MOUNTAINVIEW HOSPITAL

PATIENT SAFETY PLAN

CY 2023

CY 2023 Patient Safety Program
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CY 2022 Patient Safety Program

I. Introduction

Purpose, Scope and Responsibility

- ✓ Purpose:
  - To define the essential components of the Patient Safety Program at MountainView 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. To be effective, the plan requires the active involvement of all members of the healthcare team, as well as patients and families. The MountainView 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

- ✓ MountainView 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

Accountability:	An obligation or willingness to accept responsibility for one's actions.

Adverse Event:	Event under the control of a provider which has caused harm and requires a new or modified physician order for management of the patient's health care. See Policy RM19: Sentinel Event for specific event list and RM13: Disclosure of Adverse Events.
CSIP	The Clincial Safety Improvement Plan (CSIP) offers hospitals the opportunity to voluntarily develp and implement specific patient safety initiatives focused on issues identified by the evaluation of close calls, adverse events, and current hospital clinical performance metrics. This program aims to reduce the incidence of adverse events, reduce patient harm, and promote the development of competency of patient safety leadership. HCA PSO will guide hospitals in the submission of required program deliverables and will communicate completion results to the facilities
Hazardous condition:	Any set of circumstances (exclusive of the disease or condition in which the patient is being treated), which significantly increases the likelihood of serious adverse outcome.
Healthcare FMEA:	Healthcare Failure Mode and Effects Analysis: A proactive model for addressing potential risks within the organization.
High Reliability	An environment of "collective mindfulness" in which all staff look for and report small problems or unsafe conditions before they pose a substantial risk to the organization and when they are easy to fix. To achieve this, leadership commitment exists for achieving zero patient harm, a fully functional culture of safety throughout the organization, and the widespread deployment of highly effective process improvement tools (TJC).
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:	Major permanent loss of function, sensory, motor, or intellectual impairment not present at admission, requiring continued treatment or lifestyle change. When "major permanent loss of function" cannot be

immediately determined, patient injury is not established until either the patient is discharged with continued major loss of function, or two weeks have elapsed with persistent major loss of function, whichever occurs first.

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, 2016). (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 – effective October 1, 2013).

Sentinel Event Alert Gap Analysis: A model for prioritizing and addressing potential risks related to publish external sentinel or warning alerts.

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. (See policies – RM19: Sentinel Event and RM13: Disclosure of Adverse Events).

II. Policy

The Board of Trustees delegates responsibility for oversight of the patient safety program to the Patient Safety Committee. The Patient Safety Committee monitors and evaluates the effectiveness of the Patient Safety Program and generates feedback and actions as appropriate. The Patient Safety Committee prepares an annual report to the Quality Council, 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 Environment of Care Committee oversees non-clinical safety related processes and system issues that affect patients, employees, and visitors in the environment of care.

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

MountainView 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. MountainView Hospital fosters a just culture that is focused on prevention and identifying systemic vulnerabilities that pose a threat to the safety of our patients, staff and the facility. Patient safety events are viewed as an opportunity to learn, not blaming individuals. 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 MountainView 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 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.
Unit Safety Champions	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

MountainView Hospital Patient Safety Committee

The MVH Patient Safety Committee (PSC) or equivalent is a multidisciplinary team involving department representatives that meets not less than monthly. The Patient Safety committee or equivalent committee, is comprised of various health care professionals including but not limited to physicians and residents, nurses, pharmacists and administrators, and is chartered to oversee the implementation of the Hospital's Patient Safety Program. The Patient Safety Officer coordinates the PSC. The CEO, CMO, and Chair of Quality Council appoint medical leadership for the PSC.

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

- Medication Safety
- Quality Council
- Environment of Care
- Falls Committee
- Infection Prevention 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 other committees as appropriate per topic to gain consensus (e.g. Quality Council, Infection Prevention, Pharmacy, other). Sentinel Event Alerts and other industry alerts are routed to the appropriate committee or teams to ensure evaluation of current care processes incorporate recommended changes.

The PSC reviews 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 Council, 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, Patient Mobility, Blood and Blood Components, 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 MountainView 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. The MountainView Hospital consumer web page also includes access to an electronic version of the Patient Guide. 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.

4. Lessons Learned summaries are developed to communicate lessons learned from near misses or actual events. These summaries are shared with the leadership and employees to promote organizational learning and improvement.

VIII. Safety Improvement Activities

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 policies RM21 Facility Event and Close Call Reporting, RM13: Disclosure of Adverse Events, and SPAE Guidance Policy)
- Medication Error Reporting
- Infection Surveillance
- Culture of Patient Safety Survey
- Environmental Safety Rounds and Assessment
- Patient Experience Survey
- Leadership Walk-around and Tracers
- 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 MountainView Hospital Patient Safety Program.

The Vigilanz Safety Surveillance on-line incident reporting system is a tool for the documentation, investigation, and correction of patient safety issues as described in the organizational policy: RM21 Facility Event and Close Call Reporting. The Director of Risk Management 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.

NRS 439.877 – Monitoring and Compliance- Need to revisit

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 (CP120 – Discharge Planning)
2. Patient Identification Process (CP70 – Patient Identification)
3. 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 (CP195 – Safe Procedural and Surgical Verification)
    b. Central Line Insertion Bundle (CP131 – Adult Central Line/PICC (Non-Implanted_ Management)

Monitoring and oversight for compliance with these policies and checklists will be the ongoing responsibility of the Patient Safety Committee.

NRS 439.865– Infection Control Program

Nevada statute NRS 439.865 requires medical facilities have an infection control program to prevent and control infections within the medical facility, as well as an infection control policy. The Hospital's Infection Control Plan is attached as an addendum to the Patient Safety Plan and is reviewed annually. (See Appendix 3 – Infection Prevention and Control Plan)

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 Facility Event and Close Call Reporting and SPAE policies.
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 Committee, Medical Executive Committee, and the Board of Trustees. Disclosure of an adverse event to a patient is in accordance with policy. RM13: Disclosure of Adverse Events and the SPAE policy

IX. Reporting Patient Safety Results:

To the PSC:

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

- Audits 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:

- Lessons Learned summaries
- 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
- Risk Management dashboard
- Patient Safety dashboard

X. EVALUATION OF CY 22 PSC / Organizational Goals

GOAL	GOAL MET	GOAL NOT MET
Continue to participate in weekly rounding e.g., Patient Safety, Executive Leadership/Nursing leadership safety. This encourages discussion of safety issues and fosters a culture of safety through building respect, trust, and inclusion in the organization.		Due to the management of the COVID-19 pandemic, this goal was not consistently met. This will continue to be a goal for 2022
Implement patient advisory board as well as bioethics committee	This goal was partially met. Bioethics Committee has been implemented	Due to the management of COVID-19 pandemic, the Patient Advisory Board was not implemented. We will continue to work on Advisory Board development

		.
Increased number of failure mode & effects analysis conducted.		Due to the management of the COVID-19 pandemic, this goal was not consistently met.
Adopting HCA core strategies for reducing patient harm and mitigating organizational risk by focusing on clinical focus areas. The goal is to have zero harm events for the following clinical focus areas: Falls (5z-8z), Pressure Ulcers (stage 3-4), and Telemetry monitoring. Improve alignment with HCA Safety Science Strategies. These strategies include: Achieving compliance with Clinical Safety Improvement Program (CSIP) initiatives. a. Enhancing event identification notification and management through Vigilanz Surveillance System. This will include continued house wide education and will be measured by improving overall utilization by 40%; as well reducing patient harm events by 25% by Q32022. b. Improve communication with Facility Safety Huddles (NATE/NASH Technology) by increasing departmental utilization.	Goal partially met: Patient Harm- as an organization we still have challenges with falls and pressure injuries. We did not meet the goal of zero harm as we had 10 falls with injury and 1 stage III or above pressure injury. Telemetry- improvements include: • consistently meeting metric for start time documentation • hardwired monitoring process for expired 48-hour telemetry orders and escalation processes CSIP- received all applicable credit Viglianz – increase utilization by 40%; as well reducing patient harm events by 25% by Q32022.	
Enhance building a robust safety learning system through continued learning to frontline staff,		

Medical Staff and Graduate Medical Education. This includes, but is not limited to storytelling, lessons learned, as well as, providing education on the Great Catch Program.		
Increase Great Catch recognitions by 20% by Q32022.		
Achieve compliance with 2022 goals that were not met.		

XI. CY 23 PSC / Organizational Goals:

1. Reduce the number of patient falls with injury/pressure injuries by 5%
2. Ensure compliance with CSIP Measures that include Pressure Ulcer Prevention, Telemetry Safety, Suicide Prevention Safety

XI. 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.

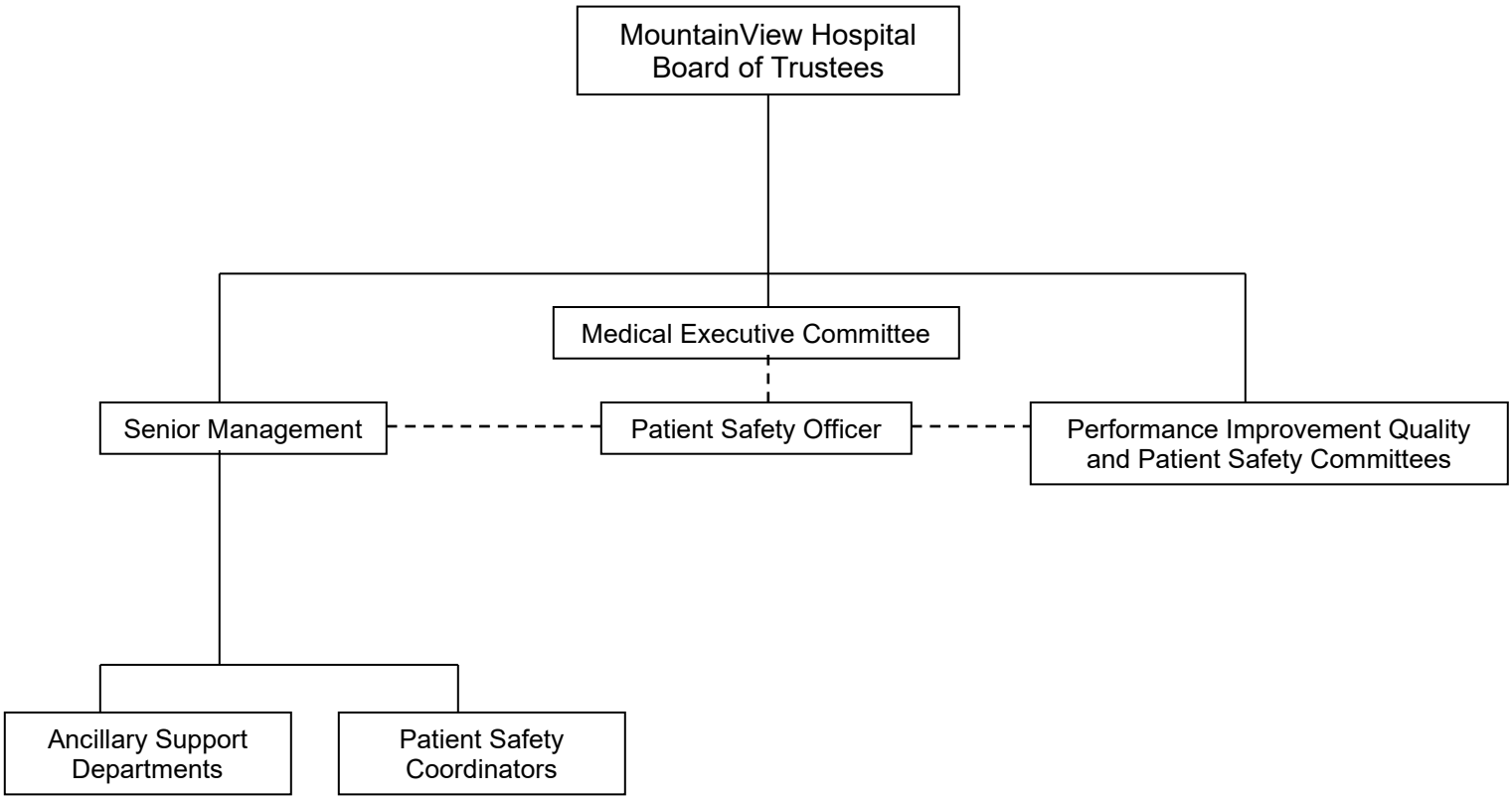
XII. The MountainView Hospital Patient Safety Program

The components of the patient safety program are outlined in Appendix One.

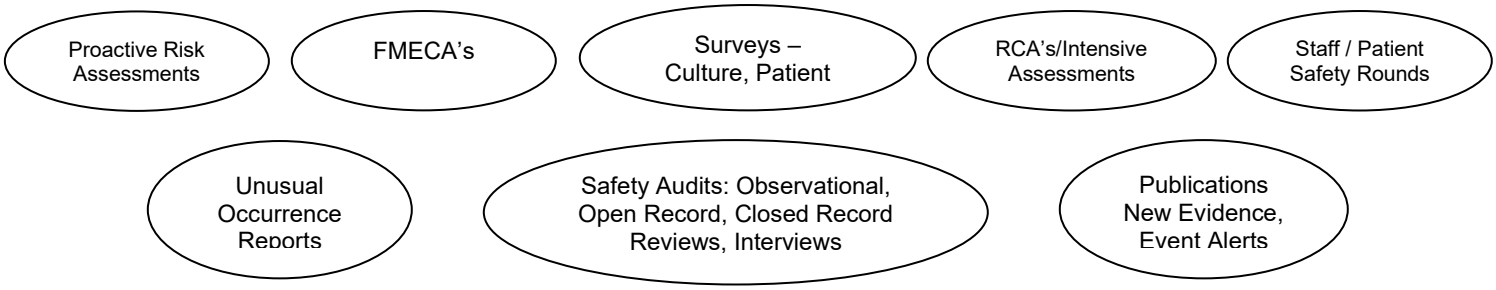
XIII. References/Authority

- The Joint Commission 2023 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

Patient Safety Program



Sources of Patient Safety Data



MOUNTAIN VIEW HOSPITAL

2023 National Patient Safety Goals Overview

The Joint Commission NPSG's	Specific Elements Within Broad Goal (Note #'s same as per The Joint Commission's NPSG's for Hospitals)	Key Content Expert Links to PSC	Audit Methodology (Cross-reference to Patient Safety Dashboard)
#1: Improve the accuracy of patient identification	**A: Use at least two patient identifiers when providing care, treatment or services**		
	A1 Blood draw and other lab specimen collection	Blood Bank Laboratory Nursing	Random observation audits (Quarterly)
	A2 Label containers in presence of patient	Blood Bank Laboratory Nursing	Random observation audits (Quarterly)
	Use distinct methods of identification for newborn patients. Note: Examples of methods to prevent misidentification may include the following: - Distinct naming systems could include using the mother's first and last names and the newborn's gender (for example, "Smith, Judy Girl" or "Smith, Judy Girl A" and "Smith, Judy Girl		
	B: Eliminate Transfusion Errors		
	B1. Blood transfusion process: match blood or blood component to the order; match the patient to the blood or blood component; use a two-person verification process	Blood Bank Laboratory Nursing	Blood Bank Audits (Quarterly)
	B2. Qualified transfusionist part of two-person verification process	Blood Bank Laboratory Nursing	Blood Bank Audits (Quarterly)

The Joint Commission NPSG's	Specific Elements Within Broad Goal (Note #'s same as per The Joint Commission's NPSG's for Hospitals)	Key Content Expert Links to PSC	Audit Methodology (Cross-reference to Patient Safety Dashboard)
	B3. Second qualified individual part of two-person verification process	Blood Bank Laboratory Nursing	Blood Bank Audits (Quarterly)
#2: Improve the effectiveness of communication among caregivers	A. Report critical results of tests and diagnostic procedures on a timely basis.		
	A1. Evaluate the timeliness of reporting the critical results of tests and diagnostic procedures.	Lab Nursing	Random charts and log audits (Quarterly)
#3: Improve the safety of using medications	A. Label all medications, medication containers (for example, syringes, medicine cups, basins), or other solutions on and off the sterile field.	Cardiac Imaging OR Nursing	Random observations and audits, all procedure areas (Quarterly)
	B. Reduce the likelihood of patient harm associated with the use of anticoagulation therapy.	Pharmacy Nursing	Random chart audits (Quarterly)
	C. Maintain and communicate accurate patient medication information.	Pharmacy Nursing	Random chart audits (Quarterly)
#6: Improve the safety of clinical alarm systems.	A. Leaders establish alarm safety as a hospital priority.	Patient Safety Officer / PS Plan	Random observations and audits (Quarterly)
	B. Identify the most important alarm signals to manage.	Patient Safety Committee	Random observations and audits (Quarterly)
	C. Establish policies and procedures for managing alarms as listed above in #B.	Patient Safety Committee	Random observations and audits (Quarterly)

The Joint Commission NPSG's	Specific Elements Within Broad Goal (Note #'s same as per The Joint Commission's NPSG's for Hospitals)	Key Content Expert Links to PSC	Audit Methodology (Cross-reference to Patient Safety Dashboard)
	D. Educate staff and LIP's about the purpose and proper operation of alarm systems for which they are responsible.	Patient Safety Committee	Random observations and audits (Quarterly)
#7: Reduce the risk of health care-associated infections	A. Comply with current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines	Infection Prevention Nursing	Random observations (Quarterly)
	B. Implement evidence-based practices to prevent healthcare associated infections due to multiple drug-resistant organisms (MDRO's)	Infection Prevention	MDRO Tracker (Quarterly)
	C. Implement evidence-based practices to prevent central line-associated bloodstream infections (CLABSI's).	Infection Prevention	Targeted Surveillance (Quarterly)
	D. Implement evidence-based practices to prevent surgical site infections (SSI's).	Infection Prevention	Targeted Surveillance (Quarterly)
	E. Implement evidence-based practices to prevent catheter associated urinary tract infections. (CAUTI's)	Infection Prevention	Targeted Surveillance (Quarterly)
#15: The organization identifies safety risks inherent in its patient population	A. The organization identifies patients at risk for suicide. [Applicable to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals.]	Nursing Risk Management	(Structural process) Random chart audits (Quarterly)
Universal Protocol	A. Pre-op verification B. Site marking C. Time-out	Cardiac Medical Imaging Nursing OR	Random observations & chart audits (Quarterly)