This plan was created and revised by VVSC's Patient Safety Committee. 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 employ safety, as well as reduce the medical/healthcare errors and/or preventable events.

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Commitment to Patient Safety:

VVSC is committed to a comprehensive approach to improving 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, and visitors, through continuous learning and improving patient safety policies, systems, and processes.

The National Patient Safety Goals for Ambulatory Healthcare will outline the patient safety goals for VVSC. The patient safety goals are:

- Improve the accuracy of patient identification
- Improve the safety of using medications
- Reduce the likelihood if patient harm associated with the use of anticoagulant therapy
- Maintain and communicate accurate patient medication information through medication reconciliation.
- Reduce the risk of healthcare associated infections
- Prevent Wrong site, wrong procedure, and wrong person surgery

VVSC has implemented the Safety plan to prevent sentinel events from occurring by implementing the “Near Miss “reporting system. A “Near Miss” is defined as an event or situation that could have resulted in an accident, injury or illness, but did not, either by chance or timely intervention. The “Near Miss” reporting system will identify medication, surgical, equipment and other “Near Miss” occurrences.

A “Near Miss” may be related to close calls relating to medications, procedures, equipment, communication (example- handoffs).

A culture of safety is promoted at VVSC. The staff are encouraged to report any situation that may result in ham to a patient by using the “Near Miss Report”. The information from the form will initiate a root cause analysis to improve the patient safety at VVSC.

Mission, Vision, and Values:

In support of our mission, vision, and values, VVSC Patient Safety and Risk Management Plan promotes:

- Prevention of sentinel events through the monitoring of “near misses”
- 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 VVSC.
- 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 Patient Safety Plan is VVSC-wide which includes but is not limited to:

- Patient safety
- Visitor safety

All staff in VVSC is 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, VVSC 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, land 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 NSR 429.875, a medical facility shall establish a Patient & Employee Safety Committee (PSC). The PSC should ensure that Risk Management and Patient Safety Plan is promoted and executed successfully.

The Patient Safety Committee Organization:

- Governing Board (GB)
- Medical Executive Committee (MEC) which is the PSC.
- Pharmaceutical and Therapeutic Committee that meets monthly as part of the Patient Safety Committee.
- Staff members of the PSC Sub-Committee for data collection for the PSC.

Roles and Responsibilities:

- In accordance with NRS 439.875, a patient safety committee at VVSC is composed of:
  - The infection control officer of VVSC
  - The patient safety officer of VVSC is the Infection Control Officer
  - At least three providers of healthcare who treat patients at VVSC, including but, without limitation, at least one member of the medical, nursing, and pharmaceutical staff (Consultant Pharmacist) of VVSC
  - One member of MEC or GB of VVSC

The roles and responsibilities are defined below:

Patient Safety Committee Responsibilities (based on NRS 49.875 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 connect with all reports of sentinel events alleged to have occurred.
- Review and evaluated the quality of measures carried out by VVSC to improve the safety of patients who receive treatment.
- Review and evaluate the quality of measures carried out by VVSC to prevent and control infections.
- Make recommendations to the MEC and GB of VVSC to reduce the number and severity of sentinel events and infections that occur.
- At least once each month, the Pharmaceutical and Therapeutic (P&T) Committee meets as part of the PSC. The P&T submits a report to the MEC that meets each calendar quarter. The MEC will review and as needed will make revisions or adds before submitting report to the GB. The report is regarding:
  (1) The number of sentinel events that occurred at VVSC during the preceding calendar months and in summary quarterly;

(2) The number and severity of infections that occurred at VVSC during the preceding calendar months and in summary quarterly.
(3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at VVSC.
(4) The number of near miss types as outlined by the World Health Organization (WHO)

- 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 (fishbone/Ishikawa diagrams), investigation, and corrective action plan implementations.
- Participates in the RCA meetings and discussions.
- Communicate honestly and openly about only data and facts to staff members involved in RCA and their supervisors/charge.

RCA team leader Responsibilities: (to be performed by the Patient Safety Officer):

- Develop a reporting culture by establishing trust by adopting a just culture in eliminating the fear of punishment.
- Accountability
- Identifying unsafe conditions
- Strengthening systems and assessment
- Organize and coordinate the RCA process.
- Assemble and encourage a supportive and proactive team members.
- 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.

Patient Safety Officer Responsibilities:

- Serve on the patient safety committee.
- Supervise the reporting of all sentinel events alleged to have occurred at VVSC, 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 VVSC.
- Report to the patient safety committee regarding any action taken in accordance with the responsibilities above.

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 (CD C), the World
- Health Organization (WHO) and the Society for Healthcare Epidemiology of America (SHEA); and
- VVSC-specific infection control developed under the supervision of an Infection Control Nurse who has undergone Infection Control education, preferably from a nationally recognized infection control organization, for the prevention and control of infection

Infection Control Officer Responsibilities (based on NRS 439.873):

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

GB Responsibilities:

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

The PSC will meet monthly at the Pharmaceutical and Therapeutic Meeting and quarterly to accomplish the following:

- Report and discuss near miss events which include:

- Number of near misses from previous calendar months and summary for the quarter.
- Number of severe infections that occurred in VVSC.

- Corrective Action Plan for the near miss occurrences and infections
  - Evaluate the corrective action plan to improve on root cause of the problem
- Patient safety/employee policies and checklists
  - At lease annually evaluate patient safety/employee policies and checklists
  - Revise the patient/employee safety policies and checklists as needed.
  - Monitor and document the effectiveness of the patient/employee safety policy.

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

- Define healthcare issues or potential risks.
- Conduct RCA
  - Reviewing and analyzing the data.
  - Reviewing the RCA process and quality improvement related activities and timeliness.
  - Brainstorming issues or the potential risks by using the fishbone diagrams.
  - Identify the contributing factors and conduct the RCA.
- Conduct Corrective Action Plan
  - Discussing corrective action process and activities to correct the root cause.
  - 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.

Objectives and Goal of the Risk Management and Patient Safety Plan

- Objectives:
  - Establish a reporting culture
  - To learn from close calls and hazardous conditions
  - To prevent sentinel events from happening
  - To improve patient safety by implementing root cause analysis and revised policies and procedures to close the safety gap
  - To use patient safety checklists to implement and audit patient and employee safety practices and interventions.
  - To promote process improvement and increase patient safety.
  - VVSC staff will use patient safety checklists 100% of the time while caring for patient perioperatively.
  - Plan: Oversight for near miss, risk with possibility of loss or injury, preventable events, patient safety concern(s), and other mandatory reporting.

- Planned Completion Date: Annually evaluate the status of the plan
- Responsible Party: Patient Safety Committee

Sentinel Events- Reporting- See Risk Management Plan
Pursuant to NRS 439.837 and NAC 439.917, within 45 days after reporting a sentinel event pursuant to NRS 439.835, VVSC will 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.

Root Cause Analysis for Identifying Special Cause
An RCA is a process for identifying the root causes of the problems(s). It focuses on the system that generated the error instead of individuals. Processes, procedures, and systems cause most medical mistakes and errors, not people. The goal is to eliminate mistakes and errors by changing the process.

RCA 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 an RCA. Not all the questions apply to all the events or cases. This table can be used individually or with the fishbone diagram.

5 Whys will be used in VVSC to explore the cause-and-effect relationship underlay of 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. The major causes in the fishbone diagrams are processes, machines, materials, measurements, people, environment. For each cause ask why five times to arrive at the root cause of the problem.

Methodology for Reducing Errors
The use of the Quality Improvement methodology Focus, Improve, Sustain and Honor (FISH) will be used: **F**ocus will define the error/defect/problem, and analyze the root cause. **I**mprove: Implement the root cause countermeasures/checklists. **S**ustain: Monitor for re-occurring near misses. **H**onor will review, recognize and refocus.

Preventing Errors by Implementing 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 VVSC who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, the environment cleaning services of VVSC; 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 VVSC 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 VVSC.

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.

Data Collection and Reporting:

The data will be collected on near miss forms and analyzed by the Risk Manager.
The types and number of near misses and actions implemented will be reported to the Patient Safety Committee and to the MEC.

Ongoing Reporting of Near Misses and Safety Plan Review:

- Monthly to the Patient/Employee Safety Committee

- Quarterly to the MEC
- Annual Review of the Patient Safety Plan/Checklists/Policies

Assessment of the Patient Safety Plan:
It is critical for VVSC to spend time each year assessing the effectiveness of its Safety Plan in its achievement of its desired goal(s) and objectives. The MEC will undertake this assessment and report to the GB. The report will outline the accomplishments and shortcomings of the Plan along with factors that influenced the performance of the Plan.

The Patient Safety Assessment Tool (PSAT) from the VA National Center for Patient Safety is used as a reference.

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.

Appendix A. The Patient Safety plan include the data from one or several of the following:

- WHO: World Health Organization
- 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
- AAAHC Accreditation for Ambulatory Health Care, Inc.

Appendix A References

- Retrieved 02.11.19 http://dpbh.nv.gov/Programs/SER/dta/Publications/Sentinel_Events_Registry_(SER)__-Publications/ Quality and Patient Safety Plan Template, *Patient Safety Plan Template*
- The World Health Organization (WHO) -Near Misses and Their Importance for Improving Patient Safety) June 2014
- Root Cause Analysis Toolkit http://www.health.state.mn.us/patientsafety/toolkit/
- Quality and Service Improvement Tools- Six Sigma Instructor Guide Jay Arthur 2003
- CQI 101 An Introduction to Continuous Quality Improvement: https://www.coursehero.com!file/13827355/CQI-Overviewppt/
- Quality Improvement http://www.hrsa.gov/guality/toolbox/methodology/gualityimprovement/
- 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/l
- 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

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

Close call-unsafe acts or conditions -errors, procedure violations or hazards-t that could have seriously harmed a patient but did not because they were identified, reported and addressed and eliminated.

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/dictionarv/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.)

Reference: Chapter 5.3.1. *Quality and Patient Safety Plan, Sentinel Events*

Appendix B National Safety Goals

Appendix C - WHO Near Miss Types

Near Miss Report