VOLUME 3: QUALITY MANAGEMENT	Effective Date: 11/26/2012
CHAPTER 7: PATIENT SAFETY	Revision Date: 05/2017
3.7.1: PATIENT SAFETY PROGRAM POLICY	Attachments: Yes ☐ No ☒

I. POLICY

California Correctional Health Care Services (CCHCS) shall maintain a Patient Safety Program to identify and improve health care processes that endanger patients and staff which if left unaddressed may cause errors and health care incidents and may result in preventable disability or death.

The CCHCS Patient Safety Program encompasses:

- Routine program surveillance to identify problematic health care processes, including a statewide centralized system for reporting patient safety issues, near misses, adverse/sentinel events, and other health care incidents;
- A biennial Patient Safety Plan which determines priority areas for statewide interventions and performance objectives;
- Statewide, regional, and institution-level interventions designed to protect patients and improve outcomes;
- Regular communication in the form of patient safety alerts, program reports, and other mechanisms to ensure that all institutions are aware of patient safety issues;
- Technical assistance, staff development programs, and decision support tools (e.g., guides, forms, checklists, and flowcharts) to support problem analysis, Root Cause Analysis, and process redesign;
- A patient safety culture that encourages staff to proactively identify and mitigate risk to patients and emphasizes continuous learning and improvement;
- A review and assessment process to ensure that patient safety issues that present immediate danger to patients and/or staff are resolved quickly and effectively and provide direction to institutions about appropriate follow up;
- A committee structure at headquarters to provide oversight to the Statewide Patient Safety Program, review patient safety reports and data, and take action to mitigate patient safety risks and prevent adverse patient outcomes;
- A committee structure at each institution that participates in the local implementation of the Patient Safety Program by reviewing patient safety reports and data at the individual care team, or institution level to identify and mitigate patient safety risks and prevent poor patient outcomes; and
- A referral process for health care incidents that involve blameworthy acts/reckless behaviors, including criminal activities.

II. PURPOSE

To protect patients from poor outcomes due to faulty health care processes and errors; improve health care quality and cost effectiveness; increase efficiencies and reduce waste; and comply with legal and regulatory requirements.

III. DEFINITIONS

Adverse Drug Reaction: Any undesired, unintended, or unexpected response to a medication administered in doses recognized as appropriate in accepted health care practice which results in one or more of the following: changing, stopping, or reducing the medication or admission to a higher level of care. An adverse drug reaction includes any undesired experience with the appropriate use of a medication product in a patient.

Adverse/Sentinel Event: An event or series of events that cause the death or serious disability of a patient, personnel, or visitor. "Serious disability" means a physical or mental impairment that substantially limits one or more of the major life activities of an individual, or the loss of bodily function, if the impairment lasts more than seven calendar days or is still present at the time of discharge, or unintentional loss of a body part.

Blameworthy Act/Reckless Behavior: A criminal act, a purposefully unsafe act, act involving patient abuse of any kind, or a situation in which an individual takes a substantial and unjustifiable risk that may result in patient harm.

Health Care Incident: An unusual or unexpected occurrence in the clinical management of a patient or patients, such as an error, adverse/sentinel event, near miss, accident, or medication event that has or may have adverse health consequences for patients and/or personnel, and requires submission of a written description of the event to the Statewide Health Care Incident Review Committee. For the purposes of this policy, health care incidents include events as described in the Health and Safety Code Section 1279.1; unusual occurrences as described in Title 22, Division 5, Chapter 12, Article 5, Section 79787; adverse drug reactions submitted to the Food and Drug Administration MedWatch Reporting Program; and Potential Quality Issue Referrals.

Medication Event: A medication-related health care incident resulting in an adverse drug reaction, medication error, near miss, omission error, or sentinel event. Medication events may include, but are not limited to, medication prescribing, verification and dispensing, administration and documentation.

Near Miss: An event or situation that could have resulted in a health care incident but did not, either by chance or through timely intervention.

Patient Safety Alert: A bulletin issued to all institutions informing them of a patient safety issue with statewide implications, which may include actions to mitigate harm to patients. For example, a patient safety alert might be issued when an adverse event is linked to malfunctioning medical equipment used by several institutions.

Root Cause Analysis: A structured and standardized process by which a multidisciplinary team analyzes a health care incident, near miss, or adverse/sentinel event, determines the fundamental reasons why the event occurred, and designs and implements a Plan of Action to prevent similar events from occurring in the future.

IV. RESPONSIBILITIES

A. Statewide

California Department of Corrections and Rehabilitation and CCHCS departmental leadership, at all levels of the organization, within the scope of their authority, shall ensure administrative, custodial, and clinical systems are in place and appropriate tools, training, technical assistance, and levels of resources are available so that health care staff can successfully implement the Patient Safety Program and establish a patient safety culture of continuous learning and improvement.

B. Regional

Regional Health Care Executives are responsible for implementation of this policy at the subset of institutions within an assigned region. Regional executive teams shall provide ongoing support and monitoring to ensure implementation of the Patient Safety Program, engage in patient safety initiatives, and use patient safety surveillance data and trends to identify and take action to mitigate patient safety risks within an individual institution or across a region.

C. Institutional

The Chief Executive Officer is responsible for implementation of this policy at the institution level. Institution leadership teams shall ensure that the institution utilizes existing forums such as local quality committees to identify and address local patient safety concerns; support and encourage timely reporting of health care incidents; and identify Patient Safety Champions to provide subject matter expertise and technical support to local staff.

V. REFERENCES

- California Code of Regulations, Title 22, Division 5, Chapter 12, Article 5, Section 79787, Reporting
- California Health and Safety Code, Division 2, Chapter 2, Article 1, Section 1250
- California Health and Safety Code, Division 2, Chapter 2, Article 3, Sections 1279, 1279.1, and 1279.2
- California Correctional Health Care Services, Inmate Medical Services Policies and Procedures, Volume 1, Chapters 29.1 and 29.2, Death Reporting and Review Program Policy and Procedure
- California Correctional Health Care Services, Inmate Medical Services Policies and Procedures, Volume 3, Chapter 7:
  - 3.7.2 Health Care Incident Reporting Policy
  - 3.7.3 Patient Safety Program Procedure: Statewide Patient Safety Committee
  - 3.7.4 Patient Safety Program Procedure: Initial Review and Assessment of Health Care Incidents
  - 3.7.5 Patient Safety Program Procedure: Institution Response to a Health Care Incident
  - 3.7.6 Patient Safety Program Procedure: Statewide Health Care Incident Review Committee
- California Correctional Health Care Services, Inmate Medical Services Policies and Procedures, Volume 9, Chapter 27, Reporting of Medication Errors and Adverse Drug Reactions
- California Department of Corrections and Rehabilitation, Mental Health Services Delivery System Program Guide, Chapter 10, Suicide Prevention and Response
- Food and Drug Administration, MedWatch: The FDA Safety Information and Adverse Event Reporting Program (http://www.fda.gov/safety/medwatch/default.htm)
- The Joint Commission (www.jointcommission.org)
- National Commission on Correctional Health Care 2008 Standards for Health Services in Prisons
- National Coordinating Council for Medication Error Reporting and Prevention

- United States Department of Veterans Affairs - Veterans Affairs National Center for Patient Safety (http://www.patientsafety.va.gov/)
- Veterans Health Administration Vision 2020 (http://www.va.gov/healthpolicyplanning/vision2020.pdf)