Pouya Mohajer, M.D., LTD dba PriMMed:

QUALITY AND PATIENT SAFETY PLAN

DATE: 03/16/2023
VERSION: 01

This plan was created and revised by the Pouya Mohajer, M.D., LTD dba PriMMed, Patient Safety committee/team. Implementation of this plan is intended to optimize the healthcare quality and patient safety outcomes, encourage recognition, reporting, and acknowledgment of risks to patient, visitor, and employee safety, as well as reduce the medical/healthcare errors and /or preventable events.

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Commitment to Patient Safety

Pouya Mohajer, M.D., LTD dba PriMMed is committed to a comprehensive approach to improving healthcare quality and patient safety by aligning with our Mission, Vision, and Values, creating an environment that supports a dynamic, proactive, and safe culture for patients, family members, visitors, and employees, through continuous learning and improving patient safety policies, systems, and processes.

Mission, Vision, and Values

In support of our mission, vision, and values, Pouya Mohajer, M.D., LTD dba PriMMed Patient Safety and Quality Improvement program promotes:

- Collaboration of healthcare, leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high quality healthcare.
- Communicate honestly and openly to foster trusting and cooperative relationships among healthcare providers, staff members, and patients and their families, to ensure accountability for the patient safety priorities.
- Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.
- Responsibility for every healthcare related decision and action.
- A focus on continuous learning and improving, system design, and the management of choices and changes, bringing the best possible outcomes or performances to the facility.
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare.
- Education of staff and physicians to assure participation of healthcare providers.

Scope and Purpose

The scope of this Quality and Patient Safety Plan is organizational-wide which includes but is not limited to

- Patient safety
- Visitor safety
- Employee safety

All staff in Pouya Mohajer, M.D., LTD dba PriMMed are required to fully support and participate in this plan, and devote their expertise to the patient safety and healthcare quality improvement process.

This plan is action oriented and solution focused. The purpose of this plan is to address patient safety related concerns, challenges and revise the program to better serve the patients and their families. To this end, Pouya Mohajer, M.D., LTD dba PriMMed has developed this Patient Safety Plan.

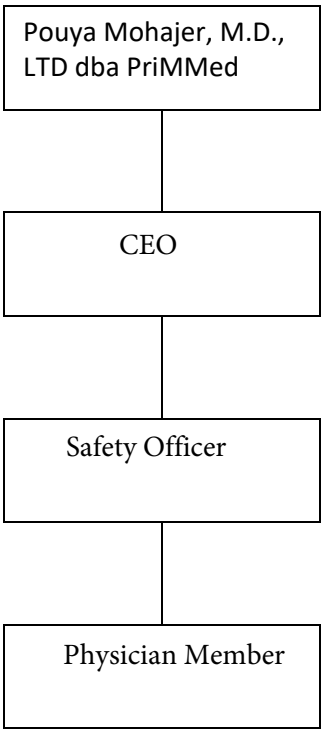
The plan focuses on the process rather than the individual, and recognizes both internal and external customers, as well as facilitates the need of analyzing and improving processes. The core principles of this plan include:

- All staff have the same goal and contribute their knowledge, vision, skill, and insight to improve the process of the Patient Safety Plan.
- Decisions will be based on data and facts, and staff will be encouraged to learn from the experiences.
- Customer based including patients, families, and visitors.
- Promote systems thinking.
- Employ well-trained and competent staff maintaining high healthcare quality.

Roles and Responsibilities

According to NRS 439.875, a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plan is promoted and executed successfully.

The Patient Safety Committee Organization



Roles and Responsibilities

- In accordance with NRS 439.875, a patient safety committee must be comprised of:
- The infection control officer of the medical facility;
- The patient safety officer of the medical facility, if he or she is not designated as the infection control officer;
- At least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility; and
- One member of the executive or governing body of the medical facility.

Based on NAC 439.920, a medical facility that has fewer than 25 employees and contractors must establish a patient safety committee comprised of:

- The patient safety officer of the medical facility;
- At least two providers of healthcare who treat patients at the medical facility, including but without limitation, one member of the medical staff and one member of the nursing staff of the medical facility; and
- The Chief Executive Officer (CEO) or Chief Financial Officer (CFO) of the medical facility.

The roles and responsibilities are defined below

Patient Safety Committee Responsibilities (based on NRS 439.875 and NRS 439.877)

- Monitor and document the effectiveness of the patient identification policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to NRS 439.877(4)(b).
- Receive reports from the patient safety officer pursuant to NRS 439.870.
- Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred.
- Review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- Review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the executive or governing body of the facility regarding:
  (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);

(2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and

(3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.

- Adopt patient safety checklists and patient safety policies as required by NRS 439.877, review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

Root Cause Analysis (RCA) Team Responsibilities

- Root Cause interviews, analysis, investigation, and corrective action plan implementations.
- Participates in the RCA meetings and discussions.
- Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders.

Patient Safety Officer Responsibilities (based on NRS 439.870)

- Serve on the patient safety committee.
- Supervise the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to NRS 439.835.
- Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the patient safety committee regarding any action taken in accordance with the responsibilities above.

Infection Control Officer Responsibilities (based on NRS 439.873)

- Serve on the patient safety committee.
- Monitor the occurrences of infections at the facility to determine the number and severity of infections.
- Report to the patient safety committee concerning the number and severity of infections at the facility.
- Take such action as determines is necessary to prevent and control infections alleged to have occurred at the facility.
- Carry out the provisions of the infection control program adopted pursuant to NRS 439.865 and ensure compliance with the program.

RCA team leader Responsibilities

- Organize and coordinate the RCA process.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA, and corrective action plan implementation process.

- Communicate the progress of the investigation, institutional barriers, and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.
- Provide training, education and direction to create RCA process that incorporate the Patient Safety and Quality Improvement elements.

Executive or Governing Body Staff Responsibilities

- Provide vision and leadership to Patient Safety and Quality Improvement process, and develop and foster a safe learning and improving culture.
- Provides oversight to the healthcare quality improvement processes and teams.
- Plan, discuss, and generate the organization patient safety goals and activities, in conjunction with the patient safety action plans

The Patient Safety Committee will meet monthly (or quarterly) to accomplish the following:

- Report and discuss sentinel events which include:
  - Number of sentinel events from previous calendar month (or quarter).
  - Number of severe infections that occurred in the facility.
- Corrective Action Plan for the sentinel events and infections
  - Evaluate the corrective action plan.
- Patient safety policies and checklists
  - At least annually evaluate Patient Safety policies and checklists
  - Revise the patient safety policies and checklists as needed.
  - Monitor and document the effectiveness of the patient safety policy.

A RCA meeting will meet as needed to accomplish the following:

- Define the healthcare issues or potential risks.
- Conduct Root Cause Analysis
  - Reviewing and analyzing the data.
  - Reviewing the RCA process and quality improvement related activities and timelines.
  - Brainstorming issues or the potential risks by using the fishbone diagrams.
  - Identify the contributing factors and conduct the Root Cause Analysis.
- Conduct Corrective Action Plan
  - Identifying the Plan-Do-Study-Act (PDSA) topics.
  - Discussing corrective action process and activities.
  - Discussing and presenting possible changes in procedure to improve areas indicated.
  - Identifying strengths and areas that need improvement.
  - Developing strategies, solutions, and steps to take next.
- Identify barriers and technical assistance needs for supporting the RCA efforts.

A meeting agenda and minutes noting follow-up tasks will be kept.

Objectives and Goals of the Quality and Patient Safety Plan

Objective	Goals	Plan	Planned Completion Date	Responsible Party
Continuously monitor safety protocols	To have no incidents	Meet as a team quarterly to evaluate feed back from providers and staff. As needed evaluate items which can improve safety.	12/31/2022	Safety Committee
Utilize training to improve patient safety	To ensure all standards and protocols are being met by each team members	Monthly training of all medical staff	12/31/2022	Safety Committee

Components and Methods

Pursuant to NRS 439.837 and NAC 439.917, within 45 days after reporting a sentinel event pursuant to NRS 439.835, the medical facility shall conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event."

Pouya Mohajer, M.D., LTD dba PriMMed will use RCA process to determine the contributing factors and the underlying reasons for the deficiencies or failures. The Plan-Do-Study (check)-Act (PDSA or PDCA) is the model, which was developed by the Institute of Health Care Improvement that we will use to test the changes.

Root Cause Analysis

A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals.

Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

Root cause analysis and action plan framework table, which was introduced by the Joint Commission. It contains 24 analysis questions. It guides the organization to the steps in a root cause analysis. Not all the questions apply to all the events or cases. This table can be used individually or with the fishbone diagram.

5 Whys technique will be used in Pouya Mohajer, M.D., LTD dba PriMMed to explore the cause and effect relationship underlay a problem. One can find the root causes by asking "why" no less than five times. This technique can be used individually or as a part of the fishbone diagram.

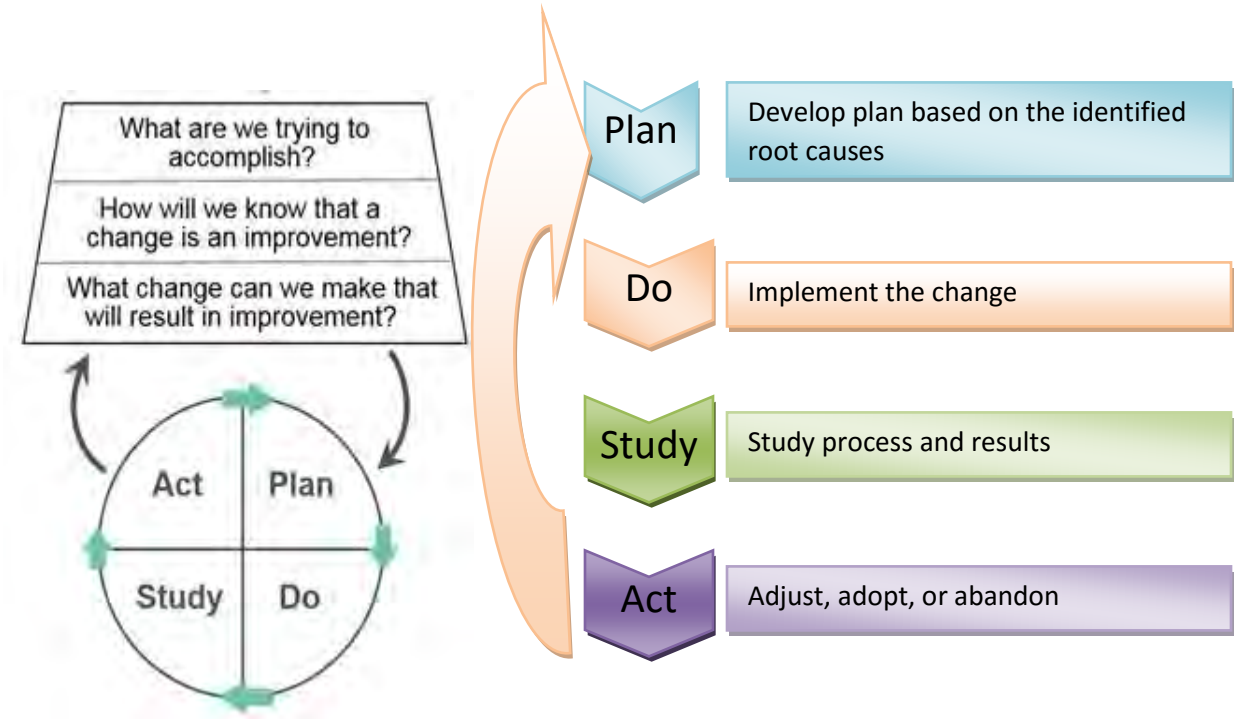
Fishbone Diagram

Once the problems are identified, a Fishbone Diagram (Appendix C) will be used for analyzing the problems. You can use the fishbone diagram individually to analyze the root causes, or use it with the root cause analysis and action plan framework table.

A Fishbone Diagram, also called a Cause-and-Effect diagram, is a useful tool for a team to structurally brainstorm by discovering possible underlying factors or root causes from different major categories for the chosen problems. General categories used include: people, methods, materials, measurements, education, procedures, process, location, environment, etc. RCA team members will brainstorm and ask multiple times, "why did this happen?" for each cause until all ideas are exhausted. The highest priority root causes will be chosen for PDSA topics. Once all the categories are established on the fishbone diagram, 5 Why's technique also can be used to drill down the problem and find the root causes.

Model for Improvement

The Model for Improvement is a collaborative and ongoing effort model to improve the product and services quality and process. It provides multi-disciplinary quality team guidance from identifying the root causes; conducting the best tests to assess possible changes, and working in collaboration for implementation of the new approaches and solutions. It guides the test of a change to determine if the change is an improvement.



The cycle is defined as follows:

- Plan--Collect data and establish appropriate goals. Identify the problem and the possible root causes, and answer the following questions.
  - What is the objective of the test?

- What are the steps for the test - who, what, when?
- How will you measure the impact of the test?
- What is your plan to collect the data needed?
- What do you predict will happen?

- Do--Make changes designed to correct or improve the situation. Use the following questions for the guidance.
  - What were the results of the test?
  - Was the cycle carried out as designed or planned?
  - What did you observe that was unplanned or expected?

- Study -- Study the effect of the changes on the situation. Data should be collected on the new process and compared to the baseline or expected results. Results should be evaluated by using the following questions as guidance.
  - Did the results match your prediction?
  - What did you learn?
  - What do you need to do next?

- Act--If the result is successful or desirable, standardize the changes and then work on the next prioritized problem or the further improvements. If the outcome is not yet successful, look for different ways to identify the causes or change the testing process.

PDSA worksheet will be used to map the potential change strategies and to establish a course of action. The PDSA worksheet and the PDSA progress report are attached in Appendix D-1.

Data Collection and Reporting

Data should drive any quality and patient safety effort. Pouya Mohajer, M.D., LTD dba PriMMed is using Red Dot for tracking the sentinel events, healthcare infection data, and (any other database) for internal data collection.

External data sources are those data sources which are collected outside the supervisory structure of the case. External data which will be utilized for Quality and Patient Safety plan include the data from:

- AHRQ: Agency for Healthcare Research & Quality
- CDC: Centers for Disease Control and Prevention
- CMS: Centers for Medicare & Medicaid Services
- NQF: National Quality Forum
- NHSN: National Healthcare Safety Network
- TJC: The Joint Commission

Ongoing Reporting and Review

Data points such as the following will be reviewed according to the schedule prescribed:

Monthly	Quarterly	Annually
1) Sentinel event monthly report 2) Severity of infection report 3) RCA assessment	1) Sentinel event quarterly report 2) Severity of infection report 3) Review and evaluate the measure of improvement of patient safety 4) Review and evaluate the measurement to prevent and control infections	1) Quality and Patient Safety Plan update 2) Checklists and Policies reviewing and revising

Assessment of the Quality and Patient Safety Plan

Please see the Patient Safety Assessment Tool (PSAT) from the VA National Center for Patient Safety for your reference.

Patient Safety Checklists and Patient Safety Policies

By NRS 439.865, the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

The patient safety checklists must follow protocols to improve the health outcomes of patients at the medical facility and must include, without limitation:

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.
- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
    - Proper instructions concerning prescription medications;
    - Instructions concerning aftercare;
    - Any other instructions concerning his or her care upon discharge; and
    - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include, the name and date of birth of the patient.

- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.

- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

Based on NRS 439.865, the patient safety plan must also include an infection control program that carries out the infection control policy. The policy must consist of:

- The current guidelines appropriate for the facility's scope of service developed by a nationally recognized infection control organization as approved by the State Board of Health which may include, the Association for Professionals in Infection Control and Epidemiology (APIC), the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO) and the Society for Healthcare Epidemiology of America (SHEA); and
- Facility-specific infection control developed under the supervision of a certified Infection Preventionist.

The patient safety checklists are listed in Appendix E. (The following links provide some patient safety checklists for your reference— a checklist example is shown in **Appendix E**.)

http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf

http://www.who.int/patientsafety/implementation/checklists/en/

The patient safety policies are listed in Appendix F. (The following link provides you some patient safety policies for your reference—a policy example is shown in **Appendix F**.)
https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1

Approval of Patient Safety Plan

According to NRS 439.865, a medical facility shall submit its patient safety plan to the governing board of the facility for approval. After a facility's patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan.

The patient safety plan must be reviewed and **updated annually** in accordance with the requirements for approval set forth in this section.

According to NRS 439.843, on or before March 1 of each year, a copy of the most current patient safety plan established to NRS 439.865 must be submitted to the Division of Public and Behavioral Health.

Reference

- Root Cause Analysis Toolkit http://www.health.state.mn.us/patientsafety/toolkit/
- Quality and Service Improvement Tools http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html
- CQI 101 An Introduction to Continuous Quality Improvement: https://www.coursehero.com/file/13827355/CQI-Overviewppt/
- Quality Improvement http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/
- Root Cause Analysis http://www.patientsafety.va.gov/professionals/onthejob/rca.asp
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2 https://www.jointcommission.org/sentinel_event.aspx
- Hospital Policies https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1
- Checklists to Improve Patient Safety http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf
- Patient Safety Checklists http://www.who.int/patientsafety/implementation/checklists/en/
- Minutes of the Meeting of the Quality and Patient Safety Committee http://www.cookcountyhhs.org/wp-content/uploads/2013/12/09-23-14-QPS-scan-Minutes.pdf
- Title 40 – Public Health and Safety https://www.leg.state.nv.us/NRS/NRS-439.html

Appendix A: Terms and Definitions

Patient Safety: The Agency for Healthcare Research Quality (AHRQ) defines patient safety as "a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events." http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

Sentinel event (NRS 439.830)

1. Except as otherwise provided in subsection 2, "sentinel event" means an event included in Appendix A of "Serious Reportable Events in Healthcare--2011 Update: A Consensus Report," published by the National Quality Forum.

2. If the publication described in subsection 1 is revised, the term "sentinel events" means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:

(a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or

(b) July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published.

3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.

(Added to NRS by 2002 Special Session, 13; A 2005, 599; 2013, 217)

Institute for Healthcare Improvement (IHI) defines **medical harm** as "unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death."

Facility-Associated Infection: (NRS 439.802)

"Facility-acquired infection" means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections;
- Ventilator-associated pneumonia;
- Central line-related bloodstream infections;
- Urinary tract infections; and
- Other categories of infections as may be established by the State Board of Health by regulation pursuant to NRS 439.890.

(Added to NRS by 2005, 599; A 2009, 553)

Medical facility (NRS 439.805)

"Medical facility" means:

- A hospital, as that term is defined in NRS 449.012 and 449.0151;
- An obstetric center, as that term is defined in NRS 449.0151 and 449.0155;
- A surgical center for ambulatory patients, as that term is defined in NRS 449.0151 and 449.019; and
- An independent center for emergency medical care, as that term is defined in NRS 449.013 and 449.0151.

(Added to NRS by 2002 Special Session, 13)

Near miss: An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Mandatory reporting: Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985;254(6):796-800.)

Risk: Possibility of loss or injury. (Merriam-Webster's Online Dictionary, Risk, Available at http://www.merriamwebster.com/dictionary/risk. Last Accessed August 2009.)

Preventable event: Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Catheter Associated Urinary Tract Infection (CAUTI): A urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CUR RENT_b.pdf.)

Central Line Associated Bloodstream Infections (CLABSI): Primary bloodstream infections that are associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection.

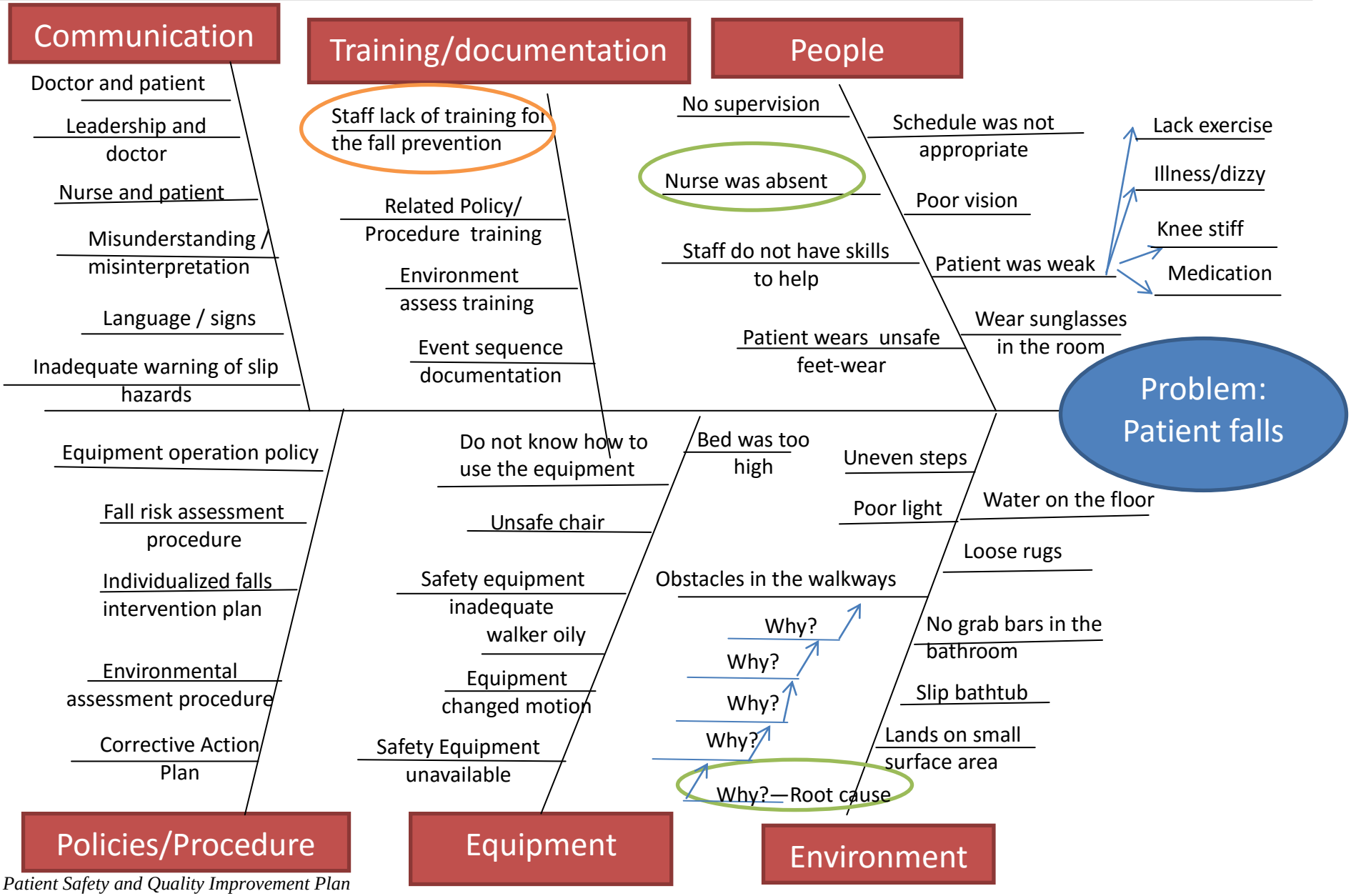
Appendix B: Patient Safety Goals

OBJECTIVE:	GOAL:	Q3 2014	Q4 2014	Q1 2015
		ACTION PLAN:		
1. Create Systems that anticipate errors & either prevent or catch them before they cause harm.	a. Enhance retrospective chart review process. b. Establish an automated surveillance process. c. Conduct a proactive risk assessment in a high risk area.		Complete an in-depth analysis of risk point utilizing the methods of FMEA.	Implement Trigger Tools. Develop automated surveillance reports in Cerner.
2. Establish Structures for reporting and a process for managing reports in the event reporting system.	a. Implement new electronic Voluntary Reporting System & participate in Patient Safety Organization. b. Develop a structure to educate employees system-wide of the process for reporting hazards, errors and adverse events. c. Establish a process for providing feedback regarding reported events.	Implemented e-MERS & PSO with UHC. Create process for reviewing & closing reports in e-MERS. Create process for communicating outcome of reported events.	Increase number of events reported by 10%.	
3. Develop a Culture of Safety where providers feel safe and supported when they report medical errors or near misses & voice concerns about patient safety.	a. Provide education on patient safety plan that emphasizes importance of blending a systems focus with appropriate individual accountability. b. Establish a recognition program that rewards safe practices. c. Improve overall perceptions of safety as measured by the Culture of Safety Survey.		Educate Medical staff, Hospital Wide Oversight & the Quality Committees on the objectives and goals of the patient safety plan. Include patient safety presentation in monthly New Employee Orientation. Develop 'Great Catch' awards program.	Re-evaluate culture of safety and develop action plan.
4. Establish Safety Priorities & Targets.	a. Develop Patient Safety Dashboard that includes national measures and benchmarks. b. Facilitate the development of action plans associated with measures not meeting benchmarks. c. Assess and improve processes related to hand-off, transition and communication	Complete 2014 Leapfrog Safety Survey. Develop method to track & report departmental progress and compliance of RCA action plans.	Present Patient Safety Dashboard monthly to Hospital Wide Oversight Committee. Establish & implement a plan to improve performance of each leap.	
5. Charter Safety Programs through teams, workgroups or projects.	a. Coordinate Improvement Efforts in order to ensure that capital, people, facilities & technologies are matched to strategic priorities for safe practices. b. Reduce and eliminate variation in care.	Establish workgroups focused on medication safety, reducing patient falls & hospital acquired pressure ulcers. Revise or develop policies, procedures and protocols.	Establish Patient Safety Council.	

Reference: Patient Safety Plan and Its Applicable Goals. 2014. Cook County Health and Hospitals System.

Patient Safety and Quality Improvement Plan

Appendix C: Fishbone Diagram



Appendix D-1: PDSA Worksheet

PDSA Worksheet

Topic:			
Person Completing Worksheet:		**Date:**	
Telephone/ Email:		**Cycle:**	
Patient Safety Committee Members			
CEOs/CFOs			
Patient Safety Officer			
Infection Control Officer			
Other Medical Staff			
Other team members			
Aim: (Describe the overall SMART goal that your team wishes to achieve.)			
Plan:			
1. List the tasks needed to set up this test of change.			
2. Predict what will happen when the test is carried out.			

3. List the steps to develop the test-who, what, and when.

Steps	**By Whom**	**By When**	**Desired Outcome**

Do: (Describe what actually happened when you ran your test, including any problems and unexpected findings.)

Study: (Describe what you learned and did you meet your measurement goal?)

Did you meet your measurement goal? Explain.	**Summarize what was learned: success, failure, unintended consequences, etc.**

Act: (Describe what you concluded from this cycle.)

Based on what was learned, please indicate what action will be considered.	**Describe what modifications to the plan will be made for the next cycle based on what you learned.**
☐ Adapt: modify changes and repeat PDSA Cycle	
☐ Adopt: expanding changes throughout organization	
☐ Abandon: change approach and repeat PDSA cycle	

Appendix D-2: PDSA Monthly / Quarterly Progress Report

Event:			
Person Complete Report:		Date:	
Patient Safety Officer		Contact Information:	

Monthly / Quarterly Report	
Items	**Description**
1. What is your goal?	
2. Report on the PDSA cycle	
3. What system and practices are working well? Explain.	
4. What areas for improvement did the data identify?	
5. What barriers or system issues have been encountered implementing action activities?	
6. Action plans to address the barriers or system issues	
7. Lesson learned	
8. Support needed	
9. Additional discussion	
Notes:	

Appendix E: Checklist Example: Injuries from Falls and Immobility

Process Change	In Place	Not Done	Will Adopt	Notes (Responsible & By When?)
Conduct fall and injury risk assessment upon admission		X		Medical Office not a hospital
Reassess risk daily and with changes in patient condition		X		Medical Office not a hospital
Implement patient-specific intervention to prevent falls and injury		X		Medical Office not a hospital
Communicate risk across the team; use handoff forms, visual cues, huddles		X		Medical Office not a hospital
Round every 1 to 2 hours for high-risk patients; address needs (e.g., 3Ps: pain, potty, position-pressure). Combine with other tasks(vital signs)		X		Medical Office not a hospital
Individualize interventions. Use non-skid floor mats, hip protectors, individualized toileting schedule; adjust frequency of rounds		X		Medical Office not a hospital
Review medications (by pharmacist); avoid unnecessary hypnotics, sedatives		X		Medical Office not a hospital
Incorporate multidisciplinary input for falls		X		Medical Office not a hospital
Prevention from PT, OT, MD, RN and PharmD		X		Medical Office not a hospital
Include patients, families and caregivers in efforts to prevent falls. Educate regarding fall prevention measures; stay with patient		X		Medical Office not a hospital
Hold post-fall huddles immediately after event; analyze how and why; implement change to prevent other falls		x		Medical Office not a hospital

Reference: Checklists to Improve Patient Safety. June 2013. Health Research & Educational Trust.

PRIMMED

POLICY AND PROCEDURE

Policy Title:	Patient Policy & Safety Procedures 5.0		
Department:	Pain Medicine/Anesthesiology		
Policy #:	P&P #5.0	**Creation Date:**	17.01.02
Approved By:	Pouya Mohajer, MD	**Approval Date:**	17.01.22
Revision Date:	22.12.09	**Review Date:**	22.12.09

PURPOSE

Patient Policy and Safety during Procedures.

SCOPE

All Procedures are Performed in Procedure Suite.

RESPONSIBILITIES

All staff in the Procedure Suite, including Surgeon, Anesthesiologist, & Medical Assistants.

DEFINITIONS

List of definitions for acronyms or uncommon words used in the policy.

PROCEDURE

A. Policy will be implemented after approval of Medical Director.
B. Time Out
    a. Correct Patient (Name & Date of Birth)
    b. Correct Site (Marked with a pen)
    c. Correct Procedure
    d. Allergies
    e. Diabetes
    f. Anticoagulants

g. Confirmation of Time Out by Staff

C. Pre-Anesthesia

These standards apply to all patients who receive anesthesia care. Under exceptional circumstances, these standards may be modified. When this is the case, the circumstances shall be documented in the patient's record. An anesthesiologist shall be responsible for determining the medical status of the patient and developing a plan of anesthesia care. The anesthesiologist, before the delivery of anesthesia care, is responsible for:

a. Reviewing the available medical record.
b. Interviewing and performing a focused examination of the patient to:
c. Discuss the medical history, including previous anesthetic experiences and medical therapy.
d. Assess those aspects of the patient's physical condition that might affect decisions regarding perioperative risk and management.
e. Ordering and reviewing pertinent available tests and consultations as necessary for the delivery of anesthesia care.
f. Ordering appropriate preoperative medications.
g. Ensuring that consent has been obtained for the anesthesia care.
h. Documenting in the chart that the above has been performed.

REFERENCES

National Safety Guidelines for Procedures

HISTORY

REVISION DATE	REVISED BY	PRIOR P&P	REASON FOR REVISION
18.01.02	POUYA MOHAJER	17.01.02	ANNUAL REVIEW
19.01.02	POUYA MOHAJER	19.01.02	ANNUAL REVIEW
20.01.02	POUYA MOHAJER	19.01.02	ANNUAL REVIEW
21.01.02	POUYA MOHAJER	20.01.02	ANNUAL REVIEW
22.01.02	POUYA MOHAJER	21.01.02	ANNUAL REVIEW
23.01.02	POUYA MOHAJER	22.01.02	ANNUAL REVIEW

PRIMMED POLICY AND PROCEDURE			
Policy Title:	**Safety Hygiene Precaution to Limit Exposure**		
Department:	Company Wide		
Policy #:	Clinical #8	**Creation Date:**	21.12.15
Approved By:	Pouya Mohajer, MD	**Approval Date:**	22.12.15
Revision Date:	22.12.15	**Review Date:**	23.03.23

PURPOSE

To control possible exposure of patients, team members, providers, and vendors to infectious risk

SCOPE

All areas within in the clinic to assist in limiting the risk of exposure.

RESPONSIBILITIES

Each team member and provider are responsible for maintaining a clean area at all times.

DEFINITIONS

MASKS – ALL PATIENTS, TEAM MEMBERS, PROVIDERS, AND VENDORS ARE REQUIRED TO WEAR PROTECTIVE FACE COVERINGS WHEN IN THE BUILDING

PROCEDURE

A. Cleaning procedures
   a. Front Office Staff
      i. Wipes down their working area every hour.
      ii. Takes every patient's temperature upon arrival.
      iii. Asks each patient the COVID questions. If patients, answer yes to any of the questions, the patient is asked to return to their vehicle and the provider is notified to determine if the patient is at risk to the clinic or not.
      iv. Wears disposable gloves to accept or hand patients any documents.
      v. Limited seating is available in the clinic. Front office staff wipes down the seating anytime a patient leaves a seat.
      vi. Walkers and wheelchairs are also wiped down upon the patient's arrival and departure from the clinic.
   b. Medical Assistants
      i. Always wears disposable gloves when assisting a patient or cleaning an area.
      ii. Change gloves in between patients and upon finishing cleaning after a procedure.
      iii. Wipes down exam rooms after each patient is discharged. This includes, but not limited to wiping down the exam room prior to replacing the table paper.

iv. Wiping down instrument used on the patient immediately after use, such as, the blood pressure machine.
v. Ensure any disposable materials has been properly disposed of immediately after use.
vi. Properly dispose of sharps in the proper sharps container and ensure the sharps container is changed immediately when full.

c. Providers
   i. Wear disposable gloves when examining or preforming procedures on a patient.
   ii. Overseeing their work area (exam rooms and procedure room) are clean at all times.

d. Cleaning Company
   i. Each night the cleaning company performs a complete cleaning of the entire clinic following all state cleaning standards.
   ii. All rooms are completing wiped down.
   iii. All garbage is removed from all areas and properly disposed of in the outside recycling bins.
   iv. All areas are vacuumed and mopped down each night.
   v. Breakroom is completely wiped down.

B. Sterilization of Medical Equipment

a. All non-disposable surgical supplies are scrubbed and cleaned using appropriate designated cleaning solution for the equipment.
b. All non-disposable surgical supplies are sterilized in the autoclave machine following the clinic sterilization protocol.

REFERENCES

Federal, State, National, Health Plan Regulations (if applicable)

HISTORY

REVISION DATE	REVISED BY	PRIOR P&P	REASON FOR REVISION
23.03.23	Pouya Mohajer, MD	21.12.15	Annual Review

PRIMMED POLICY AND PROCEDURE			
Policy Title:	Quality Control Testing and Storage of Glucometer		
Department:	Procedure Suite		
Policy #:	PS #2	**Creation Date:**	21.10.27
Approved By:	Medical Director	**Approval Date:**	21.10.27
Revision Date:	22.10.27	**Review Date:**	22.10.27

PURPOSE

To ensure reliable and accurate blood glucose results.
The control test is to be used to check the performance of the glucometer.

SCOPE

It applies to all areas of the procedure suite where glucose testing will be done.

RESPONSIBILITIES

Procedure Medical Assistant will be responsible for completing the quality control testing and ensuring proper storage of the glucometer, glucose control samples, and test strips.

DEFINITIONS

Test Strip: A test strip is a material used to measure the concentration of a chemical or some characteristic of a liquid.

Control Solution: is a liquid made up of water, glucose, buffers, and microbicides

Glucometer: an instrument for measuring the concentration of glucose in the blood.

PROCEDURE

A. The control test and check strip test will be performed when:
   a. Using the meter for the first time
   b. Using the meter for the first time in a procedure day
   c. If the meter was dropped
   d. When beginning a new vial of test strips

B. Testing the control solutions
   a. Check Expiration Dates on the control solution bottle a test strip vial label. Discard control solution if 3 months past the written opened date or past printed label expiration, whichever comes first. Discard test strips if 4 months past the written opened date or past printed label expiration, whichever comes first Use a new control solution and/or test strips if either date has passed.
   b. Allow test strips, meter, and control solution to sit at room temperature for at least 10 minutes before testing. If opening the control solution for the first time, write the date opened on the bottle along with your initials.
   c. With the cap on, gently swirl or invert the control solution bottle a few times. DO NOT SHAKE.
   d. Insert a new test strip into your meter and check that the meter is ready to perform a test.
   e. Discard the first drop and wipe off the bottle tip so that it is clean.

f. Dispense a second drop onto a hard, clean surface, then bring the test strip to the drop. Hold the test strip up to the sample until enough control solution has been applied to the test strip.
g. Check the meter as it calculates and displays the test result. Compare the test result to the appropriate control solution range printed on the test strip vial.
h. Dispose of any used test strips and store the control solution bottle with your testing supplies.

C. Documentation
a. Once you have the result from the glucose control solution test, the next step is to compare the number shown on your meter to the range specified by the manufacturer, printed on the test strip vial. The number shown on the meter should fall within the range.
b. A range for control solution results — rather than a single number — is provided because no two tests will be exactly the same. Manufacturers anticipate the possible variations from test to test and therefore provide an expected range.
c. If you find that a control solution result does not fall within the range printed on the test strip vial, you should contact the manufacturer of your meter to determine if additional troubleshooting or replacement supplies are needed.

D. Storage and Handling
a. See manufacturer insert for storage and handling for both control solution and test strips. (see attached)

E. Cleaning Glucometer
a. See manufacturer insert for cleaning glucometer in between use.

REFERENCES

Federal, State, National, Health Plan Regulations (if applicable)

HISTORY

REVISION DATE	REVISED BY	PRIOR P&P	REASON FOR REVISION
22.10.27	POUYA MOHAJER	21.10.27	ANNUAL REVIEW

PRIMMED POLICY AND PROCEDURE			
Policy Title:	HCG Quality Control Testing and Storage		
Department:	Procedure Suite		
Policy #:	PS #3	**Creation Date:**	21.11.05
Approved By:	Pouya Mohajer, MD	**Approval Date:**	22.11.05
Revision Date:	22.11.05	**Review Date:**	22.11.05

PURPOSE

To ensure reliable and accurate HCG testing.

SCOPE

It applies to all areas of the procedure suite where HCG testing will be done.

RESPONSIBILITIES

Procedure Medical Assistant will be responsible for completing the quality control testing and ensuring proper storage of HCG tests.

DEFINITIONS

HCG: human chorionic gonadotropin, a hormone secreted during pregnancy by the placenta which stimulates continued production of progesterone by the ovaries

HCG Positive Control Solution: purified human chorionic gonadotropin (HCG) in a buffered solution.

HCG Negative Control Solution: liquid containing no detectable human chorionic gonadotropin

PROCEDURE

A. External control testing should be performed when:
   a. Each new lot number box of tests
   b. Each new shipment
   c. Monthly
   d. Each new untrained operator

B. Testing the control solutions
   a. Check the Expiration Dates on the control solution bottle. Discard control solution if 3 months past the written opened date or past printed label expiration, whichever comes first. Use new a control solution if either date has passed.
   b. With cap the on, gently swirl or invert the control solution bottle a few times. DO NOT SHAKE.
   c. Dispense 3 drops directly onto the test cassette.
   d. Check the cassette test as it displays the test result. Compare the test result to the appropriate control solution, positive or negative.

C. Documentation
   a. Once there is a result document on the appropriate sheet based on the control used.

D. Storage and Handling

a. See manufacturer insert for storage and handling for control solution and cassette tests (see attached)

REFERENCES

Federal, State, National, Health Plan Regulations (if applicable)

HISTORY

REVISION DATE	REVISED BY	PRIOR P&P	REASON FOR REVISION
22.11.05	POUYA MOHAJER	21.11.05	ANNUAL REVIEW

PRIMMED

POLICY AND PROCEDURE

Policy Title:	Infection Control-Communicable Disease Screening		
Department:	All Departments		
Policy #:	Clinical #3	**Creation Date:**	22.02.25
Approved By:	Pouya Mohajer, M.D.	**Approval Date:**	22.12.22
Revision Date:	12.22.22	**Review Date:**	22.12.10

PURPOSE

This policy is in place to ensure patient safety and perform communicable disease screening. This policy will allow proper documentation regarding any possible infection.

SCOPE

Outpatient procedures

RESPONSIBILITIES

DEFINITIONS

Communicable Disease: an infectious disease that is transmissible by contact with infected individuals or their bodily discharges or fluids (such as respiratory droplets, blood, or semen), by contact with contaminated surfaces or objects, by ingestion of contaminated food or water, or by direct or indirect contact with disease vectors

PROCEDURE

A. A communicable disease screening will be completed prior to the patient's procedure.
   a. Upon check in the front desk staff will do a visual screening.
   b. Patient will be given a yes/no form to complete for possible signs and symptoms.
B. The confirmed infection will be reported to the team and a solution for future prevention will be discussed, agreed upon, and implemented immediately.

REFERENCES

Federal, State, National, Health Plan Regulations (if applicable)

HISTORY

REVISION DATE	REVISED BY	PRIOR P&P	REASON FOR REVISION
22.12.22	POUYA MOHAJER, MD	22.02.05	ANNUAL REVIEW

PRIMMED POLICY AND PROCEDURE			
Policy Title:	Infection Control-Post Procedure Follow Up		
Department:	All Departments		
Policy #:	Clinical #4	**Creation Date:**	22.02.25
Approved By:	Pouya Mohajer, M.D.	**Approval Date:**	22.12.22
Revision Date:	22.12.22	**Review Date:**	22.10.22

PURPOSE

This policy is in place to ensure patient safety and perform proper follow-up post-procedures. This policy will allow proper documentation regarding any possible infection.

SCOPE

Outpatient procedures

RESPONSIBILITIES

DEFINITIONS

Post-procedure call:

PROCEDURE

A. A post-procedure call will be made one business day following the procedure day.
   a. If there are no signs or symptoms of a possible infection, the patient will follow up with the clinic at their regularly scheduled appointment.
   b. Any report of possible infection is to be reported to the physician immediately and documented in the patient chart to ensure follow-up.

B. Upon reporting to the physician, the physician will advise having the patient follow up the same day or within 24 hours with any provider available in the clinic or instructed to go to an Urgent Care Facility/Emergency Room.
   a. The patient will come into the office to be examined and have vitals taken. The provider will assess the possible infection and determine the severity.
   b. The provider will determine if the patient needs to go to the Emergency Room immediately.

C. If patient does go to the Emergency Room, the patient will be asked to schedule a follow up when they have been discharged from the hospital. The clinic will continue to do additional follow up calls with the patient during the hospital stay.

D. If there is no need for the patient to go to the Emergency Room, then the patient will be scheduled for a follow-up deemed appropriate by the provider, but not longer than one week. The clinic will continue to do additional follow-up calls in the timeframe of that week.

E. If there is a confirmation of an infection proper treatment will be initiated. The clinic will also report the information to the Southern Nevada Health District.

F. The confirmed infection will be reported to the team and a solution for future prevention will be

discussed, agreed upon, and implemented immediately.

REFERENCES

Federal, State, and National, Health Plan Regulations (if applicable)

HISTORY

REVISION DATE	REVISED BY	PRIOR P&P	REASON FOR REVISION
22.12.22	POUYA MOHAJER, MD	22.02.05	ANNUAL REVIEW