GREEN VALLEY SURGERY CENTER
Patient Safety Plan

POLICY:

Green Valley Surgery Center will institute and administer a comprehensive and continuous Patient Safety Program for all patients to improve patient safety and reduce risk to patients through an environment that encourages:

- Recognition of risks to patient safety and medical/health care errors
- Actions to reduce these risks
- Internal reporting of incidents and potential incidents and actions taken
- Focus on processes and systems rather than individual blame

PURPOSE:

The Patient Safety Program provides a systematic, coordinated and continuous approach to maintenance and improvement of patient safety by using established mechanisms to support responses to actual occurrences, have an ongoing proactive plan to reduce medical/health errors, and integrate patient safety as a high priority in all relevant organizational processes and services.

RESPONSIBILITY:

As with patient care, it is a coordinated and collaborative effort of the entire organization to maintain and improve patient safety.

The Governing Body approves the data-driven Patient Safety Program and ensures the program reflects the complexity of the facility's organization and services, including those services furnished under contract or arrangement and focuses on the prevention and reduction of medical/health errors and adverse effects.

The Clinical Director is responsible for the management of the Patient Safety Program by:

- Coordinating all patient safety activities
- Facilitating assessment and appropriate responses to reportable events
- Monitoring Root Cause Analysis and resulting action plans
- Serving as a liaison among the departments to assure facility wide integration of the Patient Safety Program.

Each individual employee within the organization acts as a patient advocate for safety and is responsible to report patient safety occurrences and potential occurrences to the QAPI

Coordinator and the Clinical Director, who will aggregate the occurrence information and report to the Governing Body.

PROGRAM:

The scope of the Patient Safety Program includes an ongoing assessment to prevent error occurrence, maintain and improve patient safety.

Patient Safety occurrence information from aggregated data reports and individual incident occurrence reports will be reviewed to prioritize organizational patient safety efforts.

Types of Patient Safety or Medical/Health Care Errors:

- No Harm Errors – those unintended acts, either of omission or commission, or acts that do not achieve their intended outcome, that do not result in a physical or psychological negative outcome, or the potential for a negative outcome, for the patient.

- Mild-Moderate Adverse Outcome Errors – those unintended acts, either of omission or commission, or acts that do not achieve their intended outcome, that result in an identified mild to moderate physical or psychological adverse outcome for the patient.

- Any Medication Error

- Any Adverse Drug Reaction

- Any Transfusion Reaction

- Hazardous Condition – any set of circumstances, exclusive of the disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious physical or psychological adverse patient outcome.

- Sentinel Event – an unexpected occurrence involving death or serious physical or psychological injury or the risk thereof, including any process variation for which a recurrence would carry a significant chance of serious adverse outcome. Serious injury specifically includes loss of limb or function. Sentinel event criteria includes:

- The event has resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition.
- The event is one of the following (even if the outcome was not death or major permanent loss of function):
  - Suicide of a patient.
  - The sexual assault of a patient during treatment or while the patient was on the premises of the facility.
  - A hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities.
  - Medication error resulting in a patient's unanticipated death or major permanent loss of bodily function in circumstances unrelated to the natural course of the illness or underlying condition of the patient.
  - A surgical procedure on the wrong patient or on the wrong body part of a patient.
  - A foreign object accidentally left in a patient during a procedure.
  - A patient death or serious disability associated with the use or function of a device designed for patient care that is used or functions other than as intended.
  - Near Miss – any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome.

What to Do When a Patient Safety Error Occurs

Upon identification of a medical/health care error, the patient care provider will immediately:

- Perform necessary healthcare interventions to protect and support the patient's clinical condition.

- As appropriate to the occurrence, perform necessary healthcare interventions to contain the risk to others – example: immediate removal of contaminated IV fluids from supply should it be discovered a contaminated lot of fluid solutions was delivered and stocked.

- Contact the patient's attending physician and other physicians, as appropriate, to report the error, carrying out any physician orders as necessary.

- Preserve any information related to the error (including physical information). Examples of preservation of physical information are: Removal and preservation of blood unit for a suspected transfusion reaction; preservation of IV tubing, piggyback fluid for a patient with a severe drug reaction from IV medication; preservation of medication label for medications administered to the incorrect patient. Preservation of information includes documenting the facts regarding the error on an occurrence report, and in the medical record as appropriate to organizational policy and procedure.

- Report the medical/health care error to the staff member's immediate supervisor.

- Submit the incident occurrence report to the QAPI Committee per organizational policy.

Internal Reporting Of the Error/Event

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

- **No Harm Errors** – (including "no harm" medication errors), staff will document appropriately in the medical record according to organizational policy, document the circumstances regarding the no harm error on an incident occurrence report form, submit the form to the QAPI Committee and notify their immediate supervisor.

- **Mild-Moderate Adverse Outcome Errors** (including medication errors), staff will perform any necessary clinical interventions to support and protect the patient and notify the physician responsible for the patient, carrying out any necessary physician orders. Staff will then preserve any physical evidence as appropriate, notify their immediate supervisor, document facts in the medical record and on an incident occurrence report, submitting the report to the QAPI Committee per policy.

- **Adverse Drug Reaction** – staff will perform any necessary clinical interventions to support and protect the patient and notify the physician responsible for the patient, carrying out any necessary physician orders. Staff will then preserve any physical evidence as appropriate, notify their immediate supervisor, document facts appropriately in the medical record and on an incident occurrence report, submitting the report to QAPI Committee per organizational policy.

- **Transfusion Reaction** – staff will perform any necessary clinical interventions to support and protect the patient and notify the physician responsible for the patient, carrying out any necessary orders. Staff will then follow the organization policy and procedure for this event.

- **Hazardous Condition/Patient Safety Issue** - as appropriate, and if possible, staff will contain the hazardous condition or patient safety issue. Staff identifying a hazardous condition or potential patient safety issue will immediately notify their supervisor and document the findings on an incident occurrence report which is then submitted to QAPI Committee

- **Sentinel Event** – staff will perform any necessary clinical interventions to support and protect the patient and notify the physician responsible for the patient, carrying out any necessary physician orders. Staff will then follow the organizational Sentinel Event Policy and Procedure, which includes a root cause analysis and action plan.

- **Near Miss** – staff will report the near miss event to their immediate supervisor, describe the facts of the near miss on an occurrence report and submit the report to QAPI Committee.

- It is the intent of this facility to adopt a non-punitive approach in its management of errors and occurrences. All personnel are required to report suspected and identified medical/health care errors, and should do so without the fear of reprisal in relationship to, their employment. This organization supports the concept that errors occur due to a breakdown in systems and processes, and will focus on improving systems and processes, rather than disciplining those responsible for errors and occurrences. A focus will be placed on remedial actions to assist rather than punish staff members, with the individual staff member's supervisor determining the appropriate course of action to prevent error recurrence.

Root Cause Analysis

- All sentinel events and near miss occurrences will have a root cause analysis conducted to examine the cause and effect of the event through an impartial process

- A Root Cause Analysis is an interdisciplinary review process for identifying the basic or contributing causal factors that underlie a variation in performance associated with an adverse event or reportable patient safety event. It focuses primarily on systems and processes, includes an analysis of underlying cause and effect, progresses from special causes in clinical processes to common causes in organizational processes, and identifies potential improvements in processes or systems.

- The QAPI Committee is responsible for conducting the root cause analysis. It will be completed within 45 days of becoming aware of one of the reportable events. They will encourage the staff members' involvement in the root cause analysis and action plan processes, to allow the staff member an active role in process resolution.

A written Root Cause Analysis and "Action Plan" will be created which includes specific measures to correctly identify problems or areas of concern, identify strategies for implementing system improvements; and also includes outcome measures to indicate the effectiveness of system improvements in reducing, controlling or eliminating identified problem areas. The action plan must specifically address responsibility for implementation and oversight, time frames for implementation, and the strategy for measuring the effectiveness of the actions.

- The CMS, *A Guide for Performing Root Cause Analysis* format may be used. See attached.

- Results of the entire Root Cause Analysis will be presented to the Governing Body for evaluation.

Communication of Action Plans and Root Cause Analysis

- Action Plans related to a Root Cause Analysis will be shared with the entire staff upon Completion by the QAPI Committee. Possible recommendations to update or change policy and procedures may be presented to the staff, management and Governing Body to improve patient safety.

- Staff will educate patients and their families about their role in helping to facilitate the safe delivery of care. There will be a random record review verifying compliance with this educational process.

- Root Cause Analysis and Action Plans will be made available to the state health department representatives during onsite reviews.

Reporting Obligations

- Medical/Health care errors and occurrences, including sentinel events, will be reported internally and externally, through the channels established by this plan. External reporting will be performed in accordance with all state, federal and regulatory body rules, laws and requirements.

Patient Safety Program Staff Education/Training

- Staff will receive education and training during their initial orientation process and on an ongoing basis regarding job-related aspects of patient safety, including the need and method to report medical/health care errors. And, because the optimal provision of healthcare is provided in an interdisciplinary manner, staff will be educated and trained on the provision of an interdisciplinary approach to patient care.

- Medical errors results from multiple factors. Flawed systems or processed can combine with active failures by caregivers in the clinical setting to produce accidents and errors. Some contributing factors are:
  - Inadequate communication among team members
  - Incomplete review of patient health records and diagnostic studies
  - Traditional hierarchical and autocratic cultures
  - Patient – related decisions made only by physicians
  - Unclear instructions
  - Confusing packaging of medications and supplies
  - Time pressures and constraints, Multi-tasking
  - Failure to include the patient and family members in assessment and decision-making

- Staff will be trained about error reduction, which requires the commitment of all members of the health care team. Besides correcting the identified factors above, the following individual and facility changes will be focused on:
  - Reduce reliance on memory by using checklists and protocols.
  - Standardize processes as much as possible for procedures and other activities.
  - Focus on the safety aspects of products during the selection and evaluation process.
  - Promote safety related clinical competency.
  - Educate employees about the potential for errors and how to avoid them.
  - Creating a “Culture of Safety” whereby there is a change of environment from blaming individuals for errors to one in which errors are treated as opportunities to improve systems. This is accomplished by:
    - establishing a sense of trust among team members;
    - dissemination and verifying receipt of information to all levels of staff and management;
    - developing and supporting a proactive approach rather than a reactive approach;
    - making a sincere commitment to affirming safety as the first priority.

- Quarterly Patient Safety Program meetings will be incorporated into the QAPI Program and conducted to review any incident occurrence reports and review any new patient safety recommendations or alerts.