Physician Office Practice Patient Safety Plan

I.   Introduction

The Patient Safety Program supports and promotes the mission, vision and values of [Facility Name] through organizational prioritization of patient, visitor, and employee safety.

The patient safety program is implemented through the Patient Safety Committee and is supported by leadership's promotion of a safety culture that:
- Encourages recognition, reporting, and acknowledgement of risks to patient/visitor and employee safety and medical/healthcare errors
- Initiates/monitors actions to reduce risks/errors
- Internally reports findings and actions taken
- Promotes a blame-free culture facilitating the reporting and follow-up on safety concerns, errors and adverse events
- Educates staff and physicians to assure participation in the program

II.   Purpose

The Patient Safety Program is designed to enhance patient care delivery and prevent adverse outcomes of care by utilizing a systematic, coordinated and continuous approach to the improvement of patient safety. This approach focuses on actual and potential occurrences; ongoing proactive risk management; and integration of patient-safety priorities in the development and revision of processes, functions and services.

III.   Mission Vision and Values

In support of the mission, vision and values of this organization the Patient Safety Program promotes:
- Collaboration among staff members, physicians and other providers to deliver comprehensive, integrated and quality health care
- A focus on comprehensive, integrated quality service
- Open and honest communication to foster trust relationships among staff members, physicians, other providers and patients.

IV.   Objectives

The objectives of the Patient Safety Program are to:

- Encourage organizational learning about adverse or potential adverse events
- Incorporate recognition of patient safety as an integral job responsibility
- Provide patient safety education
- Involve patients in decisions about their health care and promote open communication
- Collect and analyze data, evaluate care processes for opportunities to reduce risk and initiate proactive measures
- Report internally the findings and actions taken to reduce risk
- Support sharing of knowledge to effect change

V. Responsibilities/Duties

The Patient Safety Committee provides a multidisciplinary forum for the collection and analysis of risk to patient safety and the dissemination of information on identified risk for the purpose of improving patient care. It shall review reports on occurrences including near misses to sentinel events. It shall identify those individuals or groups best situated to perform a root cause analysis and develop and implement an action plan for identified issues. It shall review, analyze and disseminate the information it receives, as appropriate, to the {Designated Individuals; Committees]. It shall provide recommendations concerning identified risks, approve plans for corrective action and evaluate the implementation of corrective actions taken.

Membership may include representatives from administration, providers, clinical and support staff. For small office practices membership may include the practice/office manager, providers, and staff representation.

VI. Scope

The types of occurrences to be addressed include, but are not limited to, near misses and actual events related to:

- a) Patient safety
- b) Adverse drug events (medication errors and adverse drug reactions)
- c) Nosocomial infections
- d) Patient falls
- e) Other patient incidents/unexpected clinical events
- f) Unsafe conditions
- g) Visitor safety
  - Visitor incidents
- h) Employee safety
  - Blood/body fluid exposures
  - Occupational diseases
  - Communicable disease exposures
  - Musculoskeletal injuries
  - Immunization programs
  - Other employee incidents
- i) Environmental safety
  - Product recalls
  - Drug recalls
  - Product/equipment malfunction
  - Construction – Infection Control Risk Assessment
  - Water quality
  - Air quality
  - Disaster planning
  - Security incidents
  - Workplace violence

Data from external sources, including but not limited to:

- Centers for Disease Control and Prevention (CDC)
- Institute for Healthcare Improvement (IHI)

- Institute for Safe Medication Practices (ISMP)
- Occupational Safety and Health Administration (OSHA)
- Published literature

VII. Definitions

Adverse (Sentinel) Event is defined as an unexpected occurrence that involves death or serious physical or psychological injury, or the risk that these might occur.

Medical Error is defined as failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim. Medical Errors may or may not cause harm.

Serious Error: An error resulting in patient injury including the potential to cause permanent injury or transient but potentially life-threatening harm

Minor Error: An error that does not cause harm or have the potential to do so

Near Miss: An error that could have caused harm but did not reach the patient because it was intercepted.

VIII. Structure

The authority for the Patient Safety plan rests with the [Specify] and has delegated the authority to implement and maintain activities described in this plan to the Patient Safety Committee.

IX. Quality Review Information

To the extent possible, and in a manner consistent with the protection of confidentiality of quality assurance and patient safety data, pertinent information will be shared between the Quality Improvement Program and the Patient Safety Program

In an attempt to protect quality review information from discovery, all quality review documents must be labeled as a Quality Review document. Documents should be in a formal format, handled by a limited number of individuals and secured in a locked file in the Quality Office accessible only to designated individuals. Be aware that Maine and Vermont do not have specific State regulations protecting quality/peer review in the physician office practice. New Hampshire does have such legislation.

X. Education

Annual staff and physician/provider education includes but is not limited to the following topics:
- Fire drills
- Intruder drill
- Emergency & Disaster drills
- Workplace Violence
- Customer Service
- Creating, Implementing, Achieving, & Maintaining a Culture of Patient Safety
- Risk Management & Error Prevention

- Team Work

XI.   Safety Improvement Activities

Specify Measures Selected for an Annual Focus: (Examples below)
- Patient satisfaction surveys, i.e., consider interviewing referring physicians
- Medical record review, (periodic), e.g., if hard copy: documentation is legible, clear, complete, signed. If electronic medical record, e.g., archived entries include date/time stamp, printed copy includes all elements of the EMR, documentation is completed according to protocol
- Complaints and resolution - to improve care and satisfaction, e.g., trend and analyze every six (6) months or annually
- Confidentiality; ensure patient and employee information is secure
- Appointment/scheduling process: accessibility to physician
- Informed Consent Doctrine: documented medical record and/or use of a consent form
- Medication management and reconciliation, i.e., allergy information (current), clearly recorded prescriptions, refills.
- Telephone triage records review/forms and oversight
- Telephone response time to callers
- Test and referral tracking: follow-up process validation
- Occurrence review

Give consideration to measures that facilitate safe practices:
- Involve patients in their health care; consider literacy issues and cultural values. Partner with patients in developing and planning their care plan.
- Use a team approach to safety; hold focused safety meetings, explore the use of daily huddles (brief meetings) with staff members; convey responsibilities and expectations, e.g., elimination of scheduling errors and miscommunication.
- Endorse open, effective communication; identify shared values and attitudes among all members of the practice. Interview and/or survey staff for attitudes, perceptions and communication barriers.
- Encourage error reporting to include near miss events. Institute non-punitive reporting that is confidential and timely. Consider recognition and rewards.
- Ensure employee and patient information or event reports shared with staff for educational purposes do not identify individuals.
- Facilitate communication skills learning, e.g., assertiveness and teamwork training.
- Examine physical premises to identify and correct potential hazardous conditions.
- Orient physicians and new employees to risk management and patient safety concepts.
- Conduct patient safety rounds
- Provide education and training on high risk processes, i.e., telephone triage

XII.   Methodology

A. Structure:
- Proactive risk prevention strategies

- Identification of High Risk Areas: (Example: Test and Referral Tracking)
- General Incidences (Example: Patient Injury)
- Potential or Actual Adverse Event: (Example: Medication Error)

B. Method:
Establish a process for:
- Identification, Selection, Prioritization
- Data Collection and Analyses
- Development of Actions
- Implementation
- Reporting
- Follow-up

C. Process Improvement:
Establish teams/individual staff members to implement processes and to monitor for effectiveness.

Utilize applicable tools to facilitate improvement for example:

- **PDCA:** (Plan, Do Check, Act) Focus is on process improvement
- **FMEA:** (Failure Mode Effect Analysis) Systematic process for identifying potential process failures before they occur with the intent to eliminate or minimize risk.
- **RCA:** Root Cause Analysis: Retrospective approach to error analysis that identifies what and how event occurred and why it happened. The focus is on the processes and systems not individuals.

XIII.   Program Evaluation
The Patient Safety Committee will submit an Annual Report to [Designated Committee] and include:

1. Definition of the scope of occurrences including sentinel events, near misses and serious occurrences

2. Detail of activities that demonstrate the patient safety program has a proactive component by identifying the high-risk process selected

3. Results of the high-risk or error-prone processes selected for ongoing measurement and analysis.

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

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

6. The results of the program that assesses and improves staff willingness to report errors

7. A description of the examples of ongoing education and training programs that are maintaining and improving staff competence and supporting an interdisciplinary approach to patient care.