HUMBOLDT GENERAL HOSPITAL
CRITICAL ACCESS HOSPITAL **Revised: 12/30/2022**
118 East Haskell St.
Winnemucca, Nevada 89445

Developed by: Quality Services Director
Revised by: Quality Services director
Department: All Departments
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POLICY: **PATIENT SAFETY PLAN**

POLICY STATEMENT: It is the policy of Humboldt General Hospital to establish measurable objectives for improving patient safety and reducing medical errors. The focus of the plan is on improving patient safety processes and reducing system and process failures, not punitive measures against staff that commit errors. Areas of emphasis in the safety program will include but are not limited to:

1. Informed Consent
2. Patient Identification
3. Surgical site verification
4. Preventive maintenance
5. Restraint compliance
6. Medication administration
7. Drug Recalls
8. Med reconciliation on admission/discharge
9. Blood product administration
10. Staff competency
11. Hand washing
12. Unsafe medical device reporting process
13. Feedback from Patient Satisfaction Survey process
14. Product Recalls
15. Core measures reporting
16. Compliance with National Patient Safety Goals

I. DEFINITIONS:

A. **No Harm Occurrence** – those unintentional acts, either of omission or commission, or acts that do not achieve their intended outcome – that do not result in a physical or psychological negative outcome, or the potential for a negative outcome, for the patient.

B. **Mild-Moderate Adverse Outcome Occurrence** – those unintended acts, either of omission or commission, or acts that do not achieve their intended outcome, that result in an identified mild to moderate physical or psychological adverse outcome for the patient.

C. **Any Medication Error, Adverse Drug Reaction or Transfusion Reaction.**

D. **Sentinel Event** – An event included in Appendix A of "Serious Reportable Events in Healthcare – 2011 Update: A Consensus Report," published by the National Quality forum; or any death that occurs in a health facility. (NRS 439.830)

E. **Near Miss** – any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome.

F. **Hazardous Condition** – any set of circumstances (exclusive of the disease or condition for which the patient is being treated) which significantly increases the likelihood of serious adverse outcome.

G. **Hospital Acquired Conditions (HACS)** – object left in surgery, air embolism, vascular catheter-associated infection, surgical site infections, patient falls, manifestation of poor control of blood sugar levels, such as diabetic ketoacidosis, hypoglycemic coma.

II. CORE PRINICPLES:

A. Humboldt General Hospital recognizes that a patient has the right to a safe environment, therefore the organization is committed to undertaking a proactive program to identify processes which may adversely affect patient safety or be associated with medical errors.

B. All departments within the organization (patient care and non-patient care) are responsible to report patient safety occurrences and potential occurrences per department, occurrence impact on the patient, remedial actions taken and the patient outcome. The Patient Safety Committee will analyze the report information and determine future patient safety activities as appropriate.

C. Our environment will encourage:

1. "Blame Free" culture where there is a minimization of individual blame or retribution for involvement in a medical error.

2. Recognition and acknowledgement of risks to patient safety.

3. Internal reporting of what has been found and the actions taken

Weekly patient safety "huddle" to include executive member, chief nursing officer or designee, patient safety officer, pharmacist, infection control officer, medical staff representative, case manager, social services and maintenance representative.

The Patient Safety Committee will meet monthly and will include the following members:

1. Executive Member
2. Chief Nursing Officer
3. Patient Safety Officer
4. Pharmacist
5. Infection Control Officer
6. Medical Staff Representative

III. PROGRAM COMPONENTS

A. Upon identification of a process or system failure and/or medical/health care error:

1. The patient care provider will immediately perform any necessary healthcare interventions to protect and support the care of the affected patient.
2. Contain the risk to others (example, immediate removal of contaminated IV fluids from floor stack should it be discovered a contaminated lot of fluid solutions was delivered and stocked).

3. Preservation of physical information related to the error for subsequent analysis (example, removal and preservation of IV tubing, fluid bag and/or pumps for a patient with a severe drug reaction form IV medication; preservation of medication label for medications administered to the incorrect patient; preservation of equipment and disposables for injuries during therapy).
4. The employee/staff member who discovers, or witnesses the event is responsible for documentation and reporting the event. A Quality Review Report will be completed and the staff member completing this documentation will state only the facts.

B. The Quality Services Director, as the designated Patient Safety Officer, is responsible for conducting a root cause analysis for the most critical events.

C. Departments involved in the process or system failure and/or medical care error will review information related to the event and identify and implement measures or process redesign to minimize the recurrence of identified events.

D. Department Supervisors will include departmental program and will ensure staff within their department practice safe processes.

E. The Patient Safety Officer will provide quarterly reports of all patient safety activities to the Medical Staff and to the governing board. Information in the report shall include: system and process failures, number and type of sentinel events, actions taken to improve safety, both proactively and in response to actual occurrences and actions taken to resolve identified problems.