medical Staff newsletters
- Patient Safety Awareness Events
- National Patient Safety Week
- Leadership, medical staff and employee meetings
- SharePoint Intranet Portal
- Quality/Safety Champions

Education programs are designed and provided to the hospital staff upon hire and on an ongoing basis to provide timely information regarding Carson Tahoe Health's Patient Safety Program, its annual goals and objectives and its accomplishments.

Ongoing education is provided through various mechanisms such as but not limited to:

- In-service training to increase knowledge of patient safety requirements.
- In-service training to encourage reporting of unanticipated adverse events and near misses
- Educational updates addressing patient safety issues, including Sentinel Event Alerts
- Patient Safety Awareness activities
- Annual update training
- Quality/Safety Champion Program Activities
- Computer based learning modules (Relias)
- Unit Based Councils
- Nursing Practice Council

G. Patient Safety Program Patient & Community Education

Patients are given information about their rights and responsibilities while receiving hospital services. Patients and, when appropriate, their families are informed about the outcomes of care, treatment, and services, including unanticipated outcomes. Patients also are given patient safety awareness materials.

H. Reporting Medical/Healthcare Errors

Carson Tahoe Health endeavors to create an environment in which it is safe for all to report and learn from errors. To promote openness/transparency, CTH shall ensure that all reported errors be handled without threat of punitive action; recognizing that most clinical incidents result from a failure of systems.

All incidents, especially clinical errors must & shall be reported immediately:

ADVERSE/NEVER EVENTS: The Hospital Never Events will be managed following the principles of the Leapfrog Policy and NRS 439.835

- CTH will apologize to the patient and/or family affected by the never event
- CTH will report the event to at least one of the following external agencies within 13 days of becoming aware that the never event has occurred:

- State reporting program for medical errors
- Patient Safety Organization (as defined in the Patient Safety and Quality Improvement act of 2005)

- CTH agrees to perform a root cause analysis, 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."
- CTH will waive all cost directly related to a serious reportable adverse event
- CTH will make a copy of this policy available to patients, patient's family members, and payers upon request.
- Following the new Leapfrog approaches to performing root cause analysis to further ensure that patients and families, as well as caregivers receive appropriate follow-up if a never event occurs:
- CTH will interview patients and/or families who are willing and able, to gather evidence for the root cause analysis.
- CTH will inform the patient and/or his/her family of the action(s) that our hospital will take to prevent future recurrences of similar events based on the findings from the root cause analysis.
- CTH will have a protocol in place to provide support for caregivers involved in never events, and make that protocol known to all caregivers and affiliated clinicians.
- CTH will perform an annual review to ensure compliance with each element of Leapfrog's Never Events Policy for each never event that occurred.

THE 29 NEVER EVENTS

Surgical Events:

1. Surgery or other invasive procedure performed on the wrong site
2. Surgery or other invasive procedure performed on the wrong patient
3. Wrong surgical or other invasive procedure performed on a patient
4. Unintended retention of a foreign object/body in a patient after surgery or other invasive procedure
5. Intraoperative or immediately postoperative/post procedure death in an ASA Class patient

Product or Device Events:

6. Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting
7. Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended
8. Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting

Patient Protection Events:

9. Discharge or release of a patient of any age, who is unable to make decisions to other than an authorized person/care taker
10. Patient death or serious injury associated with patient elopement (disappearance)
11. Patient suicide, attempted suicide, or self-harm that results in serious injury while being cared for in a healthcare setting

Care Management Events:

12. Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)
13. Patient death or serious injury associated with unsafe administration of blood products
14. Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting
15. Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy
16. Patient death or serious injury associated with a fall while being cared for in a healthcare setting
17. Any Stage 3, Stage 4, and Unstageable pressure ulcers acquired after admission/presentation to a healthcare setting
18. Artificial insemination with the wrong donor sperm or wrong egg
19. Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen
20. Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results

Environmental Events:

21. Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting
22. Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or is contaminated by toxic substances
23. Patient of staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting
24. Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting

Radiologic Events:

25. Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area

Potential Criminal Events:

26. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider
27. Abduction of a patient/resident of any age
28. Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting
29. Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting

REFERENCES:

1. CIHQ – 2023 Targeted Patient Quality & Safety Practices
2. The Leapfrog Group 2023 Hospital Survey (Section 7) Recommendation on Managing Serious Errors – Never Events Policy Statement
3. NV NR Health and Safety)
4. CTH Policies
   - Event Reporting: Involving Patients, Visitors and Other
   - Event Review
   - Quality Performance Improvement Plan (QAPI)

APPENDICES:

A. 2023 CIHQ Targeted Patient Quality & Safety Practices
B. 2023CTH Patient Safety Plan Goals and Objectives
C. Patient Safety Program Organizational Chart
D. Patient Safety Checklist

APPROVALS

_____ _____
Director Quality and Outcomes Management Date

_____ _____
System Patient Safety Officer Date

_____ _____
Chair Quality Management Committee Date

_____ _____
VP / Associate Nursing Officer Date

_____ _____
VP / Chief Medical Officer Date

_____ _____
Chair CTHS Board of Directors Date

Appendix A

CIHQ TARGETED PATIENT QUALITY & SAFETY PRACTICES

QS-1: Fall Management Program
QS-2: Pain Management

- For **inpatient** care settings:
- For **outpatient** settings:

QS-3: Provision of Interpretive / Translation Services
QS-4: Verbal / Telephone Orders
Verbal (in-person) / telephone orders pose an increased risk of miscommunication that could contribute to a medication or other error, resulting in a patient adverse event.
QS-5: Resuscitative Services
QS-6: Patient / Family Education
Patients receive the education necessary to effectively participate in their care.
Note: When appropriate, this standard applies to the patient's family and/or significant others
QS-7: Accuracy in Patient Identification
QS-8: Critical Test Results

- Critical results of laboratory and other diagnostic tests are acted upon in a timely manner

QS-9: Safe Management of Clinical Alarms
The organization assures that alarms on equipment and devices designed to alert staff of a life threatening – or potentially life threatening – patient condition are safely managed
QS-10: Protecting Patients from Self-Harm
The organization develops and implements processes to protect patients who are identified as being at risk of self-harm.

ASSESSMENT & CARE OF PATIENTS IN AN INPATIENT BEHAVIORAL HEALTH UNIT

ASSESSMENT & CARE OF PATIENTS IN AREAS OTHER THAN AN INPATIENT BEHAVIORAL HEALTH UNIT
Note: These requirements apply to patients with a complaint of, or being treated for, an emotional or behavioral disorder
ASSESSING ENVIRONMENTAL RISK
STAFF TRAINING

- Training is provided upon hire and at least every two years thereafter.

Appendix B

2023 Carson Tahoe Health (CTH) Patient Safety Plan Goals and Objectives

1. Ensure the adherence to CIHQ and state and federal regulatory standards as a baseline of Quality / Patient Safety including compliance set forth under State Patient Licensing (Nevada Safety Code).

2. Ensure each CIHQ Quality & Safety standards are met and evaluated.

3. Ensure alignment with Quality Assurance Performance Improvement Plan.

4. Ensure all adverse events or potential adverse events as described in NRS 439.805 and NRS 439.830 the Section Nevada Health and Safety Code, that are determined to be preventable, and hospital-acquired conditions (HACs), as defined by NQF and CMS, that are determined to be preventable are tracked, reported as needed and evaluated.

5. Evaluate and address Serious Safety Events/Sentinel Event Alerts through multidisciplinary approach.

6. Improve patient safety through use of PI/Six Sigma teams, Proactive Risk Assessment teams and Root Cause Analysis (RCA) teams.

7. Promote a non-punitive and blame-free culture of safety that encourages reporting of errors and near misses.
    a. To minimize blame or retribution against staff involved in patient safety incidents and to emphasize finding system and design flaws and not on individuals.
    b. Complete a Culture of Safety Survey as appropriate and necessary.

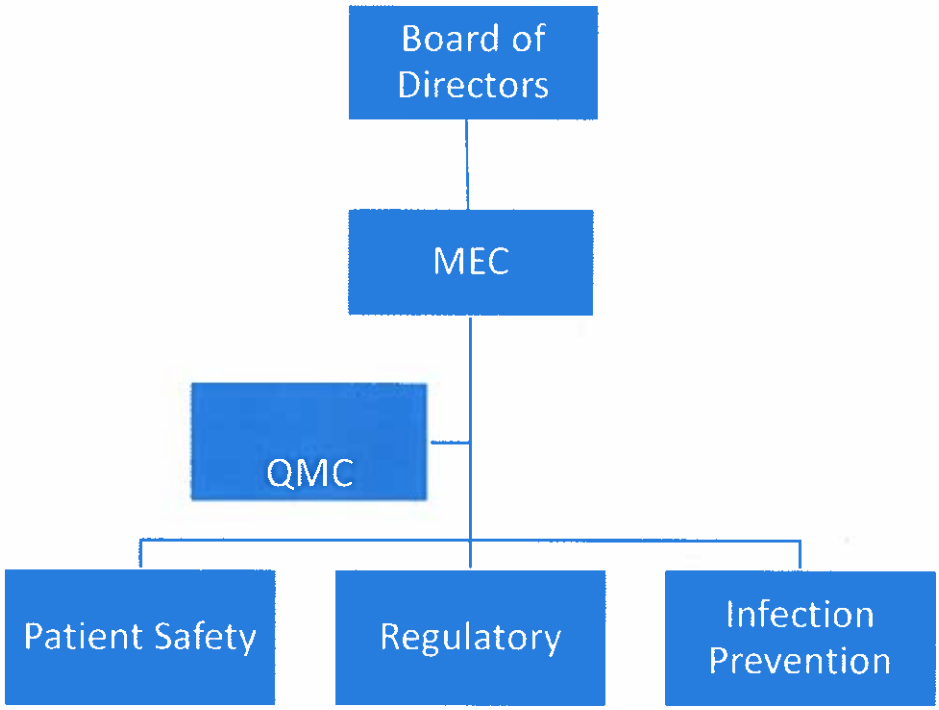
8. Improve patient safety awareness among our employees, medical staff, patients, and the community (patients).

9. Improve the reporting and analysis process for occurrences and near misses.
    a. Continue focused initiative to raise awareness about the importance of reporting near miss events.

10. Promote and collaborate with Quality Management, Nursing, Medical Staff in integration and prioritization of patient safety initiatives by assessing available data from the following resources on an ongoing basis:
    a. Core Measures, Leapfrog/National Quality Forum measures, IHI Adverse Drug Event and Mortality Reduction projects, PI Teams, Proactive Risk Assessment and Root Cause Analysis (RCA) teams, event reporting, claims, patient experience data, and Patient Grievances & Complaints.

11. Evaluate and identify opportunities for improvement regarding medication management and patient safety.

12. Support the Medication Safety Team in identifying medication safety related issues, prioritizing medication safety improvements, developing action plans and monitoring tools and implementing change.

13. Complete a proactive risk assessment as appropriate.

Appendix C
Patient Safety Reporting Structure (Org Chart)