Safety Plan and Policies for the

Reno Orthopaedic Surgery Center

555 North Arlington Ave Ste C

Reno NV 89503

TITLE: Safety Program

SCOPE: ROSC Staff

POLICY:

To adopt, implement and monitor a comprehensive environmental control program relative to safety and sanitation that involves staff, equipment operation and maintenance in order to provide a functionally and environmentally safe atmosphere for patients, personnel and visitors.

PROCEDURE:

1. A Safety Committee will be established to implement the safety and environmental control program of the facility.
2. The Safety Committee will include: Administrator, Safety Officer, Medical Director, Infection Control Officer, and Director of Surgical Services.
3. Management will appoint a Safety Officer.
4. The Safety Committee will meet monthly as part of the Medical Advisory Committee.
5. Meeting minutes will be taken and maintained.
6. Committee findings and recommendations are reported and submitted in writing to the Quality Management Improvement Committee and the Governing Board.
7. The Safety Officer will prepare the agenda and preside at the meetings. The Safety Officer is responsible for carrying out directives of the Committee and submitting reports to other committees.
8. The Committee members' responsibilities include reporting unsafe conditions, reporting all accidents or near accidents, investigating all serious accidents, contributing ideas and suggestions for improvement, making inspections, participating in In-service education and orientation, familiarizing themselves with standards for safety and sanitation, and assisting in policy and procedure development.

RESPONSIBILITIES OF SAFETY COMMITTEE:

1. To implement and review policies and procedures concerning functional safety and environmental control.
2. To function as a liaison with the Infection Control Officer.
3. To participate in the In-service Education and Orientation program.
4. To conduct Hazard surveillance.
5. To be knowledgeable regarding community safety agencies, especially those concerned with fire and other disasters.
6. To evaluate the effectiveness of the Safety Program and revise and update the program annually and as necessary.

TITLE: Anesthetic Waste Gases

SCOPE: ROSC Management

POLICY:

To provide a safe environment for staff at the Reno Orthopaedic Surgery Center

PROCEDURE:

1. There will be a scavenger system connected to a separate vacuum from each anesthesia machine. The anesthesia practitioner makes sure that the hose is attached and inspected for leaks on a daily basis.
2. Biyearly inspections with written reports are obtained by an outside company qualified to test anesthesia waste gases. Management coordinates the inspection.
3. If any leaks are found on inspection, or the safe range is exceeded, the problem is immediately remedied before further use of the machine.

TITLE: Checklist

SCOPE: ROSC Staff
Physicians
Contracted Vendors

POLICY:

To provide protocols to improve the health outcomes of patients.

PROCEDURE:

ROSC Safety Committee adopts the following criteria from WHO Guidelines for Safe Surgery 2009, and meets these criteria, as a safety checklist for patient surgery:

Objective 1: The team will operate on the correct patient at the correct site

- Verification: Correct patient, site and procedure identified on the Pre-op, Anesthesia and Intra op document.
- Marking: Preoperatively the patient participates along with the surgeon that marks the site.
- Time Out: Intra-operatively by the team and documented on the intraoperative record.

Objective 2: The team will use methods known to prevent harm from administration of anesthetics, while protecting the patient from pain

- Pulse oximetry & capnography are supplied and performed by an anesthesiologist or directed by a physician.
- Circulation is monitored and documented in surgery and post op by anesthesia and nursing.
- Temperature is monitored and recorded pre-op, intra-op and post op.
- Consciousness is monitored and recorded pre-op, intra-op and post op.

Objective 3: The team will recognize and effectively prepare for life-threatening loss of airway or respiratory function

- Airway is assessed and documented by anesthesia within the anesthesia record.
- A difficult intubation cart is equipped and ready for use by anesthesia.
- Only credentialed anesthesiologists provide anesthesia at ROSC.

Objective 4: The team will recognize and effectively prepare for risk of high blood loss:

- Large volume blood loss in not anticipated in a majority of the cases performed at ROSC
- The anesthesiologists communicate with the surgeon and evaluate each case appropriately.
- The Medical Director evaluates all questionable cases prior to surgery.
- IV's are established prior to each surgical case.
- Blood loss is recorded on the anesthesia record.
- Blood is not administered at ROSC.

Objective 5: The team will avoid inducing an allergic or adverse drug reaction for which the patient is known to be at significant risk:

- Credentialed anesthesiologists administer pharmacologic agents.
- Nursing administers medication under a physician order.
- Both physician and clinical staff are responsible for identifying the patient and the medication administered.
- A Patient Medication Reconciliation Record is obtained prior to surgery.
- Allergies and sensitivities are recorded within the electronic medical record and on the front of the paper chart.
- Allergies and sensitivities are checked and verified in the pre-op, intra-op, PACU phases of care.
- Aseptic medication technique education is performed upon hire and annually.
- Medication drawn up and labeled is administered by the same person drawing and labeling the medication.
- National patient safety goals for the medication are followed by ROSC.

Objective 6: The team will consistently use methods known to minimize the risk for surgical site infection

- Prophylactic antibiotics are administered to all surgical cases prior to surgery by the anesthesiologist.
- Sterilization process involves the use of indicators used on every tray and peel pack. A Biological is run on each load.
- A surgical hand and forearm scrub for OR is done for 2-5 minutes.
- Sterile surgical attire is provided for each surgical case.

Objective 7: The team will prevent inadvertent retention of instruments and sponges in surgical wounds

- Sponge and sharps counts are performed before and after each procedure and documented on the intra-op record.

Objective 8: The team will secure and accurately identify all surgical specimens

- All specimens have a patient label attached to the container.
- Pathology Specimen Request is complete and accompanies the patient specimen.

Objective 9: The team will effectively communicate and exchange critical information for the safe conduct of the operation.

- The team prepares for instruments, implants, intra-operative imaging, and pathology in advance of each case.
- Anesthesia issues are addressed by each anesthesiologist and surgeon prior to each case. When patient safety is in question, the case is cancelled.

Objective 10: Hospitals and public health systems will establish routine surveillance of surgical capacity, volume and results.

ROSC Management will report the following outcomes to the Nevada State Bureau of Health & Welfare Annually:

- Number of operating rooms –
- Number of procedure rooms –
- Number of surgical procedures performed
- Number of board certified Orthopaedic surgeons –
- Number of Anesthesiologists
- Day of surgery mortality rate
- Post-operative in-hospital mortality rate
- Surgical Site Infection Rate
- Surgical Complications

1. All treatment provided is ordered by the physician.

2. Any prescription given to the patient is filled at the patient's pharmacy of choice. Medication is taken as directed by the surgeon and pharmacist and documented on the discharge instruction sheet.

3. All after care and all other discharge instruction are given as ordered by the physician and documented on the discharge instruction sheet.

4. An environmental, staff and patient safety checklist is completed monthly the safety officer.

5. Orientation checklist.

TITLE: Compressed Gas Handling

SCOPE: ROSC Staff

POLICY:

To provide guidelines for safe handling of compressed gas.

PROCEDURE:

IDENTIFICATION:

1. All gases are properly labeled with contents and whether they are flammable.
2. Never rely on the color of the tank for identification of the contents.

STORAGE & HANDLING:

1. Tanks of compressed gases are stored upright and chained to a support system to minimize falling over.
2. A safety cap is used during transport of H-cylinders.
3. Always use proper DISS or pin index safety system for the gas being used.
4. The gas storage area is kept cool and out of direct rays of the sun and away from heat pipes. It is well ventilated to prevent "pocketing" of fumes, and is fireproof with some means for cooling in the event of fire.
5. Regulators, fittings or gauges will never be lubricated or come in contact with oil or grease.
6. Never use leaking or defective tubing or equipment that is in need of repair.
7. When opening cylinder valve, always open with the face pointed away from any person.
8. Care should be taken to handle tanks safely. Seek assistance if tank is too heavy to handle alone. Never handle tank with greasy hands.

DISPOSAL:

1. All anesthesia gas scavenging systems are vented to the outside.
2. Empty cylinders and tanks are returned to the distributor.

TITLE: Electrical Safety

SCOPE: ROSC Staff

POLICY:

To provide guidelines for general electrical safety

PROCEDURE:

1. All staff will observe for signs of electrical hazards. Equipment with frayed cords, exposed wire, or broken plugs will be taken out of use immediately. A sign that states "DO NOT USE" will be placed on equipment, and Management notified. Management will have the equipment repaired by the biomedical engineer.
2. Extension cords will be used only on an emergency basis.
3. All electrical devices being used in the operating room must have three-pin plugs and connect into three-hole receptacles.
4. Cheater plugs will never be used.
5. Keep fluids away from all electrical equipment.
6. Remove power plugs by grasping the plug; never pull on the cord.

TITLE: Electrical Safety Checks

SCOPE: Biomedical Engineering Contractor Management

POLICY:

To assure that patients and employees are protected from electrical shock.

PROCEDURE:

All electrical appliances or equipment destined for patient care is to have an electrical safety check performed within 90 days of purchase with annual safety checks performed thereafter.

PROCEDURE:

1. Management or designee contacts the Biomedical Engineer to perform electrical safety inspections within 90 days of purchase.
2. The Biomedical Engineering Contractor inspects the equipment and places a label stating when the inspection took place and that the item is safe for use.
3. The Biomedical Engineering Contractor has a contract with ROSC to inspect new equipment and to perform annual inspections on all electrical equipment.
4. During routine inspections, if equipment is found to be defective or hazardous, Management is informed and a decision is made as to whether the item will be replaced or repaired.

TITLE: General Safety in the Workplace

SCOPE: ROSC Staff

POLICY:

To identify general safety rules for all employees of ROSC.

PROCEDURE:

All employees of the Center will be familiar with the following the safety rules of the workplace. All employees will be responsible to observe and correct any hazards in the workplace.

1. Keep traffic areas clear of obstructions.
2. Pick up any foreign matter on floors and put in proper receptacles.
3. Wipe up spills immediately.
4. Use caution when opening doors. If no viewing window is present, open door slowly.
5. Be physically and mentally prepared for work.
6. Prevent spread of infectious disease by staying out of the workplace when ill.
7. Never engage in horseplay or practical jokes.
8. Walk, never run in the facility.
9. Heed all warning signs that caution a hazardous condition. (i.e., wet floor signs.)
10. Know the location of fire alarm pulls, extinguishers, and exits.
11. Be familiar with Emergency Codes.

TITLE: Installation of Alcohol Based Hand Sanitizers

SCOPE: Management

POLICY:

To maintain a safe environment.

PROCEDURE:

ROSC will follow CfC 416.44 (b) Standard: Safety from Fire: "Notwithstanding any provisions of the 2000 edition of the Life Safety Code to the contrary, an ASC may place alcohol-based hand rub dispensers in its facility if**—"**

1. Use of alcohol-based hand sanitizer dispenser does not conflict with any State or local codes that prohibit or otherwise restrict the placement of alcohol-based hand sanitizer dispensers in health care facilities;
2. The dispensers are installed in a manner that minimizes leaks and spills that could lead to falls;
3. The dispensers are installed in a manner that adequately protects against access by vulnerable populations; and
4. The dispensers are installed in accordance with the following provisions:

    a. Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 feet (1.8m);

    b. The maximum individual dispenser fluid capacity shall be: (1) 0.3 gallons (1.2 liters) for dispensers in rooms, corridors, and areas open to corridors. (2) 0.5 gallons (2.0 liters) for dispensers in suites of rooms;

    c. The dispensers shall have a minimum horizontal spacing of 4 feet (1.2m) from each other;

    d. Not more than an aggregate 10 gallons (37.8 liters) of ABHR solution shall be in use in a single smoke compartment outside of a storage cabinet;

e. Storage of quantities greater than 5 gallons (18.9 liters) in a single smoke compartment shall meet the requirements of NFPA 30, Flammable and Combustible Liquids Code;

f. The dispensers shall not be installed over or directly adjacent to an ignition source; and

g. In locations with carpeted floor coverings, dispensers installed directly over carpeted surfaces shall be permitted only in sprinklered smoke compartments.

TITLE: Latex Allergy

SCOPE: ROSC Staff

POLICY:

To provide for a latex safe environment for patients with known latex allergies. To help prevent or minimize the risk of an allergic anaphylactic reaction secondary to exposure and sensitization to latex.

PROCEDURE:

1. When possible, schedule procedures as first case of the day, otherwise plan for a latex safe environment.
2. Notify all health care providers of potential or known latex-allergic patient before scheduled procedure.
3. Exchange latex-free products for all latex-containing items.
4. Notify surgeon and anesthesia care provider if no alternative latex free product is available.
5. Remove latex items from OR unless no non-latex alternative exists.

    a. Remove boxes of latex gloves and replace with non-latex gloves (e.g., sterile, nonsterile).
    b. Double check all supplies and equipment for latex and remove any latex-containing items.

6. Educate patient about latex-safe plan.
7. A red allergy wristband will be placed on patient as a friendly reminder to staff caring for this patient.

TITLE: Medical Device Problem & Recall

SCOPE: ROSC Staff

PURPOSE:

To establish a uniform policy to ensure that product problems and recall information is documented, disseminated and reported according to Federal guidelines.

POLICY:

The following steps will be performed by Management for all reported product alerts and product problems:

1. ROSC will only use FDA approved implantable medical devices.
2. ROSC will use a registry to track total joint implantable devices.
3. When a product alert is received, Management determines if the product is stocked in the surgery center.
4. Reports from the EPIC Health System will contain serial and lot numbers of all implants.
5. If the product is in ROSC, appropriate action takes place according to instruction of the recall. This may include revision of usage instructions, removal of the product, or modification of the product.
6. Staff and physicians are notified by Management as to the proper action to follow.
7. If the product has been used on a patient, the manufacturer and the patient are notified.
8. If a product is used on a patient and malfunctions during use, the manufacturer must be notified and if any injury or potential injury has occurred, an incident report is filled out.
9. If a medical device has in all probability caused death, serious injury or illness of a patient, the FDA and the Nevada Department of Public Health and Environment must be notified. Management files the appropriate reports.
10. The report to the FDA must be made within ten days after the facility becomes aware the problem. The report includes the facility name and address, the device's name, serial number and model number; the manufacturer's name and address and a brief description of the event reported to the manufacturer.

8. The "Occurrence Report – Equipment Malfunction or Misuse" form must be completed and submitted to the Nevada Department of Public Health and Environment (within one (1) business day of the occurrence.
9. A copy of the recall or problem and a copy of the reports to the FDA and applicable State reports are kept on file in the facility.

TITLE: Patient Safety Plan

SCOPE: ROSC Staff

POLICY:

To provide ongoing safety and care for patients.

PROCEDURE:

1. Guidelines followed:
    a. CDC Guideline for Hand Hygiene
    b. ANSI/AAMI Comprehensive guide to steam sterilization and sterility assurance in health care facilities. Supported by CDC Guideline for Sterilization and Disinfection in Health Care Facilities.
    c. CDC Environmental Infection Control in Healthcare Facilities
    d. AORN Peri-Operative Standards and Recommended Practices
    e. APIC Text of Infection Control and Epidemiology Guideline for Isolation Precautions

2. Additional Infection Control Policies – See Infection Control in Policy Manual for details

    a. Aseptic Technique
    b. Communicable Disease Reporting
    c. Environmental Controls
    d. Facility Sanitation
    e. Housekeeping Logs
    f. Infection and Complication Tracking
    g. Laundry Guidelines
    h. Operating Room Sanitation
    i. Pest Control
    j. Sterilizer Monitoring
    k. Traffic Patterns
    l. Wound Classification
    m. Universal Precautions

3. Patient Selection and Screening

    a. Patients are pre-screened by the Surgeons and Medical Director for appropriateness for surgery.
    b. Patients with known infections and communicable disease are not a candidate for surgery at the facility.
    c. In the event that an infection or communicable disease is discovered at the facility the patient is isolated and appropriate discharge is determined by the physician. Reports are made to the appropriate agencies.

4. Patient Identification
    a. Identity is verified with two identifiers upon admission and prior to any procedure or treatment.

5. Timeout: Timeout is performed prior to procedure or surgery.

6. Discharge Teaching
    a. Discharge instructions are reviewed with the patient and significant other prior to discharge.
    b. Patient medication is reconciled prior to discharge and a copy of their Medication Reconciliation Sheet is given to the patient.
    c. Patients are educated to report general as well as specific signs and symptoms related to the procedure.
    d. Patients are given a telephone number where they can reach a surgeon 24 hours a day.

7. Post Procedure Call
    a. Two attempts to call the patient post procedure are made within 72 hours following the procedure.

8. Pathology results
        a. Pathology results are sent directly to the surgeon's office.
        b. A designated ROSC nurse follows up on all pathology results and verifies that the surgeon received and reviewed the results.

9. Pharmacy
    a. ROSC has a consulting Pharmacist who reviews, updates and educates staff on policy and procedure related to Medications. (See Medication section of Policy and Procedure)
    b. The consulting Pharmacist performs a monthly audit of the Controlled Substances, DEA 222 forms, anesthesia narcotic reconciliation, patient charts.
    c. The Pharmacist produces a monthly report, recommendations and corrective actions are made to Management, Medical Director and the Medical Advisory Committee as deemed necessary.

10. Quality Management and Improvement

    a. Clinical data is collected on, however not limited to, the following: transfers to an acute facility, infections, patient falls, other patient complications, medication incidents and medical device issues.
    b. Quality Improvement Studies are performed to analyze issues for improvement.
    c. Data is reported to the Medical Advisory Committee and Board of Directors.

11. Staff Training

    a. Staff training is provided on hire, annually and as needed.

12. Checklist and Logs
    a. Checklists and logs cover, but are not limited to the following: safety, staff skills, cart checks, temperatures and expirations.

13. Policies, Quality Management and Fire and Disaster Manual detail staff and patient safety.

TITLE: Radiation Safety

SCOPE: Physicians
Clinical Staff
Radiology Technicians

POLICYE:

To provide guidelines that will limit exposure to radiation to personnel and patients in ROSC.

PROCEDURE:

1. All personnel in the operating room will wear a lead shield while x-rays are being taken. Personnel wearing lead aprons should always face the x-ray unit.
2. Leaded shields will be used, when possible, to protect the patient's reproductive organs and thyroid during x-rays. The circulating nurse will document the type of protection used on the patient.
3. All reasonable means of reconciling an incorrect count should be implemented before using an x-ray to locate an unaccounted item.
4. Lead aprons will be laid flat or hung by the shoulders when not in use, to minimize cracking of shield.
5. The C-arm equipment will be inspected and calibrated annually by a state physicist, to ensure the equipment is working properly and meets safety regulations. Aprons and shields will be x-rayed bi-annually for any breaks in integrity. Any damaged aprons and shields will be disposed of.
6. All staff members working in the presence of fluoroscopy will wear dosimetry badges at the neck line. Dosimetry Badges will be maintained and monitored.
7. All staff assigned a dosimetry badge will be requested to report all other badge reports on an ongoing basis in order to help keep track of cumulative exposure.

8. The staff members assigned to operate the fluoroscopy equipment must carefully observe all radiation safety precautions and remind other medical personnel if radiation safety rules/practices are violated. Violations of radiation safety rules/practices must be documented and reported to Management.
9. Personnel are limited to receiving no more than the maximum permissible radiation dose limit per State or Federal guidelines.
10. Reproductive organ shielding shall be provided to all patients unless this area is essential to the clinical image.
11. All fertile female patients will be evaluated for the potential of pregnancy.
12. Thyroid shields will be worn by staff if they are in proximity to the patient.
13. The facility has an established Bio-Med agreement for the maintenance of all radiation equipment.
14. Any questions regarding radiological safety must be directed to Management who will contact the contracted X-ray technician or the state physicist.
15. Signs will be posted on OR and procedure room door when x-ray is in use.
16. Annual radiation safety competency will be completed by all staff.

TITLE: Refrigerator Monitoring

SCOPE: ROSC Staff

POLICY:

To insure medications and food that require refrigeration are kept at proper temperature.

PROCEDURE:

1. The temperature in the refrigerator used for storage of patient food or medication must be kept between 36 degrees and 46 degrees Fahrenheit.
2. Medications and food is stored in separate refrigerators.
3. Refrigerators containing patient food or medications have a thermometer.
4. Staff checks the refrigerator temperature daily.
5. The temperature is recorded daily on the flow sheet. Flow sheet is filed with Management and kept for two years.
6. If there is a variance from the recommended temperature, the nurse notifies maintenance to have the refrigerator checked.

TITLE: Reporting of Defective Equipment/Instruments

SCOPE: ROSC Staff

POLICY:

To define the protocol to be used when an instrument or piece of equipment is not working properly. To assure that equipment and instruments that are defective are removed from the system until they are repaired.

PROCEDURE:

1. When an instrument or any piece of equipment in the Operating Room or Pre-op/PACU is found to be defective, the employee discovering the problem tags the item and removes it from service. Management is notified so action can be taken to have the device repaired or replaced.
2. The employee labels the item and describes the exact problem that was observed, to improve rapid repairs.
3. Management further investigates and has the item sent for repair as needed. Management communicates with the staff that the item has been sent out of the department for repair and if a loaner can be expected.
4. Upon return of the item, the device is checked by a staff member who is familiar with the device's performance or, if necessary, it is evaluated by the Biomedical Engineering Contractor prior to being returned to service.

TITLE: Safe Use of Sterilizer

SCOPE: OR Staff
Sterile Processing

POLICY:

To assure safe use of sterilizers and prevent injuries from occurring when sterilizers are used.

PROCEDURE:

1. Employees participate in an in-service on the use of the sterilizer. They demonstrate that they can safely operate the autoclaves, and are familiar with the manual operation of the autoclaves.
2. The chamber door is opened slowly and never opened until the pressure gauge reads zero. Never look directly at the autoclave when opening the door. Excess steam may have accumulated and be released when the door is opened.
3. When removing items from the autoclave, mitts, towels or forceps are used. Never reach in the autoclave with bare hands or arms.

TITLE: Safety Precautions When Using Oxygen

SCOPE: ROSC Staff

POLICY:

To assure safe handling of oxygen in the facility.

DISCUSSION:

Oxygen is a non-flammable, non-explosive gas, however it readily supports combustion. Any material that will burn in air will ignite more readily in an oxygen-enriched atmosphere. The higher concentration of oxygen, the greater is the intensity of burning.
When oxygen is administered, the following precautions must be taken to prevent explosions and fire.

PROCEDURE:

1. The facility is a “no smoking” facility. “No Smoking” signs are posted and visitors are reminded of this policy.
2. Any defect in the oxygen administration system such as a leak or a malfunctioning flow meter must be reported to Management who contacts the appropriate service for repair or replacement of the part.
3. Oxygen equipment must have an oxygen pressure interlock system and fail safe mechanism.
4. All electrical cords and equipment must be grounded.
5. Materials such as oil, grease, alcohol and other highly flammable substances must be kept away from oxygen and oxygen equipment.
6. Be sure there is no oil on hands when handling any oxygen administration equipment.

TITLE: Safety When Moving Patients or Objects

SCOPE: ROSC Staff

POLICY:

To provide guidelines for moving patients and objects to avoid injury to staff.

PROCEDURE:

1. Lifting:

    a. Look over the object to be lifted; making sure it is not too heavy or clumsy to handle alone.
    b. Stand close to the object with feet apart for balance. Make sure footing is secure.
    c. Bend knees. Keep back as straight as possible.
    d. Get a good grip and keep the weight close to your body.
    e. Lift gradually. Straighten knees and stand. Use leg muscles. Avoid quick, jerky motions.
    f. When the weight is too heavy or the object is too bulky to lift safely, get help.

2. Pushing and pulling objects:

    a. Get a good grip on the object; hands inside handles.
    b. Keep back as straight as possible.
    c. Brace your feet for maximum leg power.
    d. Bend your knees to get the best use of your body weight.

3. Carrying:

    a. Keep the load close to your body.
    b. Make sure your vision is clear and the load does not obstruct your view.
    c. Do not change your grip while carrying the load.
    d. Always face the spot on which the load will rest.

4. Transferring:

    a. Lock bed, recliner or wheelchair
    b. Explain transfer steps
    c. Encourage independent movement from the individual
    d. Keep individual close to the body
    e. Follow steps for lifting
    f. Transfer to locked bed, recliner or wheelchair
    g. Secure
    h. individual

TITLE: Use of Side Rails

SCOPE: All Staff

POLICY:

To assure the safety of patients who have had sedation or anesthetic drugs.

PROCEDURE:

1. The side rails of stretchers are put in an upright position if the patient has been given a preoperative sedative.
2. All patients transported on a stretcher must have the side rails in an upright position.
3. When the procedure is complete and the anesthetized patient is moved to the stretcher, the side rails are put in an upright position and remain up until the patient is transferred to a recliner or discharged.

TITLE: Sentinel Event or Never Event

SCOPE: ROSC Physicians, Anesthesiologists, Staff

POLICY:

To identify and report to appropriate health regulatory agencies events resulting in an unexpected outcome. A thorough investigation for root cause analysis, implementation of improvement to reduce risk, and monitoring of the effectiveness of process improvement will occur following any reportable event.

DEFINITION:

Per NRS 439.830 defines a sentinel event as: an unexpected occurrence involving facility-acquired infection, death or serious physical or psychological injury or the risk thereof, including, without limitation, any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. The term includes loss of limb or function.

PROCEDURE:

Any event identified below is reported to the Department of Health and Human Services-Nevada Division of Public and Behavioral Health. All occurrences are reported by the next business day.

A written report using the format provided by the State is completed and returned within 5 days of the occurrence. Prevention is encouraged through safe practices by the healthcare team.

A root cause analysis will be performed for each sentinel event that occurs. Reference root cause analysis protocol.

REPORTABLE OCCURRENCES:

As of October 1, 2013 reportable events to the state Sentinel Registry include:

Surgical or Invasive Procedure Events

A. Surgery or other invasive procedure performed on the wrong site
B. Surgery or other invasive procedure performed on the wrong patient
C. Wrong surgical or other invasive procedure performed on a patient
D. Unintended retention of a foreign object in a patient after surgery or other invasive procedure

E. Intraoperative or immediately postoperative/post procedure death in an American Society of Anesthesiologists Class 1 patient

Product or Device Events

A. Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting
B. 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.
C. Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting.

Patient Protection Events

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

Care Management Events

A. 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)
B. Patient death or serious injury associated with unsafe administration of blood products
C. Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting
D. Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy
E. Patient death or serious injury associated with a fall while being cared for in a healthcare setting
F. Any Stage 3, Stage 4, or un-stage-able pressure ulcers acquired after admission/presentation to a healthcare setting
G. Artificial insemination with the wrong donor sperm or wrong egg
H. Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen
I. Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results.

Environmental Events

A. Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting
B. Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances
C. Patient or 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
D. Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting.

Radiologic Events

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

Potential Criminal Events

A. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider
B. Abduction of a patient/resident of any age
C. Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting
D. 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.

Financial Accountability

A. If an RN or Physician causes an event, the Facility will not bill the patient or the patient's insurance for any charges or fees.

Employee Advocacy Program

A. The Reno Orthopedic Clinic and Reno Orthopedic Surgery Center offer an employee advocacy program to all employees. This program provides support and resources to employees who are experiencing work or personal issues.

TITLE: Root Cause Analysis

SCOPE: ROSC Physicians, Anesthesiologists, Staff

POLICY: In the instance of a sentinel event, a root cause analysis will be performed. All staff involved in the sentinel event must attend and participate. The affected patient/ family member, as deemed appropriate, is encouraged to participate in the root cause analysis.

DEFINITION: A root cause analysis is a team approach to review the sentinel or never event, asses contributing factors, and discuss new processes to prevent future events from occurring.

PROCEDURE:

1. An incident report is to be filled out after a sentinel event occurs. The incident report should contain detailed information regarding the sentinel event. The incident report should include but is not limited to, the names of everyone involved, location and time of the event, type of incident, a detailed description of what happened, and ideas of how to prevent such events from occurring in the future. The form is returned to a supervisor or manager when completed.
2. The management team will review the incident report. If the incident has been deemed a sentinel or never even a root cause analysis is conducted.
3. A root cause analysis form is to be completed by all staff members involved in the incident. This includes any medical professional and staff involved in the care of the affected patient during the preoperative, intraoperative, and postoperative period. Within this form information will be provided including:
    A. Description of what happened.
    B. Identify contributing factors.
    C. Analysis of the root causes.
    D. Ideas for change of process to eliminate root causes.

4. Leadership, staff involved, and the patient or family member affected will conduct a meeting to review the root cause analysis form.
5. Patient/family members who are willing and able will be interviewed to collect information regarding the event.
6. Actions to prevent the issue from reoccurring is reviewed and discussed in depth.
7. The suggested preventative actions reviewed in the root cause analysis will be presented to the Medical Advisory Committee for review.
8. Once approved by the Medical Advisory Committee, the preventative action plan will be presented to the Reno Orthopedic Clinic Board for approval.
9. If approved by the Reno Orthopedic Clinic Board, preventative measures are implemented into the current workflow process.
10. Policies are updated as needed to confirm such an event does not occur again.
11. The patient/ family members will be notified of changes initiated based on the root cause analysis preformed to reduce the risk of such events from reoccurring at the Reno Orthopedic Surgery Center.