PGH PERSHING GENERAL HOSPITAL & Nursing Home	Policy Name: **Patient Safety Plan**
	Department(s) Affected **Facility Wide**
Approved by: CEO, Risk Manager, Safety Officer, Board of Director	
This P&P complies with the following regulation(s): NRS 439.865, NRS 539.830, NRS 439.877, NRS 439.843	

PURPOSE:

1. The purpose of the Organizational Patient Safety Plan at Pershing General Hospital is to improve patient safety and reduce risk to patients through an environment that encourages:

   a. Recognition and acknowledgment of risks to patient safety and medical/health care errors;

   b. The initiation of actions to reduce these risks;

   c. The internal reporting of what has been found and the actions taken;

   d. A focus on processes and systems improvement;

   e. Minimization of individual blame or retribution for involvement in a medical/health care error;

   f. Organizational learning about medical/health care errors with implemented plans of corrections;

   g. Support sharing knowledge to effect behavioral changes in itself and other healthcare organizations.

2. The Patient Safety Plan provides 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 occurrence; 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.

3. Patient care and the maintenance and improvement of patient safety, is a coordinated and collaborative effort. 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 Pershing General Hospital.

PATIENT SAFETY PROGRAM:

1. Scope of Activities:

a. The scope of the Patient Safety Program includes an ongoing assessment, using internal and external knowledge and experience, to prevent error occurrence, maintain and improve patient safety. Patient safety occurrence information from aggregated data reports and individual incident occurrence reports will be reviewed by the Risk Manager for presentation to the Safety/QA committee to prioritize organizational patient safety activity efforts. Types of patient safety or medical/health care errors included the date analyses are:

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

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

    3. Any Medication Error

    4. Any Adverse Drug Reaction

    5. Any Transfusion Reaction

    6. 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.

    7. Sentinel Event – is defined as an unexpected occurrence, involving facility acquired infection, death or serious physical or psychological injury or the risk thereof, including, without limitation, any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. The term includes loss of limb or function (NRS 439.830). It is called a sentinel event because it signals the need for immediate investigation and response.

        The Mandatory reportable sentinel events include events that have resulted in an unanticipated death or major permanent loss of function.

b. The scope of the Patient Safety Program encompasses 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. These will be an emphasis on important facility and patient care functions of:

    1. Patient Rights including freedom from abuse/neglect;

    2. Assessment of Patient;

    3. Care of Patients to include special considerations;

    4. Patient/Family and Lay Caregiver Education

    5. Continuum of Care

6. Management of Information

7. Management of Human Resources

8. Management of the Environment of Care

9. Surveillance, Prevention and Control of Infection

2. Methodology:

   a. The Safety Committee Chairperson will have administrative responsibility for the program, or the Safety Committee may assign this responsibility to another member of the committee (such as the Director of Risk/Quality Management).

   b. **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/Quality Management, who will aggregate occurrence information and present a report to the Safety Committee on a monthly basis. The report will contain aggregated information related to type of occurrence, severity of occurrence, number/type of occurrences per department, occurrence impact on the patient, remedial actions taken, and patient outcome. The Safety Committee will analyze the report information and determine further patient safety activities as appropriate. Issues of great importance will also be reported to CEO/Administration as they occur.

Run a QAR Report

   c. Through review of internal data reports and reports from external sources (including, but not limited to sentinel event report information, occurrence reporting information from state and federal sources and current literature), the Safety Committee will select at least one high-risk safety process for proactive risk assessment annually. The proactive risk assessment will include:

      1. 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. Identification of the possible effects of the undesirable variation on patients, and how serious the possible effect on the patient could be;

      2. For the most critical effects, a root cause analysis to determine why the undesirable variation leading to the effect may occur;

      3. Process and/or underlying systems will be redesigned to minimize the risk of threat undesirable variation or to protect patients from the effects of that undesirable variation;

      4. Redesigned process that are tested and implemented;

      5. Identify and implement measures of the effectiveness of the redesigned process;

      6. A strategy for maintaining the effectiveness of the redesigned process over time and its implementation.

✓ 2018 Pt. Safety Goal

d. Description of mechanisms to ensure that all components of the healthcare organization are integrated into and participate in the organization wide program.

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

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

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

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

g. Preserve any information related to the error (including physical information). Examples of preservation of physical information are: Removal and preservation of blood unit for a suspected transfusion reaction; preservation of IV tubing, 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 a Quality Review Report (QRR), and in the medical record as appropriate to organizational policy and procedure.

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

i. Submit the QRR to the Director of Risk/Quality Management per organizational policy.

j. Any individual in any department identifying a potential patient safety issue will immediately notify his or her supervisor and document the findings on a QRR. The QRR will be submitted to the Director of Risk/Quality Management per organizational policy.

k. Staff response to medical/health care errors is dependent upon the type of error identifies;

    1. No Harm Errors – (including "no harm" medication errors) – staff will *document appropriately* in the medical record according to organizational policy, document the circumstance regarding the no harm error on a QRR form, submit the form to the Director of Risk/Quality management and notify their immediate supervisor.

    2. Mild-Moderate Adverse Outcome Errors (including medication errors) – Staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then preserve any physical evidence as appropriate, notify his/her immediate supervisor, document facts appropriately in the medical record and on a QRR – submitting the report to the Director of Risk/Quality Management per organizational policy.

        a. Mediation Errors – the staff member identifying a medication error (no harm and mild-moderate harm) will notify the Pharmacy Services Department of the event and the immediate department director.

3. Adverse Drug Reaction – staff will 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 preserve any physical evidence as appropriate, notify his/her immediate supervisor, document facts appropriately in the medial record and on a QRR – submitting the report to the Director of Risk/Quality Management per organizational policy. Staff will also notify the Pharmacy Services Department.

4. Transfusion Reaction – staff will 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 Blood/Blood Component Transfusion Reaction Policy and Procedure. Blood will be saved for evaluation.

5. Hazardous Condition/Patient Safety Issue – as appropriate, and if possible, staff will contain the hazardous condition or patient safety issue, and then identify the hazardous condition or potential patient safety issue and will immediately notify his or her supervisor and document the findings on a QRR. The QRR will be submitted to the Director of Risk/Quality Management per organizational policy.

6. Sentinel Events – staff will perform any necessary clinical interventions to support and protect the patient and notify the patient/residents next of kin, guardian etc. and the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then follow the organizational Sentinel Event Policy and Procedure.

7. Near Miss – staff will report the near miss event to his/her immediate supervisor, describe the facts of the near miss on a QRR and submit the report to the Director of Risk/Quality Management.

h. Established organizational policies (such as the Sentinel Event Policy) and/or the Safety Committee will determine the organizational response to medical/health care errors and occurrence. All sentinel events and near miss occurrence will have a root cause analysis conducted and report to CEO, CNO and Department Manager. The determination of the Safety Committee Members based on internal and external data analysis and prioritizing of patient safety criticality, will be determine.

   1. Further remedial action activities necessary for identified occurrences

   2. Proactive occurrence reduction activates

   3. Necessity and benefit of root cause analysis performance for identified occurrences or proactive reduction activities

i. An effective Patient Safety Program cannot exist without optimal reporting of medical/health care errors and occurrences. Therefore, it is the intent of this institution to adopt a non-punitive approach in its management of errors and occurrences. All personnel are required to report suspected and identified medical/health care errors, and should do so without the fear of reprisal in relationship to their employment. This organization supports the concept that errors occur due to a breakdown in systems and processes, and will focus on improving systems and processes, rather than disciplining those responsible for errors and occurrences. A focus will be placed on remedial actions to assist rather than punish staff

members, with the Safety Committee and the individual staff member's department supervisor determining the appropriate course of action to prevent error recurrence.

1. Sentinel Events – staff members involved in a sentinel event occurrence will receive support from the Safety Committee regarding the staff member's professional and emotional reconciliation of the sentinel event. The Safety Committee encourages the staff member's involvement in the root cause analysis and action plan processes, 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 Social Services Department, Human Resources Department and/or his or her department supervisor.

j. Patients, and when appropriate, their families are informed about the outcomes of care, including unanticipated outcomes, or when the outcomes differ significantly from the anticipated outcomes. The Safety Committee will analyze error reporting data submitted through the Director of Risk/Quality Management for evidence of this information.

k. Staff will educate patients and lay caregivers their role in helping to facilitate the safe delivery of care. The Safety Committee will request a report on a quarterly basis consisting of random record review verifying compliance with this educational process.

l. The Patient Safety Program includes consideration, at least annually, of data, which includes information regarding barriers to effective communication among caregivers. The Safety Committee will also request on a quarterly basis, a report identifying the effectiveness of the organization to provide accurate, timely, and complete verbal and written communication among care givers and all other involved in the utilization of data.

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

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

o. Patient safety reports from the Safety Committee will be submitted to the organizational Quality Improvement Committee, which exists as the oversight committee for all Safety Committee. A monthly data report and recordings of meeting minutes will be forwarded to the Quality Improvement Committee, with all information submitted held under the auspices of the Quality Improvement Committee.

p. A report will be forwarded to the Governing Board annually on the occurrence of medical/health care errors and actions taken to improve patient safety, both in response to actual occurrences and proactively.

The patient Safety Committee will be composed of (NRS439.875):

1. Patient Safety Officer
2. Infection Control Officer
3. At least three providers of healthcare who treat patients at the medical facility including one member of the medical, nursing, and pharmaceutical staff.
4. One member of the executive or governing board of the medical facility

The patient Safety Committee will ~~meet monthly~~. @ least quarterly