Status Active PolicyStat ID 12825944

Origination Date	12/2005	Department	Quality Assurance / Performance Improvement - AQPI
Last Approved	12/2022	Applicabilities	System
Last Revised	12/2022		
Next Review	12/2023		

Patient Safety Plan, AQPI-02

RISK:

In order to prevent patient harm or adverse events, a Patient Safety Plan is essential to identify, evaluate, and take appropriate action to prevent unintended patient care outcomes, as well as protect the financial resources, tangible assets, personnel, and brand.

POLICY:

The Tahoe Forest Hospital District (TFHD) Board of Directors makes a commitment to provide for the safe and professional care of all patients, and also to provide for the safety of visitors, employees and health care practitioners. The commitment is made through the provision of this Patient Safety Plan that will identify, evaluate, and take appropriate action to prevent unintended patient care outcomes (adverse events), as well as protect the TFHD's financial resources, tangible assets, personnel and brand. Leadership structures and systems are established to ensure that there is organization-wide awareness of patient safety performance, direct accountability of leaders for that performance and adequate investment in performance improvement abilities, and that actions are taken to ensure safe care of every patient served.

This policy is integrated with a companion policy, Risk Management Plan AQPI-04.

The Tahoe Forest Hospital District endorses the National Quality Forum set of "34 Safe Practices for Better Healthcare." Further, the District ascribes to the tenets and practices of the High Reliability Organization and the Just Culture programs in the investigation of near-misses, adverse events and unexpected/unintended outcomes.

A. SCOPE & APPLICABILITY

1. This is a Health System program empowered and authorized by the Board of Directors of Tahoe Forest Hospital District. Therefore, it applies to all services and

COPY

sites of care provided by the organization.

B. RECITALS

1. The organization recognizes that a patient has the right to a safe environment, and strives to achieve an error-free healthcare experience. Therefore, the Health System commits to undertaking a proactive approach to the identification and mitigation of unexpected/unintended outcomes.
2. The organization also recognizes that despite best efforts, errors can occur. Therefore, it is the intent of the Health System to respond quickly, effectively and appropriately when an error does occur.
3. The organization also recognizes that the patient has the right to be informed of the results of treatments or procedures whenever those results differ significantly from anticipated results.

C. AUTHORITY & RESPONSIBILITY

1. **Governing Body**
   a. The Governing Body, through the approval of this document, authorizes a planned and systematic approach to preventing adverse events and implementing a proactive patient safety plan. The Governing Body delegates the implementation and oversight of this program to the Chief Executive Officer (hereinafter referred to as the "Senior Leader") and request that the Medical Staff approve the creation of a Patient Safety Committee. The Medical Staff Quality Committee will serve as the Patient Safety Committee for TFHD and the IVCH Medical Staff Committee will serve as the Patient Safety Committee for IVCH.

COPY

2. **Senior Leader**
   a. The Senior Leader is responsible for assuring that this program is implemented and evaluated throughout the organization. As such, the Senior Leader will establish the structures and processes necessary to accomplish this objective. The Senior Leader delegates the day-to-day implementation and evaluation of this program to the Medical Staff Quality Committee and the Management Team.
3. **Medical Staff**
   a. The meetings, records, data gathered and reports generated by the Patient Safety Committee shall be protected by the peer review privilege set forth at California evidence Code Section 1157 relating to medical professional peer review and for the State of Nevada subject to the same privilege and protection from discovery as the proceedings and records described in NRS 49.265.
   b. The Patient Safety Committee shall take a coordinated and collaborative approach to improving patient safety. The Committee shall seek input from and distribute information to all departments and disciplines in establishing and assessing processes and systems that may impact patient safety in the organization. The Patient Safety Committee shall

recognize and reinforce that the members of the Medical Staff are responsible for making medical treatment recommendations for their patients.

4. **Management Team**
    a. The Management Team, through the Director of Quality and Regulations and Patient Safety Officer, is responsible for the day-to-day implementation and evaluation of the processes and activities of this Patient Safety Plan.

5. **Patient Safety Officer (The Patient Safety Officer's standing committee assignments, chain-of-command and reports/reporting structure are attached as Attachment C)**
    a. The Director of Quality & Regulations or the Quality & Regulations staff designee shall be the Patient Safety Officer for the organization. The Patient Safety Officer shall be accountable directly to the Senior Leader, through the supervision of the Director of Quality and Regulations, and shall participate in the Patient Safety/Medical Staff Quality Committee.

6. **Patient Safety/Medical Staff Quality Committee**
    1. The Patient Safety Committee shall:
        1. Receive reports from the Director of Quality and Regulations and/or the Patient Safety Officer
        2. Evaluate actions of the Director of Quality and Regulations and/or Patient Safety Officer in connection with all reports of adverse events, near misses or unexpected/unintended outcomes alleged to have occurred
        3. Review and evaluate the quality of measures carried out by the organization to improve the safety of patients who receive treatment in the Health System
        4. Make recommendations to the executive committee or governing body of the Health System to reduce the number and severity of adverse events that occur
        5. Report quarterly, and as requested, to the executive committee and governing body
        6. The Patient Safety Committee members shall include, at least, the following individuals:
            1. Director of Quality and Regulations
            2. Members of the Medical Staff
            3. One member of the nursing staff (CNO or designee)
            4. Director of Pharmacy
            5. Medical Director of Quality
            6. Risk Managment/Patient Safety Officer

COPY

7. Chief Operating Officer

D. PROGRAM ELEMENTS, GOALS AND OBJECTIVES

1. Assess patient safety risk, identify threats, prevent occurrence or mitigate frequency and severity of harm when unexpected/unintended outcomes occur
2. Promote a safe environment in the Health Systems to alleviate injuries, damages or losses
3. Foster communication with patients, employees, medical staff and administration when patient safety issues are identified
4. Contribute to performance improvement activities and plans to resolve patient safety issues
5. Participate and/or consult on all patient disclosure conferences regarding unexpected/unintended outcomes utilizing the disclosure checklist
6. Utilize the Beta HEART (healing, empathy, accountability, resolution, trust) principles fostering a culture of safety and transparency including the following:
   a. Administration of the SCOR Culture of Safety survey and sharing of the results utilizing a debrief methodology
   b. Utilizing a formalized process for early identification and rapid response to adverse events integrating human factor/ergonomic analysis and high reliability organization principles
   c. A commitment to honest and transparent communication with patient and families after an adverse event
   d. Staff referral to the Peer Support/Care for the Caregiver program, which is available 24/7
   e. A process for early resolution when harm is deemed a result of inappropriate care or medical error
7. Event investigation includes assessing the environment and securing physical evidence, and utilizes cognitive interview skills of all staff involved and the patient/ family as appropriate
8. Designing or Re-designing Processes
   a. When a new process is designed (or an existing process is modified) the organization will use the Patient Safety Officer to obtain information from both internal and external sources on evidence-based methods for reducing medical errors, and incorporate best practices into its design or re-design strategies.
9. Identification of Potential Patient Safety Issues
   a. As part of its planning process, the organization regularly reviews the scope and breadth of its services. Attendant to this review is an identification of care processes that, through the occurrence of an error, would have a significant negative impact on the health and well being of the patient. Areas of focus include:
      i. Processes identified through a review of the literature
      ii. Issues identified during daily safety huddles.

COPY

iii. Issues or risks to the organization identified by the Reliability Management Team, a multidisciplinary team of staff and leadership members trained in the principles of High Reliability Organizations. (HRO).

iv. Processes identified through the organization's performance improvement program

v. Processes identified through Safety Risk Management Reports (Event Reporting, AQPI-06) and sentinel events (Sentinel/ Adverse Event/Error or Unanticipated Outcome, AQPI-1906)

vi. Processes identified as the result of findings by regulatory and/ or accrediting agencies

vii. The National Quality Forum: "Safe Practices for Better Healthcare – 02/2013 Update"

viii. Adverse events or potential adverse advents as described in HSC 1279.1 (Attachment A)

ix. Health-care-associated infections (HAI) as defined in the federal CDC National Healthcare Safety Network. (Attachment B)

x. TFHD specific results from the Safe and Reliable Healthcare Safety Culture Survey (SCOR - Safety, Communication, and Organizational Reliability)

COPY

10. Performance Related to Patient Safety

a. Once potential issues have been identified, the organization will establish performance measures to address those processes that have been identified as "high risk" to patient safety. In addition, the following will be measured:

i. The perceptions of risk to patients and suggestions for improving care.

a. The level of staff reluctance to report errors in care and staff perceptions of the organization's culture of safety as assessed through an industry-recognized external survey.

ii. Opportunities to reduce errors that reflect system issues are addressed through the organization's performance improvement program.

iii. Opportunities to reduce errors that reflect the performance of the individual care provider are addressed, as appropriate, through the Medical Staff peer review process or through the organization's human resource policy(s) using the practices and tenets of High Reliability Organization.

b. Ensure timely, honest, and transparent communication with the patient and family utilizing the Beta HEART principles that includes:

i. Assuming responsibility for the event
ii. Expressing empathy and sincerely apologizing for the event
iii. Identifying areas for improvement
iv. Designating an organizational contact who will be responsible for ongoing empathetic and transparent communication
v. Utilizing the multidisciplinary early resolution team and the claims partners to determine fair and reasonable reparation
vi. Developing a restitution plan that includes Administration and Board of Director approval

11. Responding to Errors
    a. The organization is committed to responding to known errors in care or unexpected/unintended outcomes in a manner that supports the rights of the patient, the clinical and emotional needs of the patient, protects the patient and others from any further risk, and preserves information critical to understanding the proximal and – where appropriate – root cause(s) of the error. The organization's response will include disclosure of the incident or error to the patient and/or family (as noted below in 14.a) along with care for the involved caregivers (as noted below in 12.a).
    b. Errors that meet the organization's definition of a potential sentinel event will be subjected to an intensive assessment or root cause analysis using the tenets and practice of High Reliability Organizations. Management of these types of errors is described in *Sentinel/Adverse Event/Error or Unanticipated Outcome*, AQPI-1906.

COPY

12. Supporting Staff Involved in Errors
    a. Following serious unintentional harm due to systems failures and/or errors that result from human performance failures, the involved caregivers shall receive timely and systematic care which may include: supportive medical/psychological care, treatment that is compassionate, just and respectful and involved staff shall have the opportunity to fully participate in the event investigation, risk identification and mitigation activities that will prevent future events. To that end, the organization has defined processes to provide care for the caregivers: (*Peer Support (Care for the Caregiver*), AGOV-1602)

13. Educating the Patient on Error Prevention
    a. The organization recognizes that the patient is an integral part of the healthcare team. Therefore, patients will be educated about their role and responsibility in preventing medical errors.

14. Informing the Patient of Errors in Care
    a. The organization recognizes that a patient has the right to be informed of results of care that differ significantly from that which was anticipated, known errors and unintended outcomes. Following unanticipated

outcomes, including those that are clearly caused by systems failures, the patient, and family as appropriate, will receive timely, transparent and clear communication concerning what is known about the adverse event. Management of disclosure to patients/families is described in the policy, *Disclosure of Error or Unanticipated Outcome to Patients/Families*, AQPI-1909.

15. Reporting of Medical Errors
    a. The organization has established mechanisms to report the occurrence of medical errors both internally and externally.
    b. Errors will be reported internally to the appropriate administrative or medical staff entity.
    c. Errors will be reported to external agencies in accordance with applicable local, state, and federal law, as well as other regulatory and accreditation requirements. For reporting process, see the Administrative policy, *Sentinel/Adverse Event/Error or Unanticipated Outcome*, AQPI-1906.
16. Evaluating the Effectiveness of the Program
    1. On an annual basis, the organization will evaluate the effectiveness of the patient safety program. A report on this evaluation will be provided to the Patient Safety/Medical Staff Quality Committee, Medical Staff, Senior Leader(s), and to the Governing Body.

E. Priorities for 2023

1. Complete the SCOR Culture of Safety Survey, and conduct department specific debriefings to identify survey action plans
2. Focus on organizational wide Beta HEART principle reinforcement through education, Pacesetter articles, Safety First, and electronic email reminders.
3. Utilize implemented surveillance module for case review identification for additional safety and quality opportunities.
4. Continue quarterly submission of the patient safety data to CHPSO for inclusion in reporting and benchmarking.
5. Continue with ongoing Patient Safety education through the Pacesetter Monthly Newsletter, weekly Safety Firsts, email updates, and other educational tools.
6. Achieve 5 domain Beta HEART validation in May 2023.
7. Achieve a successful triennial unannounced TFH and IVCH accreditation survey (HFAP).
8. Advance High Reliability Organization (HRO) principles with a commitment to a goal of zero harm, and evaluate the feasibility of achieving certification as a collaborative HRO through DNV.
9. Ongoing evaluation, and updates to event reporting platform, after system upgrade in July 2022.
10. Promote culture of safety with Good Catch Program initiatives.

COPY

Related Policies/Forms:

Sentinel/Adverse Event/Error or Unanticipated Outcome, AQPI-1906; Event Reporting, AQPI-06; Disclosure of Error or Unanticipated Outcome to Patients/Families, AQPI-1909; Peer Support (Care for the Caregiver), AGOV-1602; Risk Management Plan AQPI-04; The National Quality Forum: "Safe Practices for Better Healthcare – 02/2013 Update"

All Revision Dates

12/2022, 01/2022, 02/2021, 02/2020, 02/2020, 03/2019, 08/2018, 02/2017, 12/2016, 03/2014, 02/2014, 11/2013, 10/2013, 01/2012, 01/2009

Attachments

RM/PSO Standard reports and reporting

COPY

Approval Signatures

Step Description	Approver	Date
	Janet VanGelder: Director	12/2022
	Theresa Crowe: Risk Management/Privacy Officer	12/2022