Southwest Medical, Part of Optum Care

PATIENT SAFETY PLAN

MARCH 2024

The Southwest Medical Patient Safety committee/team created the plan and revises/updates it annually. Implementation of this plan is intended to optimize healthcare quality and patient safety outcomes, encourage recognition, reporting, and acknowledgment of risks to patient, visitor, and employee safety, and reduce the medical/healthcare errors and /or preventable events

Patient Safety Committee/Program
Southwest Medical, Part of Optum Care
Las Vegas, Nevada

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Commitment to Patient Safety

Southwest Medical is committed to a comprehensive approach to improving healthcare quality and 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, visitors, and employees, through continuous learning and improving patient safety policies, systems and processes.

Mission, Vision, and Values

In support of our mission, vision and values, Southwest Medical's Patient Safety and Quality Improvement program promotes:

- Collaboration of healthcare, leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high quality healthcare
- Open and honest communication to foster trusting and cooperative relationships among healthcare providers, staff members and patients and their families and 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 the facility
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare
- Education of staff and physicians to assure participation of healthcare providers

Plan Scope and Purpose

The scope of the Patient Safety Committee is organizational-wide and includes but is not limited to

- Patient safety
- Visitor safety
- Employee safety

The Committee provides oversight for patient safety activities, infection control activities, initiatives to promote patient safety and monitoring and review of medical/healthcare errors/potential errors involving patients, visitors, SMA staff, students and volunteers

All staff members at Southwest Medical are expected to fully support and participate in this plan and devote their expertise, knowledge, vision, skill, and insight to the patient safety and healthcare quality improvement process

Leadership assumes a role in establishing a culture of safety that minimizes hazards and patient harm by focusing on processes of care. The leaders of the organization are responsible for fostering a culture of safety through personal example by:

- Emphasizing patient safety as an organizational priority
- Embracing Just Culture principles and leading adaption of these principles throughout the organization
- Providing education to medical and facility staff regarding the commitment to reduction of medical errors
- Supporting proactive reduction in medical/health care errors
- Providing a platform for addressing errors should they occur in a manner that reduces likelihood of reoccurrence in the future

- Integrating patient safety priorities into the new design and redesign of all relevant organization processes, functions and services

The purpose of the Patient Safety Plan is:

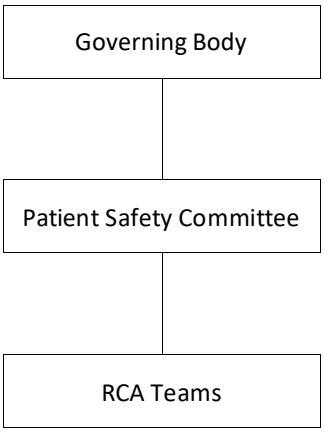
- To address patient safety related concerns and challenges
- To reduce risk
- To respect the dignity of those Southwest Medical serves by assuring a safe environment
- To periodically evaluate and revise the program to better serve patients and their families

Roles and Responsibilities

Southwest Medical created an organization-wide Patent Safety Plan that includes the medical facilities (Surgery Centers) as directed by NRS 439.875 a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plan is promoted and executed successfully

The Southwest Medical Patient Safety Committee

- Is a standing confidential interdisciplinary committee formed to manage the Southwest Medical's Patient Safety Program and Infection Prevention and Control Program through a systematic, coordinated, continuous approach
- Will meet monthly to assure maintenance and improvement of patient safety with the establishment of plans, processes and mechanisms involved in the provision of the patient care
- Will report and discuss events including:
    - Number of sentinel events from previous calendar quarter
    - Number of severe infections from previous calendar quarter
    - Corrective action plans
    - Corrective action plan evaluation
    - Patient safety policies and checklists
- Will monitor and document the effectiveness of the patient safety policy
- Will evaluate patient safety policies and checklists at least annually
- Will revise patient safety policies and checklists as needed
- Will convene a RCA meeting/team as necessary
- Review the RCA process and quality improvement related activities and timelines
- Identify barriers and technical assistance needs for supporting the RCA efforts
- Discuss corrective action process and activities



Patient Safety Committee Membership
In accordance with NRS 439.875, the Patient Safety Committee will include:

- The Patient Safety Officer
- The Infection Prevention and Employee Health Medical Director
- At least three providers of healthcare who treat patients , including but, without limitation, at least one member of the medical, nursing and pharmaceutical staff
- At least one member of the governing body
- The 2022 Committee includes:
    - Medical Director Specialties
    - Medical Director Primary Care
    - Medical Director On Demand Medicine
    - Medial Director Clinical Education Programs
    - Medical Director Surgery Centers
    - Optum Legal
    - Vice President/Operations
    - Chief Nursing Officer
    - RN Vice President/Administrator Surgery Centers
    - RN Associate Vice President On-Demand Medicine and Oncology Programs
    - RN Associate Vice President Specialties
    - Associate Vice President Imaging Services
    - Pharmacy Consultant (PharmD)
    - RN Associate Directors and Managers Surgery Centers
    - RN Associate Directors and Manager Operations
    - RN Manager Clinical Quality (PAD Department)
    - RN Manager Employee Health and Infection Prevention (PAD Department)
    - Infection Prevention/Employee Health Senior Project Coordinator (PAD Department)
    - Optum Regional Safety Manager (PAD Department)

Patient Safety Committee Responsibilities (based on NRS 439.875 and NRS 439.877)
The Patient Safety Committee is a standing confidential interdisciplinary committee formed that manages the Southwest Medical's Patient Safety Program and Infection Prevention and Control Program through a systematic, coordinated, continuous approach

- Evaluating and improving the quality of care rendered by Southwest Medical
- Collecting data and evaluating aggregate data related to individual occurrences in order to utilize performance improvement methodologies to promote patient safety and infection prevention
- Maintaining and improving patient safety with the establishment of plans, processes and mechanisms involved in the provision of the patient care
- Monitoring and documenting the effectiveness of the patient identification policy
- On or before July 1 of each year, submitting 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)
- Receiving reports from the Patient Safety Officer pursuant to NRS 439.870
- Evaluating actions of the Patient Safety Officer in connection with all reports of potential or actual sentinel events
- Reviewing and evaluating the quality of measures carried out by Southwest Medical to improve the safety of patients who receive treatment

- Reviewing and evaluating the quality of measures carried out by Southwest Medical to prevent and control infections
- Making recommendations to the governing body to reduce the number and severity of sentinel events and infections that occur
    - Report to the Governing Body:
    - The number of sentinel events at the medical facility (Surgery Centers)
    - The number and severity of infections at the medical facility (Surgery Centers)
    - Any recommendations to reduce the number and severity of sentinel events and infections
- Adopting patient safety checklists and patient safety policies as required by NRS 439.877, reviewing checklists and policies annually and revising the checklists and policies as necessary
- Directing root cause analysis teams when indicated
- Providing oversight/direction for Surgery Centers QAPI program and quality studies
- Providing oversight/direction for the Surgery Centers participation in NHSN
- Providing oversight and monitoring for the Optum Practice Health and Safety Clinical Assessment Process

Patient Safety Officer Responsibilities (based on NRS 439.870)

- Chair the Patient Safety Committee
- Supervise the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to NRS 439.835
- Take such action as necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility
- Report to the Patient Safety Committee regarding any action taken in accordance with the responsibilities above
- Promote compliance with patient safety standards and initiatives
- Reinforce expectations of the Patient Safety Plan
- Accept accountability for measurably improving safety and reducing errors
- Liaison with Southwest Medical clinical leadership including surgery center leadership, other quality committees and the Board of Directors

Infection Prevention Officer Responsibilities (based on NRS 439.873)

- Serve on the Patient Safety Committee
- Liaison with Southwest Medical clinical leadership including surgery center leadership, other quality committees and the Board of Directors
- Provide medical direction as indicated (for both patient and employee infection control issues)
- Monitor the occurrences of infections to determine the number and severity of infections
- Report to the Patient Safety Committee concerning the number and severity of infections
- Take such action as necessary to prevent and control infections alleged to have occurred
- Carry out the provisions of the infection control program adopted pursuant to NRS 439.865 and ensure compliance with the program
- Ensure compliance with current infection prevention and control standards
- Direct infection prevention initiatives
- Reinforce expectations of the Infection Control program
- Complete at least four hours of continuing education each year on topics relating to current practices in infection control and prevention

RCA Team/Meeting

Will meet as needed to:

- Define the healthcare issues or potential risks

- Conduct Root Cause Analysis
- Review and analyze data
- Brainstorm issues or the potential risks by using fishbone diagrams or the *5 Whys* technique
- Identify the contributing factors
- Develop Corrective Action Plan
- Identify Plan-Do-Check -Act (PDCA) topics
- Discuss and present possible changes in procedure to improve areas indicated
- Identify strengths and areas that need improvement
- Develop strategies, solutions, and next steps

RCA Team Leader Responsibilities

- Organize and coordinate the RCA process
- Assemble and encourage a supportive and proactive team
- 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

Root Cause Analysis (RCA) Team Responsibilities

- Root cause interviews, analysis, investigation and corrective action plan implementations
- Participate in the RCA meetings and discussions
- Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders

Governing Body Staff Responsibilities

- Provide vision and leadership to Patient Safety and Quality Improvement process
- Develop and foster a safe learning and improving culture
- Provide oversight to healthcare quality improvement processes and teams
- Plan, discuss and generate patient safety goals and activities

Quality Studies -Process Analysis (Surgery Centers)

The Surgery Centers will complete quality studies each year that include:

1. A statement of the purpose of the QI activity that includes a description of the known or suspected problem and explained significance to the Surgery Center
2. Identification of the performance goal against which Surgery Center will compare current performance
3. Description of the data that will be collected in order to determine the Surgery Center's current performance
4. Evidence of Data Collection
5. Data analysis that describes findings about the frequency, severity and source of issue
6. Comparison of the Surgery Center's current performance against identified performance goal
7. Implementation of corrective action
8. Re-measurement to objectively determine whether corrective actions achieved and sustained improvement
9. Implementation of any additional corrective action to achieve and/or sustain improved performance (and plan for on-going re-measurement)

10. Communication of findings to Surgery Center Leadership, The Patient Safety Committee, the Board of Directors and Surgery Center staff and incorporating findings into educational activities

For quality studies, the Surgery Center(s) may base topic selection on information published by accreditation bodies, National Patient Safety Goals and/or other sources of information including risk management, performance improvement, quality assurance, infection prevention and control, patient/family suggestions/expectations or process outcomes

Surgery Centers' quality studies will focus on redesign or implementation of new processes to incorporate patient safety principles and will place an emphasis on the important facility and patient care functions of:

- Rights of Patients
- Governance
- Administration
- Quality of Care
- Quality Management and Improvement
- Clinical Records and Health Information
- Infection Prevention and Control and Safety
- Facilities and Environment
- Anesthesia Services
- Surgical and Related Services
- Pharmaceutical Services
- Pathology and Medical Laboratory Services
- Diagnostic and Other Imaging Services

Infection Prevention Program

- The purpose of the Infection Control Programs is to prevent and control infections
- The Infection Control Program and the surgery Centers Infection Control Program (SSC and SCT 1600-3 Infection Control Program for Southwest Medical Surgery Center) are components of the Patient Safety Plan
- The Infection Control Programs are based on current guidelines developed by nationally recognized infection control organizations
- The Infection Control Professionals will report regularly on the number and severity of infections that occurred in the prior quarter

Infection Prevention Program – COVID 19

- Southwest Medical implemented risk reduction standards to ensure a safe environment with minimal risk of exposure for all employees, staff, contractors and patients
- Southwest Medical updates infection prevention practices as national standards evolve
- Southwest Medical offers vaccine to all employees and to patients who meet eligibility guidelines
- All patients are screened for COVID symptoms prior to scheduled surgery and on arrival at the Surgery Center
- The Surgery Centers follow infection prevention practices to decrease risk of transmission including surgical mask or better, screening visitors and distancing

Infection Prevention RN

Southwest Medical will maintain at least one Registered Nurse with training and education in infection prevention and control. While supporting the entire organization, the Infection Prevention RN will dedicate specific hours to the Surgery Centers

NHSN

- The medical facilities (Surgery Centers) will participate in the CDC's National Healthcare Surveillance Network
- Infection Prevention staff will report aggregate data and patient follow-up to the Patient Safety Committee at regularly scheduled intervals

Medical/Health Care Event (Incident)

Staff will:

- immediately report the event (incident) to supervisor
- Notify provider and obtain any orders to support the patient's clinical condition
- Initiate an Event (Incident) Report

The supervisor will:

- Communicate the event through appropriate channels to the Patient Safety Officer
- Should this occur during off-hours, the supervisor/designee will leave a voice mail message for the Patient Safety Officer
- Initiate investigation and follow-up actions
- Complete Event (Incident) Report process

The Patient Safety Officer will:

- Follow usual protocols to investigate the error
- Coordinate factual information/investigation for presentation, review and action by the Patient Safety Committee and/or other quality committees as applicable

Identification and Reporting

- SMA Policy 1600-29 (Sentinel Event Policy) and SMA Policy 190-4 (Incident Occurrence Reporting Policy) will describe the mechanism for identification and reporting a Sentinel Event/other medical error
- Southwest Medical will promote an environment that supports staff reporting and will support a Just Culture that focuses on process not individuals

Root Cause Analysis

- The Patient Safety Committee/Patient Safety Officer will provide oversight and direction for any root cause analysis of facility processes conducted for either Sentinel Events or near miss events
- The Patient Safety Officer will act as the liaison to quality committees and the Board of Directors for review/recommendations

Staff Involvement

As Southwest Medical actively supports the concept that errors occur due to a breakdown in systems and processes, staff involved in an event with an adverse outcome will be supported by:

- A non-punitive approach and without fear of reprisal
- Voluntary participation in the root-cause analysis for educational purposes and prevention of further occurrences

Reporting Requirements/Sentinel Event Reporting

- The Patient Safety Officer will direct reporting sentinel events to the Patient Safety Committee
- The Patient Safety Officer will direct reporting of any sentinel event at a medical facility per state of Nevada requirements as defined in NRS (Nevada Revised Statues) and NAC (Nevada Administrative Code)
- The Patient Safety Officer will direct reporting the number of sentinel events and recommendations to reduce the number or severity of sentinel events to the SMA Board of Directors

- The Patient Safety Officer/Committee will provide education and support to providers to ensure providers report the occurrence of a sentinel event resulting from any surgery to the Board within fourteen days after the occurrence of the sentinel event
- The Patient Safety Committee shall evaluate the actions of the Patient Safety Officer in connection with the reporting of sentinel events
- The Patient Safety Committee shall make recommendations to the SMA Board of Directors to reduce the number and severity of sentinel events and infections that occur at the facility

HealthCare Acquired Infections (HAI) Reporting
The Patient Safety Officer/Committee will provide education and support to providers to ensure if a provider identifies a patient with an infection, the provider will notify, within five days or as soon as practicable, the patient or the legal guardian or other person authorized by the patient to receive such information that the patient has an infection

The Patient Safety Officer/Committee will provide education and support to providers so that providers understand the notification may be delayed if the patient does not have a legal guardian, has not authorized any other person to receive such information and:

- Is not capable of understanding the information
- Is not conscious
- In the provider's judgment, the notification is likely to result in the patient harming himself

The Patient Safety Officer/Committee will provide education and support to providers so that providers understand if the notification is delayed, the information must be provided as soon as practicable after:

- The patient is capable of understanding the information
- The patient regains consciousness
- In the judgment of the provider, the patient is not likely to harm himself if informed about the infection
- A legal guardian or other person authorized to receive such information is available

Internal Reporting
The Patient Safety Committee will report internally to provide a comprehensive view of both the clinical and operational safety activity of the organization by submitting Patient Safety Committee minutes/reports to the SMA Board of Directors

The Patient Safety Committee will include ongoing activities such as data collection and analysis, actions taken and monitoring for the effectiveness of actions

External Reporting
The Patient Safety Committee will report externally in accordance with all state, federal and regulatory body rules, regulations and requirements

- On or before March 1 of each year, The Patient Safety Committee will submit an annual sentinel event report to the Office of Public Health Informatics and Epidemiology, Bureau of Health Statistics, Planning, Epidemiology and Response, Nevada State Health Division
- The Surgery Centers will participate in the CDC National Healthcare Surveillance Network per State of Nevada NRS and NAC

Annual Report
The Patient Safety Officer will report to the SMA Board of Directors and will include:

- Defining the scope of occurrences including sentinel events, near misses and serious occurrences

- Demonstrating a pro-active component of the patient safety program through selection of high risk or problem prone processes for ongoing measurement and analysis
- Reporting results ongoing measurement and analysis of the high-risk or error-prone processes
- Describing how the function of process design incorporates patient safety using specific examples of process design or redesign that include patient safety principles
- Describing the process for soliciting and obtaining input for improving patient safety from patient/families
- Describing staff willingness to report medical/health care errors
- Describing the procedures for communication with patients/families about adverse events or unanticipated outcomes of care
- Describing examples of ongoing in-service, education and training programs to maintain and improve staff competence and support an interdisciplinary approach to patient care

Medical Facility (Surgery Centers) Reporting Requirements
The Patient Safety Officer/Committee will report to the appropriate licensing Board, within five days, after a change in the privileges of a physician, perfusionist, physician assistant or practitioner of respiratory care that is based on:

- An investigation of the mental, medical or psychological competency of the physician, perfusionist, physician assistant or practitioner of respiratory care
- Suspected or alleged substance abuse in any form by a physician, perfusionist, physician assistant or practitioner of respiratory care

Public Disclosure
The Surgery Centers will provide the name of each physician who performed a surgical procedure at the Surgery Centers, the total number of surgical procedures performed by the physician, reported by type of medical treatment, principal diagnosis, if the information is available, by principle surgical procedure and secondary surgical procedure (SB340)

Objectives Patient Safety Plan

Objective
Encourage organizational learning about medical/health care errors
Incorporate recognition of patient safety as an integral job responsibility
Include patient safety into job specific competencies
Encourage recognition and reporting of medical/health care errors and risks to patient safety without judgment or placement of blame
Involve patients in decisions about their health care and promote open communication about medical errors/consequences which occur
Collect and analyze data, evaluate care processes for opportunities to reduce risk and initiate actions
Report internally what has been found and the actions taken with a focus on processes and systems to reduce risk
Support sharing of knowledge to effect behavioral changes in and within SMA

Components and Methods

Pursuant to NRS 439.837, a medical facility shall, upon reporting a sentinel event pursuant to NRS 439.835, 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."

Southwest Medical will use RCA process to determine the contributing factors and the underlying reasons for the deficiencies or failures. Southwest Medical will use the Plan-Do-Study (check)-Act (PDSA or PDCA) model, developed by the Institute of Health Care Improvement, to test changes

Root Cause Analysis

- A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals
- Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis
- Root Cause Analysis and action plan framework table was introduced by the Joint Commission. It contains 24 analysis questions. It guides the organization to the steps in a root cause analysis. Not all the questions apply to all the events or cases. This table can be used individually or with the fishbone diagram.

5 Whys technique can be used at Southwest Medical to explore the cause and effect relationship underlay 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.

Fishbone Diagram

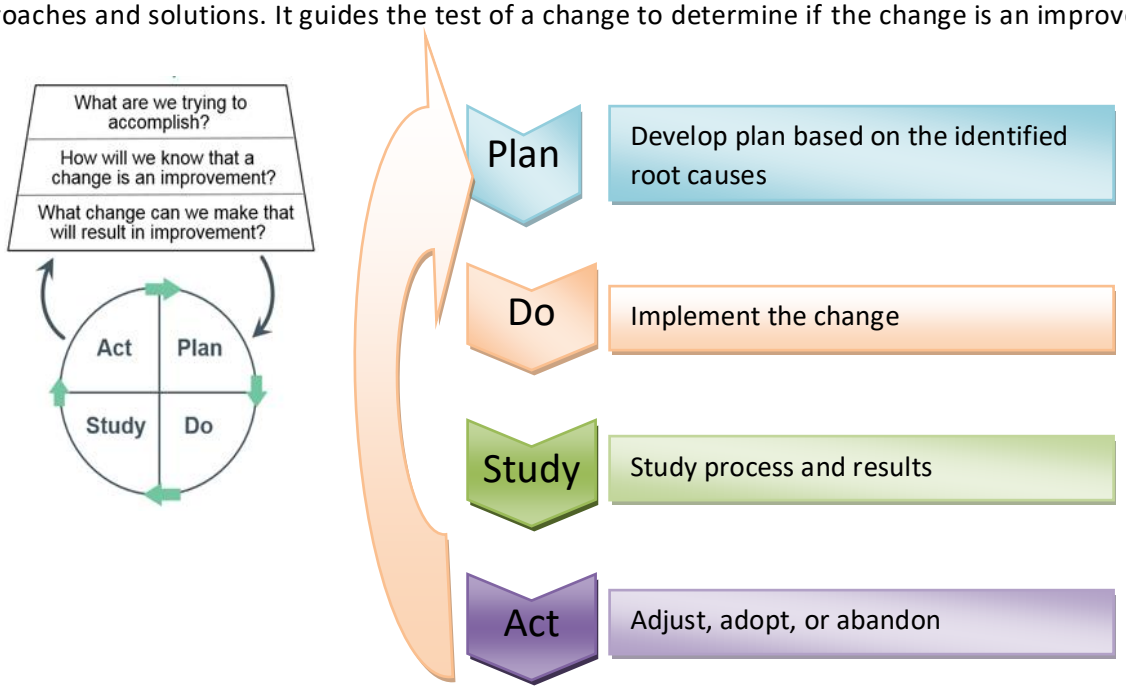
Once the problems are identified, a Fishbone Diagram can be used for analyzing the problems. Southwest Medical can use the fishbone diagram individually to analyze the root causes or can use it with the Root Cause Analysis and action plan framework table

A Fishbone Diagram, also called a Cause-and-Effect diagram, is a useful tool for a team to structurally brainstorm by discovering possible underlying factors or root causes from different major categories for the chosen problems. General categories include: people, methods, materials, measurements, education, procedures, process, location and environment.

RCA team members will brainstorm and ask multiple times, "why did this happen?" for each cause until all ideas are exhausted. The highest priority root causes will be chosen for PDSA topics. Once all the categories are established on the fishbone diagram, 5 why technique is also can be used to drill down the problem and find the root causes

Model for Improvement

The Model for Improvement is a collaborative and ongoing effort model to improve the product and services quality and process. It provides multi-disciplinary quality team guidance from identifying the root causes; conducting the best tests to assess possible changes, and working in collaboration for implementation of the new approaches and solutions. It guides the test of a change to determine if the change is an improvement.



The cycle is defined as follows:

- Plan--collect data and establish appropriate goals. Identify the problem and the possible root causes
- Do--make changes designed to correct or improve the situation
- Study -- Study the effect of the changes on the situation. Data should be collected on the new process and compared to the baseline or expected results and results should be evaluated
- Act--If the result is successful or desirable, standardize the changes and then work on the next prioritized problem or the further improvements. If the outcome is not yet successful, look for different ways to identify the causes or change the testing process.

Data Collection and Reporting

Data should drive any quality and patient safety effort. Southwest Medial will track sentinel events, healthcare infection data and other internal data collection

External data sources are those data sources which are collected outside the supervisory structure of the case. Southwest Medical may use external data from:

- 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

Ongoing Reporting and Review

The Patient Safety Committee will review Elements of the Patient Safety Plan at scheduled intervals

Monthly	Quarterly	Annually
1. Sentinel event monthly report 2. Severity of infection report 3. RCA assessments 4. Optum Practice Health and Safety Clinical Compliance and Infection Prevention Clinic Assessments	1. Incidents-including sentinel event quarterly report 2. Severity of infection report 3. Review and evaluate the measure of improvement of patient safety 4. Review and evaluate the measurement to prevent and control infections 5. Quality reports including: • Environment of Care Standards • HLD • Infection Prevention • Sterilization • Pharmacy Standards	1. Quality and Patient Safety Plan update 2. Checklists and Policies (review and revise)

Assessment of the Quality and Patient Safety Plan

Southwest Medical will review and evaluate the Patient Safety Plan at least annually

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 the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, environmental services at any medical facility
- 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 medical facility 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 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
    - Any other checklists which may be appropriate to ensure the safety of patients at the facility

The patient safety policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. The policy will require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers are full patient name and date of birth
- A policy regarding the nationally recognized standard precautionary protocols utilized by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene
- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials

Based on NRS 439.865, the patient safety plan must also include an infection control program that includes 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 (CDC), the World Health Organization (WHO) and the Society for Healthcare Epidemiology of America (SHEA)

- Facility-specific infection control developed under the supervision of a certified Infection Preventionist

Approval of Patient Safety Plan

According to NRS 439.865, Southwest Medical will submit its Patient Safety Plan to the Governing Board for approval. After the patient safety plan is approved, Southwest Medical will notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan

Southwest Medical will review and update the plan annually in accordance with State of Nevada requirements

Southwest Medical, according to NRS 439.843, will submit the most current copy of the Patient Safety Plan on or before March 1 of each year, to the Division of Public and Behavioral Health

References

- Root Cause Analysis Toolkit http://www.health.state.mn.us/patientsafety/toolkit/
- Quality and Service Improvement Tools http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html
- CQI 101 An Introduction to Continuous Quality Improvement: https://www.coursehero.com/file/13827355/CQI-Overviewppt/
- Quality Improvement http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/
- 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/1
- 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.ahrq.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:
   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
   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)

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

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
Risk is the possibility of loss or injury. (Merriam-Webster's Online Dictionary, Risk, Available at http://www.merriamwebster.com/dictionary/risk. Last Accessed August 2009.)

Preventable Event
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)

Catheter Associated Urinary Tract Infections (CAUTI)
A CAUTI is 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.)

Central Line Associated Bloodstream Infections (CLABSI)
A CLABSI is a primary bloodstream infection that is associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection