Sahara Surgery Center
2024 Patient Safety Program

Our Mission is focused on delivering the highest quality healthcare that effectively responds to the needs and safety of our patients by minimizing the possibility for injury or harm to our patients. Sahara Surgery Center has developed a Patient Safety Program to maintain an effective ongoing facility-wide, data driven process to prevent and reduce medical errors and adverse events.

Components of Patient Safety Plan

- **Significant Event/Significant Medical Error** - Any unexpected occurrence involving a death, serious physical or psychological injury or risk thereof. Serious injury specifically includes loss of limb or function. "Risk thereof" includes any process variation for which recurrence would carry a significant chance of a serious adverse outcome.

- **Adverse Events**—any event where result is not consistent with the desired plan of care and that leads to patient harm not limited to medication error.

- **Reportable Events**—Mandatory Reporting of Sentinel Events to the Nevada Sentinel Events Registry at https://dpbhrdc.nv.gov/redcap/

HISTORY

Nevada Assembly Bill 1 (AB1) was passed during the 2002 18th Special Legislative Session, and mandatory reporting of sentinel events was incorporated into Nevada Revised Statute (NRS) 439.800-890 and Nevada Administrative Code (NAC) 439.900-920. Assembly Bill 59 (AB59) was passed during the 2005 73rd Session of the Nevada Legislature, and codified "facility acquired infection" as a reportable sentinel event.

A "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.

PATIENT SAFETY OFFICER

- Designated employee of the facility
- Serve on the Patient Safety Committee
- Supervises the reporting of all sentinel events alleged to have occurred at the Facility
- Follows the Mandatory Reporting requirements according to the State of Nevada NRS 439.835
- Takes actions to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the Facility.

- Reports to the Patient Safety Committee regarding any action taken.

PATIENT SAFETY COMMITTEE

- Membership: at least three providers of health care who treat patients at the Facility, including without limitation, at least one member of the medical, nursing and pharmaceutical staff of the Facility
    - One member of the executive or governing body of the Facility
- Shall meet at least once a month
- Receives and reviews reports from the Patient Safety Officer
- Reviews and evaluates the quality measures carried out by the Facility to improve the safety of patients who receive treatment at the Facility.
- Makes recommendations to the Governing Body to reduce the number and severity of sentinel events that occur at the Facility.
    - Quarterly report to the Governing Body to include:
        - The number of sentinel events that occurred at the Facility during the preceding calendar quarter; and
        - Any recommendations to reduce the number and severity of sentinel events that occur at the Facility

Process for Reporting

1. A designated Patient Safety Officer will be assigned by the facility and register with the Sentinel Events Registry as the facility's reporting contact.
2. Complete the Nevada State Health Division Sentinel Event Report – complete online at https://dpbhrdc.nv.gov/redcap/index.php?action=myprojects

Medical Errors

1. See policy for Patient Notification of Medical Error in Administration Policy and Procedure Manual.
2. Steps in the Patient Notification of Medical Error are followed
    a. A Variance form is completed
    b. A Serious Event Analysis (SEA) is performed
    c. The patient's Medical Record is sent for Peer Review
    d. The Medical Record and peer review findings go before MEC/GB for action and/or recommendations along with the SEA Plan of action and risk reductions strategies.

Adverse Events and Reportable Events

- A variance report is completed.
- Variance is submitted to QI/Risk Manager
- Variance is reported on Service Quality Index
- If significant event: a Service Event Analysis (SEA) is performed
- Clinical Director of Quality and Risk Management for the Far West is notified
- If applicable, a Probable Claim Report (PCR) and/or JIRA notification is filed.
- Patient Medical Record is sent for peer review
- The Medical record, SEA and peer review results goes to MEC/GB for actions and/or recommendations.

Time Frames for Internal reporting of Medical Errors, Adverse Events and Reportable Events

- The person most closely involved or the person discovering the variance should prepare the variance and report to the Risk Manager or designated person as soon as possible following the event.

- Reportable events will be reported by making mandatory reports to regulatory agencies as required by laws and regulations following reporting deadlines (CMS, FDA, SMDA, local law enforcement).

Consequences for failing to report events in accordance with policy

- Employee failure to report a reportable event may result in disciplinary action.

Mechanisms for preservation and collection of event data

1. Notify:
   - QI/Risk Manager/Safety Officer
   - Administrator
   - Medical Director
   - Clinical Manager
   - QI Committee
   - HCI
   - Regional Director of Quality and Risk Management
2 If the event is a result of faulty equipment or product, equipment/product will be retained along with packaging.
3. Variance report will be completed along with Mandatory Safe Medical Device Form 3500A if applicable.
4. Investigation is initiated.
   a. Involved staff is interviewed
   b. Copy of patient medical record if applicable
   c. Copy of any medical treatment rendered outside of surgery center
   d. Decision by the QI Committee/Quality and Risk Manager as to whether or not incident is reportable.
   e. File a Probable Claim Report (PCR) with HCI if recommended by QI Committee/Quality and Risk Manager
   f. Complete FDA forms if incident is reportable and if applicable
   g. If appropriate, notify manufacturer

Process for conducting a Serious Event Analysis (SEA)

1. A committee involving representatives from each area including business office.
2. Have available the Policy and Procedure manual, Risk and QI Manuals, Medical staff Bylaws and rules and regulations, CMS regulatory statues and state regulatory statues, incident medical record, variance report, and peer review report and lastly the measurement tool to be used.
3. Review of variance report by the group
4. Review SEA form with the group
5. Staff directly involved with event will describe their interaction with the patient and the policy and procedures that support their work.
6. Identify "WHY" each contributing factor occurred or did not occur when it should have.
7. Develop a risk reduction strategy for each root cause

8. Develop a measurement strategy to evaluate effectiveness of reduction
9. All questions will be addressed
10. All investigations and rationale are documented
11. Explanations are summarized and are submitted as attachments to the MEC/GB
12. Administrator/MEC/GB will communicate actions and recommendations to Risk Manager
13. Risk Manager will hold a meeting with QI committee
14. A meeting with affected departments is held to communicate risk reduction strategies and measurement of outcome.

Patient Safety training will be provided to designated staff on an annual basis

- Training will include all Components listed above.

Sahara Surgery Center will designate one or more individuals to be responsible for the management of the Patient Safety Program. Responsibilities shall include

- Coordinating all patient safety activities/in-services
- Monthly rounds of the facility utilizing an individualized checklist for the center for compliance to policies and potential areas of risk. This checklist is printed from the Risk Manager's Workbook and returned to the Risk Manager for immediate remedy for non- compliance as well as tracking and trending of deficiencies,
- Facilitating assessment and appropriate response to reported events
- Monitoring the SEA and results in recommendations and action plans
- Serve as liaison among the Centers' departments and committees to ensure facility-wide integration of Patient Safety Program with Risk Management and report finding quarterly to the Quality Improvement Committee.

The designated person will have completed the process for the reportable event within 45 days

- A Serious Event Analysis will be completed to examine the cause and effect of the event through an impartial process
- An action plan will be developed identifying strategies that the Center intends to employ to reduce the risk of similar events occurring in the future.
  - Action plan designates responsibility for implementation and oversight.
  - Time frames for implementation will be specified
  - Strategy for measuring effectiveness will be included
- The SEA and action plan will be available for review by department representatives

Reporting Requirements

Any theft of drugs and/or diversion of controlled drugs shall be reported to the local police agency, the State Board of Pharmacy, the Nevada Department of Public Safety and/or the Drug Enforcement Administration.

Best Practices Report

All Best practice initiatives will be reviewed and the Meaningful Difference implemented after review by the Quality Committee and approved by the Governing Body.

Assembly Bill 280 (AB280)

Requires the adoption of patient safety checklists and patient safety policies to be monitored and reviewed annually by the patient safety committee at the medical facility. AB280 requires annual reporting by the medical facility to the Director of the Legislative Counsel Bureau.

HISTORY

Assembly Bill AB 280 went into effect on July 1, 2011. AB 280 was incorporated into NRS 439.865, 439.875 and requires the adoption of patient safety checklists and patient safety policies at certain medical facilities.

Patient safety checklists must follow protocols to improve the health outcomes of patients and include the following

- Documentation that the treatment provided was properly ordered by the provider of health care.
- Protocols to ensure that the room and environment of the patient is sanitary.
- Checklist when discharging a patient to verify the patient has received:
  - Proper instructions concerning prescription medications
  - Instructions concerning afteSEAre
  - Any other instructions concerning his or her discharge.
- Any other checklist to ensure the safety of the patients at the facility.

Patient safety policies to include

- Policy for appropriately identifying a patient before treatment. Policy must require the patient to be identified with at least two identifiers before each interaction with a provider of health care. Personal identifiers may include:
  - Patient name
  - Patient date of birth
- Policy regarding the nationally recognized standard precautionary protocols to be observed by health care providers, including protocols relating to hand hygiene.
- Policy to ensure compliance with the patient safety checklists and patient safety policies.

Patient safety committee shall

- Monitor and document the effectiveness of the patient identification policy.
- At least annually, review the patient safety checklists and patient safety policies.
- Revise the patient safety checklists and safety policies to ensure the checklists or policies reflect the most current standards in patient safety protocols.

Reporting

- All healthcare facilities are required by Nevada Revised Statute (NRS) to file an annual summary report even if no sentinel event has occurred at the center and to keep a current Contacts Form. The reporting website is https://dpbhrdc.nv.gov/redcap/