HORNEPAYNE COMMUNITY HOSPITAL

HUMAN RESOURCES

2011/2012

HORNEPAYNE COMMUNITY HOSPITAL
PATIENT-SAFETY PLAN

Purpose:

The Hornepayne Community Hospital Patient-Safety Plan is designed to improve patient safety, reduce risk and respect the dignity of those we serve by assuring a safe environment. Recognizing that effective medical/health care error reduction requires an integrated and co-ordinated approach, the following plan relates specifically to a systematic hospital-wide program to minimize physical injury, accidents and undue psychological stress during hospitalization. The organization wide safety program will include all activities contributing to the maintenance and improvement of patient safety. Leadership assumes a role in establishing a culture of safety that minimizes hazards and patient harm by focussing on processes of care. The leaders of the organization are responsible for fostering an environment through their personal example; emphasizing patient safety as an organizational priority; providing education to medical and hospital staff regarding the commitment to reduction of medical errors; supporting proactive education in medical/health care errors; and integrating patient safety practices into the design and redesign of all relevant organization processes, functions, and services.

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Objectives:

The objectives of the Patient-Safety Plan are to:

Encourage organizational learning about medical/health care errors

Incorporate recognition of patient safety as an integral job responsibility

Provide education of patient safety into job specific competencies

Encourage recognition and reporting of medical/health care errors and risks to patient safety without judgement or placement of blame

Involve patients in decisions about their health care and promote open communication about medical errors/consequences which occur

Collect and analyze data, evaluate care processes for opportunities to reduce risks initiate actions

Report internally what has been found and the actions taken with a focus on processes and systems to reduce risk

Roles and Responsibilities:

Improving quality and safety is everyone's job, including clinicians, front-line staff, managers and administrators.

Each department will incorporate patient-safety talks/issues at their departmental meeting.

It is everyone's responsibility to report any patient-safety concerns.

Reporting these concerns will be non-punitive.

Each department will develop a set of indicators to monitor patient-safety.

These indicators will be presented to the Quality Management Committee for analysis.

The Quality Management Committee will forward quarterly patient-safety and Quality Improvement reports to the Board of Governors.

Adopted: August 2009

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Organization & Functions:

The patient safety team will include the members of the Medical Advisory Committee. Patient safety and care will be part of the monthly meeting agenda.

The scope of the Patient-Safety Team includes medical/healthcare errors involving the patient population of all ages. Data and incident reports will be used for review and analysed.

Severity categories of medical/healthcare errors include:

a) No harm errors – an unintended act either omission or commission, or an act that does not achieve its intended outcome.

b) Mild to Moderate Adverse Outcome – any set of circumstances that do not achieve the desired outcome and result in a mild to moderate physical or psychological adverse patient outcome.

c) Hazardous Conditions – any set of circumstances, exclusive of disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious adverse outcome.

d) Near Miss – any process variation which did not affect the outcome but for which a recurrence carries a significant chance of a serious adverse outcome.

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

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Discussion with the Patient/Family/Caregivers Regarding Adverse Outcomes:

a) Events impacting the patients' clinical condition

The care-giving physician or person designated by the care-giving physician will notify the patient/family/caregiver in a timely fashion.

The patient/family/caregiver will NOT be contacted without permission and/or notification of the care-giving physician involved.

The care-giving physician will determine the appropriateness of documentation of the occurrence in the medical record.

b) Events not impacting the patient clinical condition, but causing a delay or inconvenience

The Nursing Manager will communicate with the patient/family/caregiver in the interest of patient satisfaction.

The mechanism to insure all components of the organization are integrated into the program is through a collaborative effort of multiple disciplines. This is accomplished by:

i) Reporting of potential or actual occurrence through Incident occurrence reporting policy by any employee in every department.
ii) Communication with senior management and the Health and Safety Committee involving environmental factors involved in providing an overall safe environment.

The mechanism for identification and reporting a sentinel event/other medical error will be as indicated in organizational policies.

<u>Discussion with the Patient/Family/Caregivers Regarding Adverse Outcomes (continued):</u>

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 by:

a) A non-punitive approach and without fear of reprisal
b) Participation into the root causes analysis for educational purposes and prevention of further occurrences.

Implementation of new processes or redesign of current processes will incorporate patient safety principles and an emphasis on the important hospital and patient care functions of;

Patient Rights	Patient & Family Education
Residents Rights	Continuum of Care
Patient Assessment	Leadership
Care of the Patient	Infection Control
Management of Environmental Care	
Management of Information	
Improving Organizational Performance	
Management of Human Resources	

The procedure for immediate response to medical/health care error is as follows:

a) Staff will immediately report the event to the supervisor (on off hours to the RN in charge).
b) The supervisor will immediately communicate the event to care-giving physician and Chief Executive Officer to initiate investigation and follow-up action.
c) Staff will complete the Incident Report to preserve information.
d) Staff will obtain required orders to support the patient's clinical condition.
e) The Chief Executive Officer will be notified of any situations of potential risk to others.
f) Investigation information will be presented for review and action by the MAC committee.

Discussion with the Patient/Family/Caregivers Regarding Adverse Outcomes (continued):

Solicitation of input and participation from patients and families in improving patient safety will be accomplished by:

a) Conversations with patients and families during nursing rounds.
b) Comments from patient-satisfaction surveys.

Methods to assure ongoing services, education, and training programs for maintenance and improvement of staff competence are accomplished by:

a) Providing information and reporting mechanisms to new staff in the orientation training.
b) Obtaining a confidential assessment of staff willingness to report medical errors at least annually.
c) Testing staff knowledge regarding patient safety in competency testing.
d) Evaluating staff knowledge levels and participation of patient safety principles in annual performance appraisals.