PATIENT SAFETY PLAN
2014

PROGRAM GOALS

The goal of the Patient Safety Program at University of Mississippi Medical Center (UMMC) is to promote an organizational culture that will develop our hospital system into the safest environment possible for our patients, staff, and visitors. The purpose of the Patient Safety Plan is to articulate an organizational plan of action to eliminate avoidable deaths and preventable injuries.

Patient safety at UMMC is defined as the freedom from unintended injury associated with the provision of healthcare services. Ensuring patient safety involves the establishment of operation systems and processes that minimize the likelihood of errors and maximize the likelihood of intercepting them, so patient harm will not occur. Human error cannot be avoided, but harm can be minimized with sound systems and processes.

OBJECTIVES

The following are the long-term objectives of the Patient Safety Plan:

- Eliminate harm, injuries, and death caused by preventable medical errors
- Create an environment where unsafe equipment, information technology, practices, situations, as well as near-misses and errors are identified, openly communicated, addressed and integrated into organizational learning.
- Create an environment where gender, race, or hierarchical barriers to communication, coordination, and improvement are eliminated
- Establish and maintain an infrastructure and capacity for proactive patient safety improvement, education and research
- Involve patients in decisions about their health care and promote open communication about any adverse outcomes
- Establish employee competencies in patient safety

SCOPE OF THE PATIENT SAFETY PLAN

The scope of the Patient Safety Plan encompasses patients, visitors, trainees, volunteers, and staff—including medical staff. The program addresses maintenance and improvement of patient safety in every department throughout the facility. The Patient Safety Plan includes an ongoing assessment, using internal and external knowledge and experience, to prevent error occurrence and to maintain and improve patient safety.
STRUCTURE, AUTHORITY, AND RESPONSIBILITY FOR PATIENT SAFETY

The organizational structure to support patient safety includes the Institutional Quality Board and the Environmental Health and Safety Committee. See Appendix A.

Patient Safety Officer

The role of the Patient Safety Officer is to lead the oversight of development, implementation, and coordination of the patient safety initiatives at the organizational level in collaboration with Hospital Administration. The Patient Safety Officer is involved in the facilitation of clinical quality improvement projects, serves as a resource for TJC Leadership and National Patient Safety Goals Chapters, and ensures that a continuous focus is maintained on safe patient care.

FRAMEWORK FOR SUCCESS

An underlying framework exists of organizational structure, organizational functions, and execution of culture and outcomes which must be aligned to exceed the expectations of our customers—patients, visitors, staff, and physicians. (See Appendix B). The Patient Safety Plan is organized using these three concepts.

Organizational Structure
1. Organizational planning will include budgeting of human and fiscal resources for patient safety initiatives.
2. Risk Management and Quality Administration to continue strengthening communication to include:
   a. Sentinel event reporting and follow-up
   b. Shared information from electronic reporting system
   c. Shared information regarding root cause analyses to leadership

Organizational Functions
1. Include safety as a strategic goal of the organization.
   a. Senior leadership continues to commit to including safety of patients as a strategic goal of the organization. This strategic goal will be aligned with the work of the unit practice councils.
   b. Partner with departments in quality initiatives.
2. Pursue the development of a safe and just culture.
   a. Facilitate reporting of sentinel events, near-misses, and unsafe acts.
   b. Create a strategy for inclusion of a patient and/or community member to attend Quality Board.
   c. Develop effective safety and operational management.
      i. Continue to hardwire the Unsafe Acts Algorithm (Incident Decision Tree) for management of employees involved in events, especially sentinel events.
      ii. Continue implementation of TeamSTEPPS (Strategies and Tools to Enhance Performance and Patient Safety).
   d. Continue routine Patient Safety Leadership WalkRounds™ to include a focus on patient safety.
      i. Continue entry into database to push real-time action items to leadership for timely follow-up and resolution.
   e. Continue dissemination and use of the Patient Safety Guide among nurses.
   f. Expand employees participating in Operational Excellence and other quality improvement courses.
   g. Routine assessment of organization as it relates to Stages of Maturity in Health Care Organizations’ Path to High Reliability (Mark R. Chassin and Jerod M. Loeb, The Ongoing
3. Involve and engage physicians and senior-level administrators in patient safety initiatives.
   a. Continue regularly scheduled & structured Patient Safety Leadership WalkRounds™ with PSO. Action items feed into database and to the Quality Board as agenda items if necessary.
   b. Physicians will serve as champions for all safety improvement process changes that involve physicians.
   c. Assist in integration of Institute for Healthcare Improvement (IHI) modules as well as didactic experience related to quality and safety into school curriculum of all disciplines on campus.
   d. Assist in requirement of IHI modules completion during residency for all residents at UMMC unless modules have been previously completed through another program.
   e. Continue to offer didactic teaching experience for physicians and residents via an undetermined forum including the following topics related to quality of care and patient safety: Performance Improvement/ Core Measures, Risk Management/Legal, Infection Prevention, Patient Safety, Clinical Documentation.

4. Develop and implement a safety communication plan.
   a. Include critical language from TeamSTEPPS to call a stop to any potentially unsafe situation without repercussions. Example: CUS (Concerned-Uncomfortable- Safety)
   b. Strengthen resources to improve hand-off communication at all levels. Example: Ticket to Ride
   c. Patient Safety Officer and/or Risk Management Supervisor will communicate lessons learned, unsafe acts, etc., to organization, as appropriate.
   d. Monitor AHA best practice to consolidate wristband alert colors used throughout the organization, and require Quality Board approval of wristband alert colors used on patients.
   e. Continue use of Red Rules:
      i. Central line insertion.
      ii. Time out and Surgical Count process.
   f. Communication of Patient Safety Plan and prioritized initiatives:
      i. Annual presentation to organizational leadership
      ii. Scheduled presentations: Leadership Forum, Leadership Meeting

Execution—Culture
1. Implement team resource training throughout the organization. (TeamSTEPPS began in Wiser Hospital and has spread to Children’s Hospital.)
2. Continue to foster accountability in managing the disclosure process.
3. Continue Family Activated Rapid Response house-wide, and report activations annually to Quality Board.
4. Integrate patient and family involvement with the addition of a patient and/or community member representative on Quality Board.
5. Sustain caregiver communication plan to improve hand-off communication and communication among caregivers.
6. Routinely administer patient safety survey to include those questions recommended by AHRQ (Agency for Healthcare Research and Quality).
   a. Report unit aggregated data
   b. Facilitate development of action plans based on survey results

Execution—Outcomes
1. Report measures to leadership that reflect “Are we a safe organization?”
   a. Outcome measure—How often do we harm patients?
      i. Regularly report days since last event involving surgical harm.
ii. Dissemination of monthly quality dashboard to include harm score (falls with injury, CLABSI, CAUTI, Stage 3 & 4 pressure ulcers) and surgical harm score (retained products, wrong site procedures, surgical site infections).

b. Process measure—How often do we provide best practice interventions that patients should receive?
   i. Dissemination of monthly quality dashboard to include core measure compliance appropriate to patient population. (Example: Proportion of patients receiving elevation of head-of-bed and prophylaxis for peptic ulcers and DVT)

c. Structural measure—How do we know we learned from harm events or reported significant events?
   i. When an ACA or RCA is conducted, are corrective actions implemented? (Example: How often do events re-occur in patient care areas/units?)

d. Contextual measure—How well have we created a culture of safety?
   i. Routine assessment of safety culture at the unit level within UMMC (Example: Percent of patient care areas in which 80% of staff report positive safety and teamwork climate).
Appendix A

University Mississippi Medical Center Institutional Quality Relationships
Appendix B
Alignment to Meet Patient Safety Expectations

Organizational Structure

Organizational Functions

Execution of Culture & Outcomes