

<b>The Miriam Hospital Administrative Manual</b>	<b>Subject: Patient Safety Policy</b>	<b>File Under: Medical Staff MS-09 and A-20</b>
<b>Issuing Department: Quality Management</b>		<b>Latest Revision Date: 2/13/02</b>
<b>Original Procedure Date:  2/01/01</b>	<b>Page  1-8</b>	<b>Approved By:</b>  _____ Director  _____ Executive

## POLICY

The Miriam Hospital and its Medical and Dental Staff are committed to deliver patient care that is optimal and consistent with generally recognized standards of practice and anticipated outcomes. This is monitored through an integrated Patient Safety Committee which is patient oriented and is a combined hospital and medical staff function. The benefit of an integrated program is that this relationship facilitates the communication, coordination and management of patient safety information within the hospital and maximizes the capability to monitor and make improvements in the delivery of services provided to our customers.

### **I. PURPOSE AND DESIGN**

The objective of the Patient Safety Committee is to provide a planned, ongoing, comprehensive, coordinated and integrated Hospital-wide mechanism to objectively and systematically monitor and evaluate the safety of patient care, promptly identify and resolve problems, plan education to improve patient safety and to reduce medical errors throughout the organization. The essential elements of the program include:

- The integrated Patient Safety Committee, supported by the President, Governing Body, have the authority to recommend changes and take necessary actions in order to make improvements to patient care services provided.
- Responsibility for Patient Safety activities are shared by the Medical Staff Departments, Patient Care Services, the Clinical Support Services and all other hospital departments.
- Department Chiefs, Directors and Managers of all hospital departments are responsible for the ongoing education, monitoring, and evaluation in preventing, detecting and correcting medical errors within their departments.
- There is a comprehensive and planned system for ongoing education, collection and/or evaluation of information about important patient safety issues care within each department.

- The information collected addresses the requirements of the applicable federal and state laws rules and regulations and JCAHO requirements for a Patient Safety Program.
- Undesirable patterns or trends in performance and sentinel events are intensively analyzed as part of the Patient Safety initiative.
- Appropriate actions are taken to resolve identified problems and/or identified opportunities to improve patient care and non-clinical services rendered.
- The information derived from each department's monitoring, evaluation and improvement activities is shared with other departments as deemed necessary by the Department Chief, Director, or Manager, and is integrated with information obtained from other hospital-wide patient safety activities as appropriate.
- The Patient Safety program is reviewed annually to assure the program's objectives are attained and that improvements to patient care and service delivery is made.

## II. DEFINITIONS

The following definitions are uniformly used in the hospital's Incident Report, Sentinel Event and other relevant environment of care and medication use policies.

1. **Sentinel Event-** unexpected incident involving death or serious physical or psychological injury, or the risk thereof. The phrase "the risk thereof " includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. The fundamental objective of sentinel event reporting is corrective in nature and the identification of appropriate actions to prevent recurrence.
2. **Near Miss-** used to describe any variation, which did not effect the outcome, but for which a recurrence carries a significant chance of a serious outcome. A near miss falls under the scope of a sentinel event but outside of those sentinel events subject to review by JCAHO under its sentinel event policy. Near misses are managed according to the incident report policy.
3. **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. Examples of hazardous conditions include floods, equipment failures, pests, infestations, and power outages.
4. **Adverse Drug Reaction-** any undesirable or unexpected medication related event that requires discontinuing a medication or modifying the dose, requires or prolongs hospitalization, results in disability, requires supportive treatment, is life threatening or results in death, results in congenital anomalies, or occurs following vaccination.

5. **Medication Error-** any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in control of the health care professional, patient or consumer. Such events may be related to professional practice, health care products, procedures and systems, including prescribing; order communication; product labeling; packaging, and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use.
6. **Root Cause Analysis-** A process for identifying the basic or causal factor(s) that underlies variation and performance, including the occurrence or possible occurrence of a sentinel event.
7. **Intense (Failure Mode) Analysis-** same process as root cause analysis but is used to analyze potential system failures, near misses, prevented errors.
8. **Unexpected Event-** any situation that is not consistent with the routine operation of the affiliate or routine care and safety of a patient. All events identified should be reported following the Patient Incident Report Policy utilizing the patient incident report.
9. **Unanticipated Outcome-** a result that “differs significantly” from what was anticipated to be the result of a treatment or procedure

### III. ORGANIZATIONAL ROLES AND RESPONSIBILITIES

#### Role of Governing body

The Governing Body via The Miriam Hospital Board of Trustees are committed to maintain, support and oversee a comprehensive, coordinated and integrated Hospital-Patient Safety Program as part of its responsibility to ensure the Hospital plans and delivers quality patient care and services, which are consistent with available resources and the hospital’s corporate values of respect, honesty and fairness and constant pursuit of quality. The Hospital Board of Trustees delegates the authority to oversee the activities of the Patient Safety Program to the Quality Council, although the full Board receives copies of the Annual Patient Safety Summary Report after they are reviewed by the Quality Council. The Quality Council, Patient Safety Committee, and the Quality Management and Risk Management Departments are responsible for providing direction to and coordinating the Hospital’s Patient Safety Program.

#### Role of Quality Council

The Quality Council delegates responsibility to the Patient Safety Committee to be responsible for overseeing all Patient safety activities.

## **Role of the Patient Safety Committee**

The Patient Safety Committee is a multidisciplinary Committee of The Miriam Hospital. The committee is responsible for the design, administration and review of the program for prevention, detection and correction of unexpected events resulting in improving patient safety and outcomes. Membership is cross-functional and includes representation from the medical staff, nursing, administrative leadership, and other departments such as quality, risk management, pharmacy and facilities management. Representatives of other departments are invited to meetings to address issues, policies or practices in their department. The Patient Safety Committee will provide a Summary Report quarterly to the Senior Management, to the Quality Council, and to the Medical Staff Executive Committee in accordance with the quarterly reporting schedule.

## **Roles and Responsibilities of Quality and Risk Management Departments**

- Direct and coordinate comprehensive and integrated Patient Safety activities.
- Provide educational resources and assistance with quality process and tools, root cause analysis, monitoring, evaluation and improvement activities and other reasonable support for patient safety efforts by staff, departments and committees of the hospital and medical staff.
- Establish an assessment and improvement reporting mechanism and serve as a repository for relevant data and Patient Safety Reports.
- Conduct investigations, studies and follow-up of patient safety activities as needed and analyze patterns of care and/or problems with the delivery of services to customers.
- Document evidence of corrective action(s) taken in response to identified problems under review or services targeted for improvement.
- Refer identified problems or opportunities for improvement to appropriate Department Chief, Director, Manager or Vice President and/or monitoring committees for follow-up and improvement.
- Prepare and submit summary reports to the Quality Council that summarize, review and evaluate results of ongoing patient safety activities.
- Develop communication channels with all internal and external customers, including but not limited to, patients, physicians, employees and visitors to ensure that all relevant information flows to the Risk and Quality Management Departments and the Patient Safety Committee regularly.

## **Role of the Medical Staff**

Some potential patient safety issues may be identified by nurse managers, case managers, the quality or risk management staff, or internal peer review activities and referred to the departmental chiefs, division directors or quality improvement

coordinators for their review and assessment. In addition, residents and attending physicians are expected to assist in problem identification and review.

### **Role of Hospital Departments and Services**

Each department, service and employee shares with the Hospital, the responsibility to ensure optimal achievable quality patient care and delivery of services within a safe hospital environment. All are required to support and participate in the Patient Safety Education Program. Each department manager is responsible for the implementation of departmental patient safety improvement initiatives.

## **IV. PROGRAM DESIGN**

Prevention, early identification, (detection) and correction of system problems that have the potential for an adverse patient outcome are an integral part of the Patient Safety Program. Issues needing an analysis are identified through JCAHO's definitions of high-risk issues, JCAHO Sentinel Event Alerts and through the reporting of prevented errors, near misses and incident reports. Analysis of these issues will assist in prioritizing resources for hospital system improvements and educational programs. Prevention and correction of Sentinel Events are handled as outlined in the Policy Regarding Analysis of Sentinel Events.

Cross Referenced Policies:

Policy Regarding Analysis of Sentinel Events

Incident Reports Patient and Visitors

Policy and Procedure for Reporting Events and Incidents to the Department of Health

The Miriam Hospital Risk Management Statement of Policy

Performance Improvement Plan

**PATIENT SAFETY ORGANIZATIONAL CHART**

