	POLICY TITLE: Patient Safety Plan 2024
MANUAL: Center for Quality and Patient Safety	**POLICY OWNER:** Director of Patient Safety
ORIGINATION DATE: 1/2016	**FINAL APPROVAL DATE:** 2/2024

SCOPE:

The scope of this Patient Safety Plan is organizational-wide which includes but is not limited to:

- Patient safety
- Visitor safety
- Employee safety

All UMC staff may fully support and participate in this plan, as well as devote their expertise to the patient safety and healthcare quality improvement process.

PURPOSE:

The purpose of the Patient Safety Plan is to address patient safety related concerns, challenges and revise the program to better serve patients and their families/representatives.

The plan focuses on the process and systems rather than the individual, and recognizes both internal and external customers, as well as facilitates the need for analyzing and improving processes. The core principles of this plan include:

- All staff are encouraged to contribute their knowledge, vision, skill, and insight to improve the process of the Patient Safety Plan.
- Decisions will be based on data and facts, and staff will be encouraged to learn from the experiences.
- Customer based including patients, families, and visitors.
- Promote systems thinking.
- Employ well-trained and competent staff maintaining high healthcare quality.
- Failure Mode Effect Analysis (FMEA)
- Culture of Safety Survey
- Promotion of Just Culture

University Medical Center of Southern Nevada (UMC) is committed to a comprehensive approach to improving healthcare quality and patient safety. Our commitment aligns with our mission, vision, and values to create an environment that supports a dynamic, proactive, and safe culture for patients, family members/representatives, visitors, and employees through continuous learning and improving patient safety policies, procedures, systems, and processes.

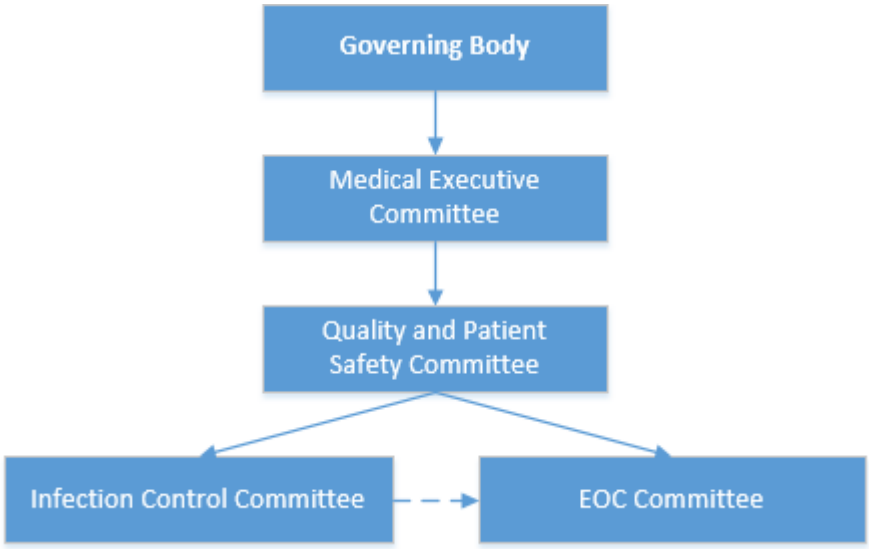
This is achieved through:

- Collaboration of healthcare, leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high quality healthcare.
- Honest and open communication that fosters trusting and cooperative relationships among healthcare providers, staff members, and patients and their families, 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 and performances to the facility.
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare.
- Education of staff and physicians to ensure participation of healthcare providers.

POLICY:

In accordance with NRS 439.875, UMC has established a Quality and Patient Safety Committee. The Quality and Patient Safety Committee is responsible to oversee UMC's Patient Safety Program and encompasses: overall patient safety and outcomes, risk management, infection control and environment of care (EOC). As directed by the Board of Governors, the Quality and Patient Safety Committee will serve as the organization's grievance committee.

Hospital Quality and Patient Safety Committee Organization



Roles and Responsibilities:

Committee:

- In accordance with NRS 439.875, the committee includes the following members:
  - The infection control officer;
  - The patient safety officer;
  - At least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing and pharmaceutical staff;
  - One member of the executive or governing body.

- Committee responsibilities per (NRS 439.875 and NRS 439.877) include, but are not limited to the following:
  - Meet at least monthly;
  - Receive reports from the patient safety officer pursuant to NRS 439.870;
  - Review and evaluate the quality measures carried out by the facility to improve the safety of patients who receive treatment, including the effectiveness of patient identification policy;
  - Review and evaluate the quality measures carried out by the facility to prevent and control infections;
  - Make recommendations to the executive or governing body to reduce the number and severity of sentinel events and infections that occur;
  - At least once each calendar quarter, report to the executive or governing body:
    - (1) The number of sentinel events that occurred at the medical facility during the previous calendar quarter;
    - (2) The number and severity of infections that occurred at the facility during the preceding calendar quarter; and
    - (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
  - On or before July 1 of each year, submit 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).
  - Adopt patient safety checklists and policies as required by NRS 439.877, review the checklists and policies annually and revise the checklists and policies as the committee determines necessary.
  - The committee shall also be responsible for generating, evaluating and reviewing proactive risk assessments for the use of such documents and records in its proceedings. All risk assessments and associated documentation and records shall be subject to the applicable privileges under NRS 49.265 and NRS 439.875 provided that it is generated or produced during the committee's review process.

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Patient Safety Officer: (NRS 439.870)

At UMC, the Patient Safety Director is designated as the Patient Safety Officer. The Patient Safety Officer shall perform all duties and responsibilities required under Nevada law, including without limitation:

- Serve on the Hospital Quality and Patient Safety Committee;
- Supervise the reporting of all sentinel events alleged to have occurred at UMC, including without limitation, performing the duties required pursuant to NRS 439.835;
- Investigate the occurrence of sentinel events and implement action plans;
- Report to the committee on actions taken to ensure patient safety.

Reporting:

Patient Safety Events:

All medical, nursing and support clinical staff should report any event, situation or circumstance that is significant or potentially significant to patient safety. These events will be reviewed and investigated as needed. This is accomplished by:

- Completing a patient safety event report in accordance with the Patient Safety Event Reporting policy and Sentinel Events/Serious Reportable Events policy.
- Department manager/designee review and completion of the manager's section of the event report.
- Quality review by the Center for Quality and Patient Safety.
- Review of significant/potentially significant events by the Patient Safety Officer.
- Unit review of actual or potential patient safety events with action plans reported through the committee.

Sentinel Events:

Pursuant to NRS 439.835:

- A person who is employed by UMC shall, within 24 hours after becoming aware of a sentinel event, notify the Patient Safety Officer of the event.
- Within 13 days after receiving notification, the patient safety officer shall report the event to the Nevada Division of Public and Behavioral Health (DPBH).
- If the Patient Safety Officer personally discovers or becomes aware of a sentinel event, in the absence of notification by another employee, the patient safety officer shall report the event to DPBH within 14 days of discovering or becoming aware of the sentinel event.

Disclosure:

Notification of patients who have been involved in a sentinel event will occur no later than 7 days after discovering or becoming aware of an event that occurred at the facility. Serious events should be disclosed by

the attending physician who has responsibility for overall care of the patient. If that is not possible, the Patient Safety Officer or designee will disclose the event to the patient.

Pursuant to NRS 439.837, upon reporting a sentinel event, UMC will conduct an investigation concerning the causes and/or contributing factors of the sentinel event and implement a plan to remedy the causes and/or contributing factors of the sentinel event.

Data Collection and Risk Assessment:

Data should drive any quality and patient safety effort. UMC utilizes both internal and external sources for data collection.

Internal sources include but are not exclusive:

- Patient Safety Reporting System (i.e., Safety Intelligence)
- Patient and family complaints or grievances
- Risk Management findings
- Morbidity/Mortality reviews
- Infection Control data
- Compliance findings
- Operative/procedural data
- Staff verbal reporting

External sources include but are not exclusive**:**

- 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
- DPBH: Nevada Division of Public and Behavioral Health

Patient Safety Checklists and Patient Safety Policies:

Patient Safety Checklists must follow protocols and are utilized to improve the health outcomes of patients. Checklists include, without limitation:

- Relationship to specific types of treatment, which include documentation that the treatment provided was properly ordered by the provider of healthcare.
- Assurances that the patient's room and overall environment is sanitary.
- For patient discharges including: proper instructions concerning prescription medications, aftercare instructions, and any individualized patient instructions for aftercare.

Patient Safety Policies include, without limitation:

- Appropriate identification of patient prior to providing treatment requiring at least two personal patient identifiers.
- Nationally recognized standard precaution protocols, including protocols relating to hand hygiene.
- Compliance with the patient safety checklists and patient safety policies.

Pursuant to NRS 439.865, Patient Safety Checklists and Policies are an extension of the Patient Safety Plan.

Annual Patient Safety Plan and Evaluation:

The Patient Safety Officer reviews and updates the Patient Safety Plan annually.
The committee reviews the Patient Safety Plan annually and submits it to the Governing Board.

The Patient Safety Officer prepares a written annual evaluation of the patient safety program. The annual report assesses patient safety events and actions taken to improve patient safety. The report is submitted through the performance improvement structure and to the Governing Board.

At a minimum, the written report will include the following:

- All system and process failures
- The number and types of sentinel events
- Whether patients and family were notified of events
- Actions taken to improve safety
- Actions taken in response to analyses related to the adequacy of staffing

Approval of Patient Safety Plan:

According to NRS 439.865, a medical facility shall submit its patient safety plan to the governing board of the facility for approval. After a facility's patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan. The plan will be maintained within UMC's electronic policy and procedure management system.
The patient safety plan must be reviewed and updated annually in accordance with the requirements for approval set forth in this section.

In compliance with NRS 439.843, on or before March 1 of each year, a copy of the most current patient safety plan established to NRS 439.865 will be submitted to the Division of Public and Behavioral Health.

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:
    a. 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
    b. 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 Institute for Healthcare Improvement (IHI) defines 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."

Near miss: An event or a situation that did not produce patient harm because it did not reach the patient, either due to chance or to capture before reaching the patient; or it if it did reach the patient, due to robustness of the patient or to timely intervention (AHRQ).

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.).

REFERENCES:

- IHI RCA2
- TJC Sentinel Event (SE) chapter
- Framework for Conducting a Root Cause Analysis and Action Plan
- NRS Title 40 – Public Health and Safety
- Patient Safety Checklists policy
- UMC Infection Prevention/Control Risk Assessment, Plan and Authority Statement
- Patient Safety Event Reporting policy
- UMC policy, Patient complaint, grievance and insurance inquiry process
- UMC policy, Just Culture - Response to Safety Events
- UMC policy, Sentinel Events/Serious Reportable

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Review Date:	**By:**	**Description:**
2/2023	Director of Patient Safety	Updated with current year, reviewed to ensure no regulation changes. Vetted by CQPS.
2/2024	Director of Patient Safety	Reviewed. Added TJC Sentinel chapter as reference. No other changes.