Barton Health

2024 Patient Safety Plan

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Executive Summary

The purpose of the Patient Safety Plan is to set the foundation for Patient Safety at Barton Health in accordance with state and regulatory requirements. The breadth of Patient Safety is vast and includes event reporting, review, follow up on errors and harm that impact or have the potential to impact patients, hazard mitigation through evidence-based tools, and reporting to internal committees and external agencies. The Patient Safety Plan addresses high reliability processes to correct opportunities for improvement and prevent identified hazards from recurrence. 2023 high priorities are reviewed which included tubing misconnections; patient identification; decreasing alarms, alerts, and notification overload; neonatal strategic plan; the Leapfrog Hospital Survey; culture measurement of patient safety; the ongoing evaluation and implementation of best practices around infectious diseases; monitoring the RN graduate program; and initiating the development of a safe staffing plan. 2024 high priorities are tubing misconnections; patient identification; decreasing alarms, alerts, and notification overload; the Leapfrog Hospital Survey; culture measurement of patient safety patient safety indicator evaluation; sepsis; patient falls; early patient mobility; and continued conversations around safe staffing plans as the organization prepares to move to Nevada. The Patient Safety Plan grants authority for Patient Safety oversight across the organization to the Chief Medical Officer and the Director of Patient Safety, Quality, Infection Prevention, and Population health. This plan is revised and updated annually or more often as needed.

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Section A

2024 Patient Safety Plan

Purpose

Barton Health is committed to continuously improving patient safety and reducing health care errors. This Patient Safety Plan ensures that Barton Health implements and maintains a patient safety program in accordance with The Joint Commission (TJC) standards, guidelines from the California Department of Public Health (CDPH), Nevada Revised Statutes (NRS), Patient Safety and Quality Improvement Act of 2005, and other regulatory agencies.

Introduction

The Patient Safety Plan supports and promotes the mission, vision, values, and strategic plan of Barton Health. This Plan implements continuous integration and coordination of patient safety activities for all medical staff, clinical departments, support service departments and service lines including trauma at Barton Health. A culture of safety inherently implies the continued attention, refinement and progression of the patient safety plan and program.

Barton Health's patient safety goal is to foster an environment and culture where patients, families, staff, providers, and leaders within the organization identify and manage actual and potential risks to patient safety thereby resulting in zero harm. All patients, providers, and staff are strongly encouraged and supported with multiple avenues/programs to speak up when safety concerns are identified. As an organization, Barton Health has an obligation to listen and respond to these concerns.

The Patient Safety Plan is designed to reduce patient safety errors and improve patient care delivery processes by utilizing a systematic, coordinated, and continuous approach to the improvement of patient safety. This approach centers on the establishment of mechanisms that support effective responses to actual occurrences; ongoing proactive reductions in health-related errors including near miss and good catch events; and integration of patient safety priorities in the design and redesign of all relevant organizational processes, functions, and services. Patient safety is emphasized in areas such as patient's rights, patient and family education, continuity of care, risk reduction, and managing performance improvement.

Each provider and employee perform a critical role in patient safety and thus, Barton Health's journey to becoming a high reliability organization. All Barton Health team members are focused on providing consistently exceptional care through an environment that supports teamwork, collaboration, and respect for other people, regardless of their position in the organization. Leaders demonstrate their commitment to quality and safety while setting expectations for those who work in the organization. Leadership evaluates the culture of safety on a regular basis.

The Chief Medical Officer and Director of Patient Safety, Quality, Infection Prevention, and Population Health, herein referred to as "Director of Patient Safety," provides oversight to the integrated patient safety program. These individuals ensure alignment of patient safety activities, compliance with regulations, and provide opportunities for all Barton Health team members to be educated and involved in patient safety initiatives.

The Director of Patient Safety and Patient Safety Department have the authority to intervene in any clinical or non-clinical activity which poses an actual or potential negative outcome to a patient's well-being. The Patient Safety Department provides leadership in the creation, initiation, and evaluation of corrective action measures for event resolution.

The Governing Body, Medical Executive Committee, and Patient Safety Committee, described below, are committed to patient safety. These bodies shall assure an environment that encourages error identification, remediation, non-punitive reporting, and prevention through education, system redesign, or process improvement for any potential or actual adverse event.

In accordance with The Joint Commission's Accreditation Participation Requirements, APR.09.02.01, this plan implies Barton Health shall:

- Educate its staff, medical staff, and other individuals who provide care, treatment, and services that concerns about the safety or quality of care provided in the organization may be reported to The Joint Commission.
- Inform its staff and medical staff that Barton Health will take no disciplinary or punitive action because an employee, physician, or other individual who provides care, treatment, and services reports safety or quality of care concerns to The Joint Commission.
- Take no disciplinary or punitive action against employees, physicians, or other individuals who provide care, treatment, and services when they report safety or quality of care concerns to The Joint Commission.

Any employee or medical staff member may contact The Joint Commission if they have a safety or quality of care concern that is not being addressed by Barton Health. All employees or medical staff members are strongly encouraged to bring any safety or quality of care concerns to the Chief Medical Officer, Director of Patient Safety, or Patient Safety Team members, without fear of punitive or disciplinary action.

In addition, patients are provided information in the patient handbook regarding their right to contact and report a complaint to The Joint Commission.

Scope of the Patient Safety Plan

The Joint Commission, CDPH, NRS, Centers for Medicare and Medicaid Services (CMS) and other regulatory agencies provide the defining framework for patient safety events. The Patient Safety Department is informed of safety event information and hazardous conditions from team members, volunteers, and medical staff practitioners across the organization through completion of event reports and verbal or written communication. This information includes actual or potential (near miss/good catch) occurrences involving inpatients, outpatients, volunteers, employees, providers, vendors, and visitors.

Risk Assessment

Proactive assessment of high-risk activities and hazardous conditions are identified through event reporting, failure mode and effect analysis (FMEA), data collection, audits (tracers), and utilization. In addition, risk reduction strategies are built into the continual process improvement system. Such strategies are obtained from available information regarding sentinel events known to occur in healthcare organizations that provide similar care and services as well as knowledge-based information including content from state patient safety organizations as well as other state, national, and international professional organizations.

Event Prioritization

Opportunities for improving patient safety issues are prioritized according to level of severity, frequency of the occurrence, potential for harm to the patient, employee or visitor involvement, and potential for liability. Ongoing review of information is performed to direct administrative and medical staffs' attention to areas of clinical care representing significant sources of actual or potential risk.

Types of medical/health care errors include, but are not limited to:

- **Adverse Event**: Per The Joint Commission (TJC, 2023), an adverse event is a patient safety event that resulted in harm to a patient. It is also defined as an unexpected occurrence meeting any of the Adverse Event criteria as designated by CDPH.
- **Error:** An unintended omission or commission of an act, or an act that does not achieve its intended outcome.
- **Good Catch/ Near Miss/Close Call:** Any patient safety event that did not reach the patient.
- **No-Harm Event**: A patient safety event that reached the patient but did not cause harm.
- **Hazardous (unsafe) Condition:** A circumstance, exclusive of the disease or condition for which the patient is being treated, which increases the probability of an adverse event.
- **Never Event/Serious Reportable Event (SRE):** An event or situation that should never occur in a healthcare facility. When Never Events occur, actions are taken to ensure compliance with the Never Event Policy which includes key steps be completed such as disclosure, apologizing, analysis, and reporting.
- **Permanent Harm:** An event or condition that reaches the individual, resulting in any level of harm that permanently alters and/or affects an individual's baseline (TJC,2023).
- **Sentinel Event:** A patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in death, severe harm (regardless of duration of harm), or permanent harm (regardless of severity of harm (Refer to *Sentinel Event* section below) and is reported to The Joint Commission. For Lake Tahoe Surgery Center, located in Nevada, a sentinel event is defined in NRS 439.830 by the National Quality Forum (Refer to Appendix A).
- **Severe harm:** An event or condition that reaches the individual, resulting in life-threatening bodily injury (including pain or disfigurement) that interferes with or results in loss of functional ability or quality of life that requires continuous physiological monitoring and/or surgery, invasive procedure, or treatment to resolve the condition (TJC, 2023).
- **Healthcare Associated Infection (HAI):** A localized or systemic condition resulting from an adverse reaction to the presence of an infectious agent(s), or its toxin(s) as defined by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN) in addition to monthly submission of all surgical site infections associated with different procedures performed at Barton Health. Potential HAIs are reviewed by the HAI Review Committee. Confirmed HAIs are reported to the Patient Safety Committee. HAIs are also reported to the Infection Control and Prevention Committee and Board Quality Committee.

Any patient safety event, incident, or condition that could have resulted or did result in harm to a patient shall be subject for review and further analysis.

Event Reporting

Identification and reporting of adverse events, including those that result from practitioner error are critical to Barton Health's efforts to continuously improve patient safety and reduce harm. To support and encourage this culture of safety, reporting of patient safety events or near misses is highly encouraged. Reporting events is the responsibility of all employees, volunteers, providers, patients, visitors, and guests. Events can be reported though many modalities including electronic, verbal, and written communication. Electronic event reporting is available on all Barton Health computer terminals. An event is reported via the electronic safety learning system/event reporting system by the individual(s) involved with and most knowledgeable about the event. (Refer to Barton Health Organizational Event Reporting Policy.)

Events are reviewed daily. High severity events are reviewed promptly to ensure immediate action is taken as warranted.

Regulatory Agency Reporting

Barton Health informs accrediting and licensing bodies when errors and events fall within that agency's reporting requirements. Team members involved in sentinel or adverse events have access to support and are included whenever possible in the root cause analysis process to ensure the potential for recurrence is minimized.

Intensive assessment may be initiated when undesirable patterns or trends are identified or serious, adverse, or sentinel events occur. This includes those events identified as unusual occurrences within the California Code of Regulations section 76551. Sentinel Events reportable to The Joint Commission and Adverse Events reportable to CDPH are delineated below. (Refer to Appendix A for Nevada Sentinel Event reporting.)

Sentinel Event
Patient safety events are determined to fall into the category of a Sentinel Event as defined by The Joint Commission (2023) when any of the following occur:

A sentinel event is a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in any of the following:

- Death
- Severe harm (regardless of duration of harm)
- Permanent harm (regardless of severity of harm) (TJC, 2023)

Or

The event is one of the following:

- Death caused by self-inflicted injurious behavior while in a healthcare setting or within 7 days of discharge from patient services or from the emergency department (ED)
- Unanticipated death of a full-term infant
- Discharge of an infant to the wrong family
- Abduction of any patient receiving care, treatment, and services

- Any elopement (that is, unauthorized departure) of a patient from a staffed around-the-clock care setting (including ED), leading to death, permanent harm, or severe temporary harm to the patient
- Administration of blood or blood products having unintended ABO and non-ABO (Rh, Duffy, Kell, Lewis, and other clinically important blood groups) incompatibilities, hemolytic transfusion reactions, or transfusions resulting in severe harm, permanent harm, or death
- Sexual abuse/assault of any patient while receiving care, treatment, and services while on site at the organization or while under the supervision or care of the organization
- Sexual abuse/ assault of a staff member, , visitor, or vendor while on site at the organization or while providing care or supervision to patients
- Physical assault (leading to death, permanent harm, or severe temporary harm) of any patient while receiving care, treatment, and services while on site at the organization or while under the care or supervision of the organization
- Physical assault (leading to death, permanent harm, or severe temporary harm) of a staff member, , visitor, or vendor while on site at the organization or while providing care or supervision to patients
- Homicide of any patient receiving care, treatment, and services while on site at the organization or while under the care or supervision of the organization
- Homicide of a staff member, licensed independent practitioner, visitor, or vendor while on site at the organization or while providing care or supervision to patients
- Surgery or other invasive procedure performed at the wrong site, on the wrong patient, or that is the wrong (unintended) procedure for a patient regardless of the type of procedure or the magnitude of the outcome. Invasive procedure is defined as a procedure in which skin or mucous membranes and/or connective tissue are incised or punctured, an instrument is introduced through a natural body orifice, or foreign material is inserted into the body for diagnostic or treatment-related purposes. Examples of invasive procedures include central line and chest tube insertion, biopsies and excisions, and all percutaneous procedures (e.g., cardiac, electrophysiology, interventional radiology). Exclusions include venipuncture, which is defined as a collection of blood from a vein. These exclusions are still considered patient safety events and should be reviewed by the appropriate teams.
- Unintended retention of a foreign object in a patient after an invasive procedure, including surgery
- Severe neonatal hyperbilirubinemia (bilirubin greater than 30 milligrams/deciliter)
- Fluoroscopy resulting in permanent tissue injury when clinical and technical optimization were not implemented and/or recognized practice parameters were not followed
- Any delivery of radiotherapy to the wrong patient, wrong body region, unintended procedure, or greater than 25% above the planned radiotherapy dose
- Fire, flame, or unanticipated smoke, heat, or flashes occurring during direct patient care caused by equipment operated and used by the organization. To be considered a sentinel event, equipment must be in use at the time of the event; staff do not need to be present.
- Any intrapartum maternal death

- Severe maternal morbidity (leading to permanent or severe harm)
- Fall in a staffed around the clock care setting or fall in a care setting not staffed around the clock during a time when staff are present resulting in any of the following: any fracture; surgery, casting, or traction; required consult/management or comfort care for a neurological (e.g., skull fracture, subdural or intracranial hemorrhage) or internal (e.g., rib fracture, small liver laceration) injury; a patient with coagulopathy who receives blood products as a result of the fall; or death or permanent harm as a result of injuries sustained from the fall (not from physiologic events causing the fall)

The above list is consistent across all Joint Commission accreditation programs, though some of these events may be unlikely to occur in certain settings.

Barton Health may voluntarily report Sentinel Events to The Joint Commission within their required reporting timeframe. There is no penalty for not reporting (TJC, 2023). (Refer to Barton Health Sentinel Event Policy.)

Adverse Event

Barton Health shall report an adverse event as defined within Health and Safety Code §1279.1 to CDPH no later than five calendar days after the event has been detected or, if the event is an ongoing urgent or emergent threat to the welfare, health, or safety of patients, personnel, or visitors no later than 24 hours after the adverse event has been detected. Events are investigated, mitigation actions initiated, and cooperation with CDPH occurs throughout the process. (Refer to Barton Health Adverse Event policy.) Barton Health will inform the patient or responsible party for the patient of the adverse event by the time the report to CDPH is made (CDPH, n.d.a., 2018).

"Adverse event" includes any of the following:

1. Surgery performed on a wrong body part that is inconsistent with the documented informed consent for that patient. A reportable event does not include a situation requiring prompt action that occurs in the course of surgery or a situation that is so urgent as to preclude obtaining informed consent.
2. Surgery performed on the wrong patient.
3. The wrong surgical procedure performed on a patient that is inconsistent with the documented informed consent for that patient. A reportable event does not include a situation requiring prompt action that occurs in the course of surgery, or a situation that is so urgent as to preclude the obtaining of informed consent.
4. Retention of a foreign object in a patient after surgery or other procedure, excluding objects intentionally implanted as part of a planned intervention and objects present prior to surgery that are intentionally retained.
5. Death during or up to 24 hours after induction of anesthesia after surgery of a normal, healthy patient who has no organic, physiologic, biochemical, or psychiatric disturbance and for whom the pathologic processes for which the operation is to be performed are localized and do not entail a systemic disturbance.
6. Patient death or serious disability associated with the use of a contaminated drug, device, or biologic provided by the health facility when the contamination is the result of generally detectable contaminants in the drug, device, or biologic, regardless of the source of the contamination or the product.
7. Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. For purposes of this

subparagraph, "device" includes, but is not limited to, a catheter, drain, or other specialized tube, infusion pump, or ventilator.

8. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a facility, excluding deaths associated with neurosurgical procedures known to present a high risk of intravascular air embolism.
9. An infant discharged to the wrong person.
10. Patient death or serious disability associated with patient disappearance for more than four hours, excluding events involving adults who have competency or decision-making capacity.
11. A patient suicide or attempted suicide resulting in serious disability while being cared for in a health facility due to patient actions after admission to the health facility, excluding deaths resulting from self-inflicted injuries that were the reason for admission to the health facility.
12. A patient death or serious disability associated with a medication error, including, but not limited to, an error involving the wrong drug, the wrong dose, the wrong patient, the wrong time, the wrong rate, the wrong preparation, or the wrong route of administration, excluding reasonable differences in clinical judgment on drug selection and dose.
13. A patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products.
14. Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a facility, including events that occur within 42 days post-delivery and excluding deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy, or cardiomyopathy.
15. Patient death or serious disability directly related to hypoglycemia, the onset of which occurs while the patient is being cared for in a health facility.
16. Death or serious disability, including kernicterus, associated with failure to identify and treat hyperbilirubinemia in neonates during the first 28 days of life. "Hyperbilirubinemia" means bilirubin levels greater than 30 milligrams per deciliter.
17. A Stage 3 or 4 ulcer, acquired after admission, excluding progression from Stage 2 to Stage 3 if Stage 2 was recognized upon admission.
18. A patient death or serious disability due to spinal manipulative therapy performed at the health facility.
19. A patient death or serious disability associated with an electric shock while being cared for in a health facility, excluding events involving planned treatments, such as electric countershock.
20. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by a toxic substance.
21. A patient death or serious disability associated with a burn incurred from any source while being cared for in a health facility.
22. A patient death associated with a fall while being cared for in a health facility.
23. A patient death or serious disability associated with the use of restraints or bedrails while being cared for in a health facility.
24. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider.
25. The abduction of a patient of any age.
26. The sexual assault on a patient within or on the grounds of a health facility.
27. The death or significant injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds of a facility.
28. An adverse event or series of adverse events that cause the death or serious disability of a patient, personnel, or visitor.

Never Events/Serious Reportable Events

Barton Health reports National Quality Forum (2023) Never Events/SREs to the appropriate agency based on the circumstances of the event and criteria met of the regulatory agencies (e.g., CDPH, The Joint Commission, Nevada Division of Public and Behavioral Health). Never Events/ SREs include:

1. Surgical or Invasive Procedure Events
   1A. Surgery or other invasive procedure performed on the wrong site.
   1B. Surgery or other invasive procedure performed on the wrong patient.
   1C. Wrong surgical or other invasive procedure performed on a patient.
   1D. Unintended retention of a foreign object in a patient after surgery or other invasive procedure.
   1E. Intraoperative or immediately postoperative/post procedure death in an ASA Class 1 patient.
2. Product or Device Events
   2A. Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting.
   2B. Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended.
   2C. Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting.
3. Patient Protection Events
   3A. Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person.
   3B. Patient death or serious disability associated with patient elopement (disappearance).
   3C. Patient suicide, attempted suicide, or self-harm resulting in serious injury, while being cared for in a healthcare setting.
4. Care Management Events
   4A. Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration).
   4B. Patient death or serious injury associated with unsafe administration of blood products.
   4C. Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting.
   4D. Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy.
   4E. Patient death or serious injury associated with a fall while being cared for in a healthcare setting.
   4F. Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting.
   4G. Artificial insemination with the wrong donor sperm or wrong egg.
   4H. Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen
   4I. Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results.
5. Environmental Events
   5A. Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting.
   5B. Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances.
   5C. Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting.

5D. Patient death or serious injury associated with the use of restraints or bedrails while being cared for in a healthcare setting.

6. Radiologic Events
   6A. Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area.
7. Potential Criminal Events
   7A. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider.
   7B. Abduction of a patient/resident of any age.
   7C. Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting.
   7D. Death or significant injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting.

Provider-Preventable Conditions

Federal law requires Provider-Preventable Conditions (PPCs) that occur during treatment of Medi-Cal and Medicaid patients be reported. These include both healthcare-acquired conditions (HCAC) and other provider-preventable conditions (OPPC). State of California (2023) HCACs and OPPCs are reported to the Department of Health Care Services after discovery and confirmation that the patient is a Medi-Cal beneficiary. Nevada HCACs are reported through the Nevada sentinel event registry.

HCACs are defined as:

- Air embolism
- Blood incompatibility
- Catheter-associated urinary tract infection (UTI)
- Deep vein thrombosis/pulmonary embolism (excluding pregnant women and children under 21 years of age)
- Falls and trauma that result in fractures, dislocations, intracranial injuries, crushing injuries, burns and electric shock
- Foreign object retained after surgery
- Iatrogenic pneumothorax with venous catheterization
- Manifestations of poor glycemic control
  -Diabetic ketoacidosis
  -Nonketotic hyperosmolar coma
  -Hypoglycemic coma
  -Secondary diabetes with ketoacidosis
  -Secondary diabetes with hyperosmolarity
- Stage III and IV pressure ulcers
- Surgical site infection following:
  - Mediastinitis following coronary artery bypass graft (CABG)
  - Bariatric surgery, including laparoscopic gastric bypass, gastroenterostomy and laparoscopic gastric restrict surgery
  - Orthopedic procedures for spine, neck, shoulder, and elbow
  - Cardiac implantable electronic device (CIED) procedures
- Vascular catheter-associated infection

OPPCs are also known as “never events” and Serious Reportable Events under Medicare. For Medi-Cal, OPPCs are defined as:

- Wrong surgical or other invasive procedure performed on a patient

- Surgical or other invasive procedure performed on the wrong body part
- Surgical or other invasive procedure performed on the wrong patient

Providers must report these three OPPCs when these occur in any health care setting. “Invasive procedure” refers to a surgical procedure.

Patient Safety Organization Reporting

Barton Health is a member of the Collaborative Healthcare Patient Safety Organization (CHPSO), which serves as its Patient Safety Organization. Patient Safety Work Product is submitted to CHPSO in accordance with the Patient Safety and Quality Improvement Act of 2005. (Refer to Patient Safety Evaluation System Policy for further details.)

Investigation: Root Cause Analysis, Common Cause Analysis, and Process Improvements

In any event when an adverse/sentinel event or hazardous condition has occurred, the issue is revisited, and the status mitigated through a risk reduction strategy using the Root Cause Analysis (RCA) process. Reportable Adverse or Sentinel Events shall be subject to an immediate in-depth RCA.

RCAs shall be convened by the Director of Patient Safety or designee and include team members either directly or indirectly involved in the event. Members from uninvolved departments may be invited to provide additional information. Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting the RCA. The Root Cause Analysis and Action Plan Framework Table, introduced by The Joint Commission, contains 24 analysis questions that guide the organization through the steps in a root cause analysis. Not all the questions apply to all the events or cases. The 5 Whys technique is utilized to explore the cause-and-effect relationship underlay a problem. Root causes can be identified by asking “why” no less than five times. During the RCA, events are deconstructed to identify the key causes that may have contributed to the event. The deconstruction process leads to action items designed to eliminate or control system hazards or vulnerabilities directly related to causal and contributory factors. The Veterans Affairs National Center for Patient Safety Action Hierarchy is used to assure strong corrective action items are identified.

Common Cause Analysis (CCA) is performed when multiple events are aggregated to identify commonalities among the causes. Such analysis permits identification of the breadth and depth of vulnerabilities within the system.

Process Improvement teams are formed when an issue affecting more than one service line is identified and a near miss may or may not be involved. There may be no adverse patient outcome in connection with the event, however, the potential for a patient event should the issue recur is likely. PIs may also result from discussions during RCAs where a system improvement process is identified as a result of a patient event. Team members convene and identify key factors involved in the process through deconstruction that may have contributed to the situation and create action items to mitigate the identified issues.

RCA and PI workgroups construct action items and assign them to appropriate individuals for completion. Providers and staff involvement are considered essential since they are the team members on the front line with the most knowledge of the actual day-to-day workings of the processes. Individuals assigned action items are required to complete the tasks within a designated amount of time

depending upon the breadth of the item. Action items may be forwarded to other appropriate bodies for further in-depth evaluation, review, response, revision, or development of policies or procedures when applicable. Action item progress and completion is reported to the Patient Safety Department.

As a learning organization utilizing Just Culture, Barton Health focuses on systems and processes, not individuals, during RCA or PI event review.

Disclosure

Full disclosure of serious medical errors, reportable events and any unanticipated outcomes are communicated to patients/families by the practitioner with the assistance of the Risk Manager, Director of Patient Safety, Patient Safety Team members, or designee as appropriate. (Refer to Barton Health Disclosure of Unanticipated Outcome Policy and the Never Event Policy.)

Patient Safety Committee

The Patient Safety Committee is a multidisciplinary team focused on review and discussion of patient events resulting in a near-miss or an untoward outcome as well as process improvements for the purposes of improving patient safety and the quality of care delivered to Barton Health's patients.

The Patient Safety Committee is a standing committee of the Medical Staff. The committee's membership is delineated in Barton Health's Medical Staff Rules.

The Patient Safety Committee shall review and discuss serious patient events, reportable adverse events and sentinel events, HAIs, mortality rates, Sentinel Event Alerts, and systems issues identified by peer review processes. Adverse/sentinel patient events include unanticipated events that affect patient care or patient safety and encompass all service lines of care.

The Committee promotes the application of evidence-based methods in the resolution of patient safety events and reviews RCA, CCA, and PI workgroup recommendations which ultimately minimize the recurrence of comparable patient events or near misses. Recommendations can be revised, added, or deleted through this committee.

The Lake Tahoe Surgery Center Patient Safety, Quality, and Infection Control Committee is a subcommittee of, and reports to, the Patient Safety Committee. Refer to Appendix A.

Department Directors, Managers or designees are active participants who complete assigned action items within an appropriate timeframe designated by the work group, Director of Patient Safety, Patient Safety Team, Chief Medical Officer, or Patient Safety Committee. Directors/Managers are responsible for implementing action items and reporting back to the Patient Safety Committee and/or the Patient Safety Department with status updates and upon completion of assigned action items. Directors/Managers are responsible for ensuring continued compliance exists with their direct reports and implemented process changes are sustained.

Events and PIs shall be closed through the Patient Safety Committee when all assigned action items have been completed, any associated audits exhibit compliance, and all remaining concerns are addressed.

The Director of Patient Safety or designee shall report patient safety events and process improvements from the Patient Safety Committee to the Medical Executive Committee and Governing Board.

Patient Safety Risk Reduction

Several approaches are utilized at Barton Health to reduce the risk of a patient safety event. The Joint Commission's National Patient Safety Goals, National Healthcare Safety Network (NHSN), Institute for Healthcare Improvement (IHI), Agency for Healthcare Research and Quality (AHRQ), National Patient Safety Foundation, and CHPSO are examples of utilized resources to prevent and reduce the likelihood of serious patient safety events. Sentinel Event Alerts released through The Joint Commission are also analyzed for compliance.

National Patient Safety Goals
Compliance with The Joint Commission's National Patient Safety Goals are monitored and evaluated on a continual basis. Data analyses of these audits are reported to and reviewed by Quality Council on a biannual basis. Noncompliance is forwarded to and addressed by the appropriate Department Director/Manager. The Director/Manager formulates an action plan with the goal of improving the affected element score within their department and reports on actions and compliance at appropriate committees.

Patient Safety audits (tracers) are conducted on a regular basis. Immediate training is provided to staff when non-compliance with policy elements is observed.

Sentinel Event Alerts
Sentinel Event Alerts, published through The Joint Commission, are communicated through the Patient Safety Committee. Compliance status and opportunities for improvement are addressed through workgroups consisting of affected Department Directors/Managers, Executive Team Members, and others as appropriate to formulate risk reduction strategies and follow up through an action plan. Action items within the action plan are assigned to individuals who are required to complete the tasks within a designated amount of time depending upon the breadth of the item. Action items may be forwarded to other appropriate bodies for further in-depth evaluation, review, response, revision, or development of policies or procedures when applicable. Action item progress and completion is reported to the Patient Safety Department.

Culture of Safety Surveys
Barton Health uses valid and reliable national surveys on patient safety to assess the culture of safety within the organization. Per CDPH requirements, culture of safety surveys are completed at least every 24 months (California Hospital Association, 2021).

Scientific Model Integration
The patient safety program has been developed with scientific knowledge in a foundational aspect including concepts from:

- James T. Reason's Swiss Cheese Model of Accident Causation
- Deming's PDSA or Model for Improvement (Plan, Do, Study, Act –PDSA)

- Failure Mode and Effects Analysis (FMEA) or Failure Mode, Effects and Criticality Analysis (FMECA)
- Re-engineering (Human factor re-engineering such as signage for High Alert Medications, Pop up alert in medication dispensing cabinets, tall man lettering for look-alike sound alike drugs in medication usage process, etc.)
- Rapid Cycle Improvement (IHI Collaborative approach termed the 'Breakthrough Series,' to bring about rapid cycle improvements. Fundamental to the collaborative approach is the acceptance of a model and establishment of infrastructure through which collaborating organizations can identify and prioritize aims for improvement and gain access to the methods, tools, materials etc.)
- RCA^2: Improving Root Cause Analyses and Actions to Prevent Harm
- Process Improvement such as Lean and Six Sigma concepts
- Evidence-based practice and clinical practice guidelines

Educational Enhancement Activities

The Patient Safety Plan provides the opportunity to reduce patient safety events and hazardous conditions through education, proper and effective orientation, and annual training. Barton Health's clinical orientation program emphasizes medical error reduction and specific job-related aspects of patient safety. Ongoing patient safety training for Barton Health team members including providers is offered through various teaching strategies including, but not limited to, newsletters, bulletin boards, online learning formats, skills labs, and didactic experiences. Program content may include education specific to patient safety related events or advancements in patient safety practice. As appropriate, this training incorporates methods of high reliability team training such as TeamSTEPPS by the American Hospital Association to foster an interdisciplinary, collaborative approach to the delivery of patient care and reinforces the need and mechanisms to report patient safety concerns.

Patient Safety Evaluation

Annually, patient safety activities shall be reviewed and presented to the Patient Safety Committees.

Patient Safety Plan Approval, Revision, and Review

The Patient Safety Committee shall review and approve this plan at least once a year, but more often as necessary, to evaluate and update the plan, and to incorporate advancements in patient safety practices. Quality Council shall review and approve this plan at least annually.

Authority

The authority to implement the Patient Safety Plan rests with Barton Health's Governing Body, Medical Executive Committee, and Patient Safety Committee.

Approval

This plan was approved by the following committees:

Patient Safety Committee on 12/13/2023

Quality Council on 1/10/2024

Section B:

2023 Patient Safety Priority Evaluation

The Patient Safety Plan identifies and defines goals and specific objectives to be accomplished each year. In 2023, Barton Health's high priorities for Patient Safety included tubing misconnections; patient identification; decreasing alarms, alerts, and notification overload; the continuation of the neonatal strategic plan; the Leapfrog Hospital Survey; culture measurement of patient safety; monitoring the electronic event reporting and patient relations platforms; the ongoing evaluation and implementation of best practices around SARs-CoV-2/COVID-19 and emerging infectious diseases; evaluating the revised massive transfusion protocol (MTP); monitoring the new RN graduate program; and initiating the development of safe staffing plan.

Measures to prevent adverse events associated with misconnecting intravenous, enteral feeding, and epidural lines remained a priority in 2023. Barton Health proactively addresses prevention of adverse events associated with misconnecting IV, enteral, and epidural lines through product purchasing and assessment of connector availability throughout the organization as well as through staff education and awareness. A complete conversion to the ISO standard enteral feeding lines occurred in 2015. Manufacturers are beginning to distribute redesigned neuraxial tubing that cannot be mistakenly interconnected. To ensure compliance with California state law, Neuraxial (NRFit®) connectors with redesigned incompatible connectors will be transitioned as soon as they are available. Progress was made with neuraxial (NRFit®) connector availability from vendors. A group has been established to review and evaluate implementation.

Patient identification is an NPSG and must be performed prior to any patient interaction across Barton Health. Errors in the patient identification process continued across the organization during 2023. Patient identification education was included in annual training, new hire orientation, and in several issues of *The Brief*, a weekly patient safety publication. Emphasis on correct patient identification will continue in 2024 through an FMEA along with the continuation of Just Culture practices encouraged.

Alarms, alerts, and notification overload are threats to patient safety. The burden from alarms, alerts, and notifications from medical and communication devices as well as health information technology systems combined can lead to staff fatigue and increases the potential for an immediate response to a clinically significant event to be delayed or go unaddressed. In concert with this concern, NPSG.06.01.01 focusing on clinical alarm system safety remained a high priority for Barton Health. This was accomplished through an ongoing review of alarms associated with the team communication system, Voalte, where alert noise burden was minimized.

The Leapfrog Hospital Survey, focused on ensuring safe patient care is provided, was submitted in 2023. Assessment, analysis, and submission recommendations for each of the survey's sections were completed with key stakeholder involvement prior to the survey submission deadline. These efforts resulted in the healthcare organization receiving maximum scores in a majority of the areas that were submitted.

The electronic incident reporting system patient event and patient relations modules were upgraded in 2022 to align better with current evidence-based practices and the Agency for Healthcare Research and Quality's Common Formats. Collaboration among stakeholders including front-line team members ensured a more efficient and user-friendly system. These modules were monitored during 2023 and showed an increase in report submission rates in the acute care setting. In addition, an updated employee event module was implemented in early November ensuring better alignment with data requests from the healthcare organization's workers compensation vendor.

Surveys measuring patient safety culture in the hospital was conducted in 2023. Evidence-based surveys help identify strengths and opportunities that support a culture of safety and high-quality patient care. Survey findings showed a consistently high-level of patient safety engagement by staff and leaders across all surveyed areas. In addition, departments were asked to work on a goal to improve one domain or question within the survey. Areas worked on handoff, communication, reporting and errors and work pace and staffing. Teams reported improved communication and discussion on near miss and harm events within their departments.

A strategic plan for providing neonatal care in the inpatient setting occurred in 2022. This plan, with multi-disciplinary and collaborative input, focused on several aspects involved in high quality care to ensure this patient population's needs are met. In addition, a University of California, Davis perinatologist was hired as a part-time neonatal service's medical director. Work on this program continued in 2023. However, it was determined by CDPH that this action was no longer needed and that current services are safe and meet the community's patient care needs.

The massive transfusion protocol, used for critically ill patients experiencing massive hemorrhage, was revised and interprofessional team training occurred in 2022. Monitoring of this program, which includes liquid plasma, for compliance and opportunities occurred in 2023. Liquid plasma allows for the complete MTP supply to be released promptly in one cooler. This significantly decreased the time of MTP activation/order to time of blood product distribution. Monitoring and compliance of this program occurs with a collaboration between clinical lab leadership and the trauma department.

Barton Health proactively addressed concerns related to the SARs-CoV-2/COVID-19 pandemic from 2020 through 2022. Barton Health ensured a safe environment for staff, providers, and patients by continually evaluating and following SARs-CoV-2/COVID-19 guidelines in accordance with all federal, state, and county recommendations. The healthcare organization continued to monitor and implement guidance around SARs-CoV-2/COVDI-19 and other emerging infectious diseases such as M Pox and C. *auris* in 2023.

With national RN staffing shortages, Barton Health initiated hiring new RN graduates to fill vacancies in the nursing division in 2021. 2022 and 2023 focused on continuing and improving a high-quality on boarding and educational process to ensure the delivery of safe patient care by these team members. The program has been well received within the organization and to date, four cohorts have successfully completed the program with a fifth cohort currently enrolled in the new graduate program.

Finally, with regard to nursing workforce, the initiation of a safe staffing plan commenced in 2023. A shared governance staffing committee whose structure will be to ensure staffing plans, guidelines, and assignments despite objections (ADOs) are reviewed by this collaborative group will be further developed in 2024. Staffing plans will be evidence-based, align with regulatory agencies, and address staffing requirements as the hospital begins preparation for a future move to Nevada.

Section C:

2024 Patient Safety Priorities

The Patient Safety Plan identifies and defines goals and specific objectives to be accomplished each year. In 2024, Barton Health's high priorities for Patient Safety include tubing misconnections; an FMEA on patient identification; monitoring alarms, alerts, and notification overload; the Leapfrog Hospital Survey; culture measurement of patient safety; patient safety indicator evaluation; sepsis; patient falls; early patient mobility; and the development of a safe nurse staffing plan.

Measures to prevent adverse events associated with misconnecting intravenous, enteral feeding, and epidural lines will remain a priority in 2024. Barton Health proactively addresses prevention of adverse events associated with misconnecting IV, enteral, and epidural lines through product purchasing and assessment of connector availability throughout the organization as well as through staff education and awareness. As described in the 2023 priority evaluation, neuraxial (NRFit®) connectors with redesigned incompatible connectors will be transitioned at Barton Health to ensure compliance with California state law. In 2023, an interprofessional team was reconvened and in communication with vendors to coordinate the neuraxial transition in 2024.

Patient identification is an NPSG and must be performed prior to any patient interaction across Barton Health. In the second half of 2022, it was observed that errors in the patient identification process occurred across the organization. An educational initiative was launched in Quarter 4, 2022. Despite emphasis on correct patient identification throughout 2023, patient identification errors persisted across the organization. In collaboration with the Executive Team, an organizational FMEA on patient identification will commence in 2024.

Alarms, alerts, and notification overload are threats to patient safety. The burden from alarms, alerts, and notifications from medical and communication devices as well as health information technology systems combined can lead to staff fatigue and increases the potential for an immediate response to a clinically significant event to be delayed or go unaddressed. In concert with this concern, NPSG.06.01.01 focusing on clinical alarm system safety will remain a high priority for Barton Health.

The Leapfrog Hospital Survey, focused on ensuring safe patient care is provided, will be submitted in 2024. Assessment, analysis, and submission recommendations for the survey will be-completed with key stakeholder involvement.

While an acute care culture of safety survey was performed in Q1 2023 and an organizational culture survey was disseminated in Q 4 2023, a survey on patient safety culture specific to the Skilled Nursing Facility was not completed. This will be performed in 2024. The survey helps to identify strengths and opportunities that support a culture of safety and high-quality resident care.

Patient Safety Indicators (PSIs) are used by AHRQ and CMS (2020) to evaluate a healthcare organization's performance on safety-related adverse events after surgeries, procedures, and childbirth. Review of the ten PSIs will be monitored by the Patient Safety Department during 2024. Emphasis will be placed on system, process, and human factors in an effort to reduce the risk of harm associated with medical care.

Sepsis is one of the ten PSIs that will be elevated to a value-based purchasing measure in 2024. As such and given organizational scores below the tenth percentile, additional emphasis on technological support, education, documentation efficiencies, and core measure compliance will be a high priority in 2024.

Patient falls were identified in 2023 as an area with opportunities for improvement. As such, a common cause analysis with acute care team members was convened to address falls on the Medical-Surgical/Orthopedic floor. While there was an increase in attention, urgency, and interventions around patient falls, outcomes fluctuated and remained above the desired 3.92 per 1,000 patient days rate. Interprofessional collaboration with focus on Medical-Surgical/Orthopedic and organizational falls will remain a 2024 patient safety priority.

In concert with increased awareness around falls, the Intensive Care Unit initiated a project on early mobility to support discharge readiness, reduce deconditioning, and decrease length of stay. The Bedside Mobility Assessment Tool (BMAT) 2.0, a valid and reliable functional assessment program, was piloted in Q 2 2023 and was readily implemented by the nursing team. BMAT 2.0 offers safe mobility assessments, identifies strengthening strategies, and directs staff to the correct mobility equipment to ensure patient safety during transfers and while ambulating (Boynton et al., 2020). The success of this program will be spread to the remaining second floor acute care area in 2024.

Finally, regarding nursing workforce, a shared governance staffing committee whose structure will be to ensure staffing plans, guidelines, and assignments despite objections (ADOs) are reviewed by this collaborative group will be further developed in 2024. Safe staffing plans will be evidence-based, align with regulatory requirements, and address nurse staffing as the hospital begins preparation for a future move to Nevada.

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Appendix A:

2024 Lake Tahoe Surgery Center Patient Safety Plan

This plan was created and revised by the Lake Tahoe Surgery Center Patient Safety, Quality and Infection Control Committee, a subcommittee of Barton Health's Patient Safety Committee. Implementation of this plan is intended to optimize healthcare patient safety outcomes, encourage recognition, reporting, and acknowledgment of risks to patient, visitor, and employee safety, as well as reduce the medical/healthcare errors and /or preventable events. This Patient Safety Plan ensures that Barton Health implements and maintains a patient safety program in accordance with The Joint Commission standards, Nevada Revised Statutes (NRS), Patient Safety and Quality Improvement Act of 2005, and other regulatory agencies.

Patient Safety Plan
Lake Tahoe Surgery Center

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Commitment to Patient Safety

Lake Tahoe Surgery Center 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 the mission, vision, values, and strategic plan of Barton Health, Lake Tahoe Surgery Center's Patient Safety program promotes:

- Collaboration of healthcare, leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high-quality healthcare.
- Communicate honestly and openly to foster 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 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.
- An environment and culture where patients, families, staff, and leaders within the organization identify and manage actual and potential risks to patient safety thereby resulting in zero harm.
- An ongoing proactive reduction in health-related errors including near miss and good catch events.
- Integration of patient safety priorities in the design and redesign of all relevant organizational processes, functions, and services.

Scope and Purpose

The scope of this Patient Safety Plan is specific to Lake Tahoe Surgery Center, a department of Barton Health, which includes but is not limited to:

- Patient safety
- Visitor safety
- Employee safety

All Lake Tahoe Surgery Center staff are required to fully support and participate in this plan and devote their expertise to the patient safety and healthcare quality improvement process. Each employee performs a critical role in patient safety and thus, Barton Health's journey to becoming a high reliability organization. All Barton Health-Lake Tahoe Surgery Center team members are focused on providing consistently exceptional care through an environment that supports teamwork collaboration, and respect for other people, regardless of their position in the organization. Leaders demonstrate their commitment to patient safety while setting expectations for those who work in the organization. Leadership evaluates the culture of safety on a regular basis.

This plan is action oriented, and solution focused. The purpose of this plan is to address patient safety related concerns, or challenges and revise the program to better serve the patients and their families. To this end, Lake Tahoe Surgery Center has developed this Patient Safety plan.

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

- All staff have the same goal and 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.

Patient Safety Committee Roles and Responsibilities

According to NRS 439.875, a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Patient Safety Plan is promoted and executed successfully.

The Patient Safety Committee reporting hierarchy:

Roles and Responsibilities

- In accordance with NRS 439.875, a patient safety committee must be comprised of:
- The Patient Safety Officer of the medical facility. At Barton Health, the Director of Patient Safety has oversight of the Patient Safety Officer and serves in this role;
- The infection preventionist of the medical facility;
- 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 of the medical facility; and
- One member of the executive or governing body of the medical facility.

The roles and responsibilities are defined below.

Lake Tahoe Surgery Center Patient Safety, Quality, and Infection Control Committee Responsibilities (based on NRS 439.875 and NRS 439.877)

- Monitor and document the effectiveness of the Patient Identification policy.
- **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).
- Receive reports from the Director of Patient Safety/Patient Safety Officer pursuant to NRS 439.870.
- Evaluate actions of the Patient Safety Department in connection with all reports of sentinel events alleged to have occurred.
- Review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- Review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least quarterly, due to the number of employees in the facility, report to the executive or governing body of the facility regarding:
  (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);
  (2) The number of infections that occurred at the facility during the preceding calendar month or quarter; and
  (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
- Adopt patient safety checklists and patient safety policies as required by NRS 439.877, review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

Lake Tahoe Surgery Center Patient Safety, Quality, and Infection Control Committee will meet quarterly to accomplish the following:

- Report and discuss sentinel events which include:
  - Number of sentinel events from previous calendar month (or quarter).
  - Number of severe infections that occurred in the facility.
- Corrective Action Plan for the sentinel events and infections
  - Evaluate the corrective action plan.
- Patient safety policies and checklists
  - At least annually evaluate patient safety policies and checklists
  - Revise the patient safety policies and checklists as needed.
  - Monitor and document the effectiveness of the patient safety policy.
- A meeting agenda and minutes noting follow-up tasks will be kept.

Root Cause Analysis (RCA) Team Responsibilities

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

RCA Team Leader/Facilitator 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 an RCA process that incorporates Patient Safety Improvement elements.

Director of Patient Safety (based on NRS 439.870)

- Provide oversight to the integrated Barton Health patient safety program.
- Serve on the Lake Tahoe Surgery Center Patient Safety, Quality, and Infection Control 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 he or she determines to be 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 Lake Tahoe Surgery Center Patient Safety, Quality, and Infection Control Committee, Patient Safety Committee, and Governing Board actions taken related to the sentinel event.
- Ensure alignment of patient safety activities, compliance with regulations, and provide opportunities for all Barton Health team members to be educated and involved in patient safety initiatives.
- Oversee, monitor, and evaluate safety activities, manage the program that measures and analyzes safety levels, and help identify problem areas for correction.
- The Director of Patient Safety has the authority to intervene in any clinical or non-clinical activity which poses an actual or potential negative outcome to a patient's well-being. The Director of Patient Safety involves leadership in the creation, initiation, and evaluation of corrective action measures for event resolution.
- Report to the Patient Safety Committee regarding any action taken in accordance with the responsibilities above.

Infection Preventionist Responsibilities (based on NRS 439.873)

- Serve on the Lake Tahoe Surgery Center Patient Safety, Quality, and Infection Control Committee.
- Monitor the occurrences of infections at the facility to determine the number and severity of infections.
- Report to the Patient Safety, Quality, and Infection Control Committee and Patient Safety Committee concerning the number of infections at the facility.
- Take such action as determined necessary to prevent and control infections alleged to have occurred at the facility.
- Carry out the provisions of the infection control program adopted pursuant to NRS 439.865 and ensure compliance with the program.

Executive Member Responsibilities

- Provide vision and leadership to the Lake Tahoe Surgery Center Patient Safety, Quality, and Infection Control Committee and develop and foster a safe learning and improving culture.
- Provides oversight to the integrated patient safety program.
- Plan, discuss, and generate the organization patient safety goals and activities, in conjunction with the patient safety action plans.
- Ensure alignment of patient safety activities, compliance with regulations, and provide opportunities for all Barton Health team members to be educated and involved in patient safety initiatives.

Objectives and Goals of the Patient Safety Plan

Objective	Goals	Plan	Planned Completion Date	Responsible Party
To control known and potential safety hazards to patients, visitors, and staff.	Strive for zero harm.	Patient Safety Plan as presented	Ongoing	The Director of Patient Safety and Patient Safety Committee presiding over Barton Health are responsible for managing and coordinating the organization-wide safety program in collaboration with other departments, services and disciplines including Lake Tahoe Surgery Center.

To establish a safety program that incorporates all activities within Lake Tahoe Surgery Center which contribute to the maintenance and improvement of staff and patient safety and reduction of medical/health care errors.	Provide education to all staff on the elements of the Lake Tahoe Surgery Center Patient Safety Plan.	Education provided upon hire	Ongoing	The Director of Patient Safety and Patient Safety Committee presiding over Barton Health are responsible for managing and coordinating the organization-wide safety program in collaboration with other departments, services and disciplines including Lake Tahoe Surgery Center.
To create a culture in which patients, visitors and employees can identify and manage actual and potential risks to patient and staff safety.	In-service all personnel on the use and completion of event reports.	Education provided upon hire	Ongoing	The Director of Patient Safety and Patient Safety Committee presiding over Barton Health are responsible for managing and coordinating the organization-wide safety program in collaboration with other departments, services and disciplines including Lake Tahoe Surgery Center.

To develop a culture that encourages recognition and acknowledgement of risks to safety including medical health care errors, facility-acquired infections, initiation of actions to reduce risks, internal minimization of individual blame or retribution, and organizational learning about errors.	Reduce the risk of safety related incidents by proactively evaluating systems in place and making any necessary changes.	Evaluate near-miss events through RCAs and PIs presented at Patient Safety, Quality, and Infection Control Committee and encourage Just Culture.	Ongoing	The Director of Patient Safety and Patient Safety Committee presiding over Barton Health are responsible for managing and coordinating the organization-wide safety program in collaboration with other departments, services and disciplines including Lake Tahoe Surgery Center.
To develop an environment that supports sharing of knowledge to affect behavioral changes in itself and other healthcare organizations to improve patient safety.	Reduce the risk of safety related incidents by proactively evaluating systems in place and making any necessary changes.	Evaluate near miss events through RCAs and PIs presented at the Patient Safety, Quality, and Infection Control Committee and encourage Just Culture.	Ongoing	The Director of Patient Safety and Patient Safety Committee presiding over Barton Health are responsible for managing and coordinating the organization-wide safety program in collaboration with other departments, services and disciplines including Lake Tahoe Surgery Center.

Empower patients to understand and participate in their healthcare.	Provide communication and education to patients relating to their care.	Provide education through various methods based on learning assessment.	Ongoing	The Director of Patient Safety and Patient Safety Committee presiding over Barton Health are responsible for managing and coordinating the organization-wide safety program in collaboration with other departments, services and disciplines including Lake Tahoe Surgery Center.

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.

Patient Safety Risk Reduction

Several approaches are utilized at Barton Health to reduce the risk of a patient safety event. The Joint Commission's National Patient Safety Goals, National Healthcare Safety Network (NHSN), Institute for Healthcare Improvement (IHI), Agency for Healthcare Research and Quality (AHRQ), Hospital Quality Institute, and California Hospital Patient Safety Organization (CHPSO) are some examples of utilized resources to prevent and reduce the likelihood of serious patient safety events. Sentinel Event Alerts released through The Joint Commission are also analyzed for compliance.

Sentinel Event Alerts

Sentinel Event Alerts, published through The Joint Commission, are communicated through the Patient Safety Committee. Compliance status and opportunities for improvement are addressed through workgroups consisting of affected Department Directors, Executive Team Members, and others as appropriate to formulate risk reduction strategies and follow up through an action plan. Action items within the action plan are assigned to individuals who are required to complete the tasks within a designated amount of time depending upon the breadth of the item. Action items may be forwarded to other appropriate bodies for further in-depth evaluation, review, response, revision, or development of policies or procedures when applicable. Action item progress and completion is reported to the Patient Safety Department.

Scientific Model Integration

The patient safety program has been developed with scientific knowledge in a foundational aspect including concepts from:

- Deming's PDSA or Model for Improvement (Plan, Do, Study, Act –PDSA)
- Failure Mode and Effects Analysis (FMEA)
- Re-engineering (Human factor re-engineering such as signage for High Alert Medications, pop up

alert in Pyxis medication dispensing system, tall man lettering for look-alike sound alike drugs in medication usage process, etc.)

- Rapid Cycle Improvement (Institute of Health Care Improvement [IHI]) Collaborative approach termed the 'Breakthrough Series,' to bring about rapid cycle improvements. Fundamental to the collaborative approach is the acceptance of a model and establishment of infrastructure through which collaborating organizations can identify and prioritize aims for improvement and gain access to the methods, tools, materials etc.)
- RCA^2: Improving Root Cause Analyses and Actions to Prevent Harm
- Process Improvement (PI) such as Lean and Six Sigma concepts
- Evidence-based practice and clinical practice guidelines

Educational Enhancement Activities

The Patient Safety Plan provides the opportunity to reduce patient safety events and hazardous conditions through education, proper and effective orientation, and annual training. Barton Health's clinical orientation program emphasizes medical error reduction and specific job-related aspects of patient safety. Ongoing patient safety training for Barton Health team members including practitioners is offered through various teaching strategies including, but not limited to, bulletin boards, online learning formats, skills labs, and didactic experiences. Program content may include education specific to patient safety related events or advancements in patient safety practice. As appropriate, this training incorporates methods of team training such as TeamSTEPPS by AHRQ to foster an interdisciplinary, collaborative approach to the delivery of patient care and reinforces the need and mechanisms to report patient safety concerns.

Investigation: Root Cause Analysis and Process Improvements

In any event when an adverse/sentinel event or hazardous condition has occurred, the issue is revisited, and the status mitigated through a risk reduction strategy using the Root Cause Analysis (RCA) process. Lesser events are managed through either an RCA or Process Improvement (PI). Reportable Adverse or Sentinel Events shall be subject to an immediate in-depth RCA.

RCAs shall be convened by the Director of Patient Safety or designee and includes team members either directly or indirectly involved in the event. Members from uninvolved departments may be invited to provide additional information. Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting the RCA. The Root Cause Analysis and Action Plan Framework Table, introduced by the Joint Commission, contains 24 analysis questions that guide the organization through the steps in a root cause analysis. Not all the questions apply to all the events or cases. The 5 Whys technique will be used to explore the cause-and-effect relationship underlay a problem. One can find the root causes by asking "why" no less than five times. During the RCA, events are deconstructed in an effort to identify the key causes that may have contributed to the event. The deconstruction process leads to action items designed to eliminate or control system hazards or vulnerabilities directly related to causal and contributory factors. The Veterans Affairs National Center for Patient Safety Action Hierarchy is used to assure strong corrective action items are identified.

An RCA meeting will meet as needed to accomplish the following:
Define the healthcare issues or potential risks.

- Conduct Root Cause Analysis
  - Review and analyze the data.
  - Review the RCA process and improvement related activities and timelines.
  - Identify the contributing factors and conduct the Root Cause Analysis.
- Conduct Corrective Action Plan
  - Discuss corrective action process and activities.
  - Discuss and present possible changes in procedure to improve areas indicated.
  - Identify strengths and areas that need improvement.
  - Develop strategies, solutions, and steps to take next.
- Identify barriers and technical assistance needs for supporting the RCA efforts.

Process Improvement teams are formed when an issue affecting more than one service line is identified and a near miss may or may not be involved. There may be no adverse patient outcome in connection with the event, however, the potential for a patient event should the issue recur is likely. PIs may also result from discussions during RCAs where a system improvement process is identified as a result of a patient event. Team members convene and identify key factors involved in the process through deconstruction that may have contributed to the situation and create action items to mitigate the identified issues.

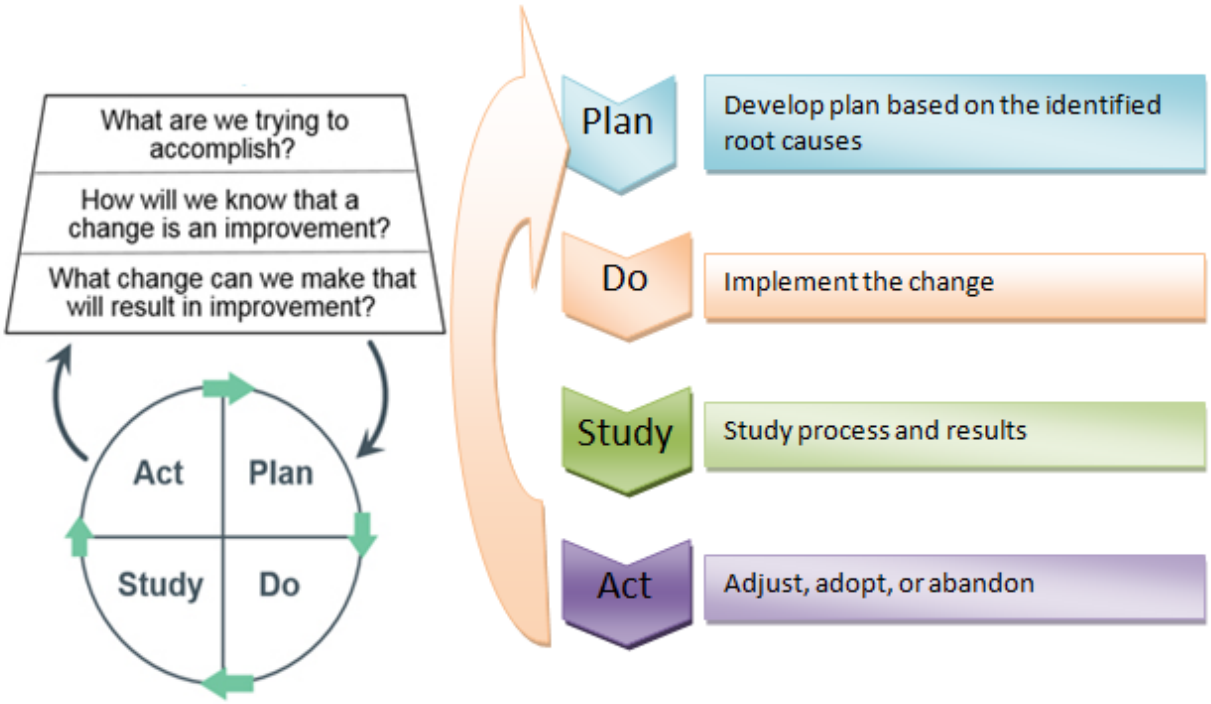
RCA and PI workgroups construct action items and assign them to appropriate individuals for completion. Staff involvement is considered essential since they are the team members on the front line with the most knowledge of the actual day-to-day workings of the processes. Individuals assigned action items are required to complete the tasks within a designated amount of time depending upon the breadth of the item. Action items may be forwarded to other appropriate bodies for further in-depth evaluation, review, response, revision, or development of policies or procedures when applicable. Action item progress and completion is reported to the Patient Safety Department.

As a learning organization utilizing Just Culture, Barton Health focuses on systems and processes, not individuals, during RCA or PI event review.

Lake Tahoe Surgery Center will use the RCA process to determine the contributing factors and the underlying reasons for the deficiencies or failures. The Plan-Do-Study-Act (PDSA) is the model, which was developed by the Institute of Health Care Improvement that will be utilized to test the changes.

Model for Improvement

The Model for Improvement is a collaborative and ongoing effort model to improve product, services, and processes. It provides multi-disciplinary 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 and answer the following questions.
    - What is the objective of the test?
    - What are the steps for the test - who, what, when?
    - How will you measure the impact of the test?
    - What is your plan to collect the data needed?
    - What do you predict will happen?
- *Do*--Make changes designed to correct or improve the situation. Use the following questions for the guidance.
    - What were the results of the test?
    - Was the cycle carried out as designed or planned?
    - What did you observe that was unplanned or expected?
- *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. Results should be evaluated and by using the following questions as guidance.
    - Did the results match your prediction?
    - What did you learn?
    - What do you need to do next?
- *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 patient safety efforts. Lake Tahoe Surgery Center utilizes an electronic event reporting system for tracking events, sentinel events, healthcare infection data, and information for internal data collection.

External data sources are those data sources which are collected outside the supervisory structure of the case. External data which will be utilized for the Patient Safety plan include 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

Data points such as the following will be reviewed according to the schedule prescribed:

Monthly	Quarterly	Annually
1) Sentinel event monthly report as needed 2) Severity of infection report as needed 3) RCA assessment as needed	1) 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	1) Patient Safety Plan update 2) Review and revise Patient Safety checklists and policies

Assessment of the Patient Safety Plan

The Patient Safety Committee shall review and assess/approve this plan at least once a year, but more often as necessary, to evaluate and update the plan, and to incorporate advancements in patient safety practices.

Patient Safety Checklists and Patient Safety Policies

In accordance with 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, a janitor of the medical facility; and
- 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 employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure the patient's room and environment is sanitary.
- A checklist to be 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; and
    - 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. Such policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include the name and date of birth of the patient. Refer to Barton Health's Patient Identification policy.
- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene. Refer to Baron Health's Hand Hygiene policy.
- 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. Refer to Patient Safety Observational Tracers policy.

Based on NRS 439.865, the patient safety plan must also include an infection control program that carries out 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); and
- Facility-specific infection control developed under the supervision of a certified Infection Preventionist.

The patient safety checklists are listed in LTSC Attachment A.
The patient safety policies are listed in LTSC Attachment B.

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. At Barton Health, this is accomplished by the plan being approved through the Lake Tahoe Surgery Center Patient Safety, Quality, and Infection Control Committee, the Barton Health Patient Safety Committee, and the Governing Board. 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 patient safety plan must be reviewed and updated annually in accordance with the requirements for approval set forth in this section.

According to 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 must be submitted to the Division of Public and Behavioral Health.

Authority

The authority to implement the Patient Safety Plan rests with Barton Health's Governing Body, Medical Executive Committee, and Patient Safety Committee.

2023 Lake Tahoe Surgery Center Patient Safety Priority Review and 2024 Patient Safety Priorities

During 2024, Lake Tahoe Surgery Center will strive to achieve two different priorities to ensure safe patient care. During 2023, the surgical site infection (SSI) rate was 0%. Staff education was provided during the year and opportunities for improvement were prioritized by the SSI Taskforce. In 2024, LTSC would like to maintain a surgical site infection rate of less than 0.1%.

Lake Tahoe Surgery Center had zero never events during 2023. In an effort to reduce the potential for harm, Lake Tahoe Surgery Center will strive to maintain zero harm during 2024. Physician and staff education is ongoing. The Patient Safety, Quality, and Infection Control Committee reviews all event reports and action items will be assigned to the appropriate staff. Education will occur immediately following an event, near miss or good catch.

References

Agency for Healthcare Research and Quality. (2014). *The patient safety and quality improvement act of 2005.* http://www.ahrq.gov/policymakers/psoact.html

Centers for Disease Control and Prevention. (2021). *Healthcare-associated infections (HAIs).* http://www.cdc.gov/hai/

The Joint Commission Standard APR.09.02.01

The Joint Commission Standard LD.04.04.05

The Joint Commission. (2024). *National Patient Safety Goals effective January 2024 for the Ambulatory Health Care program*. https://www.jointcommission.org/standards/national-patient-safety-goals/ambulatory-health-care-national-patient-safety-goals/

Nevada Division of Public and Behavioral Health. (2021). *Sentinel event registry.* http://dpbh.nv.gov/Programs/SER/Sentinel_Events_Registry_(SER)-Home/

Nevada Revised Statutes. Health and safety of patients at certain medical facilities. NRS 439.800-439.890

U.S. Department of Veterans Affairs. (2021). *Root cause analysis.* https://www.patientsafety.va.gov/professionals/onthejob/rca.asp

LTSC Attachment A: 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:
   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)

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-Acquired 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; and
- 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: 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: 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 2009 Update.)

Catheter Associated Urinary Tract Infection (CAUTI): A urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place for greater than 2 calendar days on the date of event, with day of device placement being Day 1, and an indwelling urinary catheter was in place on the date of event or the day before. If an indwelling catheter was in place for greater than 2 calendar days and then removed, the date of event for the UTI must be that day of discontinuation or the next day for the UTI to be catheter-associated (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN): Patient Safety Component Manual; 2017. Available at https://www.cdc.gov/nhsn/pdfs/pscmanual/pcsmanual_current.pdf

Central Line Associated Bloodstream Infections (CLABSI): Primary bloodstream infections that are 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.

LTSC Attachment B: Patient Safety Patient Safety Checklists & Policies for Lake Tahoe Surgery Center

REPORT TO THE DIRECTOR OF THE LEGISLATIVE COUNSEL BUREAU PURSUANT TO ASSEMBLY BILL 280 OF THE 2011 LEGISLATIVE SESSION – SUBMITTED BY:

Lake Tahoe Surgery Center

212 Elks Point Rd Suite 201, Zephyr Cove NV 89448

YEAR – June 1, 2023 – June 30, 2024

Check Lists Include:	Developed	Revisions*	Usage**	Review***
Related to the following specific types of treatments*		(date of revision)	(Unit/department)	
Patient Room & Environment Sanitation (Cleaning Checklists)		July 7, 2022	ASC	
Discharge Checklist		October 28, 2014	PACU	X (on EHR)
Pre-op Checklist		May 2, 2015	PRE-OP/OR	X (on EHR)
Safety Checklist	May 2, 2015	June 1, 2016	OR	X (on EHR)
Sign-In	May 2, 2015	June 1, 2016	OR	X (on EHR)
Fire Safety	May 2, 2015	June 1, 2016	OR	X (on EHR)
Timeout	May 2, 2015	June 1, 2016	OR	X (on EHR)
Sign-out	May 2, 2015	June 1, 2016	OR	X (on EHR)
Environmental Rounds (quarterly)		September 22, 2020	ASC	X
Infection Control Survey (monthly)			ASC	X
Surgical Services Audit		June 29, 2015	ASC	X
Medication Refrigerator		April 2019	PRE-OP/PACU/OR	X
IVF/Blanket Warmer Temperature		April 2019	PRE-OP/PACU/OR	X
Wipe Warmer	June 6, 2022		PRE-OP	X
Lab Refrigerator	February 7,		ASC	X

	2022			
OR Temperature/Humidity		May 25, 2022	ASC	X
Washer Sterilizer Cleaning			STERILIZATION	X
Daily, weekly, monthly duties		May 31, 2022	PRE-OP/PACU/OR	X
Crash Cart		December 1, 2020	NURSING	X
Pediatric Crash Cart		December 1, 2020	NURSING	X
Malignant Hyperthermia Cart		June 4, 2019	NURSING	X
Hand Hygiene Audit		Adopted February 2021	ASC	X
Medication Labeling Audit		December 8, 2016	ASC	X
Patient Safety Policies Include:	**Developed**	**Revisions**	**Usage**	**Review**
Patient Identification		February 7, 2022	ASC	X
Hand Hygiene		September 27, 2018	ASC	X
Ambulatory Health Care National Patient Safety Goals		2023	ASC	
Medication Reconciliation		April 22, 2021	ASC	X
Handoff Communication		July 29, 2021	ASC	X
Universal Protocol: Universal Protocol for Invasive Procedures (Surgical Site Verification)		March 26, 2020	ASC	X
Preparation and Administration of Medications		May 2022	ASC	X
Hazard Communications Program		February 22, 2019	ASC	X
Injury and Illness Prevention Plan		April 21, 2023	ASC	
Material Safety Data Sheets		Online SDS	ASC	X

Exposure Control Plan		December 24, 2020	ASC	X
Code Gray- Assaultive or Abusive Person		March 30, 2015	ASC	X
Workplace Violence Prevention Plan		March 16, 2023	ASC	
Interim Life Safety Measures (ILSM)		November 8, 2021	ASC	X
Summary of Review	**Total # developed**	**Total # revised**	**Total # Reviewed**	
Patient Safety Checklists	0	1	22	
Patient Safety Policies	0	3	11	

*Checklists and Patient Safety Policies were reviewed for the stated time period. Need for revision is noted by the date the revision was made.

**Usage outlines the unit/departments the checklists are used in.

***As part of the annual review any required revisions will be identified. If revisions are required, this is noted in the revision box. Any additional patient safety checklists or policies identified will be noted in this (review) column. If the annual review reveals no changes are required, this box will be marked with an “X.” An “X” means that the checklists and policies were reviewed but no changes were required.

Reports are due on or before July 1 of each year.