June 13, 2024

TO: Legal Counsel

News Media
Salinas Californian
El Sol
Monterey County Herald
Monterey County Weekly
KION-TV
KSBW-TV/ABC Central Coast
KSMS/Entravision-TV

The next regular meeting of the **QUALITY AND EFFICIENT PRACTICES COMMITTEE - COMMITTEE OF THE WHOLE** of **SALINAS VALLEY HEALTH**[1] will be held **MONDAY, JUNE 17, 2024, AT 8:30 A.M., DOWNING RESOURCE CENTER, CEO CONFERENCE ROOM 117, SALINAS VALLEY HEALTH MEDICAL CENTER, 450 E. ROMIE LANE, SALINAS, CALIFORNIA**. (V*isit* **SalinasValleyHealth.com/ virtualboardmeetinglink** *for Public Access Information*).

Allen Radner, MD
Interim President/Chief Executive Officer

SalinasValleyHealth.com | 450 E. Romie Lane | Salinas, CA 93901 | T 831-757-4333

[1]Salinas Valley Memorial Healthcare System operating as Salinas Valley Health

Salinas Valley HEALTH

Committee Voting Members: **Catherine Carson**, Chair, **Rolando Cabrera, MD**, Vice-Chair, **Clement Miller,** Chief Operating Officer, **Carla Spencer**, Chief Nursing Officer; **Alison Wilson, DO**, Medical Staff Member.

Advisory Non-Voting Members: Cheryl Piozzoli, Patient/Family Advisor, Administrative Executive Team.

**QUALITY AND EFFICIENT PRACTICES COMMITTEE**
**COMMITTEE OF THE WHOLE**
**SALINAS VALLEY HEALTH[1]**

**MONDAY, JUNE 17, 2024, 8:30 A.M.**
**DOWNING RESOURCE CENTER, CEO CONFERENCE ROOM 117**

**Salinas Valley Health Medical Center**
**450 E. Romie Lane, Salinas, California**

**(Visit SalinasValleyHealth.com/virtualboardmeeting for Public Access Information)**

# AGENDA

1. Call to Order / Roll Call

2. Public Comment

   This opportunity is provided for members of the public to make a brief statement, not to exceed three (3) minutes, on issues or concerns within the jurisdiction of this District Board which are not otherwise covered under an item on this agenda.

3. Approve the Minutes of the Quality and Efficient Practices Committee Meeting of May 13, 2024. (CARSON)
   - Motion/Second
   - Action by Committee/Roll Call Vote

4. Patient Care Services Update (SPENCER)
   Procedural Unit Practice Council

5. Upcoming Proposed CMS Reporting Changes (KUKLA)

6. Program Plan Review (KUKLA)
   - Quality Assessment and Performance Improvement Plan
   - Infection Prevention Program Plan
   - Patient Safety Program Plan
   - Risk Management Plan

7. Closed Session

8. Reconvene Open Session/Report on Closed Session

9. Adjournment
   The next Quality and Efficient Practices Committee Meeting is scheduled for **Monday, July 15, 2024 at 8:30 a.m.**

[1]Salinas Valley Memorial Healthcare System operating as Salinas Valley Health

This Committee meeting may be attended by Board Members who do not sit on this Committee. In the event that a quorum of the entire Board is present, this Committee shall act as a Committee of the Whole. In either case, any item acted upon by the Committee or the Committee of the Whole will require consideration and action by the full Board of Directors as a prerequisite to its legal enactment.

The Committee packet is available at the Committee Meeting, at www.SalinasValleyHealth.com, and in the Human Resources Department of the District. All items appearing on the agenda are subject to action by the Committee.

Requests for a disability related modification or accommodation, including auxiliary aids or services, in order to attend or participate in a meeting should be made to the Board Clerk during regular business hours at 831-759-3050. Notification received 48 hours before the meeting will enable the District to make reasonable accommodations.

**QUALITY & EFFICIENT PRACTICES COMMITTEE**
**COMMITTEE OF THE WHOLE**
**SALINAS VALLEY HEALTH**

**AGENDA FOR CLOSED SESSION**

*Pursuant to California Government Code Section 54954.2 and 54954.5, the board agenda may describe closed session agenda items as provided below. No legislative body or elected official shall be in violation of Section 54954.2 or 54956 if the closed session items are described in substantial compliance with Section 54954.5 of the Government Code.*

**CLOSED SESSION AGENDA ITEMS**

**HEARINGS/REPORTS**
(Government Code §37624.3 & Health and Safety Code §§1461, 32155)

**Subject matter**: (Specify whether testimony/deliberation will concern staff privileges, report of medical audit committee, hospital internal audit report, or report of quality assurance committee): ______________________

1. Report of the Medical Staff Quality and Safety Committee
   - Sepsis review – A. Kukla
   - CMS star reports-July release, ORYX TJC report, -A. Kukla
2. Quality and Safety Board Dashboard Review (KUKLA)
3. Consent Agenda:
   - Diagnostic Excellence /ECRI Hazards report-A. Kukla
   - Disease Specific Care: Joint Program – L. Meraz Gottfried
   - Restraints Report
   - Environment of Care: Fire Safety Mgmt, EH, IC
   - Pathology Tissue Reviews 4Q 2023
   - Disease Specific Care: Stroke
   - Risk Management/Patient Safety Full Report
   - Accreditation and Regulatory Committee Full Report

**ADJOURN TO OPEN SESSION**

*CALL TO ORDER*
*ROLL CALL*

*(Chair to call the meeting to order)*

*PUBLIC COMMENT*

Salinas Valley HEALTH

**DRAFT SALINAS VALLEY HEALTH[1]**
**QUALITY AND EFFICIENT PRACTICES COMMITTEE MEETING**
**COMMITTEE OF THE WHOLE**
**MEETING MINUTES MAY 13, 2024**

Committee Member Attendance:

Voting Members Present: **Catherine Carson**, Chair, **Rolando Cabrera, MD,** Vice Chair, **Clement Miller**, COO, and **Alison Wilson, DO**, Medical Staff Member;

Voting Members Absent: **Lisa Paulo,** CNO;

Advisory Non-Voting Members Present: James Gilbert, MD, Interim CMO, Allen Radner, MD, Interim President/CEO, (via teleconference), and Gary Ray, CLO (via teleconference).

Other Board Members Present, Constituting Committee of the Whole: Director Juan Cabrera (via teleconference).

*Alison Wilson, DO, arrived at 8:39 am.*

## 1. CALL TO ORDER/ROLL CALL

A quorum was present and Chair Carson called the meeting to order at 8:33 a.m. at the Downing Resource Center CEO Conference Room 117.

## 2. PUBLIC COMMENT

None

## 3. APPROVAL OF MINUTES FROM THE QUALITY AND EFFICIENT PRACTICES COMMITTEE MEETING OF APRIL 15, 2024.

Approve the minutes of the April 15, 2024 Quality and Efficient Practices Committee meeting. The information was included in the Committee packet.

**PUBLIC COMMENT:**
None

**MOTION:**

Upon motion by Committee member Miller, second by Committee Vice-Chair Dr. Cabrera, the minutes of the April 15, 2024 Quality and Efficient Practices Committee Meeting were approved as presented.

**ROLL CALL VOTE:**

Ayes: Chair Carson, Dr. Cabrera, and Miller;
Noes: None;
Abstentions: None;
Absent: Paulo and Dr. Wilson.

**Motion Carried**

[1]Salinas Valley Memorial Healthcare System operating as Salinas Valley Health

## 4. CONSIDER APPROVAL OF THE APPOINTMENT OF A COMMUNITY MEMBER TO THE QUALITY AND EFFICIENT PRACTICES COMMITTEE AS A PATIENT AND FAMILY ADVISOR

Consider Approval of the Appointment of a Community Member to the Quality and Efficient Practices Committee as a Patient and Family Advisor.

**Committee Discussion:** Cheryl Pirozzoli is a member of the Salinas Valley Health Patient/Family Advisory Committee, had a career in social work, and is currently a Board member of Volunteer Services. It is considered best practice to have community members on Board Committees.

**PUBLIC COMMENT:**
None

**MOTION:**

Upon motion by Committee member Miller, second by Committee member Vice-Chair Dr. Cabrera, the Quality and Efficient Practices Committee recommends Board approval of the Appointment of community member Cheryl Pirozzoli as a Patient and Family Advisor to the Quality and Efficient Practices Committee.

**ROLL CALL VOTE:**

Ayes: Chair Carson, Dr. Cabrera, and Miller;
Noes: None;
Abstentions: None;
Absent: Paulo and Dr. Wilson.

**Motion Carried**

## 5. PATIENT CARE SERVICES UPDATE: ONCOLOGY UNIT PRACTICE COUNCIL

Carla Spencer, MSN, RN, NEA-BC, Associate Chief Nursing Officer introduced Megan Ackerman, BSN, SNIII, OCN who provided an update on the Oncology Unit Practice Council's work. The Council includes members from Oncology and Outpatient Infusion. A full report was provided in the packet.

Current Initiatives include:

- **Hypersensitivity Reaction Kit/Policy update & education**
- **Quality & Safety Metrics**
    - Audits: Medication Reconciliation, PPE, Care Plan
    - Guardrail Usage
    - Fall Action Plans
- **Increase percentage of ONCC[2] Certified Nurses**
- Chemotherapy Safety: USP 800[3] Review & Continued Safe Handling Education/Competency
- Extravasation Policy updated & education provided
- Monthly journal club
- Acuity-based scheduling

The 2024 Goals include:

- Continue hypersensitivity kit project, education, & monitoring for best practice
- Exceed national benchmarks in area specific NSIs4 for guardrail usage & patient falls
- Increase OCN Certified RNs by 1%

The Council is working on the following projects:

- *Hypersensitivity Reaction Kit/Policy update & education:* Includes collaboration with pharmacy, providers and inpatient/outpatient oncology units. Promoting the Oncology Nursing Society (ONS) Chemotherapy Immunotherapy Provider Card, education, revised guidelines, policies/ procedures and hypersensitivity kit to align with best practice.
- *Quality & Safety:* Includes monthly practice audits, guardrail monitoring (98% compliance) and fall prevention.
- *Oncology Certified Nurses:* Eligibility requirements were reviewed. An OCN review course was held March 16, 2024. Current certification rate is 45%.

## 6. CLOSED SESSION

Chair Carson announced that the item to be discussed in Closed Session is *Hearings/Reports* as listed on the closed session agenda. The meeting recessed into Closed Session under the Closed Session protocol at 8:46 a.m.

## 7. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION

The Committee reconvened for Open Session at 9:37 a.m. Chair Carson reported that in Closed Session, the Committee discussed *Hearings/Reports* as published on the closed session agenda as follows:

1. Report of the Medical Staff Quality and Safety Committee
   - Taylor Farms Family Health & Wellness Center (M. Ceralde)
   - Transitions of Care (M. Orta, L. Meraz-Gottfried)
2. Quality and Safety Board Dashboard Review (KUKLA)
3. Star Review/CMS Care Compare
4. Infection Prevention Program Plan
5. Consent Agenda:
   - Critical Care/Progressive Care Cluster
   - Perinatal Services
   - Organ Donation
   - Resuscitation
   - Sleep Medicine
   - Environmental Services
   - Nursing Admin (Transporters, Interpreter Svc)
   - Laboratory
   - P&T and Infection Control Committee

The Quality and Efficient Practices Committee received and accepted the reports and consent agenda items, and Infection Prevention Program Plan. No additional action was taken.

## 8. ADJOURNMENT

There being no other business, the meeting adjourned at 9:38 a.m. The next Quality and Efficient Practices Committee Meeting is scheduled for **Monday, June 17, 2024** at 8:30 a.m.

_____________________________________

Catherine Carson, Chair
Quality and Efficient Practices Committee

# Patient Care Services Update

**Presented by:**
Carla Spencer, MSN, RN, NEA-BC
Chief Nursing Officer

**Featuring:**
Procedural Unit Practice Council

Monday, June 17, 2024

# Procedural Unit Practice Council

## Departments:

**Cath Lab Holding Area/Cath Lab**

- Suzette Urquides, DNP, MPA, RN, CCRN
- Megan Giovanetti, MBA, R.T.(R)(CI)(ARRT)

**Cardiology/CDOC**

- Meghan Canchola, BSN, RN

**Cardiac Wellness**

- Elizabeth Grogin, BSN, RN, CCRP (Chair)

**Diagnostic Imaging**

- Megan Lopez, MSN, RN, CNL, VA-BC
- Jacqueline Banuelos, BSN, RN (Co-Chair)
- Kristen Tritt, BSN, RN

## Advisors:

- Sherri Arias, MSN, RN, CNML, HACP
- Rebecca Rodriguez, MSN, RN, CEN, CPHQ
- Christianna Kearns, MBA, RDCS, FACHE

# Current Initiatives:

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## Cath Lab/Cath Holding Outpatient Cardiac Procedures

- Patient Readiness/On-Time Starts

## Cardiac Wellness

- New Patient Guidebook
- Peripheral Arterial Disease Procedures [PAD]

## Diagnostic Imaging

- Patient Experience

# Cath Lab/Cath Holding

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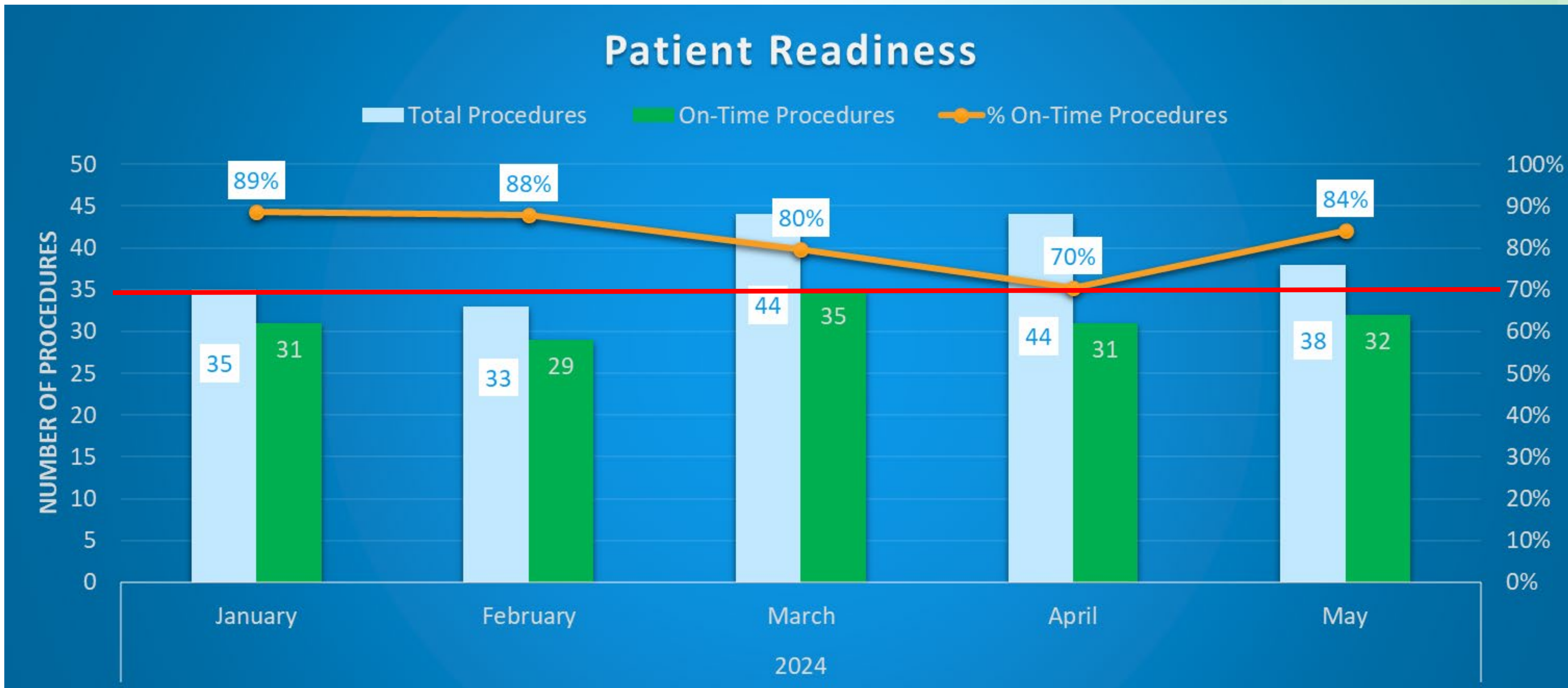
**>25% increase in number of patient procedures in FY2024 vs FY2023**

# Patient Readiness/On-Time Starts

Salinas Valley HEALTH

**GOAL: To have first patients in each room ready for physician scrub in by scheduled start time, at least 70% of the time**

**Patient draped 5 minutes before scheduled start time**



# Cardiac Wellness

Salinas Valley HEALTH

## Improved Collaboration between Phase I/Heart Center and Phase II/Outpatient Cardiac Rehab:

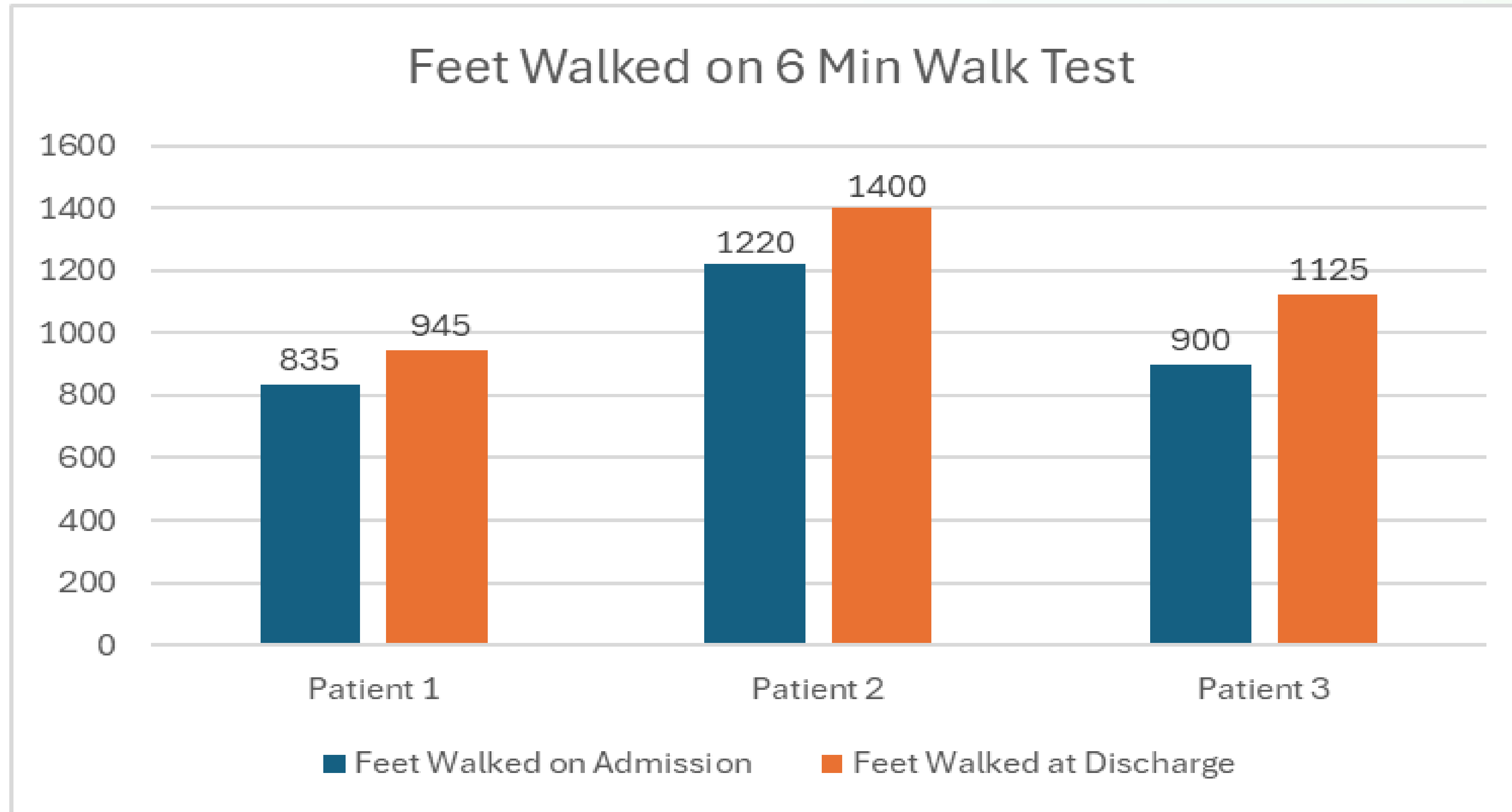
- Developed the new patient guidebook scheduled for release by August 2024.
- The care coordination between Phase I and Phase II Cardiac rehab teams will be featured in our next Magnet® document

## PAD[1] patient data supports improvement in:

- Increased distance walked
- Improved quality of life (VascuQoL[2] Questionnaire)

[1] Peripheral Arterial Disease Procedures [PAD]
[2] Vascular Quality of Life Questionnaire [VascuQol]

# PAD Data[1]




[1] Peripheral Arterial Disease Procedures [PAD]

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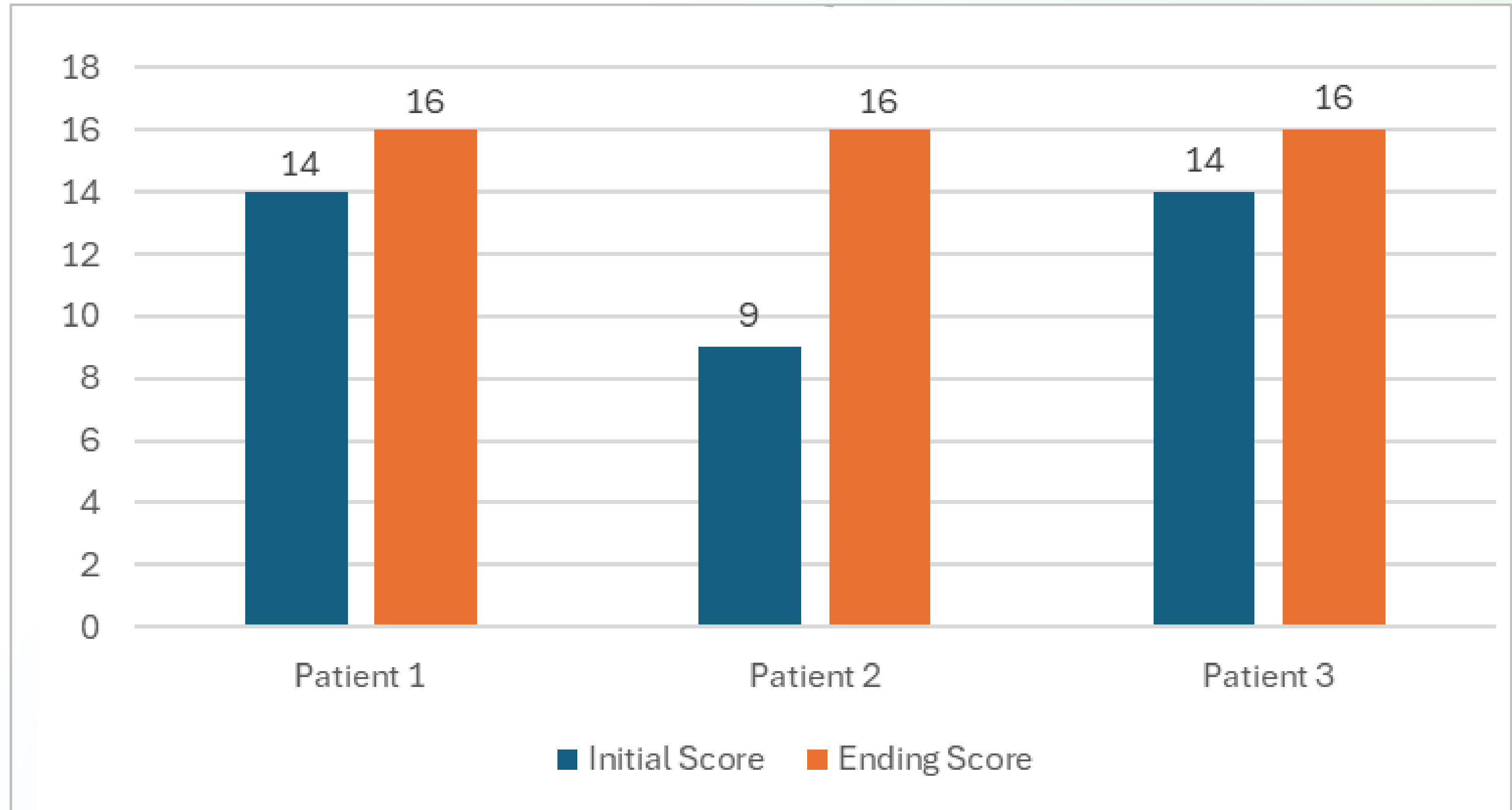
# VascuQoL Score[1]

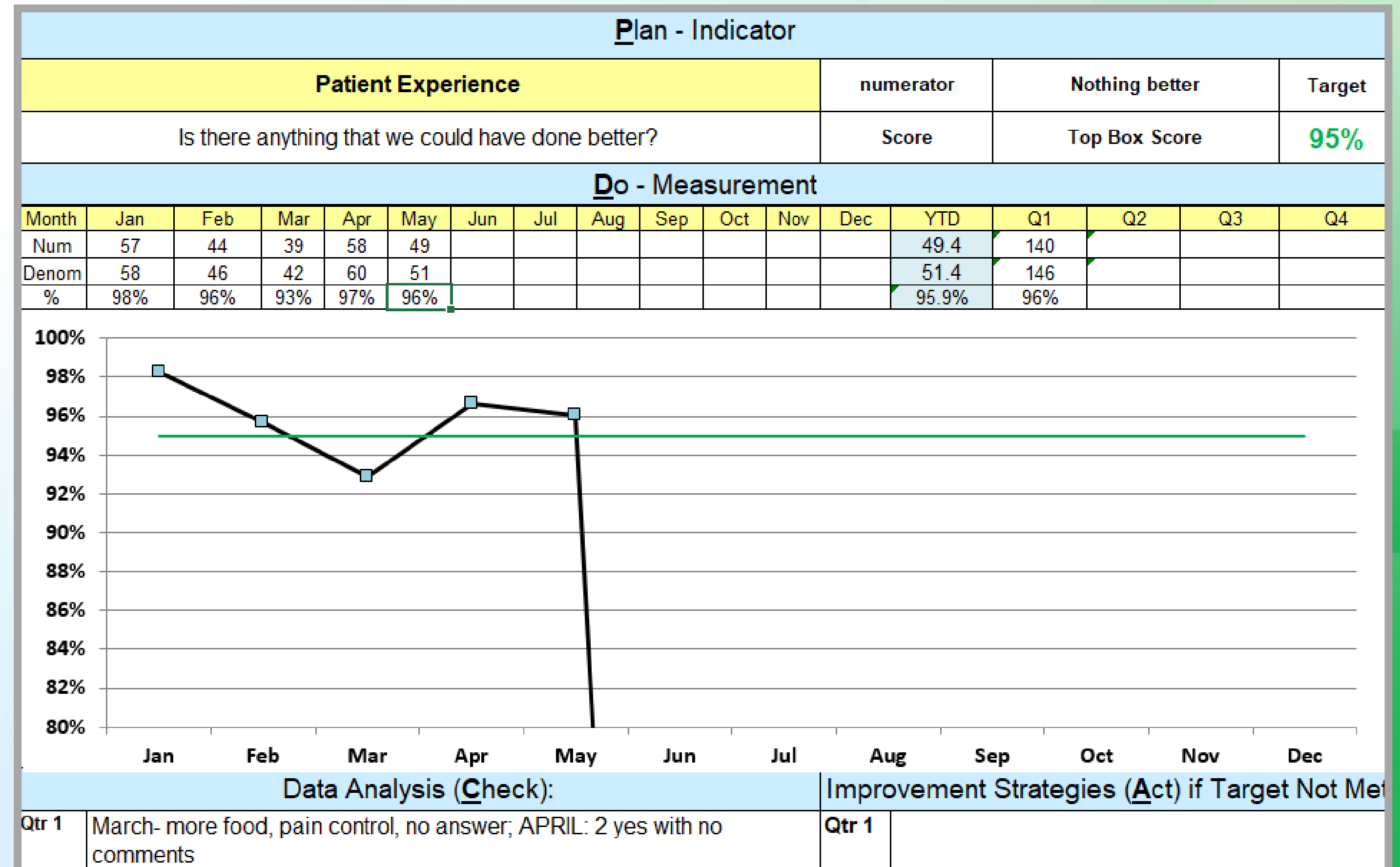



[1] Vascular Quality of Life Questionnaire [VascuQoL]

# Diagnostic Imaging

**The Diagnostic Imaging unit is focusing on several performance improvement projects and we are highlighting:**

- Patient Experience Data



Plan - Indicator

| Patient Experience | numerator | Nothing better | Target |
|---|---|---|---|
| Is there anything that we could have done better? | Score | Top Box Score | 95% |

Do - Measurement

| Month | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | YTD | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Num | 57 | 44 | 39 | 58 | 49 | | | | | | | | 49.4 | 140 | | | |
| Denom | 58 | 46 | 42 | 60 | 51 | | | | | | | | 51.4 | 146 | | | |
| % | 98% | 96% | 93% | 97% | 96% | | | | | | | | 95.9% | 96% | | | |



| Data Analysis (Check): | | Improvement Strategies (Act) if Target Not Met | |
|---|---|---|---|
| Qtr 1 | March- more food, pain control, no answer; APRIL: 2 yes with no comments | Qtr 1 | |

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# Future Initiatives

- **Start tracking blood pressure control to align with AHA[1] guidelines [Cardiac Wellness]**
- **On time starts Angiography [DI suite]**
- **Nurse Protocol for PICCs[2] Tip confirmation [DI RN]**

[1] American Hospital Association [AHA]
[2] Peripherally Inserted Central Catheter [PICC]

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# Any questions?

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# CMS: Proposed measures CY2025 and other quality updates

*June 2024*

Dr. Aniko Kukla DNP, RN, PNP
Director of Quality and Patient Safety
Patient Safety Officer

# Governmental focus: Patient Safety and Health Equity – Major Changes

IPPS proposed rules 2025

35934 Federal Register / Vol. 89, No. 86 / Thursday, May 2, 2024 / Proposed Rules

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**Centers for Medicare & Medicaid Services**

**42 CFR Parts 412, 413, 431, 482, 485, 495, and 512**

**[CMS–1808–P]**

**RIN 0938–AV34**

**Medicare and Medicaid Programs and the Children's Health Insurance Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2025 Rates; Quality Programs Requirements; and Other Policy Changes**

**AGENCY:** Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

**ACTION:** Proposed rule.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments via express or overnight mail to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1808–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

For information on viewing public comments, we refer readers to the beginning of the **SUPPLEMENTARY INFORMATION** section.

**FOR FURTHER INFORMATION CONTACT:** Donald Thompson, and Michele Hudson, (410) 786–4487 or *DAC@cms.hhs.gov*, Operating Prospective Payment, MS–DRG Relative Weights, Wage Index, Hospital Geographic Reclassifications, Graduate Medical Education, Capital Prospective Payment, Excluded Hospitals, Medicare Disproportionate Share Hospital (DSH) Payment Adjustment, Sole Community

Based Purchasing Program—Administration Issues.

Melissa Hager, *melissa.hager@cms.hhs.gov*, and Ngozi Uzokwe, *ngozi.uzokwe@cms.hhs.gov*—Hospital Inpatient Quality Reporting Program and Hospital Value-Based Purchasing Program—Measures Issues Except Hospital Consumer Assessment of Healthcare Providers and Systems Issues.

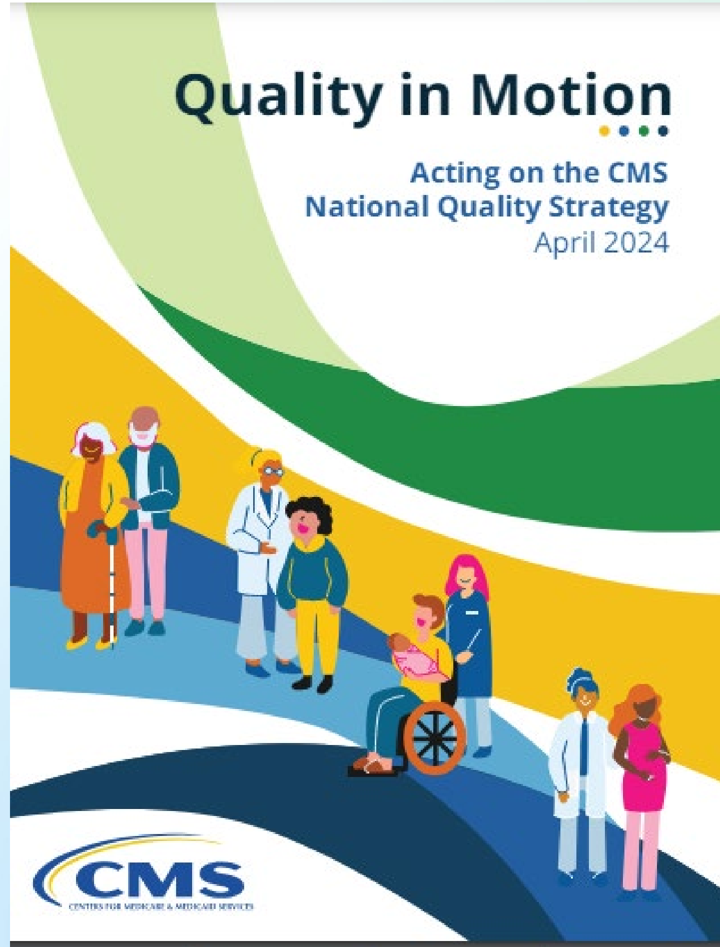
Elizabeth Goldstein, *elizabeth.goldstein@cms.hhs.gov*, Hospital Inpatient Quality Reporting and Hospital Value-Based Purchasing—Hospital Consumer Assessment of Healthcare Providers and Systems Measures Issues.

Ora Dawedeit, *ora.dawedeit@cms.hhs.gov*, PPS-Exempt Cancer Hospital Quality Reporting—Administration Issues.

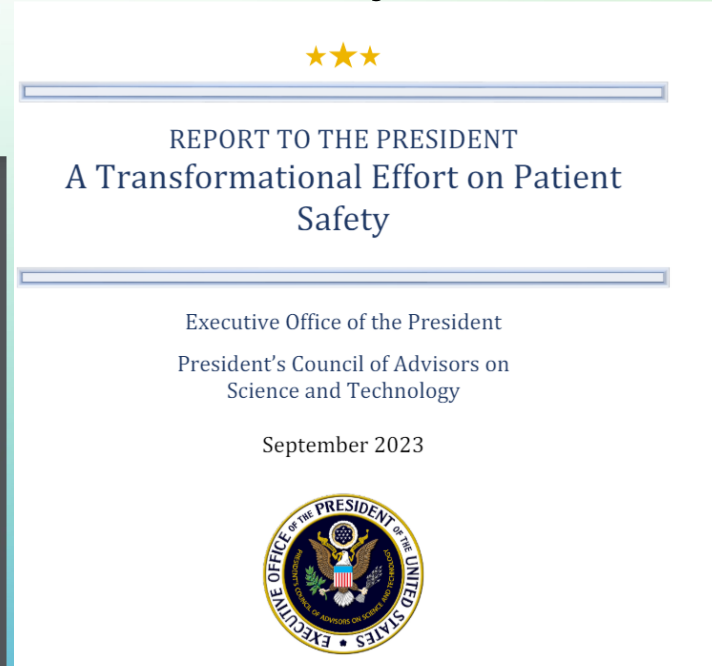
Leah Domino, *leah.domino@cms.hhs.gov*, PPS-Exempt Cancer Hospital Quality Reporting Program—Measure Issues.

Lorraine Wickiser, *lorraine.wickiser@*

CMS national strategy




President's Advisory Council




National Quality Foundation joins coalition with TJC

Health equity DEI organizations

IHI and WHO influence

New rules and regulations

Salinas Valley HEALTH

# Increase in electronic measure reporting

## Proposed Increase to Measures & Submissions from 2025 IPPS Proposed Rule

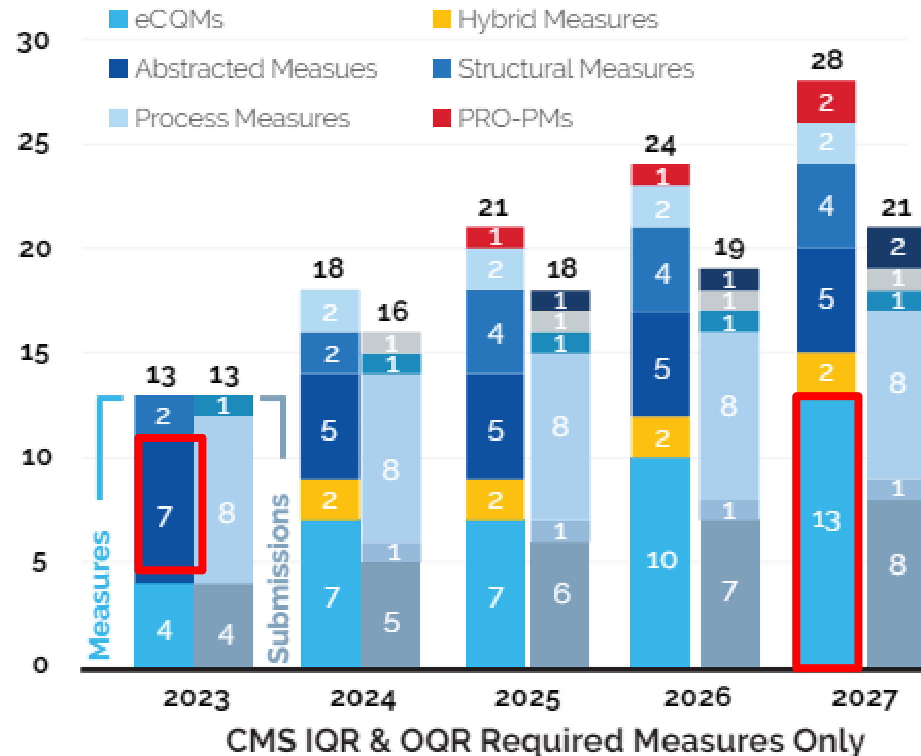
**Each new measure means more time and resources spent adhering to the program requirements.**

**New measures require:**

- Measure education: Quality leader
- Validation
- Mapping
- Clinical workflow adjustments
- Measure education: Clinician workflow changes

**New submissions require:**

- File preparation and validation
- File submission
- Troubleshooting with CMS
- Gathering and disseminating results post-submission



# Structural Measures

## ADDITIONAL STRUCTURAL MEASURES

**CMS is proposing to require submission of two new Structural measures in 2025.**

- Patient Safety Structural measure
- Age Friendly Hospital Structural measure

Both measures work just like the HCHE measure with 5 domains that you must positively attest yes to all 5 domains to earn full credit for these measures.

# Proposed Adoption of the Patient Safety Structural Measure

| Attestation Domain | Intent |
|---|---|
| **Domain 1**: Leadership Commitment to Eliminating Preventable Harm | The senior leadership and governing board at hospitals set the tone for commitment to patient safety, must be accountable for patient safety outcomes, and ensure that patient safety is highest priority for the hospital. |
| **Domain 2:** Strategic Planning & Organizational Policy | Hospital must leverage strategic planning and organization policies to demonstrate a commitment to safety as a core value. Hospitals should acknowledge the goal of zero preventable harm. |
| **Domain 3**: Culture of Safety & Learning Health Systems | Hospitals must integrate a suite of evidence-based practices and protocols that are fundamental to cultivating a hospital culture that prioritizes safety and establishes a learning system both within and across hospitals. |
| **Domain 4**: Accountability & Transparency | Accountability for outcomes, as well as transparency around safety events and performance, represent the cornerstones of a culture of safety. There must exist a culture that promotes event reporting without fear or hesitation, and safety data collection and analysis with the free flow of information. |
| **Domain 5**: Patient & Family Engagement | Hospital must embed patients, families, and caregivers as co-producers of safety and health through meaning involvement in safety activities, quality improvement, and oversight. |

Proposal to Adopt the Patient Safety Structural Measure Beginning with the **CY 2025** Reporting Period/FY 2027 Program Year

The Patient Safety Structural Measure consists of five domains, each representing a complementary, but separate safety commitment. For a hospital to affirmatively attest to a domain, and receive a point for that domain, a hospital would evaluate and determine whether it engaged in each of the statements that comprise the domain, for a total of five possible points (one point per domain; there would not be partial points for a domain). The hospital's overall score for the Patient Safety Structural measure can range from a total of 0 to 5 points.

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# Structural Measure: Age Friendly (Geriatric Care)

- Domain 1- Eliciting Patient Healthcare Goals
- Domain 2- Responsible Medication Management
- Domain 3- Frailty Screening and Intervention
- Domain 4- Social Vulnerability
- Domain 5- Age Friendly Care Leadership

The Age Friendly Structural measure consists of five domains, each representing a complementary, but separate safety commitment. For a hospital to affirmatively attest to a domain, and receive a point for that domain, a hospital would evaluate and determine whether it engaged in each of the statements that comprise the domain, for a total of five possible points (one point per domain; there would not be partial points for a domain). The hospital's overall score for the Age Friendly Structural Measure can range from a total of 0 to 5 points.

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# HCHAPS

## ADDITIONAL HCHAPS SUB-MEASURES

**Three new sub-measures:**

- Care Coordination
- Restfulness of Hospital Environment
- Information about Symptoms

- These three new sub-measures would be publicly reported beginning in **October 2026**.
- Remove “Care Transition” reporting on Care Compare in **January 2026.**
- Additionally, the current “Responsiveness of Hospital Staff” sub-measure would be altered starting in **January 2025**, with the “Call Button” questions being removed from the survey and a new “Get Help” question being added.

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# Transforming Episode Accountability Model

Starts January 1st, 2026

The Transforming Episode Accountability Model (TEAM) is a new mandatory payment model proposed by CMS in the 2025 IPPS Proposed Rule. Its goal is to improve the care given to Medicare beneficiaries by holding hospitals accountable for specific episodes of care. The idea is to see if financial accountability can reduce Medicare costs while maintaining or even improving the quality of care provided to beneficiaries.

## Historical Context on TEAM

**Why is CMS Doing This?**

- Fragmented and costly care for Medicare beneficiaries
- Need for improved care coordination and health outcomes

**CMS's Goal**

- Financial accountability to incentivize care coordination
- Reduction of unnecessary or duplicate services
- Enhancing overall care experience for beneficiaries

If the proposed TEAM proves successful, it could pave the way for "managing episodes as a standard practice in Traditional Medicare."
(Page 1083 for more context)

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# TEAM Eligible Episodes

Page 1137

**The TEAM model only includes five specific episodes.**

1. Coronary Artery Bypass Graft (CABG)
2. Lower Extremity Joint Replacement (LEJR)
3. Major Bowel Procedure
4. Surgical Hip/Femur Fracture Treatment (SHFFT)
5. Spinal Fusion

These episodes represent high-expenditure, high-volume care delivered to Medicare beneficiaries.

# TEAM Quality Measures

Page 1164

CMS selected quality measures that focused on care coordination, patient safety, and patient-reported outcomes (PROs).

1. (For all episodes) **Hybrid Hospital-Wide All-Cause Readmission Measure**
2. (For LEJR episodes only) **THA/TKA PRO-PM (Inpatient)**
3. (For all episodes) **PSI 90**

# TEAM Model Health Equity Reporting

Page 1256

## Other Health Equity Reporting Requirements

1. **Submit a Health Equity Plan (first year voluntary)**
   This plan must include:
   a. How you will identify health disparities
   b. How you will identify health equity goals with a description of how you will use them to monitor and evaluate progress in reducing the identified health disparities
   c. A description of the health equity plan intervention strategy
   d. How you will identify health equity performance measure(s), the data sources used to construct those measures, and an approach to monitor and evaluate those measures
2. **Submit patient demographic data (first year voluntary)**
   a. Data may include race, ethnicity, language, disability, sexual orientation, gender identity, and sex characteristics.

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# QAPI plan – no changes in the plan Performance improvement aims updated

Updates to appendix A

Added for 2024 -2025

1. ERAS Program implementation
2. Diagnostic Excellence Program implementation
3. Age Friendly (Geriatric) Program implementation
4. Structural Patient Safety measure implementation
5. Continue with Hand Hygiene and Opioid/pain PI plans
6. Develop more robust reporting and performance improvement for health equity. Add health equity specific outcome goals.

Salinas Valley HEALTH

# Infection Prevention Plan Updated

Status Pending PolicyStat ID 15668446

| | |
|---|---|
| Last Approved | N/A |
| Next Review | 1 year after approval |
| Owner | Melissa Deen: Manager Infection Prevention |
| Area | Plans and Program |

## Infection Prevention Program Plan

## I. PURPOSE

**Infection Prevention 2024/2025 Risk Assessment**

| EVENT | PROBABILITY | SEVERITY = (MAGNITUDE - MITIGATION) | | | | | | RISK |
|---|---|---|---|---|---|---|---|---|
| | | HUMAN IMPACT | PROPERTY IMPACT | BUSINESS IMPACT | PREPARED-NESS | INTERNAL RESPONSE | EXTERNAL RESPONSE | |
| | *Likelihood this will occur* | *Possibility of death or injury* | *Physical losses and damages* | *Interruption of services* | *Preplanning & Prevention* | *Time, effectiveness, resources* | *Community/ Mutual Aid staff and supplies* | *Relative threat** |
| Issue | *0 = N/A 1 = Low 2 = Moderate 3 = High* | *0 = N/A 1 = Low 2 = Moderate 3 = High* | *0 = N/A 1 = Low 2 = Moderate 3 = High* | *0 = N/A 1 = Low 2 = Moderate 3 = High* | *0 = N/A 1 = Low 2 = Moderate 3 = High* | *0 = N/A 1 = Low 2 = Moderate 3 = High* | *0 = N/A 1 = Low 2 = Moderate 3 = High* | *0 - 100%* |
| **Device-related infection** | | | | | | | | |
| - Blood Stream Infection | 2 | 2 | 1 | 2 | 3 | 3 | 1 | **44%** |
| - Ventilator Associated Infection | 1 | 2 | 1 | 1 | 3 | 3 | 1 | **20%** |
| - Urinary Tract Infection | 2 | 2 | 1 | 2 | 3 | 3 | 1 | **44%** |
| - Implant from Surgical Procedure | 2 | 2 | 1 | 1 | 3 | 3 | 1 | **41%** |
| - Drain or Tube - Temporary | 1 | 2 | 1 | 1 | 2 | 2 | 0 | **15%** |
| - Ostomy or Related Opening | 1 | 2 | 1 | 1 | 2 | 2 | 0 | **15%** |
| - Peritoneal Dialysis | 1 | 1 | 1 | 1 | 2 | 2 | 0 | **13%** |
| - Shunt | 1 | 1 | 1 | 1 | 2 | 1 | 0 | **11%** |
| - Other | | | | | | | | **0%** |
| **Resistant Microbes** | | | | | | | | |
| - MRSA | 2 | 1 | 1 | 1 | 2 | 2 | 1 | **30%** |
| - VRE | 1 | 1 | 1 | 1 | 1 | 1 | 1 | **11%** |

# Pt Safety plan and Risk Management Plan updated- attachment and reference links

Salinas Valley HEALTH

BETA HEALTHCARE GROUP

Provided for the exclusive use of BETA Healthcare Group members

## Just Culture Algorithm™

v4.0

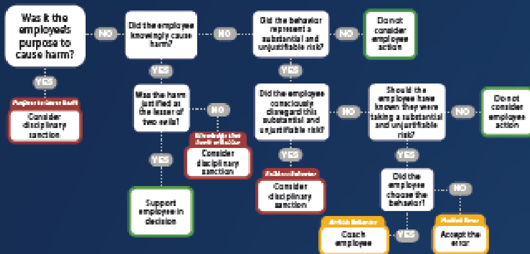
### Threshold Investigation

- What happened?
- What normally happens?
- What does procedure require? (if applicable)
- Why did it happen?
- How was the organization managing the risk?

### DUTY TO AVOID CAUSING UNJUSTIFIABLE RISK OR HARM

Did an employee put an organizational interest or value in harm's way?

- potential or actual harm to persons or property




ACTIONS

with system

Human Error / At-Risk Behavior / Reckless Behavior / Knowledge & Purpose: • modify system performance shaping factors

with employee

Human Error: • console employee • remedial action

At-Risk Behavior: • coach employee • remedial action

Reckless / Knowledge & Purpose: • disciplinary sanction • remedial action

### DUTY TO FOLLOW PROCEDURAL RULES

Did the employee breach a duty to follow a procedural rule?

ACTIONS

with system

Human Error / At-Risk Behavior / Reckless Behavior: • modify system performance shaping factors

with employee

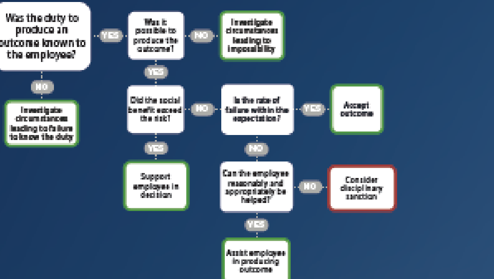
Human Error: • console employee • remedial action

At-Risk Behavior: • coach employee • remedial action

Reckless Behavior: • disciplinary sanction • remedial action

### DUTY TO PRODUCE OUTCOMES

Did the employee breach a duty to produce an outcome?




ACTIONS

with system

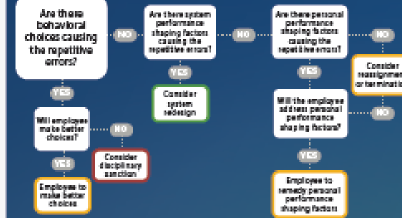
Duty to Produce an Outcome: • modify system performance shaping factors

with employee

Duty to Produce an Outcome: • help employee produce better outcomes • disciplinary sanction

### REPETITIVE HUMAN ERROR

Is there a series of human errors that make this employee an outlier in performance?




ACTIONS

with system

Repetitive Human Error: • modify system performance shaping factors

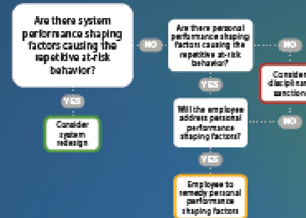
with employee

Repetitive Human Error: • employee to address personal performance shaping factors • employee to make better behavioral choices

### REPETITIVE AT-RISK BEHAVIOR

Is there continuing at-risk behavior around a single task?

Is there continuing at-risk behavior across a variety of tasks?




ACTIONS

with system

Repetitive At-Risk Behavior: • modify system performance shaping factors

with employee

Repetitive At-Risk Behavior: • employee to address personal performance shaping factors • disciplinary sanction

### DEFINITIONS

**AT-RISK BEHAVIOR:** behavioral choice that increases risk where risk is not recognized or is mistakenly believed to be justified

**COACHING:** a values-supportive discussion with the employee on the need to engage in better behavioral choices

**DISCIPLINARY SANCTION:** punitive deterrent to encourage an individual or group to refrain from undesired behavioral choices

**HUMAN ERROR:** inadvertently doing other than what was intended: a slip, lapse, or mistake

**IMPOSSIBILITY:** condition outside of employee's control that prevents duty from being fulfilled

**KNOWINGLY CAUSE HARM:** having knowledge that harm is practically certain to occur

**PERFORMANCE SHAPING FACTORS:** attributes that impact the likelihood of human errors or behavioral drift

**PURPOSE TO CAUSE HARM:** conscious objective to cause harm

**RECKLESS BEHAVIOR:** behavioral choice to consciously disregard a substantial and unjustifiable risk

**REMEDIAL ACTION:** actions taken to aid employee including education, training, and/or reassignment to task appropriate to knowledge and skill

**SOCIAL BENEFIT:** a higher order benefit to society or the organization

**SUBSTANTIAL AND UNJUSTIFIABLE RISK:** a behavioral choice where the risk of harm outweighs the social benefit attached to the behavior

Status **Pending** PolicyStat ID **16030641**

| | | | |
|---|---|---|---|
| Last Approved | N/A | Owner | Aniko Kukla: Director Quality & Patient Safety |
| Next Review | 1 year after approval | Area | Plans and Program |

# Quality Assessment and Performance Improvement Plan

## I. SCOPE

A. The purpose of the Organizational Quality Assessment and Performance Improvement (QAPI) Program Plan at Salinas Valley Health Medical Center (SVHMC), under the Salinas Valley Health is to ensure that the Governing Body, medical staff and professional services staff demonstrate a consistent endeavor to deliver safe, effective, optimal patient care and services in an environment of minimal risk. Furthermore, the QAPI Plan is used as a mechanism to develop, implement, and maintain an effective, ongoing, organization-wide, data-driven quality assessment and performance improvement program through a planned, systematic, and interdisciplinary approach to improving the care, treatment and services provided. This is an organization-wide plan. It applies to all inpatient, outpatient departments and ambulatory outpatient services, licensed under SVHMC including those services furnished under contract or arrangement.

B. The QAPI Program is designed to promote an environment where patient care and services are continually improved, where professional performance and employee competence are maximized, and in which operational systems are efficient. Through an interdisciplinary and integrated process, patient care and the processes that affect patient care are measured and assessed to provide optimal outcomes. The Board of Directors, Medical Staff, organizational leaders and all personnel assume appropriate accountability for the quality of care and services provided at SVHMC. The QAPI Program is designed to align with and support the organizational MISSION, VISION, AND GOALS STATEMENT.

C. In concert with the organizational QAPI Program, professional nursing practice care at Salinas Valley Health Medical Center is guided by a Professional Practice Model, developed by the nursing staff. The nursing mission is to heal, protect, empower and teach. The nursing vision is to be an innovative leader in nursing excellence - a place where patients choose to come and nurses want to practice. Other components of the Professional Practice Model include shared governance, respectful, collaborative professional relationships, recognition and reward for professional nursing development and a care delivery model which embraces a relationship-based, collaborative approach emphasizing partnerships with our colleagues, patients, families and the community. Clinical Nurses, ancillary staff, support staff and medical staff participate in quality committees to make interprofessional decisions at the organizational level to improve processes and quality of care. These decision making committees include committees in Administrative Quality; Safety and Reliability; Shared Governance and ad hoc subcommittees where nursing sensitive measures and

nursing practice initiatives are incorporated into the overall organizational performance improvement.

# II. OBJECTIVES/GOALS

A. **Objectives**

1. The organizational QAPI program includes an overall assessment of the efficacy of performance improvement activities with a focus on continually improving care provided and on patient safety practices conducted throughout the organization. The program encompasses elements of the mission, vision, goals and organizational strategic objectives and consists of performance improvement, patient safety and quality control activities. Indicators are objective, measurable, based on current knowledge and experience, and are structured to produce statistically valid, data driven measures of care provided. This mechanism also provides for evaluation of improvements and the stability of the improvement over time when appropriate.
2. The QAPI Plan includes data collection, data aggregation and analysis, analysis of undesirable patterns or trends, identifying and managing sentinel events, improving performance, patient safety and reducing risk of adverse / sentinel events, and conducting proactive risk reduction activities, including processes that involve the Medical Staff as well as clinical and support services. The QAPI program is implemented in conjunction with the organizational PATIENT SAFETY PROGRAM PLAN **and the** RISK MANAGEMENT PLAN

B. **Goals**

1. The goals for the QAPI Program are developed from information gathered during routine and special risk assessment activities, annual evaluation of the previous year's program activities, performance monitoring and environmental monitoring.
2. Annually the organization defines at least one improvement priority. In collaboration with organizational strategic objectives, the following priorities have been established for 2024:
    - Annual Quality and Safety Pillar Strategic Initiatives
    - Patient Perception of Care, Services and Treatment
    - Patient Flow Initiatives
    - Regulatory Reporting Requirements, including Value Based Purchasing
    - Adherence to National Patient Safety Goals
    - Maintenance of Disease Specific Care Certification Designations
    - Pain Management and Opioid Reduction Strategies
    - Safety and Reliability Improvement Initiatives
    - Magnet Recognition/Nurse Sensitive Indicators
    - Health Equity
    - Diagnostic Excellence and Error Prevention
    - Early Recovery After Surgery
    - Age Friendly Initiative

# III. DEFINITIONS

| | |
|---|---|
| A. CMS | Centers for Medicare and Medicaid Services |
| B. MEC | Medical Executive Committee |
| C. PIT | Process Improvement Team |
| D. QAPI | Quality Assessment and Performance Improvement |
| E. QSC | Quality and Safety Committee |

# IV. PLAN MANAGEMENT

A. **Plan Elements**

1. **Measuring Performance**

a. Data Collection
The Board of Directors, in collaboration with medical staff and hospital administrative leaders, establish priorities for data collection as well as the frequency for collection. Data collected for high priority processes are used to monitor the stability of existing processes, identify opportunities for improvement, and identify changes that lead to improvement, or sustain improvement. The Program is expected to show improvement in measures for which there is evidence that patient outcomes will be improved and medical errors will be reduced. Data are collected and analyzed for the following (not a comprehensive list):

- Performance improvement priorities identified by leaders
- Operative or other procedures that place patients at risk of disability or death
- All significant discrepancies between preoperative and postoperative diagnoses, including pathologic diagnoses
- Adverse patient events
- Adverse events related to using moderate or deep sedation or anesthesia
- Blood management
- The results of resuscitation / Effectiveness of its response to change or deterioration in a patient's condition
- Medication errors
- Adverse drug reactions
- Patient perception of the safety and the quality of care, treatment or services
- Processes that improve patient outcomes such as fall reduction activities including assessment, interventions and education
- National Patient Safety Goals
- Processes as defined in the organizations Infection Control Program, Environment of Care Program, and Patient Safety Program

- Organ Procurement Organization processes
- Staff opinions and needs, staff perceptions of risk to individuals, staff suggestions for improving patient safety, and willingness to report adverse events
- Core measure data and other required Centers for Medicare and Medicaid Services (CMS) measures
- Patient flow processes
- Contracted services
- Emergency Management
- Other areas as outlined in the Quality Oversight structure

Measurement of the above areas may be organization-wide in scope, targeted to specific areas, departments and services, or focused on selected populations. A reporting calendar has been defined for department and operational reporting. This is a dynamic document and may change throughout the year based on priorities and/or metric outcome trends.

Relevant information developed from the following activities is integrated into performance improvement initiatives as required:

- Patient safety
- Clinical outcomes
- Key financial/utilization indicators including length of stay
- Risk management
- Quality control
- Infection control surveillance and reporting
- Research when applicable
- Autopsies
- Other relevant data as required or identified

2. **Assessing Performance**

   a. **Data Compilation and Analysis**
   Data aggregation and analysis transforms data into information. Data are systematically aggregated and analyzed in order to monitor the effectiveness and safety of services and quality of care, and assess performance levels, patterns, or trends.

      i. Data aggregation is performed at the frequency appropriate to the activity or process.

      ii. Statistical tools and techniques are used to display and analyze data whenever possible.

      iii. Data are analyzed and compared internally over time and externally with other sources of information when available.

iv. When available, comparative data are used to determine if there is excessive variability or unacceptable levels of performance.

v. Results of data analysis are used to identify improvement opportunities.

3. **Improving Performance**
    a. Information from data analysis is used to make changes that improve performance and safety. The Board of Directors, in collaboration with medical staff and hospital leaders, establish priorities for improvement opportunities and requests action be taken on those priorities.
        - Information from data analysis including data from new or modified services is used to identify and implement changes that will improve performance and patient safety.
        - Improvement strategies are evaluated to confirm that they have resulted in improvement, and are tracked to ensure that improvements are sustained.
        - Additional actions are taken when the improvements do not achieve or sustain the desired outcomes.
        - Changes that will reduce the risk of sentinel events are identified and implemented.
4. **Identifying and Managing Adverse or Unexpected Occurrences**
    a. Processes for identifying and managing sentinel events are defined in the organization wide ADVERSE EVENTS - REPORTABLE.
5. **Proactive Risk Reduction Program**
    a. Salinas Valley Health Medical Center has dedicated a consistent effort to reduce potential harm to patients and prevent unanticipated adverse events by remaining proactive in approaches to performance improvement. Periodically, a systematic proactive evaluation method is completed on a process to evaluate and identify how it might fail and determine the relative impact a failure might have. This process assists to identify the key parts in a process that require change.
6. **Priority Patient Population**
    a. The priority patient populations are based on high-risk, high volume, high risk/ low volume and/or problem prone areas with consideration of the incidence, prevalence and severity of problems in those areas which may affect patient outcomes, safety and quality of care.
7. **Analysis of Staffing**
    a. When undesirable patterns, trends or variations in performance related to the safety or quality of care are identified from data analysis or a single undesirable event, the adequacy of staffing (number, skill mix, competency), including nurse staffing is analyzed for possible cause. Additionally, processes related to work flow, competency assessment, credentialing, supervision of staff, orientation, training and education may also be analyzed.

b. When analysis reveals a problem with the adequacy of staffing, the QSC is informed of the results of the analysis and actions taken to resolve the identified problem(s).

B. **Plan Management**

1. **Performance/Process Improvement Model**

   a. Salinas Valley Health Medical Center utilizes a wide range of systematic and structured problem-solving approaches to plan, design, measure, assess and improve organizational performance/processes. Methodologies include Lean for Healthcare, F O C U S – P D C A and Rapid Cycle Improvement.

   - F O C U S – P D C A.
     **F** – Find a process to improve.
     **O** – Organize a team that understands the process.
     **C** – Clarify how the current process works.
     **U** – Understand the causes of process variation, the "root cause".
     **S** – Select changes that will improve the process.

     **P** – Plan how the changes will be implemented.
     **D** – Do/implement the plan.
     **C** – Check the results of the improvement plan by collecting post-implementation data.
     **A** – Act on the findings of post-implementation data by standardizing the process or testing another change.
   - Systems Redesign
     Utilizes concepts such as eliminating waste, process mapping, one piece flow; just in time, standardization, and workload leveling.
   - Rapid Cycle Improvement / Kaizen
     When appropriate, the *rapid cycle improvement* process may be utilized. The advantages of the rapid cycle improvement process include:
     - Using a small sample to test a proposed change idea quickly.
     - Testing ideas side by side with existing processes.
     - Testing many ideas quickly.
     - Providing opportunities for failures without impacting performance.
     - Minimizing resistance to successful change.

2. **Performance/Process Improvement Teams**

   a. A performance/process improvement team is defined as a group of knowledgeable people, who are close to the process, that cooperate to achieve a common goal. Teams are composed of individuals with expertise in the process(es) that require(s) improvement.

3. **Performance/Process Improvement Team Request**

   a. A request for approval for a formal performance/process improvement team

(PIT) may be presented to the Quality Interdisciplinary or Safety and Reliability Committee for consideration of a performance improvement team. PITs will be considered when interdisciplinary and/or interdepartmental processes require improvement that cannot be accomplished by an individual or by the individual department(s) or discipline(s). In order to prioritize and coordinate organizational improvement processes and resources, interdisciplinary / interdepartmental teams may be approved by the Quality and Safety Committee. NOTE: Individual departments may charter teams for the purpose of improving processes specific to their departments.

C. **Plan Responsibility**

1. Performance / Process Improvement Structure
    a. The Quality Oversite Structure outlines the quality and performance improvement structure and processes. A calendar for reporting is defined annually and changes made ongoing as the needs of the organization changes. The Quality Management Department, in collaboration with facility leaders, staff and medical staff, facilitates the implementation of the QAPI Program.
    b. **Governing Board**
        i. Responsibility for performance improvement rests with every employee of Salinas Valley Health Medical Center. Overall responsibility rests with the Board of Directors. The Board of Directors requires review and evaluation of patient care activities by the Quality and Efficient Practices Board Committee to measure and improve the quality and efficiency of patient care and services in the organization.
        ii. In exercising its supervising responsibility, the Board:
            1. Reviews and approves the QAPI, Risk Management and Patient Safety Program Plans.
            2. Reviews periodic reports on findings, actions, and results of program activities, including input from the populations served via results of patient experience data.
            3. Reviews reports on the following: all system or process failures; the number and type of sentinel events; whether the patients and the families were informed of the event; results of analyses related to adequacy of staffing; all actions taken to improve safety, both proactively and in response to actual occurrences.
            4. Assesses the QAPI, Risk Management and Patient Safety Programs' effectiveness and efficiency and required modification, as necessary.
            5. Provides resources and support for performance improvement, change management, patient safety and risk management functions related to the quality and safety of patient care, including sufficient staff, access to information and training throughout the hospital.

c. **Medical Executive Committee (MEC)**

   i. MEC authorizes the establishment of an interdisciplinary Quality and Safety Committee to implement the QAPI program.
   ii. MEC is accountable to the Board of Directors for the oversight of performance improvement activities to ensure that one level of care is rendered to all patients.
   iii. The Medical Staff participates in developing measures to evaluate care systematically. Their participation may be in individual departments, medical staff committees, or on interdepartmental or interdisciplinary process/performance improvement teams.
   iv. The medical staff departments review and evaluate the results of ongoing measures that include the medical staff review functions as well as risk management, patient safety, infection control, case management, and organizational planning.

d. **Organizational Leaders**

   i. Set expectations for performance/process improvement.
   ii. Develop plans for performance/process improvement.
   iii. Manage processes to improve hospital performance.
   iv. Review results from key financial indicators in order to ensure overall financial stability.
   v. Monitor contracted services by establishing expectations for the performance of the contracted services.
   vi. Participate in performance/process improvement activities when appropriate.
   vii. Ensure participation from appropriate individuals in organization wide performance/process improvement activities.
   viii. Ensure that new or modified processes or services incorporate the following:
      - Needs and/or expectations of patients, staff and others.
      - Results of performance improvement activities, when available.
      - Information about potential risk to patients, when available.
      - Current knowledge, when available and relevant.
      - Information about sentinel events, when available and relevant.
      - Testing and analysis to determine whether the proposed design or redesign is an improvement.
      - Collaboration with staff and appropriate stakeholders to design services.
   ix. Ensure that an integrated patient safety program is implemented

throughout the organization.

x. Establish and maintain operational linkages between risk management activities related to patient care and safety, and performance improvement activities.

xi. Ensure compliance with state and federal laws, and the Joint Commission regulations/standards.

e. **Support Service Departments/Department Directors**

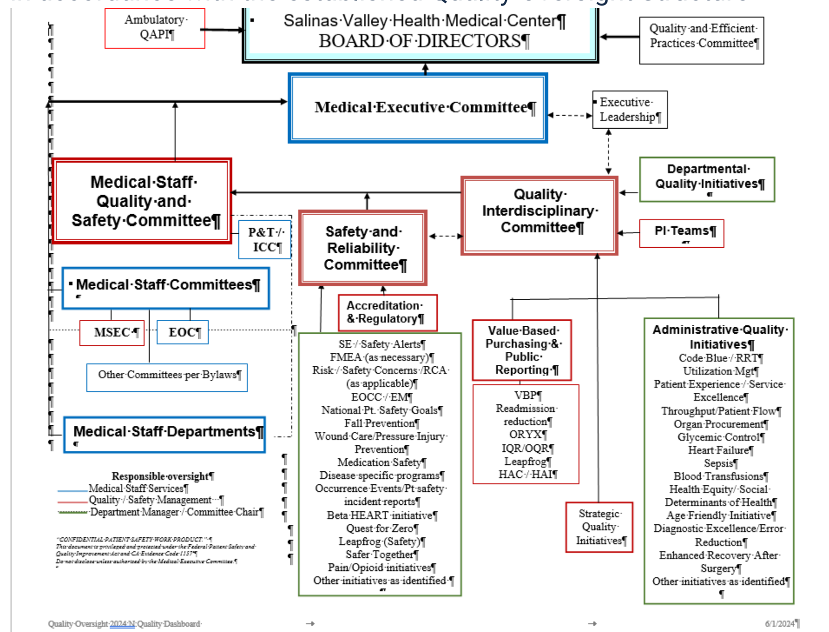
i. The Department leaders are accountable to the Organizational Leaders, QSC and the Board of Directors for the quality of care/ services and performance of their staff and departments. Departments participate in the systematic measurement and assessment of the quality of care/services they provide. The Department Directors:

ii. Promote the development of standards of care and measures to assess the quality of care/services rendered in their departments.

iii. Monitor the processes in their areas, which affect patient safety, care, outcomes and the patient's perception of care received.

iv. Promote the integration of their department's performance improvement activities with those of other support services and the Medical Staff through participation in performance improvement teams.

v. Report the results of applicable performance improvement activities in accordance with the established Quality Oversight Structure




D. **Performance Measurement**

1. The performance measurement process is one part of the evaluation of the effectiveness of the QAPI Program Plan. Performance measures have been established to measure important aspects of care. Leaders are responsible to determine what

measures will be evaluated at least every 2 year. These measures are updated / revised ongoing as compliance is sustained.

2. To ensure that the appropriate approach to planning processes of improvement; setting priorities for improvement; assessing performance systematically; implementing improvement activities on the basis of assessment; and maintaining achieved improvements, the organizational QAPI program is evaluated for effectiveness at least annually and revised as necessary.
3. **Confidentiality**
    a. All information related to performance improvement and patient safety activities performed by the Medical Staff or hospital personnel in accordance with this plan are confidential and protected under the Patient Safety Work Product and California Evidence Code 1157.
    b. Some information may be disseminated on a "need to know basis" as required by agencies such as federal review agencies, regulatory bodies, the National Practitioners Data Bank, or any individual or agency that proves a "need to know" as approved by the Medical Executive Committee, Organizational Leaders, and/or the Governing Body.
    c. HIPAA regulations will be followed.

E. **Orientation and Education**
    1. Orientation, education and/or training is provided on an as needed basis.

# V. REFERENCES

A. The Joint Commission
B. Title 22 (CDPH)
C. CMS

## Attachments

Quality Oversight 2024 SVHMC.doc

## Approval Signatures

| Step Description | Approver | Date |
| --- | --- | --- |
| Policy Committees | Rebecca Alaga: Regulatory/ Accreditation Coordinator | Pending |

| Policy Owner | Aniko Kukla: Director Quality & Patient Safety | 06/2024 |
| --- | --- | --- |

## Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **15668446**

| Last Approved | N/A | Owner | Melissa Deen: Manager Infection Prevention |
|---|---|---|---|
| Next Review | 1 year after approval | Area | Plans and Program |

# Infection Prevention Program Plan

## I. PURPOSE

This plan describes the infection control program of Salinas Valley Health Medical Center (SVHMC) and Out-patient clinics, which is designed to provide for the coordination of all infection surveillance prevention activities and to deliver safe, cost-effective care to our patients, staff, visitors, and others in the healthcare environment (with emphasis on populations at high risk of infection). The program is designed to prevent and reduce hospital-associated infections and provide information and support to all staff regarding the principles and practices of Infection Prevention (IP) to support the development of a safe environment for all who enter the facility. The Infection Prevention Plan will be reviewed annually to determine its effectiveness in meeting the program's goals.

The plan provides oversight to the:

- Completion and evaluation of the Infection Prevention Risk Assessment
- Establishment of Infection Prevention Goals
- Identification of Surveillance Activities
- Review of Infection Prevention Data
- Preparation of emergency management activities to deal with the surge of agents/individuals
- Education of all staff to ensure a broad understanding of Infection Prevention strategies and individual requirements

The Plan guides all components of the hospital governing board, medical staff, administration, management, and staff, including clinical and non-clinical services, obtaining excellent patient outcomes that reduce the impact of healthcare-associated infections.

## II. INFECTION CONTROL SCOPE OF SERVICES/ PROCESSES/STRUCTURE

**Geographic location and community environment**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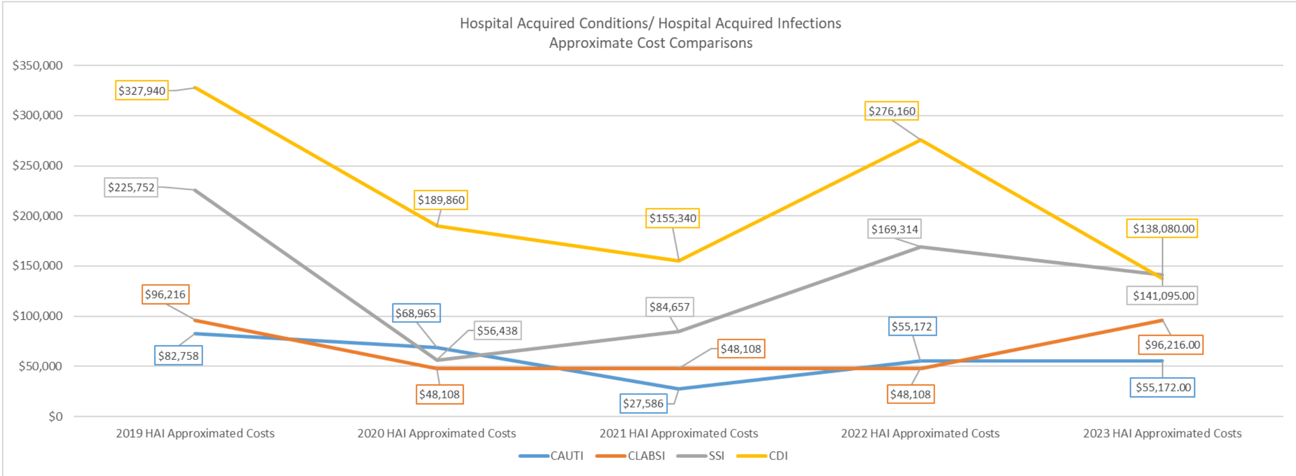
SVHMC is part of Salinas Valley Health. The healthcare system is an integrated network of healthcare programs and services, and at the core is a level 2 public district hospital with 263 beds, which employs approximately 1600 full-time employees, located in the town of Salinas, the county of Monterey on the central coast of the state of California. Salinas Valley Health has specialty clinics throughout the region, most centrally located near the hospital. Specialized programs include the Comprehensive Community Cancer Program, Joint Replacement Center, Regional Spine Center, Women and Children Center, Salinas Valley Health Clinic, Stroke Center, Taylor Farms Family Health and Wellness Center in Gonzales, Outpatient Infusion Center and the Regional Wound Healing Center. In addition, the hospital has a Level III neonatal Intensive Care Unit (NICU) and an expanded Level II Emergency Department. In 2023, there were 18,004 hospital admissions, with 43,736 patient days. The total number of Emergency service visits for 2023 was 63,955. OR surgical services performed 2,028 cases in 2023, averaging 5.6 cases daily.

Infection Prevention Financial Data Summary is based on the Agency for Healthcare Research and Quality (AHRQ) National Scorecard Report 2017. AHRQ summary of meta-analysis additional cost estimates for Hospital-Aquired Conditions (HACs) or Hospital Acquired Infections (HAIs) Estimated costs (95% confidence interval) per HAI ranging per event. Salinas Valley Health Medical Center had an approximate cost loss in 2019 for Catheter-Associated Urinary Tract Infection (CAUTI): $82,758, then in 2023, $55,172. Central-line Associated Bloodstream Infections (CLABSI) approximate cost loss in 2019 was $96,216, and in 2023, $96,216. Surgical Site Infections (SSI) approximate cost losses for 2019 are $225,752; for 2023, they are $141,095. Lastly, the approximate cost loss for C. difficile infections (CDI) for 2019 is $327,940, and $138,080 in 2023. (See below graph) In summary, HAC/HAI costs have reduced from 2019 in comparison to 2023. Salinas Valley Health Medical Center performance improvement measures for HAC/HAIs have made positive strides in preventing hospital-acquired infections and improving patient outcomes.




SVHMC serves Monterey County communities, which include Salinas, Seaside, Monterey, Soledad, Marina, Prunedale, Greenfield, Pacific Grove, King City, Gonzalez, and all other surrounding communities. SVHMC serves adjacent communities, such as Watsonville, Santa Cruz, San José, Big Sur, and Aptos. Monterey County area is surrounded by hills, mountains, streams, and the Pacific Ocean 15 miles to the west. The economy is primarily based on tourism and agriculture in the coastal regions of the Salinas River Valley. Most of the county's people live near the northern coast and Salinas Valley, while the southern coast and inland mountain regions are sparsely populated. Per the 2022 updated California Census data, the county's population was 432,858; 263,285 are Hispanic. The county seat and largest city is Salinas. The City of Salinas's population in 2017 was 157,596, with a population decrease since 2000 by -0.01%. The Patient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population mix consists of African American 2.5%, American Indian 0.2%, Asian 5.6%, Hispanic 57.9%, and White 30.6%, which includes residents, people experiencing homelessness, and immigrants and seasonal farm workers. Per the 2020 National Census, 91.3% of Monterey County residents speak Spanish; 2.1% speak Tagalog. The estimated median household income from the 2020 Census Bureau for Monterey County residents is $128,227 annually; updated 2022 data shows a decrease in annual revenue to $91,043

Reported by Monterey County Public Health, 2022 Community Health Assessment, and additional Communicable Diseases reports that SVHMC that would potentially impact SVHMC:

- Specific diseases or conditions that showed a statistically significant increase in incidence rates were chlamydia, with an incidence rate of 500.6 (CA value 484.7), fall/winter respiratory viral illnesses (RSV, Influenza, and COVID-19), and syphilis.
- Although coccidioidomycosis rates have decreased in the last several years (per 100,000 population), from 56.6 in 2018 to 8.7 in 2023, SVHMC still sees a significant number of active cases in infectious disease clinics and in-patient hospitalizations. The populations affected the most are individuals 50 and older, mainly in Monterey's South County. The racial and ethnic groups most affected are African Americans.
- The most commonly reported enteric illnesses were campylobacteriosis, salmonellosis, and shigellosis. Affected population groups differed between these enteric pathogens, but incidence rates were generally highest among children under 15.
- Reported by Monterey County Public Health, 2012 Epidemiological Impact of Communicable Diseases, Sexually transmitted infections (STIs) represented the most significant portion of diseases reported in Monterey County. Individuals aged 15 to 24 accounted for the majority of reported chlamydia and gonorrhea cases. African Americans and Others (comprised of individuals of Native American/Alaskan Native, Multiracial, and Other racial groups) were disproportionally affected by chlamydia and gonorrhea. Men who have sex with men (MSM) were disproportionately affected by syphilis.
- MCPHD outbreaks of Syphilis in pregnant women and women of childbearing age, April 2019.Then again, in 2022, with increased incidence in mothers with congenital disease with increased transmission to infants. Syphilis incidence rate increased from 7.0 to 11.1 in 2022.
- MCPHD increased in Tuberculosis cases in 2023; the populations affected the most are those 50 years and older. The racial and ethnic groups most affected are African Americans and Hispanics.
- CDPH/MCPHD alerts to infectious disease outbreaks either nationally, state , or locally in the last year:
    - RSV and other respiratory virus activity continue to evolve, and new evidence emerges; the California Department of Public Health (CDPH) will collaborate with local health departments to assess and provide additional updates as they become available. CDPH provides brief guidance regarding vaccination, testing, treatment, and other preventive measures for respiratory viruses, January 2023
    - All Facilities Letter (AFL) notifying all hospitals about recommendations from the Centers for Disease Control and Prevention (CDC) regarding Ebola virus disease (EVD) preparedness, January 2023
    - Emergence of Candida auris in Healthcare Facilities in Northern California, February 2023
    - Shigella XDR (nationally), March 2023
    - CAHAN Alert, Potential Risk for New Monkeypox Cases. May 15, 2023


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- All Facility Letter (AFL) 22-09.1: Coronavirus Disease 2019 (COVID-19) Vaccine and Booster Recommendations for Clinically Eligible Individuals (This AFL supersedes AFL 22-23.1)
- AFL 22-23.2: Guidance for Response to Surge in Respiratory Viruses among Pediatric Patients (This AFL supersedes AFL 22.09)
- All Facilities Letter (AFL) 21-20.2 Coronavirus Disease 2019 (COVID-19) Vaccine Recommendations for Eligible Individuals Prior to Discharge (This AFL supersedes AFL 21-20.1)
- AFL 22-33.1 Guidance for Response to Surge in Respiratory Viruses Among Adult Patients (This AFL supersedes AFL 22-33)
- June, 2023:
    - CDC status of the ongoing fungal meningitis outbreak and highlights interim recommendations for diagnosis and treatment.
    - CDC/CDPH Preventing a Resurgence of Mpox Cases in California
    - CDC Bicillin® L-A (Benzathine Penicillin G) Shortage
    - CDC Health Advisory 493 - Guidance on Measles during the Summer Travel Season
    - CDC Health Alert Network (HAN) Health Advisory: Locally Acquired Malaria Cases Identified
    - CDPH News Release: Record Rainfall Raises Risk of Mosquito-borne Diseases
    - CDPH News Release: Potential Increased Risk for Valley Fever Expected
- CDC Health Alert Network (HAN) Health Advisory: Increased Respiratory Syncytial Virus (RSV) Activity in Parts of the Southeastern United States: New Prevention Tools Available to Protect Patients, September 2023.
- •09/06/23: CAHAN Disease Notification - CDC Health Alert Network (HAN) Health Advisory: Increased Respiratory Syncytial Virus (RSV) Activity in Parts of the Southeastern United States: New Prevention Tools Available to Protect Patients
- October 2023:
    - CAHAN All Facilities Letter – AFL 23-30 Guidance for Response to Anticipated Adult and Pediatric Surges in Respiratory Virus Transmission
    - CAHAN Disease Notification - CDPH Health Advisory: Preparation for Respiratory Virus Season (COVID-19, Influenza and RSV)
    - CAHAN Disease Notification - CDPH Health Advisory: Early Respiratory Syncytial Virus (RSV) Activity and Use of RSV Prevention Products
    - CAHAN Disease Notification - CDPH Health Advisory: Increase in Mpox Cases in California: Updates on Identification, Laboratory Testing, Management and Treatment, and Vaccination for Mpox
- •CAHAN All Facilities Letter – AFL 23-33: Coronavirus Disease 2019 COVID-19) Vaccine Recommendations for Eligible Individuals Prior to Discharge (This AFL supersedes AFL 21-20.2), November 2023.
- Increase in respiratory illnesses globally: The CDC is monitoring respiratory illnesses around the world. Some countries have reported elevated levels of respiratory illness


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activity. Respiratory illnesses are monitored by the CDC around the world. Some countries have reported elevated levels of respiratory illness activity. Circulating respiratory illnesses include influenza, COVID-19, respiratory syncytial virus (RSV) infection, and Mycoplasma pneumoniae infection, December 2023.

The hospital has identified the Infection Prevention Manager as the individual with clinical authority over the infection prevention program. The Infection Preventionist (IP) is a qualified individual who manages the ongoing infection prevention program. Qualifications include appropriate education and training and obtaining & maintaining certification (CIC) in infection control.

The Infection Preventionist 's role is ongoing with regular over-site and collaborative efforts in surveillance, specific environmental monitoring, continuous quality improvement, consultation, committee involvement, outbreak and isolation management, and regulatory compliance and education.

The infection prevention function reports to the Senior Administrative Director of Quality & Safety, who reports to the Chief Medical Officer and the SVHMC Administration. Responsibilities of the infection Preventionist include, but are not limited to:

- Managing the Infection Prevention Program under the direction of the Pharmacy & Therapeutics/ Infection Prevention Committee.
- Collecting and coordinating data collection, tabulation, and reporting of healthcare-associated and communicable infections
- Facilitating the ongoing monitoring of the effectiveness of prevention/control activities and interventions
- Educating selected patients, families, and hospital staff about infection prevention principles
- Serving as a consultant to patients, employees, physicians and other licensed independent practitioners, contract service workers, volunteers, students, visitors, and community agencies
- Taking action on recommendations of the Pharmacy & Therapeutics/Infection Prevention Committee and Environment of Care Committee
- Surveillance Rounds in clinical areas
- Active Participation in the Antimicrobial Stewardship Program

The Medical Staff Committee is a multidisciplinary team that sanctions the Pharmacy & Therapeutics/ Infection Prevention Committee. The Medical Director for Infection Prevention is an Infectious Disease Physician and Committee member. The IP Medical Director works collaboratively with the infection preventionist to administer and manage the infection control program. The committee membership is responsible for developing and implementing strategies for components/functions of the Infection Prevention Program. It includes representation from the Medical Staff, Administration, Nursing Service, Safety, Physician Office Practices, Laboratory, Performance Improvement, EVS, Operating Room, Pharmacy, and Community Health. Determining the effectiveness of the key processes for preventing infections is an ongoing function of the Committee. Pharmacy & Therapeutics/Infection Prevention Committee meeting minutes are reported to the Medical Staff Committee, then to SVHMC Administration and Board of Directors to assess the adequacy of resources allocated to support infection prevention activities.

# III. AUTHORITY

A. Integration of Hospital Components and Functions into Infection, Prevention Activities


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Infection prevention is integrated into clinical departments. Clinical departments identify department-specific infection prevention concerns. Department-specific infection prevention policies are developed from the concerns. Each department's specific infection prevention policies are reviewed/ revised every three years. The department director/manager or designee and infection preventionist discuss proposed revisions before submitting them to the Pharmacy & Therapeutics/Infection Prevention Committee for approval. After approval, the policies are reviewed and approved by the Medical Staff, the SVHMC Administration, and the Board of Directors. Once final approval is obtained, the infection preventionist communicates decisions to the department director/manager. Before implementation, major policy revisions or changes are discussed at the Pharmacy & Therapeutics/Infection Prevention Committee and Quality Interdisciplinary Committee.

Infection Prevention Policies are developed to guide the practice and provide consistency in applying principles throughout the organization. These policies are available on the SVHMC Intranet called the "STAR net" and are communicated to staff upon hire, yearly, during safety and leadership meetings, and as updates or changes occur.

# IV. DEFINITIONS

**N/A**

# V. STRATEGIES

A. RISK ASSESSMENT

An annual assessment/reassessment is conducted to determine the presence and changing needs of the organization and surrounding community to assist in the design and development of appropriate facility-specific strategies to address the unique and emerging characteristics of the hospital environment. The hospital evaluates risk for the transmission and acquisition of infectious agents throughout the hospital and is based on the collection of the following information:

- Identify risks for transmission of infectious diseases based on patient/community demographics, medical services provided, and epidemiological trends.
- The characteristics of the population served
- The results of the hospital's infection prevention data

The Risk Assessment is completed on at least an annual basis or whenever significant changes are noted to occur in any of the above-stated criteria.

Once the risks are identified, the organization prioritizes those of epidemiological significance.

The tool was revised to precisely capture the risk of acquiring or transmitting central line bloodstream infections, multi-drug resistant organisms and surgical site infections, and catheter-associated urinary tract infections.

B. STRATEGIES TO ADDRESS THE PRIORITIZED RISKS

Specific strategies are developed and implemented to address the prioritized risks. These strategies may include policy and procedure establishment, surveillance and monitoring activities,


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education and training programs, environmental and engineering controls, or combinations thereof.

General Scope and Activities of the Infection Control Program

1. Maintenance of a sanitary physical environment, including but not limited to high and low-level disinfection
2. Management of staff, physicians, and other personnel, including but not limited to screening for exposure and immunity to infectious diseases
3. Mitigation of risk associated with patient infections present on admission
4. Mitigation of risks contributing to healthcare-associated infections
5. Active surveillance
6. Communication/coordination with outside agencies
7. Pandemic Management

C. ACTIVE SURVEILLANCE

The Infection Preventionist is responsible for facilitating hospital-wide surveillance and processes to prevent infections. Surveillance methods include daily nursing unit rounding, review of positive lab culture reports, review of newly admitted patients, and referrals from Nursing, Case Management, and Physicians.

Based on the population served, the following indicators were chosen for 2023-2024 to guide infection control surveillance activities:

- All Healthcare Onset Central line Bloodstream Infections
- All healthcare-onset catheter-associated Urinary Tract Infections
- Central Line Insertion Practices (CLIP) & Compliance
- All Healthcare Onset Multi-Drug Resistant Organisms (MDRO), including:
    - Clostridium difficile Surveillance Facility-wide,
    - MRSA Bloodstream Infections Facility-wide
    - VRE Bloodstream Infections Facility-wide
- Infections such as multi-drug resistant organisms (MDRO), including admission & discharge screening and surveillance of MRSA per California Senate Bill 1058
- All Surgical Site Infections designated by CDPH & CMS via NHSN
- CMS requirements for reporting Healthcare Worker Vaccination data for SARS-COV-2 into NHSN
- CDPH and Cal OSHA requirements for reporting SARS-COV-2 outbreaks in healthcare workers
- CPDH Reportable Diseases, including Seasonal Influenza and Active Tuberculosis patients
- Environment of Care Surveillance Rounds
- Hand Hygiene


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The CDC/NHSN definitions are used to determine the presence of nosocomial infection. The comprehensive data collection process is based on current scientific knowledge, accepted practice guidelines, and all applicable laws and regulations. NHSN is the database where all events (infections) are credited and conferred rights to all mandated agencies (i.e., CDPH, CMS, etc.)

D. REGULATORY AGENCIES AND GUIDELINES

In addition, administrative involvement and the Pharmacy & Therapeutics/Infection Prevention Committee and Environment of Care Committee facilitate the committee's/function's role as a compliance body, assuring guidelines and standards of regulatory and accreditation organizations are applied consistently throughout the organization. Guidelines and standards of the Occupational Safety and Health Administration (OSHA), The Joint Commission, the Center for Medicare and Medicaid Services (CMS), the Centers for Disease Control and Prevention (CDC), National Healthcare Safety Network (NHSN), The Association for Practitioners in Infection Control and Epidemiology (APIC), and California Department of Public Health (CDPH), state and federal laws are integrated into the organization's infection prevention policies as they are developed and compliance is monitored ongoing.

E. ROLE OF THE INFECTION PREVENTIONIST:

- Surveillance and evaluation identified clusters of infection
- Reduce the incidence of preventable infection.
- Maintain formal and informal systems to identify trends in infection occurrence.
- Investigate and recommend action to resolve identified Infection Prevention concerns.
- Communication of significant problems to administration and medical staff through designated channels promptly.
- Institutional policies and procedures for the surveillance and prevention of infection:
  - Develop and maintain Infection Prevention Plan.
  - Define the activities of the Infection Prevention Department.
- Consultative services to departmental Infection Prevention Programs:
  - Assist departments to develop and implement department-specific procedures.
  - Assist departments in defining their role and scope in surveillance and prevention of infection.
  - Assist departments with compliance with the requirements of regulatory and accrediting agencies.
  - Facilitate cost containment and revenue preservation.
- Collaborates with the SVHMC Employee Health Department:
  - Consults on processes/procedures to minimize and manage risks of infection to staff.
  - Receives reports, evaluates, documents, and reports diseases of epidemiologic significance in employees, defined as any infectious disease.
- Education in Infection Prevention is provided to hospital staff, including hospital employees, physicians, volunteers, and students.


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- Liaison between the State and Local Public Health Department and SVHMC.

F. OUTBREAK MANAGEMENT

Outbreaks may be identified during surveillance activities. The infection control practitioner is authorized to take immediate action to control any outbreak utilizing sound epidemiologic principles in investigating its origin and root cause analysis. See policy OUTBREAKINVESTIGATION.

G. DEFINITIONS USED IN IDENTIFYING HEALTHCARE-ASSOCIATED INFECTIONS

The CDC/NHSN provides definitions for healthcare-associated infections to create statistics that are as comparable as possible to statistics cited in the literature. The CDC/NHSN updates the definitions bi-annually. It must be noted that the CDC/NHSN definitions are statistical, NOT clinical. Therefore, a clinical situation that warrants treatment may not always meet the CDC/NHSN definition of HAI definition.

H. INTEGRATION OF THE INFECTION CONTROL PROGRAM INTO SVHMC'S PERFORMANCE IMPROVEMENT PROGRAM

The infection prevention program is fully integrated with the hospital's overall process for assessing and improving organizational performance. Risks, rates, and trends in healthcare-associated infections are tracked over time. This information is used to strengthen prevention activities and to reduce nosocomial infection rates to the lowest possible levels. The infection prevention program works collaboratively with the employee health program to reduce the transmission of infections, including vaccine-preventable infections, from patients to staff and staff to patients. Employee health data is also aggregated, tracked, and trended over time to identify opportunities for improvement.

Management systems, including staff and data systems, assist in achieving these objectives. Such systems support activities, including data collection, analysis, interpretation, and presentation of findings using statistical tools. Findings from the Pharmacy & Therapeutics/Infection Prevention Committee are provided to the Quality & Safety Committee, Medical Staff Committee, the SVHMC Administration and Board of Directors

The following infection prevention information is currently reported at least quarterly through the organization's performance improvement (PI) activities:

- CPDH Reportable Diseases, including Seasonal Influenza and Active Tuberculosis patients
- Catheter-Associated Urinary Tract Infections (CAUTI)
- Central Line-Associated Bloodstream Infections (CLABSI)
- Central Line Insertion Practices (CLIP) & Compliance
- Multi-Drug Resistant Organisms (MDRO) rates :
  - Clostridium difficile Surveillance Facility-wide,
  - MRSA Bloodstream Infections Facility-wide
  - VRE Bloodstream Infections Facility-wide
- Hand Hygiene Facility-wide
- Surgical Site Infections (per NHSN guidelines) on Cardiac (CBGB/CBGC), Caesarian


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Sections, Total Hip, Total Knee, Colectomy, Hysterectomy

- See Attachments: Risk Assessment Grid and Correlating Performance Improvement Plan

I. GOALS

Based on the Risk Assessment, SVHMC establishes goals on an annual basis to reflect the current trends and environmental factors of the hospital and community. The following goals are established yearly, and additional goals are established as needed based on the ongoing assessments, surveillance, circumstance, and data trends, which shall include:

- Decrease CAUTI hospital-wide from SIR 0.173 in 2022 to 0.381 in 2023. *SIR Goal: HHS Goal = below 0.75*
- Decrease CLABSI hospital-wide SIR from 0.563 in 2022 to 0.559 in 2023. SIR Goal: HHS Goal = below 0.5
- Decrease Utilization of Central Lines and Foley Catheters.
- Clostridium difficile: There will be an ongoing reduction facility-wide SIR of 0.631 in 2022 to 0.299 in 2023. *HHS Goal= below 0.70*
- Sustain Hand Hygiene compliance rate >80%.
- Surgical Site Infection (SSI) hospital-wide SIR from 0695 in 2022 to 0.607 in 2023. SIR Goal: HHS Goal = below 0.5
- Surgical Site Infection (SSI) reduction by implementing an SSI prevention bundle.
- Decrease the possible transmission of infection on portable equipment, reusable equipment, etc., by evaluating EVS standards of practice and implementing tools to aid in improving EVS processes.
- Evaluating and monitoring High and Low-Level Disinfection processes hospital-wide.
- Environment of Care Surveillance

J. EMERGENCY PREPAREDNESS AND MANAGEMENT

Infection Preventionist(s) participate in the hospital-wide emergency plan via the Hospital Incident Command System (HICS). In the HICS system, a Biological / Infectious Disease Medical Specialist will be called in as needed by the Incident Commander.

Multiple established resources exist in the event of an influx of potentially infectious patients. The hospital is part of the Monterey County Emergency Response System and has an Emergency Manual for all the regional hospitals listing resources regarding infectious patients, including bioterrorism. The Infection Prevention Department works collaboratively with the local and state health departments that serve as resources.

The infection prevention department regularly receives updates from the local and state health departments regarding emerging infections in the community and state, as well as surge capacity and syndrome surveillance. The syndromes monitored are asthma, diarrhea, gastroenteritis, vomiting, fever, rash, sepsis / septic shock, and chicken pox.

The hospital communicates this information to licensed independent practitioners and staff if


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patterns are identified. Medical Staff would be notified and communicate the information to the medical providers via the staff structure. The nursing staff also has a similar structure; the Chief Nursing Officer would be notified, and information would be communicated to nursing directors and unit managers for communication to staff. The hospital has an education department that can assist, if needed, in staff education.

The hospital has developed a process that details the hospital's planned response to an influx of infectious patients. The plan addresses infectious control practices for patients, post-exposure management, management of large-scale exposures, post-incident debriefing, laboratory support, and CDC information if needed. If needed, the hospital has a nurse-staffing plan that can be implemented to care for patients over an extended period.

Supporting documents:

- EMERGING INFECTIOUS DISEASES INFECTION PREVENTION PANDEMIC PLAN
- ISOLATION - STANDARD AND TRANSMISSION-BASED PRECAUTIONS
- EMPLOYEES EXPOSURES & PREVENTION PLANS: SPECIFIC DISEASE EXPOSURES AND WORK RESTRICTIONS
- EMERGENCY OPERATIONS PLAN
- INFLUENZA PANDEMIC PLAN
- Aerosol Transmitted Diseases Exposure Control Plan
- INFECTION PREVENTION AUTHORITY STATEMENT

# VI. ORIENTATION AND EDUCATION

A. Orientation, education, and training is provided on an as-needed basis.

# VII. DOCUMENTATION

A. ANNUAL EVALUATION OF PLAN

The Infection Prevention Performance Improvement Report is updated/reviewed quarterly at Pharmacy & Therapeutics/Infection Prevention Committee meetings. New risks or changes in priorities are identified throughout the year. At the end of each year, the outcomes of each identified goal are determined and considered for inclusion in next year's plan. The revised Plan is taken to the Pharmacy & Therapeutics/Infection Prevention Committee and Environment of Care Committee for final revisions and approval.

# VIII. REFERENCES


A. The Joint Commission Infection Prevention and Control

B. Title 22 Infection Control Program 70739

C. APIC Text of Epidemiology and Infection Control and Epidemiology, Association for Professionals in Infection Control and Epidemiology (APIC), Inc., 2023

D. National Healthcare Safety Network (NHSN) Patient Safety Component Manual January 2023: https://www.cdc.gov/nhsn/pdfs/pscmanual/pcsmanual_current.pdf




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E. California Department of Public Health, Communicable Disease Data. https://www.cdph.ca.gov/data/statistics/Pages/CDdata.aspx.

F. Monterey County Health Department: https://datasharemontereycounty.org

G. Monterey County Health Department, Communicable Diseases Report: Salinas, California: Public Health Bureau, Communicable Disease Unit. https://www.co.monterey.ca.us/government/departments-a-h/health/public-health/communicable-disease-unit

H. US Census Bureau, https://www.census.gov/data/tables/2020/dec/2020-apportionment-data.html

I. ***NHSN Reports***, the webpage contains reports organized by the year of data included in the report. The annual reports include the Antimicrobial Resistance Reports, National and State-specific Healthcare-Associated Infections Progress Reports, and additional NHSN reports and resources; 2004 to 2020. https://www.cdc.gov/nhsn/datastat/index.html.

J. The NHSN Standardized Infection Ratio (SIR), A Guide to the SIR. Updated 02/2021. https://www.cdc.gov/nhsn/pdfs/ps-analysis-resources/nhsn-sir-guide.pdf

K. Estimating the Additional Hospital Inpatient Cost and Mortality Associated With Selected Hospital-Acquired Conditions, 2017. https://www.ahrq.gov/hai/pfp/haccost2017-results.html

## Attachments

2024_2025 IP Risk Assessment Analysis.pdf

2024_2025 Risk Assessment PI Plan.doc

## Approval Signatures

| Step Description | Approver | Date |
|---|---|---|
| Quality Improvement Committee | Aniko Kukla: Director Quality & Patient Safety | Pending |
| Policy Committees | Rebecca Alaga: Regulatory/ Accreditation Coordinator | 05/2024 |
| Policy Owner | Melissa Deen: Manager Infection Prevention | 04/2024 |

## Standards

No standards are associated with this document


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Status **Draft** PolicyStat ID **15896450**

| | | | |
|---|---|---|---|
| Last Approved | N/A | Owner | Aniko Kukla: Director Quality & Patient Safety |
| Next Review | N/A | Area | Plans and Program |

# Patient Safety Program Plan

# I. PURPOSE

A. To describe the components of the Patient Safety Program at Salinas Valley Health Medical Center (SVHMC) under the Salinas Valley Health, which supports and promotes the mission, vision, and strategic plan for the organization. The program plan is designed to reduce medical errors and hazardous conditions and reduce preventable patient safety events by utilizing a systematic, coordinated and continuous evidence based approach to maintenance and improvement of the health and safety of our patients. The components are outlined in the following sections:

- Patient Safety Program Scope and Purpose
- Patient Safety Plan Annual Goals and Objectives
- Patient Safety Program Organizational Structure & Responsibilities
- Patient Safety Program Elements
- Patient Safety Plan Management

B. To deliver health care to our community with the commitment to provide safe and equitable high quality health care to all patients we serve.

- The organization recognizes that a patient has the right to a safe environment, and an error free care experience. Therefore, the organization commits to undertaking a proactive approach to the identification and mitigation of medical errors.
- The organization also recognizes that despite our best efforts, errors can and will occur. Therefore, it is the intent of the organization to respond quickly, effectively, and appropriately when an error does occur.
- The organization also recognizes that the patient has the right to be informed of the results of treatments or procedures whenever those results differ significantly from anticipated results.

# II. PATIENT SAFETY PROGRAM SCOPE AND PURPOSE

A. The purpose of the organizational Patient Safety Program Plan is to develop, implement and evaluate a patient safety program that improves patient safety and reduces risk to patients through an environment that encourages:

- Recognition and acknowledgement of risks to patient safety and medical/health care errors that impact achieving better outcomes.
- The initiation of actions to promote a culture of safety throughout the facility which includes but are not limited to safe integration of technology when possible.
- Creation of a non-punitive approach for reporting, analyzing and evaluating errors and problems.
- Facilitation of sharing knowledge to effect behavioral changes and organizational improvement to reduce risk and improve patient safety.
- Implementation of known proactive practices that promote patient safety and decrease variation and defects (waste).
- Promotion of the rapid redesign of unsafe care processes, methods and systems in response to actual and potential adverse events that are validated, to ensure reliability.
- Development of methods for analyzing systems and processes to track and monitor patient safety.
- The internal reporting/communication of identified risks and the action taken to promote a standardized way for interdisciplinary teams to communicate and collaborate.
- Organization-wide education about medical/health care errors.
- Adherence to regulatory and accreditation standards related to Patient Safety.

B. The Patient Safety Program Plan establishes mechanisms that support effective responses to actual occurrences; ongoing proactive reduction in medical/health care errors; and integration of patient safety priorities into the new design and redesign of all relevant organization processes, functions and services.

C. As patient care and patient services are coordinated and collaborative efforts, the approach to optimal patient safety involves multiple departments and disciplines in establishing the plans, processes and mechanisms that comprise patient safety activities. The Patient Safety Program Plan outlines the components of the organizational Patient Safety Program.

D. The purpose of the Patient Safety Program is:

- To improve patient safety and reduce patient risk throughout SVHMC with emphasis on reduction of morbidity and mortality.
- To ensure the SVHMC Board of Directors, Medical Staff, Leadership, and Staff consistently evaluate, monitor, improve and document patient safety activities.
- To provide a mechanism to assist SVHMC in accomplishing its strategic goals and

objectives relative to the quality and safety of patient care.

- To promote and encourage staff participation in reporting of patient safety incidents into the electronic Incident Reporting System (RlDatix) and to emphasize finding system and design flaws (the "how" of events/errors) and not on individuals (the "who" of events/errors).
- To ensure the Patient Safety Program Plan elements are integrated into the Organization's Quality and Performance Improvement Plan and the strategic vision.

E. Salinas Valley Health supports a Just Culture philosophy and approach to adverse event investigation and response and has adopted the BETA Healthcare Group Just Culture Algorithm for responding to the behaviors of their employees in a fair and just manner. (Appendix A)

F. The Patient Safety Program is an organization-wide program and applies to all sites, services and care settings under SVHMC. The program spans all these areas and encompasses all administrative, medical staff, nursing and support activities and includes integration of patient safety priorities into the new design and redesign of all relevant organization processes, functions and services.

G. The scope of the Patient Safety Program includes an ongoing assessment, using internal and external knowledge and experience, to prevent error occurrence, and maintain and improve patient safety. The program encompasses the patient population, visitors, volunteers, students and staff (including Medical Staff) to address maintenance and improvement in patient safety issues in every department throughout SVHMC. There will be an emphasis on important SVHMC and patient care functions as outlined by regulatory and accreditation requirements (i.e. CMS Conditions of Participation, The Joint Commission, Title 22, Health and Safety Codes, etc.)

H. The Patient Safety Program Plan is evaluated and reviewed annually and will include objectives to meet SVHMC's annual patient safety goals and Strategic Plan:

- The Patient Safety Plan is approved by the SVHMC Quality and Safety Committee, Medical Executive Committee and the SVHMC Board of Directors on an annual basis.
- The Board of Directors delegates the responsibility for SVHMC Patient Safety Program oversight to the SVHMC Medical Executive Committee and the Quality and Safety Committee.
- The designated Patient Safety Officer for SVHMC will have administrative responsibility for the program and review and update the Patient Safety Plan as needed.
- SVHMC staff will report unusual occurrences and/or unexpected events as part of the patient safety program, (which includes the full range of safety issues, from potential or no harm errors, to hazardous conditions and sentinel events), that may affect patient safety and/or quality of patient care as outlined in the Sentinel Event/ Unexpected Occurrence policy.
- The Patient Safety Program also considers data obtained from other organizational needs assessments, such as Information Management Needs Assessment, Risk Reduction Plans, which includes information regarding barriers to effective

communication among caregivers.

I. All departments within the organization (patient care and non-patient care departments) are responsible to report patient safety occurrences and potential occurrences to their direct supervisor (Manger/Director), Patient Safety Officer, Risk Manager or via Incident Reporting System. A report to the appropriate SVHMC Committees occurs in accordance with the established Quality Oversight Structure. The report may contain aggregated information related to type of occurrence, severity of occurrence, number/type of occurrences per department, occurrence impact on the patient, remedial actions taken and patient outcome. The Quality & Safety Committees will analyze the report information and determine further patient safety activities as appropriate.

# III. PATIENT SAFETY PLAN ANNUAL GOALS/ OBJECTIVES

I. The overall purpose of the Patient Safety Program is to create a safe environment. The patient safety plan and program strives to meet or exceed the annual Patient Safety Goals and Objectives.

- SVHMC Patient Safety Program Plan Goals and Objectives:
    1. Support department efforts to adhere to The Joint Commission and other regulatory standards as a baseline of Quality and Patient Safety.
    2. Support department efforts to adhere to National Patient Safety Goals and Patient Safety Licensing Requirements and to continuously evaluate standards to attain and / or achieve sustained compliance.
    3. Oversee the process of tracking, reporting (as needed) and evaluating all adverse events or potential adverse events as described in the Section 1279.1 of the Health and Safety Code, that are determined to be preventable, and facility-acquired infections (HAIs), as defined by the NHSN, that are determined to be preventable.
    4. Review Sentinel Event and other Patient Safety Alerts.
    5. Improve patient safety through use of Proactive Risk Assessments and/or Root Cause Analysis (RCA)/Comprehensive Systematic Analysis teams as needed.
    6. Promote a Culture of Safety by minimizing blame or retribution against staff involved in patient safety incidents and to emphasize finding system and design flaws (the how" of events/errors) and not on individuals (the "how" of events/errors). See attachment A (Just Culture Algorythm)
    7. Improve patient safety awareness by enhancing Proactive Patient Safety Initiatives by increasing patient safety awareness for patients among our employees, medical staff, patients and the community.
    8. Integrate and prioritize the patient process and outcome improvement initiatives in accordance with the QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PLAN

9. Evaluate and identify opportunities for improvement regarding medication management and patient safety.
10. Participate in Beta Healthcare Pro-Active Risk Assessments and Initiatives.
11. Partner with California Healthcare Patient Safety Organization (CHPSO), National Patient Safety Foundation and the Emergency Care Research Institute (ECRI) to eliminate preventable harm and improving the quality and safety of health care delivery at SVHMC.

# IV. PATIENT SAFETY PROGRAM ORGANIZATIONAL STRUCTURES/ RESPONSIBILITIES

A. The SVHMC operational structure is aligned to meet the function of the Patient Safety Program. The goals and objectives of the Patient Safety Program are integrated into the functions of each of the following organizational / operational groups: SVHMC Quality & Safety Committees, Medical Executive Committee, Quality and Efficient Practices Committee of the Board and the SVHMC Board of Directors. At all levels SVHMC leaders provide the foundation for an effective patient safety system by: Promoting learning; Motivating staff to uphold a fair and just safety culture; Providing a transparent environment in which quality measures and patient harms are freely shared with staff; Modeling professional behavior; Removing intimidating behavior that might prevent safe behaviors and Providing the resources and training necessary to take on improvement initiatives.

1. **Board of Directors**

- The SVHMC Board of Directors, through the approval of this document, authorizes the establishment of a planned and systematic approach to preventing and addressing patient safety. The Board delegates the implementation and oversight of this program to the Patient Safety Officer. It is the ultimate responsibility of the SVHMC Board of Directors to ensure quality and safe patient care throughout the organization. Key responsibilities of the Board of Directors regarding Patient Safety are seen in activities such as:

a. Critically examines SVHMC and medical staff processes to assure high standards.
b. Monitors the adequacy and appropriateness of the Medical Staff processes.
c. Delegates' oversight of medical care to the Medical Staff per California law.
d. Approves the Patient Safety Program Plan.
e. Reviews SVHMC performance on key quality and safety indicators including sentinel/never events, and holds senior leadership, physician leadership, mid-level management, and frontline caregivers directly accountable for results.

2. **Patient Safety Officer**
    - The Patient Safety Officer is responsible for assuring that this program is implemented and evaluated throughout the organization. As such, the Patient Safety Officer will establish the structures and processes necessary to accomplish this objective.
    - The Patient Safety Office will review, and in collaboration with relevant leaders, identify and implement actions as necessary for all critical events within 5 days of the event. The Patient Safety Officer or designee will review non critical incidents for trends / patterns or concerns and share with appropriate leaders, Quality Management and/or medical staff as necessary.
    - The Patient Safety Officer communicates and collaborates with Administration and department leaders and others in an effort to ensure coordination in reduction of harm and promote safe practices as well as a safe culture of reporting.
    - Oversees the Culture of Safety survey as defined by the organization.
    - Meets routinely with leaders and staff on the Patient safety Program goals, objectives and outcomes.
    - Is available to all persons under SVHMC when questions or concerns are raised concerning the safety of patients. Collaborates with the Environmental Health and Safety Officer for other safety concerns.
3. **Medical Executive Committees (MEC)**
    - As delegated by the SVHMC Board of Directors and consistent with its bylaws, policies and rules and regulations, the Medical Executive Committee is responsible for the day-to-day implementation and evaluation of the processes and activities noted in this program. These Patient Safety responsibilities include but are not limited to:
        a. Reviewing Patient Safety initiatives and activities.
        b. Approving the Patient Safety Program Plan and providing subsequent recommendations for approval to the Board.
        c. Identifying opportunities to improve patient care, patient safety, and SVHMC's performance. This responsibility is shared with Quality and Safety Committees of SVHMC.
4. **Senior Leadership Team**
    - As delegated by the SVHMC Board of Directors, the Senior Leadership Team responsibilities include:
        a. Incorporating Patient Safety function into the Strategic Plan.
        b. Reviewing and approving the Patient Safety Program Plan.
        c. Ensuring that processes are in place for communicating relevant Patient Safety information throughout SVHMC and identifying opportunities to improve Patient Safety. Allocating sufficient

resources needed to improve Patient Safety.

d. Evaluating the culture of safety and quality as indicated, using valid and reliable tools and using the reliable tools to create a culture of safety and quality.

e. Promoting a culture of safety in which staff is encouraged to identify and communicate opportunities for improvement, report patient safety risks, disclose significant process / protocol variances ('near misses') and participate in performance improvement activities.

5. **Quality and Safety Committees**

- The Quality and Safety Committee's responsibilities for patient safety include:

  a. Overseeing all Patient Safety activities, which include approving, prioritizing and facilitating operationalization of the Plan.

  b. Reviewing and evaluating the Patient Safety Plan and provides its subsequent recommendations for approval to medical staff, Senior Leadership and the Board.

  c. Reviewing Patient Safety reports and identifying opportunities to improve Patient Safety. This responsibility is shared with medical staff and Leadership.

  d. Reviewing action plans resulting from teams for intensive assessment of adverse events.

  e. Reviewing and evaluating reports regarding the progress and effectiveness of Patient Safety initiatives and improvement activities.

  f. Ensuring that Patient Safety is incorporated in the design of processes, functions and services.

  g. Oversees the committee for the Safety and Reliability Council

6. **Patient Safety Advisory Team (PSAT)**

- This ad-hoc committee is comprised of key representatives from leadership to:

  a. Evaluate reported events related to patient safety and quality care that occur within SVHMC to determine whether the event is treated as a sentinel event and/or is reportable according to state and regulatory requirements.

  b. The Regulatory and Accreditation team oversees the PSAT process and collaborates with the Quality and Risk Departments for evaluation of events as necessary.

7. **Medical Staff**

- The Medical Staff supports Patient Safety through the following:

a. Incorporates SVHMC patient safety goals into various section, committee and department meetings.

b. Provides patients with continuing care and quality of care meeting the professional standards of the medical staff, which incorporates patient safety goals.

c. Participates in educational and other collaborative activities (proactive risk assessment, event investigation, and performance improvement activities).

8. **Staff**

- To achieve the goal of delivering safe and high quality care, employees are given the empowerment with responsibility and authority to actively participate in SVHMC's Patient Safety Program. SVHMC uses department level resources or educational resources to conduct focused patient safety monitors, support additional education and awareness, and to provide timely feedback on patient safety issues and the effectiveness of our patient safety program. The Patient Safety Committee supports staff to embed quality and patient safety initiatives into consistent daily practice and to assist management in monitoring compliance and progress toward a goal.

# V. PATIENT SAFETY PROGRAM ELEMENTS

A. Designing or Re-designing Processes - When a new process is designed (or an existing process is modified) the organization will use information from both internal and external sources on reducing medical errors and incorporate this information into its design or re-design strategies.

B. Identification of Potential Patient Safety Issues - As part of its planning process, the organization regularly reviews the scope and breadth of its services. Attendant to this review is an identification of care process that, through the occurrence of an error, would have a significant negative impact on the health and well-being of the patient. Areas of focus include:

1. Processes identified through a review of the literature.
2. Processes identified through the organization's performance improvement program.
3. Processes identified through occurrence reports and sentinel events.
4. Processes identified as the result of findings by regulatory and/or accrediting agencies.
5. Processes as identified under patient safety organizations, including but not limited to CHPSO, NQF, The Joint Commission Safety / Sentinel Event Alerts, ECRI, National Patient Safety Foundation, etc.

C. Performance Related to Patient Safety - Once potential issues have been identified, the organization will establish performance measures to address those processes that have been identified as "high risk" to patient safety.

1. Performance measurement data will be collected, aggregated, and analyzed as

necessary to determine if opportunities to improve safety and reduce risk are identified. If so, the organization will prioritize those processes that demonstrate significant variation from desired practice, and allocate the necessary resources to mitigate the risks identified.

D. Opportunities to reduce errors that reflect system issues are addressed through use of failure mode effect analysis through the organization's performance improvement program.

E. Opportunities to reduce errors that reflect the performance of the individual care provider are addressed, as appropriate, through the Medical Staff peer review process or through the organization's human resource policy(s).

F. Proactive Risk Assessments - The organization is committed to ongoing proactive risk assessments using internal and external knowledge and experience to prevent error occurrence, as well as maintain and improve patient safety.

G. At least every 18 months, the organization will select at least one high-risk care process upon which to proactively improve performance. The process selected will be subjected to a failure-mode-effect analysis based on accepted standards of care. Those gaps that are felt to be most critical will be subjected to intensive analysis. The process will then undergo redesign (as necessary) to mitigate any risks identified. This may be accomplished through review of internal data reports and reports from external sources (including, but not limited to, The Joint Commission sentinel event report information, ORYX and Core Measure performance data, occurrence reporting information from State and Federal sources and current literature), and through the performance improvement priority criteria grid. All elements of high-risk safety related process will be described using work tools as necessary (i.e., flowcharts, cause and effect diagrams).

H. Reporting of Process or System Failure and/or medical/health care errors and response.

    1. The organization is committed to responding to errors in care in a manner that supports the rights of the patient, the clinical and emotional needs of the patient, protects the patient and others from any further risk, and preserves information critical to understanding the proximal and where appropriate root/causative cause(s) of the error. To that end, the organization has established a variety of policies and procedures to address these issues:
        - Medical/health errors and occurrences including sentinel events will be reported internally to the appropriate administrative or medical staff entity.
        - Errors will be reported to external agencies in accordance with applicable local, state, and federal law, as well as other regulatory and accreditation requirements.
        - Taylor Farms Family Health and Wellness Incidents resulting in hospitalization or death will be reported to The Compliance Team (TCT) within 48 hours.

    2. The organization has established mechanisms to report the occurrence of medical errors both internally and externally, per policy and through the channels established by this plan. External reporting will be performed in accordance with all state, federal and regulatory body rules, laws and requirements. Immediately upon identification, the patient care provider will:

- Perform necessary healthcare interventions to protect and support the patient's clinical condition.
- As appropriate to the occurrence, perform necessary healthcare interventions to contain the risk to others – example: immediate removal of contaminated IV fluids from floor stock should it be discovered a contaminated lot of fluid solutions was delivered and stocked.
- Contact the patient's attending physician and other physicians, as appropriate, to report the error, carrying out any physician orders as necessary;
- Preserve any information related to the error (including physical information). Examples of preservation of physical information are: Removal and preservation of blood unit for a suspected transfusion reaction; preservation of IV tubing, fluids bags and/or pumps for a patient with a severe drug reaction from IV medication; preservation of medication label for medications administered to the incorrect patient. Preservation of information includes documenting the facts regarding the error on an occurrence report and in the medical record as appropriate to organizational policy and procedure;
- Report the process/system failure or medical/health care error to the staff member's immediate supervisor.
- Submit the occurrence report via the Occurrence Reporting System.
- Any individual in any department identifying a process/system failure and/or potential patient safety issue will immediately notify his or her supervisor and document the findings in an occurrence report or contact the Patient Safety Office.

3. Staff response to provide/system failures and/or medical/health care errors is dependent upon the type of error identified
4. The Sentinel Event Policy will determine the organizational response to process/system failures and/or medical/health care errors and occurrences.
5. Supporting Staff Involved in Errors - An effective Patient Safety Program cannot exist without optimal reporting of process/system failures and medical/health care errors and occurrences. Therefore, it is the intent of this institution to adopt a non-punitive, just culture approach in its management of failures, errors and occurrences.
    - All personnel are **required** to report suspected and identified medical/health care errors, and should do so without the fear of reprisal in relationship to their employment. This organization supports the concept that errors occur due to a breakdown in systems and processes, and will focus on improving systems and processes, rather than disciplining those responsible for errors and occurrences. A focus will be placed on remedial actions to ensure appropriate course of action to prevent reoccurrence rather than punish/place blame on staff.
    - As part of this organization's culture of safety and quality, any staff member who has concerns about the safety or quality of care provided by

the organization may report these concerns to The Joint Commission or the California Department of Public Health. The organization supports the staff member's right to report these concerns and will take no disciplinary or retaliatory action against the staff member for reporting the safety or quality of care concern to The Joint Commission.

- Staff will be queried regarding their willingness to report medical/health care errors via the Patient Safety Culture Survey. The goal of the survey is to validate the following:
    a. Staff and leaders value transparency, accountability, and mutual respect.
    b. Safety is everyone's first priority.
    c. Behaviors that undermine a culture of safety are not acceptable, and thus should be reported to organizational leadership by staff, patients, and families for the purpose of fostering risk reduction
    d. Collective mindfulness is present, wherein staff realizes that systems always have the potential to fail and staff are focused on finding hazardous conditions or close calls at early stages before a patient may be harmed. Staff does not view close calls as evidence that the system prevented an error but rather as evidence that the system needs to be further improved to prevent any defects.
    e. Staff who do not deny or cover up errors, but rather want to report errors to learn from mistakes and improve the system flaws that contribute to or enable patient safety events. Staff knows that their leaders will not focus on blaming providers involved in errors, but rather focus on the systems issues that contributed to or enabled the patient safety event.
    f. By reporting and learning from patient safety events, staff creates a learning organization.
- The organization recognizes that individuals involved in an error may need emotional and psychological support. To that end, the organization has defined processes to assist employees and members of the Medical Staff.
    a. Employees can be referred to the organizations "Employee Assistance Program" for assistance.
    b. Members of the Medical Staff can be referred to the "Physician Health/Well Being Committee" for assistance.

I. Educating the Patient on Error Prevention - The organization recognizes that the patient is an integral part of the healthcare team. Therefore, patients will be educated about their role and responsibility in preventing medical errors.

    1. The Patient Safety Program includes a survey of patients, their families, volunteers and staff (including medical staff) opinions, needs and perceptions of risks to

patients and requests suggestions for improving patient safety.

J. Patients, and when appropriate their families are informed about the outcomes of care, including unanticipated outcomes, or when the outcomes differ significantly from the anticipated outcomes. Informing the Patient of Errors in Care - The organization recognizes that a patient has the right to be informed of results of care that differ significantly from that which was anticipated. The Attending physician / other physician is responsible for assuring that the patient is informed of errors in care.

K. Dissemination of Information - Lessons learned from root cause/comprehensive causative analyses, system or process failures, and the results of proactive risk assessments shall be disseminated to appropriate staff that provides care, treatment and service pertinent to the specific issue.

# VI. PATIENT SAFETY PLAN MANAGEMENT

A. **Patient Safety Program Resources**

1. Designated resources have been provided to assist the organization to meet the goals and objectives of the Patient Safety Program and to facilitate the implementation of the Patient Safety Program Plan.
2. The Risk Management, Quality Management and Patient Safety Divisions and all Departments are the primary source of support for patient safety improvement activities within SVHMC. These departments include staff to assist with the integration of event investigation, data management, analysis, clinical processes and patient outcomes.
3. SVHMC is committed to providing psychological support to staff involved in serious patient safety events or critical/sentinel events. Sources of support include:
    - Human Resources
    - Employee Assistance Program
    - Clinical Social Work Department
    - Rights and Ethics Committee

B. **Patient Safety Problem Identification, Notification & Resolution Process**

1. When a situation occurs that may risk patient safety, SVHMC staff is requested to report unusual occurrences and/or unexpected event as outlined in the ADVERSE EVENTS - REPORTABLE Policy using any of the following reporting mechanisms:
    - On-line Occurrence/Event Report or can elect to notify Administration directly.
        a. Direct Notification can include:
            - Notification to Department manager/supervisor
            - Notification to the Patient Safety Officer
            - Notification to Administrative Supervisor
            - Notification to Quality, Risk, Infection Control

2. When a situation arises that requires immediate response to a patient safety event, the staff makes any necessary changes to prevent further harm to the patient, communicates with the patient and/or patient's family and notifies the Administrative Supervisor. The Administrative Supervisor is responsible for informing the Administrator on-call, the Patient Safety Officer or their designee. DISCLOSURE OF UNANTICIPATED OUTCOMES POLICY

C. **Patient Safety Program - SVHMC Staff & Medical Staff Education**

1. SVHMC communicates patient safety information throughout the organization to effect behavioral changes in itself and other healthcare organizations. Examples of communication methods include:
    - Posters in key locations.
    - Medical Staff intranet portal.
    - Patient Safety on STARnet (http://starnet/)
    - Patient Safety Awareness Events.
    - Leadership, medical staff and employee meetings.
2. Education programs are designed and provided to the staff upon hire and on an ongoing basis to provide timely information regarding the Patient Safety Program, its annual goals and objectives and its accomplishments. Education includes the staff member's right to report any safety or quality of care concerns to The Joint Commission and the California Department of Public Health. Because the optimal provision of healthcare is provided in an interdisciplinary manner, staff will be educated and trained on the provision of an interdisciplinary approach to patient care.
3. Ongoing education is provided through various mechanisms such as but not limited to:
    - In-service training to increase knowledge of patient safety requirements
    - In-service training to encourage reporting of unanticipated adverse events and near misses and in identifying patient safety events that should be reported
    - Educational updates addressing patient safety issues, including Sentinel Event Alerts.
    - Patient Safety Awareness activities.
    - Computer based learning modules.

D. **Patient Safety Program Patient & Community Education**

1. Patients are given information about their rights and responsibilities while receiving services. Patients and, when appropriate, their families are informed about the outcomes of care, treatment and services, including unanticipated outcomes.).
2. Patients may be given patient safety awareness materials, such as The Joint Commission's "Speak Up" brochure.

# VII. REFERENCES


A. Center for Medicare Services (CMS) Conditions of Participation

B. Joint Commission Sentinel Event Policy

C. The Joint Commission Standards.

D. To ERR is Human: Building a Safer Health System

E. Crossing the Quality Chasm: A New Health System for the 21st Century

F. OIG Report on Medical Error 12-00

G. HSC §442.5, HSC §1254.4, HSC §1255.8, HSC §1279.6, HSC §1279.7, HSC §1288.6, HSC §1288.7, HSC §1288.8, HSC §1288.9, HSC §1288.95

H. National Patient Safety Foundation

I. The Just Culture Community, www.justculture.org

J. California Senate Bill 1058, (Infection Control and Prevention)

K. California Senate Bill 444 (Patient Safety Plan)

L. Healthcare Performance Improvement (2011) The HPI SEC & SSER Patient Safety Measurement System for Healthcare. https://www.cec.health.nsw.gov.au/__data/assets/pdf_file/0008/569537/Known-Complications-HPI-White-Paper.pdf


## Attachments

BETA 4.0 JC Algorithm-rv1.pdf

## Approval Signatures

| Step Description | Approver | Date |
| --- | --- | --- |

## Standards

No standards are associated with this document

# BETA HEALTHCARE GROUP

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# Just Culture Algorithm™

v4.0

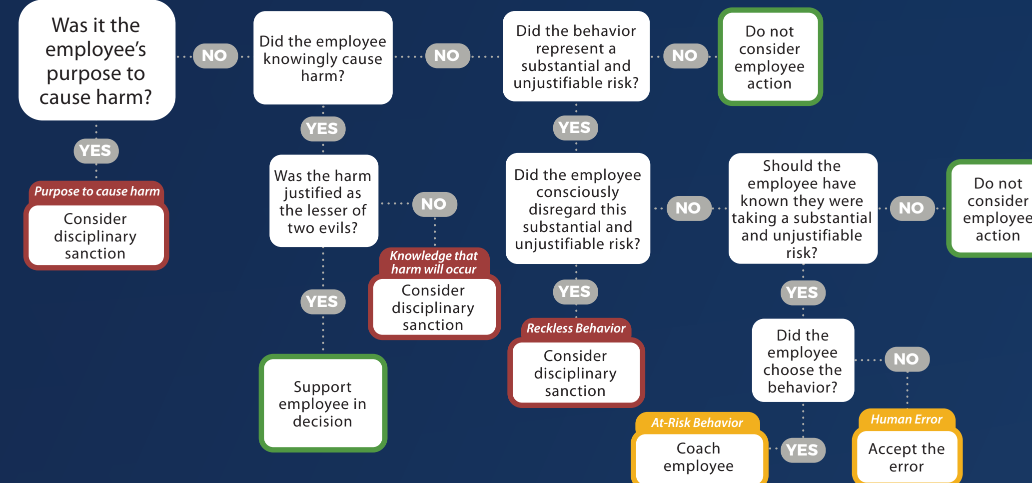
## Threshold Investigation

- What happened?
- What normally happens?
- What does procedure require? (if applicable)
- Why did it happen?
- How was the organization managing the risk?

## DUTY TO AVOID CAUSING UNJUSTIFIABLE RISK OR HARM

Did an employee put an organizational interest or value in harm's way?

- potential or actual harm to persons or property




### ACTIONS

**with system**

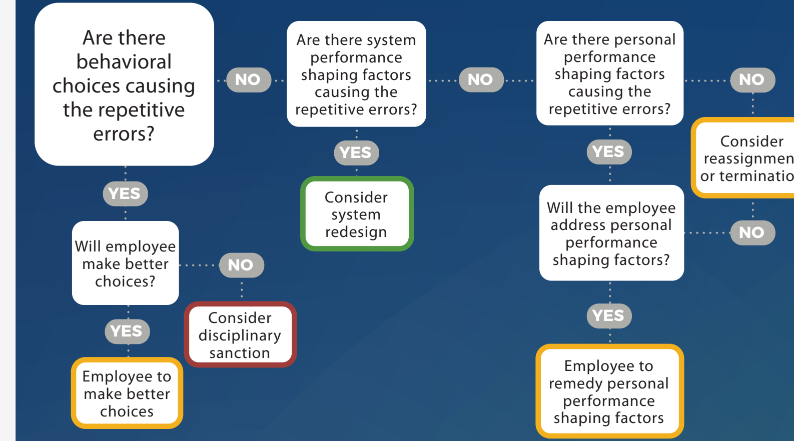
| | |
|---|---|
| *Human Error*<br>*At-Risk Behavior*<br>*Reckless Behavior*<br>*Knowledge & Purpose* | • modify system performance shaping factors |

**with employee**

| | |
|---|---|
| *Human Error* | • console employee<br>• remedial action |
| *At-Risk Behavior* | • coach employee<br>• remedial action |
| *Reckless Knowledge & Purpose* | • disciplinary sanction<br>• remedial action |

## REPETITIVE HUMAN ERROR

Is there a series of human errors that make this employee an outlier in performance?




### ACTIONS

**with system**

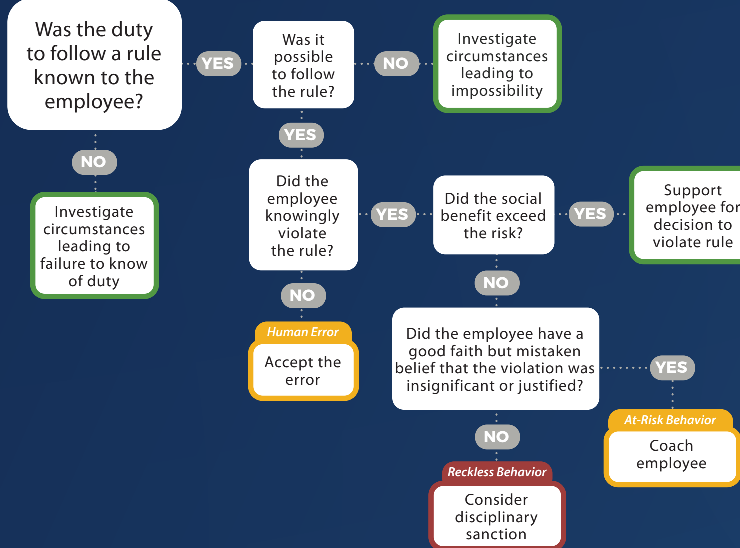
| | |
|---|---|
| *Repetitive Human Errors* | • modify system performance shaping factors |

**with employee**

| | |
|---|---|
| *Repetitive Human Errors* | • employee to address personal performance shaping factors<br>• employee to make better behavioral choices |

## DUTY TO FOLLOW PROCEDURAL RULES

Did the employee breach a duty to follow a procedural rule?




### ACTIONS

**with system**

| | |
|---|---|
| *Human Error*<br>*At-Risk Behavior*<br>*Reckless Behavior* | • modify system performance shaping factors |

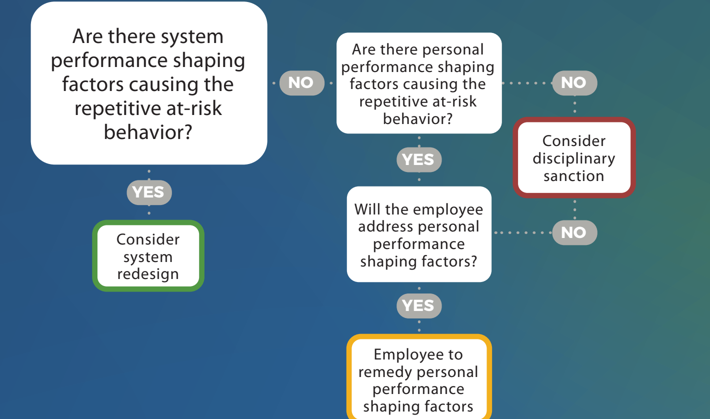
**with employee**

| | |
|---|---|
| *Human Error* | • console employee<br>• remedial action |
| *At-Risk Behavior* | • coach employee<br>• remedial action |
| *Reckless Behavior* | • disciplinary sanction<br>• remedial action |

## REPETITIVE AT-RISK BEHAVIOR

Is there continuing at-risk behavior around a single task?

Is there continuing at-risk behavior across a variety of tasks?




### ACTIONS

**with system**

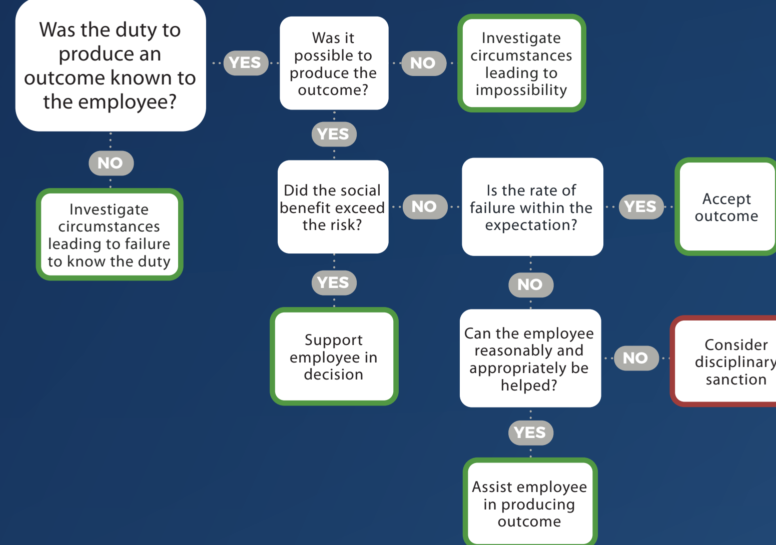
| | |
|---|---|
| *Repetitive At-risk Behavior* | • modify system performance shaping factors |

**with employee**

| | |
|---|---|
| *Repetitive At-risk Behavior* | • employee to address personal performance shaping factors<br>• disciplinary sanction |

## DUTY TO PRODUCE OUTCOMES

Did the employee breach a duty to produce an outcome?




### ACTIONS

**with system**

| | |
|---|---|
| *Duty to Produce an Outcome* | • modify system performance shaping factors |

**with employee**

| | |
|---|---|
| *Duty to Produce an Outcome* | • help employee produce better outcomes<br>• disciplinary sanction |

## DEFINITIONS

**AT-RISK BEHAVIOR:** behavioral choice that increases risk where risk is not recognized or is mistakenly believed to be justified

**COACHING:** a values-supportive discussion with the employee on the need to engage in better behavioral choices

**DISCIPLINARY SANCTION:** punitive deterrent to encourage an individual or group to refrain from undesired behavioral choices

**HUMAN ERROR:** inadvertently doing other than what was intended: a slip, lapse, or mistake

**IMPOSSIBILITY:** condition outside of employee's control that prevents duty from being fulfilled

**KNOWINGLY CAUSE HARM:** having knowledge that harm is practically certain to occur

**PERFORMANCE SHAPING FACTORS:** attributes that impact the likelihood of human errors or behavioral drift

**PURPOSE TO CAUSE HARM:** conscious objective to cause harm

**RECKLESS BEHAVIOR:** behavioral choice to consciously disregard a substantial and unjustifiable risk

**REMEDIAL ACTION:** actions taken to aid employee including education, training, and/or reassignment to task appropriate to knowledge and skill

**SOCIAL BENEFIT:** a higher order benefit to society or the organization

**SUBSTANTIAL AND UNJUSTIFIABLE RISK:** a behavioral choice where the risk of harm outweighs the social benefit attached to the behavior

## The Three Duties

| DUTY TO AVOID CAUSING UNJUSTIFIABLE RISK OR HARM | DUTY TO FOLLOW PROCEDURAL RULES | DUTY TO PRODUCE OUTCOMES |
|---|---|---|
| • values-focused<br>• “conduct unbecoming”<br>• see all five behaviors | • reliability-focused<br>• “the recipe”<br>• see only three of the five behaviors | • mission-focused<br>• “the cake”<br>• cannot see the five behaviors |

## The Five Behaviors

| HUMAN ERROR | AT-RISK BEHAVIOR | RECKLESS | KNOWLEDGE | PURPOSE |
|---|---|---|---|---|
| Unintended conduct: inadvertently doing other than what was intended: a slip, lapse, or mistake | A choice where risk is not recognized, or is mistakenly believed to be justified | Conscious disregard of a substantial and unjustifiable risk of harm | Knowingly causing harm (sometimes justified) | A purpose to cause harm (never justified) |
| ACCEPT | COACH | DISCIPLINARY SANCTION | DISCIPLINARY SANCTION | DISCIPLINARY SANCTION |

**Evaluate All Independent of the Actual Outcome**

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Status Pending PolicyStat ID 15587212

| Last Approved | N/A | Owner | Brenda Bailey: Manager Risk |
|---|---|---|---|
| Next Review | 1 year after approval | Area | Plans and Program |

# Risk Management Plan

# I. SCOPE

A. Enterprise Risk Management is a systematic process of identifying events, evaluating and reducing losses associated with patient, personnel or visitor injuries, property loss or damages and other sources of potential legal liability.

B. The Risk Management Program Plan is enacted to protect Salinas Valley Health Medical Center (SVHMC) and all entities under their purview against the adverse consequences of accidental losses, regardless of source, effectively managing losses that may occur, and to enhance the continuous improvement of patient care services in a safe healthcare environment.

C. The CEO and Board of Directors have given the authority to the Risk Management Division to implement, monitor and track the elements of the Enterprise Risk Management Program under cover of this plan.

D. This enterprise risk management framework is geared to achieving the entity's objectives, set forth in four categories:

   i. *Strategic* – high-level goals, aligned with and supporting its mission

   ii. *Operations* – effective and efficient use of its resources

   iii. *Reporting* – reliability of reporting

   iv. *Compliance* – compliance with applicable laws and regulations.

E. The Risk Management Program Plan is organization wide and applies to all departments, programs and services at SVHMC. The scope of the program will encompass the patient population, employees, visitors, volunteers, students and other personnel providing services at SVHMC including medical staff. SVHMC has entities other than the acute care hospital under the Health System purview and these SVHMC entities adhere to this Risk Management Program Plan.

F. The Risk Management Program Plan establishes an approach to monitoring, evaluating, and managing risks throughout the organization. A risk is an uncertain event or condition that, if it

occurs, has a negative or positive effect on the organization.

G. Salinas Valley Health supports a Just Culture philosophy and approach to adverse event investigation and response and has adopted the BETA Healthcare Group Just Culture Algorithm for responding to the behaviors of their employees in a fair and just manner.

# II. OBJECTIVES/GOALS

A. In order to approach the process of Risk Management systematically, SVHMC utilizes the following four-step model for Risk Management

1. The identification of risks
2. The analysis of the risk identified
3. The treatment of risks
4. The evaluation of risk treatment strategies

B. This model assists in setting priorities for Risk Management activities and ensures a comprehensive Risk Management effort. Any single strategy or combination of the above Risk Management strategies may be employed to best manage a given situation.

C. **Risk Identification:**

1. Risk Identification is the process whereby awareness of risks in the health care environment that constitute potential loss exposures for the facility is identified.
2. The following information services may be utilized to identify potential risks:
    a. Identification of trends through the incident reporting system
    b. Patient, visitor, staff and physician complaint reports
    c. Performance improvement functions
    d. Peer review activities
    e. Informal discussions with management and staff members

D. **Risk Analysis:**

1. Risk Analysis is the process of determining the potential severity of the loss associated with an identified risk and the probability that such a loss will occur. These factors establish the seriousness of a risk and will guide management in the selection of an appropriate risk treatment strategy.

E. **Risk Treatment:**

1. Risk Treatment refers to the range of choices available to leadership in handling a given risk. Risk Treatment strategies include the following:
    a. Risk acceptance involves assuming the potential loss associated with a given risk and making plans to cover any financial consequence of such losses.
    b. Risk avoidance is a strategy utilized when a given risk poses a particularly serious threat that cannot be effectively reduced, and the conduct or service giving rise to the risk may perhaps be avoided.

c. Risk reduction or minimization involves various loss control strategies aimed at limiting the potential consequences or frequency of a given risk without totally accepting or avoiding the risk. Strategies may include system redesign, staff education, policy and procedure revision and other interventions aimed at controlling adverse occurrences without completely eliminating risk activities.

F. **Risk Management Evaluation:**

1. The final step in the Risk Management process is risk management evaluation. The effectiveness of the techniques employed to identify, analyze and treat risks are assessed and further action taken when warranted. If improvement and/or resolution of the risk are evident, additional follow-up will be done at predetermined intervals to evaluate continued improvement. This evaluation is in concert with the Salinas Valley Health Medical Center Patient Safety Program Plan and Quality Assessment and Performance Improvement Plan.

# III. DEFINITIONS

# IV. PLAN MANAGEMENT

## A. Plan Elements

1. The Risk Management Program is concerned with a variety of issues and situations that hold the potential for liability or losses for the hospital/organization. It addresses the following categories of risk:

**Patient-Related Risks, including but not limited to:**

- Patient Safety and all elements therein
- Policies and Procedures
- Licensing and Accreditation processes
- Confidentiality and appropriate release of patient medical information/protected health information (PHI)
- Patient Rights
- The securing of appropriate informed patient consent for medical treatment
- Nondiscriminatory treatment of patients, regardless of race, religion, national origin or payment status
- Protections of patient valuables from loss or damage

**Medical Staff-Related Risks**

- Medical Staff peer review and quality/performance improvement activities
- Confidentiality and protection of the data obtained
- Medical Staff credentialing, appointment and privileging processes

**Employee -Related Risks**

- Maintaining a safe work environment
- Reduction of the risk of occupational illnesses and injury
- Provision for the treatment and compensation of workers who suffer on-the-job injuries and work-related illnesses
- Ensuring nondiscrimination in recruitment, hiring and promotion of employees

**Technology**

- Maintaining Risk Management Information Systems (RMIS), Electronic Health Records (EHR)
- Meaningful Use, social networking and cyber liability.

**Strategic**

- Managed care relationships/partnerships
- Mergers, acquisitions, divestitures, joint ventures, affiliations and other business arrangements
- Contract administration

**Financial**

- **Access** to capital or external financial ratings through business relationships or the timing and recognition of revenue and expenses
- Costs associated with malpractice, litigation, and insurance, capital structure, credit and interest rate fluctuations, foreign exchange, growth in programs and facilities, capital equipment, corporate compliance (fraud and abuse), accounts receivable, days of cash on hand, capitation contracts, billing and collection

**Legal/Regulatory**

- The failure to identify, manage and monitor legal, regulatory, and statutory mandates on a local, state and federal level fraud and abuse, licensure, accreditation, product liability, management liability, Centers for Medicare and Medicaid Services (CMS) Conditions of Participation (CoPs) and Conditions for Coverage (CoC), as well as issues related to intellectual property.

**Other Risks**

- Ensuring mechanisms to prevent and reduce the risk of losses associated with fire, flood, severe weather and utilities malfunction
- Ensuring the development and implementation of emergency preparedness plans
- Ensuring that appropriate protocols are in place for hazardous materials/waste

management

- Maintaining a safe environment for patients and visitors
- Assisting Quality/Performances Improvement efforts to identify those areas which represent an opportunity to improve patient care and reduce risk.

2. Enterprise risk management consists of eight interrelated components. These are derived from the way management runs an enterprise and are integrated with the management process. Enterprise risk management is not strictly a serial process, where one component affects only the next. It is a multidirectional, iterative process in which almost any component can and does influence another. These components are:
    a. *Internal Environment* – The internal environment encompasses the tone of an organization, and sets the basis for how risk is viewed and addressed by the facility, people, including risk management philosophy and risk appetite, integrity and ethical values, and the environment in which we operate.
    b. *Objective Setting* – Objectives must exist before leaders can identify *potential* events affecting their achievement. Enterprise risk management ensures that management has in place a process to set objectives and that the chosen objectives support and align with our mission and are consistent with our risk appetite.
    c. *Event Identification* – Internal and external events affecting achievement of our objectives must be identified, distinguishing between risks and opportunities. Opportunities are channeled back to leaders strategy or objective-setting processes.
    d. *Risk Assessment* – Risks are analyzed, considering likelihood and impact, as a basis for determining how they should be managed. Risks are assessed on an inherent and a residual basis.
    e. *Risk Response* – Leadership selects risk responses – avoiding, accepting, reducing, or sharing risk – developing a set of actions to align risks with the entity's risk tolerances and risk appetite.
    f. *Control Activities* – Policies and procedures are established and implemented to help ensure the risk responses are effectively carried out.
    g. *Information and Communication* – Relevant information is identified, captured, and communicated in a form and timeframe that enable people to carry out their responsibilities. Effective communication also occurs in a broader sense, flowing down, across, and up the entity.
    h. *Monitoring* – The entirety of enterprise risk management is monitored and modifications made as necessary. Monitoring is accomplished through ongoing leadership activities, separate evaluations, or both.

# B. Plan Management

1. The Plan Elements, although some may not be under the direct accountability /responsibility of the Risk Management Division, may be assured through, but not limited to the following tasks.
    a. Investigate adverse occurrences to assess and determine how similar occurrences might be averted, review patterns and trends, control the loss related to the adverse

occurrence, and identify areas for performance improvement.

b. Assess premise/property for potentially hazardous conditions which may present unnecessary risk to employees, patients, and visitors and make risk recommendations.

c. Review the performance of persons providing care to patients to identify practices which may present unnecessary risks to patients or deviate from acceptable standards.

d. Participate in policy and procedure review to update, amend, edit, and revise to reflect appropriate care, legislative requirements, and minimize or prevent liability ramifications.

e. Participate in response and management of regulatory investigations.

f. Organize educational programs on risk management topics to promote awareness of risk management and safe practices.

g. Report Effectiveness - Periodic reports are provided by the various areas previously described to assess the effectiveness of their monitoring. Outcome evaluations are conducted and reported annually as part of the Quality and Safety Committee.

h. Claims Management - Coordinate the management of claims against SVHMC in a timely, organized, manner. The Risk and Patient Safety Department, in concert with the Safety Officer investigates complaints, grievances, safety related events, incidents and actual or potential claims by a process protected from discovery. Safety events or Claims presenting serious exposure are reported immediately to the appropriate individuals. Issues concerning the hospital will be investigated and resolved with the assistance of Quality Management, affected departments, and staff, administration, physicians, and patient / family as needed. The results of the findings are provided to the appropriate individuals or committee. Matters involving care provided by the physician are forwarded to the Medical Staff Department for further review and response as indicated. See Attachment "B" Claims Process Map.

# C. Plan Responsibility

1. Everyone in the organization has some responsibility for enterprise risk management. The Board of Directors provides important oversight to enterprise risk management, and is aware of and concurs with the risk appetite.
2. The Chief Executive Officer is ultimately responsible to assure the implementation of the Risk Management Program Plan.
3. The Risk and Patient Safety Division under the authority of the CMO is responsible for the implementation of the Risk Management Program Plan. The Risk Manager and Patient Safety Officer works in concert with other departments and leaders such as, Human Resources, Employee Health, Infection Prevention, Quality Management, Accreditation and Regulatory, Safety Officer, Medical Staff Services and others to assure full implementation of the Program Plan.
4. All leadership supports the risk management philosophy; promotes compliance with our risk appetite, and manages risks within their spheres of responsibility consistent with risk tolerances. These leaders are also responsible for executing enterprise risk management in

accordance with established directives, policies, procedures and protocols as outlined by SVHMC.

5. A number of external parties, such as customers, vendors, business partners, external auditors, regulators, and financial analysts often provide information useful in effecting enterprise risk management, but they are not responsible for the effectiveness of, nor are they a part of, this program plan.

   See Attachment "A" for Risk Management Program Structure

# D. Confidentiality

1. Confidentiality shall be in effect for all Risk Management activities.
2. All communication and documentation generated as part of the Risk Management program are to be confidential and subject to the state and federal laws protecting such documents from discovery, including Attorney: Client Privileges and Patient Safety Work Product as applicable. It is the intent of this Risk Management Program Plan to apply all existing legal standards and state or federal statutes to provide protection to the documents, proceedings, and individuals involved in the program.
3. The medical staff Quality and Safety Committee is responsible for the oversight of the Risk Management Program. All information, data, reports, minutes, or memoranda relating to the implementation of this Risk Management Program Plan are solely for use in the course of internal quality control for the purpose of reducing morbidity and mortality and improving the environment of care.
4. Any and all documents and records that are part of the internal Risk Management program as well as the proceedings, reports and records from any of the involved committees shall be maintained in a confidential manner. Disclosure to any judicial or administrative proceedings will occur only under court order or legal mandate and in accordance with the Patient Safety Work Product protections.

# E. Performance Measurement

1. The performance measurement process is one part of the evaluation of the effectiveness of the Risk Management Program. Performance measures may be established to measure at least one important aspect of the Risk Management Program.
2. On an annual basis, the Safety and Reliability Committee and Quality and Safety Committee evaluates the scope, objectives, performance, and effectiveness of the Plan to manage risks to the staff, visitors, and patients at Salinas Valley Memorial Hospital.

# F. Orientation and Education

1. Evaluation of the education and training needs of hospital staff and healthcare providers; participating in events annually to promote risk initiatives, making recommendations, coordinating and or conducting in-service programs, submitting information for medical staff physician education and issuing materials in the field of Risk Management is critical to the success of the Risk Management Program Plan.

# V. REFERENCES

A. Risk Management Handbook for Healthcare Organizations

B. California Evidence Code 1157

C. Patient Safety and Quality Improvement Act of 2005; 42 U.S.C. 299b-21

D. American Society for Health Care Risk Management of the American Hospital Association

E. INFORMATION SECURITY RISK MANAGEMENT #1010

## Attachments

BETA 4.0 JC Algorithm-rv1.pdf

## Approval Signatures

| Step Description | Approver | Date |
|---|---|---|
| QSC | Aniko Kukla: Director Quality & Patient Safety | Pending |
| Policy Committees | Rebecca Alaga: Regulatory/ Accreditation Coordinator | 04/2024 |
| Policy Owner | Brenda Bailey: Manager Risk | 04/2024 |

## Standards

No standards are associated with this document

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# Just Culture Algorithm™

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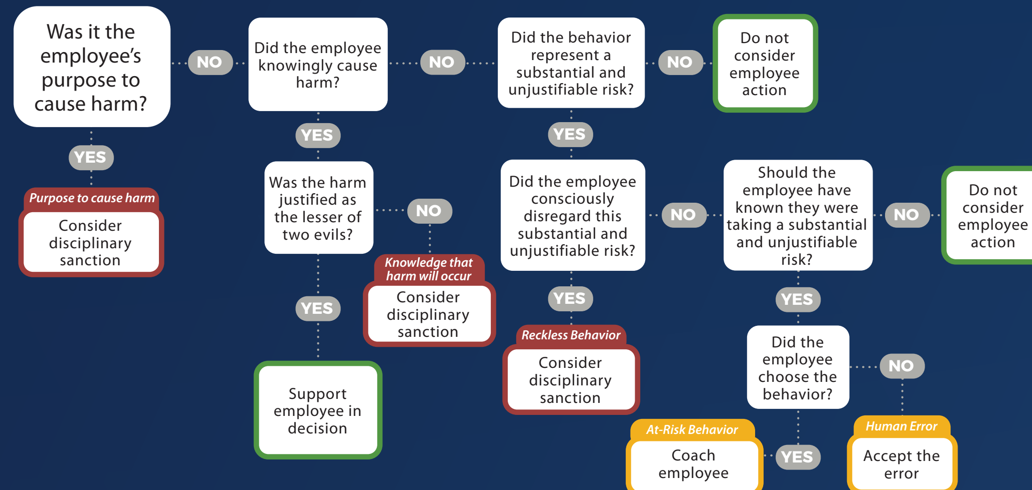
## Threshold Investigation

- What happened?
- What normally happens?
- What does procedure require? (if applicable)
- Why did it happen?
- How was the organization managing the risk?

## DUTY TO AVOID CAUSING UNJUSTIFIABLE RISK OR HARM

Did an employee put an organizational interest or value in harm's way?

- potential or actual harm to persons or property




### ACTIONS

with system

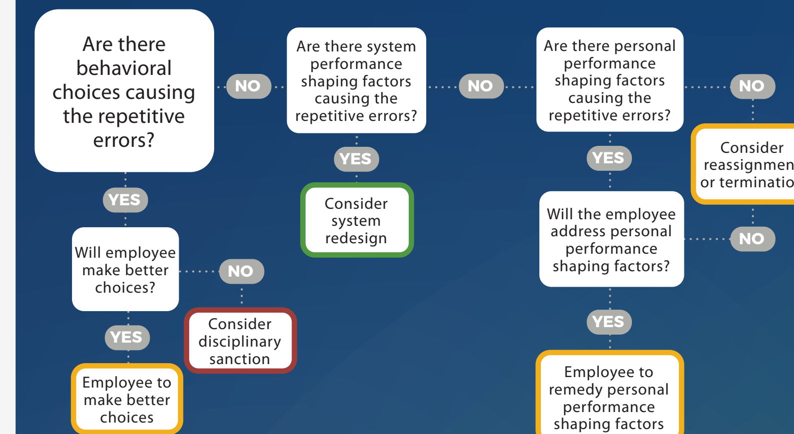
| | |
|---|---|
| *Human Error*<br>*At-Risk Behavior*<br>*Reckless Behavior*<br>*Knowledge & Purpose* | • modify system performance shaping factors |

with employee

| | |
|---|---|
| *Human Error* | • console employee<br>• remedial action |
| *At-Risk Behavior* | • coach employee<br>• remedial action |
| *Reckless*<br>*Knowledge & Purpose* | • disciplinary sanction<br>• remedial action |

## REPETITIVE HUMAN ERROR

Is there a series of human errors that make this employee an outlier in performance?




### ACTIONS

with system

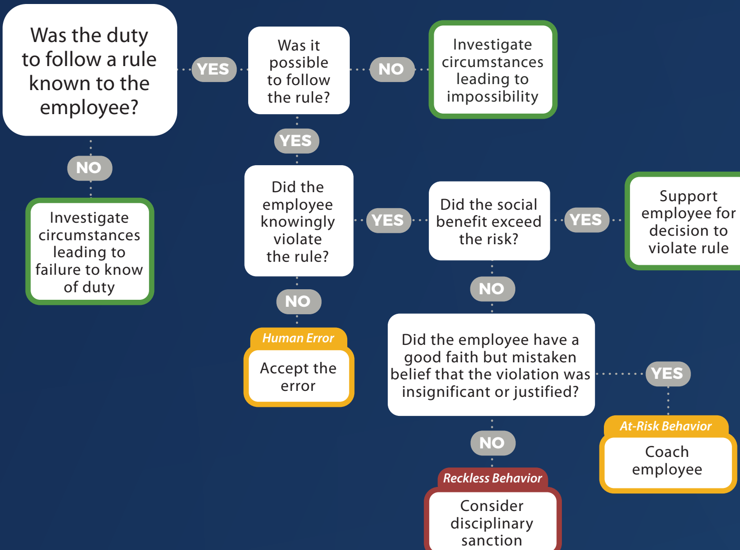
| | |
|---|---|
| *Repetitive Human Errors* | • modify system performance shaping factors |

with employee

| | |
|---|---|
| *Repetitive Human Errors* | • employee to address personal performance shaping factors<br>• employee to make better behavioral choices |

## DUTY TO FOLLOW PROCEDURAL RULES

Did the employee breach a duty to follow a procedural rule?




### ACTIONS

with system

| | |
|---|---|
| *Human Error*<br>*At-Risk Behavior*<br>*Reckless Behavior* | • modify system performance shaping factors |

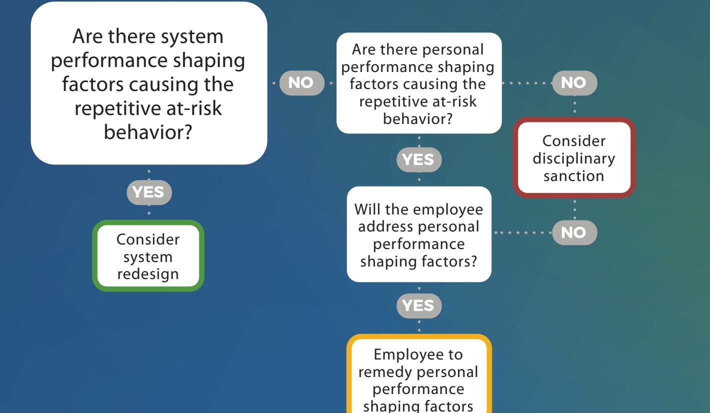
with employee

| | |
|---|---|
| *Human Error* | • console employee<br>• remedial action |
| *At-Risk Behavior* | • coach employee<br>• remedial action |
| *Reckless Behavior* | • disciplinary sanction<br>• remedial action |

## REPETITIVE AT-RISK BEHAVIOR

Is there continuing at-risk behavior around a single task?

Is there continuing at-risk behavior across a variety of tasks?




### ACTIONS

with system

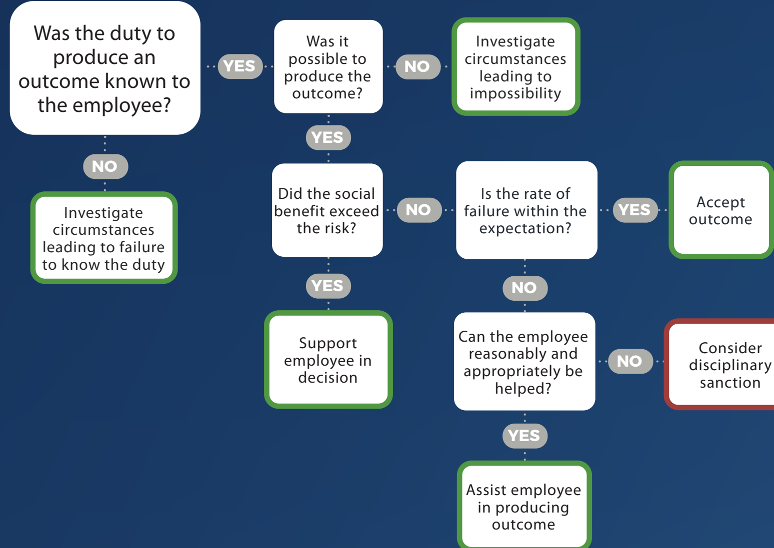
| | |
|---|---|
| *Repetitive At-risk Behavior* | • modify system performance shaping factors |

with employee

| | |
|---|---|
| *Repetitive At-risk Behavior* | • employee to address personal performance shaping factors<br>• disciplinary sanction |

## DUTY TO PRODUCE OUTCOMES

Did the employee breach a duty to produce an outcome?




### ACTIONS

with system

| | |
|---|---|
| *Duty to Produce an Outcome* | • modify system performance shaping factors |

with employee

| | |
|---|---|
| *Duty to Produce an Outcome* | • help employee produce better outcomes<br>• disciplinary sanction |

## DEFINITIONS

**AT-RISK BEHAVIOR:** behavioral choice that increases risk where risk is not recognized or is mistakenly believed to be justified

**COACHING:** a values-supportive discussion with the employee on the need to engage in better behavioral choices

**DISCIPLINARY SANCTION:** punitive deterrent to encourage an individual or group to refrain from undesired behavioral choices

**HUMAN ERROR:** inadvertently doing other than what was intended: a slip, lapse, or mistake

**IMPOSSIBILITY:** condition outside of employee's control that prevents duty from being fulfilled

**KNOWINGLY CAUSE HARM:** having knowledge that harm is practically certain to occur

**PERFORMANCE SHAPING FACTORS:** attributes that impact the likelihood of human errors or behavioral drift

**PURPOSE TO CAUSE HARM:** conscious objective to cause harm

**RECKLESS BEHAVIOR:** behavioral choice to consciously disregard a substantial and unjustifiable risk

**REMEDIAL ACTION:** actions taken to aid employee including education, training, and/or reassignment to task appropriate to knowledge and skill

**SOCIAL BENEFIT:** a higher order benefit to society or the organization

**SUBSTANTIAL AND UNJUSTIFIABLE RISK:** a behavioral choice where the risk of harm outweighs the social benefit attached to the behavior

## The Three Duties

| DUTY TO AVOID CAUSING UNJUSTIFIABLE RISK OR HARM | DUTY TO FOLLOW PROCEDURAL RULES | DUTY TO PRODUCE OUTCOMES |
|---|---|---|
| • values-focused<br>• "conduct unbecoming"<br>• see all five behaviors | • reliability-focused<br>• "the recipe"<br>• see only three of the five behaviors | • mission-focused<br>• "the cake"<br>• cannot see the five behaviors |

## The Five Behaviors

| HUMAN ERROR | AT-RISK BEHAVIOR | RECKLESS | KNOWLEDGE | PURPOSE |
|---|---|---|---|---|
| Unintended conduct: inadvertently doing other than what was intended: a slip, lapse, or mistake | A choice where risk is not recognized, or is mistakenly believed to be justified | Conscious disregard of a substantial and unjustifiable risk of harm | Knowingly causing harm (sometimes justified) | A purpose to cause harm (never justified) |
| ACCEPT | COACH | DISCIPLINARY SANCTION | DISCIPLINARY SANCTION | DISCIPLINARY SANCTION |

**Evaluate All Independent of the Actual Outcome**

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*CLOSED SESSION*

*(Report on Items to be Discussed in Closed Session)*

# *RECONVENE OPEN SESSION/ REPORT ON CLOSED SESSION*

# ***ADJOURNMENT***