PURPOSE:

I. The purpose of the Patient/Resident Safety Plan (PRSP) is to improve patient safety and reduce risk to patient/residents through an environment that promotes:
   a. Recognition and acknowledgment of risks to patient safety and medical/health errors;
   b. The initiation of actions to reduce these risks;
   c. The internal reporting of findings and the actions taken;
   d. A focus on processes and systems;
   e. Minimization of individual blame or retribution for involvement in a medical / health care error;
   f. Organizational learning about medical/health care errors and safety factors;
   g. Support of the sharing of knowledge to effect behavioral changes within Boulder City Hospital (BCH)
   h. Individual responsibility to identify report and participate in the solution of safety risks.

POLICY:

NOTE: The term Patient will be used throughout this policy to represent patients, residents and clients.

I. The PRSP provides a systematic, coordinated and continuous approach to the maintenance and improvement of patient safety through:
   a. The establishment of mechanisms that support effective responses to actual occurrences;
   b. Ongoing proactive reduction in medical / health care errors; and
   c. Integration of patient safety priorities into the new design and redesign of all relevant organization processes, functions and services.
   d. Zero tolerance for workplace violence. BCH strives to maintain a harmonious work environment free from violence and intimidation. Weapons of any kind are prohibited. Violent acts, threatening, harassing, discriminating, disruptive behavior (conflict that disrupts the work and jeopardizes the safety of individuals) and/or coercing behavior are prohibited and may result in disciplinary action up to and including termination (for employees) and/or legal action as warranted.

II. As patient care and therefore the maintenance and improvement of patient safety, is a coordinated and collaborative effort, the approach to optimal patient safety involves multiple departments and disciplines in establishing the plans, processes and mechanisms that comprise the activities to maintain patient safety. This plan works in conjunction with the facility-wide Safety/Emergency Preparedness Manual which has inter-facility and department specific policies as necessary to address safety concerns such as Fire, Emergency Preparedness for Internal and External Disasters, Pandemic Events, etc.
   The PRSP was developed by the interdisciplinary Safety Committee and approved by the Medical Staff, Board of Trustees and Administration and outlines the components of the organization's PRSP.

PROCEDURE:

I. Scope of Activities
   a. Ongoing assessment, monitoring, tracking and trending with analysis using internal and external knowledge and experience to:
      i. Prevent error occurrence
      ii. Maintain and improve patient safety
   b. Patient/Resident Safety Occurrence Information:
      i. Collected from aggregated data reports and individual occurrence reports.
      ii. Will be reviewed by the Safety Committee.
      iii. Is used to prioritize organizational patient safety activity efforts.

II. Types of Patient/resident Safety or Medical/Health Care Errors
   a. No Harm Errors
      i. Unintended acts, either of omission or commission;

ii. Acts that do not achieve their intended outcome; and/or
iii. Acts that do not result in a physical or psychological negative outcome, or the potential for a negative outcome, to the patient

b. Mild to Moderate Adverse Outcome Errors
i. Any medication error (mindful of the errors that result from: incomplete and/or inaccurate medication orders, transcription and documentation; not adhering to the 5 rights of medication administration; inappropriate labeling as well as inappropriate monitoring and storage of medications)
ii. Any Adverse Drug Reaction (ADR)
iii. Any transfusion reaction
iv. Hazardous Condition
1. Any set of circumstances, exclusive of the disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious physical or psychological adverse patient outcome.
v. Any Healthcare Associated Infection (HAI) including but not limited to Central Line Associated Blood Infections (CLABSI); Catheter Related Urinary Tract Infections (CAUTI); c-diff infections
vi. Any Health Care Associated Stage III or IV Pressure Ulcer
vii. Any patient falls with injury
viii. Any patient aspiration
ix. Any motor vehicle accident wherein a patient was a passenger

c. Sentinel Event (SE):
i. Unexpected adverse occurrence involving death or serious injury or psychological injury or the risk thereof. Serious injury specifically includes the loss of limb or function. A sentinel event is an adverse event of a severe and urgent nature that can result in an unexpected and undesirable patient outcome. (Example: Surgery on the wrong patient or removal of the incorrect limb). The phrase “the risk thereof” includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. A Sentinel Event: (Refer to BCH Policy, “Sentinel Events”)
ii. Potentially involves a continuing threat to patient care or safety
iii. Has significant potential for being reflective of serious underlying systems problems within an organization
iv. Potentially undermines public confidence in the organization
v. A “Near Miss” is any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome. Refer to BCH Policy, “Sentinel Events” For this policy, all reference to Sentinel Events includes Near Miss events as well.

III. Scope of Program
a. Encompasses:
i. Patient, resident and client population;
ii. Visitors;
iii. Volunteers; and
iv. Staff (including Medical Staff)

b. Addresses:
i. Maintenance and improvement in patient/resident safety issues in every department throughout the facility
ii. Emphasizes hospital and patient care functions of:
1. Ethics, Rights & Responsibilities
2. Provisions of Care
3. Improving Organization Performance

4. Leadership
5. Medication Management
6. Management of the Environment of Care
7. Management of Human Resources
8. Management of Information
9. Surveillance, Prevention, and Control of Infection

c. Assures:
   i. All departments have current Safety Manual available on-line
   ii. Emergency Preparedness Quick Reference Guide "Red Book" is available in high traffic areas
   iii. Senior Leaders are FEMA trained (100,200, and 700) and NIMS compliant
   iv. Hospital Decontamination Program (and related equipment) is available and compliant with current regulations
   v. Enforced Hand Hygiene policy
   vi. Adherence to Standard Precautions with implementation of Isolation Precautions when necessary
   vii. Maintenance of a sanitary environment through interdepartmental collaboration, product and service evaluation and monitoring effectiveness

IV. Methodology
a. Responsibility
   i. The Committee meets monthly and is responsible for oversight of the Patient/Resident Safety Program
   ii. The Patient Safety Officer will have administrative responsibility for the program
b. Membership will include but not be limited to:
   i. Safety Officer
   ii. Physician
   iii. Chief Nursing Officer/Patient Safety Officer
   iv. Pharmacy Staff Representative
   v. Human Resources Representative
   vi. Laboratory Representative
   vii. Long Term Care Representative
   viii. Acute Nursing Services Representative
   ix. Purchasing/Central Supply Representative
   x. Environmental Services Representative
   xi. Chief Executive Officer
   xii. Risk Manager
   xiii. Infection Control Nurse
   xiv. Program Manager GeroPsych
c. Communication
   i. **All departments**, both patient care and non-patient care are responsible to report patient safety occurrences and potential occurrences to the Risk Manager. Through the Quality Reporting and Resolution system (QRR)
   ii. Risk Manager will aggregate occurrence information and present a report to the Committee on a quarterly basis.
   iii. The report will contain aggregated information related to:
      1. Type of occurrence;
      2. Severity of occurrence;
      3. Number/type of occurrences per department;
      4. Occurrence impact on the patient;
      5. Remedial actions taken; and
      6. Patient/resident outcome.
   iv. The Committee will:

1. Analyze the report information; and
2. Determine further patient safety activities as appropriate.

v. The Committee will make recommendations for action and implementation and will follow-up as appropriate. Safety information is relayed to Department Managers, the Medical Executive Committee and the Board of Trustees who will then share the information during meetings and/or through communiqués.

V. Review of Internal and External Reports

a. To include, but not be limited to:
   i. Sentinel event report information;
   ii. HAI statistical report;
   iii. Fire and Disaster Drill reports;
   iv. Occurrence reporting;
   v. Injury Report;
   vi. Information from state and federal sources;
   vii. Current literature;
   viii. Performance Improvement reports.
   ix. Safety Survey results (performed at least annually)

b. The Committee will select at least one high-risk safety process for an annual proactive risk assessment.

c. The proactive risk assessment will include:
   i. Assessment of the intended and actual implementation of the process.
   ii. Identify the steps in the process if there may be any undesirable variations.
   iii. Identification of possible effects of the undesirable variation on patient/residents.
   iv. How serious the possible effects on the patient/resident could be.
   v. For the most critical effects, conduct a failure mode event analysis (FMEA) to determine why the undesirable variation leading to that effect may occur.
   vi. Redesign the process and/or underlying systems to:
      1. Minimize the risk of that undesirable variation; or
      2. Protect patient/residents from the effects of that undesirable variation.
   vii. Test and implement the redesigned process.
   viii. Identify and implement measures of the effectiveness of the redesigned process.
   ix. Implement a strategy for maintaining the effectiveness of the redesigned process over time.

VI. Identification of a Medical/Health Care Error

a. Note that the following Quality Improvement Policies are pertinent to this section: Medication Errors [HWN 139], Decreasing Medication Errors [HWN 142] and Safe Medication Practices [HWN 145]

b. The staff member will immediately:
   i. Perform and/or obtain necessary healthcare interventions to protect and support the patient's clinical condition;
   ii. As appropriate to the occurrence, perform necessary healthcare interventions to contain the risk to others – example: immediate removal of any recalled item from stock.
   iii. Contact the patient's attending physician and other physicians, as appropriate, to report the error, carrying out any physician orders as necessary;
   iv. Preserve any information related to the error including physical information such as:
      1. Removal and preservation of blood unit for a suspected transfusion reaction;
      2. Preservation of IV tubing, fluids bags and/or pumps for a patient/resident with a severe drug reaction from IV medication;
      3. Preservation of medication label for medications administered to the incorrect patient/resident;
      4. Documenting the facts regarding the error in the medical record *as appropriate* to organizational policy and procedure;

5. Reporting the medical/health care error to Department Director and Attending Physician; and,
6. Enter the occurrence report into the Quality Review Report system. Risk Manager will review.

c. Any individual in any department identifying a potential patient safety issue will:
   i. Immediately notify his/her supervisor; and
   ii. Document the findings in QRR system.

d. Patient, and family member as appropriate; and officiating agency will be notified timely of safety concerns and/or medical errors including HAI, ADR, SE, etc.

VII. Response

a. Staff response to medical/health care errors is dependent upon the type of error identified.

b. Error types:

i. <u>Near miss</u>
   1. Report the near miss event to immediate supervisor;
   2. Describe the facts of the near miss in the QRR System

ii. <u>No harm errors (including “no harm” medication errors)</u>
   1. Document appropriately in the medical record according to policy;
   2. Document the circumstances regarding the no harm error in the QRR system; and
   3. Notify the immediate supervisor.

iii. <u>Mild to moderate adverse outcome errors (including medication errors)</u>
   1. Perform any necessary clinical interventions to support and protect the patient/resident;
   2. Notify the physician and staff responsible for the patient/resident;
   3. Carry out any necessary physician orders;
   4. Preserve any physical evidence as appropriate;
   5. Notify immediate supervisor;
   6. Document facts appropriately in the medical record and in the QRR system.

iv. <u>Adverse Drug Reaction</u>
   1. Perform any necessary clinical interventions to support and protect the patient;
   2. Notify the physician staff responsible for the patient;
   3. Execute any necessary physician orders;
   4. Preserve any physical evidence as appropriate;
   5. Notify immediate supervisor;
   6. Document facts appropriately in the medical record and in the QRR system;
   7. Report ADR to Pharmacy via an ADR form; and
   8. Notify patient/resident and/or family

v. <u>Transfusion Reaction</u>
   1. Perform any necessary clinical interventions to support and protect the patient;
   2. Notify the physician responsible for the patient;
   3. Carry out any necessary physician orders.
   4. Follow the Administration of Blood and/or Blood Products and the Adverse Reaction to Blood Transfusion policies in House Wide P & P Manual including completion of a QRR

vi. <u>Hazardous Condition Patient Safety Issue</u>
   1. As appropriate, and if possible, staff will:
      a. Contain the hazardous condition or patient safety issue;
      b. Immediately notify supervisor;
      c. Document the findings in the QRR System;
      d. Notify patient
      e. Notify agencies as appropriate

2. BCH has identified three significant clinical safety concerns based on the age of the population we serve and the historical data analyzed:
    a. Falls with injuries
    b. Aspiration
    c. Hospital Acquired Infection
3. For significant safety concerns, BCH has established:
    a. A mechanism to identify individuals at risk
    b. Plans to prevent the occurrence of these safety concerns
    c. A reporting mechanism using the Quality Review and Report system (internal) to track, trend and analyze data reporting to the appropriate internal committees including the Safety Committee, Quality Improvement Committee, Medical Quality Improvement Committee, Medical Executive Committee, and the Board of Trustees
    d. Timely forward reporting of pertinent information to applicable agencies including but not limited to the State of Nevada Bureau of Health Care Quality and Compliance, the Ombudsman, the Sentinel Event Registry, the Southern Nevada Health District, etc.
    e. At a minimum annual staff education regarding these safety concerns

vii. <u>Sentinel Event</u>
1. Perform any necessary clinical interventions to support and protect the patient;
2. Notify the physician and staff responsible for the patient;
3. Carry out any necessary physician orders; and
4. Notify the patient documenting notification;
5. Follow the Sentinel Event Policy and Procedure (see BCH Policy “Sentinel Events” in House Wide P & P Manual).
6. Report event to the appropriate committees including Safety, Quality Improvement and Medical Quality Improvement, Medical Executive and Board of Trustees

VIII. Organizational Response
a. Established policy and/or the Hospital Quality Improvement Committee will determine the organizational response to medical/health care errors and occurrences.
b. Sentinel events and “Near Misses” will have a root-cause analysis conducted.
c. The Committee, based on internal and external data analysis and prioritizing of patient safety criticality, will determine:
    i. Further remedial action activities necessary for identified occurrences;
    ii. Proactive occurrence reduction activities; and
    iii. Necessity and benefit of root cause analysis performance for identified occurrences or proactive reduction activities.
d. Resolution
    i. Non-Punitive Approach
        1. An effective Patient/Resident Safety Program cannot exist without optimal reporting of medical/health care errors and occurrences.
        2. The intent of this institution is to adopt a non-punitive approach in its management of errors and occurrences.
        3. All personnel are ***<u>required</u>*** to report suspected and identified medical/health care errors and should do so without the fear of reprisal in relationship to their employment.
        4. This organization supports the concept that errors occur due to a breakdown in systems and processes.
        5. Focus will be given on improving systems and processes rather than disciplining those responsible for errors and occurrences.

6. A focus will be placed on remedial actions to ***assist*** rather than punish staff members.
7. The Committee and the individual department Managers will determine the appropriate course of action to prevent error recurrence.

ii. Sentinel Events

1. Staff members involved in a sentinel event occurrence will receive support to facilitate the staff member's professional and emotional reconciliation of the sentinel event.
2. The staff member will be allowed an active role in process resolution as well as the root-cause analysis and action plan processes.
3. Any staff member involved in a sentinel event or other medical/health care error may request and receive supportive personal counseling as per the Sentinel Event Policy and Procedure and Employee Assistance Program.

e. Evaluation

i. The Patient/Resident Safety Program includes an annual survey of patients, their families, volunteers and staff (including medical staff) opinions, needs and perceptions of risks to patients and requests suggestions for improving patient/resident safety.

ii. In keeping with a non-punitive philosophy designed to encourage reporting and resolution of errors, the staff will be queried annually regarding safety concerns including their willingness to report medical/health care errors.

f. Education

i. Staff will receive education and training:

1. During their initial orientation process; and
2. On an ongoing basis regarding job-related aspects of patient safety.

ii. Education and training will include:

1. The need and method to report medical/health care errors and other safety concerns;
2. Providing the optimal provision of healthcare in an interdisciplinary manner; and
3. An interdisciplinary approach to patient care.

g. Reporting

i. BCH values transparency working together as an organization accountable to the licensing and quality agencies as well as to our patients, staff, medical staff, volunteers and our community

ii. Medical/health care errors and occurrences, including sentinel events, will be reported internally and externally per hospital policy and through the channels established by this plan.

iii. External reporting will be performed in accordance with all state, federal and regulatory body rules, laws and requirements. Refer to House wide policy HWN 135 Reportable Events.

iv. Patient safety reports from the Safety Committee will be submitted to the Medical Executive Committee and the Quality Improvement Committee.

v. The Board of Trustees has the opportunity to review and ask questions during every other month meeting as the minutes of committees are contained within the Medical Executive Committee minutes for approval by the board.