July 1, 2018

Rick Combs, Director
Legislative Counsel Bureau
401 S. Carson Street
Carson City, NV 89701-4747

Dear Mr. Combs:

Pursuant to NRS 439.877(4)(d) (AB280), which requires patient safety committees in medical facilities to report annually on the facilities review, revision, and usage of patient safety checklists and policies, the following is a summary of Incline Village Community Hospital activities during July 1, 2017 through June 30, 2018.

We had no new checklists or policies created for the purposes of this Patient Safety initiative. Most checklists and policies were reviewed. Several checklists were replaced with new checklists and several patient safety policies required some revisions. Attached you will find a report summarizing the specific checklists and policies. I have also attached the Tahoe Forest Health System's Patient Safety Plan which is updated annually.

Please do not hesitate to contact me or my staff should you require additional information.

Sincerely,

Dawn Lockwood
Patient Safety Officer
Tahoe Forest Hospital and Incline Village Community Hospital
dlockwood@tfhd.com
530-582-6423

TAHOE FOREST HEALTH SYSTEM

Origination Date:	*12/2005*
Last Approved:	*01/2018*
Last Revised:	*02/2017*
Next Review:	*01/2019*
Department:	*Quality Assurance / Performance Improvement - AQPI*
Applies To:	*System*

Patient Safety Plan, AQPI-02

PURPOSE:

To develop, implement, and evaluate a patient safety program for the Tahoe Forest Health System which includes Tahoe Forest Hospital (TFH) and Incline Village Community Hospital (IVCH), (hereinafter referred to as the "organization").

The Tahoe Forest Hospital District (TFHD) Board of Directors makes a commitment to provide for the safe and professional care of all patients, and also to provide for the safety of visitors, employees and health care practitioners. The commitment is made through the provision of this Patient Safety Plan that will identify, evaluate, and take appropriate action to prevent unintended patient care outcomes (adverse events), as well as protect the TFHD's financial resources, tangible assets, personnel and brand. Leadership structures and systems are established to ensure that there is organization-wide awareness of patient safety performance, direct accountability of leaders for that performance and adequate investment in performance improvement abilities, and that actions are taken to ensure safe care of every patient served.

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This policy is integrated with a companion policy, Risk Management Plan AQPI-04.

The Tahoe Forest Hospital District endorses the National Quality Forum set of "34 Safe Practices for Better Healthcare." Further, the District ascribes to the tenets and practices of the Just Culture program in the investigation of near-misses, adverse events and unexpected/unintended outcomes.

A. SCOPE & APPLICABILITY

1. This is a Health System program empowered and authorized by the Board of Directors of Tahoe Forest Hospital District. Therefore, it applies to all services and sites of care provided by the organization.

B. RECITALS

1. The organization recognizes that a patient has the right to a safe environment, and strives to achieve an error-free healthcare experience. Therefore, the Health System commits to undertaking a proactive approach to the identification and mitigation of unexpected/unintended outcomes.
2. The organization also recognizes that despite best efforts, errors can occur. Therefore, it is the intent of the Health System to respond quickly, effectively and appropriately when an error does occur.
3. The organization also recognizes that the patient has the right to be informed of the results of treatments or procedures whenever those results differ significantly from anticipated results. Patients and patient representatives are informed of unexpected/unintended outcomes as described in 4.8.1

below.

C. AUTHORITY & RESPONSIBILITY

1. **Governing Body**
    a. The Governing Body, through the approval of this document, authorizes a planned and systematic approach to preventing adverse events and implementing a proactive patient safety plan. The Governing Body delegates the implementation and oversight of this program to the Chief Executive Officer (hereinafter referred to as the "Senior Leader") and request that the Medical Staff approve the creation of a Patient Safety Committee. The Medical Staff Quality Committee will serve as the Patient Safety Committee for TFHD and the IVCH Medical Staff Committee will serve as the Patient Safety Committee for IVCH.
2. **Senior Leader**
    a. The Senior Leader is responsible for assuring that this program is implemented and evaluated throughout the organization. As such, the Senior Leader will establish the structures and processes necessary to accomplish this objective. The Senior Leader delegates the day-to-day implementation and evaluation of this program to the Medical Staff Quality Committee and the Management Team.
3. **Medical Staff**
    a. The meetings, records, data gathered and reports generated by the Patient Safety Committee shall be protected by the peer review privilege set forth at California evidence Code Section 1157 relating to medical professional peer review and for the State of Nevada subject to the same privilege and protection from discovery as the proceedings and records described in NRS 49.265.
    b. The Patient Safety Committee shall take a coordinated and collaborative approach to improving patient safety. The Committee shall seek input from and distribute information to all departments and disciplines in establishing and assessing processes and systems that may impact patient safety in the organization. The Patient Safety Committee shall recognize and reinforce that the members of the Medical Staff are responsible for making medical treatment recommendations for their patients.
4. **Management Team**
    a. The Management Team, through the Director of Quality and Regulations, is responsible for the day-to-day implementation and evaluation of the processes and activities of this Patient Safety Plan.
5. **Patient Safety Officer (The Patient Safety Officer's standing committee assignments, chain-of-command and reports/reporting structure are attached as Attachment C)**
    a. The Director of Quality & Regulations or the Quality & Regulations staff designee shall be the Patient Safety Officer for the organization. The Patient Safety Officer shall be accountable directly to the Senior Leader, through the supervision of the Director of Quality and Regulations, and shall participate in the Patient Safety/Medical Staff Quality Committee.
6. **Patient Safety/Medical Staff Quality Committee**
    1. The Patient Safety Committee shall:
        1. Receive reports from the Director of Quality and Regulations and/or the Patient Safety Officer

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2. Evaluate actions of the Director of Quality and Regulations and/or Patient Safety Officer in connection with all reports of adverse events, near misses or unexpected/unintended outcomes alleged to have occurred
3. Review and evaluate the quality of measures carried out by the organization to improve the safety of patients who receive treatment in the Health System
4. Make recommendations to the executive committee or governing body of the Health System to reduce the number and severity of adverse events that occur
5. Report quarterly, and as requested, to the executive committee and governing body
6. The Patient Safety Committee members shall include, at least, the following individuals:
    1. Director of Quality and Regulations or the Patient Safety Officer designee, if not one and the same
    2. Members of the medical staff
    3. One member of the nursing staff (CNO or designee)
    4. Director of Pharmacy
    5. Medical Director of Quality
    6. Risk Manager, if not one and the same as the Patient Safety officer
    7. Chief Operating Officer

D. PROGRAM ELEMENTS, GOALS AND OBJECTIVES

1. Assess patient safety risk, identify threats, prevent occurrence or mitigate frequency and severity of harm when unexpected/unintended outcomes occur
2. Promote a safe environment in the Health Systems to alleviate injuries, damages or losses
3. Foster communication with patients, employees, medical staff and administration when patient safety issues are identified
4. Contribute to PI activities and plans to resolve patient safety issues
5. Participate and/or consult on all patient disclosure conferences regarding unexpected/unintended outcomes
6. Manage losses, claims or litigation when adverse events occur.
7. **Designing or Re-designing Processes**
    a. When a new process is designed (or an existing process is modified) the organization will use the Patient Safety Officer to obtain information from both internal and external sources on evidence-based methods for reducing medical errors, and incorporate best practices into its design or re-design strategies.
8. **Identification of Potential Patient Safety Issues**
    a. As part of its planning process, the organization regularly reviews the scope and breadth of its services. Attendant to this review is an identification of care processes that, through the occurrence of an error, would have a significant negative impact on the health and well being of the patient. Areas of focus include:
        i. Processes identified through a review of the literature
        ii. Processes identified through the organization's performance improvement program

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iii. Processes identified through Safety Risk Management Reports (Event Reporting AQPI-06) and sentinel events (**Sentinel/Adverse Event/Error or Unanticipated Outcome, AGOV-35**)

iv. Processes identified as the result of findings by regulatory and/or accrediting agencies

v. The National Quality Forum: "Safe Practices for Better Healthcare – 02/2013 Update"

vi. Adverse events or potential adverse advents as described in HSC 1279.1. (Attachment A)

vii. Health-care-associated infections (HAI) as defined in the federal CDC National Healthcare Safety Network. (Attachment B)

viii. Adverse events associated with misconnecting intravenous lines, enteral feeding tubes, and epidural lines.

ix. TFHD specific results from the AHRQ Patient Safety Culture Survey

9. **Performance Related to Patient Safety**

   a. Once potential issues have been identified, the organization will establish performance measures to address those processes that have been identified as "high risk" to patient safety. In addition, the following will be measured:

   b. The perceptions of risk to patients and suggestions for improving care.

      i. The level of staff reluctance to report errors in care and staff perceptions of the organization's culture of safety as assessed through an industry-recognized external survey.

   c. Opportunities to reduce errors that reflect system issues are addressed through the organization's performance improvement program.

   d. Opportunities to reduce errors that reflect the performance of the individual care provider are addressed, as appropriate, through the Medical Staff peer review process or through the organization's human resource policy(s) using the practices and tenets of the Just Culture.

10. **Proactive Risk Assessments**

    a. Through implementation of this Patient Safety Plan, and integrated with the Risk Management Plan and other performance improvement processes, the Department of Quality and Regulations will systemically identify and mitigate patient safety risks and hazards with an integrated approach in order to continuously reduce preventable patient harm. Identified opportunities for improvement will then undergo redesign (as necessary) to mitigate any risks identified. A patient safety risk assessment by an external resource will be performed at least every 24 months and reported to the organization as described herein under "reporting structure." A focused patient safety risk assessment will be performed annually by the Patient Safety Officer and reported to the organization as described herein under "reporting structure."

11. **Responding to Errors**

    a. The organization is committed to responding to known errors in care or unexpected/unintended outcomes in a manner that supports the rights of the patient, the clinical and emotional needs of the patient, protects the patient and others from any further risk, and preserves information critical to understanding the proximal and – where appropriate – root cause(s) of the error. The organization's response will include care for the involved caregivers as noted below in 4.6.1. To that end, the organization has established a variety of policies and procedures to address these

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issues,

b. Errors that meet the organization's definition of a potential sentinel event will be subjected to an intensive assessment or root cause analysis using the tenets and practice of the Just Culture. Management of these types of errors is described in Sentinel/Adverse Event/Error or Unanticipated Outcome, AGOV-35.

12. **Supporting Staff Involved in Errors**

    a. Following serious unintentional harm due to systems failures and/or errors that result from human performance failures, the involved caregivers shall receive timely and systematic care which may include: supportive medical/psychological care, treatment that is compassionate, just and respectful and involved staff shall have the opportunity to fully participate in the event investigation, risk identification and mitigation activities that will prevent future events. To that end, the organization has defined processes to provide care for the caregivers: (Support for Employee Caregivers Involved in Sentinel or Adverse Events AHR-110)

13. **Educating the Patient on Error Prevention**

    a. The organization recognizes that the patient is an integral part of the healthcare team. Therefore, patients will be educated about their role and responsibility in preventing medical errors.

14. **Informing the Patient of Errors in Care**

    a. The organization recognizes that a patient has the right to be informed of results of care that differ significantly from that which was anticipated, known errors and unintended outcomes. Following serious unanticipated outcomes, including those that are clearly caused by systems failures, the patient, and family as appropriate, will receive timely, transparent and clear communication concerning what is known about the adverse event. Management of disclosure to patients/families is described in the Administrative policy, Disclosure of Unanticipated Adverse Outcome to Patients/Families AGOV-15.

15. **Reporting of Medical Errors**

    a. The organization has established mechanisms to report the occurrence of medical errors both internally and externally.

    b. Errors will be reported internally to the appropriate administrative or medical staff entity.

    c. Errors will be reported to external agencies in accordance with applicable local, state, and federal law, as well as other regulatory and accreditation requirements. For reporting process, see the Administrative policy, Sentinel/Adverse Event/Error or Unanticipated Outcome, AGOV-35.

16. **Evaluating the Effectiveness of the Program**

    1. On an annual basis, the organization will evaluate the effectiveness of the patient safety program. A report on this evaluation will be provided to the Patient Safety/Medical Staff Quality Committee, Medical Staff, Senior Leader(s), and to the Governing Body.

Related Policies/Forms: Sentinel/Adverse Event/Error or Unanticipated Outcome, AGOV-35; Event Reporting AQPI-06; Disclosure of Unanticipated Adverse Outcome to Patients/Families AGOV-15; Support for Employee Caregivers Involved in Sentinel or Adverse Events AHR-110; Risk Management Plan AQPI-04; The National Quality Forum: "Safe Practices for Better Healthcare – 02/2013 Update"

All revision dates: 02/2017, 12/2016, 03/2014, 02/2014, 11/2013, 10/

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2013, 01/2012, 01/2009

Attachments:

image1.jpeg

Process Flow for Risk Manager-Patient Safety.pdf

Approval Signatures

Step Description	Approver	Date
	Janet VanGelder: Director	01/2018
	Dawn Lockwood: Physician Quality Reporting Specialist	01/2018

Applicability

Tahoe Forest Hospital District

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REPORT TO THE DIRECTOR OF THE LEGISLATIVE COUNSEL BUREAU PURSUANT TO NRS 439.877(4) (d) – SUBMITTED BY:

Incline Village Community Hospital
880 Alder Ave.
Incline Village, NV 89451
Dawn Lockwood, MPT - Patient Safety Officer
July 1, 2017 – June 30, 2018

Check Lists Developed Include:	**Usage****	**Review*****	**Revisions***
Adverse Drug Events	All Patients	X	
Barcode Medication Administration	All Employees		11/2017
Medication Reconciliation Policy for IVCH	All Patients	X	
Discharge Medications	All Patients		
Case Management Discharge Planning	Adult and Pediatric Patients	X	
Food Medication Interactions	All Patients	X	
Labeling of Medications	All Patients	X	
Medication Administration	All Patients	X	
Medication Events	All Employees and Patients	X	
Medication Orders	Adult and Pediatric Patients		11/2017
EVS Cleaning: Patient Rooms and Treatment Areas	All Employees		
EVS: Cleaning Isolations Precaution Rooms	All EVS Staff		
Perioperative Services: EVS Cleaning the Surgical Procedural Area	All Employees		
EVS General Techniques and Procedures	All Employees		
Adult Admission, Transfers, Discharges, and Triage: Critical Care Services	Adult Critical Care Patients		8/2017
Code Blue Management	All Patients and Visitors	X	
Pediatric Code Blue Management	Pediatrics	X	
Procedural Sedation for Therapeutic / Diagnostic Procedures	Adult and Pediatric Patients		1/2018
Blood Gas Laboratory: Quality Control & Clinical Correlation Program	All Employees	X	
Blood Gas Laboratory: Review of Patient Data and Quality Controls	All Employees	X	
W&F: Vaginal Birth Sponge, Sharps, and Instruments	W&F Patients	X	
Blood and Blood Component Administration, Adult	Adults		6/2018
W&F: Magnesium Sulfate, Administration and Monitoring of the obstetrical Patient	W&F Patients	X	

Suicide Attempt – Self Harm Precautions	All Patients	X	
Safe Surgery checklist (Time Out)	All Patients		10/2017
Event Disclosure Checklist	All Patients	X	
Patient Safety Policies developed include:	**Usage**	**Review**	**Revisions**
Patient Identification	All inpatients and outpatients		2/2018
Hand Hygiene, Antisepsis, and Artificial Fingernails	All Employees, Patients, Physicians, Volunteers, Visitors, General Public	X	
Patient Safety Plan	All Patients		1/2018
Event Reporting	All Employees	X	
Safe Patient Handling and Mobility (SPHM) – Acute Care	All Patients		6/2018
Workplace Violence Prevention	All Employees, Patients, Physicians, Volunteers, Visitors, General Public		5/2018

Summary of Review	**Total # developed**	**Total # Reviewed**	**Total # revised**
Patient Safety Checklists	0	18	6
Patient Safety Policies	0	6	4

*Checklists and Patient Safety Policies were reviewed for the stated time period. Need for revision is noted by the date the revision was made.
**Usage outlines the units/departments in which the checklists are used.
***As part of the annual review any required revisions will be identified. If revisions are required this is noted in the revision box. Any additional patient safety checklists or policies identified will be noted in this (review) column. If the annual review reveals no changes are required this box will be marked with an "X". An "X" means that the checklists and policies were reviewed but no changes were required.

- Reports are due on or before July 1 of each year, address report to:
  Director LCB
  Rick Combs (2016)
  director@lcb.state.nv.us
  Copy to: Megan.Comlossy@lcb.state.nv.us
  Carson City, NV 89701