QUALITY AND PATIENT SAFETY PLAN

This plan was created and revised by the_ Sun Valley Surgery Center _ Patient Safety committee/team. Implementation of this plan is intended to optimize the healthcare quality and 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.

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Commitment to Patient Safety

Sun Valley 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 improvement of patient safety policies, systems, and processes.

Mission, Vision, and Values

In support of our mission, vision, and values, Sun Valley Surgery Center Patient Safety and Quality Improvement 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.

Scope and Purpose

The scope of this Quality and Patient Safety Plan is organizational-wide/hospital-wide/agency-wide which includes but is not limited to:

- Patient safety
- Visitor safety
- Employee safety

All staff in Sun Valley Surgery Center are required to fully support and participate in this plan and devote their expertise to the patient safety and healthcare quality improvement process.

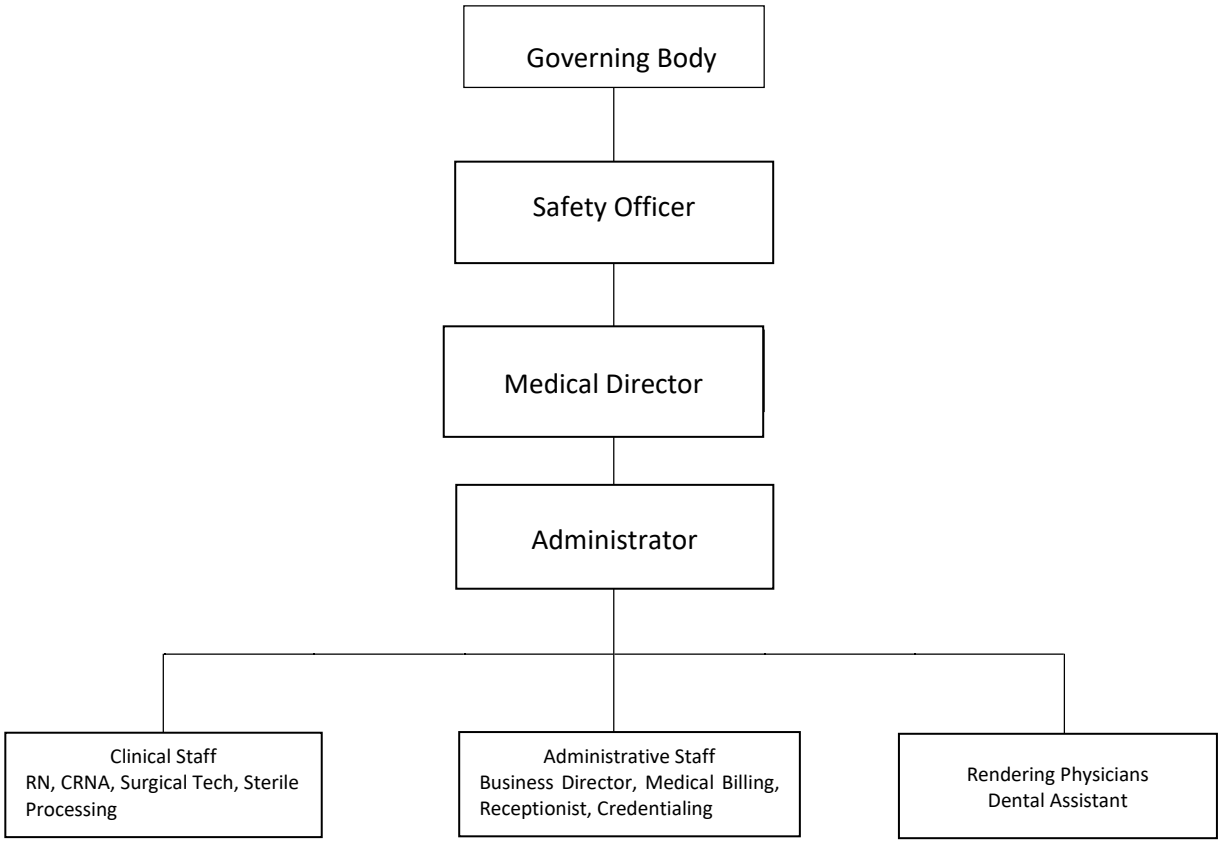
This plan is action oriented, and solution focused. The purpose of this plan is to address patient safety related concerns, challenges and revise the program to better serve the patients and their families. To this end, Sun Valley Surgery Center has developed this Patient Safety Plan.

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 experience.
- Customer based including patients, families, and visitors.
- Promote systems thinking.
- Employ well-trained and competent staff maintaining high healthcare quality.

Roles and Responsibilities

The Patient Safety Committee Organization



Roles and Responsibilities

Patient Safety 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 patient safety officer pursuant to NRS 439.870.
- Evaluate actions of the patient safety officer 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 once each quarter reports 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 quarter.

  (2) The number and severity of infections that occurred at the facility during the preceding quarter.

  (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.

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.

Patient Safety Officer Responsibilities (based on NRS 439.870)

- Serve on the patient safety 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 patient safety committee regarding any action taken in accordance with the responsibilities above.

Infection Control Officer Responsibilities (based on NRS 439.873)

- Serve on the patient safety committee.
- Monitor the occurrences of infections at the facility to determine the number and severity of infections.
- Report to the patient safety committee concerning the number and severity of infections at the facility.
- Take such action as determines is 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.

RCA team leader 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 RCA process that incorporate the Patient Safety and Quality Improvement elements.

RCA Facilitator Responsibilities

- Creating a clear and precise problem definition
- Ensuring that all incident causes are identified and documented in the proper causal relationships.
- Encouraging "out of the box" thinking of the team members during the solution identification process
- Summarize the results of the RCA with recommended solutions for submittal to Safety Officer for committee review.

Executive or Governing Body Staff Responsibilities

- Provide vision and leadership to Patient Safety and Quality Improvement process and develop and foster a safe learning and improving culture.
- Provides oversight to the healthcare quality improvement processes and teams.
- Plan, discuss, and generate the organization patient safety goals and activities, in conjunction with the patient safety action plans.

The Patient Safety Committee will meet quarterly to accomplish the following:

- Report and discuss sentinel events which include:
  - Number of sentinel events from previous 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 RCA meeting will meet as needed to accomplish the following:

- Define the healthcare issues or potential risks.
- Conduct Root Cause Analysis
  - Reviewing and analyzing the data.
  - Reviewing the RCA process and quality improvement related activities and timelines.
  - Brainstorming issues or the potential risks by using the fishbone diagrams.
  - Identify the contributing factors and conduct the Root Cause Analysis.
- Conduct Corrective Action Plan
  - Identifying the Plan-Do-Study-Act (PDSA) topics.
  - Discussing corrective action process and activities.
  - Discussing and presenting possible changes in procedure to improve areas indicated.
  - Identifying strengths and areas that need improvement.
  - Developing strategies, solutions, and steps to take next.
- Identify barriers and technical assistance needs for supporting the RCA efforts.
  A meeting agenda and minutes noting follow-up tasks will be kept.

Objectives and Goals of the Quality and Patient Safety Plan

Objective	Goals	Plan	Planned Completion Date	Responsible Party

Components and Methods

Pursuant to NRS 439.837 and NAC 439.917, within 45 days after reporting a sentinel event pursuant to NRS 439.835, Sun Valley Surgery Center will 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."

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

Root Cause Analysis

A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals.

Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

Root cause analysis and action plan framework table, which was introduced by the Joint Commission. It contains 24 analysis questions. It guides the organization to the steps in a root cause analysis. Not all the questions apply to all the events or cases. This table can be used individually or with the fishbone diagram.

5 Whys technique will be used in Sun Valley Surgery Center to explore the cause-and-effect relationship underlay a problem. One can find the root causes by asking “why” no less than five times. This technique can be used individually or as a part of the fishbone diagram.

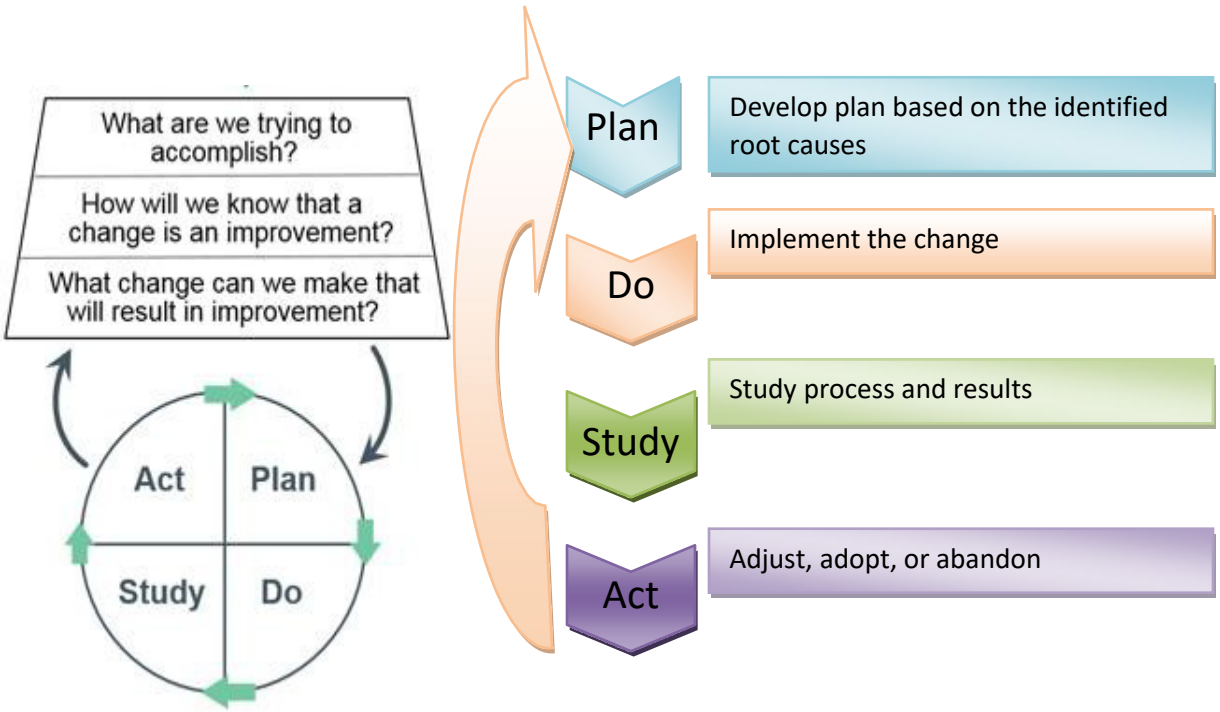
Fishbone Diagram

Once the problems are identified, a Fishbone Diagram (Appendix C) will be used for analyzing the problems. You can use the fishbone diagram individually to analyze the root causes or use it with the root cause analysis and action plan framework table.

A Fishbone Diagram, also called a Cause-and-Effect diagram, is a useful tool for a team to structurally brainstorm by discovering possible underlying factors or root causes from different major categories for the chosen problems. General categories used include people, methods, materials, measurements, education, procedures, process, location, environment, etc. RCA team members will brainstorm and ask multiple times, "why did this happen?" for each cause until all ideas are exhausted. The highest priority root causes will be chosen for PDSA topics. Once all the categories are established on the fishbone diagram, 5 Why's technique also can be used to drill down the problem and find the root causes.

Model for Improvement

The Model for Improvement is a collaborative and ongoing effort model to improve the product and services quality and process. It provides multi-disciplinary quality 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 guidance.
  - What were the results of the test?
  - Was the cycle carried out as designed or planned?
  - What did you observe 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 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 further improvements. If the outcome is not yet successful, look for different ways to identify the causes or change the testing process.

The PDSA worksheet will be used to map the potential change strategies and to establish a course of action. The PDSA worksheet and the PDSA progress report are attached in Appendix D-1.

Data Collection and Reporting

Data should drive any quality and patient safety effort. Sun Valley Surgery Center is using HST Pathways for tracking the sentinel events, healthcare infection data, and SVSC Audits Spreadsheets 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 Quality and Patient Safety plan include the 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. 2) Severity of infection report 3) RCA assessment	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) Quality and Patient Safety Plan update 2) Checklists and Policies reviewing and revising

Assessment of the Quality and Patient Safety Plan

Patient Safety	Sun Valley Surgery Center
Policy Name:	**Patient Safety Program**

POLICY:

Sun Valley Surgery Center will institute and administer a comprehensive and continuous Patient Safety Program for all patients to improve patient safety and reduce risk to patients through an environment that encourages:

- Recognition of risks to patient safety and medical/health care errors
- Actions to reduce these risks.
- Internal reporting of incidents and potential incidents and actions taken
- Focus on processes and systems rather than individual blame.

PURPOSE:

The Patient Safety Program provides a systematic, coordinated, and continuous approach to maintenance and improvement of patient safety by using established mechanisms to support responses to actual occurrences, have an ongoing proactive plan to reduce medical/health errors, and integrate patient safety as a high priority in all relevant organizational processes and services.

RESPONSIBILITY:

As with patient care, it is a coordinated and collaborative effort of the entire organization to maintain and improve patient safety.

The Governing Body approves the data-driven Patient Safety Program and ensures the program reflects the complexity of the facility's organization and services, including those services furnished under contract or arrangement and focuses on the prevention and reduction of medical/health errors and adverse effects.

The Patient Safety Officer is responsible for the management of the Patient Safety Program by:

- Coordinating all patient safety activities
- Facilitating assessment and appropriate responses to reportable events
- Monitoring Root Cause Analysis and resulting action plans.

- Serving as a liaison among the departments to assure facility wide integration of the Patient Safety Program.

Each individual employee within the organization acts as a patient advocate for safety and is responsible to report patient safety occurrences and potential occurrences to the QAPI Coordinator and the Clinical Director, who will aggregate the occurrence information and report to the Governing Body.

PROGRAM:

The scope of the Patient Safety Program includes an ongoing assessment to prevent error occurrence, maintain and improve patient safety.

Patient Safety occurrence information from aggregated data reports and individual incident occurrence reports will be reviewed to prioritize organizational patient safety efforts.

Types Of Patient Safety Or Medical/Health Care Errors:

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

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

- Any Medication Error

- Any Adverse Drug Reaction

- Any Transfusion Reaction

- Hazardous Condition - any set of circumstances, exclusive of the disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious physical or psychological adverse patient outcome.

- Sentinel Event - an unexpected occurrence involving death or serious physical or psychological injury or the risk thereof, including any process variation for which a recurrence would carry a significant chance of serious adverse outcome. Serious injury specifically includes loss of limb or function. Sentinel event criteria includes:

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- The event has resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition.
- The event is one of the following (even if the outcome was not death or major permanent loss of function):
  - Suicide of a patient.
  - The sexual assault of a patient during treatment or while the patient was on the premises of the facility.
  - A hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities.
  - Medication error resulting in a patient's unanticipated death or major permanent loss of bodily function in circumstances unrelated to the natural course of the illness or underlying condition of the patient.
  - A surgical procedure on the wrong patient or on the wrong body part of a patient.
  - A foreign object accidentally left in a patient during a procedure.
  - A patient death or serious disability associated with the use or function of a device designed for patient care that is used or functions other than as intended.
  - Near Miss - any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome.

What To Do When A Patient Safety Error Occurs

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

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

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

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

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- Preserve any information related to the error (including physical information). Examples of preservation of physical information are: Removal and preservation of blood unit for a suspected transfusion reaction; preservation of IV tubing, piggyback fluid for a patient with a severe drug reaction from IV medication; preservation of medication label for medications administered to the incorrect patient. Preservation of information includes documenting the facts regarding the error on an occurrence report, and in the medical record as appropriate to organizational policy and procedure.

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

- Submit the incident occurrence report to the QAPI Committee per organizational policy.

Internal Reporting Of The Error/Event

Staff response to medical/health care errors is dependent upon the type of error identified:

- **No Harm Errors** - (including "no harm medication errors), staff will document appropriately in the medical record according to organizational policy, document the circumstances regarding the no harm error on an incident occurrence report form, submit the form to the QAPI Committee and notify their immediate supervisor.

- **Mild-Moderate Adverse Outcome Errors** (including medication errors), staff will perform any necessary clinical interventions to support and protect the patient and notify the physician responsible for the patient, carrying out any necessary physician orders. Staff will then preserve any physical evidence as appropriate, notify their immediate supervisor, document facts in the medical record and on an incident occurrence report, submitting the report to the QAPI Committee per policy.

- **Adverse Drug Reaction** - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician responsible for the patient, carrying out any necessary physician orders. Staff will then preserve any physical evidence as appropriate, notify their immediate supervisor, document facts appropriately in the medical record and on an incident occurrence report, submitting the report to QAPI Committee per organizational policy.

- **Transfusion Reaction** - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician responsible for the patient, carrying out any necessary orders. Staff will then follow the organization policy and procedure for this event.

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- **Hazardous Condition/Patient Safety Issue** - as appropriate, and if possible, staff will contain the hazardous condition or patient safety issue. Staff identifying a hazardous condition or potential patient safety issue will immediately notify their supervisor and document the findings on an incident occurrence report which is then submitted to QAPI Committee

- **Sentinel Event** - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician responsible for the patient, carrying out any necessary physician orders. Staff will then follow the organizational Sentinel Event Policy and Procedure, which includes a root cause analysis and action plan.

- **Near Miss** - staff will report the near miss event to their immediate supervisor, describe the facts of the near miss on an occurrence report and submit the report to QAPI Committee.

- It is the intent of this facility to adopt a non-punitive approach in its management of errors and occurrences. All personnel are required to report suspected and identified medical/health care errors and should do so without the fear of reprisal in relationship to, their employment. This organization supports the concept that errors occur due to a breakdown in systems and processes, and will focus on improving systems and processes, rather than disciplining those responsible for errors and occurrences. A focus will be placed on remedial actions to assist rather than punish staff members, with the individual staff member's supervisor determining the appropriate course of action to prevent error recurrence.

Root Cause Analysis

- All sentinel events and near miss occurrences will have a root cause analysis conducted to examine the cause and effect of the event through an impartial process.

- A Root Cause Analysis is an interdisciplinary review process for identifying the basic or contributing causal factors that underlie a variation in performance associated with an adverse event or reportable patient safety event. It focuses primarily on systems and processes, includes an analysis of underlying cause and effect, progresses from special causes in clinical processes to common causes in organizational processes, and identifies potential improvements in processes or systems.

- The QAPI Committee is responsible for conducting the root cause analysis. It will be completed within 45 days of becoming aware of one of the reportable events. They will encourage the staff members' involvement in the root cause analysis and action plan processes, to allow the staff members an active role in process resolution.

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A written Root Cause Analysis and "Action Plan" will be created which includes specific measures to correctly identify problems or areas of concern, identify strategies for implementing system improvements; and includes outcome measures to indicate the effectiveness of system improvements in reducing, controlling or eliminating identified problem areas. The action plan must specifically address responsibility for implementation and oversight, time frames for implementation, and the strategy for measuring the effectiveness of the actions.

- The Joint Commission recommended "A Framework for a Root Cause Analysis and Action Plan in Response to a Sentinel Event" format may be used. See attached.

- Results of the entire Root Cause Analysis will be presented to the Governing Body for evaluation.

Communication of Action Plans and Root Cause Analysis

- Action Plans related to a Root Cause Analysis will be shared with the entire staff upon Completion by the QAPI Committee. Possible recommendations to update or change policy and procedures may be presented to the staff, management and Governing Body to improve patient safety.

- Staff will educate patients and their families about their role in helping to facilitate the safe delivery of care. There will be a random record review verifying compliance with this educational process.

- Root Cause Analysis and Action Plans will be made available to the state health department representatives during onsite reviews.

Reporting Obligations

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

Patient Safety Program Staff Education/Training

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

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- Medical errors result from multiple factors. Flawed systems or processed can combine with active failures by caregivers in the clinical setting to produce accidents and errors. Some contributing factors are:
    - Inadequate communication among team members
    - Incomplete review of patient health records and diagnostic studies
    - Traditional hierarchical and autocratic cultures
    - Patient - related decisions made only by physicians
    - Unclear instructions
    - Confusing packaging of medications and supplies
    - Time pressures and constraints, Multi-tasking
    - Failure to include the patient and family members in assessment and decision- making.

- Staff will be trained in error reduction, which requires the commitment of all members of the health care team. Besides correcting the identified factors above, the following individual and facility changes will be focused on:
    - Reduce reliance on memory by using checklists and protocols.
    - Standardize processes as much as possible for procedures and other activities.
    - Focus on the safety aspects of products during the selection and evaluation
    - process.
    - Promote safety related clinical competency.
    - Educate employees about the potential for errors and how to avoid them.
    - Creating a "Culture of Safety" whereby there is a change of environment from blaming individuals for errors to one in which errors are treated as opportunities to improve systems. This is accomplished by:
        - establishing a sense of trust among team members;
        - dissemination and verifying receipt of information to all levels of staff and management;
        - developing and supporting a proactive approach rather than a reactive approach;
        - making a sincere commitment to affirming safety as the first priority.

- Quarterly Patient Safety Program meetings will be incorporated into the QAPI Program and conducted to review any incident occurrence reports and review any new patient safety recommendations or alerts.

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Approval of Patient Safety Plan

According to NRS 439.865, a medical facility shall submit its patient safety plan to the governing board of the facility for approval. After a facility's patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan.

The 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.

Reference

- Root Cause Analysis Toolkit http://www.health.state.mn.us/patientsafety/toolkit/
- Quality and Service Improvement Tools http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html
- CQI 101 An Introduction to Continuous Quality Improvement: https://www.coursehero.com/file/13827355/CQI-Overviewppt/
- Quality Improvement http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/
- Root Cause Analysis http://www.patientsafety.va.gov/professionals/onthejob/rca.asp
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2 https://www.jointcommission.org/sentinel_event.aspx
- Hospital Policies https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1
- Checklists to Improve Patient Safety http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf
- Patient Safety Checklists http://www.who.int/patientsafety/implementation/checklists/en/
- Minutes of the Meeting of the Quality and Patient Safety Committee http://www.cookcountyhhs.org/wp-content/uploads/2013/12/09-23-14-QPS-scan-Minutes.pdf
- Title 40 – Public Health and Safety https://www.leg.state.nv.us/NRS/NRS-439.html

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Appendix A: Checklist Example: Injuries from Falls and Immobility

Process Change	In Place	Not Done	Will Adopt	Notes (Responsible & By When?)
Conduct fall and injury risk assessment upon admission				
Reassess risk daily and with changes in patient condition				
Implement patient-specific intervention to prevent falls and injury				
Communicate risk across the team; use handoff forms, visual cues, huddles				
Round every 1 to 2 hours for high-risk patients; address needs (e.g., 3Ps: pain, potty, position-pressure). Combine with other tasks (vital signs)				
Individualize interventions. Use non-skid floor mats, hip protectors, individualized toileting schedule; adjust frequency of rounds				
Review medications (by pharmacist); avoid unnecessary hypnotics, sedatives				
Incorporate multidisciplinary input for falls				
Prevention from PT, OT, MD, RN and PharmD				
Include patients, families and caregivers in efforts to prevent falls. Educate regarding fall prevention measures; stay with patient				
Hold post-fall huddles immediately after event; analyze how and why; implement change to prevent other falls				

Reference: Checklists to Improve Patient Safety. June 2013. Health Research & Educational Trust

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Appendix B: Root Cause Analysis and Action Plan

Level of Analysis		Questions	Findings	Root Cause?	Ask Why?	Take Action?
What happened?	Sentinel Event	What are the details of the event? (Brief Description)				
		When did the event occur? (Date, day of week, time)				
		What area/service was impacted?				
Why did it happen?	The process or activity in which the event occurred.	What were the steps in the process, as designed? (A flow diagram may be helpful here)				
What were the proximate factors? (typically "special cause" variation)		What steps were involved in (contributed to) the event?				
	Human factors	What human factors were relevant to the outcome?				
	Equipment factors	How did the equipment performance affect the outcome?				
	Controllable environmental factors	What factors directly affected the outcome?				
	Uncontrollable external factors	Are they truly beyond the organization's control?				
	Other	Are there any other factors that have directly influences this outcome?				
		What other areas of services are impacted?				

The following template is provided as an aid in organizing the steps in a root cause analysis. Not all possibilities and questions will apply in every case and there may be others that will emerge in the course of the analysis. However, all possibilities and questions should be fully considered in your quest for “root cause” and risk reduction.

As an aid to avoiding “loose ends” the three columns on the right are provided to be checked off for later reference.

- **“Root Cause?”** - should be answered “yes” or “no” for each finding. A root cause is typically a finding related to a process or system that has a potential for redesign to reduce risk. If a particular finding that if relevant to the event is not a root cause, be sure that is addressed later in the analysis with a “why?” question. Each finding that is identified as a root cause should be considered for an action and addressed in the action plan.

- **“Ask Why?”** - should be checked off whenever it is reasonable to ask why the particular finding occurred (or didn’t occur when it should have (in other words, to drill down further). Each item checked in this column should be addressed in the analysis with a “Why?” question. If it is expected that any significant finding that are not identified as root causes themselves have “roots.”

- **“Take Action?”** - should be checked for any finding that can reasonably be considered for a risk reduction strategy. Each item checked in this column should be addressed later in the action plan. It will be helpful to write down the number of the associated Action item on page 3 in the “Take Action?” column for each of the findings that requires action.

Level of Analysis		Questions	Findings	Root Cause?	Ask Why?	Take Action?
What happened? **Why did that happen? What systems and processes underlie those proximate factors?** (common cause variation here may lead to special cause variation in dependent processes)	**Human Resources Issues.**	To what degree is staff properly qualified and currently competent for their responsibilities?				
		How did actual staffing compare with ideal levels?				
		What are the plans for dealing with contingencies that would tend to reduce effective staffing levels?				
		To what degree is staff performance in the operating process (es) addressed?				
		How can orientation and in-service training be improved?				

Level of Analysis		Questions	Findings	Root Cause?	Ask Why?	Take Action?
	Information management issues.	To what degree is all necessary information available when needed? Accurate? Complete? Unambiguous?				
		To what degree is communication among participants adequate?				
	Environmental management issues.	To what degree was the physical environment appropriate for the processes being carried out?				
		What systems are in place to identify environmental risks?				
		What emergency and failure-mode responses have been planned and tested?				
	Leadership issues: -corporate culture	To what degree is the culture conductive to risk identification and reduction?				
	-encouragement communication	What are the barriers to communication of potential risk factors?				
	- clear communication of priorities	To what degree is the prevention of adverse outcome communicated as a high priority?				
	- uncontrollable factors	What can be done to protect against the effects of these uncontrollable factors?				

Action Plan	Risk Reduction Strategies	Measures of Effectiveness
For each of the findings identified in the analysis as reading an action, indicate the planned action expected, implementation data and associated measure of effectiveness **OR** -If after consideration of such a finding a description is made not to implement as associated risk reduction strategy, indicate the rationale for not taking action at this time. -Check to be sure that the selected measure will provide data that will permit assessment of the effectiveness of the action. -Consider whether pilot testing of a planned improvement should be conducted. -Improvements to reduce risk should ultimately be implemented in all areas where applicable, not just where the event occurred. Identify where the improvements will be implemented.	**ACTION ITEM #1**	
	ACTION ITEM #2	
	ACTION ITEM #3	
	ACTION ITEM #4	
	ACTION ITEM #5	
	ACTION ITEM #6	
	ACTION ITEM #7	
	ACTION ITEM #8	
Cite any books or journal articles that were considered in developing this analysis and action plans:		