CARING PROFESSIONALS HOSPICE

Patient Safety Program

Effective Date: 01/03/2017 **Policy No. 7.21**

POLICY

Hospice leaders ensure implementation of a patient safety program.

PURPOSE

To define Hospice-wide patient safety program. To promote a safe environment for patients and staff. To reduce process and system failures and risks.

REFERENCE

The Joint Commission CAHMC Standard: LD.04.04.05; Medicare CoP #s: 418.58c, 418.58e; CHAP Standards: CI.5b, CI.5f, CII.7k, CII.7l; ACHC Standard: HSP6-2A

RELATED DOCUMENTS

"*Annual Safety Program Evaluation: Governing Body Report*" form

PROCEDURE

1. The Administrator and Director is responsible to oversee and manage Hospice's Safety Program.

2. The scope of the program's oversight includes (but is not limited to):
   - Patient and employee incident/variance reporting and investigation.
   - Significant medication error, adverse drug reaction and adverse drug event investigation.
   - QAPI data indicative of patient safety issues.
   - Sentinel events.

3. All services and staff will coordinate and implement patient safety policies, procedures and processes.

4. Procedures for immediately responding to process or system failures include:
   - Caring for the affected patient and/or employee.
   - Containing risks to others.
   - Preserving factual information for subsequent analysis.

5. Internal systems for reporting system or process failures include incident/variance reporting, root cause analysis and reports to staff, QAPI and Governing Body as appropriate.

6. External systems for reporting system or process failures will comply with any applicable law or regulation.

7. Responses to unanticipated adverse events include analysis and investigations with potential proactive risk assessments and/or risk reduction activities.

8. Defined support system for staff members who have been involved in a sentinel event includes counseling through the human resources department or the employee assistance program.

9. Leaders will provide an annual report to the Governing Body regarding actions taken to improve patient safety (in response to actual occurrences or proactively) and on process or system failures.