HACKETTSTOWN REGIONAL MEDICAL CENTER
Administrative Policy and Procedure

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TITLE: PATIENT SAFETY PLAN

I. PURPOSE

To outline the structure of the Patient Safety Program which creates a culture that values safety, disclosure of errors, and process improvement. The program supports a non-punitive environment that encourages the reporting of medical errors and the use of quality and system analysis to design processes to prevent medical errors from occurring. Data analysis is integrated into an annual evaluation, risk assessment, and goals and objectives which are communicated organization-wide to improve patient safety.

II. DEFINITIONS

Adverse Event – An event that is a negative consequence of care that results in unintended injury or illness, which may or may not have been preventable.

Close Call (formerly Near Miss) – An occurrence that could have resulted in an adverse event but was prevented.

Error – An unintended act, either of omission or commission or an act that does not achieve its intended outcome

Event – A discrete, auditable and clearly defined occurrence.

Incident – Any identified defect, error, medical accident, sentinel event, medication error, significant procedural variance, or other threat to safety that could result in patient injury; an unintended event in the system of care with actual or potentially negative consequences to the patient.

Patient Safety – Freedom from accidental illness or injury while receiving healthcare services.

Preventable Event – An event that could have been anticipated and prepared against but occurs because of an error or other system failure.

Root Cause Analysis – A process for identifying the basic or causal factors that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event.

Sentinel Event – An unexpected occurrence involving death or serious physical or psychological injury or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or risk thereof" includes any process variation for which a recurrence carries a significant chance of serious adverse outcome.

Serious Preventable Event (SPAE) – An adverse event that is a preventable event and results in death or loss of body part or disability or loss of bodily function lasting more than seven days or still prevent at time of discharge from a healthcare facility.

III. SCOPE

The Patient Safety Program is a hospital-wide program and applies to all departments and services of Hackettstown Regional Medical Center (HRMC). The events to be addressed include all patient occurrences, ranging from "no-harm" to "near misses" to sentinel events. All serious preventable adverse events will be reported to the New Jersey Department of Health and Senior Services (DHSS) as outlined in the "Patient Safety Act," P.L. 2004, Chapter 9. The program also proactively addresses external issues (i.e., National Patient Safety Goals and issues identified in Sentinel Event Alerts) to prevent them from occurring in this facility.

IV. RESPONSIBILITY

A. Governing Board – The authority for the Patient Safety Program rests with the Governing Board (The Board). The Board delegates the authority to implement and maintain the activities described herein to the President/CEO of the hospital.

B. President/CEO – The President/CEO of HRMC through management and administrative staff, supports ongoing efforts to identify patient safety risks and reduce the likelihood of injury. The President/CEO of the hospital appoints the Chief Nursing Officer and the Risk Management Coordinator as co-chairs of the Patient Safety Committee which has oversight of the organization-wide Patient Safety Program. The Risk Management Coordinator is the hospital's Patient Safety Officer.

C. Administrative Directors & Managers – All Administrative Directors and Managers are responsible for correction of working conditions, processes, and procedures that increase the likelihood of patient harm; for ensuring that employees under their direction receive relevant information and education concerning the Patient Safety Program; for ensuring prompt reporting of events or situations of actual or potential patient harm; and for promoting a climate of non-punitive error reporting and continuous patient safety improvement.

D. Patient Safety Committee – This committee is a stand alone committee that oversees the activities of the Patient Safety Program. Membership includes the Chief Nursing Officer, Chief Medical Officer, Director of Performance Improvement, Director of Nursing, Pharmacy Director, Education Manager, Risk Management Coordinator, Safety Officer, and other members as needed. The Patient Safety Committee meets no less than six (6) times each year.

Duties of the Patient Safety Committee:

a. Developing a Patient Safety Plan.
b. Timely Reporting of Serious Preventable Adverse Events (SPAE) to New Jersey Health & Senior Services Department.
c. Developing measures to minimize preventable adverse events and reviewing evidenced based patient safety practices to enhance patient safety.
d. Developing an internal tracking system of close calls and adverse events and quarterly analysis of the data to detect trends.
e. Developing and implementing a training program for all professionals and direct care staff to enable them to recognize close calls, adverse events and SPAEs.
f. Distribute information to employees regarding anonymous reporting of close

calls and adverse events.

g. Assembling a team to conduct a root cause analysis (RCA) of every SPAE and on an annual basis conduct an RCA of a preventable event or close call not subject to mandatory reporting.
h. Recommending appropriate modifications to the facility's systems, technologies or policies/procedures based on the RCA.
i. Documenting whether the facility accepted/rejected or modified the committee's recommendations including the rationale.
j. Monitoring policies/procedures to determine their impact on preventable adverse events.

V. REPORTING OF PATIENT SAFETY EVENTS

A. Non-Punitive Reporting Policy

The hospital recognizes that if we are to succeed in creating a safe environment for our patients, we must create an environment in which it is safe for caregivers to report and learn from errors. The hospital will promote openness and require that mistakes be reported, while insuring that reported mistakes will be handled without a threat of punitive action.

1. The hospital recognizes that most clinical incidents are due to a failure of systems. Our goal is to identify and track issues and errors in order to continuously improve the system.

2. All incidents, particularly clinical errors, must be reported in a timely manner according to the Incident Reporting Policy. Employees will not be punished for reporting errors. This will not, however, negate the initiation of additional education and training for that individual, if warranted. This policy will not protect individuals who consistently fail to participate in detection, reporting and remedies to prevent errors, nor will it protect individuals who are reckless in care administration (identified by ongoing trends). It will not protect individuals when there is reason to believe criminal activity or criminal intent may be involved.

3. The hospital will strive to establish a culture that actively supports and encourages the reporting of errors and near-misses (i.e., the "Great Catch" awards for employees that identify a safety issue and resolve it before it reaches the patient). Employees who knowingly fail to report a clinical error are subject to disciplinary action in accordance with existing hospital policies.

B. Internal Tracking System

1. Employees and professional staff members are required to report any incident, adverse event, close call, significant procedural variance, or other risk to safety that could result in patient injury, hazardous conditions, or risk in the environment of care.

2. An Incident Report will be completed and submitted to the Risk Management Coordinator in accordance with the policy on Incident Reporting. The Department Manager will assure completion of the Incident Report. Any Manager receiving a report of a possible Sentinel Event or Near-miss, SPAE or close

call will assure prompt notification of the of the Risk Management Coordinator and/or Administrator-On-Call to determine the status of the event.

C. Reporting of Serious Reportable Adverse Event (SPAE) to the NJDHSS

1. The Risk Management Coordinator is the individual responsible for timely reporting of all SPAEs to the NJDHSS.
2. In the absence of the Risk Management Coordinator, the Administrative Coordinator will advise the Administrator-On-Call of the event.
3. See Reportable Events Policy AD96 for procedure.

D. Root Cause Analysis

1. The Patient Safety Committee and the key individuals involved in the event will conduct a root cause analysis on all SPAEs reported to the NJDHSS and annually on a close call or preventable adverse event not subject to mandatory reporting.

VI. ACTION TO ENSURE PATIENT SAFETY

A. The employee(s), professional staff and manager(s) involved in an event/accident will take immediate action to ensure safety of the patient, staff and others in the environment.

B. Preservation of all items involved in the incident will be undertaken. If an immediate procedural change is determined to be necessary, the involved manager(s) and professional staff members will work with the Risk Management Coordinator and the Administrator-On-Call to communicate a safety alert and make any immediate changes that might be required.

VIII. SUPPORT FOR THE PATIENT, FAMILY AND CAREGIVER

When an event has occurred with significant consequences for the patient, appropriate support from within the hospital should be mobilized in a coordinated fashion to assist the patient, family and the caregiver. Support may include but not be limited to Pastoral Care, Social Services and Patient Relations.

A. Disclosure of Event to Patient/Family

1. When an adverse event occurs or when an outcome differs significantly from the anticipated outcome, the patient (and when appropriate, family) should be informed. This should occur as soon as reasonably possible. See Disclosure Policy AD41.

B. Data Collection and Risk Assessment

The goal of data collection and risk assessment is to determine error frequency and type to reduce the likelihood of patient incidents or negative experiences with the potential for injury, illness, accident or other loss to patient.

C. Data Sources (including but not limited to):

<u>Internal:</u>
Incident Reports and Database Information
Medication Use and Adverse Drug Reactions (ADRs)

Data from the Patient Complaint/Issue database
Risk Management and Safety findings
Compliance findings
PI and special study findings
Infection Control information
Case Reviews: Surgical Case, Blood Use, Autopsy, Restraint
Peer Review activities
Morbidity/Mortality Review findings
Departmental PI/Service indicators

External:
Joint Commission Sentinel Event Alerts
National Patient Safety Goals
Quality Improvement Organization Initiatives/Core Measures
Accreditation/regulatory deficiencies
Professional Liability Carrier recommendations and alerts
NJ Department of Health & Senior Services

D. Measure (Data Evaluation)

Evaluation of collected data will be undertaken to identify levels of performance, trends, or patterns that vary significantly from what is expected, possibly requiring a change in systems or processes.

E. Assess and Improve

1. When undesirable variations are identified, the hospital will involve those individuals, disciplines, and departments/services closest to the process in assessment and improvement initiatives.

2. The hospital has adopted the PDCA methodology for problem solving:
Plan – Do – Check – Act

3. Applicable quality tools and techniques will be utilized during this process.

F. Proactive Risk Review

1. HRMC proactively evaluates its current practices to ensure incorporation of best practices established through external data sources such as Joint Commission's National Patient Safety Goals and Sentinel Event Alerts.

2. Data analysis provides information for both the annual Risk Assessment and subsequent Goals and Objectives.

IX. EDUCATION & COMMUNICATION

A. The Patient Safety Committee will develop a training program for all employees and medical staff on recognizing and reporting SPAEs, adverse events, close calls and the process for filing anonymous reports to the NJDHSS of close calls and preventable events that are not reportable. New employees and medical staff will be trained during orientation.

B. The organization will disseminate the annual Patient Safety Goals & Objectives and internally and externally generated data and information to healthcare workers to insure that the lessons learned are communicated and utilized to reduce the risk of error.

C. Information on the Patient Safety Program will be provided in New Employee Orientation.

X. ONGOING AND ANNUAL PROGRAM REVIEW

A. A report on medical/healthcare errors identified and actions taken to improve patient safety will be submitted quarterly to the Performance Improvement Steering Committee, Professional Practice Committee of the Governing Board, and Governing Board.

B. The following documents will be provided annually for review and approval by the Performance Improvement Steering Committee, Professional Practice Committee of the Governing Board and the Governing Board:

The Patient Safety Plan (AD86)
Annual Evaluation of Patient Safety Program
Annual Patient Safety Risk Assessment
Annual Goals and Objectives of Patient Safety Program

REFERENCES:
Reportable Events – AD96
Incident Reporting – AD64
Disclosure – AD41