

NORTHERN NEVADA ADULT MENTAL HEALTH SERVICES (NNAMHS)
POLICY AND PROCEDURE

SUBJECT: CONSUMER SAFETY PROGRAM

NUMBER: NN-EC-19

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ORIGINAL DATE: 2/18/10

REVIEW/REVISE DATE: 7/18/13

APPROVAL: Cody L. Phinney Agency Director

I. PURPOSE

To enhance consumer care delivery and prevent adverse outcomes of care by employing a systematic, coordinated, and continuous approach to the improvement of consumer safety.

II. POLICY

The Consumer Safety Program is supported by leadership's promotion of a blame-free culture of safety that:

1. Facilitates reporting and follow-up on errors, adverse events, risks, and safety concerns.
2. Initiates monitors and takes action to reduce errors and risks of errors.
3. Reports findings and actions taken.
4. Educates employees to ensure their knowledge of and participation in the program.

III. REFERENCES

1. Nevada Revised Statutes (NRS) 439.865 to 439.890 Patient safety plan; patient safety committee; patient safety officer; patient safety checklists and policies.
2. NRS 439.802 Facility-acquired infection defined.
3. National Quality Forum: www.qualityforum.org.
4. The Joint Commission National Patient Safety Goals.
5. NNAMHS Policy NN-EC-08 Safety Management.
6. NNAMHS Policy NN-IC-06 Hand Hygiene.
7. NNAMHS Policy NN-IC-07 Standard Precautions.
8. NNAMHS Nursing Policy 300-1 Administration of Medications.
9. NNAMHS Form MR 189 Nursing Discharge Instructions.

IV. DEFINITIONS

1. Sentinel Event: An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called "sentinel" because they signal the need for immediate investigation and response.
2. Near Miss: Any process variation that did not affect an outcome but for which a recurrence carries a significant chance of a serious adverse outcome.
3. Facility Acquired Infection: A localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:
 - a. Surgical site infections.
 - b. Ventilator-associated pneumonia.
 - c. Central line-related bloodstream infections.
 - d. Urinary tract infections.

V. OBJECTIVES

1. To collect and analyze data to evaluate processes for opportunities to proactively reduce risk and correct potential system failures.
2. To respond appropriately to any error, adverse event, or sentinel event.
3. To incorporate recognition of consumer safety as an integral job responsibility.
4. To encourage organizational learning about adverse or potential adverse events.

VI. SCOPE

A. Areas of focus shall include sentinel events, near misses and other incidents related to:

1. Facility-acquired infections.
2. Medication errors.
3. Adverse drug events.
4. Drug recalls.
5. Other product recalls.
6. Consumer falls.
7. Other consumer incidents.
8. Blood and body fluid exposures.
9. Communicable disease exposures.
10. Influenza vaccination program.

B. Data from external sources, including but not limited to:

1. The Joint Commission.
2. Centers for Medicare and Medicaid Services.
3. Centers for Disease Control and Prevention.
4. Institute for Safe Medication Practices.
5. National Quality Forum.

VII. CONSUMER SAFETY COMMITTEE

- A. The Consumer Safety Committee provides a multidisciplinary forum for the analysis of risk to consumer safety and for the dissemination of information on identified risk for the purpose of improving consumer care.
- B. Membership shall include:
 - 1. The Consumer Safety Officer – the Performance Improvement Coordinator.
 - 2. The Agency Director.
 - 2. The Director of Nursing.
 - 4. The Director of Pharmacy Services.
 - 5. The Infection Control Officer.
 - 6. The Education Coordinator.
 - 7. The Facilities Supervisor.
 - 8. The Medical Director or other member of the medical staff.
- C. The Consumer Safety Committee has adopted consumer safety checklists and policies, including, but not limited to:
 - 1. Checklists related to specific types of treatment.
 - 2. Checklists ensuring that the consumer's environment is sanitary.
 - 3. A discharge checklist which includes instructions concerning aftercare and medications.
 - 4. Any other checklist which may be appropriate to ensure consumer safety.
 - 5. A policy for appropriately identifying a consumer with two personal identifiers.
 - 6. A hand hygiene policy regarding standard precautions.
- D. The Consumer Safety Committee shall meet monthly and shall:
 - 1. Review reports and evaluate the actions of the Consumer Safety Officer on sentinel events and other incidents.

2. Review and disseminate information it receives to the appropriate committees or individuals.
3. Make recommendations concerning identified risks and evaluate the implementation of corrective action plans.
4. Review the patient safety checklists and policies at least annually and revise as necessary.
5. Ensure compliance with the patient safety checklists and policies, which may include:
 - a. Hand hygiene monitoring.
 - b. Audits of sanitation materials.
 - c. Review of medical records.
 - d. Performance improvement indicator reports.
 - c. Communication to employees.

E. The Consumer Safety Officer shall:

1. Serve on the Consumer Safety Committee.
2. Manage the agency incident reporting system.
3. Report all sentinel events to the Nevada Sentinel Events Registry.
4. Conduct investigations, root cause analyses, and monitor corrective action plans for completion and effectiveness.
5. Take action in collaboration with the Consumer Safety Committee and leadership to ensure the safety of consumers.
6. Report quarterly, to the Local Governing Body, the number and severity of sentinel events, and any recommendations to reduce the number and severity of sentinel events.
7. On or before July 1 of each year, submit a report to the Director of the Legislative Counsel Bureau for transmittal to the Legislative Committee on Health Care. The report shall include a summary of any new checklist development, or, revision and use of the checklists and policies.

VIII. SAFETY IMPROVEMENT ACTIVITIES

- A. Incident reporting trending and analysis.
- B. Medication error reporting and trending.
- C. Other potential errors/prescription interventions tracked by pharmacy.
- D. Infection surveillance and prevention.
- E. Monitoring hand hygiene.
- F. Tracking seclusion and restraint data.
- G. Appropriate implementation of input from consumers, families, and employees.
- H. Environmental safety rounds.
- I. Environmental safety monitoring by Environment of Care Committee.
- J. Reactive analysis (root cause analysis) of incidents.
- K. Proactive risk assessment (failure mode effect analysis).

IX. EMPLOYEE EDUCATION AND TRAINING

- A. Employees are educated on safety issues, policies, and procedures during new employee orientation, including department specific orientation.
- B. Annual and bi-annual employee education includes safety education.
- C. Employees are updated on all new policies or policy revisions.
- D. Employees participate on teams for proactive or reactive analysis and are, thus encouraged to participate in the improvement of safety.