



<b>VOLUME 3: QUALITY MANAGEMENT</b>	Effective Date: 11/26/2012
<b>CHAPTER 7: PATIENT SAFETY</b>	Revision Date: 05/2017
<b>3.7.3: PATIENT SAFETY PROGRAM PROCEDURE: STATEWIDE PATIENT SAFETY COMMITTEE</b>	Attachments: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

**I. PROCEDURE OVERVIEW**

This procedure outlines the membership and responsibilities of the California Correctional Health Care Services (CCHCS) Statewide Patient Safety Committee which provides oversight to the Patient Safety Program.

The Statewide Patient Safety Committee establishes a Patient Safety Plan, designs a centralized health care incident reporting system to collect data and identify patient safety issues, and provides training and decision support materials to help staff perform Root Cause Analysis (RCA) and redesign health care processes. The Statewide Patient Safety Committee shall encourage staff to proactively identify and mitigate risk to patients and emphasize continuous learning and improvement.

**II. DEFINITIONS**

**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.

**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.

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**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.

## III. PROCEDURE

### A. Responsibilities

1. The CCHCS Statewide Patient Safety Committee protects patient safety and improves the health care services delivery system by:
  - a. Designing a surveillance system for the centralized collection and review of data pertinent to patient safety;
  - b. Reviewing program data, including health care appeals, death review, utilization management, litigation and correspondence, and reports from external stakeholders to identify and mitigate risk to patients;
  - c. Ensuring that CCHCS maintains an effective process for initial assessment, appropriate referral, and timely conclusion of reported health care incidents;
  - d. Establishing patient safety priorities and objectives;
  - e. Working with other business or program areas to redesign health care processes when required to improve patient safety;
  - f. Assisting in developing and implementing statewide initiatives to protect patient safety;
  - g. Assisting in developing statewide training programs and decision support tools (e.g., guides, forms, checklists, and flowcharts) to support problem analysis, RCA, and process redesign;
  - h. Identifying system or process lapses that may have a statewide impact and issuing patient safety alerts;
  - i. Communicating patient safety findings and recommendations to program leads, other committees, and business or program areas;
  - j. Coordinating committee activities including, but not limited to, the Death Review Committee and their recommendations, with the activities or initiatives of other health care committees and programs;
  - k. Documenting recommendations related to identified problems and resolution of such recommendations, or other actions taken in response thereto, within appropriate timeframes determined by the Statewide Patient Safety Committee;
  - l. Producing periodic reports of patient safety information for all health care staff;
  - m. Supporting initiatives to encourage reporting of all health care incidents including medication events, near misses, and adverse/sentinel events.
2. The CCHCS Statewide Patient Safety Committee shall designate staff at statewide and regional levels as members of the Statewide Health Care Incident Review Committee (HCIRC).
  - a. The HCIRC shall meet every business day.
  - b. Representatives from health care disciplines (Medical Services, Nursing Services, Pharmacy Services, the Mental Health Program, and Dental Services) at statewide and regional levels shall be selected to serve on the HCIRC.

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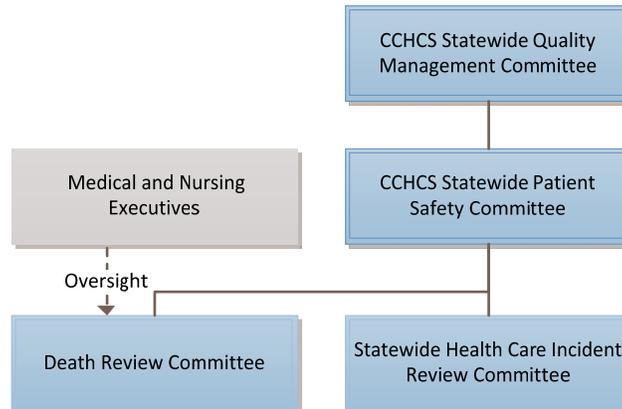
- c. Members of the HCIRC serve a secondary role as a Health Care Incident Review Executive (HCIRE) responsible for the review of all reported health care incidents which are deemed potential adverse/sentinel events, medication errors with an assigned severity level 4 through 6, or any other anomalous health care incident, and where appropriate, shall provide direction regarding institution-level review and follow-up activities, RCAs, peer review referrals, or referrals to the hiring authority. The HCIREs shall determine the appropriate disposition and document their findings of the health care incident.
- B. Committee Membership, Quorum Requirements and Meeting Frequency**
1. The statewide Chief Quality Officer or designee shall serve as chairperson for the CCHCS Statewide Patient Safety Committee. The chairperson is responsible for ensuring that the Statewide Patient Safety Committee meets regularly, the committee agenda reflects the responsibilities and actions described in this procedure, and committee decisions are appropriately documented.
  2. The statewide program lead in each respective health care discipline (Medical Services, Nursing Services, Pharmacy Services, the Mental Health Program, and Dental Services), as well as the program leads in Legal and Health Care Policy and Administration, shall select at least one designee to serve on the Statewide Patient Safety Committee. The Statewide Patient Safety Committee Chairperson shall work with Regional Health Care Executives to select at least one member of the Regional Health Care Executive Team to serve on the committee on a rotational basis for at least 12 months. Other program representatives may be asked to serve as members at the Statewide Patient Safety Committees discretion.
  3. All voting members may choose a designee to serve in their stead. Non-voting members, such as presenters and guests, may attend as appropriate and approved by the committee.
  4. Each member has one vote, and a quorum exists when more than one-half of the voting members are present.
  5. The Statewide Patient Safety Committee shall meet at least quarterly and more often as necessary.

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## C. Reporting Relationships

The CCHCS Statewide Patient Safety Committee reports to the CCHCS Quality Management Committee and provides oversight to the Statewide HCIRC. Refer to Figure 1.

*Figure 1. Reporting Relationships: Statewide Patient Safety Committee*



## IV. 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, Chapter 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:
  - 3.7.1 Patient Safety Program Policy
  - 3.7.2 Health Care Incident Reporting Policy
  - 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

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- 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](http://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://patientsafety.va.gov/>)
- Veterans Health Administration Vision 2020 (<http://va.gov/healthpolicyplanning/vision2020.pdf>)