PAM Health Specialty Hospital of Reno
235 W. 6th St 2nd Floor
Reno, Nevada, 89503
2024 Patient Safety Plan

Purpose:

PAM Health Specialty Hospital of Reno has developed a Patient Safety Program Plan in collaboration with Quality Assurance Performance Improvement, Infection Control, Pharmacy and Therapeutics, Environment of Care, and Utilization Review committees in order to provide guidelines for implementation of an integrated patient safety program hospital wide and to comply with the requirements for the State of Nevada. In accordance with Hospital Scope of Services, it is the intent of the hospital leadership to foster a safe and safety-conscious environment that promotes wellbeing, acknowledges and addresses risks, and encourages interdisciplinary safety and education focusing on process improvements.

Scope:

Overall Patient Safety responsibilities in conjunction with the 2024 NPSG's include the following:

1. **Accuracy of patient identification**. Improve the accuracy of patient identification through the use of two patient identifiers whenever performing procedures, administering medications and/or blood, obtaining blood or other specimens, or providing treatments.

2. **Staff communication.** Improve staff communication as contained in the *Handoff Communication Guidelines*, located under "Policies and Procedures" on the PAM Health intranet website with focus on SBAR and Patient Hand-off communication.

3. **Medication safety.** Improve the safety using LASA and High Alert Medication as contained in the PAM Health policy, *Medication Safety: High Alert Medications*.

4. **Infection Prevention: Ensure** the identification, reporting, prevention and control of infections, including proper hand hygiene and use of PPE as contained in the PAM Health policies. **The Infection Control Plan** and its addendums (COVID 19), and other polices covering Blood and Body Fluid Exposure, Environmental Disinfection, **Single Use of Drugs and Devices** and the use of Isolations Precautions as contained in the Infection Control and Quality Management policy section.

5. **Patient Safety Risk 1.** Reduce patient falls and injuries. Utilization of the PAM Health policy for *Fall Prevention*. Implement fall prevention as recommended by the Fall Prevention Committee, and analysis of data from the Post Fall Huddle form, and the Post Fall Analysis data collection.

6. **Patient Safety Risk 2.** Reduce the risk of suicide. Per PAM Health policy screening and identification of patients at risk for suicide utilizing the PHQ 2-9 suicide screening tool.

7. **Clinical Alarm Systems: Improve** the effectiveness of clinical alarm systems as contained in the PAM Health policy, *Safety – Alarms Clinical Equipment*.

8. **Preventing and Correcting Errors in Labeling and Storing of Prescription Medications**. Improve medication labeling and storage as contained in the PAM Health policy and in conjunction with Cardinal Health, *Medication Storage, Dispensing Medications – General*, and other policies contained in the Cardinal Pharmacy program.

9. **Safe Administration of Prescription Medications, Controlled Substances and Other Medications.** Ensure safe administration of medication as contained in the PAM Health and Cardinal policy; Administration of Drugs, and other policies contained in the pharmacy section of PAM Health policies.

10. **Identification, Investigation and Report Sentinel Events**. Ensure prompt identification, investigation and reporting of sentinel events, as contained in the PAM Health policy, Sentinel Events, and as prescribed by **NRS 439.800** and following guidelines established by the Nevada State Department of Health's Sentinel Event Registry.

11. **Environment of Care:** Provide oversite of the maintenance of a safe and sanitary environment of care throughout the facility by conducting environmental rounds, infection control rounds, and day-to-day observations by supervisory staff as contained in the PAM Health policies and the **Safety Management Plan**, **Infection Control Plan**, and other policies under Quality Management and Engineering. Ongoing collaboration with EVS and Plant Operations of the host of Hospital (Northern Nevada Medical Center) is in place.

12. **Patient Safety Checklists: Continued** use, adoption and implementation of patient safety checklists to improve health outcomes within the medical facility and to ensure patient safety is constant, consistent, and correct.

Current checklists in use:

- Admission Checklist
- PICC Procedural Note/Timeout
- Debridement Procedure Note/Timeout
- Blood Transfusion Monitoring Record/Verification
- Stroke Admission Checklist
- Fall Checklist

The primary focus of the Patient Safety Program is the Patient; however, the program also addresses the safety of visitors and staff. The scope of the Patient Safety Program includes but is not limited to the occurrence of the following:

- Adverse Drugs Reactions
- Falls
- Restraints
- Medication Errors
- Infections
- Near Misses
- Sentinel Events
- Hazardous Conditions (Including Workplace violence)

The Patient Safety Program also includes oversite over the Environment of Care. Currently the Patient Safety Program has oversite of seven (7) Environment of Care Plans:

1. Safety management Plan
2. Security Management Plan
3. Life Safety Management Plan/Fire Safety
4. Medical Equipment Plan
5. Emergency Preparedness Plan
6. Hazardous Materials and Waste Management Plan
7. Utilities Management Plan

Annual review of each of the seven (7) plans are preformed and reported to the Environment of Care Committee, Quality Management Committee, Patient Safety Committee as well as the Medical Executive Committee and the Governing Board of the hospital.

Methodology

The Patient Safety program includes both proactive and responsive components.

Proactive: The proactive patient safety component emphasizes a proactive error reduction and avoidance program. The following are reviewed proactively to identify patient safety issues:

1. Medical equipment and medication risk assessment activities
2. Sentinel event alert risk reduction activities
3. Performance improvement indicators (department specific) and monitoring activities
4. Patient satisfaction reports
5. Medical record review reports

6. Staff orientation, evaluation, education, and training activities to include skills fairs and online training modules.
7. Failure Mode and Effects analysis
8. Medical Staff Credentialing/Peer Review
9. Incident occurrence report tracking and trending

Failure Mode Event Analysis (FMEA) will be conducted at a minimum of every 18 months. The process to be studied each cycle will be determined in collaboration with the medical staff, hospital leadership, and hospital staff.

Information from patient safety organizations such as National Institute for Health, Institute for Safe Medical Practices, and The Joint Commission will be disseminated to the appropriate departments and committees for action and implementation of recommendation if applicable.

Responsive: The hospital will utilize information obtained from risk assessments, sentinel events alerts, performance improvement measures, medical records review, and other data in order to track, trend, and respond to patient safety issues. Patient safety related issues will be ranked based on severity. The following will be reviewed for reactive safety issues:

1. Root Cause Analysis
2. Intensive Assessment and Analysis/FMEA
3. Incident occurrence report findings
4. Patient Complaint/Grievance Response
5. Performance Improvement Measures
6. Patient Satisfaction Survey Reports
7. Serious Event Notifications/Sentinel Event Reporting
8. Culture of Patient Safety
9. Hazard Vulnerability Analysis

Patient Safety Committee and Reporting

Patient Safety is the responsibility of all employees and medical staff members. The Patient Safety Program is multi-faceted, and responsibility will be shared among individuals, groups, departments, and teams. Each performance improvement team is multidisciplinary and has representatives from hospital and medical staff. Reports from the performance improvement teams are sent to the Quality and Patient Safety Committees, Medical Executive Committee and the Governing Board for review.

In compliance with State of Nevada Regulations, the Patient Safety Committee will be comprised of:

- Patient Safety Officer (annually appointed) by the medical facility.
- At least three (3) providers of health care who treat patients at the medical facility, including, without limitation, at least one member of the medical, nursing, and pharmaceutical staff of the medical facility.

- One member of the executive committee or governing body of the medical facility

- The Patient Safety Committee is also multidisciplinary with representation from the following areas:
    - Clinical Departments
    - Pharmacy and Therapeutics
    - Safety Committee
    - Quality/Risk Management
    - Hospital Infection Control

The Patient Safety Committee functions include but are not limited to:

1. Review and evaluate internal and external patient safety data from the following sources for opportunities of improvement in the safety of patient care processes:

    a. Risk and Safety Management
    b. External Data Reports
    c. Sentinel Event Alerts from the Joint Commission
    d. Healthcare Reports
    e. Regulatory Reports
    f. Patient/family complaints and grievances

2. Continually improve processes of care delivery based on data analysis.

3. Develop policies and procedures as a result from process improvement activities and corresponding checklists.

4. Develop and approve Patient Safety Education for medical and hospital staff.

5. Conduct annual risk assessment of patient safety issues/strategies from internal and external reports.

PAM Specialty Hospital of Reno believes in a non-punitive environment in order to maximize reporting of near misses, adverse outcomes, and sentinel events as it has been demonstrated that many errors occur as a result of system or process failures.

Disciplinary action may be considered when an individual takes action to hide an incident, is malicious or untruthful in reporting, when facts and circumstances suggest that an error was deliberate or in reckless disregard to patient and/or staff safety, or when the individual consistently fails in detection, reporting or remedies to prevent mistakes.

Reporting of patient safety issues to an outside agency will be done when required by regulation or as determined by the Administrator/CEO/Corporate PAM.

The activities of the Patient Safety Program, annual review of the Patient Safety Plan, appropriate policies, forms, checklists and best practices will be reported to the Patient Safety Committee, the Medical Executive Committee, and the Governing Board as outlined in the Performance Improvement Plan and the PAM reporting calendar. Communication within the hospital and medical staff is the key to successful patient safety program and will be encouraged.

Education and training are an important and effective tool in assuring the Patient Safety program is clearly understood, particularly error identification and reporting and the basic approaches to Patient Safety. Education and training in regard to patient safety is included in new hire general and clinical orientation and is reviewed annually. The Relias Learning Management System is utilized for annual education, and ongoing education needs as identified related to patient safety.

Patient and family education is provided about their roles in promoting and facilitating the safe delivery of care, in partnership with hospital staff and medical providers.