Kindred Hospital Las Vegas – Flamingo Campus

Patient Safety Plan

January 2024

This plan was created and revised by the Kindred Hospital Las Vegas Flamingo Campus 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.

Patient Safety Committee/Program

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Commitment to Patient Safety

Kindred Hospital Las Vegas Flamingo Campus 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, Kindred Hospital Las Vegas Flamingo Campus 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/hospital-wide/agency-wide which includes but is not limited to:

- Patient safety
- Visitor safety
- Employee safety

All staff in Kindred Hospital Las Vegas Flamingo Campus 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, Kindred Hospital Las Vegas Flamingo Campus has developed this Patient Safety Plan.

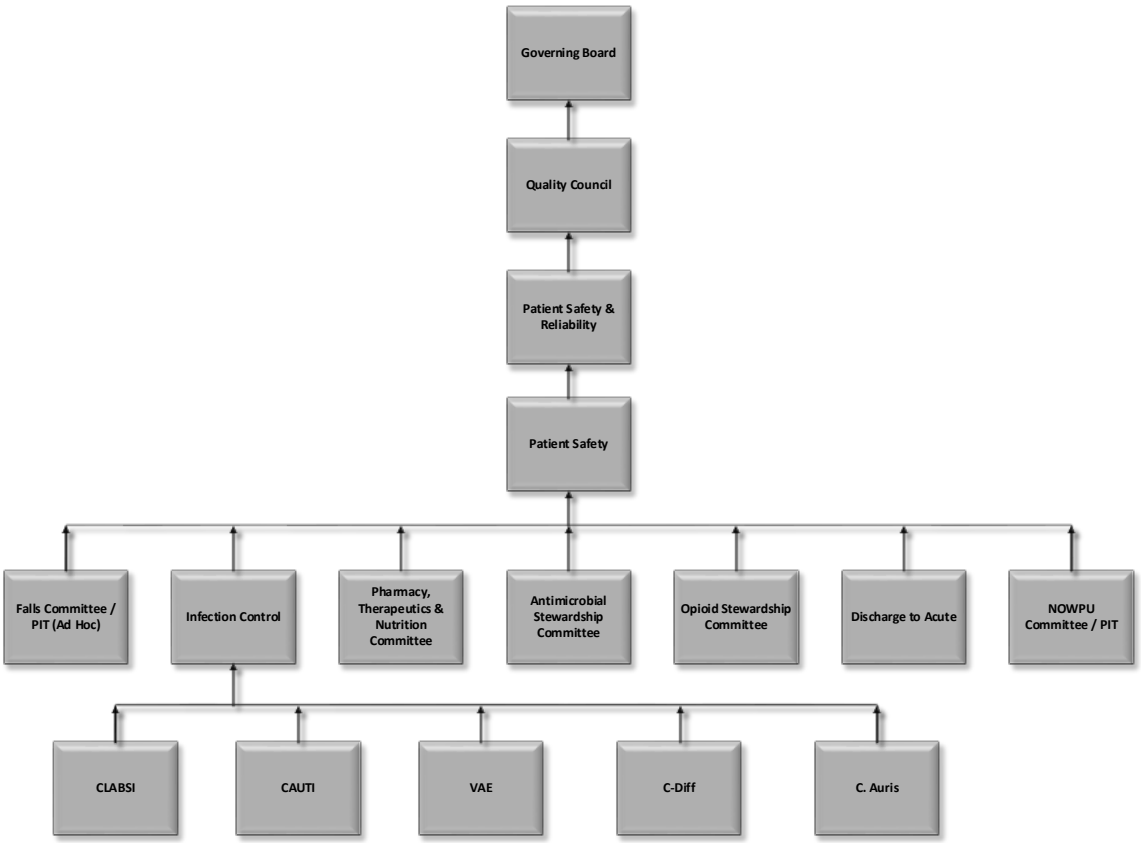
The plan focuses on the process rather than the individual, and recognizes both internal and external customers, as well as facilitates the need of analyzing and improving processes. The core principles of this plan include:

- 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 experience.
- Customer based (which includes patients, families, and visitors).
- Promoting system thinking.
- Employ well-trained and competent staff to maintain 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 Organizational Chart



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.

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.

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 determined as 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.

Root Cause Analysis (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 incorporates the Patient Safety and Quality Improvement elements.

RCA Facilitator Responsibilities

- Provide vision and leadership to the Root Cause Analysis Process.
- Work with the Director of Quality Management to ensure process changes are implemented.
- Guide the staff in the process of discovery and mitigation of future process failures.

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.

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's patient safety goals and activities, in conjunction with the patient safety action plans
- Provide fiduciary responsibilities

The Patient Safety Committee will meet 10 times per calendar year to accomplish the following:

- Report and discuss sentinel events which include:
  - Number of sentinel events from the previous calendar month.
  - 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.

RCA meetings will be convened as needed to accomplish the following:

- Define the healthcare issues or potential risks
- Conduct Root Cause Analysis
  - Written meeting agenda and minutes will be recorded.
  - Reviewing and analyzing the data.
  - Identifying the contributing factors
  - Reviewing the RCA and Quality Improvement processes and related activities and timelines.
  - Utilizing PI Tools to assist in identifying root causes including (not all inclusive):
    - Brainstorming
    - Flow Charting
    - Cause & Effects tools, i.e., Fishbone Diagram
    - 5 Whys Analysis
    - Data Analysis Tools, i.e., Run/Control Charts, Pareto Charts
- Conduct Corrective Action Plan
  - Identifying the Plan-Do-Study-Act (PDSA) topics.
  - Identifying strengths and areas that need improvement.
  - Discussing corrective action process and activities.
  - Discussing and presenting possible changes in procedures/processes to improve areas indicated.
  - Developing strategies, solutions, and next steps.
- Identify barriers and technical assistance needs for supporting the RCA efforts.

Evaluation of the 2023 Patient Safety Plan

The 2023 Patient Safety Plan measures resulted as below:

- Sentinel Events = 0
- CLABSI's total (Benchmark 0.98):
  - 2022: 2 (rate 0.27)
  - 2023: 1 (rate 0.16) ↓
- CVL utilization (Benchmark 0.46):
  - 2022: CVL 7309 days /Utilization=0.51
  - 2023: CVL 6097 days /Utilization=0.47 ↓
- CAUTI's total (Benchmark 1.01):
  - 2022: (rate =1.07)
  - 2023: (rate= 1.49) ↑
- Urinary Catheter Utilization (Benchmark 0.29):
  - 2022: IUC-5602 days /Utilization= 0.39
  - 2023: IUC-4027 days /Utilization =0.31 ↓

- NOWPU = 8.64%, N = 21, downward trending throughout 2023. did not meet goal to reduce by 10% over 2022 = 5.04%, N = 13 (Data source Business Warehouse)
- Employee Health = Flu vaccination Rate, 2021-2022 = 98%, 2022-2023 = 97%. Met goal of 95% (Data Source IC Plan)
- Antimicrobial Stewardship = (Goal to reduce antibiotic usage to, </= 35% of total drug cost) 24.7%
- Fall Reduction = No falls with major injury, 3 falls with minor injury, 19 total falls in 2023, Rate = 1.45 per 1000 patient days 2022 Rate = 2.29 per 1000 Pt. Days. Met goal of 10% reduction in all falls.
- Unplanned Return to Acute Hospital within 30 days of Admission = 2023 rate = 16.45%, 2022 rate = 14.59(Data source Business Warehouse), increased over 2022.

Objectives and Goals of the Quality and Patient Safety Plan

Objective	Goals 2024 (Per NQP Goals)	Plan	Planned Completion Date	Responsible Party
CLABSI Prevention	≤ 0.75 = 4 points for SIR or ≤1.00 = 2 points for rate	1. Educate and re-enforce with the staff the importance of patient bathing with CHG and initiate hospital specific risk reduction strategy with CHG bathing as a quality improvement effort. 2. Monthly audits of bathing processes and the use of CHG especially for patients who have IV lines and indwelling catheters. 3. Daily central line audits to be conducted and coordinated by ICP and nursing supervisors or trained designee with oversight by ICP. All audits will be submitted to ICP for review. Corrective action plans will be completed by DNCS.	12/31/2024	**ICP/COO/DNCS /Education**

CAUTI Prevention	<0.7 = 2 points; <0.35 = 4 points	1. Educate and re-enforce staff compliance to the previously approved urinary catheter protocol. 2. Reeducate and continue to re-enforce staff understanding with previously approved urinary catheter protocol and the daily need for assessment/documentation of catheter need which includes rationale. 3. Daily urinary catheter maintenance audits will be conducted and coordinated by the ICP and the nursing supervisors or trained designee with ICP oversight. 4. Implement remediation process to involve nursing staff in education presentations regarding CAUTI prevention during staff meetings to enhance responsibility and knowledge to decrease occurrences.	12/31/2024	**ICP/COO/Education**
C-Diff	</= 0.4 = 2 points </= 0.2 = 4 points	1. Verify patient infection status and history on admission. 2. Obtain cultures based on evidenced based signs and symptoms. 1. Incorporate Antimicrobial Stewardship recommendations	12/31/2024	**ICP/COO/Education**
Employee Health Flu immunization rate of employees	75.89% = 1 point >/= 90% = 2 points	1. Vaccine education and offer at time of hire to include required vaccines, influenza, and other mandated vaccines. 2. Provide CDC, state health department and other regulatory education to staff and patients/families.	12/31/2024	**COO/DNCS/Employee Health Nurse**

		3. Audit and report compliance to Patient Safety Committee as scheduled on use of face masks, PPE, and hand hygiene by all personnel in patient care areas (audits)		
Antimicrobial Stewardship	<30% of cost per patient day	1. Antibiotics are reported and analyzed on days of therapy per thousand patient days. 2. Committee provides antimicrobial education to staff, practitioners and leadership as needed.	12/31/2024	**COO/DOP**
Fall Reduction with Major Injury	</= .01% = 4 points </= 0.12% = 2 points	1. Fall risk assessment completed for each patient upon admission and with a patient post fall or a change in medications that increases the risk for falls. 2. Will continue to track and trend all falls.	12/31/2024	**COO/DNCS/Education**
Unplanned Return to Acute (within 30 days)	8.1 - 10% = 6 points < 8% = 10 points	1. Continue 100% review of RTAs within 30 days for issues and trends and follow up with staff and providers as required.	12/31/2024	**COO/DNCS/MEC**
Restraint Use Reduction	Benchmark = 77.48 per 1000 patient days	1. Continue daily review 100% restrained patients for appropriateness, i.e., Briefs/Debriefs, ICT 2. Track and trend use. 3. Continue monitoring of regulatory requirements of restraint use, i.e., provider orders, patient monitoring.	12/31/2024	**COO/DNCS/Education**

Components and Methods

Pursuant to NRS 439.837, a medical facility shall, upon reporting a sentinel event pursuant to NRS 439.835, 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."

Kindred Hospital Las Vegas Flamingo 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, which 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.

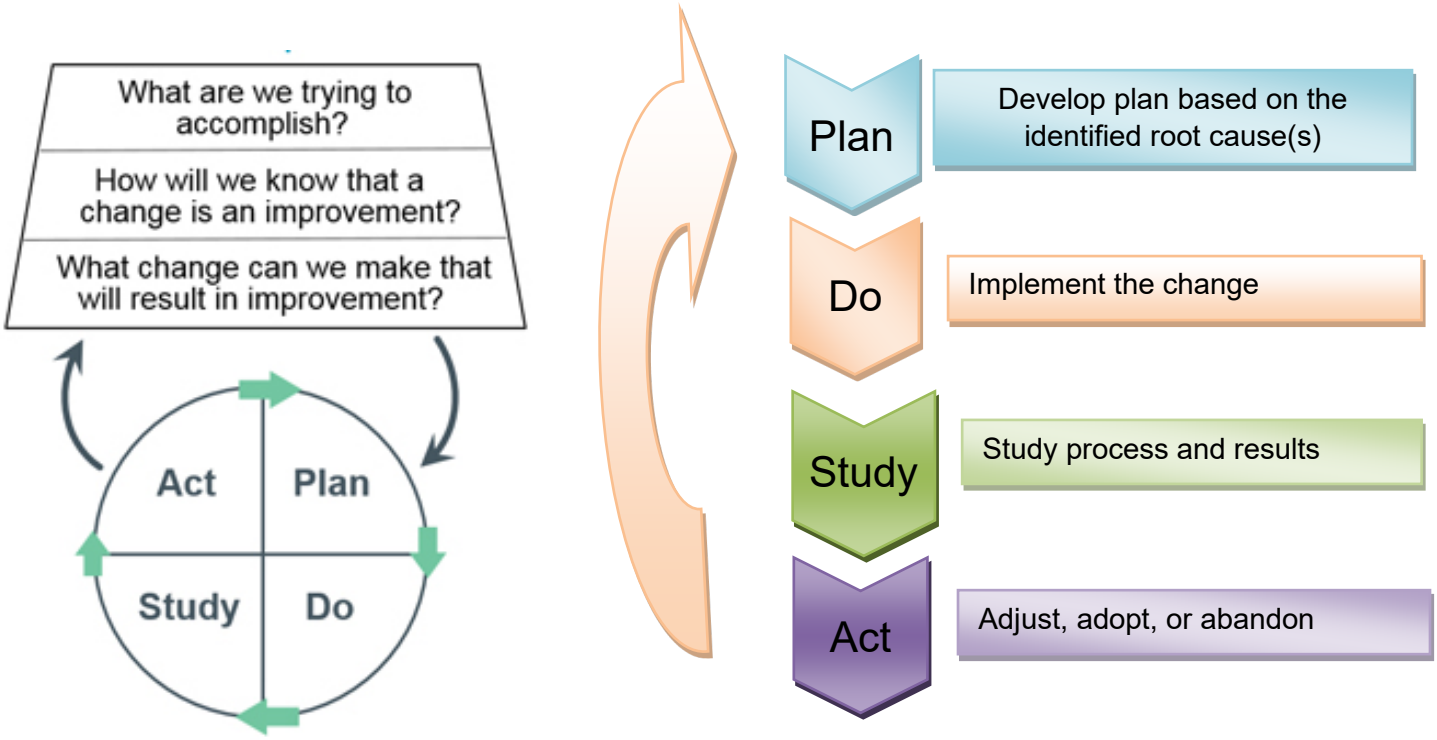
Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

A Root Cause Analysis and action plan framework table, which was introduced by The Joint Commission, 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 Kindred Hospital Las Vegas Flamingo Campus to explore the cause-and-effect relationship underlay a problem. One can find the root causes by asking “why” no less than five times.

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.



Data Collection and Reporting

Data should drive any quality and patient safety effort. Kindred Hospital Las Vegas Flamingo Campus is using the Kindred ClearSight Event Reporting System for tracking the incident and sentinel events, NHSN for reporting healthcare infection data, WebIZ for reporting vaccinations, Nevada RedCap for reporting sentinel events, and Business Warehouse and Meditech 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 established reporting schedule:

- Sentinel events
- Severity of infection report
- Checklists and Policies reviews and revisions
- Results of Root Cause Analysis and Action Plans

Patient Safety Policies and Checklists

By 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, EVS personnel 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.

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.

References

- Title 40 – Public Health and Safety https://www.leg.state.nv.us/NRS/NRS-439.html
- Root Cause Analysis Toolkit https://www.health.state.mn.us/patientsafety/toolkit/
- 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
- Patient Safety Resources Improvement Area: Patient Safety | Institute for Healthcare Improvement (ihi.org)
- Patient Safety Resources National Patient Safety Foundation. | PSNet (ahrq.gov)
- Patient Safety Checklists Patient safety (who.int)
- Checklists to Improve Patient Safety http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf
- Quality Improvement Health Resources and Services Administration | HRSA
- CQI 101 An Introduction to Continuous Quality Improvement: https://www.coursehero.com/file/13827355/CQI-Overviewppt/
- Hospital Policies Establish Policies and Procedures for Conducting Patient Safety Activities | PSO (ahrq.gov)

Attachments

- Attachment A: Terms and Definitions
- Attachment B: Table of Contents: Patient Safety Program and Policies
- Attachment C: Table of Contents: Infection Control Program and Policies
- Attachment D: Table of Contents: Risk Management Program and Policies
- Attachment E: List of Safety Kindred Hospital Flamingo Safety Checklists

Attachment 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_CURRENT_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.

Attachment B: Table of Contents: Patient Safety Program and Policies

Kindred Hospitals

HOSPITAL CORE
POLICY and PROCEDURE MANUAL

Patient Care Manual

SECTION – 07 PATIENT SAFETY

Number	Title
H-PC 07-001	CORE: Patient Safety Program
H-PC 07-002	CORE: Two Patient Identifiers
H-PC 07-003	CORE: Identification of Patient Allergies
H-PC 07-004	CORE: Latex Allergy/Sensitivity Management
H-PC 07-005	CORE: Remote Visual Monitoring (RVM)
H-PC 07-006	CORE: Contraband & Searches
H-PC 07-007	CORE: Responsibilities in Event Reporting
H-PC 07-008	CORE: Responsibilities in Grievance Process
H-PC 07-009	CORE: Physical Restraints (Violent and Non-Violent Behavior) and Seclusion **FORM**: H-PC 07-009 A CORE: Restraint Death Log
H-PC 07-011	CORE: Critical Test Results Communication
H-PC 07-012	CORE: Patients off the Unit (Including Elopement)
H-PC 07-014	CORE: Evaluating the Effectiveness of Clinical Alarm Systems **FORM**: H-PC 07-014 A CORE: Medical Equipment Clinical Alarms Risk Assessment
H-PC 07-015	CORE: Continuous Cardiac Monitoring (Telemetry) **FORMS:** H-PC 07-015 A CORE: Triage Algorithm for Telemetry Monitoring H-PC 07-015 B CORE: Telemetry Interruption Algorithm
H-PC 07-019	CORE: Emergency Care
H-PC 07-020	CORE: Resuscitative Services for Specialty Units **FORM:** H-PC 07-020 A CORE: Resuscitative Services Plan (Sample)
H-PC 07-021	CORE: Rapid Response Team (RRT)
H-PC 07-024	CORE: Emergency Medical Screening and Transfer (Formerly known as EMTALA)

Attachment C: Table of Contents: Infection Control Program and Policies

Kindred Hospitals

HOSPITAL CORE
POLICY and PROCEDURE MANUAL

Infection Prevention & Control Manual

SECTION – 01 ADMINISTRATION

Number	Title
H-IC 01-001	CORE: Infection Prevention and Control Program
H-IC 01-002	CORE: Authority Statement **FORM**: H-IC 01-002 A CORE: Authority Designation of Infection Preventionist
H-IC 01-003	CORE: Surveillance of Healthcare Associated Infection
H-IC 01-004	CORE: Reporting of Diseases **FORMS**: H-IC 01-004 A CORE: Centers for Disease Control and Prevention Infection Control Transfer Form
H-IC 01-005	CORE: Management of an Outbreak and/or Epidemic **FORM:** H-IC 01-005 A CORE: Example of Management & Investigation of an Outbreak and/or Epidemic
H-IC 01-006	CORE: Ebola Preparedness **FORMS:** H-IC 01-006 A CORE: Triage of Suspected Ebola H-IC 01-006 B CORE: Donning/Doffing Trained Observer Checklist (sample)
H-IC 01-007	CORE: Pandemic Plan

Attachment D: Table of Contents: Risk Management Program and Policies

Kindred Hospitals

HOSPITAL CORE
POLICY and PROCEDURE MANUAL

Management and Leadership Manual

SECTION – 04 RISK MANAGEMENT

Number	Title
H-ML 04-001	CORE: Event Reporting System **FORMS**: H-ML 04-001 A CORE: Downtime Event Reporting Form H-ML 04-001 B CORE: Quality Review Follow Up H-ML 04-001 C CORE: Visitor Event Reporting H-ML 04-001 D CORE: Event Reporting System Severity Level Definitions
H-ML 04-003	CORE: Investigating Serious and Sentinel Events **FORMS**: H-ML 04-003 A CORE: Memo for Quality Council Subcommittee H-ML 04-003 B CORE: Handbook on Performing a Root Cause Analysis and Action Plan in Response to a Serious or Sentinel Event H-ML 04-003 C CORE: Event Algorithm H-ML 04-003 D CORE: Sentinel Event Analysis of Death Related to Healthcare Associated Infections
H-ML 04-005	CORE: Communication of Unanticipated Outcome, Including Apology and Disclosure
H-ML 04-006	CORE: Medical Device Event Reporting **FORM:** H-ML 04-006 A CORE: Downtime Medical Device Event Report
H-ML 04-008	CORE: Patient Complaint/Grievance Process **FORMS**: H-ML 04-008 A CORE: Downtime Complaint Grievance Log H-ML 04-008 B CORE: Downtime Patient & Family Complaint/Grievance Report

Confidential and Proprietary Information Revised: 06/2023

Attachment E: Patient Safety Checklists

A list of the current policies covering the above- referenced checklists include, but are not limited to the following:

Checklist Title
Hand Hygiene & PPE Use
Crash Cart Supplies
Patient Admission CMS Checklist
Patient Discharge CMS Checklist
Medication Refrigerator Temperature Log
Food Refrigerator/Freezer Temperature Log
Bath Warmers Temperature Log
Procedure Pre & Post Checklists, including Universal Precautions (Time Out)
Central Line Insertion Checklist
Central Line Surveillance Rounds
Infection Surveillance (CAUTI, CLABSI, D-Diff, MDRO)
Foley Insertion Checklist
Urinary Catheter Rounds
Houdini-Catheter Checklist
Terminal Patient Room Cleaning
EVS Cleaning Checklists
Mock Code Evaluation
Patient Suicide Admission Assessment
Suicide Environment Checklist
Patient Turning & Repositioning Rounds/Audits
TPN Administration Nursing Checklist
Lipid Administration Nursing Checklist
Medication Administration Checklist
Fall Prevention & Post Fall Analysis
Environment of Care Rounding
Fire Drills
Restraint Freedom Program components
Critical Test Communication Protocol
Interdisciplinary Care Team Rounding
Emergency CPR Checklist