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Owner	Stephanie Herider
Area	PT SAFETY - POLICIES
Applicability	Mesa View Regional Hospital

2024 Patient Safety Plan

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PURPOSE

The purpose of the Patient Safety Plan is to provide a systematic, coordinated and continuous approach to the maintenance and improvement of patient safety through the establishment of mechanisms that support effective responses to actual occurrences; ongoing proactive reduction in medical/health care errors; and integration of patient safety priorities into the new design and redesign of all relevant organization processes, functions and services. The goal of the Patient Safety Plan is to provide a safe environment for patients and their families. The approach to optimal patient safety involves multiple departments and disciplines in establishing the plans, processes and mechanisms that comprise the patient safety activities at the Hospital. The purpose includes creating an environment that encourages:

- Recognition and acknowledgment of risks to patient safety and medical/health errors;
- The initiation of actions to reduce these risks;
- The internal reporting of what has been found and the actions taken;
- A focus on processes and systems;
- Minimization of individual blame or retribution for involvement in a medical/healthcare error;
- Organizational learning about medical/healthcare errors;
- Support of the sharing of that knowledge to effect behavioral changes in itself and other health care organizations; and
- Disclosure of the outcomes of care, treatment and services will be communicated by the physician.

The Patient Safety Plan developed by the interdisciplinary Quality Improvement Committee and approved by the Medical Executive Committee, and the Board of Trustees, outlines the components of the organization-wide Patient Safety Program.

SCOPE OF ACTIVITIES

The Patient Safety program is an organization-wide program that includes and integrates all activities within the organization and ECRI PSO. which contributes to the maintenance and improvement of patient safety, healthcare quality and healthcare outcomes.

The scope of the Patient Safety Program involves an ongoing assessment, using internal and external knowledge and experience, to prevent occurrence of errors and to maintain and improve patient safety. Patient safety event information from aggregated data reports and individual event reports will be reviewed by the Quality Improvement Committee and the High Reliability Organization Team to prioritize organizational patient safety activity efforts.

In addition to internal knowledge and experience, the services and information that the ECRI. offers will be reviewed and evaluated to include:

- Best Practices and Took Kit Development;
- Comparative Analysis of Adverse Event Reported in the Event Reporting System;
- Unsafe Behavior Evaluations;
- Raise safety awareness through the internal publication of anonymized Action Plans from root cause analysis;
- Develop and publish Patient Safety Alerts; and

Patient Safety Event Work Product:

Types of patient safety events, adverse outcomes, or medical/health care errors included in data analysis are:

- Event Reports- those events and outcomes reportable to the Director of Risk Management by an Event Report (Form RM 3301) during downtime or by entering the occurrence into the Event Reporting System include processes and outcomes of care that may result in no harm through serious injury or death. Examples include , but not limited to, falls, medication variances, adverse drug reactions, intravenous therapy variances, procedure variances, procedure complications, patient complaints and AMA and elopement discharges. These may also include near miss events.
- Hemolytic transfusion reactions reported through the transfusion review channels.
- 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.
- Serious Safety Event & Sentinel Event: applies to events that have 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. In addition, there are other event types that are considered sentinel due to the severity of the event even though the outcome was not death or permanent loss of function unrelated to the natural course of the patient's illness or underlying condition.
- Serious Safety Event & Sentinel event criteria and the procedures involved are detailed in the sentinel event and root cause analysis policies and procedures including definitions of near misses, which require a root cause analysis.

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- Never Events and Hospital Acquired Conditions including:
  Surgical events:
- Surgery performed on the wrong body part;
- Surgery performed on the wrong patient;
- Wrong surgical procedure performed on a patient;
- Unintended retention of a foreign object in a patient after surgery or other procedure;
- Intraoperative or immediately postoperative death in an American Society of Anesthesiologists Class I patient; or
- Product or device events:
- Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the health care facility;
- Patient death or serious disability associated with the use or function of a device in patient care, in which the device is used for functions other than as intended; or
- Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a health care facility e.g., luer connecters are implicated in or contribute to many of these errors because they enable functionality of dissimilar tubes to be connected.

Patient protection events:

- Infant discharged to the wrong person;
- Patient death or serious disability associated with patient elopement (disappearance); or
- Patient suicide or attempted suicide resulting in serious disability, while being cared for in a health care facility

Care management events:

- Patient death or serious disability associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration);
- Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA-incompatible blood or blood products;
- Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a health care facility;
- Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a health care facility;
- Death or serious disability (kernicterus) associated with failure to identify and treat hyperbilirubinemia in neonates;
- Stage 3 or 4 pressure ulcers acquired after admission to a health care facility; or
- Patient death or serious disability due to spinal manipulative therapy

Environmental events:

- Patient death or serious disability associated with an electric shock or electrical cardio-version while being cared for in a health care facility;

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- Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances;
- Patient death or serious disability associated with a burn incurred from any source while being cared for in a health care facility;
- Patient death or serious disability associated with a fall while being cared for in a health care facility; or
- Patient death or serious disability associated with the use of restraints or bed rails while being cared for in a health care facility.

Criminal events:

- Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider
- Abduction of a patient of any age;
- Sexual assault on a patient within or on the grounds of the health care facility;
- Death or significant injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of the health care facility; or
- Environment of care significant incidents involving employee, visitor, utility or property damage

Sources of external knowledge and experience include the Sentinel Event Alerts. Published by The Joint Commission, safety alerts published by the Food and Drug Administration, Patient Safety Alerts, adverse outcome and lessons learned from RCA's, information from insurance carriers and other private and public healthcare safety organizations.

The scope of the organization-wide Safety Program encompasses all people including the patient population, visitors, volunteers and staff (including medical staff). The program addresses maintenance and improvement in patient safety issues in every department throughout the facility, as well as employee safety, physical plant and facilities, equipment and supply-related safety issues, among other safety issues. To promote efficiency, there is an Environment of Care Committee, chaired by the Environmental Safety Officer, that addresses employee events and safety, workers compensation, needle sticks and products, visitor Events, hazard surveillance, and the safety management plans. To promote integration, communication and analysis of inter-related issues, there is cross membership between the committees, and both committees report to the Medical Executive Committee and the Board of Trustees. for oversight and further integration of related issues. Physician peer review of medical errors is also conducted at the Medical Executive Committee level (or at their direction).

The Serious Safety Event Rate (SSER) will then be reviewed at least weekly. The SSER should be considered Patient Safety Work Product and will be reported to the following council/committees, Patient Safety, Medical Executive and the Board of Directors. This rate will also be reported to the Patient Safety Committee and the ECRI PSO.

The Quality Improvement Committee is a multidisciplinary body with representatives from the Medical Staff, administration and clinical and non-clinical areas. Members may include bt are not limited to: Medical Staff Member, Administrator, Chief Nursing Officer, Director of Quality, and Director of Risk Management.

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The meeting frequency should be at least every other month. The organizations' Director of Quality or Risk Management will serve as the Patient Safety Officer in most instances.

Procedures

Committee responsibilities:

1. The interdisciplinary Quality Improvement Committee is responsible for the oversight and management of the Patient Safety Program. This includes making recommendations to organization leaders regarding the adequacy of resources allocated to support patient safety activities. The committee will oversee data and analysis in order to prioritize patient safety activities, including, but not limited to patient safety work product, Medication Variances, Infection Surveillance, Safety Surveillance, Staff Perceptions of and suggestions for improving patient safety, Staff willingness to report errors (Employee Surveys), Patient/Family perceptions of, and suggestions for improving patient safety, and results of any risk assessment surveys by department.
2. The Quality Improvement Committee is responsible to review and approve the organization-wide and departmental patient safety-related policies, procedures and ECRI PSO information. This should include the content of any proactive risk self-assessments prior to data collection, as well as patient/family education regarding their role in helping to facilitate the safe delivery of care.
   All departments within the organization (patient care and non-patient care departments) are responsible to report patient safety occurrences, and potential occurrences to the Director of Risk Management, who will aggregate occurrence information and present a report to the Quality Improvement Committee on a every other month basis. This Patient Safety Work Product report will contain aggregated information related to the cause or nature of the occurrence, severity of occurrence, number/type of occurrences per department, occurrence impact on the patient, improvement actions taken, and patient outcome. The Patient Safety Committee will analyze the report information and determine further patient safety activities as appropriate. Any undesirable patterns or trends in patient safety and sentinel events should be intensively analyzed. Intense analysis involves studying a process to learn in greater detail about how it is performed or how it operates, how it can malfunction, and how errors occur.
3. Patient complaints and concerns or ideas about patient safety should be reported to and evaluated by the Quality Improvement Committee. Patient safety information input regarding employee willingness to report and related information from patient and employee surveys should also be reviewed and evaluated. (Resolution of individual patient complaints is handled by the department director of the involved department and the Director of Risk Management.)
4. The Quality Improvement Committee reviews alerts or guidance from external sources, including TJC, Institute for Safe Medication Practices, the Food and Drug Administration and consider whether their recommendations should and could be implemented at the organization as a proactive measure to reduce patient safety risks.
5. Patient safety occurrences requiring a report to an external agency such the F.D.A., Board of Pharmacy, Center for Medicare Administration, a manufacturer or the state department of health, should also be reported to the Quality Improvement Committee. This report should include an analysis of the occurrence as to underlying causes, any improvement actions recommended and/or taken and, when available, the results of those improvement actions.

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6. Through review of internal data reports and reports from external sources (including TJC sentinel event report information, and other sources such as available occurrence reporting information from state and federal sources and current literature), the Quality Improvement Committee will select at least one high-risk safety process for proactive risk assessment annually using a Failure Mode Effects Analysis methodology.

The proactive risk assessment will include:

- Assessment of the intended and actual implementation of the process to identify the steps in the process where there is, or may be, undesirable variation (failure mode). For each identified failure mode, identify the possible effects of the undesirable variation on patients, and how serious the possible effect on the patient could be (criticality);
- For the most critical effects, conduct a root cause analysis to determine why the variation (failure mode) leading to that effect may occur;
- Redesign the process and/or underlying systems to minimize the risk of that failure mode or to protect patients from the effects of that failure mode;
- Test and implement the redesigned process;
- Identify and implement measures of the effectiveness of the redesigned process; and
- Implement a strategy for maintaining the effectiveness of the redesigned process over time.

Organization-wide activities:

1. Education regarding employee responsibilities for patient safety is included in initial and annual orientation programs, both by the Director of Risk Management and department manager. This includes reporting requirements and mechanisms. As appropriate, training which incorporates methods of team training to foster an interdisciplinary, collaborative approach to patient care delivery is provided. The Quality Improvement Committee and other committees may recommend education as a patient safety improvement activity at any time throughout the year. Training on failure mode analysis, effects and criticality analysis should be done for those involved with this risk reduction tool.
2. Patient safety is included as a regular agenda item for at least the clinical and support service departments of the organization. The intent is to foster a culture of "patient safety as job number one", "Safety First". Patient safety is a high priority function in the design and redesign of processes, functions and systems that impact or involve patient care.
3. At any given time, the performance of critical steps in at least one high-risk process is the subject of ongoing measurement and periodic analysis to determine the degree of variation from intended performance.
4. Initiate and comply with TJC National Patient Safety Goals, and/or other regulatory or accrediting standards, by implementing the goals' elements of performance to improve Patient Safety.

Actions upon Error or Event:

Upon identification of a medical/health care error/event, the patient care provider should:

- As appropriate to the occurrence, perform healthcare interventions to contain the risk to the patient or others

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- Contact the patient's attending physician and other physicians, as appropriate, to report the error or event, carrying out physician orders as necessary.
- The patient's attending physician should contact the patient's family, guardian, Power of Attorney or significant other to make aware of the error or event.
- Preserve any information (Preservation Checklist) related to the error or event (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, fluids bags and/or pumps 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 Event 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 Event Report to the Director of Risk Manager per the Patient Safety Evaluation System.

Individuals in any department identifying a potential patient safety issue should notify their supervisor and document the findings on an Event Report. This Patient Safety Work Product includes patient safety near misses. The paper Event Report should be submitted to the Director of Risk Manager. Events that are reported through the on-line Event Reporting System will automatically be sent to the Director of Risk Management

Staff response to medical/health care occurrences is dependent upon the type of occurrence identified:

- 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 should notify their supervisor and document the findings on an Event Report form. The Event Report form will be submitted to the Director of Risk Manager utilizing the online Event Reporting System or paper event report during system downtime. .
- Serious Safety Event & Sentinel Event - staff should perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then follow the organizational Sentinel Event Policy and Procedure. A root cause analysis should be performed for any sentinel event and near miss as defined in the sentinel event policy and procedure.
- Near Miss – staff should report the near miss event to their immediate supervisor, describe the facts of the near miss on an event report and submit the report to the Director of Risk Manager via the on-line Event Reporting System or paper form during system downtime. . A proactive risk assessment may be performed to prevent recurrence if it is determined that a recurrence poses a significant safety risk to future patients. This may be determined by the Director of Risk Manager,the Quality Improvement Committee and/or High Reliability Organization if there is any disagreement as to risk potential.

An effective Patient Safety Program cannot exist without optimal reporting of medical/health care errors and occurrences. Therefore, it is the intent of this organization 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 relation to their employment.

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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.

Staff Support:

Staff members involved in a sentinel event occurrence will receive support from the Director of Risk Manager regarding the staff member's professional and emotional reconciliation of the sentinel event. The staff member's involvement in the root cause analysis and action plan processes is encouraged, to allow the staff member an active role in process resolution. Additionally, any staff member involved in a sentinel event or other medical/health care error may request and receive supportive personal counseling from the hospital's counseling service available with the employees benefits. The Human Resource Director is to assist the employee in receiving the services necessary to assist the staff member through the crisis.

Disclosure:

Physician to communicate to patients, and when appropriate, their families regarding the unanticipated outcomes of care, or when the outcomes differ significantly from the anticipated outcomes. The Quality Improvement Committee will monitor for compliance with this standard through the information management function of record reviews, and through reports from the Patient Safety Officer of evidence found upon individual record review for other risk management purposes. (See also policy regarding disclosure of unanticipated outcomes.)

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Communication:

1. Medical/health care errors and occurrences, including sentinel events, will be reported to the ERCI PSO and externally, per hospital policy through the channels established by this plan. External reporting will be performed in accordance with state, federal and regulatory body rules, laws and requirements (i.e., regarding medical devices in accordance with the Safe Medical Devices Act.).
2. An annual report will be compiled by the Quality Improvement Committee and forwarded to the Medical Executive Committee and on to the governing board. This report shall include at least aggregate data regarding patient safety, an analysis thereof (conclusions), recommendations and actions taken to improve patient safety, both in response to actual occurrences and pro-actively. These reports shall be protected to the extent allowable under the disclosure laws applicable to peer review, Quality Improvement processes, and risk management.
3. The governing board, upon evaluation of received reports (at a minimum, annually), should assess the allocation of resources, the assignment of personnel and their time, the provision of information services and data management processes, and staff training in terms of adequacy of their allocation of human, information, physical and financial resources to support patient safety improvement priorities.

Patient and Family Education:

The organization urges patients and families to get involved in their care. Educational efforts to increase consumer awareness and involvement are supported by the Centers for Medicare and Medicaid Services and TJC as a critical process to improve patient safety. The organization encourages patients and

families to:

- Speak up if they have questions or concerns, and if they don't understand, ask again. Encouraging patients that it is their right to know
- Pay attention to the care received. Making sure you are getting the right treatments and medications by the right health care professionals. Don't assume anything.
- Educate yourself about diagnosis, the medical tests you are undergoing and your treatment plan.
- Ask a trusted family member or friend to be your advocate.
- Know what medications you take and why you take them. Medication errors are the most common health care mistakes.
- And to participate in all decisions about your treatment. You are the center of the health care team.

Approval Signatures

Step Description	Approver	Date
MEC, BOT	Charlene Kelly	01/2024
Approver	Stephanie Herider	12/2023
Owner	Charlene Kelly	12/2023

Applicability

Mesa View Regional Hospital