



<b>VOLUME 3: QUALITY MANAGEMENT</b>	Effective Date: 11/26/12
<b>CHAPTER 7: PATIENT SAFETY</b>	Revision Date(s):
<b>3.7.1: PATIENT SAFETY PROGRAM POLICY</b>	Attachments: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

**I. POLICY**

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

The CCHCS Patient Safety Program includes:

- Routine program surveillance to identify problematic health care processes, including a statewide system for reporting patient safety issues, “near misses”, and adverse/sentinel events;
- An annual Patient Safety Plan, which determines priority areas for statewide interventions and performance objectives;
- Statewide and institution-level interventions designed to protect patients and improve outcomes;
- Regular communication in the form of patient safety alerts, program reports, and other mechanisms to ensure that all institutions are aware of patient safety issues;
- Technical assistance, staff development programs, and decision support tools, such as forms, checklists, and flowcharts, to support root cause analysis and process redesign;
- A patient safety culture that encourages staff to proactively identify and mitigate risk to patients and emphasizes continuous learning and improvement;
- A triaging process to ensure that patient safety issues that present immediate danger to patients and/or staff are resolved quickly and effectively and provide direction to institutions about appropriate follow up;
- A headquarters committee to provide oversight to the statewide Patient Safety Program, review patient safety data, and take action to prevent poor patient outcomes; and
- A referral process for adverse or sentinel events that involve blameworthy acts, including criminal activities.

**II. PURPOSE**

The CCHCS Patient Safety Program serves to:

- Protect patients from poor outcomes due to faulty health care processes and clinical errors;
- Improve health care quality and cost effectiveness;
- Increase efficiencies and reduce waste; and
- Comply with legal and regulatory requirements.

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## III. DEFINITIONS

**Adverse/Sentinel Event:** An event or series of events that cause the death or serious disability of a patient, personnel, or visitor. “Serious disability” means a physical or mental impairment that substantially limits one or more of the major life activities of an individual, or the loss of bodily function, if the impairment lasts more than seven days or is still present at the time of discharge, or unintentional loss of a body part. For the purposes of this policy, adverse events include sentinel events as described in the California Health and Safety Code 1279.1 and unusual occurrences as described in California Code of Regulations, Title 22, Division 5, Chapter 1, Article 7, Section 70737.

**Near Miss:** An event or situation that could have resulted in an adverse/sentinel event but did not, either by chance or through timely intervention.

**Death Review:** A Process by which an objective reviewer evaluates the care provided to a patient prior to the patient’s death, identifies system failures and professional practice issues, and makes recommendations for improvements or peer review activity to address identified problems.

**Root Cause Analysis:** A standardized process by which a multi-disciplinary team reviews a health care incident, near miss, or adverse/sentinel event, determines the fundamental reasons that the event occurred, and creates an improvement plan to prevent the event from occurring in the future.

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

## IV. RESPONSIBILITIES

Responsibility for implementation of this policy and associated procedure(s) is delegated to the Chair of the Headquarters’ Patient Safety Committee, and to the headquarter chief executives in each health care discipline.

## V. REFERENCES

Joint Commission on Accreditation of Health Care Organizations (JCAHCO)

National Commission on Correctional Health Care (NCCHC) 2008 Standards for Health Services in Prisons

California Health and Safety Code Sections 1250 and 1279

California Code of Regulations, Title 22, Division 5, Chapter 1, Article 7, Section 70737

Inmate Medical Services Policies and Procedures (IMSP&P) Volume 3, Chapter 7:

- 3.7.2 Adverse/Sentinel Event Review Policy
- 3.7.3 Death Reporting and Review Policy
- 3.7.4 Patient Safety Program Procedure: Patient Safety Committee
- 3.7.5 Patient Safety Program Procedure: Initial Triage/Assessment of Adverse/Sentinel Events
- 3.7.6 Patient Safety Program Procedure: Institution Response to an Adverse/Sentinel Event

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- 3.7.7 Patient Safety Program Procedure: Headquarters Adverse/Sentinel Event Committee
- 3.7.8 Death Reporting and Review Procedure

United States Department of Veterans Affairs - Veterans Affairs National Center for Patient Safety (NCPS) (<http://www.patientsafety.gov/>); Culture Change: Prevention, Not Punishment (<http://www.patientsafety.gov/vision.html>)