Patient Safety Plan

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Prepared by: Muhammad Islam, MBBS, MS, MCH
Director of Patient Safety & Patient Safety Officer

Authorization:

AVP. Peri-operative Services: Anny Yeung, RN

Chief Administrative Officer: David Conley, MBA

Chief Nursing Officer: Margaret Jackson, RN

Asst. Chief Medical Officer: Michael Zenilman, MD

Chief Medical Officer: Michael Lucchesi, MD

Chief Executive Officer: Debra Carey, MS

President: John LaRosa, MD

Reviewed by: All Members of the Patient Safety Committee
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.

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, AHRQ (Agency for Healthcare Research and Quality) indicators (20 Hospital-level PSI/ Patient Safety Indicator) etc. 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. In all operational areas of Bayridge facility will be monitored for patient safety compliances by its staff continuously and will be reported to the Patient Safety Committee.

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

| NPSG.01.01.01 | Hospital wide monthly Two patient’s identifier is met across the continuum of care report. 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.02.01.01 | Hospital wide monthly report of verbal order and VORB, service based and Attending based with patient’s MR#, who gives the verbal order, lab report, etc and confirmed by whom (person) |
| NPSG.02.02.01 | Hospital wide monthly non compliance report of unauthorized abbreviation usage in MR and contributing factor in monthly medication error report. Patient’s MR# and Attending physician (name or number) |
| 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 test and critical results and values( compile the report after collating the results by Radiology and Pathology laboratory services on their indicators) |
| NPSG.02.05.01 | Hospital wide monthly report of Hand off communication tool is used unit base. Patient’s MR#, unit. Review the process of interruption |
| NPSG.03.03.01 | Annual evaluation and Poster of Look A Like and Sound Like drug. |
| NPSG.03.04.01 | Two qualified professional verify verbally and visually medication labels for the accuracy, should be performed service and unit based |
| NPSG.03.05.01 | The Hospital uses approved protocol for Anticoagulation therapy management |
| NPSG.07.01.01 | Hospital wide monthly report of unit based and health care provider based compliance on Hand Hygiene |
| NPSG.07.02.01 | Quarterly report of identified cases of unanticipated death or major permanent loss of function with a health care associated infection |
| 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 |
| NPSG.07.05.01 | Hospital wide program for preventing surgical site infections (SSI) & its reporting |
| NPSG.08.01.01 | 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.09.02.01 | Monthly Falls report (Patient’s MR#, Attending number) with intervention, classification and improvement. The Hospital establishes reduction program |
| NPSG.13.01.01 | Monthly report of Patient’s concerns. Refer to Concerns Over Patient’s Complaint Committee (COPC) and Department of Patient Relations |
| NPSG.15.01.01 | Monthly report of Suicidal assessment of vulnerable patient’s. (Patient MR#, unit, Attending number) |
| NPSG.16.01.01 | Hospital wide program on identifying clinical service outcome and deployment of forces to the adult areas where patient’s deteriorating status is anticipated. Data of Adult Code Team activities |
| UP.01.01.01 | 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) |
| UP.01.02.01 | |
| UP.01.03.01 | |
| 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) |

These indicators are directly related to the guidelines below;

**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.

A  For verbal or telephone orders or for telephonic reporting of critical test results, verify the Complete order or test result by having the person receiving the information record and “read-back” the complete order or test result. (NPSG 02.01.01)

B  Standardize a list of abbreviations, acronyms, symbols, and dose designations that are not to be used throughout the organization (NPSG 02.02.01)

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 Tests and Critical Results. (NPSG 02.03.01)

E  Implement a standardized approach to “hand off” communications, including an opportunity to ask and respond to questions. (NPSG 02.05.01)

Goal 3  Improve the safety of using medications.

C  Identify and, at a minimum, annually review a list of look-alike/sound-alike drugs used by the organization, and take action to prevent errors involving the interchange of these drugs. (NPSG 03.03.01)

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)

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)

B  Manage as sentinel events all identified cases of unanticipated death or major permanent loss of function associated with a health care-associated infection. (NPSG 07.02.01)

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 9 Reduce the risk of patient harm resulting from falls.

A Implement a fall reduction program including an evaluation of the effectiveness of the program. (NPSG 09.02.01)

Goal 13 Encourage patients’ active involvement in their own care as a patient safety strategy.

A Define and communicate the means for patients and their families to report concerns about safety and encourage them to do so. (NPSG 13.01.01)

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

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

Goal 16 Improve recognition and response to changes in a patient’s condition.

A The organization selects a suitable method that enables health care staff members to directly request additional assistance from a specially trained individual(s) when the patient’s condition appears to be worsening. [Critical Access Hospital, Hospital] (NPSG 16.01.01)

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)

Institute of Health Improvement organization’s protecting 5 Million Lives from Harm Campaign:

IHI estimates that 15 million incidents of Patient Harm occur in U.S Hospitals each year. IHI’s 5 Million Lives campaign is a national campaign to reduce incidents of medical harm in U.S hospitals. The 5 Million Lives Campaign asks hospitals to improve the care they provide in order to protect patients from five million incidents of medical harm over a 24-month period, ending December 9, 2008. It represents a continuation of the largest improvement effort undertaken in recent history by the health care industry. SUNY-Downstate also participates in that program and plans to implement and continue working on the following interventions as part of their participation in the 5 Million Lives Campaign:

1. Prevent Methicillin-Resistant Staphylococcus Aureus (MRSA) infection…by reliably implementing scientifically proven infection control practices throughout the hospital
2. Reduce harm from high-alert medications…starting with a focus on anticoagulants, sedatives, narcotics, and insulin
3. Reduce surgical complications… by reliably implementing the changes in care recommended by the Surgical Care Improvement Project (SCIP)
4. Prevent pressure ulcers… by reliably using science-based guidelines for prevention of the serious and common complications
5. Deliver reliable, evidence-based care for congestive heart failure…to reduce readmissions
6. Get Boards on board…by defining and spreading new and leveraged processes for hospital Boards of Directors, so they can become far more effective in accelerating the improvement of care.
7. Deploy Rapid Response Teams…at the first sign of patient decline – and before catastrophic cardiac or respiratory event.
8. Deliver reliable, evidence-based care for acute myocardial infarction…to prevent deaths from heart attack.
9. Prevent adverse drug events…by reconciling patient medications at every transition point in care.
10. Prevent central line infections…by implementing a series of interdependent, scientifically ground steps.
11. Prevent surgical site infections…by following a series of steps, including reliable, timely administration of correct perioperative antibiotics.
12. Prevent **ventilator – associated pneumonia**...by implementing a series of interdependent scientifically grounded steps.

We develop strategic plan to carry out continuous safety initiatives. We try to identify our risk areas- why and how it occurs and what we can do to mitigate it. We develop our patient safety program in the light of some practically proven scientific evaluations, such as:

- **‘Shewhart cycle’** (Plan, Do, Check, Act – PDCA),
- **Deming’s ‘85/15 Theory’** (85% of the problems detected are process or system related and 15% are traceable to individuals)
- The concept of ‘**Juran’s Trilogy**’ (product performance that results in customer satisfaction; freedom from product deficiencies which avoid customer dissatisfaction),
- **Crosby’s ‘Conformance to Expectations’** (Do it right at the first time to have a quality product in a cost-effective way)
- **‘Six Sigma’** Breakthrough Strategy (Identification, Characterization, Optimization or achieve breakthrough improvement and Institutionalization or transform how day to day business is conducted)
- **‘Re-engineering’** (Human factor re-engineering such as signage for High Alert Medications, Pop up alert in Pyxis medication dispensing system, Tall man lettering for Look a like sound a like drugs in medication usage process etc.)
- **‘Rapid Cycle Improvement’** (IHI Collaborative approach termed the ‘Breakthrough Series’, to bring about rapid cycle improvements. Fundamental to the collaborative approach is the acceptance of a model and establishment of infrastructure through which collaborating organizations can identify and prioritize aims for improvement and gain access to the methods, tools, materials etc.)
- **Evidence based practice** plays an important role in deciding and updating the patient safety indicators.

**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 frame to respond, acknowledge and enforce the Class I recall is one business day and Class II & III is seven calendar days. This process management is done manually (hand delivery) and electronically (e-mail, fax etc). 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 will be evaluated yearly.

The Director of Patient Safety / Patient Safety Officer (PSO) 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.

**Reporting Flow Map**

Patient Safety Committee will report 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:**
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.

Composition of the Patient Safety Committee

Membership is by appointment of the Chairperson and includes representatives from administration, clinical services, environmental and support services. 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 Executive Performance Improvement Council with any outstanding
patient safety issues. Additional meetings may be scheduled at the call of the Committee Chair including the formation of any subgroups for an 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