Patient Safety Plan

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I. Introduction

Purpose, Scope and Responsibility

- ✓ Purpose:
  - To define the essential components of the Patient Safety Program at Southern Hills Hospital, which is committed to ensuring a safe environment and reliable care processes.
  - To cultivate a culture of patient safety through the ongoing promotion of a safe practices and personal accountability.
- ✓ Scope: Patient safety is everyone's responsibility. The Southern Hills Hospital Patient Safety Program covers all activities and functions relating to patient safety at all sites and services within the organization.
- ✓ Responsibility: Leaders, employees, members of the medical staff, students and volunteers are to be familiar with and involved in the Patient Safety Program.

Participation in Patient Safety Organization

- ✓ Southern Hills Hospital is committed to an organizational environment aimed at improving patient safety and the quality of healthcare provided to the Hospital. To further this objective, the Hospital contracted with HCA Patient Safety Organization, LLC ("HCA PSO, LLC"), a federally certified Patient Safety Organization ("PSO"), to receive assistance in conducting a wide variety of patient safety activities intended to reduce medical errors in a legally protected environment.
  Generally speaking, patient safety work product ("PSWP") is not subject to subpoena or discovery in state or federal court, in administrative proceedings, or pursuant to the Freedom of Information Act ("FOIA"), and cannot be disclosed except as permitted under the Patient Safety and Quality Improvement Act ("PSQIA") and its associated regulations. *(See 42 CFR § 3.204, Privilege of patient safety work product; and 42 CFR § 3.206, Confidentiality of patient safety work product.)*
  The Hospital will be receiving and exchanging patient safety information with the PSO, including event or incident reports and investigations, analytic tools such as root cause analyses, patient safety communications, quality reviews, and other documents aimed at improving patient safety. Documents will be submitted in a standardized format to allow for comparison with like providers. As part of this effort, the Hospital will operate a Patient Safety Evaluation System ("PSES") designed to encourage internal reporting of adverse events, near misses, and unsafe conditions for purposes of reporting to HCA PSO, LLC. The PSES will be the vehicle for collecting, managing, and analyzing information for patient safety purposes. Designated Hospital personnel will collect patient safety information and report it to HCA PSO, LLC on an ongoing basis for analysis and feedback.

Definition of Terms

Adverse Event:	A consequence of care that results in an undesired outcome.
CSIP:	THe Clinical Safety Improvement Plan (CSIP) offershospitals the opportunity to voluntarily develop and implement specific patient safety initiatives focused on issues identified by the evaluation of close call, adverse events, and current hospital clinical performance metrics. The program aims to reduce incidence of adverse events, reduce patietn harm, and promote the development of competency of patient safety leadership. HCAPSO will guide hospitals in the submission of required program deliverables and will communicate completion results to the facilities
Healthcare FMEA:	Healthcare Failure Mode and Effects Analysis: A proactive model for addressing potential risks within the organization.
Human Error:	An unintended act, or failure to act, that results in actual or potential patient injury, harm or adverse event in the process of care delivery.
Near miss:	Any process variation that did not affect the patient outcome, but for which a recurrence carries a significant chance of serious adverse outcome.
Non-punitive:	No punishment or disciplinary action imposed for specific error.
Patient injury:	Physical damage that substantially limits one or more of the major life activities of an individual

in the short term, which may become a disability if extended in the long term

Level of Harm:

1. None- unsfate situation
2. Minor- Monitoring
3. Moderate- Treatment required
4. Major- Increased Length of Stay
5. Catastrophic- Critical Care
6. Interventions to sustain life
7. Death

Patient safety event: All adverse events or potential adverse events that are deemed preventable and Healthcare associated infections as defined by the CDC that are deemed to be preventable.

PSQIA The Patient Safety and Quality Improvement Act (PSQIA) of 2005, Pub. L. 109-41, 42 U.S.C. 299b-21-b-26 (for which the final rule implementing the regulations became effective on January 19, 2009), was enacted in response to growing concern about patient safety in the United States and the Institute of Medicine's 1999 report, *To Err is Human: Building a Safer Health System*. The goal of the Act is to improve patient safety by encouraging voluntary and confidential reporting of events that adversely affect patients.

PSO A Patient Safety Organization (PSO) means a private or public entity or component thereof that is listed as a PSO by the Secretary of Health and Human Services. A health insurance issuer or a component organization of a health insurance issuer may not be a PSO. The PSO enters into bona fide contracts, each of a reasonable period of time,

each with a different provider for the purpose of receiving and reviewing patient safety work product.

PSES

A Patient Safety Evaluation System (PSES) means the collection, management, or analysis of information for reporting to or by a PSO.

PSWP

Patient Safety Work Product (PSWP) (1) Except as provided in (2) below, patient safety work product means any data, reports, records, memoranda, analyses (such as root cause analyses), or written or oral statements (or copies of any of this material) (i) Which could improve patient safety, health care quality, or health care outcomes; and (A) Which are assembled or developed by a provider for reporting to a PSO and are reported to a PSO, which includes information that is documented as within a patient safety evaluation system for reporting to a PSO, and such documentation includes the date the information entered the patient safety evaluation system; or (B) Are developed by a PSO for the conduct of patient safety activities; or (ii) Which identify or constitute the deliberations or analysis of, or identify the fact of reporting pursuant to, a patient safety evaluation system. (2)(i) Patient safety work product does not include a patient's medical record, billing and discharge information, or any other original patient or provider information; nor does it include information that is collected, maintained, or developed separately, or exists separately, from a patient safety evaluation system. Such separate information or a copy thereof reported to a PSO shall not by reason of its reporting be considered patient safety work product. (ii) Patient safety work product assembled or developed by a provider for reporting to a PSO may be removed from a patient safety evaluation system and no longer considered patient safety work product if: (A) The information has not yet been reported to a PSO; and (B) The provider documents the act

and date of removal of such information from the patient safety evaluation system. (iii) Nothing in this part shall be construed to limit information that is not patient safety work product from being: (A) Discovered or admitted in a criminal, civil or administrative proceeding; (B) Reported to a Federal, State, local or Tribal governmental agency for public health or health oversight purposes; or (C) Maintained as part of a provider's recordkeeping obligation under Federal, State, local or Tribal law.

Reliability: The extent of consistent performance over time.

Safety Culture: The safety culture of a hospital is the product of individual and group beliefs, values, attitudes, perceptions, competencies, and patterns of behavior that determine the organization's commitment to quality and patient safety. (TJC)

Sentinel Event: A patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in death, permanent harm, and/or severe temporary harm (TJC, 2020). (A permanent loss of function related to the natural course of the patient's illness or underlying condition is not a Sentinel Event.) The State of Nevada defines a sentinel event as an event included in Appendix A of "Serious Reportable Events in Healthcare – 2011 Update: A Consensus Report," published by the National Quality Forum (Nevada Revised Statutes NRS §439.830 – (2015).

Unusual Occurrence: Any event or condition not consistent with the normal or usual operation of the hospital or department and which has the potential for causing patient or visitor injury or property damage.

II. Policy

The Board of Trustees delegates responsibility for oversight of the patient safety program to the Patient Safety Committee. Patient Safety Committee monitors and evaluates the effectiveness of the Patient Safety Program and generates feedback and actions as appropriate. Patient Safety Committee prepares a quarterly report to the Quality Care Committee who then reports to the ~~Quality Care Committee,~~ Medical Executive Committee (MEC)~~,~~ and the Board of Trustees (BOT). The report includes at a minimum, occurrence or trending of patient safety indicators and actions taken in response to actual occurrences as well as proactive assessments of high-risk activities. The Patient Safety and Environment of Care Committee oversees non-clinical safety related processes and system issues that affect patients, employees, and visitors in the environment of care.

Patient Safety and Risk Management maintains the hospital-wide occurrence reporting system for patients, employees, and visitor occurrences and a referral system for hospital staff and physicians to report potential claims. Risk Management in conjunction with Hospital Quality and Patient Safety Leaders investigate actual and potential safety risk within the organization. They also evaluate occurrences to identify those that may require immediate follow up actions or meet the Sentinel Event, the Safe Medical Device Act, or regulatory agency reporting criteria, including CMS, FDA, OSHA, State of Nevada DHHS, or Joint Commission. Notification is made to Administration, Risk Management, appropriate regulatory and accrediting agencies, equipment manufacturers and other appropriate individuals as necessary.

The Organization ensures timely coordination and dissemination of reporting and data management of patient safety information at the appropriate medical staff/organizational committees for review and discussion.

III. Culture of Safety

Southern Hills Hospital is committed to creating a culture of safety by designing or redesigning systems and processes geared to prevent, detect, and minimize the hazards and likelihood of error; as well as a continuous approach to the improvement of patient safety. Southern Hills Hospital is focused on prevention, not blaming individuals with a just culture approach. Patient safety events are viewed as an opportunity to learn. The Hospital believes in balancing the organization's accountability and the individual's accountability for assuring safe practices and a safe environment to care for patients.

IV. Structure, Roles and Responsibilities

The philosophy guiding the promotion of a culture of patient safety is accountability. To achieve a culture of patient safety the following accountabilities are expected at Southern Hills Hospital:

Role	***Accountability***	***Specific Tasks***
Board of Trustees, with Senior Leadership	Set goals, monitor performance & require accountability.	• Receive regular and thorough reports on patient safety risks, hazards and progress towards performance improvement objectives from the MEC and Quality Care/ Patient Safety Committee. • Receive regular and thorough briefings regarding the results of culture measurement and performance improvement initiatives • Require multi-cause analysis of errors that lead to injury. • Set performance improvement goals for safety improvement. • Hold hospital leaders accountable for achieving the integrated patient safety agenda. • Receive systematic and regular assessment of resource and budget allocations to key systems (patient safety systems, human resources, quality systems, technology) related to the patient safety agenda.
Administrative (CEO, COO, CNO, VP's, Directors, & Physician Leaders	Set the agenda for the rest of the team	• Ensure that an integrated patient safety program is implemented throughout the hospital. • Set performance improvement priorities and identify how the hospital adjusts priorities in response to unusual or urgent events. • Allocate adequate resources for measuring, assessing and improving the hospital's performance and improving patient safety. • Measure and assess the effectiveness of the performance improvement and safety improvement activities. • Monitor implementation for of corrective action of patient safety events. • Ensure remedial activities, identified through analysis of reported patient safety events, are implemented, effective, and do not cause unintended adverse consequences. • Develop a proactive approach to reducing errors. • Encourage an environment of openness & collaboration. • Support a dialogue about outcomes between patients and clinicians including systems to obtain direct feedback from patients regarding performance of the organization • Educate staff about safety. • Support staff and lead by example.

Role	***Accountability***	***Specific Tasks***
Patient Safety Officer/CMO/ Chief of Staff	Lead patient safety initiatives with the medical staff and organizational staff	• Lead an integrated patient safety program. • Serve as the primary point of contact for questions about patient safety, and coordinate patient safety for education and deployment of system changes. • Execute performance improvement priorities and adjusts priorities in response to unusual or urgent events. • Assure effectiveness in measuring, assessing and improving the hospital's performance and improving patient safety. • Lead a proactive approach to reducing errors and make recommendation to reduce patient safety events. • Lead in an environment of openness & collaboration. • Assure dialogue about patient safety issues occurs effectively between patients and clinicians. • Report progress regularly, and educate about patient safety • Support staff and lead by example.
Quality/ Patient Safety Coordinators	Day to day coordination and facilitation of safety initiatives	• Implement operational aspects of the patient safety program throughout the hospital. • Implement proactive patient safety management that assures immediate, appropriate response to unusual or urgent events. • Participate in measuring, assessing and improving the hospital's performance and improving patient safety. • Be accountable for patient safety initiatives and strengthening a culture of safety in day to day practice. • Support an environment of openness & collaboration. • Support a dialogue about patient safety issues between patients and clinicians. • Report progress regularly, and educate about patient safety. • Support staff and lead by example.
Pharmacists	Ensure safe medication usage	• Ensure that authoritative, up-to-date drug information is available in reference form in patient care areas and prescribers' offices. • Periodically examine all drug products stored in patient care areas and procedures on drug storage/distribution to patient care areas. • Minimize the need for nurses to calculate, manipulate, or mix medications. • Establish a pharmacy led interdisciplinary team to spearhead medication safety activities. • Provide leadership to develop safe medication delivery systems.

Role	***Accountability***	***Specific Tasks***
Clinicians & Medical Staff	Monitor, report, & learn.	• Medical staff and other employee job descriptions and competency evaluations incorporate accountability for safety. • Medical staff & employees participate in education on the importance of safety, surveillance, and expectations for reporting safety concerns, beginning with orientation. • Medical staff & employees evaluations include an individual's contributions to safety for the organization. • Medical staff & employees are positively acknowledged for disclosing errors, near-misses, and safety concerns. • Employees and physicians work collaboratively assuring responsibilities of the team to the patients are met, and noticing errors before they cause harm. • Participate in the facility reporting system for PS events, both actual and potential event.
Patients/visitors	Involved partners in prevention.	• Inform doctors and nurses about medications they take, including prescriptions, over-the-counter drugs and dietary supplements. • Ask for written information about possible side effects. • Inform the doctors and nurses about allergies & adverse reactions. • Ask a relative or friend to be an advocate. • Learn about their medical condition by asking their doctor, nurse, and other reliable sources. • Upon hospital discharge, ask doctors for an explanation of the treatment plan to be used at home. • Provide feedback regarding performance of the organization • Report safety concerns through the Patient Safety hotline and other venues available.

V. Mechanisms for Coordination

Patient Safety Committee

The Patient Safety Committee (PSC) is a subcommittee of the Quality Care/Infection Prevention Council that provides a forum for addressing and coordinating all patient care and patient safety activities hospital wide. The committee is charged with operationalizing the Patient Safety program which incorporates initiatives including, but not limited to, NQF Safe Practices, Joint Commission National Patient Safety Goals and Leapfrog initiatives. The Patient Safety Committee is comprised of various health care professionals including, but not limited to, physicians, nurses, pharmacists and administrators and is chartered to oversee the implementation of the Patient Safety Program.

Structures that support the Patient Safety Committee or equivalent works in conjunction with other safety measures, including but not limited to:

- Medication Safety

- Quality Care/Infection Prevention Council
- Environment of Care Committee

The PSC reviews and develops implementation strategies for the NPSG's. Strategies include assessing and developing a culture of patient safety, encouraging a non-punitive reporting environment, developing a best practice infrastructure to foster the design of safety into our systems, and monitoring of systems risks and improvements. The PSC networks with the other committees as appropriate by topic to gain consensus (e.g. Infection Prevention, CNO-Pt. Care Directors, Pharmacy, Critical Care etc.). Sentinel Event Alerts and other industry alerts are routed to the appropriate committee or teams to ensure evaluation of current care processes with incorporation of recommended changes.

The VP of Quality/Risk Management and the Patient Safety Officer review~~s~~ Sentinel Event Alerts, other industry alerts, compliance to The Joint Commission National Patient Safety Goals, State regulatory requirements, adverse events and potential adverse events that are deemed to be preventable, health care associated infections as defined by the CDC that are deemed to be preventable, and assures recommendations are integrated into processes. Additional resources such as national and local professional organizations/associations are monitored for changes in standards and potential risk events. Regular summary reports of progress are reported to the designated Quality Care Committee, Medical Executive Committee, and the Board of Trustees.

The PSC reviews and approves plans to address key organizational concerns, such as Falls, Restraint Reduction, Patient/Family Education, Medication Safety, Adverse Drug Reactions (ADR's), Pressure Ulcer Prevalence, Health Care Associated Infections and Environmental issues updates.

The PSC recommends and provides direction for training on key initiatives and educational strategies related to patient safety.

VI. Communicating with Patients about Safety

It is Southern Hills Hospital's philosophy that accountability for patient safety is imbedded in a collaborative relationship involving our Board of Trustees, administrative leadership, our medical staff, employees, patients and family.

Patient safety awareness information is posted in public areas throughout the hospital. This information contains basic strategies for patients to assist in assuring their safety. The admission and discharge patient information also contains information on the patient role in safety. Patient Guides are provided to in-patients upon admission, and includes strategies prevent untoward events such as falls, medication errors, and infections while in the hospital. Annually, Patient Safety Awareness Week activities are planned to educate and inform staff, patients and the community. Information and additional resources are provided to assure patient involvement in their care.

Patients or their families may contact the hospital to report patient safety concerns as well as to the State of Nevada Department of Health and Human Services or to the Joint Commission. The hospital's website and other patient materials include information on how to report issues internally as well as to the Joint Commission.

Patients are randomly selected to participate in completing the Patient Experience Survey after discharge, which include questions related to the patient safety experience. These results are reported to the hospital.

VII. Education

1. Staff Education
   - General orientation, on-going in-service and other education and training programs will emphasize specific job-related aspects of patient safety
   - Specific Patient Safety Program training at orientation and annually thereafter will include:
     - An overview of the Patient Safety Program
     - Staff's role and responsibilities in the Patient Safety Program
     - Event reporting, including the events requiring reporting and the process for reporting events.
     - Methods to support and foster an interdisciplinary and collaborative approach to the delivery of patient care;
     - Examples of specific job-related aspects of patient safety.

2. Physician Education - An overview of the Patient Safety Program is 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 and Culture of Safety processes.

3. Organizational Learning: Patient safety is everyone's responsibility. Everyone has a responsibility to report. By reporting concerns, it enables the organization to learn and improve processes, procedures, and systems.

VIII. <u>Safety Improvement Activities</u>

Prioritization of Patient Safety Activities

Prioritization elements are defined in the annual performance improvement plan and apply to patient safety initiatives. The PSC annual goals are listed at the end of this plan and meet the prioritization elements.

Routine safety-related data collection analysis

- Unusual Occurrence reporting (see SPAE Guidance Policy)
- Medication Error Reporting

- Infection Surveillance
- Culture of Patient Safety Survey
- Environmental Safety Rounds and Assessment
- Patient Experience Survey
- Executive Safety Rounds
- National Patient Safety Goal Dashboard
- Annual Leapfrog (NQF Safe Practices) Survey
- Sentinel Event Alert Compliance
- Institute for Safe medication Practices(ISMP) and other industry Alerts
- Employee feedback survey

Identification, reporting, and management of patient safety events

1. To effectively improve processes and systems, health care providers should not be fearful of punishment of retribution for reporting mistakes.
2. An accessible multifaceted non-punitive, just culture reporting system exists .
3. Errors and accidents are tracked in an attempt to establish trends and patterns, to learn from them and prevent reoccurrence.
4. Healthcare providers participate in reporting and developing improved processes to effectively evaluate errors and near misses.
5. Reporting errors and near misses are a critical component of the Southern Hills Hospital Patient Safety Program.

The Vigilanz on-line incident reporting system is a tool for the documentation, investigation, and correction of patient safety issues as described in the organizational policy: The Patient Safety Director coordinates this process.

Organization or Medical Staff committees refer patient safety issues to the Patient Safety Officer for review at the PSC and corrective action.

Monitoring and Compliance

Nevada statute NRS 439.877 requires medical facilities to adopt patient safety checklists and patient safety policies. These patient safety checklists are protocols used to improve the outcomes of patients at the hospital to include:

1. Patient Discharge Process-Healthy Living (Meditech)
2. Patient Identification Process (Policy)
3. Patient room/environment sanitation and cleaning (Sodexho 7-Step Cleaning Process)
4. Additional patient safety checklists which may be appropriate to ensure the safety of patients in the facility. These include, but are not limited to the following:
    a. Universal Protocol (Safe Procedural and Surgical Verification)
    b. Central Line Insertion Bundle (Meditech)
    c. Hand Hygiene (Audit)

Proactive Risk Identification and Reduction:

1. Opportunities for improvement regarding patient safety issues and hazardous conditions are identified through trending of actual or potential occurrences involving patients or visitors and/or evidence-based literature (e.g. The Joint Commission Sentinel Event Alerts).
2. When an identified opportunity for improvement is identified, it is analyzed by the involved care providers according to level of severity, frequency of occurrence, potential for harm and liability.
3. At least every 18 months, one high-risk or error-prone process is selected for Failure Mode Effect Analysis (FMEA) process. The underlying systems are examined and modified or redesigned to minimize the risk of the identified failure mode.
4. Trending of adverse events, environmental safety issues, aggregate data collection, and review of intensive assessments are part of the identification and management of risks to safety and are used to prevent reoccurrences.
5. Serious unusual occurrences and sentinel events are reviewed with determination made for intensive assessment and root cause analysis according to the SPAE policy.
6. Near miss events are reviewed and root cause analysis conducted as deemed appropriate.
7. Regular communication about patient safety and risk management is conducted with designated Quality Care Committee, Medical Executive Committee, and the Board of Trustees.
   Disclosure of an adverse event to a patient is in accordance with the SPAE policy.

IX. Reporting Patient Safety Results:

To the PSC:

The Patient Safety Committee reviews and recommends actions on the following reports:

- Audits and performance improvement activities on Patient Safety
- National Patient Safety Goals and Safe Practices compliance (including accordance with NRS 439.877)
- Culture of Patient Safety Survey
- Leapfrog Survey

To organization staff and medical staff:

Organizational staff receives patient safety results and information on:

- Culture of Safety Survey
- Patient experience survey results on patient safety components.
- National Patient Safety Goals and Safe Practices compliance (including accordance with NRS 439.877)
- Leapfrog Survey

To executive leadership and Board of Trustees:

The Board of Trustees and Executive Leadership receives periodic reports on:

- Culture of Safety Survey
- Leapfrog Survey
- Results of intensive analyses related to patient safety issues

X. Annual Review

The Patient Safety Program is reviewed annually and revised as necessary. It is submitted annually for review and approval by the Medical Executive Committee and the Board of Trustees.

XI. References/Authority

- The Joint Commission 2022 NPSG's
- HCA Patient Safety Organization PSO Operating Policy and Procedure
  Federal Register- Department of Health and Human Services 42 CFR Part 3
  Patient Safety and Quality Improvement

Appendix One

Strategic Priorities for 2022 - Goals

- ☐ Continue Non-punitive reporting program with recognition of a minimum of one employee; four appreciation opportunities throughout the year "Great Catch Award"
- ☐ Continue weekly Executive Leader Safety Briefs and Rounds
- ☐ Achieve 95% compliance with oxytocin process measures each quarter 4Q21 – 3Q22.
- ☐ Complete and submit all Serious Event Analyses (SEAs) to the PSO
- ☐ Submit 95% of all patient event and close call reports designated as PSWP within 60 days
- ☐ Continue Monthly Falls Committee in 2022
- ☐ Achieve compliance with Clinical Safety Improvement Program (CSIP) initiatives.
- ☐ Reduce Hospital Falls by 10%
- ☐ Reduce Hospital Aquired Pressure Injuries by 10%