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Flamingo Surgery Center

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Owner	Cheryl Libby-Schanbacher: Administrator
Area	Facilities and Environment
Applicability	Far West - Flamingo Surgery Center

Patient Safety Program

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Our Mission is committed to care and the improvement of human life. We strive to deliver high quality, cost effective healthcare in the community. We are focused on delivering the highest quality healthcare that effectively responds to the needs and safety of our patients by minimizing the possibility for injury or harm. Flamingo Surgery Center has developed a Patient Safety Program to maintain an effective ongoing facility-wide, data driven process to prevent and reduce medical errors and adverse events.

COMPONENTS OF PATIENT SAFETY PLAN:

1. Significant event/Significant Medical Error- Any unexpected occurrence involving a death, serious physical or psychological injury to risk thereof. Serious injury specifically includes loss of limb or function. "Risk thereof" includes any process variation for which recurrence would carry a significant change of a serious adverse outcome.
2. Adverse Events- any event where the result is not consistent with the desired plan of care and that leads to patient harm, not limited to medication error.
3. Reportable events- Mandatory Reporting of Sentinel Events to the Nevada Sentinel Events Registry and Nevada State Health Division, Bureau of Health Planning and Statistics.

   Attention: Sentinel Events Registry
   4150 Technology Way Suite 104
   Carson City, NV 89706

   Nevada Assembly Bill 1 (AB1) was passed during the 2002 18th Special Legislative Session, and mandatory reporting of Sentinel Events was incorporated into Nevada Revised Statue (NRS) 439.800-890 and Nevada Administrative Code (NAC) 439.900-920. Assembly Bill 59 (AB 59) was passed during 2005 73rd Session of the Nevada Legislature, and codified "facility acquired infection" as a reportable sentinel event.

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A "sentinel event" is defined as an unexpected occurrence involving facility-acquired infection, death or serious physical or psychological injury or the risk thereof, including, without limitation, any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. The term includes loss of limb or function (NRS 439.830). It is called a sentinel event because it signals the need for immediate response.

PROCESS FOR REPORTING:

1. A designated Patient Safety Officer will be assigned by the facility. The Risk Manager will register with the Sentinel Events Registry as the facility's reporting contact.
2. Complete the Nevada State Health Division Sentinel Event Report- Amendment by fax to 775-684-4156 or send Certified Mail with a return receipt to: Nevada State Health Division, Bureau of Health Planning and Statistics Att: Sentinel Events Registry, 4150 Technology Way, Suite 104, Carson City, NV 89706.

MEDICAL ERRORS

1. See policy for Patient Notification of Medical Error in Policy and Procedure Manual.
2. Steps in the Patient Notification of Medical Error are followed
    a. A variance form is completed
    b. A Root Cause Analysis (RCA) is performed
    c. The patient's Medical Record is examined by Peer Review
    d. The Medical Record and peer review findings are reported to the Medical Executive Committee (MEC) and Governing Body (GB) for action and/or recommendations along with the RCA Plan of action and risk reduction strategies.

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ADVERSE EVENTS AND REPORTABLE EVENTS

1. A variance report is completed.
2. Variance is submitted to Risk Manager/ QI (Quality Improvement)
3. Variance is reported to HCA Service Quality Index
4. If significant event: A Root Cause Analysis is performed.
5. The Market Quality Risk Manager (MQRM) and Clinical Service Group Quality Director for the HCA West is notified.
6. If applicable, a Probable Claim Report (PCR) is filed.
7. Patient Medical Record is submitted for peer review.
8. The Medical Record, RCA and peer review results goes to the MEC/GB for actions and/or recommendations.

TIME FRAME FOR INTERNAL REPORTING OF

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MEDICAL ERROS, ADVERSE EVENTS AND REPORTABLE EVENTS:

1. The person most closely involved or the person discovering the variance should prepare the variance and report to the Risk Manager or Designated person as soon as possible following the event.
2. Reportable events will be reported by completing mandatory reports for regulatory agencies as required by law and regulations, adhering to reporting deadlines (CMS, FDA, SMDA, and local law enforcement).

CONSEQUENCES FOR FAILING TO REPORT EVENTS IN ACCORDANCE WITH POLICY:

1. Employee failure to report a reportable event may result in disciplinary action.

MECHANISMS FOR PRESERVATION AND COLLECTION OF EVENT DATA

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1. Notify:
    - QI/Risk Manager/Safety Officer/Patient Safety Officer
    - Administrator
    - Medical Director
    - Clinical Director
    - QI Committee
    - Health Care Insight (HCI)
    - MQRM for Far West Division
2. If an event is a result of faulty equipment, the device will be removed from service. If a product is involved, it will be retained along with packaging.
3. Variance report will be completed along with Mandatory Form 3500A, Safe Medical Device if applicable.
4. Investigation is initiated.
    a. Involved staff is interviewed.
    b. Copy of patient medical record, if applicable.
    c. Copy of any medical treatment rendered outside of the Surgery Center.
    d. Decision of the QI Committee/Quality and Risk Manager as to whether or not incident is reportable.
    e. File a Probable Claim Report (PCR) with HCI if recommended by QI Committee/ Quality and Risk Manager.

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f. Complete FDA forms if incident is reportable and if applicable.
g. If appropriate, notify manufacturer

PROCESS FOR CONDUCTING A ROOT CAUSE ANALYSIS (RCA)

1. A group is formed involving representatives from each department.
2. Have available the Policy and Procedure Manual, Risk and QI Manuals, Medical Staff Bylaws and Rules and Regulations, CMS regulatory statues and state regulatory statues, involved Medical Record, Variance Report, Peer Review Report and the measurement tool to be used as appropriate to the event.
3. Review of the variance report by the group.
4. Review the RAC form with the group.
5. Staff directly involved with the event will describe their interaction with the patient and the P&P that support their actions.
6. Identify "WHY" each contributing factor occurred or did not occur.
7. Develop a risk reduction strategy for each root cause.
8. Develop a measurement tool to evaluated the effectiveness of reduction strategies.
9. All questions will be addressed.
10. All investigations and rationale are documented.
11. Explanations are summarized and are submitted as attachments to the MEC/GB.
12. Administrator/MEC/GB will communicate actions and recommendations to the Risk Manager.
13. Risk Manager will communicate with QI Committee.
14. A meeting with involved departments is held to communicate risk reduction strategies and measurement of outcome.

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PATIENT SAFETY TRAINING WILL BE PROVIDED TO DESIGNATED STAFF ON AN ANNUAL BASIS

Training will include all Components listed above.

FLAMINGO SURGERY CENTER WILL DESIGNATE ONE OR MORE INDIVIDUALS TO BE RESPONSIBLE FOR THE MANAGEMENT OF THE *PATIENT SAFETY PROGRAM.*

RESPONSIBILITIES INCLUDE:

1. Coordinating all patient safety activities/in-services
2. Monthly safety rounds of the facility utilizing an Individualized checklist for the Center for compliance to policies and potential areas of risk.

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3. Facilitating assessment and appropriate response to reported events.
4. Monitoring the RCA results, recommendations and action plans.
5. Serve as liaison among the Centers' departments and committees to ensure facility-wide integration of the Patient Safety Program with Risk Management and report findings quarterly to the Quality Improvement Committee.

DESIGNATED PERSON WILL HAVE COMPLETED THE PROCESS FOR THE REPORTABLE EVENT WITHIN 60 DAYS.

1. A root cause analysis will be completed to examine the cause and effect of the event through an impartial process.
2. An action plan will be developed identifying strategies that the Center intends to employ to reduce the risk of similar events occurring in the future.
    - Action Plan designates responsibility for implementation and oversight.
    - Time frames for implementation will be specified.
    - Strategy for measuring effectiveness will be included.
3. The RCA and action plan will be available for review by department representatives.

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REPORTING REQUIREMENTS

Any theft and/or diversion of Controlled Substances shall be reported to the local police agency, the State Board of Pharmacy, the Nevada Department of Public Safety and/or the Drug Enforcement Administration.

PATIENT SAFETY COMMITTEE

- Is comprised of the designated Patient Safety Officer, the Medical Director, an Executive Member (Administrator), Clinical Director, department Managers, consulting Pharmacist and staff members.
- Meets monthly to discuss any safety concerns.
- Reports Quarterly to the QI Committee.

Approval Signatures

Step Description	Approver	Date
QI / MEC / Governing Body	Cheryl Libby-Schanbacher: Administrator	01/2024

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Administrator Approval	Cheryl Libby-Schanbacher: Administrator	01/2024
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Applicability

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