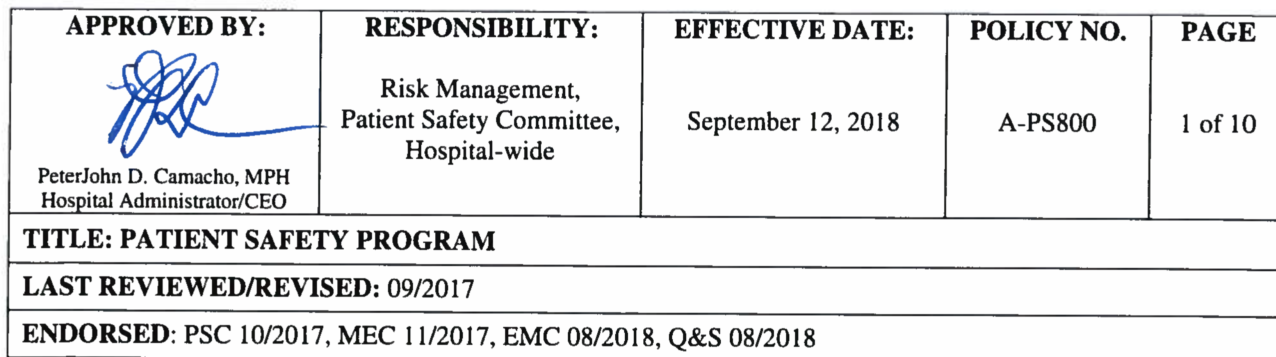
GUAM MEMORIAL HOSPITAL AUTHORITY
ADMINISTRATIVE MANUAL



APPROVED BY:	RESPONSIBILITY:	EFFECTIVE DATE:	POLICY NO.	PAGE
PeterJohn D. Camacho, MPH Hospital Administrator/CEO	Risk Management, Patient Safety Committee, Hospital-wide	September 12, 2018	A-PS800	1 of 10
TITLE: PATIENT SAFETY PROGRAM				
LAST REVIEWED/REVISED: 09/2017				
ENDORSED: PSC 10/2017, MEC 11/2017, EMC 08/2018, Q&S 08/2018				

PURPOSE:

The purpose of this policy is to institute a Patient Safety Program for the Guam Memorial Hospital Authority (GMHA). This policy facilitates education, communication, consistency and effectiveness of the program.

This Patient Safety Program ensures that GMHA implements and maintains a patient safety program in accordance with regulatory agencies [The Joint Commission (TJC), Centers for Medicare and Medicaid Services (CMS)], and standards of practice by different licensing authorities from state and federal regulatory agencies).

RESPONSIBILITY:

It is the responsibility of all employees of GMHA to be familiar with the contents of this program and adhere to the procedure outlined within.

DISTRIBUTION:

This Patient Safety Program shall be distributed hospital-wide and online.

INTRODUCTION:

The Patient Safety Program supports and promotes the mission, vision, and values of GMHA through the practice of developing and implementing a culture of safety among its consumers. This implies, but not limit, to its patients, staff, contractors, physicians, volunteers, and visitors.

In a just culture of safety and quality, all individuals are focused on maintaining excellence in providing care. Safety and quality thrive in an environment that supports teamwork and respect for other people, regardless of their position in the organization. Leaders demonstrate their commitment to quality and safety, and set expectations for those who work in the organization. Leaders evaluate the culture on a regular basis. **At GMHA, we conduct a culture of safety survey every two years. We utilize an evaluation tool that borrows from both the Agency for Healthcare Research and Quality's (AHRQ's) Hospital Survey on Patient Safety Culture and the Institute for Safe Medication Practice's (ISMP's) Survey on Disrespectful Behavior in Healthcare.**

The Program implements through the continuous integration and coordination of the patient safety activities of the medical staff, clinical departments and support service departments at GMHA, that have the responsibility for various aspects of patient and staff safety. Each employee of the organization performs a dedicated and critical role in ensuring patient safety.

The organization wide patient safety program is designed to reduce medical errors and hazardous conditions by utilizing a systematic, coordinated and continuous approach to the improvement of patient safety. This approach centers on the establishment of mechanisms that support effective responses to actual occurrences and hazardous conditions; ongoing proactive reductions in medical/health care errors; and integration of patient safety priorities in the design and redesign of all relevant organizational processes, functions and services.

The Governing Body (Board of Trustees), Medical Executive Committee (MEC) and Executive Management Council (EMC) are committed to patient safety, assuring a just culture that encourages error identification, remediation, non-punitive reporting and prevention through education, system redesign or process improvement for any adverse events.

Proactive assessment of high risk activities and hazardous conditions are identified through healthcare failure mode and effect analysis (HFMEA), aggregate data collection and utilization. In addition, available information about sentinel events known to occur in healthcare organizations that provide similar care and services and knowledge based information for risk reduction are built in the system progressively.

The Patient Safety Program Policy offers the opportunity through the education module, proper and effective orientation and training that emphasizes clinical and nonclinical aspects of patient safety, an interdisciplinary approach to patient care, improvement of patient safety and the requirement and mechanism to report medical errors.

Emphasis also is placed upon patient safety in areas such as patient’s rights, patient family education, continuity of care and plan for managing performance deficit. Full disclosure of serious medical errors, reportable events and any unanticipated outcome are made to patients/families through the provider as appropriate. GMHA has a program to inform accrediting and licensing bodies, as appropriate.

SCOPE:

I. PROACTIVE RISK IDENTIFICATION AND PROCESS FOR MITIGATING THE RISK FACTORS

The Patient Safety Program is a systemic, organization-wide program, using TJC’s National Patient Safety Goals (NPSG), the Centers for Medicare and Medicaid’s (CMS) Never Events, Standards of Practice of Professional Organizations, and healthcare laws of Guam and the federal government, and evidence-based guidelines. The program requires education, identification, and reporting of sentinel events, adverse events, unusual events or near miss events. Data gathering, analysis, and implementation of corrective actions are performed to improve patient safety and minimize or eliminate actual or potential liabilities. The program is the central point for data collection, and evaluation of sentinel event, adverse event, unusual event, and near miss event reporting throughout the hospital.

Opportunities for improvement regarding patient safety issues are prioritized according to level of severity, frequency of the occurrence, potential for harm to the patient, and potential for liability. Ongoing review of information is performed to direct the administrative and medical staffs’ attention to areas of clinical care representing significant sources of actual or potential risk.

Types of medical / health care errors included in data analysis are:

A. <u>NEAR MISS</u>

Any process variation which did not affect the outcome due to a screening by chance but for a recurrence carries a significant chance of a serious adverse outcome. Some may call it a potential for error.

B. OCCURRENCE

An event that is not consistent with routine patient care or hospital procedure which either did not or could have resulted in injury, loss to a patient or visitor or which may give rise to a claim against the Hospital, an employee of the hospital, or a member of the hospital medical staff.

C. ERROR

An unintended act, either omission or commission, or an act that does not achieve its outcome such as medication errors and adverse drug events or reactions.

D. 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 serious physical or psychological adverse patient outcome.

E. 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.

Note: ***Intentional unsafe acts are not within the definition of adverse events and should be addressed through avenues other than the Patient Safety Committee.*** *This is any event that results from a criminal act; a purposefully unsafe act; an act related to alcohol or substance abuse; or events involving alleged or suspected patient abuse by a privileged provider, staff member, volunteer, contractor, or student/trainee.*

II. INVESTIGATION, ANALYSIS, COORDINATION AND REPORTING

A broad range of data analysis will be reported to and reviewed by the Patient Safety Committee (PSC) monthly. The results of investigations and analytical reviews shall, in turn, be forwarded by the committee to the appropriate entities for further, in-depth evaluation, review and responses. Responses shall include any corrective action taken or plan for corrective action. The PSC serves as a clearing house for these data and information that affect patient safety. Any incident, process, event and condition may be subject to investigation through a credible comprehensive systematic analysis. Intensive assessment may be initiated when undesirable patterns or trends are identified or a sentinel event occurs. Proactively this plan suggests conducting at least one system based failure mode effect analysis (FMEA) every 18 months to 2 years.

In accordance with TJC’s Accreditation Participation Requirements this plan maintains that:

- GMHA educates its staff that any employee who has concerns about the safety or quality of care provided in the hospital may report these concerns to TJC or CMS.
- GMHA also educates the staff that no disciplinary or punitive action will be taken when an employee reports safety or quality of care concerns internally or externally to TJC or CMS.

- GMHA takes no disciplinary or punitive action against employees when they do report safety or quality of care concerns internally or externally to TJC or CMS.

III. EVENT TRENDING AND REPORTING

Providing periodic reports on specific sets of indicators is a routine essential of GMHA's Patient Safety Plan. The set-up of indicators is done through internal and external metrics and approved by the Patient Safety Committee. Presently, we follow the guidelines of National Patient Safety Goals by the Sentinel Event Advisory Board of The Joint Commission. Additionally, information derived from analysis of the Patient Safety/Risk Management Database will be used for the measurement, assessment, and improvement of key processes and systems to reduce risks or potential risks. Significant trends will be included as part of the Patient Safety Committee's quarterly report to the Quality and Safety BOT Subcommittee.

IV. SENTINEL EVENT ALERTS AND BEST PRACTICES

Each Joint Commission Sentinel Event Alert and best practices identified through patient safety related activities will be routed to the appropriate parties for consideration of the recommended risk-reduction strategies. The Patient Safety Committee will act on the sentinel event alert within 90 days and will subsequently educate the organization about the sentinel event alert and its efforts to reduce risk and promote patient safety regarding the topic discussed in the sentinel event alert.

V. INTERNAL PATIENT SAFETY ALERTS AND ADVISORIES

Patient Safety Alerts and Advisories are issued by the Patient Safety Officer (PSO) to notify the field when actual or potential threats to the life or health of patients have been identified. Patient Safety Alerts disseminate urgent notices that require specific, mandatory, and timely action on the part of the recipient(s). Patient Safety Advisories are issued when a potential threat due to equipment design, procedural issues, or training has been identified. Patient Safety Advisories provide recommendations that are general in nature and implementation of the recommendations are subject to local conditions and judgment; departments must either implement the recommendations or implement equivalent or higher level of safety than provided by the recommendations.

VI. CONFIDENTIALITY AND SECURITY:

Comprehensive Systematic Analyses and other records created under the guidance of the Patient Safety Program, are protected medical quality assurance documents, and exempt from the requirements of the Freedom of Information Act. **Strict Confidentiality** must be maintained. Patient Safety Program-related documentation will be maintained in a secure location within the Compliance Office for a period of at least three years.

VII. PUBLIC RELATIONS:

Depending on the event, the hospital should notify legal counsel to facilitate any external communications, including contact with the media or requests for public information.

VIII. ORGANIZATION, AUTHORITY AND RESPONSIBILITY

The authority to implement the Patient Safety Plan rests with the Guam Memorial Hospital Authority's Governing Body, Medical Executive Committee, Executive Management Council, and the Patient Safety Committee. This plan is evaluated yearly.

A. HOSPITAL ADMINISTRATOR/CEO

The Hospital Administrator/Chief Executive Officer shall establish and maintain the Patient Safety Program with emphasis on the implementation of a Just Culture for the organization.

B. PATIENT SAFETY COMMITTEE

The committee provides a multidisciplinary forum for the collection of an analysis of risk to patient safety and the dissemination of information on identified risk for the purpose of improving patient care and reducing morbidity and mortality within GMHA. The hospital shall utilize the Safety Learning System as its reporting tool. The committee shall review reports typically ranging from “no harm” frequently occurring “near misses” to sentinel events with serious adverse outcomes, claims and identified risks, which are gathered in accordance with the program. It shall identify those individuals or groups best situated to perform a root cause analysis and develop and implement an action plan for these identified gaps in patient safety. It shall review, analyze, and disseminate the information it receives, as appropriate, to the Quality and Safety Committee on a quarterly basis. It shall provide recommendations concerning identified risks and where appropriate shall request and approve plans for corrective action and evaluate the implementation of corrective actions taken. Deadlines for submission shall be identified with each item that is introduced and documented in the minutes.

The Patient Safety Committee will coordinate the risk mitigating efforts on environment of care issues with the organizational Environment of Care Committee to assure membership overlaps and will provide appropriate information to that committee in a manner consistent with the protection of confidentiality of patient and patient safety information. Likewise, the hospital’s Environment of Care Committee will bring patient safety concerns to the Patient Safety Committee as those arise.

See also the Patient Safety Committee Team Charter attached.

C. PATIENT SAFETY OFFICER

The Hospital Administrator/CEO shall designate the Patient Safety Officer, who in turn shall lead the committee. On behalf of the committee, the Patient Safety Officer shall provide reports at least quarterly to the Executive Management Council, Medical Executive Committee, and Quality and Safety BOT Subcommittee concerning the occurrences of errors, and actions taken to improve patient safety, both in response to actual occurrences and proactively. In addition, the Patient Safety Officer advises these groups regarding clinical issues that may necessitate changes to policies and procedures, orientation, on-going education, or resource allocation. The Patient Safety Officer is authorized by the committee to conduct investigations, participate as an advisor, and has the responsibility for gathering information on risks to patient safety.

D. MEDICAL STAFF

Each member of the medical staff shall participate in the hospital-wide occurrence reporting system and in preparation and implementation of corrective action activities in the event of an identified risk. Each clinical department shall implement the requirements of the plan, in accordance with regulatory patient safety standards and established criteria for patient care and safety, by developing appropriate policies and procedures, identifying cases of potential risk areas and correcting identified safety concerns.

E. DEPARTMENT HEADS

Each hospital department, which provides or affects patient care, will report and investigate patient safety risks and events that occur within its purview, identifying causal factors, and developing actions to correct and improve patient safety outcomes. Each department shall assure the participation of its employees in the hospital-wide occurrence reporting system and in the preparation and implementation of corrective action plans. Department Heads are responsible for orientation of new staff members to the department and, as appropriate, to job and task-specific safety procedures. When necessary, the Patient Safety Officer will provide department heads with investigation guidance and assistance in developing safety programs or policies. Department Heads are expected to facilitate comprehensive systematic analyses, when necessary.

F. STAFF MEMBERS & MEDICAL STAFF

Individual GMHA staff members are responsible for learning and following job and task-specific procedures for safety operations. Staff will participate in the hospital-wide incident reporting system and required education and training programs. Staff are expected to participate in comprehensive systematic analyses, when necessary.

COMMITTEE REPORTING REQUIREMENTS:

A. INTERNAL REPORTING

To provide a comprehensive view of both the clinical and operational safety activity of the organization:

1. The minutes/reports of the Patient Safety Committee will be submitted through the Patient Safety Officer to the Quality and Safety BOT Subcommittee.

2. Quarterly reports will include ongoing activities, such as data collection and analysis presented in a dashboard.

B. EXTERNAL REPORTING

1. A high risk or error prone process will be selected annually for concentrated activity, ongoing measurement and periodic analysis. The selected topic and approach will be communicated to the Quality and Safety Committee through a memorandum.

2. External reporting will be completed in accordance with all state, federal, and regulatory body rules, regulations, and requirements.

C. THE PATIENT SAFETY OFFICER WILL SUBMIT AN ANNUAL REPORT TO THE BOARD OF TRUSTEES (BOT) WHICH WILL INCLUDE:

1. A summary of patient safety events to include the following:

    a. A description of key learnings that have made the most significant improvements to professional practice and actions taken.
    b. A description of how the key learnings were shared.
    c. A description of patient safety improvements that have occurred because of the actions taken.

2. A description of what the hospital has done in response to any Sentinel Event Alert.

3. A description of the examples of ongoing in-service and other education and training programs that are maintaining and improving staff competency and supporting an interdisciplinary approach to patient care.

4. A description of how the function of process design that incorporates patient safety has been carried out using specific examples of process design or redesign that include patient safety principles.

5. The results of how input is solicited and participation from patients and families in improving patient safety is obtained.

REFERENCES:

Centers for Medicare and Medicaid Services. (March 15, 2013). *AHRQ Common Formats: Information for Hospitals and State Survey Agencies (SAs)- Comprehensive Patient Safety Reporting Using AHRQ Common Formats.* Retrieved October 2, 2015 from https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-13-19.pdf

Marx D. (May 2003). How building a 'just culture' helps an organization learn from errors. *OR Manager, 19*(5), 14-5, 20.

The Joint Commission. Behaviors that undermine a culture of safety. *Sentinel Event Alert.* July 9, 2008. Retrieved October 2, 2015 from http://www.jointcommission.org/sentinel_event_alert_issue_40_behaviors_that_undermine_a_culture_of_safety/

The Joint Commission. Leadership committed to safety. *Sentinel Event Alert*. August 27, 2009. Retrieved October 2, 2015 from http://www.jointcommission.org/sentinel_event_alert_issue_43_leadership_ ommitted_to_safety/

The Joint Commission. (2015). Patient Safety System. *Comprehensive Accreditation Manual for Hospital.* (PS1-28).

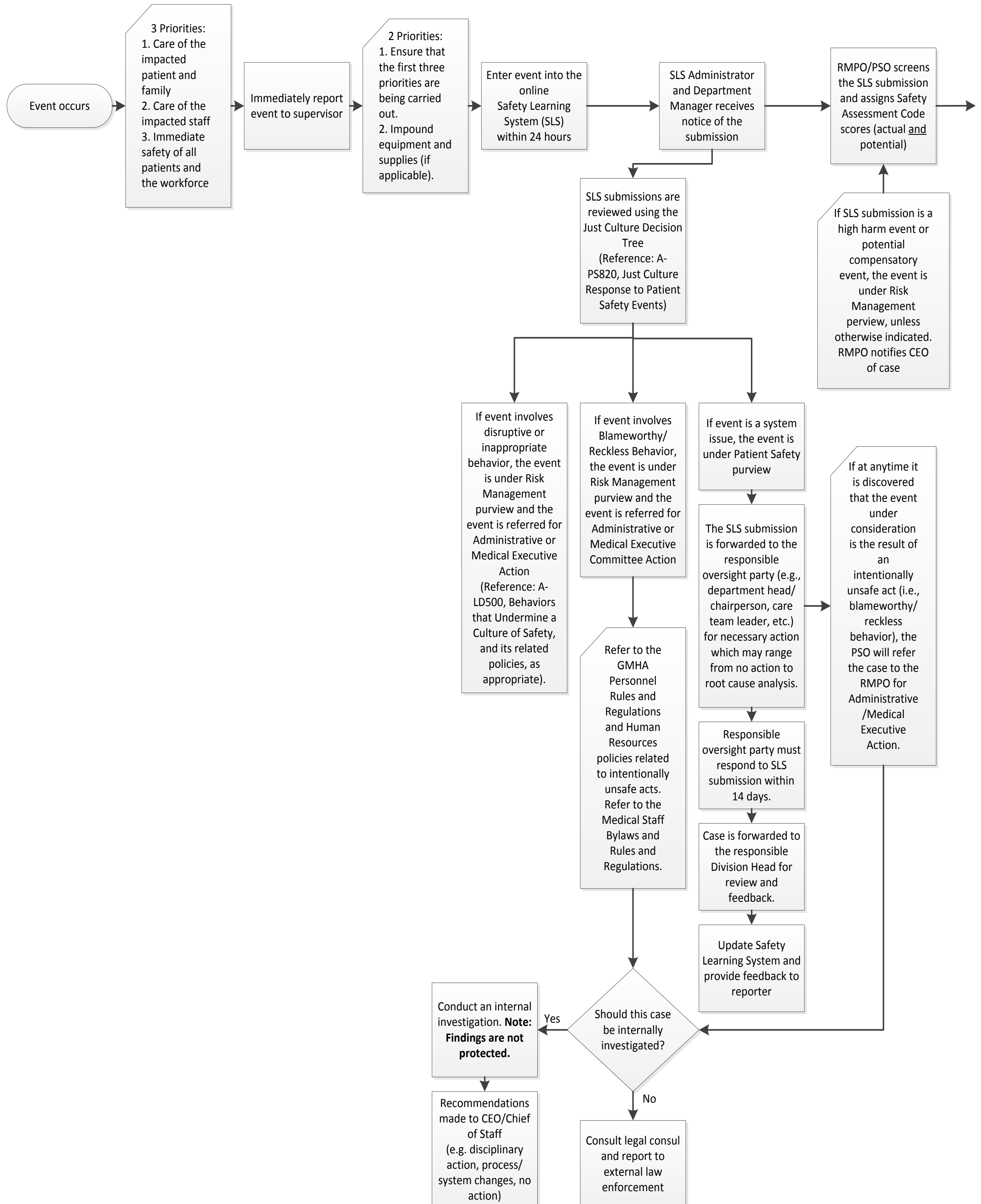
RESCISSION:

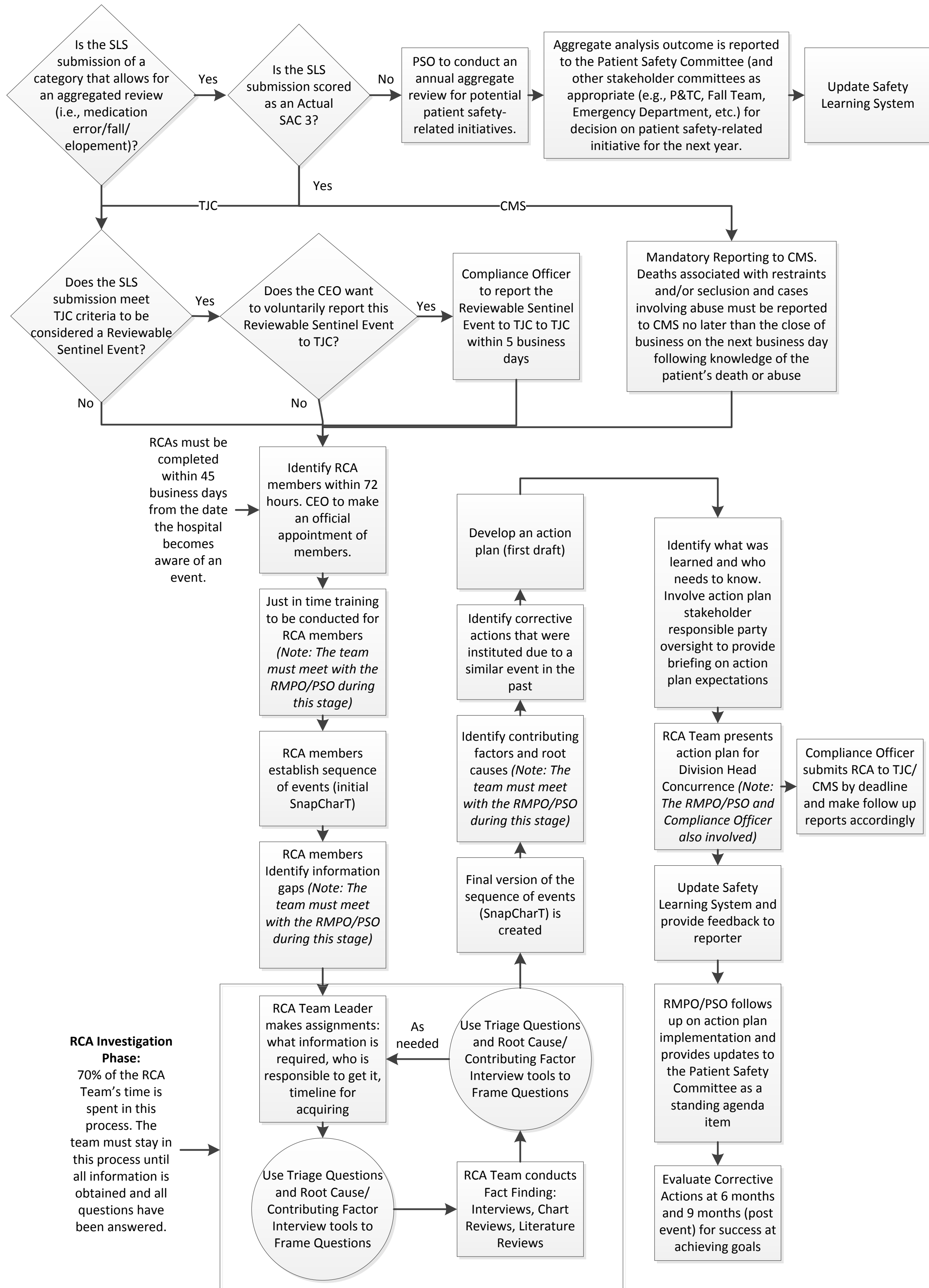
Policy No. A-PS800, *Patient Safety Program* of the Administrative Manual interim approved October 31, 2017.

ATTACHMENT:

I. Reported Event Process
II. MEMORANDUM: Assignment to Safety Working Team

ATTACHMENT I: **REPORTED EVENT PROCESS**




Is the SLS submission of a category that allows for an aggregated review (i.e., medication error/fall/ elopement)?
Yes
Is the SLS submission scored as an Actual SAC 3?
No
PSO to conduct an annual aggregate review for potential patient safety-related initiatives.
Aggregate analysis outcome is reported to the Patient Safety Committee (and other stakeholder committees as appropriate (e.g., P&TC, Fall Team, Emergency Department, etc.) for decision on patient safety-related initiative for the next year.
Update Safety Learning System
Yes
TJC
CMS
Does the SLS submission meet TJC criteria to be considered a Reviewable Sentinel Event?
Yes
Does the CEO want to voluntarily report this Reviewable Sentinel Event to TJC?
Yes
Compliance Officer to report the Reviewable Sentinel Event to TJC to TJC within 5 business days
Mandatory Reporting to CMS. Deaths associated with restraints and/or seclusion and cases involving abuse must be reported to CMS no later than the close of business on the next business day following knowledge of the patient's death or abuse
No
No
RCAs must be completed within 45 business days from the date the hospital becomes aware of an event.
Identify RCA members within 72 hours. CEO to make an official appointment of members.
Just in time training to be conducted for RCA members (Note: The team must meet with the RMPO/PSO during this stage)
RCA members establish sequence of events (initial SnapCharT)
RCA members Identify information gaps (Note: The team must meet with the RMPO/PSO during this stage)
RCA Investigation Phase:
70% of the RCA Team's time is spent in this process. The team must stay in this process until all information is obtained and all questions have been answered.
RCA Team Leader makes assignments: what information is required, who is responsible to get it, timeline for acquiring
As needed
Use Triage Questions and Root Cause/ Contributing Factor Interview tools to Frame Questions
Use Triage Questions and Root Cause/ Contributing Factor Interview tools to Frame Questions
RCA Team conducts Fact Finding: Interviews, Chart Reviews, Literature Reviews
Final version of the sequence of events (SnapCharT) is created
Identify contributing factors and root causes (Note: The team must meet with the RMPO/PSO during this stage)
Identify corrective actions that were instituted due to a similar event in the past
Develop an action plan (first draft)
Identify what was learned and who needs to know. Involve action plan stakeholder responsible party oversight to provide briefing on action plan expectations
RCA Team presents action plan for Division Head Concurrence (Note: The RMPO/PSO and Compliance Officer also involved)
Compliance Officer submits RCA to TJC/ CMS by deadline and make follow up reports accordingly
Update Safety Learning System and provide feedback to reporter
RMPO/PSO follows up on action plan implementation and provides updates to the Patient Safety Committee as a standing agenda item
Evaluate Corrective Actions at 6 months and 9 months (post event) for success at achieving goals

ATTACHMENT II

Guam Memorial Hospital Authority
Aturidåt Espetåt Mimuriåt Guåhan
850 GOV. CARLOS CAMACHO ROAD
OKA, TAMUNING, GUAM 96913
TEL.: (671) 647-2544 or (671) 647-2330
FAX: (671) 649-0145

Date:

MEMORANDUM

TO:

FROM: Hospital Administrator/CEO

SUBJECT: Assignment to Safety Working Team

REFERENCE: Patient Safety Program

ENCLOSURE: Patient Safety Form Event# _________

Per reference above, effective immediately, you are hereby appointed duties and responsibilities as a member of the Sentinel Event Investigative Team under the leadership of the Patient Safety Officer for the Patient Safety Event # __________ (obtain from the Patient Safety Officer). Available information (see enclosure), indicates this event meets the criteria for a sentinel event.

You will be guided in the performance of your investigation by the indicated reference above and The Joint Commission standards.

You have been selected to serve on this investigative team because you have been determined as being most closely associated with the event.

The team will complete a Root Cause Analysis (RCA) and Action Plan under the Joint Commission guidelines. You are to develop a Plan of Action and Milestones (POA&M) for completion of the RCA and Action Plan and are responsible for providing frequent updates of your progress to the JC Compliance Officer. Finally, you will present your POA&M to the Patient Safety Committee on (Date). Your final report with action plan must include review by the appropriate committees and administrators and is due to the Patient Safety Committee no later than (Date).

Your analysis should include use of appropriate quality tools, such as flow diagrams and charts. Various tools can be used to clarify the correct process, develop a modified process, or convey to all concerned, the proper procedures to be followed in the future. The hospital's Patient Safety Officer, Joint Commission Compliance Officer, and Performance Improvement Committee Chairperson will provide you with the necessary assistance.

Note that documents and records created pursuant to this appointment are Quality Assurance materials, which are confidential and privileged.