



Patient Safety Plan

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All Members of the Executive Performance Improvement Council
All Members of the Medical Executive Committee**

PURPOSE:

The purpose of this plan is to institute a Patient Safety Program for the organization. This plan facilitates education, communication, consistency and effectiveness of the program.

This patient safety plan ensures that SUNY- Downstate Medical Center implements and maintains a patient safety program in accordance with the Joint Commission standards, Standard of Practices by different Licensing authority and guidelines from state and federal regulatory agencies.

RESPONSIBILITY:

It is the responsibility of all employees of SUNY- Downstate Medical Center to be familiar with the contents of this plan and adhere to the procedure outlined within.

DISTRIBUTION:

This Patient Safety Plan shall be distributed hospital-wide and online.

Introduction

The Patient Safety Plan supports and promotes the mission, vision and values of State University of New York – Downstate Medical Center through **the practice of developing and implementing a culture of safety among its consumers, which implies but not limit to its patient, staff and visitors.**

In a culture of safety and quality, all individuals are focused on maintaining excellence in providing care. Safety and quality thrive in an environment that supports teamwork and respect for other people, regardless of their position in the organization. Leaders demonstrate their commitment to quality and safety, and set expectations for those who work in the organization. Leaders evaluate the culture on a regular basis. **In SUNY-Downstate Medical Center, University Hospital at Brooklyn, we conduct a culture of safety survey by the second quarter in every two years. We have a culture of safety evaluation tool in the light of AHRQ model. On the www.downstate.edu/patientsafety web site, one can enter in the survey form through intranet and complete the survey electronically as per instruction. Those of the employee that does not have any intranet computer connection, their supervisors should provide a departmental computer with Internet Explorer to go to the survey site and complete the survey on the web.**

The Plan implements through the continuous integration and coordination of the patient safety activities of the medical staff, clinical departments and support service departments at the University Hospital at Brooklyn, that have the responsibility for various aspects of patient and staff safety. Each employee of the organization performs a dedicated and critical role in ensuring patient and employee safety.

The organization wide patient safety program is designed to reduce medical errors and hazardous conditions by utilizing a systematic, coordinated and continuous approach to the improvement of patient safety. This approach 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.

University Hospital at Brooklyn integrated patient safety program is implemented through the Hospital Patient Safety Department. Director of Patient Safety/ Patient Safety Officer 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.

Patient Safety Officer has the authority to intervene any clinical or non-clinical activities, which poses negative outcome to the patient's well being, and involves the hospital leadership in the initiation of corrective action measures. Having a Patient Safety Officer is important and crucial key not only to the success of the Patient Safety Plan in the organization, but also to the success of the organization as a whole.

The Governing Body, Medical Executive Committee and Executive Performance Improvement Council 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 events.

Proactive assessment of high risk activities and hazardous conditions are identified through FMEA (failure mode and effect analysis), aggregate data collection and utilization. In addition, available information about sentinel events known to occur in health care organizations that provide similar care and services and knowledge based information for risk reduction are built in the system progressively.

The Patient Safety Plan offers the opportunity through the education module, proper and effective orientation and training that emphasizes clinical and non clinical aspects of patient safety, an interdisciplinary approach to patient care, improvement of patient safety and the requirement and mechanism to report medical errors. Staff involved in serious /sentinel events have access to support.

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. Full disclosure of serious medical errors, reportable events and any unanticipated outcome are made to patients/families through the provider as appropriate. Hospital has a program to inform the accrediting and licensing bodies as appropriate.

To develop a culture of safety, communicating information about patient safety is an important responsibility that should not always fall to managers alone. It is important to employ strategies that consistently inform and engage staff in patient safety activities. Certain situations increase the risk of adverse events and should prompt staff to be even more safety conscious than usual. Examples include patients with same last name, trials of new equipment, and research protocols. Identifying these higher risk situations and bringing them to the attention of all staff members at the start of each shift decreases the likelihood of errors and adverse events.

Scope of the Patient Safety Plan:

Proactive Risk Identification and Process for Mitigating the Risk Factors

Patient safety department is informed about the safety event information collected by Performance Improvement and Risk Management departments using the National Patient Safety Goals by 'The Joint Commission', using standards of practice of professional organizations and health care law of Department of Health of New York State and Federal guidelines provided by CMS and other regulatory agencies. The information includes actual or potential occurrences involving inpatients, outpatients, employees and visitors. Information is provided to the department from all the employees and medical staff through completion of incident reports and verbal communication.

Opportunities for improvement regarding patient safety issues are prioritized according to level of severity, frequency of the occurrence, potential for harm to the patient, employee or visitor and potential for liability. Ongoing review of information is performed to direct the administrative and medical staffs' attention to areas of clinical care representing significant sources of actual or potential risk.

Types of medical / health care errors included in data analysis are:

- + **Near Misses:** Any process variation which did not affect the outcome due to a screening by chance but for a recurrence carries a significant chance of a serious adverse outcome. Some may call it a potential for error.
- + **Occurrence:** 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 or visitor or which may give rise to a claim against the Hospital, an employee of the hospital, or a member of the hospital medical staff.
- + **Error:** An unintended act, either omission or commission, or an act that does not achieve its outcome such as medication errors and adverse drug events or reactions
- + **Hazardous Condition:** Any set of circumstances, exclusive of the disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious physical or psychological adverse patient outcome.
- + **Sentinel Event:** An unexpected occurrence involving death or serious physical or psychological injury or the risk thereof including any process variation for which a recurrence would carry a significant chance of serious adverse outcome. Serious injury specifically includes loss of limb or function.

Any care giving process with a **misuse, under use or overuse** of care will also be a subject for review and further analysis.

Investigation, Analysis, Coordination and Reporting

A broad range of data analysis will be reported to and reviewed by the Patient Safety Committee monthly. 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 responses. Responses shall include any corrective action taken or plan for corrective action. The Patient Safety Committee serves as a clearing house for these data and information that affect patient Safety. Any incident, process, event and condition may be subject to investigation through the Root Cause Analysis method as determined by the RCA Committee or refer to the other venues such as Provision of Care, Departmental Performance Improvement Committee etc. Intensive assessment may be initiated when undesirable patterns or trends are identified or a serious or sentinel event occurs. Proactively this plan suggests to conduct at least one system based **Failure Mode Effect Analysis (FMEA)** in a year. For the year of 2009 the FMEA took place on "**Medication Delay in the Usage Process**".

In accordance with the Joint Commission's Accreditation Participation Requirements - **APR.09.02.01** this plan implies to:

- UHB educates its staff that any employee who has concerns about the safety or quality of care provided in the hospital may report these concerns to The Joint Commission.

- UHB also informs the staff that no disciplinary or punitive action will be taken when an employee reports safety or quality of care concerns to The Joint Commission.
- UHB takes no disciplinary or punitive action against employees when they do report safety or quality of care concerns to The Joint Commission.

Patient Safety Indicators in the University Hospital at Brooklyn and SUNY Downstate at Bayridge

Providing periodic (monthly, quarterly etc) Report on specific sets of indicators is a routine essential of the Hospital Patient Safety Plan. The set up of indicators is done through internal and external metrics and approved by the Patient Safety Committee. Presently, we follow the guidelines of National Patient Safety Goals by the sentinel event advisory board of The Joint Commission. In any event, when we find that an error occurred, we revisit the issue and dedicate ourselves to mitigate the status through a risk reduction strategy. All Patient Safety Indicators for National Patient Safety Goals are observed effectively and continuously in all patient care areas of SUNY Downstate at Bayridge facility monthly. In all operational areas of Bayridge facility are monitored for patient safety compliances by its staff continuously and is reported to the Patient Safety Committee monthly.

Sentinel Event Alert:

The event has resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition.*

Or

The event is one of the following (even if the outcome was not death, or major permanent loss of function unrelated to the natural course of the patient's illness or underlying condition):

- Suicide of any patient receiving care, treatment and services in a staffed around-the-clock care setting or within 72 hours of discharge
- Unanticipated death of a full-term infant
- Abduction of any patient receiving care, treatment, and services

*A distinction is made between an adverse outcome that is primarily related to the natural course of the patient's illness or underlying condition (not reviewed under the Sentinel Event policy) and a death or major permanent loss of function that is associated with the treatment (including "recognized complications") or lack of treatment of that condition, or otherwise not clearly and primarily related to the natural course of the patient's illness or underlying condition.

Major permanent loss of function means sensory, motor, physiologic, or intellectual impairment not present on admission requiring continued treatment or lifestyle change. When "major permanent loss of function" can not be immediately determined, applicability of the policy is not established until either the patient is discharged with continued major loss of function, or two weeks have elapsed with persistent major loss of function, whichever occurs first.

- Discharge of an infant to the wrong family
- Rape
- Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities
- Surgery on the wrong patient or wrong body part

- Unintended retention of a foreign object in a patient after surgery or other procedure
- Severe neonatal hyperbilirubinemia (bilirubin> 30 milligrams/deciliter)
- Prolonged fluoroscopy with cumulative dose> 1500 rads to a single field or any delivery of radiotherapy to the wrong body region or > 25% above the planned radiotherapy dose, etc.

We have a Hospital wide interdisciplinary response mechanism to all the sentinel event alerts. It is done through a correction plan to intercept any such occurrence in our health care facility and to its consumers. To address any patient safety issue related to sentinel event alerts, we construct immediately an interdisciplinary sub-committee to formulate the risk reduction strategy and follow up through an action plan.

In the patient safety plan it includes our performance and measure of success through an analysis of Patient Safety Indicators based on multiple patient safety programs, such as; National Patient Safety Goals by the Joint Commission, AHRQ Patient Safety Indicators, IHI's 5 Million Live campaign.

Our patient safety indicators are as followed to construct the monthly patient safety report through direct observation of practice, real-time concurrent medical record review (sample size is the full census of the unit at the time of review once a month), Retrospective chart review (sample size is at least 10% to more to demonstrate sufficient measure of elements), etc. The data collection and analysis is conducted at a multidisciplinary level and organizational patient safety reporting is constructed and communicated through the Department of Patient Safety.

Each one of these indicators is constructed with the simulation of the Joint Commission's National Patient Safety Goals Implementation Expectations for requirement of each standard. Measure of success for compliance on each standard's requirement is expected to be 90% (Ninety percent) and above to a full compliance level of 100%.

PATIENT SAFETY INDICATORS for Monthly Analysis

NPSG.01.01.01	Hospital wide monthly report on the use of two patient identifiers is met across the continuum of care. It includes comparing the ID Band.
NPSG.01.03.01	Eliminate transfusion errors related to patient misidentification by observing two person bedside or chair side verification process
NPSG.02.03.01	Measure and assess, and if appropriate, take action to improve the timeliness of reporting, and the timeliness of receipt by the responsible licensed caregiver, of critical results or values for the tests.
NPSG.03.04.01	Label all medications, medication containers, and other solutions on and off the sterile field in perioperative and other procedural settings. Note: Medication containers include syringes, medicine cups, and basins.
NPSG.03.05.01	Reduce the likelihood of patient harm associated with the use of anticoagulant therapy. Note: This requirement applies only to hospitals that provide anticoagulant therapy and/or long term anticoagulation prophylaxis (for example, atrial fibrillation) where the clinical expectation is that the patient's laboratory values for coagulation will remain outside normal

	values. This requirement does not apply to routine situations in which short-term prophylactic anticoagulation is used for thrombo-embolism prevention (for example, related to procedures or hospitalization) and the clinical expectation is that the patient's laboratory values for coagulation will remain within, or close to, normal values.
NPSG.07.01.01	Hospital wide monthly report of unit based and health care provider based compliance on Hand Hygiene
NPSG.07.03.01	Hospital wide program on health care-associated infection due to Multidrug-resistant organism (MDRO) & its reporting. This requirement applies to, but is not limited to MRSA, CDI, VRE & Multiple drug-resistant gram negative bacteria
NPSG.07.04.01	Hospital wide program for preventing central line associated bloodstream infections (CLABS) & its reporting Note: This requirement covers short- and long- term central venous catheters and peripherally inserted central catheter (PICC) lines.
NPSG.07.05.01	Hospital wide program for preventing surgical site infections (SSI) & its reporting
NPSG.08.01.01 NPSG.08.02.01 NPSG.08.03.01 NPSG.08.04.01	Monthly compliance of Home Medication List and its application at admission, transfer and Discharge stages. A copy of the list is provided to the next provider and to the patient/family. For minimal medication usage for a short duration (i.e., less than 24 hours) a modified med. Reconciliation is performed
NPSG.15.01.01	The hospital identifies safety risks inherent in its patient population. Monthly report of Suicidal risk screening for vulnerable patients. (Patient MR#, unit, Attending number) Note: This requirement applies only to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals.
UP.01.01.01 UP.01.02.01 UP.01.03.01	Monthly report of Universal Protocol (preoperative verification process, marking the operative site and conduct a "time out" immediately before starting the procedure as per hospital policy and DOH protocol)
Medication Safety and Error Reporting	Monthly Medication Error Rate Report through intervention, investigation of self-reporting and incident report mechanism with distribution of attributable variables (according to MEDMARX-Quantros classification of United States Pharmacopeia)
NPSG.03.06.01 From July 1st, 2011	Maintain and Communicate accurate patient medication information. During admission the complete home medication list needs to be obtained from the patient or the designated family member and at discharge a complete medication history needs to provide to the patient and/or family to communicate it with the next provider. (any level of care changes information will be communicated according to the hospital specific policy – in this case during level of care changes all old medication orders needs to be discharged and new medication orders needs to be prescribed)

All National Patient Safety Goal standards are explained in the related written policy and procedures in the dedicated UHB Policy and procedure website under the web address of: <http://www.uhb.org/pnp/P&p.asp?lookfor=C@PtSaf>

National Patient Safety Goals guideline:

Goal 1 Improve the accuracy of patient identification

- A Use at least two patient identifiers when providing care, treatment or services (NPSG 01.01.01)
- C Eliminate transfusion errors related to patient misidentification. (NPSG 01.03.01)

Goal 2 Improve the effectiveness of communication among caregivers.

- C Measure and assess, and if appropriate, take action to improve the timeliness of reporting, and the timeliness of receipt by the responsible licensed caregiver, of critical test results and values. Timely Reporting of Critical Results or values for the tests. (NPSG 02.03.01)

Goal 3 Improve the safety of using medications.

- D Label all medications, medication containers (for example, syringes, Medicine cups, basins), or other solutions on and off the sterile field. (NPSG-03.04.01)
- E Reduce the likelihood of patient harm associated with the use of anticoagulation therapy. (NPSG 03.05.01)

*** Effective July 1st, 2011- “Maintain and communicate accurate patient medication information” replaces Goal 8 of Medication Reconciliation.**

Goal 7 Reduce the risk of health care- associated infections.

- A Comply with the current World Health Organization (WHO) Hand Hygiene Guidelines or Centers for Disease Control and Prevention (CDC) hand hygiene guidelines. (NPSG 07.01.01)
- C Preventing Multi- Drug resistant Organism Infections (revised NPSG 07.03.01)
- D Preventing Central Line-Associated Blood Stream Infections (revised NPSG 07.04.01)
- E Preventing Surgical Site Infections (revised NPSG 07.05.01)

Goal 8 Accurately and completely reconcile medications across the continuum of care.

- A There is a process for comparing the patient’s current medications with

- those ordered for the patient while under the care of the organization. (NPSG 08.01.01)
- B A complete list of patient's medications is communicated to the next provider of service when the patient is referred or transferred to another setting, service, practitioner or level of care within or outside the organization. (NPSG 08.02.01)
- C Providing a Reconciled Medication List to the Patient (revised NPSG 08.03.01)
- D Modified Medication Reconciliation for the settings in which medications are minimally used (revised NPSG 08.04.01)

Goal 15 The organization identifies safety risks inherent in its patient population.

- A Organization identifies patients at risk for suicide. (NPSG 15.01.01)

Universal Protocol

- A Conducting a Pre-Procedure Verification process (revised UP01.01.01)
- B Marking the Procedure Site (revised UP01.02.01)
- C Performing a Time-Out (revised UP01.03.01)

Agency for Health-care Research and Quality (AHRQ) indicators:

1. Complications of anesthesia (PSI 1)
2. Death in mortality DRGs (PSI 2)
3. Decubitus ulcer (PSI 3)
4. Failure to rescue (PSI 3)
5. Foreign body left in during procedure (PSI 5)
6. Iatrogenic pneumothorax (PSI 6)
7. Selected infections due to medical care (PSI 7)
8. Postoperative hip fracture (PSI 8)
9. Postoperative hemorrhage or hematoma (PSI 9)
10. Postoperative physiologic and metabolic derangements (PSI 10)
11. Postoperative respiratory failure (PSI 11)
12. Postoperative pulmonary embolism or Deep Vein Thrombosis (PSI 12)
13. Postoperative Sepsis (PSI 13)
14. Postoperative wound dehiscence in abdominopelvic surgical patients (PSI 14)
15. Accidental puncture and laceration (PSI 15)
16. Transfusion reaction (PSI 16)
17. Birth trauma – injury to neonate (PSI 17)
18. Obstetric trauma -- vaginal delivery with instrument (PSI 18)
19. Obstetric trauma --vaginal delivery without instrument (PSI 19)
20. Obstetric trauma –cesarean delivery (PSI 20)

Product Safety Recall and Alert Information Management & Reporting:

To ensure that product safety information is received and disseminated to all users and other relevant personnel within the hospital so that necessary actions can be taken in a timely manner and documented appropriately. All product safety information must be distributed to the relevant departments and/or individual users as soon as it is received. All areas and users are responsible for acknowledging receipt of the information, taking necessary action and providing documentation of that action to the Department of Risk Management immediately. Currently, in SUNY –Downstate Medical Center the approved time for web based Recall Management Process of RASMAS is divided in two types and each types are subdivided into three phases to complete the process, Urgent recall and Standard recall; for urgent recall, the three phases are given 3(three) days each to total of 9(nine) days and for the standard recall the three phases are given 5(five) days each to total of 15(fifteen) days to complete the process. Product Safety Recall and Alerts enforcement and updates will be reported to and monitored by the Product Safety sub-committee of Patient Safety Committee, and will remain on the Patient Safety Committee agenda until all compliances are completed. [\(Please see the policy no: RM-7 on “Product safety and recall information management”\)](#). The Product Safety sub-committee will be reviewing any forthcoming and outstanding issues related to any product recall and alert information and its management and will report it to Patient safety Committee. As per Medical Executive Committee, a reminder letter will be issued to all partial or non-compliant areas or services at the end of each month and record will be provided to the Chair of Medical Executive Committee, Chief Medical Officer, Chair of Executive Performance Improvement Council, Chair of Patient Safety Committee and Department of Risk Management for any or all final resolution. A quarterly review on trend analysis will be submitted up to the Governing Body.

Patient Safety Educational Enhancement Activities- Translating Research into Practices

The clinical orientation program emphasizes medical error reduction and specific job-related aspects of patient safety. Ongoing in-service and other educational programs emphasize specific job-related aspects of patient safety. As appropriate, this training incorporates methods of team training to foster interdisciplinary, collaborative approach to the delivery of patient care and reinforces the need and way to report medical errors.

The Department of Patient Safety initiates the plans and conducts educational activities in coordination with other educational efforts undertaken in the Hospital (such as, ICL or institute of continuous learning and new residents and employee orientation, interdisciplinary performance improvement meeting, monthly orientation of ambulatory staff etc).

The Safety of the health care delivery system is enhanced by the involvement of the patient as appropriate to his/her condition as a partner in the health care process. The comment and patient satisfaction survey encourages the patients’ participation and suggestions for changes in the SUNY-Downstate Medical Center. Specific attention is directed at educating patients and families about their role in helping to facilitate the safe delivery of care through a multidisciplinary collaborative effort.

An enhancement program envisioned with the initiation of transforming the culture of safety through the series of actions such as research, operational, educational, ethical and legal that focuses on methods of avoiding or preventing adverse patient outcomes or injuries that stem from the processes of health care. The explicit goal of this enhancement component is to build on the work already performed by SUNY- Downstate employees to synthesize and

evaluate processes for reducing errors, thereby informing decisions regarding the aspects of healthcare that must be notified in order to enhance the patient safety. Dissemination of the program may follow through journal club, literature review and publications, invited lectures, site visits etc.

Organization, Authority and Responsibility

The authority to implement the Patient Safety Plan rests with the SUNY-Downstate Medical Center's Governing Body, Medical Executive Committee, Patient Safety Committee, Executive Performance Improvement Council, Provision of Care Committee and Departmental Committees' interdisciplinary collaboration. This plan is evaluated yearly.

The Director of Patient Safety / Patient Safety Officer (PSO) enforces the plan at a multidisciplinary level and reports to the Chief Medical Officer, who provides the strategic oversight of the Patient Safety Program.

It will coordinate the risk mitigating efforts on environment of care issues with the organizational Environment of Care Committee to assure membership overlaps and will provide appropriate information to that Committee in a manner consistent with the protection of confidentiality of patient and patient safety information. Likewise, the Hospital's Environment of Care Committee will bring patient safety concerns to the Patient Safety Committee as those arise.

The Patient Safety Committee is formed to improve patient outcomes and reduce morbidity and mortality within SUNY- Downstate Medical Center.

The record keeping, data and knowledge collected by this Patient Safety Committee shall only be used for those purposes, consistent with the purpose set forth in the New York State Public Law (J-M) 2805. As such, the records, data and knowledge collected by this committee are intended to be confidential, privileged and not for public records and shall not be available for any legal proceedings as per the New York State Public Law.

The reporting structure flow map explains the scope of the Patient Safety Committee for the implementation of the Patient Safety Plan.

DUTIES

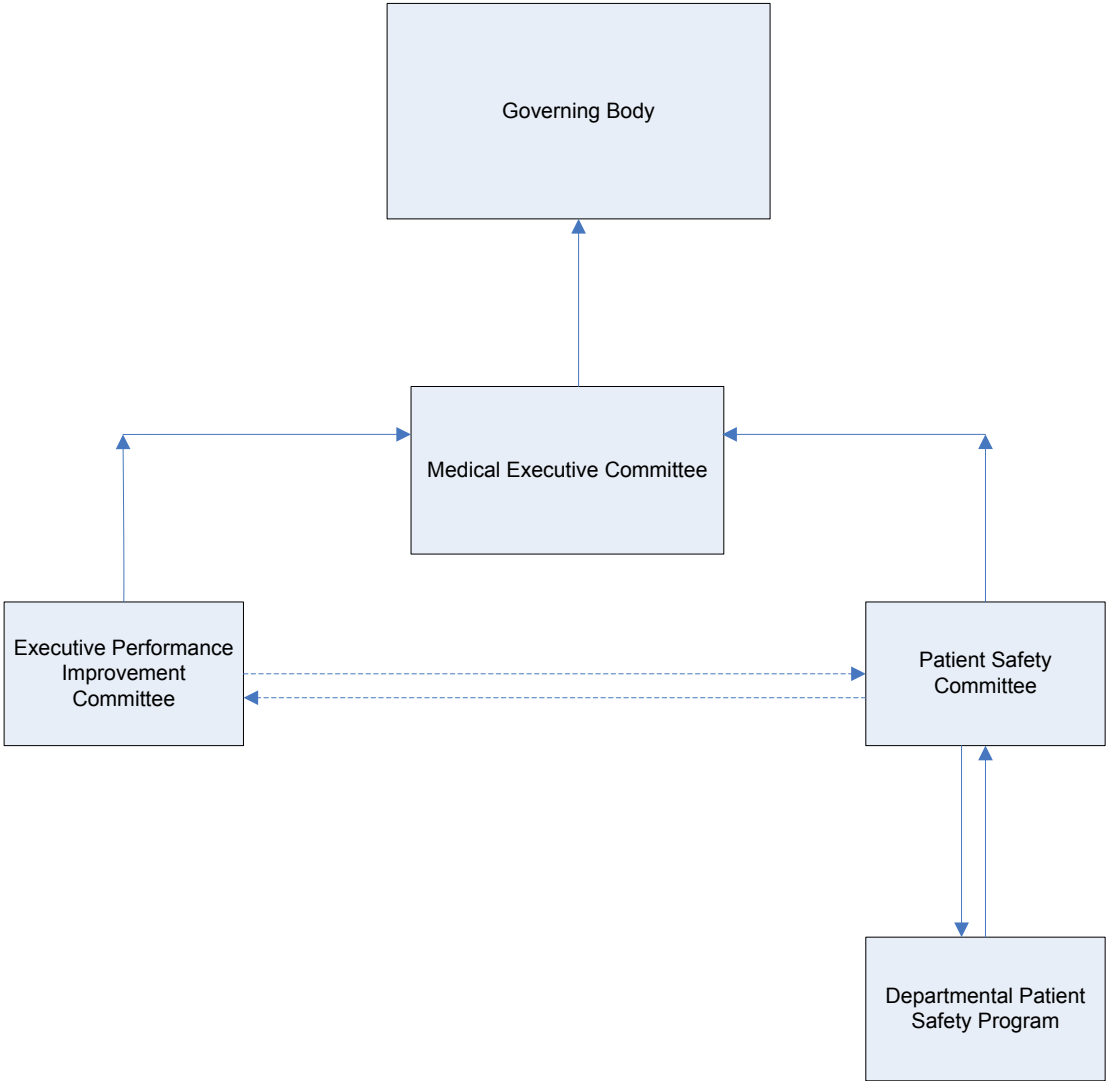
Patient Safety Committee

The committee provides a multidisciplinary forum for the collection of and analysis of risk to patient safety and the dissemination of information on identified risk for the purposes of improving patient care and reducing morbidity and mortality within the Hospital. It shall review reports on occurrences typically ranging from 'No Harm' frequently occurring 'Near Misses' to 'Sentinel Events' with serious adverse outcomes, claims, and identified risks, which are gathered in accordance with this plan. The Committee will promote the application of evidence-based methods and will promote the use of shared metrics in the evaluation of related patient safety activities.

Reporting Flow Map

Patient Safety Committee reports to the **Medical Executive Committee** and build continuous horizontal communication with the Executive Performance Improvement Council. This will then go through the Medical Executive Committee to the Governing Body. The Patient Safety Plan will be carried out at the departmental level. Any feedback from departments will come to the Patient Safety Committee and Executive Performance Improvement Council and will be communicated to the Medical Executive Committee by the Patient Safety Committee.

Patient Safety Committee Reporting Flow Map:



Composition/ Structure of the Patient Safety Committee

The Director of Patient Safety (Patient Safety Officer) Chairs the Patient Safety Committee. Membership is by appointment of the Chairperson and includes representatives from administration, clinical services, environmental and support services of all inpatient, outpatient areas including all off-site clinics. The Patient Safety Committee will meet a minimum of ten (10) times per year usually once a month. The Patient Safety Committee reports quarterly to the Governing Body and monthly to the Medical Executive Committee and shares any outstanding patient safety issues with the Executive Performance Improvement Council. Additional meetings may be scheduled at the call of the Committee Chair including the formation of any subgroups for any outstanding patient safety issue. Any designated member from each discipline can also represent the service. Membership of the Patient Safety Committee will include, but is not limited to the person responsible for:

1. Director of Patient Safety (PSO)
2. Chairman of Environment of Care Committee
3. Chairman of Provision of Care Committee
4. Director of Performance Improvement
5. Deputy Directors of Nursing
6. Director of Risk Management
7. Director of Regulatory Affairs
8. Directors of Nursing from OR/ Peri operative Services
9. Director of Pharmacy
10. Director of Respiratory Care Services
11. Director/ Administrators of Laboratory, Pathology, Blood Bank & Radiology
12. Director of Infection Control
13. Director of Nursing Performance Improvement and Delegate from ICL
14. Director of Hospital Information Management
15. Chief Medical Information Officer
16. Director of Admitting
17. Director of Data Management
18. Two Active Medical Staff (from different services as a rotation)
19. Director of Medical Board
20. Director of F, M&D and Environmental Services
21. Director/ Manager of Human Resources
22. Director of Nutrition and Dietary Services
23. Director of SMIC
24. Performance Improvement Managers from all services
25. Administrators from Central Sterile Services
26. Administrator from Radiology Services
27. Administrators from Ambulatory Services
28. Administrators from Dialysis Services
29. Administrator from Midwood Clinic
30. Administrator from Throop Clinic
31. Administrator from Lefferts Clinic
32. Administrators from SUNY Downstate at Bay Ridge
33. Senior Associate Administrators
34. Chief Nursing Officer
35. Chief Administrative Officer
36. Assistant Chief Medical Officers
37. Chief Medical Officer
38. Chief Executive Officer

Evaluation of Patient Safety Plan for 2010-2011
Department of Patient Safety
Patient Safety Committee Meeting of February 14, 2011

Executive Summary:

A- Hospital wide Patient Safety Report:

SUNY- Downstate Medical Center University Hospital at Brooklyn has a Patient Safety Committee by the representation of leadership to frontline staff. The committee is chaired by the Director of Patient Safety (Patient Safety Officer). The Director of Patient Safety gives the strategic oversight and implementation expectations of Patient Safety Plan with an interdisciplinary collaboration. The program is overseen by the Chief Medical Officer (Medical Director).

In 2010-11, the rate of compliance on all the National Patient Safety Goals is measured. This is an ongoing process evaluation. We have steady and positive progression to achieve our goal for full compliance in all the care giving areas on the National Patient Safety Goals. A monthly report is provided to the Patient Safety Committee, the Departmental P.I. committees and the Medical Executive Committee. The quarterly report is provided to the Executive Improvement Council and the Governing Body.

B- Hospital wide ongoing Patient Safety Programs in 2010-2011:

1. **Patient Identification ad-hoc committee** is working on the multiple improvement projects to develop and sustain the safe patient identification process, such as :
 - a. Patients' demographics verification process is in the developmental phase. A summary report is published to analyze the different categories of errors that are encountered during the registration process. A hospital wide practice is under consideration.
 - b. Ongoing monitoring by direct observation technique, concurrent and retrospective medical record review for the full compliance of Patient Identification process
 - c. Staff education and acknowledgement to establish the responsibility and accountability
 - d. Addressing the implementation issue for overall Bar-coding for patient identification, Bar-coded label in patient's chart, electronic OR reservation form, etc.
 - e. Revision of the hospital wide "Patient Identification" policy and adopt a uniform process of using two patient identifiers in the inpatient and outpatient areas, including the off-site clinics are underway from the second quarter (approximately) of 2010.
 - f. An interdisciplinary staff education program on specimen tube labeling and patient identification, took place in the Park-side dialysis center.

2. **Timely reporting of critical results** is in practice for the laboratory test result reporting, cardiology test result reporting, radiology result reporting. Intervention report with the outliers is published monthly. In some of the cases it was found that the lab technician is kept on hold by the units during the communication with the critical results.

For 2010 the joint commission's standard for not using the "DO NOT ABBREVIATION LIST" moved to the Information Management standard IM.02.02.01. We still have challenges to overcome with not to write "QD, qd, U and u" on medication order form, medication reconciliation list and in the medical record. With the implementation of CPOE Medication Management module medication orders cannot be prescribed with the unauthorized abbreviations. But in the different sections of paper based medical record still have some QD and U (in the internal medicine progress notes, medication reconciliation form, progress notes, etc).

3. **Medication safety practice** monitoring is ongoing on the issues related to Medication Management. Some of the identified safety highlights are described as follows:

- a. In the inpatient units medication carts are identified with the discharged patient's medication are found in the active patient's medication cart.
- b. Novolog Flex pens for one patient are found in different patient's drawers.
- c. Some of the Intravenous Diluent bags are found without label and patient's identification.
- d. For multi dose vial standard expiration policy of 28 days are not followed in some of the instances.
- e. A new format for the Medication Error Reporting is underway and is expected to be published from the second quarter of 2011. Medication Safety sub-committee of the Pharmacy and Therapeutics committee and Patient Safety committee are working on it.

4. Hospital wide **Anticoagulation therapy management program** was implemented partially by January of 2009. Initially it was started in the intensive care units with a gradual expansion to all other units. We have an Anticoagulation therapy management guideline and protocol. We have established a baseline data collection monitoring tool. Patient Safety Committee and Pharmacy & Therapeutics Committee are the oversight of this program. Educating staff to use the protocol, collecting data on time, are the scopes for improvement that we are focusing on.

- a. This program includes an adult full dose and low dose protocol to provide therapeutic regimen
- b. Collecting the blood specimen to receive the laboratory findings on aPTT level timely by a nurse/ physician/ phlebotomist in a 24/7/365 basis.
- c. Changing the Heparin regimen according to the guideline by a nurse/ physician and follow through the utilization of medication by a Pharmacist. Transcription of changes should be reflected on the MAR (medication administration record). Clinical staff education by the Departments of ICL and Pharmacy are ongoing.

- d. Utilizing the base line data collection monitoring tool to ensure the quality assessment part of the program by Performance Improvement Manager, Patient Safety Coordinator and Pharmacist
 - e. The Anticoagulation Therapy Management Team is continuously monitoring the program for its effectiveness. Departments of Performance Improvement and Patient Safety are collecting the data on the anticoagulation safety and efficacy.
 - f. Robust patient education on their anticoagulation therapy is ongoing by the Department of ICL, Nutrition Service.
5. A multidisciplinary **failure mode effect analysis (FMEA)** project on “**Establish Effective Communication to Provide Patient Centered Care**” was started in the third quarter of 2010 and was completed in the first quarter of 2011. Risk Priorities for this proactive process were identified and continuous interdisciplinary process improvement is ongoing. The report was presented in the Patient Safety Committee meeting and the Executive Performance Improvement Council meeting of March 2011.
 6. The Department of Infection Control and The Hospital Infection Control Committee is working on the staff compliances on Hand Hygiene and reduce the risk of health care associated infections, such as Prevent health care associated infections due to multidrug -resistant organisms in acute care hospitals, prevent central line- associated bloodstream infections and implement evidence-based practices for preventing surgical site infections.
 7. The hospital wide identification of safety risks inherent in its patient population and “**Suicidal Ideation**” screening process is ongoing. The Department of Psychiatry and the Nursing are overseeing the program. Recently, the screening form is revised and updated.
 8. The Universal Protocol applies to all surgical and non-surgical invasive procedures. The Universal Protocol is implemented and practiced with its highest capacity. The actual time-out process is practiced all across, however, in some cases it was identified that the participation of all the team members are not uniform, meaning during the time-out, all participating providers must pay full attention to the process. Pre verification of the patient’s identification, marking of the correct site and side of the body and performing a time-out before the procedure is crucially important to be 100% compliant with the standard and in our practices.
It is very important to complete the Universal Protocol Form during time-out.
 9. **Culture of Safety Survey** was completed in August 2009. A new culture of safety survey is due for 2011. The expected date for conducting the survey will be the third quarter of 2011. It will be a hospital wide web based survey. We adopted the AHRQ model for this culture of safety survey. Overall consensus on this survey of 2009 was positive by the staff (front line staff to leadership). There are some areas that we have some opportunities for improvement.

Focus points: Responses are equal in agreement and disagreement

1. Staff work longer hours
2. Person, rather than problem is written up

3. We have enough staff (more disagreement than the agreement)
4. Shift changes are problematic for patients in this hospital
5. Things “fall between cracks” during transferring patients across units
6. Problems often occur in cross unit communication

- a) Improvement can be made in communication across units
- b) Improvement can be made in communication at tour or shift change time
- c) Emphasizing that any proposed improvements are not meant as personal critiques but system wide implementation.

10. Product Safety Process Improvement: We implemented a Web-based Recall Management System- RASMAS in January 2010.

The Product safety policy was revised in March accordingly. Continuous process monitoring and improvement is ongoing. This system gives us better opportunity to tracking and trending for our action and response in closing out an alert or recall. We used to manage only medical device as a product safety item. With the help of RASMAS, we can manage 14 categories of products (such as, Pharmaceuticals, Biologics, OR products, Medical Devices, Facilities and Environmental products, Food and nutritional products, etc). We have product safety coordinators to manage each of the domains and an interdisciplinary group of responders are working along the coordinators. The volume of monthly recall is significantly higher than the previous system. Hospital is managing thousands of recalls a year compare to tens and hundreds. The office of Risk Management and RASMAS database has all the information. We evaluate the process and update the staff through our monthly Patient Safety Committee meeting. The Risk Management, the Product Safety sub-committee, the Patient Safety Committee, the Departmental P.I Committees, EPIC and the Medical Executive Committee are overseeing the process. Currently, we are exploring the ideas of how to manage the recalls by RASMAS in our new acquisition of the Long Island College Hospital.