Introduction
The Patient Safety Program supports and promotes the Mission and Vision of Richmond State Hospital (RSH) through continuous improvement of patient, visitor, volunteer and employee safety. This program is implemented through the integration and coordination of the patient safety activities of the medical staff, clinical departments, and support service departments that have responsibility for various aspects of patient and employee safety. In addition, the program also promotes the critical role that each employee plays in ensuring patient, visitor, volunteer and staff safety.

Authority
The Governing Body, Medical Staff, and Senior Leadership Team are committed to patient safety, assuring an environment that encourages error identification, remediation, non-punitive reporting and prevention through education, system redesign or process improvement for any adverse event.

At the direction of the Governing Body, it is the responsibility of Senior Leadership to establish a hospital-wide patient safety program within the performance improvement activities.

Patient Safety entails a framework for proactively identifying the potential and actual risks to safety, identifying the underlying cause(s) of the potential or actual risk, and making the necessary improvements to reduce risk. It also entails analysis, and making necessary improvements.

By undertaking a proactive risk assessment, the hospital can correct process problems and reduce the likelihood of experiencing adverse events. The processes that have the greatest potential for affecting patient safety should be the primary focus for risk assessments. The choice of which process that will be assessed may be based in part on information published periodically by TJC about frequently occurring sentinel events and processes that pose high risk to patients.

This system-based approach is driven by organization leadership; anchored in the organization’s mission, vision, and strategic plan; endorsed and actively supported by medical staff and clinical leadership; implemented by leaders; integrated and coordinated throughout the organization’s staff; and continuously re-engineered using proven, proactive performance improvement modalities. In addition, effective reduction of errors and other factors that contribute to unintended adverse outcomes in an organization requires an environment in which patients, their families, and organization staff and leaders can identify and manage actual and potential risks to safety.

Patient Safety Program
The program centers on the establishment of mechanisms that support effective responses to actual occurrences and hazardous conditions; ongoing proactive reductions in medical/health care errors; and integration of patient-safety priorities in the design and redesign of all relevant organizational processes, functions and services.

Emphasis also is placed upon patient safety in areas such as patient’s rights, patient family education, continuity of care, and plan for managing performance deficit/s.
Full disclosure of serious medical errors, reportable events and any unanticipated outcomes are made to patients/families as appropriate.

At least once a year, the leaders provide governance with written reports on the following:
- All system or process failures
- The number and type of sentinel events
- Whether the patients and the families were informed of the event
- All actions taken to improve safety, both proactively and in response to actual occurrences
- The determined number of distinct improvement projects to be conducted annually
- All results of the analysis related to the adequacy of staffing.

The hospital has procedures to inform the appropriate agencies and accrediting bodies. The leaders encourage external reporting of significant adverse events, including voluntary reporting programs in addition to mandatory programs.

**Patient Safety Program Goals**
- Create and maintain a culture of quality and safety.
- Continuously improve patient safety and minimize and/or prevent the occurrence of errors, events, and system breakdowns leading to harm to patients, staff, volunteers, visitors, and others through proactive risk management and patient safety activities;
- Minimize adverse effects of errors, events, and system breakdowns when they do occur;
- Minimize losses to the organization overall by proactively identifying, analyzing, preventing, and controlling potential clinical, business, and operational risks;
- Facilitate compliance with regulatory, legal, and accrediting agency requirements;
- Protect human and intangible resources.

Employees and volunteers are responsible for actively participating in the Patient Safety Program. An active participant will:
- Assume responsibility for identifying processes or systems that could potentially lead to errors and adverse events.
- Know and follow organizational and departmental policies and procedures applicable to assigned duties.
- Avoid taking shortcuts or encouraging others in the organization to short cut established policies and procedures as a means of facilitating patient care.
- Inform patient and families about care, medications, treatments, and procedures; encourage them to ask questions, and participate with caregivers in the development of their treatment plan.
- Use sound judgment and awareness of potential hazards before taking action.
- Participate in required organizational and developmental patient safety education programs and other activities designed to improve department and organizational patient safety.
- Report serious events and incidents promptly, in accordance with established hospital policy and procedure.
- Assume responsibility for one’s own professional development and education to individual performance and promote patient safety.
Medical Staff
Each member of the medical staff shall participate in the hospital-wide incident reporting system and in the preparation and implementation of corrective action activities in the event of identified risks. Medical staff members shall incorporate patient safety indicators into its Medical Staff monitoring and evaluation systems for the purpose of monitoring and evaluating the safety/quality of patient care, treatment and services.

Departments
Each hospital department, which provides or affects patient care, will report identified patient safety risks to the Patient Safety Committee and correct identified safety concerns. Each department shall assure the participation of its members in the hospital-wide incident reporting systems and in the preparation and implementation of corrective action plans. Department heads are responsible for orientation of new staff members to the department and, as appropriate, to job and task-specific safety procedures. It is the responsibility of all supervisors to emphasize with their employees the importance of safety procedures in the areas where they work and to put in practice all safety measures available on a regular basis.

RSH employees
Patient safety has been identified as an organizational priority. To support this initiative, RSH will provide education to all staff regarding the commitment to reduction of medical errors, support of 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. Individual RSH staff members are responsible for learning and following job and task-specific procedures for safe operations. Staff will participate in hospital-wide incident reporting systems and should do so without fear of reprisal. Staff involved in serious/sentinel events have access to support.

Patients
All patients, upon admission, are informed of safety measures in place to help ensure their safety. These measures include, but are not limited to:

- Use of security cameras
- Falls prevention program
- Use of two patient identifiers for medications and other procedures
- Infection prevention and control practices
- Emergency preparedness
- Read back of verbal orders for accuracy
- Elimination of dangerous abbreviations
- Medication reconciliation
- Seclusion and restraint reduction

Patients are also encouraged to take responsibility, such as reporting safety concerns when they become aware of one. Patients, and families, if authorized by applicable confidentiality statutes, are informed about adverse outcomes of care, including unanticipated outcomes, or when the outcomes differ significantly from the anticipated outcomes.

Patient Safety Committee
The Richmond State Hospital integrated Patient Safety Program is implemented through the Patient Safety Committee. This committee provides oversight and ensures alignment of patient safety activities
and opportunities for all individuals who work in the organization to be educated and to participate in safety initiatives.

The Patient Safety Committee is comprised of the;
Professional Practice Directors or their designees,
Pharmacy Director,
Risk Manager,
Safety/ Security Director,
Infection Prevention and Control Nurse,
and as appropriate Staff Development Director, and other leaders.

The hospital’s approach to patient safety/performance improvement is continuously assessed and revised to meet the goal of ensuring that patient outcomes are continually improved and safe patient care is provided. Examples of information utilized to achieve this goal include variance related data such as medication errors and falls; infection control surveillance; sentinel event alerts; and TJC/CMS Quality Measurement Data, as well as, patient satisfaction reports. Staffing effectiveness data, patient complaints, patient falls, and staff turnover and employee injuries is also addressed.

The Quality Management Department (QM) will prepare risk and other departmental data for reporting to the Patient Safety Committee. In addition, committees, departments and TJC teams will report outliers, non-compliant standards and EP’s, unresolved safety issues, corrective action plans, and other safety concerns to the Patient Safety Committee.

The results of investigations and analytical reviews shall, in turn, be forwarded, by the committee, to the appropriate entities for further, in-depth evaluation, review and response. Responses shall include any corrective action taken or a plan for corrective action. The patient Safety Committee will serve as a clearinghouse for these data and information which effect patient safety.

The Patient Safety Committee will meet at least ten times per year and will report on a regular basis to Senior Leadership.

**Internal Reporting** – in order to have an effective patient safety improvement and management program, there must be an emphasis on reporting all types of events that may harm or have harmed patients. RSH has adopted a non-punitive approach in its management of adverse events and reporting. All members of the Medical Staff and employees are required to report suspected and or identified medical errors and should do so without the fear of reprisal in relationship to their employment. The focus of attention is on the performance of systems and processes instead of the individual although reckless behavior and blatant disregard for safety are not tolerated.

However in the event that a member of the Medical Staff or employee participates in willful or malicious misconduct, sabotage, substance abuse, criminal activity, fails to report the event truthfully or in a timely fashion, or makes an egregious error demonstrating a lack of fundamental knowledge necessary to carry out his/her job responsibilities, RSH may institute disciplinary or corrective action. Failure to report may also cause RSH to report a licensed healthcare professional to his/her respective state professional licensure board, in accordance with Indiana State guidelines.

As the field of patient safety evolves, the effectiveness of various approaches to improving patient safety will be studied and evaluated. RSH will consult the literature, examine the experiences of others
that have responded to similar issues, and consider recommendations made by various authorities in developing alternatives to reduce the possibility of error or having the error reach the patient.

The Patient Safety Plan will be evaluated at least every 2 years, or as changes occur, and revised as necessary.

**Key Definitions**

**Error**- The failure of a planned action to be completed as intended (i.e., error of execution) or the use of an incorrect plan to achieve an aim (i.e., error of planning) [Institute of Medicine Report, *To err is Human: Building a Safer Health Care System*] or an unintended act, either of omission or commission, or an act that does not achieve its intended outcome. [TJC]

**Adverse event**- An injury caused by medical management rather than the underlying condition of the patient. An adverse event attributable to error is a “preventable adverse event” [Institute of Medicine Report, *To Err is Human, Building a Safer Health Care System*]

**Sentinel Event**- An unexpected occurrence involving death or serious physical or psychological injury. Serious injury specifically includes loss of limb or function or the “risk thereof. Sentinel events that are subject to review by TJC include: Suicide of a patient in a setting where the patient receives round-the-clock care, infant abduction or discharge to the wrong family; rape; hemolytic transfusion reaction involving the administration of blood or blood products having major blood group incompatibilities, and surgery on the wrong patient or wrong body part.

**Risk Thereof**- The phrase “or the risk there of” includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.

**Near Miss**- Any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome. [TJC]

**Root Cause Analysis**- A process for identifying the basic or causal factor(s) that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event. A root cause analysis focuses primarily on systems and processes, not individual performances. It progresses from special causes in clinical processes to common causes in organization processes and identifies potential improvements in processes or systems that would tend to decrease the likelihood of such events in the future or determines, after analysis, no such improvements opportunities exist. [TJC]

**Failure Mode Effects the Criticality Analysis**- A proactive approach to assessing the intended and actual implementation of a process to identify steps in the process where there is, or may be, undesirable variation or failure modes; the possible effect on patients for each identified failure effects, a root cause analysis is conducted to determine why the variation leading to that effect may protect patients from the effects of that failure mode. [TJC]

**Action Plan**- The product of root cause analysis that identifies the strategies that hospital intends to implement to reduce the risk of similar events occurring in the future. The plan addresses responsibility for implementation, oversight, pilot testing as appropriate, timelines, and strategies for measuring the effectiveness of the actions. [TJC]
Serious Event- An event, occurrence, or situation involving the clinical care of a patient in a medical facility that results in death or compromises patient safety and results in an unanticipated injury requiring the delivery of additional health services to the patient.

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

Infrastructure Failure- An undesirable or unintended event, occurrence, or situation involving the infrastructure of the facility, discontinuation or significant disruption of a service, which could seriously compromise patient safety.

Patient Safety- Freedom from accidental injury while receiving health care services. An environment and culture that emphasizes the importance of the elimination of seclusion and restraint.