April 13, 2023

TO: Legal Counsel

News Media
Salinas Californian
El Sol
Monterey County Herald
Monterey County Weekly
KION-TV
KSBW-TV/ABC Central Coast
KSMS/Entravision-TV

The next regular meeting of the **QUALITY AND EFFICIENT PRACTICES COMMITTEE - COMMITTEE OF THE WHOLE** of the **SALINAS VALLEY HEALTH**[1] will be held **MONDAY, APRIL 17, 2023, AT 8:30 A.M., HEART CENTER TELECONFERENCE ROOM, SALINAS VALLEY HEALTH MEDICAL CENTER, 450 E. ROMIE LANE, SALINAS, CALIFORNIA** or via **TELECONFERENCE** (*visit* **SalinasValleyHealth.com/virtualboardmeetinglink** *for Access Information*).

Pete Delgado
President/Chief Executive Officer

[1]Salinas Valley Memorial Healthcare System operating as Salinas Valley Health

Committee Members: Catherine Carson, Chair; Rolando Cabrera, MD, Vice Chair; Pete Delgado, President/CEO; Allen Radner, MD, Chief Medical Officer; Clement Miller, Chief Operating Officer; Lisa Paulo, Chief Nursing Officer; Rakesh Singh, MD, Medical Staff Member; Michele Averill, Community Member

QUALITY AND EFFICIENT PRACTICES COMMITTEE
COMMITTEE OF THE WHOLE
SALINAS VALLEY HEALTH[1]

MONDAY, APRIL 17, 2023 8:30 A.M.
HEART CENTER TELECONFERENCE ROOM

Salinas Valley Health Medical Center
450 E. Romie Lane, Salinas, California
or via Teleconference
(Visit svmh.com/virtualboardmeeting for Access Information)

AGENDA

1. Call to Order / Roll Call

2. Approve the Minutes of the Quality and Efficient Practices Committee Meeting of March 20, 2023. (DELGADO)
   - Motion/Second
   - Action by Committee/Roll Call Vote

3. Patient Care Services Update (PAULO)
   - Research & Evidence Based Practice Council Report

4. Healthgrades Patient Safety Excellence Award (KUKLA)

5. Contract Evaluations Summary (KUKLA)

6. Public Input

   This opportunity is provided for members of the public to make a brief statement, not to exceed three (3) minutes, on issues or concerns within the jurisdiction of this District Board which are not otherwise covered under an item on this agenda.

7. Closed Session

8. Reconvene Open Session/Report on Closed Session

9. Risk Management Plan 2023 (KUKLA)

10. Patient Safety Plan 2023 (KUKLA)

11. Adjournment
    The next Quality and Efficient Practices Committee Meeting is scheduled for **Monday, May 22, 2023 at 8:30 a.m.**

[1]Salinas Valley Memorial Healthcare System operating as Salinas Valley Health

This Committee meeting may be attended by Board Members who do not sit on this Committee. In the event that a quorum of the entire Board is present, this Committee shall act as a Committee of the Whole. In either case, any item acted upon by the Committee or the Committee of the Whole will require consideration and action by the full Board of Directors as a prerequisite to its legal enactment.

The Committee packet is available at the Committee Meeting, at www.svmh.com, and in the Human Resources Department of the District. All items appearing on the agenda are subject to action by the Committee.

Requests for a disability related modification or accommodation, including auxiliary aids or services, in order to attend or participate in a meeting should be made to the Board Clerk during regular business hours at 831-755-0741. Notification received 48 hours before the meeting will enable the District to make reasonable accommodations.

QUALITY & EFFICIENT PRACTICES COMMITTEE
COMMITTEE OF THE WHOLE

AGENDA FOR CLOSED SESSION

Pursuant to California Government Code Section 54954.2 and 54954.5, the board agenda may describe closed session agenda items as provided below. No legislative body or elected official shall be in violation of Section 54954.2 or 54956 if the closed session items are described in substantial compliance with Section 54954.5 of the Government Code.

CLOSED SESSION AGENDA ITEMS

HEARINGS/REPORTS
(Government Code §37624.3 & Health and Safety Code §§1461, 32155)

Subject matter: (Specify whether testimony/deliberation will concern staff privileges, report of medical audit committee, hospital internal audit report, or report of quality assurance committee):

- Reports of the Medical Staff Quality and Safety Committee
  - Risk Management/Patient Safety Report
  - Accreditation and Regulatory Report
  - Disease Specific Care Program
    - Chest Pain Program
    - Total Joint Program
  - Review Quality and Safety Dashboard Development Results and Current Data
- Consent agenda item:
  - Pharmacy and Therapeutics/Infection Prevention & Antibiotics Stewardship Committee

REPORT INVOLVING TRADE SECRET
(Government Code §37606 & Health and Safety Code § 32106)

Discussion will concern: (Specify whether discussion will concern proposed new service, program, Trade Secret, Strategic Planning, Proposed New Programs and Services:

- Consent agenda item:
  - Contract evaluation

ADJOURN TO OPEN SESSION

CALL TO ORDER
ROLL CALL

(Chair to call the meeting to order)

SALINAS VALLEY HEALTH[1]
QUALITY AND EFFICIENT PRACTICES COMMITTEE MEETING
COMMITTEE OF THE WHOLE
MEETING MINUTES MARCH 20, 2023

Committee Members Present: Catherine Carson, Chair, Michele Averill *(Via Teleconference)*, Rolando Cabrera, MD, Vice-Chair, Pete Delgado, Clement Miller, Lisa Paulo, Allen Radner, MD, and Rakesh Singh, MD;

Committee Members Absent: None

Other Board Members Present Constituting Committee Of The Whole**:**
Joel Hernandez Laguna and Victor Rey, Jr. *(Via Teleconference)*

Michele Averill, joined the meeting at 8:45 a.m.

Vice Chair Cabrera left at 9:31.

CALL TO ORDER/ROLL CALL

A quorum was present and Chair Carson called the meeting to order at 8:34 a.m. Downing Resource Center, CEO Conference Room 117.

APPROVAL OF MINUTES FROM THE QUALITY AND EFFICIENT PRACTICES COMMITTEE MEETING OF FEBRUARY 22, 2023

Approve the minutes of the Quality and Efficient Practices Committee for the February 22, 2023 meeting, as presented. The information was included in the Committee packet.

No public input received:

MOTION:

Upon motion by Vice-Chair Cabrera, second by Committee Member Delgado, the Quality and Efficient Practices Committee minutes of February 22, 2023 were approved.

Ayes: Committee members: Dr. Cabrera, Delgado, Miller, Paulo, Radner, Dr. Singh, Carson; Noes: None; Abstentions: None; Absent: none. Motion Carried.

PATIENT CARE SERVICES UPDATE

Ms. Paulo introduced Meghan Ackerman, BSN, RN, OCN, UPC Chair, who provided a report on the Oncology Practice Council including information on a monthly journal club, monthly practice audits, employee recognition, professional development, practice improvement, best practices and upcoming projects. A full report was provided in the packet.

Discussion: Currently the UPC recognizes staff with a poster quarterly. Salinas Valley Health uses an outside vendor for cryopreservation. Two floor nurses have been added to the Council for frontline caregiver collaboration.

PUBLIC INPUT

No public comment received.

[1]Salinas Valley Memorial Healthcare System operating as Salinas Valley Health

CLOSED SESSION

Chair Carson announced that the item to be discussed in Closed Session is *Hearings/Reports – Report of the Medical Staff Quality and Safety Committee*. The meeting recessed into Closed Session under the Closed Session protocol at 8:48 a.m.

RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION

The Committee reconvened Open Session at 9:27 a.m., Chair Carson reported that in Closed Session, the Committee discussed *Hearings/Reports – Report of the Medical Staff Quality and Safety Committee*.

No action taken in the Closed Session.

REVIEW OF RECENT REGULATORY AND ACCREDITATION VISITS

Lilia Meraz-Gottfried, Director/Clinical Development, reported on regulatory and accreditation visits in February and March 2023. Action plans including education were reviewed. Of note one of the surveyors commented how engaged the staff are post pandemic. Director Carson commented about the success of these surveys. A full report was included in the packet.

REPORTABLE ADVERSE EVENTS PROCEDURES

Proposed revisions of Serious Reportable Events Policy and Attachment A were included in the packet. If event is determined to be reportable and potentially causing harm to a patient the Patient Safety Officer will notify the Board of Directors. After the full investigation is completed and the action plans are implemented, the Board of Directors will receive a detailed report on the sentinel/serious adverse event, through the regular reporting structure. The policy will go to the Policy Committee in April, then the Board for full approval.

Director Carson clarified Attachment A to the policy meets the CDPH Health and Safety code definition of sentinel and serious events.

QUALITY/PATIENT SAFETY DASHBOARD DEVELOPMENT

The goal is to have a combined dashboard to report to QEP monthly and the Board quarterly. The proposed dashboard was reviewed. A full report was included in the packet.

Director Carson suggested obtaining baseline data. The committee agreed to add ER Throughput to Patient and Employee Safety category and move Workplace Violence to Others to Consider.

ADJOURNMENT

There being no other business, the meeting adjourned at 9:48 a.m. The next Quality and Efficient Practices Committee Meeting is scheduled for **Monday, April 17, 2023 at 8:30 a.m.**

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Catherine Carson, Chair
Quality and Efficient Practices Committee

/KmH

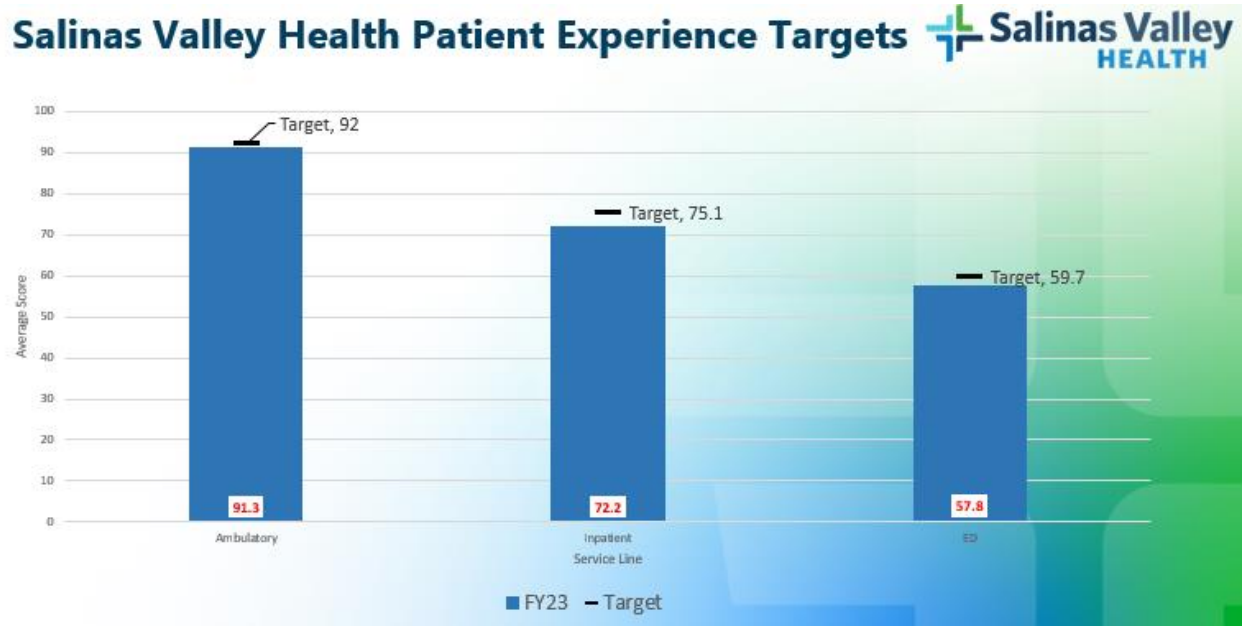
Board Paper: Quality & Efficient Practices Committee

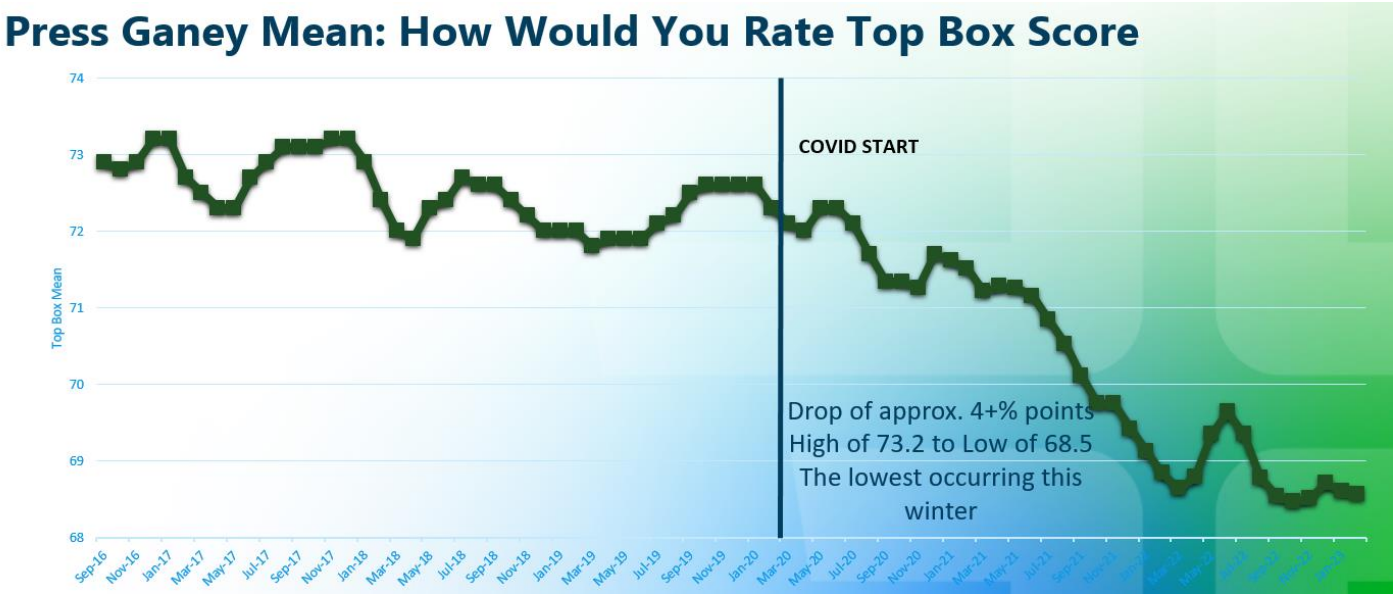
Agenda: Patient Care Services Update
Executive Sponsor: Lisa Paulo, MSN/MPA, RN
Date: April 17, 2023

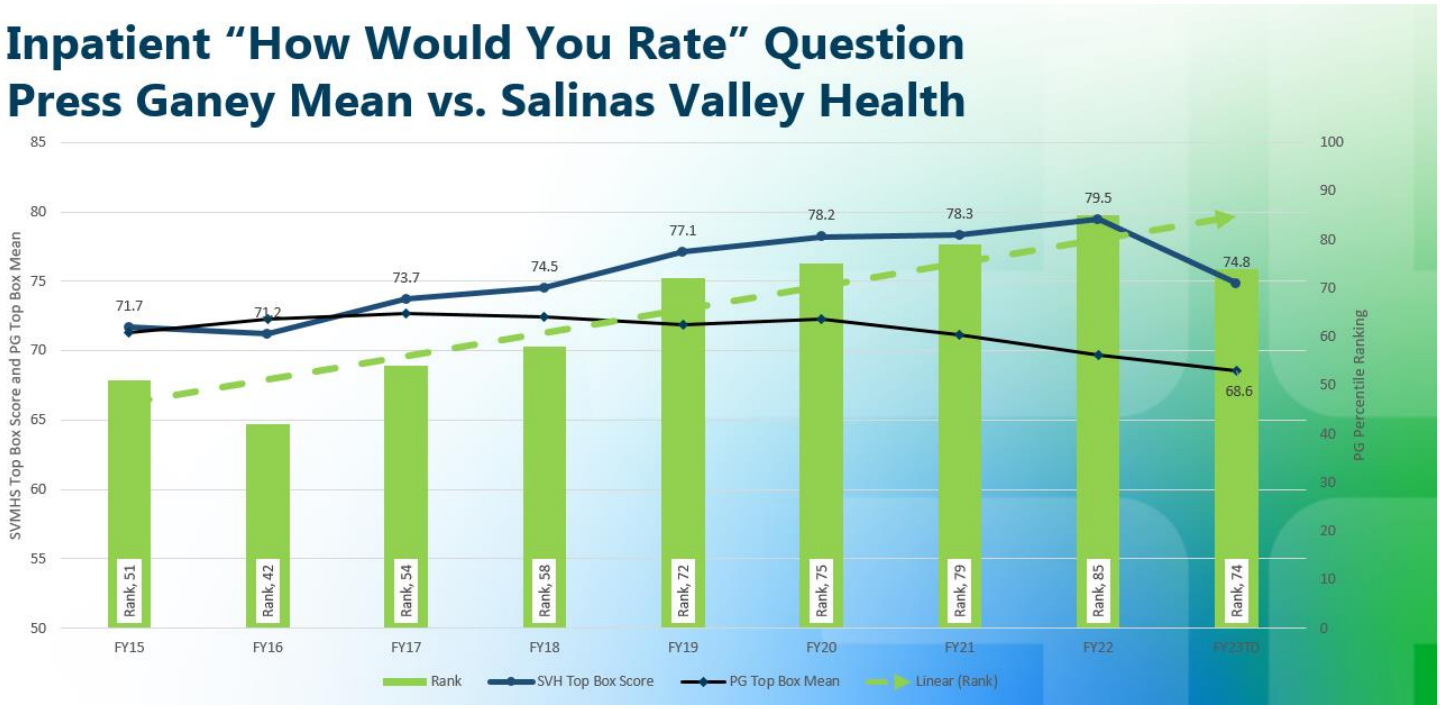
Pillar/Goal Alignment:

☒ Service ☐ People ☒ Quality ☐ Finance ☐ Growth ☐ Community

PATIE NT EXPERIENCE:







Salinas Valley Health Percentile Ranking Inpatient Dashboard: By Received Date

SVH Percentile Ranking Inpatient Dashboard: RECEIVED DATE											
AS OF 4/3/23											
Top Box Score	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	FY23TD	SVMHS Targets
Rate hospital 0-10	73.8	77.9	75.9	70.5	75.5	73.7	75.3	75.3	72.7	74.8	80.0
COMM W/ NURSES	77.9	80.3	80.9	78.2	80.0	81.5	74.2	79.6	80.8	79.4	82.1
RESPONSE OF HOSP STAFF	70.9	67.0	64.6	62.9	64.4	73.2	59.8	66.5	65.5	66.3	69.6
COMM W/ DOCTORS	79.7	79.4	78.7	78.6	80.9	83.1	80.7	82.1	81.4	80.5	82.5
HOSPITAL ENVIRONMENT	63.8	63.1	64.3	60.7	59.6	64.9	59.7	63.2	64.3	62.8	65.4
Cleanliness of hospital environment	81.0	76.4	82.0	79.5	73.3	83.0	70.1	79.9	79.2	78.3	81.8
Quietness of hospital environment	46.6	49.7	46.6	42.0	45.9	46.9	49.4	46.5	49.4	47.3	49.1
COMM ABOUT MEDICINES	64.9	66.3	69.6	60.5	73.1	77.7	60.3	63.1	71.1	67.2	70.1
DISCHARGE INFORMATION	93.7	90.1	83.6	90.4	87.9	93.4	84.4	91.7	92.4	89.7	91.1
CARE TRANSITIONS	56.6	58.2	55.0	57.0	57.6	57.3	55.4	55.9	56.3	56.9	59.9
Average HCAHPS	72.6	72.8	71.6	69.8	72.4	75.6	68.7	72.2	73.1	72.2	75.1
SVMHS Target	75.1	75.1	75.1	75.1	75.1	75.1	75.1	75.1	75.1	75.1	75.1
Percentile Ranking	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	FY23TD	KEY
Rate hospital 0-10	68	83	78	57	76	69	75	76	66	74	0-25%ile
COMM W/ NURSES	46	65	70	50	64	73	27	63	71	61	25-50%ile
RESPONSE OF HOSP STAFF	80	70	61	55	62	87	41	71	68	71	51-75%ile
COMM W/ DOCTORS	56	55	51	50	66	77	64	73	69	63	76-99%ile
HOSPITAL ENVIRONMENT	45	42	47	31	27	53	31	46	51	44	
Cleanliness of hospital environment	87	75	89	85	64	91	49	85	83	80	
Quietness of hospital environment	11	18	11	5	10	15	21	15	21	17	
COMM ABOUT MEDICINES	78	84	92	56	96	99	55	74	94	89	
DISCHARGE INFORMATION	96	84	30	86	68	95	35	91	93	81	
CARE TRANSITIONS	77	83	71	79	81	78	73	75	76	78	
N Size	150	177	169	157	164	134	158	150	157	1438	

Salinas Valley Health ED Ranking Dashboard : By Received Date

ED Ranking Dashboard: RECEIVED DATE - As of 4/6/2023											
Top Box Score	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	FY23TD	SVMHS Targets
ED Rating	63.4	57.9	60.9	54.6	52.7	54.9	63.9	65.3	64.2	61.6	66.9
Std Arrival	35.0	30.7	31.2	32.4	29.5	24.4	33.9	36.7	34.0	31.9	39.5
Std Nurses	61.9	61.5	63.0	59.1	58.7	59.1	59.8	66.3	63.3	61.3	65.3
Std Doctors	64.1	67.0	67.3	57.7	58.0	60.5	61.7	65.4	64.0	62.6	67.1
ED Overall Score	59.7	58.8	60.2	54.6	54.6	54.2	57.9	61.9	60.0	57.8	59.7
SVMHS Target	*59.7*	*59.7*	*59.7*	*59.7*	*59.7*	*59.7*	*59.7*	*59.7*	*59.7*	*59.7*	
Percentile Ranking	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	FY23TD	KEY
ED Rating	51	25	37	18	13	18	45	46	45	37	0-25%ile
Std Arrival	15	10	10	12	8	3	15	19	14	10	26-50%ile
Std Nurses	20	20	25	14	14	15	17	33	24	19	51-75%ile
Std Doctors	37	49	51	16	17	24	28	41	36	31	76-99%ile
Overall Ranking	28	26	32	15	14	15	23	34	28	22	
N Size	252	219	235	236	211	282	240	197	274	2183	

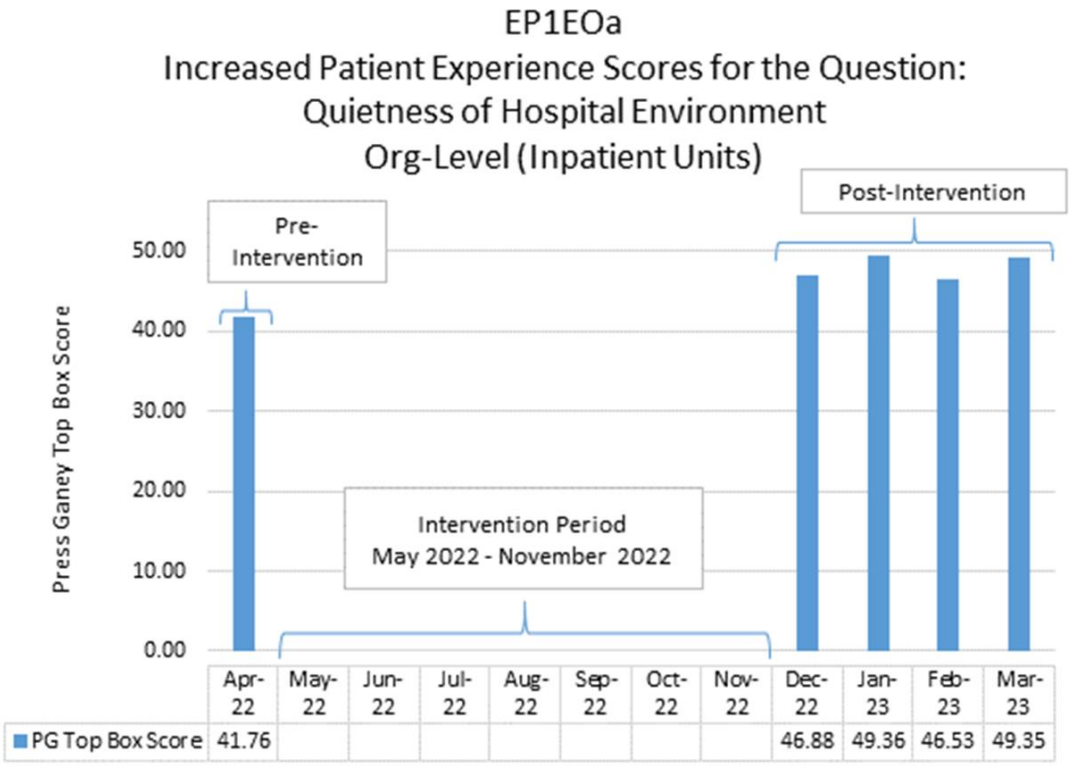
Salinas Valley Health Ambulatory Percentile Ranking Dashboard: By Received Date

AMBULATORY Percentile Ranking Dashboard: RECEIVED DATE											
AS OF 4/6/23											
Top Box Score	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	FY23TD	SVMHS Targets
Facility rating 0-10	80.9	84.3	90.6	80.3	86.9	85.5	85.3	91.7	85.5	85.2	**87.7**
COMMUNICATION	87.3	85.4	89.2	89.0	91.0	89.6	88.6	88.0	89.4	88.8	**89.2**
FACILITY/PERSONAL TRTMENT	96.8	92.0	97.5	93.8	95.3	94.6	96.7	97.5	97.6	95.8	**96.1**
DISCHARGE	97.4	95.2	93.2	94.7	95.9	95.5	95.6	96.3	95.6	95.5	**95.3**
Average CAHPS	**90.6**	**89.2**	**92.6**	**89.5**	**92.3**	**91.3**	**91.5**	**93.4**	**92.0**	**91.3**	**92.0**
SVMHS Target	***92.0***	***92.0***	***92.0***	***92.0***	***92.0***	***92.0***	***92.0***	***92.0***	***92.0***	***92.0***	
Percentile Ranking	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	FY23TD	KEY
Facility rating 0-10	15	29	51	12	42	33	31	76	32	30	0-25%ile
COMMUNICATION	9	3	6	17	36	22	13	10	17	13	26-50%ile
FACILITY/PERSONAL TRTMENT	46	2	38	7	17	13	45	67	69	28	51-75%ile
DISCHARGE	73	17	2	10	26	18	19	34	18	17	76-100%ile
Sample	47	51	53	71	61	69	75	48	62	548	

Celebrate Wins: TOP Quartile Club

HC Percentile Ranking Dashboard								
AS OF 4/3/2023								
HC Top Box Score	1Q23	2Q23	3Q23	Jan-23	Feb-23	Mar-23	FY23TD	HC TGT
Rate hospital 0-10	83.3	79.0	79.7	95.5	69.2	76.2	80.8	84.0
COMM W/ NURSES	79.7	79.4	80.0	85.5	69.2	87.3	79.8	82.1
RESPONSE OF HOSP STAFF	75.7	63.6	65.3	59.7	57.6	80.9	68.6	75.7
COMM W/ DOCTORS	86.2	81.9	86.0	84.9	80.7	93.7	84.5	85.3
Cleanliness of hospital environment	81.8	81.3	80.9	90.9	73.1	80.0	81.6	82.1
Quietness of hospital environment	41.8	43.2	53.6	60.9	42.3	60.0	46.0	47.4
COMM ABOUT MEDICINES	61.3	64.8	58.8	58.3	47.5	83.9	61.8	69.6
DISCHARGE INFORMATION	84.4	88.0	91.9	90.5	88.1	97.5	88.3	92.0
CARE TRANSITIONS	54.8	59.9	55.6	59.8	47.1	62.4	57.0	61.3
Average Score	**73.4**	**72.4**	**73.1**	**76.2**	**64.6**	**81.5**	**73.1**	**76.8**
Target Score	*76.8*	*76.8*	*76.8*	*76.8*	*76.8*	*76.8*	***76.8***	
Telemetry Benchmark Rank	1Q23	2Q23	3Q23	Jan-23	Feb-23	Mar-23	FY23TD	0-25%ile
Rate hospital 0-10	95	88	90	99	62	82	92	26-50%ile
COMM W/ NURSES	73	69	74	94	21	96	74	51-75%ile
RESPONSE OF HOSP STAFF	97	75	82	63	57	99	89	76-100%ile
COMM W/ DOCTORS	94	82	94	93	78	99	92	
Cleanliness of hospital environment	93	94	93	99	73	91	94	
Quietness of hospital environment	18	27	58	77	24	76	36	
COMM ABOUT MEDICINES	75	83	63	58	16	99	75	
DISCHARGE INFORMATION	53	72	94	88	76	99	78	
CARE TRANSITIONS	82	92	82	92	49	95	85	
N Size	68	76	70	23	26	21	217	

Celebrate Wins: Quiet at Night Narrative



Examples of Continued Efforts

Salinas Valley HEALTH

PX Specific:

- Huron Engagement
- Professional Governance Structure
  - Evidence Based Practice Cohort Course
- Performance Improvement Analyst
  - Information/expertise support
  - 3x3 Challenge
  - Expansion of focus
  - Patient Experience Week
- Service Excellence Education
- Charge RN Education Day
- Executive Commitment

Employee Specific:

- Employee Engagement – customized action plans
- Health Partners Engagement
- The Good Listening Project
- Schwartz Round implementation
- Peer Feedback Training
- Wellness Your Way
- 1440 – Multiversity
- Unit focused support

QUALITY:

Research & Evidence-Based Practice Council (REBP)

Norma Coyazo, MSN, RN,L&D (Chair)
Celina Medina, MSN, RN, ICU (Co-Chair)
Abigail Acosta, MSN, RN, PACU
Kristen Green Meadows, BSN, ICU
Megan Lopez, MSN, RN, Procedural
Kristen Wisner, PhD, RNC-OB,CNS, C-EFM, NE-BC
Stephanie R. Frizzell, MSN, RN, Education Department
Julie Vasher, DNP, RNC-OB, CNS,C-EFM, C-ONQS,(Advisor)

Salinas Valley HEALTH

Purpose

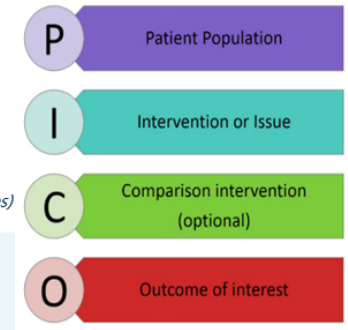
Salinas Valley HEALTH

Promote research and evidenced-based practice (EBP) at SVH and to build a capacity for nursing research and the use of evidence-based practice to advance clinical excellence. The council assists in the research and EBP process, and fosters and supports investigative role development and dissemination of findings.

Where We Are:

2023 EBP Cohort Workshop

- Cohort workshop includes 4 sessions
- Define evidence-based practice (EBP)
  (Is a problem-solving approach that integrates best available evidence, clinical expertise, and patient values)
- PICO question
  (An acronym used to formulate a well defined searchable question)
- Johns Hopkins tools
- Literature review



Clinical Inquiry

Literature review

Implementation

Dissemination

What We've Done:

Nursing Innovation Fund

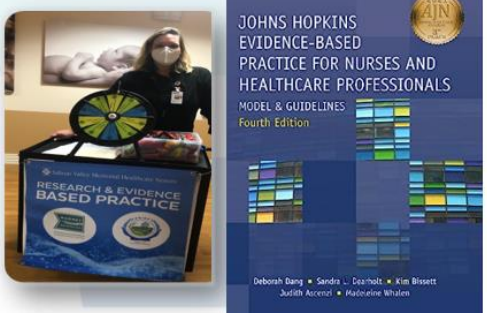
- Fund contributions are made to the Salinas Valley Health Foundation through the Employee Giving Program
- Foster clinical and organizational excellence by supporting nursing innovation
- In June, we are supporting two clinical nurses presenting at Stanford's Interprofessional Healthcare Conference

REBP Workshop

- Leadership Cohort

Education

- Provide education to new grad nurses within the resident program to introduce EBP
- Create a REBP rounding cart in which REBP members rounded throughout the hospital with the goal of increasing clinical nurse knowledge about REBP



Nursing Evidenced-Based New Initiatives

- HAPI (Hospital Acquired Pressure Injury) Bundle
  - Goal is to prevent and decrease hospital acquired pressure injury
- Hypersensitivity Kit
  - Goal is to increase RN knowledge, confidence and to streamline the response to hypersensitivity reactions

**REBP council supported the project leaders in creating their PICO questions, use of John Hopkins tools, and literature review.*

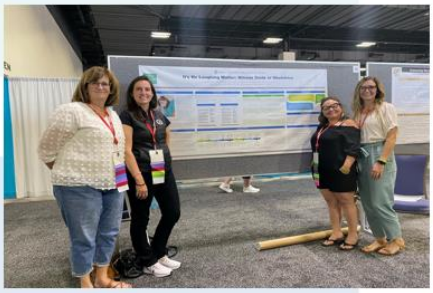
Research:

Healthcare Provider's Perspective and Practices on Bereavement Support:

- Qualitative research study
- Obtained current bereavement practice survey from ICU, ED, and telemetry step-down units
- Collaborated with California State University Monterey Bay (CSUMB) and Samuel Merritt
- REBP provided the participation of the first personal investigator (PI) and oversaw the study

Poster Presentation at AMSN & AWHONN

- **Thumbprint-in-a-Bottle"** poster from Med-Surg was presented at the 31st Annual Medical-Surgical Nursing Convention (AMSN) in San Antonio, Texas
- **"It's No Laughing Matter: Nitrous Oxide in Obstetrics"** from Labor Delivery was presented at Association of Women's Health, Obstetric and Neonatal Nurse (AWHONN) National Conference in Colorado



Recruited Alyssa Erikson, PhD, RN, CNE

- Associate Professor & Chair of the Department of Nursing at CSUMB
- Collaborated with REBP council to host the EBP cohort workshops for clinical nursing and new leaders

Abstract Development Class

- Hosted by Alyssa Erikson, PhD, RN, CNE
- An abstract provides: *A description of a clinical problem or research question, the methods used to address it and the significant results and implications*

What is Coming:

2023 Poster Expo

- The annual poster expo will be held during Nurses and Hospital Week (May)
- 12 posters will be presented that showcase the great work of our nurses

Quality and Safety Committee Report to Quality and Efficient Practices Committee

April 17th, 2023

Open agenda items

Quality & Safety National Recognition

Spring Leapfrog Score: will be announced May 3rd, 2023

Healthgrades Patient Safety Excellence Award 2023:

* Award is based on CMS 2019-2021 data and excludes patients with COVID diagnosis.

SVHMC had better than expected Patient Safety Indicator rates for:

- occurrence of pressure injuries
- post-procedural and surgical bleeding rates and
- occurrence of pulmonary embolism and leg DVTs.

Contract Evaluations

A comprehensive evaluation and review of SVHMC Direct and Indirect and CMO contracts are completed every three years

SVHMC:

Direct Contracts - Exercise the option to renew or extend 27 of the 27 contracts because vendors have met required criteria.

Indirect Contracts – Exercise the option to renew or extend 322 of the 322 contracts because vendors have met required criteria.

NOTE: There were 2 Direct and 4 Indirect contracts that had opportunities for improvement and action plans and monitoring are in effect.

CMO contracts:

Direct Contracts: Exercise the option to renew or extend 72 of the 72 as they have met the required criteria.

Indirect Contracts: Exercise the option to renew or extend 76 of the 76 as they have met the required criteria.

NOTE: the contract for Vesta is a new contract, it had areas of opportunity and an action plan has been established and monitoring is in effect.

PUBLIC INPUT

CLOSED SESSION

(Report on Item to be Discussed in Closed Session)

RECONVENE OPEN SESSION/
REPORT ON CLOSED SESSION

Status Draft PolicyStat ID 13417050

Last Approved	N/A	Owner	Brenda Bailey: Risk Manager
Last Revised	N/A	Area	Plans and Program
Next Review	N/A		

Risk Management Plan

I. SCOPE

A. Enterprise Risk Management is a systematic process of identifying events, evaluating and reducing losses associated with patient, personnel or visitor injuries, property loss or damages and other sources of potential legal liability.

B. The Risk Management Program Plan is enacted to protect Salinas Valley ~~Memorial Healthcare System~~Health (~~SVMHS~~SVH) and all entities under their purview against the adverse consequences of accidental losses, regardless of source, effectively managing losses that may occur, and to enhance the continuous improvement of patient care services in a safe healthcare environment.

C. The CEO and Board of Directors have given the authority to the Risk Management Division to implement, monitor and track the elements of the Enterprise Risk Management Program under cover of this plan.

D. This enterprise risk management framework is geared to achieving the entity's objectives, set forth in four categories:

   i. *Strategic* – high-level goals, aligned with and supporting its mission

   ii. *Operations* – effective and efficient use of its resources

   iii. *Reporting* – reliability of reporting

   iv. *Compliance* – compliance with applicable laws and regulations.

E. The Risk Management Program Plan is organization wide and applies to all departments, programs and services at ~~SVMHS~~SVH. The scope of the program will encompass the patient population, employees, visitors, volunteers, students and other personnel providing services at ~~SVMHS~~SVH including medical staff. ~~SVMHS~~SVH has entities other than the acute care hospital under the Health System purview and these ~~SVMHS~~SVH entities adhere to this Risk Management Program Plan.

F. The Risk Management Program Plan establishes an approach to monitoring, evaluating, and managing risks throughout the organization. A risk is an uncertain event or condition that, if it

occurs, has a negative or positive effect on the organization.

G. Salinas Valley Health supports a Just Culture philosophy and approach to adverse event investigation and response and has adopted the BETA Healthcare Group Just Culture Algorithm for responding to the behaviors of their employees in a fair and just manner.

II. OBJECTIVES/GOALS

A. In order to approach the process of Risk Management systematically, ~~SVMHS~~SVH utilizes the following four-step model for Risk Management

1. The identification of risks
2. The analysis of the risk identified
3. The treatment of risks
4. The evaluation of risk treatment strategies

B. This model assists in setting priorities for Risk Management activities and ensures a comprehensive Risk Management effort. Any single strategy or combination of the above Risk Management strategies may be employed to best manage a given situation.

C. **Risk Identification:**

1. Risk Identification is the process whereby awareness of risks in the health care environment that constitute potential loss exposures for the facility is identified.
2. The following information services may be utilized to identify potential risks:
    a. Identification of trends through the incident reporting system
    b. Patient, visitor, staff and physician complaint reports
    c. Performance improvement functions
    d. Peer review activities
    e. Informal discussions with management and staff members

D. **Risk Analysis:**

1. Risk Analysis is the process of determining the potential severity of the loss associated with an identified risk and the probability that such a loss will occur. These factors establish the seriousness of a risk and will guide management in the selection of an appropriate risk treatment strategy.

E. **Risk Treatment:**

1. Risk Treatment refers to the range of choices available to leadership in handling a given risk. Risk Treatment strategies include the following:
    a. Risk acceptance involves assuming the potential loss associated with a given risk and making plans to cover any financial consequence of such losses.
    b. Risk avoidance is a strategy utilized when a given risk poses a particularly serious threat that cannot be effectively reduced, and the conduct or service giving rise to the risk may perhaps be avoided.

c. Risk reduction or minimization involves various loss control strategies aimed at limiting the potential consequences or frequency of a given risk without totally accepting or avoiding the risk. Strategies may include system redesign, staff education, policy and procedure revision and other interventions aimed at controlling adverse occurrences without completely eliminating risk activities.

F. **Risk Management Evaluation:**

1. The final step in the Risk Management process is risk management evaluation. The effectiveness of the techniques employed to identify, analyze and treat risks are assessed and further action taken when warranted. If improvement and/or resolution of the risk are evident, additional follow-up will be done at predetermined intervals to evaluate continued improvement. This evaluation is in concert with the Salinas Valley ~~Memorial Hospital~~Medical Center Patient Safety Program Plan and Quality Assessment and Performance Improvement Plan.

III. DEFINITIONS

IV. PLAN MANAGEMENT

A. Plan Elements

1. The Risk Management Program is concerned with a variety of issues and situations that hold the potential for liability or losses for the hospital/organization. It addresses the following categories of risk:

Patient-Related Risks, including but not limited to:

- Patient Safety and all elements therein
- Policies and Procedures
- Licensing and Accreditation processes
- Confidentiality and appropriate release of patient medical information/protected health information (PHI)
- Patient Rights
- The securing of appropriate informed patient consent for medical treatment
- Nondiscriminatory treatment of patients, regardless of race, religion, national origin or payment status
- Protections of patient valuables from loss or damage

Medical Staff-Related Risks

- Medical Staff peer review and quality/performance improvement activities
- Confidentiality and protection of the data obtained
- Medical Staff credentialing, appointment and privileging processes

Employee -Related Risks

- Maintaining a safe work environment
- Reduction of the risk of occupational illnesses and injury
- Provision for the treatment and compensation of workers who suffer on-the-job injuries and work-related illnesses
- Ensuring nondiscrimination in recruitment, hiring and promotion of employees

Technology

- Maintaining Risk Management Information Systems (RMIS), Electronic Health Records (EHR)
- Meaningful Use, social networking and cyber liability.

Strategic

- Managed care relationships/partnerships
- Mergers, acquisitions, divestitures, joint ventures, affiliations and other business arrangements
- Contract administration

Financial

- **Access** to capital or external financial ratings through business relationships or the timing and recognition of revenue and expenses
- Costs associated with malpractice, litigation, and insurance, capital structure, credit and interest rate fluctuations, foreign exchange, growth in programs and facilities, capital equipment, corporate compliance (fraud and abuse), accounts receivable, days of cash on hand, capitation contracts, billing and collection

Legal/Regulatory

- The failure to identify, manage and monitor legal, regulatory, and statutory mandates on a local, state and federal level fraud and abuse, licensure, accreditation, product liability, management liability, Centers for Medicare and Medicaid Services (CMS) Conditions of Participation (CoPs) and Conditions for Coverage (CoC), as well as issues related to intellectual property.

Other Risks

- Ensuring mechanisms to prevent and reduce the risk of losses associated with fire, flood, severe weather and utilities malfunction
- Ensuring the development and implementation of emergency preparedness plans
- Ensuring that appropriate protocols are in place for hazardous materials/waste

management

- Maintaining a safe environment for patients and visitors
- Assisting Quality/Performances Improvement efforts to identify those areas which represent an opportunity to improve patient care and reduce risk.

2. Enterprise risk management consists of eight interrelated components. These are derived from the way management runs an enterprise and are integrated with the management process. Enterprise risk management is not strictly a serial process, where one component affects only the next. It is a multidirectional, iterative process in which almost any component can and does influence another. These components are:
    a. *Internal Environment* – The internal environment encompasses the tone of an organization, and sets the basis for how risk is viewed and addressed by the facility, people, including risk management philosophy and risk appetite, integrity and ethical values, and the environment in which we operate.
    b. *Objective Setting* – Objectives must exist before leaders can identify *potential* events affecting their achievement. Enterprise risk management ensures that management has in place a process to set objectives and that the chosen objectives support and align with our mission and are consistent with our risk appetite.
    c. *Event Identification* – Internal and external events affecting achievement of our objectives must be identified, distinguishing between risks and opportunities. Opportunities are channeled back to leaders strategy or objective-setting processes.
    d. *Risk Assessment* – Risks are analyzed, considering likelihood and impact, as a basis for determining how they should be managed. Risks are assessed on an inherent and a residual basis.
    e. *Risk Response* – Leadership selects risk responses – avoiding, accepting, reducing, or sharing risk – developing a set of actions to align risks with the entity's risk tolerances and risk appetite.
    f. *Control Activities* – Policies and procedures are established and implemented to help ensure the risk responses are effectively carried out.
    g. *Information and Communication* – Relevant information is identified, captured, and communicated in a form and timeframe that enable people to carry out their responsibilities. Effective communication also occurs in a broader sense, flowing down, across, and up the entity.
    h. *Monitoring* – The entirety of enterprise risk management is monitored and modifications made as necessary. Monitoring is accomplished through ongoing leadership activities, separate evaluations, or both.

B. Plan Management

1. The Plan Elements, although some may not be under the direct accountability /responsibility of the Risk Management Division, may be assured through, but not limited to the following tasks.
    a. Investigate adverse occurrences to assess and determine how similar occurrences might be averted, review patterns and trends, control the loss related to the adverse

occurrence, and identify areas for performance improvement.

b. Assess premise/property for potentially hazardous conditions which may present unnecessary risk to employees, patients, and visitors and make risk recommendations.

c. Review the performance of persons providing care to patients to identify practices which may present unnecessary risks to patients or deviate from acceptable standards.

d. Participate in policy and procedure review to update, amend, edit, and revise to reflect appropriate care, legislative requirements, and minimize or prevent liability ramifications.

e. Participate in response and management of regulatory investigations.

f. Organize educational programs on risk management topics to promote awareness of risk management and safe practices.

g. Report Effectiveness - Periodic reports are provided by the various areas previously described to assess the effectiveness of their monitoring. Outcome evaluations are conducted and reported annually as part of the Quality and Safety Committee.

h. Claims Management - Coordinate the management of claims against ~~SVMHS~~SVHMC in a timely, organized, manner. The Risk and Patient Safety Division, in concert with the Patient Safety Officer investigates complaints, grievances, safety related events, incidents and actual or potential claims by a process protected from discovery. Safety events or Claims presenting serious exposure are reported immediately to the appropriate individuals. Issues concerning the hospital will be investigated and resolved with the assistance of Quality Management, affected departments, and staff, administration, physicians, and patient / family as needed. The results of the findings are provided to the appropriate individuals or committee. Matters involving care provided by the physician are forwarded to the Medical Staff Department~~, in concert with the Safety Officer investigates complaints, grievances, safety related events, incidents and actual or potential claims by a process protected from discovery. Safety events or Claims presenting serious exposure are reported immediately to the appropriate individuals. Issues concerning the hospital will be investigated and resolved with the assistance of Quality Management, affected departments, and staff, administration, physicians, and patient / family as needed. The results of the findings are provided to the appropriate individuals or committee. Matters involving care provided by the physician are forwarded to the Medical Staff Department~~ for further review and response as indicated. See Attachment "B" Claims Process Map.

C. Plan Responsibility

1. Everyone in the organization has some responsibility for enterprise risk management. The Board of Directors provides important oversight to enterprise risk management, and is aware of and concurs with the risk appetite.
2. The Chief Executive Officer is ultimately responsible to assure the implementation of the Risk Management Program Plan.

3. The Risk and Patient Safety Division under the authority of the CMO is responsible for the implementation of the Risk Management Program Plan. The Risk Manager and the Patient Safety Officer ~~works~~work in concert with other departments and leaders such as, Human Resources, Employee Health, Infection Prevention, Quality Management, Accreditation and Regulatory, Safety Officer, Medical Staff Services and others to assure full implementation of the Program Plan.
4. All leadership supports the risk management philosophy; promotes compliance with our risk appetite, and manages risks within their spheres of responsibility consistent with risk tolerances. These leaders are also responsible for executing enterprise risk management in accordance with established directives, policies, procedures and protocols as outlined by SVMHS.
5. A number of external parties, such as customers, vendors, business partners, external auditors, regulators, and financial analysts often provide information useful in effecting enterprise risk management, but they are not responsible for the effectiveness of, nor are they a part of, this program plan.

   See Attachment "A" for Risk Management Program Structure

D. Confidentiality

1. Confidentiality shall be in effect for all Risk Management activities.
2. All communication and documentation generated as part of the Risk Management program are to be confidential and subject to the state and federal laws protecting such documents from discovery, including Attorney: Client Privileges and Patient Safety Work Product as applicable. It is the intent of this Risk Management Program Plan to apply all existing legal standards and state or federal statutes to provide protection to the documents, proceedings, and individuals involved in the program.
3. The medical staff Quality and Safety Committee is responsible for the oversight of the Risk Management Program. All information, data, reports, minutes, or memoranda relating to the implementation of this Risk Management Program Plan are solely for use in the course of internal quality control for the purpose of reducing morbidity and mortality and improving the environment of care.
4. Any and all documents and records that are part of the internal Risk Management program as well as the proceedings, reports and records from any of the involved committees shall be maintained in a confidential manner. Disclosure to any judicial or administrative proceedings will occur only under court order or legal mandate and in accordance with the Patient Safety Work Product protections.

E. Performance Measurement

1. The performance measurement process is one part of the evaluation of the effectiveness of the Risk Management Program. Performance measures may be established to measure at least one important aspect of the Risk Management Program.
2. On an annual basis, the Safety and Reliability Committee and Quality and Safety Committee evaluates the scope, objectives, performance, and effectiveness of the Plan to manage risks to

the staff, visitors, and patients at Salinas Valley Memorial Hospital.

F. Orientation and Education

1. Evaluation of the education and training needs of hospital staff and healthcare providers; participating in events annually to promote risk initiatives, making recommendations, coordinating and or conducting in-service programs, submitting information for medical staff physician education and issuing materials in the field of Risk Management is critical to the success of the Risk Management Program Plan.

V. REFERENCES

A. Risk Management Handbook for Healthcare Organizations
B. California Evidence Code 1157
C. Patient Safety and Quality Improvement Act of 2005; 42 U.S.C. 299b-21
D. American Society for Health Care Risk Management of the American Hospital Association
E. INFORMATION SECURITY RISK MANAGEMENT #1010

Attachments

A: Risk Management Program Structure

Approval Signatures

Step Description	Approver	Date

Standards

No standards are associated with this document

History

Status Draft PolicyStat ID 13353523

Last Approved	N/A	Owner	Aniko Kukla: Director Quality & Patient Safety
Last Revised	N/A	Area	Plans and Program
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Patient Safety Program Plan

I. PURPOSE

A. To describe the components of the Patient Safety Program at Salinas Valley Health Medical Center under the Salinas Valley Memorial ~~Hospital~~Health (~~SVMH) under the Salinas Valley Memorial Healthcare System (SVMHS~~SVH), which supports and promotes the mission, vision, and strategic plan for the organization. The program plan is designed to reduce medical errors and hazardous conditions and reduce preventable patient safety events by utilizing a systematic, coordinated and continuous evidence based approach to maintenance and improvement of the health and safety of our patients. The components are outlined in the following sections:

- Patient Safety Program Scope and Purpose
- Patient Safety Plan Annual Goals and Objectives
- Patient Safety Program Organizational Structure & Responsibilities
- Patient Safety Program Elements
- Patient Safety Plan Management

B. To deliver health care to our community with the commitment to provide safe and high quality equitable health care to all patients we serve.

- The organization recognizes that a patient has the right to a safe environment, and an error free care experience. Therefore, the organization commits to undertaking a proactive approach to the identification and mitigation of medical errors.
- The organization also recognizes that despite our best efforts, errors can and will occur. Therefore, it is the intent of the organization to respond quickly, effectively, and appropriately when an error does occur.
- 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.

II. PATIENT SAFETY PROGRAM SCOPE AND PURPOSE

A. The purpose of the organizational Patient Safety Program Plan is to develop, implement and evaluate a patient safety program that improves patient safety and reduces risk to patients through an environment that encourages:

- Recognition and acknowledgement of risks to patient safety and medical/health care errors that impact achieving better outcomes.
- The initiation of actions to promote a culture of safety throughout the facility which includes but are not limited to safe integration of technology when possible.
- Creation of a non-punitive approach for reporting, analyzing and evaluating errors and problems.
- Facilitation of sharing knowledge to effect behavioral changes and organizational improvement to reduce risk and improve patient safety.
- Implementation of known proactive practices that promote patient safety and decrease variation and defects (waste).
- Promotion of the rapid redesign of unsafe care processes, methods and systems in response to actual and potential adverse events that are validated, to ensure reliability.
- Development of methods for analyzing systems and processes to track and monitor patient safety.
- The internal reporting/communication of identified risks and the action taken to promote a standardized way for interdisciplinary teams to communicate and collaborate.
- Organization-wide education about medical/health care errors.
- Adherence to regulatory and accreditation standards related to Patient Safety.

B. The Patient Safety Program Plan establishes mechanisms that support effective responses to actual occurrences; ongoing proactive reduction in medical/health care errors; and integration of patient safety priorities into the new design and redesign of all relevant organization processes, functions and services.

C. As patient care and patient services are coordinated and collaborative efforts, the approach to optimal patient safety involves multiple departments and disciplines in establishing the plans, processes and mechanisms that comprise patient safety activities. The Patient Safety Program Plan outlines the components of the organizational Patient Safety Program.

D. The purpose of the Patient Safety Program is:

- To improve patient safety and reduce patient risk throughout ~~SVMH~~SVHMC with emphasis on reduction of morbidity and mortality.
- To ensure the ~~SVMH~~SVHMC Board of Directors, Medical Staff, Leadership, and Staff consistently evaluate, monitor, improve and document patient safety activities.
- To provide a mechanism to assist ~~SVMH~~SVHMC in accomplishing its strategic goals

and objectives relative to the quality and safety of patient care.

- To promote and encourage staff participation in patient safety incidents and to emphasize finding system and design flaws (the "how" of events/errors) and not on individuals (the "who" of events/errors).
- To ensure the Patient Safety Program Plan elements are integrated into the Organization's Quality and Performance Improvement Plan and the strategic vision.

E. Salinas Valley Health supports a Just Culture philosophy and approach to adverse event investigation and response and has adopted the BETA Healthcare Group Just Culture Algorithm for responding to the behaviors of their employees in a fair and just manner.

F. The Patient Safety Program is an organization-wide program and applies to all sites, services and care settings under ~~SVMH~~SVHMC. The program spans all these areas and encompasses all administrative, medical staff, nursing and support activities and includes integration of patient safety priorities into the new design and redesign of all relevant organization processes, functions and services.

G. The scope of the Patient Safety Program includes an ongoing assessment, using internal and external knowledge and experience, to prevent error occurrence, and maintain and improve patient safety. The program encompasses the patient population, visitors, volunteers, students and staff (including Medical Staff) to address maintenance and improvement in patient safety issues in every department throughout ~~SVMH~~SVHMC. There will be an emphasis on important ~~SVMH~~SVHMC and patient care functions as outlined by regulatory and accreditation requirements (i.e. CMS Conditions of Participation, The Joint Commission, Title 22, Health and Safety Codes, etc.)

H. The Patient Safety Program Plan is evaluated and reviewed annually and will include objectives to meet ~~SVMH~~SVHMC's annual patient safety goals and Strategic Plan:

- The Patient Safety Plan is approved by the ~~SVMH~~SVHMC Quality and Safety Committee, Medical Executive Committee and the ~~SVMH~~SVHMC Board of Directors on an annual basis.
- The Board of Directors delegates the responsibility for ~~SVMH~~SVHMC Patient Safety Program oversight to the ~~SVMH~~SVHMC Medical Executive Committee and the Quality and Safety Committee.
- The designated Patient Safety Officer for ~~SVMH~~SVHMC will have administrative responsibility for the program and review and update the Patient Safety Plan as needed.
- ~~SVMH~~SVHMC staff will report unusual occurrences and/or unexpected events as part of the patient safety program, (which includes the full range of safety issues, from potential or no harm errors, to hazardous conditions and sentinel events), that may affect patient safety and/or quality of patient care as outlined in the Sentinel Event/Unexpected Occurrence policy.
- The Patient Safety Program also considers data obtained from other organizational needs assessments, such as Information Management Needs Assessment, Risk Reduction Plans, which includes information regarding barriers to effective communication among caregivers.

I. All departments within the organization (patient care and non-patient care departments) are responsible to report patient safety occurrences and potential occurrences to their direct supervisor (Manger/Director), Patient Safety Officer, Risk Manager or via Incident Reporting System. A report to the appropriate ~~SVMH~~SVHMC Committees occurs in accordance with the established Quality Oversight Structure. The report may contain aggregated information related to type of occurrence, severity of occurrence, number/type of occurrences per department, occurrence impact on the patient, remedial actions taken and patient outcome. The Quality & Safety Committees will analyze the report information and determine further patient safety activities as appropriate.

III. PATIENT SAFETY PLAN ANNUAL GOALS/ OBJECTIVES

I. The overall purpose of the Patient Safety Program is to create a safe environment. The patient safety plan and program strives to meet or exceed the annual Patient Safety Goals and Objectives.

- ~~SVMH~~SVHMC Patient Safety Program Plan Goals and Objectives:

1. Support department efforts to adhere to The Joint Commission and other regulatory standards as a baseline of Quality and Patient Safety.
2. Support department efforts to adhere to National Patient Safety Goals and Patient Safety Licensing Requirements and to continuously evaluate standards to attain and / or achieve sustained compliance.
3. Oversee the process of tracking, reporting (as needed) and evaluating all adverse events or potential adverse events as described in the Section 1279.1 of the Health and Safety Code, that are determined to be preventable, and facility-acquired infections (HAIs), as defined by the NHSN, that are determined to be preventable.
4. Review Sentinel Event and other Patient Safety Alerts.
5. Improve patient safety through use of Proactive Risk Assessments and/or Root Cause Analysis (RCA)/Comprehensive Systematic Analysis teams as needed.
6. Promote a Culture of Safety by minimizing blame or retribution against staff involved in patient safety incidents and to emphasize finding system and design flaws (the how" of events/errors) and not on individuals (the "how" of events/errors).
7. Improve patient safety awareness by enhancing Proactive Patient Safety Initiatives by increasing patient safety awareness for patients among our employees, medical staff, patients and the community.
8. Integrate and prioritize the patient process and outcome improvement initiatives in accordance with the QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PLAN
9. Evaluate and identify opportunities for improvement regarding medication management and patient safety.

10. Participate in Beta Healthcare Pro-Active Risk Assessments and Initiatives.
11. Partner with California Healthcare Patient Safety Organization (CHPSO), National Patient Safety Foundation and the Emergency Care Research Institute (ECRI) to eliminate preventable harm and improving the quality and safety of health care delivery at SVMH.

IV. PATIENT SAFETY PROGRAM ORGANIZATIONAL STRUCTURES/ RESPONSIBILITIES

A. The ~~SVMH~~SVHMC operational structure is aligned to meet the function of the Patient Safety Program. The goals and objectives of the Patient Safety Program are integrated into the functions of each of the following organizational / operational groups: SVMH Quality & Safety Committees, Medical Executive Committee and the SVMH Board of Directors. At all levels SVMH leaders provide the foundation for an effective patient safety system by: Promoting learning; Motivating staff to uphold a fair and just safety culture; Providing a transparent environment in which quality measures and patient harms are freely shared with staff; Modeling professional behavior; Removing intimidating behavior that might prevent safe behaviors and Providing the resources and training necessary to take on improvement initiatives.

1. **Board of Directors**

- The ~~SVMH~~SVHMC Board of Directors, through the approval of this document, authorizes the establishment of a planned and systematic approach to preventing and addressing patient safety. The Board delegates the implementation and oversight of this program to the Patient Safety Officer. It is the ultimate responsibility of the ~~SVMH~~SVHMC Board of Directors to ensure quality and safe patient care throughout the organization. Key responsibilities of the Board of Directors regarding Patient Safety are seen in activities such as:
    a. Critically examines ~~SVMH~~SVHMC and medical staff processes to assure high standards.
    b. Monitors the adequacy and appropriateness of the Medical Staff processes.
    c. Delegates' oversight of medical care to the Medical Staff per California law.
    d. Approves the Patient Safety Program Plan.
    e. Reviews ~~SVMH~~SVHMC performance on key quality and safety indicators including sentinel/never events, and holds senior leadership, physician leadership, mid-level management, and frontline caregivers directly accountable for results.

2. **Patient Safety Officer**

- The Patient Safety Officer is responsible for assuring that this program is implemented and evaluated throughout the organization. As such, the Patient Safety Officer will establish the structures and processes necessary to accomplish this objective.
- The Patient Safety Office will review, and in collaboration with relevant leaders, identify and implement actions as necessary for all critical events within 5 days of the event. The Patient Safety Officer or designee will review non critical incidents for trends / patterns or concerns and share with appropriate leaders, Quality Management and/or medical staff as necessary.
- The Patient Safety Officer communicates and collaborates with Administration and department leaders and others in an effort to ensure coordination in reduction of harm and promote safe practices as well as a safe culture of reporting.
- Oversees the Culture of Safety survey as defined by the organization.
- Meets routinely with leaders and staff on the Patient safety Program goals, objectives and outcomes.
- Is available to all persons under ~~SVMH~~SVHMC when questions or concerns are raised concerning the safety of patients. Collaborates with the Environmental Health and Safety Officer for other safety concerns.

3. **Medical Executive Committees (MEC)**
    - As delegated by the ~~SVMH~~SVHMC Board of Directors and consistent with its bylaws, policies and rules and regulations, the Medical Executive Committee is responsible for the day-to-day implementation and evaluation of the processes and activities noted in this program. These Patient Safety responsibilities include but are not limited to:
        a. Reviewing Patient Safety initiatives and activities.
        b. Approving the Patient Safety Program Plan and providing subsequent recommendations for approval to the Board.
        c. Identifying opportunities to improve patient care, patient safety, and ~~SVMH~~SVHMC's performance. This responsibility is shared with Quality and Safety Committees of ~~SVMH~~SVHMC.
4. **Senior Leadership Team**
    - As delegated by the ~~SVMH~~SVHMC Board of Directors, the Senior Leadership Team responsibilities include:
        a. Incorporating Patient Safety function into the Strategic Plan.
        b. Reviewing and approving the Patient Safety Program Plan.
        c. Ensuring that processes are in place for communicating relevant Patient Safety information throughout ~~SVMH~~SVHMC and identifying opportunities to improve Patient Safety. Allocating sufficient resources needed to improve Patient Safety.

d. Evaluating the culture of safety and quality as indicated, using valid and reliable tools and using the reliable tools to create a culture of safety and quality.

e. Promoting a culture of safety in which staff is encouraged to identify and communicate opportunities for improvement, report patient safety risks, disclose significant process / protocol variances ('near misses') and participate in performance improvement activities.

5. **Quality and Safety Committees**

- The Quality and Safety Committee's responsibilities for patient safety include:

a. Overseeing all Patient Safety activities, which include approving, prioritizing and facilitating operationalization of the Plan.

b. Reviewing and evaluating the Patient Safety Plan and provides its subsequent recommendations for approval to medical staff, Senior Leadership and the Board.

c. Reviewing Patient Safety reports and identifying opportunities to improve Patient Safety. This responsibility is shared with medical staff and Leadership.

d. Reviewing action plans resulting from teams for intensive assessment of adverse events.

e. Reviewing and evaluating reports regarding the progress and effectiveness of Patient Safety initiatives and improvement activities.

f. Ensuring that Patient Safety is incorporated in the design of processes, functions and services.

g. Oversight committee for the Safety and Reliability Council

6. **Patient Safety Advisory Team (PSAT)**

- This ad-hoc committee is comprised of key representatives from leadership to:

a. Evaluate reported events related to patient safety and quality care that occur within ~~SVMH~~SVHMC to determine whether the event is treated as a sentinel event and/or is reportable according to state and regulatory requirements.

b. The Regulatory and Accreditation team ~~oversights~~oversees the PSAT process and collaborates with the Quality and Risk Departments for evaluation of events as necessary.

7. **Medical Staff**

- The Medical Staff supports Patient Safety through the following:

a. Incorporates ~~SVMH~~SVHMC patient safety goals into various

section, committee and department meetings.

b. Provides patients with continuing care and quality of care meeting the professional standards of the medical staff, which incorporates patient safety goals.

c. Participates in educational and other collaborative activities (proactive risk assessment, event investigation, and performance improvement activities).

8. **Staff**

- To achieve the goal of delivering safe and high quality care, employees are given the empowerment with responsibility and authority to actively participate in ~~SVMH~~SVHMC's Patient Safety Program. ~~SVMH~~SVHMC uses department level resources or educational resources to conduct focused patient safety monitors, support additional education and awareness, and to provide timely feedback on patient safety issues and the effectiveness of our patient safety program. The Patient Safety Committee supports staff to embed quality and patient safety initiatives into consistent daily practice and to assist management in monitoring compliance and progress toward a goal.

V. PATIENT SAFETY PROGRAM ELEMENTS

A. Designing or Re-designing Processes - When a new process is designed (or an existing process is modified) the organization will use information from both internal and external sources on reducing medical errors and incorporate this information into its design or re-design strategies.

B. Identification of Potential Patient Safety Issues - 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 process 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:

1. Processes identified through a review of the literature.
2. Processes identified through the organization's performance improvement program.
3. Processes identified through occurrence reports and sentinel events.
4. Processes identified as the result of findings by regulatory and/or accrediting agencies.
5. Processes as identified under patient safety organizations, including but not limited to CHPSO, ~~NQF~~National Quality Forum, The Joint Commission Safety / Sentinel Event Alerts, ECRI, National Patient Safety Foundation, etc.

C. Performance Related to Patient Safety - 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.

1. Performance measurement data will be collected, aggregated, and analyzed as necessary to determine if opportunities to improve safety and reduce risk are

identified. If so, the organization will prioritize those processes that demonstrate significant variation from desired practice, and allocate the necessary resources to mitigate the risks identified.

D. Opportunities to reduce errors that reflect system issues are addressed through use of failure mode effect analysis through the organization's performance improvement program.

E. 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).

F. Proactive Risk Assessments - The organization is committed to ongoing proactive risk assessments using internal and external knowledge and experience to prevent error occurrence, as well as maintain and improve patient safety.

G. At least every 18 months, the organization will select at least one high-risk care process upon which to proactively improve performance. The process selected will be subjected to a failure-mode-effect analysis based on accepted standards of care. Those gaps that are felt to be most critical will be subjected to intensive analysis. The process will then undergo redesign (as necessary) to mitigate any risks identified. This may be accomplished through review of internal data reports and reports from external sources (including, but not limited to, The Joint Commission sentinel event report information, ORYX and Core Measure performance data, occurrence reporting information from State and Federal sources and current literature), and through the performance improvement priority criteria grid. All elements of high-risk safety related process will be described using work tools as necessary (i.e., flowcharts, cause and effect diagrams).

H. Reporting of Process or System Failure and/or medical/health care errors and response.

1. The organization is committed to responding to errors in care 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/causative cause(s) of the error. To that end, the organization has established a variety of policies and procedures to address these issues:
    - Medical/health errors and occurrences including sentinel events will be reported internally to the appropriate administrative or medical staff entity.
    - Errors will be reported to external agencies in accordance with applicable local, state, and federal law, as well as other regulatory and accreditation requirements.
    - Taylor Farms Family Health and Wellness Incidents resulting in hospitalization or death will be reported to The Compliance Team (TCT) within 48 hours.

2. The organization has established mechanisms to report the occurrence of medical errors both internally and externally, per policy and through the channels established by this plan. External reporting will be performed in accordance with all state, federal and regulatory body rules, laws and requirements. Immediately upon identification, the patient care provider will:
    - Perform necessary healthcare interventions to protect and support the

patient's clinical condition.

- As appropriate to the occurrence, perform necessary healthcare interventions to contain the risk to others – example: immediate removal of contaminated IV fluids from floor stock should it be discovered a contaminated lot of fluid solutions was delivered and stocked.
- Contact the patient's attending physician and other physicians, as appropriate, to report the error, carrying out any physician orders as necessary;
- Preserve any information related to the error (including physical information). Examples of preservation of physical information are: Removal and preservation of blood unit for a suspected transfusion reaction; preservation of IV tubing, fluids bags and/or pumps for a patient with a severe drug reaction from IV medication; preservation of medication label for medications administered to the incorrect patient. Preservation of information includes documenting the facts regarding the error on an occurrence report and in the medical record **as appropriate** to organizational policy and procedure;
- Report the process/system failure or medical/health care error to the staff member's immediate supervisor.
- Submit the occurrence report via the Occurrence Reporting System.
- Any individual in any department identifying a process/system failure and/or potential patient safety issue will immediately notify his or her supervisor and document the findings in an occurrence report or contact the Patient Safety Office.

3. Staff response to provide/system failures and/or medical/health care errors is dependent upon the type of error identified
4. The Sentinel Event Policy will determine the organizational response to process/system failures and/or medical/health care errors and occurrences.
5. Supporting Staff Involved in Errors - An effective Patient Safety Program cannot exist without optimal reporting of process/system failures and medical/health care errors and occurrences. Therefore, it is the intent of this institution to adopt a non-punitive, just culture approach in its management of failures, errors and occurrences.
    - All personnel are **required** to report suspected and identified medical/health care errors, and should do so without the fear of reprisal in relationship to their employment. This organization supports the concept that errors occur due to a breakdown in systems and processes, and will focus on improving systems and processes, rather than disciplining those responsible for errors and occurrences. A focus will be placed on remedial actions to ensure appropriate course of action to prevent reoccurrence rather than punish/place blame on staff.
    - As part of this organization's culture of safety and quality, any staff member who has concerns about the safety or quality of care provided by the organization may report these concerns to The Joint Commission or

the California Department of Public Health. The organization supports the staff member's right to report these concerns and will take no disciplinary or retaliatory action against the staff member for reporting the safety or quality of care concern to The Joint Commission.

- Staff will be queried regarding their willingness to report medical/health care errors via the Patient Safety Culture Survey. The goal of the survey is to validate the following:
    a. Staff and leaders value transparency, accountability, and mutual respect.
    b. Safety is everyone's first priority.
    c. Behaviors that undermine a culture of safety are not acceptable, and thus should be reported to organizational leadership by staff, patients, and families for the purpose of fostering risk reduction
    d. Collective mindfulness is present, wherein staff realizes that systems always have the potential to fail and staff are focused on finding hazardous conditions or close calls at early stages before a patient may be harmed. Staff does not view close calls as evidence that the system prevented an error but rather as evidence that the system needs to be further improved to prevent any defects.
    e. Staff who do not deny or cover up errors, but rather want to report errors to learn from mistakes and improve the system flaws that contribute to or enable patient safety events. Staff knows that their leaders will not focus on blaming providers involved in errors, but rather focus on the systems issues that contributed to or enabled the patient safety event.
    f. By reporting and learning from patient safety events, staff creates a learning organization.

- The organization recognizes that individuals involved in an error may need emotional and psychological support. To that end, the organization has defined processes to assist employees and members of the Medical Staff.
    a. Employees can be referred to the organizations "Employee Assistance Program" for assistance.
    b. Members of the Medical Staff can be referred to the "Physician Health/Well Being Committee" for assistance.

I. Educating the Patient on Error Prevention - 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.
    1. The Patient Safety Program includes a survey of patients, their families, volunteers and staff (including medical staff) opinions, needs and perceptions of risks to patients and requests suggestions for improving patient safety.

J. Patients, and when appropriate their families are informed about the outcomes of care, including unanticipated outcomes, or when the outcomes differ significantly from the anticipated outcomes. Informing the Patient of Errors in Care - The organization recognizes that a patient has the right to be informed of results of care that differ significantly from that which was anticipated. The Attending physician / other physician is responsible for assuring that the patient is informed of errors in care.

K. Dissemination of Information - Lessons learned from root cause/comprehensive causative analyses, system or process failures, and the results of proactive risk assessments shall be disseminated to appropriate staff that provides care, treatment and service pertinent to the specific issue.

VI. PATIENT SAFETY PLAN MANAGEMENT

A. **Patient Safety Program Resources**

1. Designated resources have been provided to assist the organization to meet the goals and objectives of the Patient Safety Program and to facilitate the implementation of the Patient Safety Program Plan.
2. The Risk Management, Quality Management and Patient Safety Divisions and all Departments are the primary source of support for patient safety improvement activities within ~~SVMH~~SVHMC. These departments include staff to assist with the integration of event investigation, data management, analysis, clinical processes and patient outcomes.
3. ~~SVMH~~SVHMC is committed to providing psychological support to staff involved in serious patient safety events or critical/sentinel events. Sources of support include:
    - Human Resources
    - Employee Assistance Program
    - Clinical Social Work Department
    - Rights and Ethics Committee

B. **Patient Safety Problem Identification, Notification & Resolution Process**

1. When a situation occurs that may risk patient safety, SVMH staff is requested to report unusual occurrences and/or unexpected event as outlined in the ~~ADVERSE EVENTS - REPORTABLES~~SAFETY EVENT REPORTING Policy using any of the following reporting mechanisms:
    - On-line Occurrence/Event Report or can elect to notify Administration directly.
        a. Direct Notification can include:
            - Notification to Department manager/supervisor
            - Notification to the Patient Safety Officer
            - Notification to Administrative Supervisor
            - Notification to Quality, Risk, Infection Control
2. When a situation arises that requires immediate response to a patient safety event,

the staff makes any necessary changes to prevent further harm to the patient, communicates with the patient and/or patient's family and notifies the Administrative Supervisor. The Administrative Supervisor is responsible for informing the Administrator on-call, the Patient Safety Officer or their designee. DISCLOSURE OF UNANTICIPATED OUTCOMES POLICY

C. **Patient Safety Program - ~~SVMH~~SVHMC Staff & Medical Staff Education**

1. ~~SVMH~~SVHMC communicates patient safety information throughout the organization to effect behavioral changes in itself and other healthcare organizations. Examples of communication methods include:
    - Posters in key locations.
    - Medical Staff intranet portal.
    - Patient Safety on STARnet (http://starnet/)
    - Patient Safety Awareness Events.
    - Leadership, medical staff and employee meetings.
2. Education programs are designed and provided to the staff upon hire and on an ongoing basis to provide timely information regarding the Patient Safety Program, its annual goals and objectives and its accomplishments. Education includes the staff member's right to report any safety or quality of care concerns to The Joint Commission and the California Department of Public Health. Because the optimal provision of healthcare is provided in an interdisciplinary manner, staff will be educated and trained on the provision of an interdisciplinary approach to patient care.
3. Ongoing education is provided through various mechanisms such as but not limited to:
    - In-service training to increase knowledge of patient safety requirements
    - In-service training to encourage reporting of unanticipated adverse events and near misses and in identifying patient safety events that should be reported
    - Educational updates addressing patient safety issues, including Sentinel Event Alerts.
    - Patient Safety Awareness activities.
    - Computer based learning modules.

D. **Patient Safety Program Patient & Community Education**

1. Patients are given information about their rights and responsibilities while receiving services. Patients and, when appropriate, their families are informed about the outcomes of care, treatment and services, including unanticipated outcomes.).
2. Patients may be given patient safety awareness materials, such as The Joint Commission's "Speak Up" brochure.

VII. REFERENCES

A. Center for Medicare Services (CMS) Conditions of Participation
B. Joint Commission Sentinel Event Policy
C. The Joint Commission Standards.
D. To ERR is Human: Building a Safer Health System
E. Crossing the Quality Chasm: A New Health System for the 21st Century
F. OIG Report on Medical Error 12-00
G. HSC §442.5, HSC §1254.4, HSC §1255.8, HSC §1279.6, HSC §1279.7, HSC §1288.6, HSC §1288.7, HSC §1288.8, HSC §1288.9, HSC §1288.95
H. National Patient Safety Foundation
I. The Just Culture Community, www.justculture.org
J. California Senate Bill 1058, (Infection Control and Prevention)
K. California Senate Bill 444 (Patient Safety Plan)

Attachments

ATD.pdf

Cal-oshaguidanceswineflu.pdf

Interim_enforcement_H1N1 CAL OSHA 09082009.pdf

Approval Signatures

Step Description	Approver	Date

Standards

No standards are associated with this document

History

Comment by Kukla, Aniko: Director Quality & Patient Safety on 4/3/2023, 10:12PM EDT

> Changed name of the hospital and medical center. Added the word equitable to the purpose under point B. And Risk Manager added Just Culture language.

ADJOURNMENT