Rancho Los Amigos National Rehabilitation Center

ADMINISTRATIVE POLICY AND PROCEDURE

SUBJECT: PATIENT SAFETY PROGRAM PLAN

Policy No.: A126
Supersedes: February 29, 2016
Revised: April 11, 2019

I. PURPOSE:

A. To describe the scope of Patient Safety Program at Rancho Los Amigos National Rehabilitation Center (RLANRC).

B. To define "patient safety events" – during patient care processes, the failure of (1) a planned action to be executed as intended, (2) planning care timely, or (3) using a correct plan to achieve an aim are patient safety events. Patient safety events include but not limited to the events listed in "State of California Health and Safety Code Division 2, Licensing Provisions, Chapter 2. Health Facilities, Article 3, Regulations 1279.1" (Attachment A).

C. To guide compliance of RLANRC with current Patient Safety standards as required by Joint Commission National Patient Safety Goals, Health and Safety Code enforced by the California Department of Public Health General Acute Care Relicensing Survey, and other National and State Regulatory Agencies.

D. To recommend hospital leadership, managers and front line staff to demonstrate consistent efforts to evaluate, monitor, improve and document patient safety activities.

E. To advise on activities by which RLANRC can achieve its strategic goals in accordance with the Strategic Plan for Safety and Quality of RLANRC and the Department of Health Services (DHS), County of Los Angeles (LAC).

F. To promote the "Just Culture" patient safety culture within RLANRC that encourages reporting and discussing errors and near misses with emphasis in education and learning and redesign of system processes according to DHS, LAC Policy and Procedure 311.4 "Safe and Just Culture" rather than individual blame.

II. INTEGRATION OF PATIENT SAFETY INTO ORGANIZATIONAL PLAN

Please see RLANRC organizational chart as a reference in the Attachment B. The RLANRC Quality Improvement Committee has formed the Patient Safety Committee with multidisciplinary members to focus on patient safety issues and activities across RLANRC.

III. SCOPE OF THE PATIENT SAFETY PLAN

RLANRC Patient Safety Plan is a multidisciplinary, hospital- wide program that is committed to improve patient safety and to reduce the risk of harm to patients, staff and visitors, at all levels of the Organization in concert with facilities within the DHS, LAC. The organization has designated a Facility Safety Officer under the Facilities Management responsible for the environment of care safety and will work in coordination with the RLANRC physician patient safety officer, the patient safety education officer, and the nursing patient safety coordinator.

This Program is consistent with the Mission, Values and Vision of the Organization and directed to:

A. Create centralized and coordinated oversight of patient safety.
B. Meet or exceed the Joint Commission National Patient Safety Goals and standards and update the practice of patient safety based on the latest national initiatives.
C. Recognize, prevent, and manage actual and potential risks to patient safety.
D. Encourage recognition and acknowledgement of risks to patient safety and the potential for medical/health care associates injuries to address safety across the entire care continuum.
E. Initiate actions to reduce patient safety events based on data aggregated by the Quality and Risk Management Department, reported patient safety events to UHC Safety Intelligence™, periodic Patient Safety Culture Survey, and evidence-based practice.
F. Promote transparency within the organization by developing and implementing internal reporting and discussing adverse events and near misses to explore potential areas to improve. Ultimately, the RLANRC staff members are encouraged to implement remedial actions.
G. Support the health care workforce - focusing on systems and processes rather than individuals promoting a "just culture" acknowledging that human error is often unavoidable but still addressing accountability based on the DHS Safe and Just Culture Policy 311.4.
H. Encourage organizational learning from health care related errors and near misses by communicating with leadership and front line staff to promote patient safety at RLANRC.
I. Share knowledge of patient safety for behavioral changes and improve patient safety.
J. Integrate patient safety priorities into the design and redesign of all relevant organizational processes, functions and services to ensure that technology is safe and optimized to improve patient safety.
K. Collaborate with Environment of Care Department to recommend safety and security measures that are consistent with patient-centered practice for the population that we served. The environment of care consistent with patient safety includes but is not limited the 7 elements stated by the Joint Commission: Safety (infection control), Security, Control of Hazardous Materials, Emergency Management Plan, Life Safety, Medical Equipment, and Utility Systems.
O. Cooperate and collaborate with the facilities under the Office of Safety, Risk Management, Compliance and Privacy at DHS LAC and RLANRC Quality Improvement Committee for initiatives and activities that will enhance patient safety at RLANRC.
P. Communicate and collaborate with RLANRC departments/committees for the compliance of regulatory standards.

IV. ORGANIZATIONAL STRUCTURE

A. Responsibilities

1. Physician Patient Safety Officer

a. The Department of Health Services Quality Improvement-Patient Safety Program has appointed a physician or physician-equivalent representative with a doctorate degree as a Physician Patient Safety Officer and will assign his/her responsibilities at RLANRC (Attachment C).

b. The Physician Patient Safety Officer is directly accountable to the Chief Medical Officer (CMO) and Chief Executive Officer (CEO) of RLANRC and to the physician Director of Quality, Patient Safety and Risk management and the Office of Safety, Risk Management, Compliance and Privacy at the DHS, LAC.
c. Working closely with the CEO, CMO and CNO of RLANRC, the Physician Patient Safety Officer should maintain a close working relationship with the directors of risk management, quality improvement, pharmacy, infection control, information technology, and other disciplines. The role of the Physician Patient Safety Officer is defined by the Joint Commission and the Institute for Healthcare Improvement and listed in the Attachment C, "Patient Safety Officer Activities for Safe and Reliable Care."
d. The Physician Patient Safety Officer will Chair the RLANRC Patient Safety Committee with the Patient Safety Education Officer & the Nursing Patient Safety Coordinator.
e. The CEO and CMO have the ultimate responsibility for patient safety at RLANRC.

2. Patient Safety Education Officer and Nursing Patient Safety Coordinator

a. The RLANRC Patient Safety Education Officer and the Nursing Patient Safety Coordinator collaborate with the RLANRC Patient Safety Physician Officer as the Patient Safety Core at RLANRC to mitigate patient safety related issues at RLANRC and to lead the RLANRC Patient Safety Committee.
b. The RLANRC Patient Safety Education Officer and the Nursing Patient Safety Coordinator are active members of the DHS Patient Safety Committee organized by the DHS Office of Safety, Risk Management, Compliance and Privacy. These two officers will serve as voices and liaisons of allied health and nursing professionals from RLANRC.
c. The RLANRC Patient Safety Education Officer is invited by the chair of the RLANRC Professional Staff Association and serves his/her responsibilities based on data and evidence-driven patient safety education at RLANRC.
d. The Patient Safety Nursing Coordinator is directed by the RLANRC Chief Nursing Officer to address nursing-related patient safety initiatives and issues at RLANRC.

3. Patient Safety Committee

The Patient Safety Committee is a multidisciplinary team established to monitor the execution of the Hospital-wide Patient Safety Plan/Program. The functions of the Patient Safety Committee include, but are not limited to:

a. Develop and annually review this patient safety plan needed to support effective patient safety and update the plan to incorporate advancements in patient safety practice.
b. Receive and review reports of patient safety events as defined in Section I above and Section IV B below.
c. Monitor implementation of corrective actions for patient safety events, the status of patient safety efforts, and activities to further identify where patient safety improvement efforts should be focused.

d. Recommend plans of action to eliminate future patient safety events. The plan can be derived by the evidence [III.E. above], patient safety related concerns raised by RLANRC staff, the DHS Patient Safety Committee initiatives, the Joint Commission Sentinel Event Alerts, the results of patient safety executive rounds, and best practices of scientific evidence.
e. Advocate and champion the activities to address National Patient Safety Goals and Sentinel Event Alerts by the Joint Commission and recommendations by the National Patient Safety Foundation.
f. Promote patient safety related activities, such as medication safety, infection control, environmental safety at RLANRC, respectful discussion of patient safety events, and the initiatives at the DHS Patient Safety Committee.
g. Participate in proactive risk analysis (e.g. Root Cause Analysis, Failure Modes, Effects, and Criticality Analysis) selected by the Patient Safety Core and/or the Quality and Risk Management Department.
h. Develop processes to promote the wellbeing of RLANRC staff that may be at risk for being secondary victims, e.g. involved in a sentinel event or adverse event
i. Promote patient safety awareness, patient safety learning, and patient safety culture for the RLANRC staff, patients, and visitors.
j. Maintain documentation reflecting the supporting structure, processes and evidence of effectiveness of the Patient Safety Plan.
k. Advise RLANRC-wide leadership about patient safety related issues.

B. Structural Components

RLANRC has three processes for the communication and reporting of patient safety related concerns/events.

a. Patient Safety event reports are received, reviewed in the UHC Safety Intelligence™ system, to develop actionable plans taken at the following, but not limited, Medical Staff Committees:

1. Medical Executive Committee
2. Executive Council
3. Quality Improvement Committee
4. Patient Experience Committee
5. Pharmacy and Therapeutic Committee
6. Infection Prevention Committee
7. Credentials Committee
8. Medical Staff Department Chairs Committee

b. RLANRC staff members are encouraged to use any form of communication as appropriate to raise their concerns directly to the Physician Patient Safety Officer.

c. Other Hospital-wide Committees to report to the Patient Safety Committee include but are not limited to:

1. Ambulatory Care Committee
2. Systems of Care Directors/Committees
3. Operations Council
4. Environment of Care Committee
5. Medication Safety Committee
6. Radiation Safety Committee
7. Nursing Executive/Practice Council
8. Rehabilitation Therapies Council

V. AUTHORITY

A. The CEO and CMO of RLANRC are responsible for overseeing the Hospital Patient Safety Plan as part of the overall management responsibilities delegated by Governing Body at RLANRC. The CMO reviews and approves any request from the Physician Patient Safety Officer.
B. The DHS QIPS Patient Safety Officer appoints the Organization Physician Patient Safety Officer, with designated responsibilities and accountability (Section IV. A.1. above).
C. The Quality Improvement Committee as delegated by the Board of Supervisors, DHS Director/Chief Medical Officer, and as empowered by the RLANRC Professional Staff Association through its Bylaws is responsible for patient safety. It has formed the Patient Safety Committee at RLANRC to carry out this function. The responsibilities of the Quality Improvement Committee related to patient safety are delineated in scope of the Patient Safety Plan/Program.

VI. RLANRC PROFESSIONAL STAFF QUALITY IMPROVEMENT COMMITTEE

Responsibilities of the Quality Improvement Committee related to Patient Safety include but are not limited to:

A. Plan, prioritize and design operational patient safety activities.
B. Review and evaluate the Patient Safety Plan/Program and performance data to provide its recommendations for approval to the Executive Council and Governing Body.
C. Identify potential opportunities to improve patient safety. This responsibility is shared with the Patient Safety Committee.
D. Provide direction for addressing patient safety issues and assign subcommittees, teams, or task forces to resolve specific issues.
E. Review and evaluate reports regarding the progress and effectiveness of patient safety improvement activities.
F. Advocate and facilitate Communication of patient safety initiatives across the organization.
G. Manage the flow of information to ensure follow-up and organizational learning.
H. Ensure that patient safety is incorporated in the design of processes, functions, and services.

VII. ORGANIZATION-WIDE STAFF

The attending staff at RLANRC supports patient safety by:

A. Incorporating Organization-wide patient safety goals into each Department, Service, Programs, and Committees.
B. Providing patients with quality care and service, meeting professional standards while integrating patient safety goals.
C. Participating in various continuous learning activities for patient safety (e.g. learning through the DHS Employee Patient Safety Handbook, annual DHS Patient Safety Conference, Patient Safety Huddles/Quizzes and RLANRC observation of National Patient Safety Week) and supporting colleagues to engage in patient safety related learning and initiatives.
D. Communicating relevant patient safety related issues through the use of UHC Safety Intelligence™ system and Patient Safety Committee members.
   Employees are encouraged to "speak-up" to the RLANRC Patient Safety Physician Officer if they have any concerns regarding patient safety and are requested to provide suggestions for improvement. Follow-ups of the recommendation are examined periodically at the Patient Safety Committee meetings.
E. Using the DHS communication strategy "AIDET" (Acknowledge, Introduction, Duration, Explanation, and Thank you - Five basics of Communication) to support colleagues, interact with internal and external customers at RLANRC.
F. Being encouraged to monitor patient safety preventively; the monthly "Good Catch" award is an organizational recognition of catching near misses.

VIII. COMMUNICATION ABOUT PATIENT SAFETY

A. Communication with Patients

1. Patient Rights are incorporated into the General Consent form and provided to each patient on admission to the hospital and renewed yearly in ambulatory care.
2. Patient Rights posters are posted throughout the facility.
3. Patients, and when appropriate, their families are informed about the outcomes of care, treatment, and services, including unanticipated outcomes. Refer to Administrative Policy B518 "Disclosure of Unanticipated Outcomes."
4. The three DHS-wide Patient Safety Brochures (for inpatients, outpatients and patients for surgery or procedures) are available for all patients during the admitting process at the registration desk; they are also accessible through "Patient Education" section of the DHS Patient Safety corporate Sharepoint® site. These booklets provide tips for patient safety and a HOT LINE telephone number where they can report any safety and quality concerns 24/7.
5. Patient Safety HOT LINE posters are located throughout the facility for patients, family members and employees. The Poster will list RLANRC, DHS, and the Joint Commission telephone numbers where they may also report any safety and/or quality concerns.

B. Communication with Hospital Staff

The Hospital communicates patient safety information throughout the organization utilizing:

1. Patient Safety Committee website on the RLANRC Intranet
2. Posters in key locations
3. DHS e-Newsletters and the "Quality, Risk, Safety" section at the DHS Intranet, Sharepoint®
4. Patient safety awareness events
5. Activities to observe the annual National Patient Safety Week
6. RLANRC Patient Safety Executive Rounds
7. Patient safety educational activities, e.g. RLANRC continuing medical education activities, Nursing and staff Competency, Patient Safety Monthly Quiz, regular staff meetings
8. Executive Council, Management Staff Meeting, Professional Staff Association, and Departmental meetings

IX. ON-GOING EMPLOYEE EDUCATION

A. New Hire Orientation. Newly hired employees are oriented to the following:

1. Organization Mission and Goals
2. Rancho Orientation/Reorientation Handbook
2. Organization Patient Safety Plan and Goals
3. National Patient Safety Goals
4. Ways to report errors, near misses, sentinel and critical events and concerns
5. Organization Policies and Procedures pertinent to patient safety, e.g. DHS Safe and Just Culture 311.4, RLANRC Administrative Policy B704 "Event Notification Reporting" and Infection Control A128.1

B. All RLANRC staff members are encouraged to:

1. Respond to RLANRC Patient Safety Quizzes, when given
2. Observe national patient safety week activities
3. Read the annual DHS Patient Safety Employee Handbook
4. Complete the DHS-wide patient safety modules
5. View DHS *MedSafety Blast* for medication safety
6. Attend the annual DHS Patient Safety Conference
7. In-service training to increase knowledge of patient safety and reporting
8. Continuing medical/professional education activities at RLANRC

All staff members of RLANRC periodically complete:

1. Monthly Safety In-service Modules
2. Quarterly Infection Control Learning Modules
3. DHS-wide staff core competency annual study and testing
4. Hospital-wide survey readiness fairs

X. PATIENT SAFETY IMPROVEMENT ACTIVITIES

Assist and invite Rancho stakeholders to engage in patient safety initiatives lead by the DHS QIPS for all DHS facilities (e.g. tube label project; surgical time-out standardization initiative).

Key function/performance improvement activities are described in the Continuous Compliance Guide: Achieving Continuous Excellence "ACE Handbook"

XI. PATIENT SAFETY EXECUTIVE ROUNDS

Patient Safety Executive Rounds have been implemented and done periodically in all areas of RLANRC facilitated by the Physician Patient Safety Officer and members of the Patient Safety Committee. Members of RLANRC attending staff, such as leaders in the Exec Council, multidisciplinary representatives, service managers, nursing managers, and supervisors/instructors, are all invited to attend.

The Patient Safety Executive Rounds address various aspects of safety, e.g. infectious control, safe environment of care, medication safety, and knowledge of patient safety in patients and staff at RLANRC. Examples of the rounds are: the identification of potential safety hazards in the care environment; the interview with patients who are on blood thinner medications to evaluate their knowledge and adherence in safety precautions related to the therapy. The Patient Safety Executive Rounds are opportunities for staff to effectively discuss their concerns to the leaderships within the practice environment.

The findings of the Rounds are reviewed, discussed, and tracked at the Patient Safety Committee periodically. Summarized results of the Patient Safety Executive Rounds with recommendations are submitted to the CEO and CMO.

XII. PATIENT SAFETY SURVEYS

RLANRC supports the patient safety activities initiated by the LAC DHS QIPS and conducts periodical Patient Safety Culture Survey to assess the perception of staff in reporting unanticipated adverse events, potential risks to patients, and patient safety culture.

XIII. REPORTING MECHANISMS

A. Internal
   1. Organization internal reporting mechanisms are described in the Event Notification Reporting Policy B704.

B. External
   1. Administrative Policy B704 "Event Notification Reporting."

2. External Reports are considered those sent to the DHS, QIPS Program, State Department of Health Services, Licensing and Certification Division and other relevant Regulatory Agencies.
3. The Organization Governing Body will report to the DHS Governing Body, at least annually, Occurrence of Medical /Health Care Errors and Actions taken.

XIV. IMMEDIATE RESPONSE TO PATIENT SAFETY EVENTS

Upon notification or identification of an event involving patient safety or near misses, the RLANRC Staff will immediately:

A. Perform necessary healthcare interventions to protect and support the affected patient.
B. Contact the patient's attending physician (s) to report the event, carrying out any physicians' orders as necessary. Document the facts of the incident on the patient's medical records.
C. Save and preserve any evidence and information related to the event. Examples include but are not limited to:

   1. Preservation of blood products unit (s) involved in a suspected transfusion reaction
   2. Preservation of IV tubing, fluid bags and/or pumps when a patient experiences a severe drug reaction from IV medications
   3. Preservation of medications labels, ventilators or monitors involved in an adverse outcome for the patient
   4. Preservation of information regarding the incident via online event notification system-- UHC Safety Intelligence™ system
   5. Report the event to the immediate supervisor in a timely manner

D. The Attending Physician will:
   1. Inform the patient, and when appropriate, his/her family regarding the outcome of care including the unanticipated events, or when the outcomes deviations are significant from the anticipated or expected outcome.
   2. Submit an Event Notification Report to Risk Management Department

XV. MECHANISMS FOR STAFF SUPPORT

The Organization is committed to providing Psychological and Pastoral Support to the members of the staff involved in a serious patient safety event or critical/sentinel events. Resources for support include:

A. Human Resources
B. Employee Assistance program
C. Clinical Social Work Department
D. Chaplain
E. Bioethics Committee
F. Medical Staff Aid Committee.

XVI. PATIENT SAFETY PROGRAM EFFECTIVENESS INDICATORS/MEASURES

RLANRC is a member of the National Safety Network, National Association of Public Hospitals. The goals shared at this Network have been addressed at RLANRC. The following Performance measures are reviewed at the Patient Safety Committee and other relevant Committees (e.g. Medication Safety Committee, Quality Improvement Committee) to determine the effectiveness of the Organization Patient Safety Program:

A. National Patient Safety Goals compliance
B. California Department of Public Health General Acute Care Relicensing Survey Medication Error Reduction Plan (MERP)
C. Verbal orders usage
D. Restraint usage
E. Deaths review
F. Patient falls occurrences and fall prevention plans
G. Rapid response team analysis
H. Event notification statistics
I. Patient violence
J. Pain management compliance
K. Elopement of cognitively impaired patients
L. Environment of care measures
M. IHI, Save 100,000 and 5 Million Lives Campaigns compliance
N. Patient Safety Culture Survey – periodic results
O. AHRQ Patient Safety Outcome measures endorsed by the Center for Medicare & Medicaid Services https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/hospitalqualityinits/outcomemeasures.html):
   PSI 04 - Death among surgical inpatients with serious treatable complications
   PSI 90 - Composite - Complication/patient safety for selected indicators

XVII. DEFINITIONS/TERMINOLOGY

A. Near Miss: Any process variation which did not adversely affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome.
B. Hazardous condition: Any set of circumstances, not related to the disease or medical condition for which the patient is being treated, that significantly increases the likelihood of a serious adverse outcome.
C. Adverse Drug reaction: An adverse reaction to a medication that is: undesirable, unintended, or unexpected within therapeutically acceptable doses. (Pharmacy Policy & Procedure 1.15.0)
D. Sentinel Event: An unexpected occurrence involving death or serious physical or psychological injury or the risk thereof. The Joint Commission periodically updates their reports of Sentinel Events which is used to help monitor and implement to improve patient safety at RLANRC.
E. Harm: Refers to outcomes or results of patient safety events.

RELATED POLICY AND PROCEDURES

A. Administrative P&P B704 – Event Notification Reporting (See RLANRC Intranet)
B. Administrative Policy B509 " Patient Rights and Responsibilities"
C. Administrative Policy B 518 "Disclosure of Unanticipated Outcomes"

REFERENCES:

- State of California Health and Safety Code Division 2, Licensing Provisions, Chapter 2. Health Facilities, Article 3, Regulations 1279.1" http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=HSC§ionNum=1279.1 Last accessed 1/25/2016.
- Institute of Medicine: To Err is Human: Building a Safer Health System,
- Washington, D.C. National Academy Press, 2000.
- Institute of Medicine Reports 2001 and 2003
- The Joint Commission Comprehensive Accreditation Manual for Hospitals
- The Joint Commission-National Patient Safety Goals 2016
- The Joint Commission- The Essential Guide for Patient Safety Officers, 2nd Edition, 2012
- RLANRC Administrative P&P A101: Mission, Vision and Values
- RLANRC Medication Errors Reduction Plan
- RLANRC Quality and Performance Improvement Plan.
- DHS Policy 311.4 Safety and Just Culture. http://myladhs.lacounty.gov/polproc/DHS_Policies_and_Procedures/0300-0399%20Operations%20Policy/DHS_POLICY_0311_4.pdf Last accessed 1/22.2016
- Kaiser Permanente Patient Safety University. From Science to Execution Conference, Los Angeles, April 2015
- National Patient Safety Foundation, Free from Harm, Accelerating Patient Safety Improvement, 2016.
- Institute for Healthcare Improvement –Leadership Guide to Patient Safety, 2006
- Institute for Healthcare Improvement - Patient Safety Executive Development Program, March 2013
- Senate Bill No. 158, requires general acute care hospitals (GACHs), acute psychiatric hospitals (APHs), special hospitals (SHs) and skilled nursing facilities (SNFs) to establish patient safety plans (HSC § 1279.6) and hand hygiene programs (HSC § 1279.7) to improve patient safety and reduce patient suffering resulting from preventable events. https://www.cdph.ca.gov/services/boards/Documents/SB158chaptered09_25_08.pdf Last accessed 1/22/2016.
- California Department of Public Health General Acute Care Relicensing Survey. http://www.cdph.ca.gov/programs/LnC/Pages/GeneralAcuteCareRelicensingSurvey-ComingSoon.aspx Last accessed 1/22/2016.

ATTACHMENTS:

A. State of California Health and Safety Code Division 2, Licensing Provisions, Chapter 2. Health Facilities, Article 3, Regulations 1279.1. http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=HSC§ionNum=1279.1 Last accessed 1/26/2016.
B. Organizational Chart (See RLANRC Intranet for most current version)
C. Patient Safety Officer Activities for Safe and Reliable Care

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