

CENTRAL STATE HOSPITAL  
PLAN

SUBJECT: CLIENT SAFETY PLAN

ANNUAL REVIEW MONTH: April

RESPONSIBLE FOR REVIEW: Client Safety Committee Chairperson

LAST REVIEW DATE: July 2006

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**I. PURPOSE:**

The purpose of the Client Safety Plan is to formally establish a mechanism to identify actual or potential safety risks and develop corrective measures to address those risks. Central State Hospital recognizes the importance of establishing a safety awareness culture and dedicates available resources to the identification of events that may contribute to an unsafe environment. Our goal is to be proactive in our approaches to reduce or eliminate safety risk to our clients. This is done through ongoing monitoring efforts to identify potential or actual risk. Further, systems have been designed to collect, review and analyze data to identify trends should an untoward event occur and implement corrective measures to prevent a reoccurrence.

The Client Safety Plan encourages the involvement of staff, clients and visitors in identification of safety risk and in the recognition of potential/real unsafe areas, as well as in the implementation of processes to provide for the overall safety of healthcare providers and consumers. This shall be accomplished through the effective reduction of medical/healthcare errors, and other factors that could contribute to unintended adverse outcomes through the management of the physical environment, and the implementation of Safety, Risk Management, and Security Programs.

**II. AUTHORITY:**

The Governing Body, through the CSH Leadership Team and the Medical Executive Committee, authorizes the development, implementation, and oversight of the Client Safety Plan to the Client Safety Committee.

**III. SCOPE:**

The Client Safety Plan supports the Central State Hospital mission and vision by providing the mechanisms to improve client safety and reduce identified risk to clients. This is accomplished through the analysis of data from various direct care and support functions of the hospital. Management of the physical environment, safety, security, medical equipment management, and related risk management programs is coordinated through the Environment of Care Function Team.

A. Data analysis and internal monitoring of client safety functions include, but are not limited to:

1. Medication Error/Discrepancy Reports
  2. Adverse Drug Reaction Reports
  3. Mortality reviews
  4. Morbidity/clinical case reviews
  5. Incident Reports
  6. Root cause analysis
  7. Human rights investigations
  8. Client complaints
  9. Client Accident/Injury Reports
  10. Pharmacy interventions
  11. Licensing agency complaints/investigations
  12. Medical record reviews
  13. Hazard Vulnerability Analyses
  14. Failure Modes and Effects Analyses
- B. Data from external sources, including but not limited to:
1. Agency for Healthcare Research and Quality
  2. Centers for Disease Control and Prevention (CDC)
  3. JCAHO Standards, National Patient Safety Goals and Sentinel Event Alerts
  4. Occupational Safety and Health Administration (OSHA) Advisories
  5. Published literature
- C. Proactive Approaches:
1. Speak Up Campaign
  2. Staff/Client/Family Input
  3. Unit Rounds
    - Environmental
    - Clinical
    - Infection Control
  4. Monitoring Activities
  5. Licensure Input/Comments

#### IV. DEFINITIONS:

- A. **ERROR:** An unintended act, either of omission or commission, or an act that does not achieve its intended outcome.

#### TYPES OF ERRORS:

##### 1. **PERFORMANCE ERROR:**

- a. Inadequate preparation of the client before procedure;
- b. Technical error;
- c. Inadequate monitoring of client after procedure;
- d. Use of inappropriate or outmoded form of therapy;
- e. Avoidable delay in treatment; and
- f. Physician or other professional practicing outside area of expertise/competence.

##### 2. **PREVENTION ERROR:**

- a. Failure to take precautions to prevent accidental injury;

- b. Failure to use indicated tests;
- c. Failure to act on results of tests or findings;
- d. Use of inappropriate or outmoded diagnostic tests;
- e. Avoidable delay in treatment; and
- f. Physician or other professional practicing outside area of expertise or competence.

**3. *DIAGNOSTIC ERROR:***

- a. Failure to use indicated tests;
- b. Failure to act on results of tests or findings;
- c. Use of inappropriate or outmoded diagnostic tests;
- d. Avoidable delay in diagnosis; and
- e. Physician or other professional practicing outside area of expertise or competency.

**4. *DRUG TREATMENT ERROR:***

- a. Error in dose or method of use;
- b. Failure to recognize possible antagonistic or complimentary drug-drug interactions;
- c. Use of inappropriate drug;
- d. Avoidable delay in treatment; and
- e. Physician or other professional practicing outside area of expertise or competence.

**5. *SYSTEM ERROR:***

- a. Defective equipment or supplies;
- b. Equipment or supplies not available;
- c. Inadequate monitoring system;
- d. Inadequate training or supervision of staff;
- e. Inadequate reporting or communications;
- f. Delay in providing or scheduling of service;
- g. Inadequate testing; and
- h. Inadequate functioning of a hospital service.

**B. *CLIENT NOTIFICATION ERROR:***

An error resulting in severe adverse consequences to the client. This type of error requires that the client and/or family member be notified. If a client experiences severe adverse consequences as a result of a medical error, the physician will notify the client and, when appropriate, their families/significant other (s) after consultation with the Clinical Director. Severe adverse consequence will be defined as any medically compromised condition requiring admission to an acute-medical care hospital (for example, Oconee Regional Medical Center). If the client is competent to give consent and does so, the family/significant other(s) will be notified. If not competent or if decision-making capacity is severely compromised due to the resultant medical condition, the procedure for family or emergency notification will be utilized for notification purposes. This notification will be documented in the medical record.

- C. ***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. Also includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.
- D. ***NEAR MISS:*** Any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome. Such a near miss falls within the scope of the definition of a sentinel event, but outside the scope of those sentinel events that are subject to review by the JCAHO.

- E. **HAZARDOUS CONDITION:** Any set of circumstances (exclusive of the disease or condition for which the client is being treated) that significantly increases the likelihood of a serious adverse outcome.

**V. OBJECTIVES:**

- A. Monitor the mechanisms developed to address activities that impact the Client Safety Program, from “Near Misses” and frequently occurring incidents, to sentinel events with serious adverse outcomes.
- B. Ensure that all components of the hospital organization are integrated into and participate in the Client Safety Program.
- C. Develop and maintain policies and procedures for immediate response to medical/healthcare errors, to include care of the affected client, containment of risk to others, and preservation of factual information for subsequent analysis.
- D. Develop mechanisms for responding to various types of incidents such as root cause analysis in response to a sentinel event, and for conducting proactive risk reduction activities.
- E. At least quarterly, report to the Leadership Team the incidents related to medical/healthcare errors and actions taken to improve client safety. This report shall address response to actual occurrences and proactive programs to improve client safety.
- F. At least annually, assist the Leadership Team in the selection at least one high-risk process and conduct a Failure Modes and Effects Analysis to identify any undesirable variances or outcomes.
- G. Implement recommendations of the National Safety Goals.
- H. Review and evaluate recommendations from the Sentinel Event Alerts; implement appropriate actions.
- I. Review past survey data, including mock surveys, to identify opportunities for improvement and implement plans of correction.
- J. Educate staff on the client safety plan.
- K. Define safety teams on each unit and define their role to ensure client safety.
- L. Assist the Leadership Team in the evaluation of the hospital organizational safety culture

**VI. CSH LEADERSHIP TEAM:**

- A. Ensures the implementation of an integrated Client Safety Program.
- B. Ensures that the processes for identifying and managing sentinel events and near misses are defined and implemented. Makes assignment of appropriate staff to the hospital Incident Analysis Team.
- C. Ensures that an ongoing, proactive program for identifying risks to client safety and reducing medical/healthcare errors is defined and implemented. Identifies at least one high risk process annually to conduct a proactive risk assessment using an intensive analysis process such as a failure mode and effects analysis or root cause analysis.
- D. Ensures that client safety issues are given a high priority and addressed when processes, functions, or services are designed or redesigned.
- E. Implements recommendations of Sentinel Event Alerts and National Safety Goals.
- F. Develop and evaluate the hospital client safety culture.
- G. Ensures that all Function Teams identify and respond to client safety issues in their respective function areas.
- H. Supports a planning process that provides for setting performance improvement priorities and identifies how the hospital adjusts priorities in response to unusual or urgent events.

- I. Develops an environment that encourages recognition and acknowledgement of risks to client safety and medical/healthcare errors and promotes cooperation and communication. Staff shall be encouraged to report medical/healthcare errors without fear of retribution.
- J. Allocates adequate resources for measuring, assessing, and improving client safety.
- K. Designates and appoints qualified individuals to serve on the Client Safety Committee.
- L. Defines and provides support systems for staff involved in sentinel events.

**VII. CLIENT SAFETY COMMITTEE:**

The CSH Medical Executive Committee on Client Safety shall manage the hospital-wide Client Safety Program. The sub-committee shall have representation from Risk Management, Performance Improvement, Safety, Nursing, Medicine, Clinical Services, and others as needed. The Client Safety Sub-committee shall be directly responsible for the following:

- A. Develop an on-going, proactive program for identifying risks to client safety and to reduce medical/healthcare errors.
- B. Identify one high-risk process annually through data analysis, Hazard Vulnerability Analysis, National Patient Safety Goals, Sentinel Event Alerts, or through other means.
- C. Review National Safety Goals and Sentinel Event Alerts and assign/recommend action responsibility to the appropriate function team(s)/Departments/Individuals.
- D. Coordinate/assist with Root Cause Analyses as directed by the Leadership Team.
- E. Meeting minutes, internal and external reports shall be considered confidential, and managed as peer review information.

**VIII. Incident Analysis Team:**

The Incident Analysis Team ensures that the hospital has a coordinated and systematic mechanism for reviewing unexpected client outcomes, and a process for identifying and managing sentinel events. The Team provides these functions in accordance with the Official Code of Georgia, JCAHO standards, CSH Policies, and DMHDDAD Policy Memorandum 2.101.

**IX. PERFORMANCE IMPROVEMENT:**

- A. Gathers for analysis, available information from within the hospital and from other organizations about potential risks to clients in order to reduce the risk to clients affected by new or redesigned processes, functions, or services.
- B. When significant undesirable performance or variation is detected, intense analysis is initiated to determine where to focus changes for improvement.

**X. RISK MANAGEMENT:**

- A. Provides legal, risk management, and release of information services for the ultimate benefit of the client.
- B. Provides requested information to customers in a timely manner, as required by law.
- C. Coordinates the completion, processing, and filing of legal documentation concerning clients' hospitalization.

**XI. INFORMATION MANAGEMENT:**

- A. Information Management is integrated into the design and implementation of the Client Safety Plan.

- B. Assures accurate, timely, and complete verbal and written communication among caregivers and all others involved in the utilization of the data.
- C. Establishes mechanisms for timely and appropriate communications with the client and family about the outcomes of care, treatment, and services provided.

**XII. RIGHTS AND ETHICS FUNCTION TEAM:**

Review the mechanisms for informing clients and families of adverse medical/healthcare events and unanticipated outcomes.

**XIII. TRAINING AND EDUCATION:**

- A. On-going education and training programs shall be provided to maintain and improve staff competence in support of client safety.
- B. All staff responsible for client safety shall participate in ongoing education and training programs that emphasize specific job-related functions of client safety.
- C. Training shall incorporate team training that fosters an interdisciplinary approach to client care and reinforces the need to report medical/healthcare errors

**XIV. CONTINUUM OF CARE:**

Throughout all phases of client care, client needs are matched with appropriate resources within the continuum of care. Transitions between levels of care shall be planned and coordinated to promote effective communications between family, social work, nursing, primary physician care, and follow-up care.

**XV. ENVIRONMENT OF CARE:**

- A. The Environment of Care Function Team shall coordinate and collaborate with the Client Safety Committee on client safety initiatives that pertain to the physical environment, medical equipment, life safety, and other Environment of Care functions. The Hospital Safety Director shall develop and implement proactive programs to identify, reduce and eliminate environmental hazards that adversely impact client safety.
- B. The EOC Team shall analyze and evaluate data relating to client safety, and recommend actions to the Leadership Team.

**XVI. INFORMATION COLLECTION AND EVALUATION SYSTEM (ICES):**

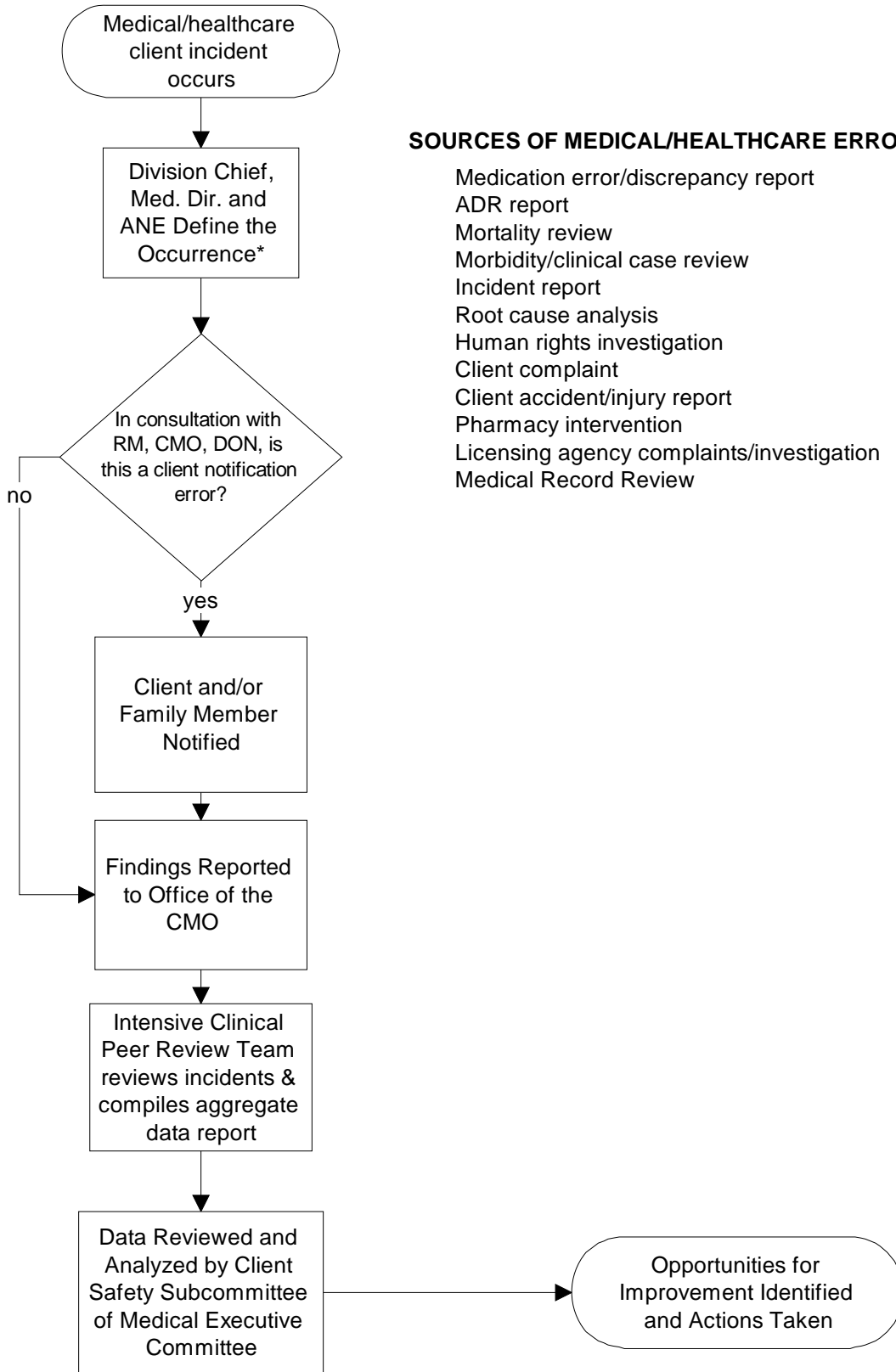
- A. The CSH Leadership Team and the Performance Improvement Committee review information collected and evaluated through the Performance Improvement process monthly.
- B. The CSH Leadership Team reviews hospital performance Indicators monthly, and recommends corrective action.
- C. Risk Management Indicators are reviewed monthly by the CSH Leadership Team with actions and responsibilities assigned as needed.
- D. Through the Quarterly Review Process, the Leadership Team reviews data related to client safety programs, processes, and outcomes.

**Approved:**

**This plan has been approved by the CMO and CEO on 7/27/2006.**

Attachment:  
Attachment I – Medical/Healthcare Error Identification and Action Process

### MEDICAL/HEALTHCARE ERROR IDENTIFICATION AND ACTION PROCESS



### SOURCES OF MEDICAL/HEALTHCARE ERRORS

- Medication error/discrepancy report
- ADR report
- Mortality review
- Morbidity/clinical case review
- Incident report
- Root cause analysis
- Human rights investigation
- Client complaint
- Client accident/injury report
- Pharmacy intervention
- Licensing agency complaints/investigation
- Medical Record Review

\*Near Miss, No-harm error, Performance error, Hazardous Conditions, etc.