Baptist Health South Florida

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Administrative

POLICY TITLE: Patient Safety Plan

Responsible Department: Risk Management / Patient Safety

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SUMMARY & PURPOSE:
The purpose of the Patient Safety Plan at Baptist Health South Florida is to provide a framework for proactively identifying the potential and actual risks to safety, identifying the underlying cause(s) of the potential or actual risk, and making the necessary improvements to reduce risk. This is accomplished through an environment that encourages:

- Focus on processes and systems
- Recognize and acknowledge the risks to patient safety and healthcare errors
- Initiate actions to reduce risks
- Communicate within the organization and across the health system of what has been found and the actions taken
- Participate in external reporting programs
- Minimize individual blame or retribution for involvement in a healthcare error
- Provide organizational learning about cause and prevention of healthcare errors within the organization and across the health system
- Share knowledge to effect behavioral changes
- Involve multiple departments and disciplines in establishing the plans, processes and mechanisms which comprise the patient safety activities

POLICY:
Our first obligation as a health care provider is to "do no harm." Patient Safety is defined as freedom from accidental or unintended injury; ensuring patient safety involves the establishment of operational systems and processes that minimize the likelihood of error and maximize the likelihood of intercepting them when they occur.

Baptist Health South Florida uses a systematic, coordinated and continuous approach to the maintenance and improvement of patient safety and to ensure compliance with patient safety-related regulatory directives.

Patient safety is a critical and fundamental aspect of the quality of medical care and services and is a key responsibility of leadership, whose role it is to ensure that safety is maintained and improved through direct, purposeful efforts of or by the entire organization. Leadership is responsible to proactively explore potential system failures, to analyze and take action on problems that have occurred and to encourage the reporting of incidents/adverse events and near misses. The leaders are responsible for fostering such an environment through their personal example and by supporting effective responses to actual occurrences of unanticipated adverse events; ongoing proactive reduction of safety risks to patients; and integration of safety priorities into the design and redesign of all relevant organization processes, functions, and services.

SCOPE/APPLICABILITY:
There are no exemptions to this policy.

PROCEDURES TO ENSURE COMPLIANCE:

1. The scope of the Patient Safety Plan includes an ongoing assessment, using internal and external knowledge and experience, to prevent error occurrence, maintain and improve patient safety. Patient safety incident information (Patient Safety Work Product) from aggregate data reports will be reviewed to prioritize organizational patient safety goals.

2. Types of patient safety or medical errors included in analysis are:
   a. Incident - any occurrence, accident, or event that is not anticipated and has the potential to result in injury, or has caused injury or that is not consistent with the routine care of the patient, or the routine operations of the facility.

   b. Adverse Event – An event over which healthcare personnel could exercise control and which is associated in whole or in part with medical intervention, rather than the condition for which such intervention occurred

   c. Error - An unintended act, either of omission or commission, or an act that may or may not achieve its intended outcome.

   d. Code 15 – An adverse event reported to the Agency for Health Care Administration via a Code 15 Report as required by FS 395.

      i. The death of patient;
      ii. Brain or spinal damage;
      iii. The performance of a surgical procedure on the wrong patient;
      iv. The performance of a wrong-site procedure;
      v. The performance of a wrong surgical procedure;
      vi. The performance of a surgical procedure that is medically unnecessary or otherwise unrelated to the patient's diagnosis or medical condition;
      vii. The surgical repair of damage resulting from planned surgical procedure where the damage is not a recognized specific risk as disclosed to the patient and documented through the informed consent process, or;
      viii. The performance of procedures to remove unplanned foreign objects remaining from surgical procedure.

e. A *"sentinel event"* is 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 following is a subset of sentinel events that are subject to review by The Joint Commission:

i. 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,

or

ii. Suicide of any individual receiving care in a staffed around-the-clock care setting or within 72 hours of discharge
iii. Unanticipated death of a full-term infant
iv. Abduction of any patient receiving care, treatment, and services
v. Discharge of an infant to the wrong family;
vi. Rape, assault (leading to death or permanent loss of function), or homicide of any patient receiving care, treatment, and services
vii. Rape, assault (leading to death or permanent loss of function), or homicide of a staff member receiving care, treatment, and services
viii. Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities (ABO, Rh, other blood groups)
ix. Invasive procedure, including surgery, on the wrong patient or wrong site or wrong procedure
x. Unintended retention of a foreign object in a patient after surgery or other invasive procedure
xi. Severe neonatal hyperbilirubinemia (bilirubin >30 milligrams/deciliter)
xii. Prolonged fluoroscopy with cumulative dose >1500 rads to a single field, or any delivery of radiotherapy to the wrong body region or >25% above the planned radiotherapy dose;

f. Near Miss – An event or situation that has the potential to cause an adverse event, but fails to do so by chance or because it was intercepted

g. Medication Incident – A medication incident may be identified as any preventable event involving a pharmaceutical that may or may not lead to the inappropriate dispensation or administration of a medication by a healthcare professional.

h. 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 adverse outcome, i.e.:

i. Use of Restraints
ii. Pain Management – PCA, epidurals, narcotic drips
iii. Falls
iv. Moderate Sedation
v. Blood and Blood Products
vi. Critical Values
vii. Communication

3. The scope of the Patient Safety Plan encompasses the patient, family, friends, volunteers, vendors, employees, and medical staff. The Plan addresses maintenance and improvement in patient safety issues in every department throughout the facility. There will be an emphasis on important patient-focused functions and organization functions, such as:

a. Ethics, Rights and Responsibilities
b. Provision of Care, Treatment and Services

c. Medication Management
d. Surveillance, Prevention and Control of Infection
e. Improving Organization Performance
f. Leadership
g. Management of the Environment of Care
h. Management of Human Resources
i. Management of Information

4. Processes, systems, or structures in a health care organization that can significantly impact the provision of safe, high-quality care and can create great risk for negative outcomes should the processes, systems, or structures not function properly. The Priority Focus Areas (PFA) are as follows:

   a. Assessment and Care/Services
   b. Communication
   c. Credentialed and Privileged Practitioners
   d. Equipment Use
   e. Infection Control
   f. Information Management
   g. Medication Management
   h. Organization Structure
   i. Orientation and Training
   j. Rights and Ethics
   k. Physical Environment
   l. Quality Improvement
   m. Patient Safety
   n. Staffing

5. Priority setting is sensitive to emerging needs such as those identified through patient safety work product; data collection and assessment, unanticipated adverse occurrences, changing regulatory requirements, significant patient and staff needs, changes in the environment of care, or changes in the community.

   The planning process for establishing priority performance improvement activities regarding patient/ environmental safety shall give priority consideration to:

   a. Processes that affect a large percentage of patients
   b. Processes that place patients at risk if not performed well or if performed when not indicated
   c. Processes that have been or are likely to be problem-prone

6. Patient Safety Work Product - Data Sources and Analysis
   a. Incident Reports: All incident reports are reviewed by the Risk Management department for adverse outcomes to facilitate timely reporting to the Agency for Health Care Administration. Based upon internal and external data analysis and prioritizing of patient safety criticality, a determination will be made regarding level of analysis in response to the unanticipated outcomes.

   b. The leaders support the various mechanisms to measure, analyze, and manage variation in the performance of defined processes that affect patient safety. Inconsistency in the performance of processes, as intended by their design and described in the organization's policies and procedures, frequently leads to unanticipated and undesired results. In order to minimize risk to patients due to such variation, the leaders ensure that the performance of processes indentified as error-prone or high-risk regarding patient safety is measured and analyzed, and when significant variation is identified, appropriate corrective actions are taken to enhance the system(s). Aggregation of data is the responsibility of the workgroup/taskforce or committee.

c. Proactive Risk Assessment: The proactive component of the program includes an annual selection of at least one high-risk or error-prone process for concentrated activity, ongoing measurement and periodic analysis. The selection may be based on information published by The Joint Commission sentinel Event Alerts, and/or other sources of information including risk management, performance improvement, quality management, infection control, research, patient/family suggestions/expectations or process outcomes.

d. Failure Mode and Effects Criticality Analysis (FMECA): A procedure by which each potential failure mode in a system is analyzed to determine the results or effects thereof on the system. And to classify each potential failure mode according to its severity. The criticality score is the indicator to determine prioritization. The higher score indicates the top priority. The process will be redesigned to minimize the risk of failure modes through the incorporation of patient safety principles. The redesigned process will be tested and implemented. Measures to determine effectiveness of the redesigned process will be identified and implemented. Strategies to achieve and maintain success overtime will be identified and implemented as necessary.

e. Other data sources
   i. TJC Sentinel Event Alerts
   ii. Complaints
   iii. Infection Control
   iv. Employee engagement survey
   v. Patient satisfaction survey
   vi. Patient safety literature
   vii. Patient Safety Score Card
   viii. National Quality Measures
   ix. BHSF Patient Safety Partnership
   x. Regulatory agencies, e.g., TJC, AHCA, DOH, CMS, professional licensing boards
   xi. National organizations associated with safety standards, e.g., National Quality Forum (NQF), Institute for Safe Medication Practices (ISMP), Institute of Healthcare Improvement)IHI). National Patient Safety Found (NPSF)

7. Baptist Health's patient safety organization; Patient Safety Partnership, goal is to improve the quality and safety of health care delivery. It provides a framework by which all entities of Baptist Health will report patient safety work product, on a privileged and confidential basis, for the aggregation and analysis of patient safety events. The primary goal of this reporting is to improve patient safety and to reduce the incidence of events that adversely effect patient safety.

   a. Patient safety work product (PSWP) is all data collected through the various activities previously identified, included but not limited to; incident reporting, various monitoring and measurement activities related to patient safety, analysis conducted via RCA, FMECA, complaints and grievances, survey data, etc.

   b. PSWP will be submitted to the Patient Safety Evaluation System of each entity for review and submission to the Patient Safety Partnership.

   c. The Patient Safety Partnership will serve in the following activities:
      i. To collect and analyze PSWP
      ii. To develop and dissemination information regarding patient safety, such as recommendations, protocols, or information regarding best practices
      iii. To utilize PSWP for the purposes of encouraging a culture of safety and providing feedback and assistance to effectively minimize patient risk
      iv. To secure and preserve confidentiality with respect to PSWP

8. Non-Punitive Reporting Philosophy and Just Culture: An effective patient safety program relies upon full reporting of errors and unusual occurrences. Baptist Health facilities will support and encourage its employee's efforts to improve clinical processes through incident reporting. We recognize that errors most often occur due to breakdown in systems and processes, and our primary focus is on improving processes that can lead to medical errors. Therefore, all personnel are required to report errors, unusual occurrences as well as "near misses" and should do so without fear of discipline or negative impact upon their employment. However, certain situations may result in disciplinary action. These include:

    a. Hiding errors
    b. Illegal activities
    c. Drug diversion,
    d. Intentional wrongdoing,
    e. Gross or repeated negligence,
    f. Patient abuse or neglect, and/or
    g. Events that by their nature are required to be reported to government or licensure agencies

9. Staff Education/Support
    a. An introduction to Patient Safety is given to all employees during general hospital orientation. This includes the need and method to report near misses or medical/health care errors.
    b. Unit specific orientation continues staff education. Staff are educated and trained on the interdisciplinary approach to patient care and teamwork.
    c. Patient safety concepts are included in ongoing annual safety training.
    d. As this organization supports the concept that errors occur due to a breakdown in systems and processes, staff involved in an event with an adverse outcome will be supported through:
        i. A non-punitive approach and without fear of reprisal
        ii. Participation in the root cause analysis for greater understanding of processes, work-around avoidance, education and prevention
        iii. Provision of Pastoral Care, Social Work or Employee Assistance Program should the need arise
    e. On a biannual basis, staff will be queried regarding their willingness to report medical/health care errors.

10. Patient Safety Champions

    A Patient Safety Champion is a staff level resource person whose role involves sharing information and tips on patient safety goals and practices with co-workers.
    a. The Role of Patient Safety Champions:
        i. To make patient safety a monthly items at staff meetings
        ii. Discusses patient safety goals , new safety procedure or new literature regarding patient safety
        iii. Post materials in work area/bulletin boards
        iv. Takes time to praise a fellow employee for doing the right thing to protect patient safety
        v. Confidentially reminds other employees of safety practices (hand washing, use of personal protective equipment, answering alarms, etc)
        vi. Is available to answer questions on the National Patient Safety Goals

11. Patient Education
    a. Staff educates patients and their families about their role in helping to facilitate the safe delivery of care. At the time of admission patients are given a patient safety brochure which highlights safety strategies for avoidance of falls, medication errors and how to call for a rapid response team; Code Help.
    b. Patients and when appropriate, their families, are informed about outcomes of care including unanticipated outcomes (unusual occurrences), or when outcomes differ significantly from the anticipated outcomes.

12. Patient Safety Reporting Framework

Patient safety data and/or information is reported, reviewed and discussed at the entity Patient Safety Committee. Information is provided in written summaries or verbal reports to and between leadership and staff. Patient safety information is reported up to the entity governing board, the entity Safety (EOC) Committee, the entity Performance Improvement Council and the BHSF Quality and Patient Safety Steering Council as appropriate. This reporting framework provides for the flow of information horizontally and vertically.

13. The Patient Safety Plan is evaluated annually by the patient safety committee members.

14. At least once a year, the leaders provide the governing board with written reports on the following:

    a. All system and process failures
    b. The number and type of sentinel events
    c. Whether the patients and the families were informed of the event
    d. All actions taken to improve safety, both proactively and in response to actual occurrence
    e. The determined number of distinct improvement projects to be conducted annually
    f. All results of the analyses related to the adequacy of staffing

SUPPORTING/REFERENCE DOCUMENTATION:

- The Joint Commission: National Patient Safety Goals
- The Joint Commission: Sentinel Event Policy
- Florida Statute 395.0197
- The Patient Safety and Quality Improvement Act of 2005
- TJC Leadership chapter LD.04.04.05 EP13
- TJC Performance Improvement chapter PI.02.01.01 EP14

RELATED POLICIES, PROCEDURES, AND ASSOCIATED FORMS:

- BHSF Administrative Policy: 1402 Incident Reporting – Risk Management / Patient Safety
- BHSF Administrative Policy:1401 Disclosure of Unanticipated Outcomes – Risk Management / Patient Safety
- BHSF Administrative Policy: Sentinel Event Policy – Risk Management / Patient Safety

ENFORCEMENT & SANCTIONS:

"Violations of this policy may lead to revocation of system privileges and/or disciplinary action including termination. Anyone willfully violating this policy will be subject to disciplinary action up to and including termination."