HAWAII HEALTH SYSTEMS C O R P O R A T I O N *"Touching Lives Everyday"* **Policies and Procedures**	**Department:** Legal	**Policy No.:** **PAT 0011**
		Revision No.: N/A
	Issued by: Quality Council	**Effective Date:** July 1, 2001
Subject: ***Patient Safety Program***	**Approved by:** Thomas M. Driskill, Jr. President & CEO	**Supersedes Policy:** N/A
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I. PURPOSE: The purpose of this policy is to require each Hawaii Health Systems Corporation (HHSC) facility to implement an integrated patient safety program with Joint Commission on Accreditation of Healthcare Organizations Standards in support of Patient Safety and Medical Healthcare Error Reduction.

II. POLICY STATEMENT: Each facility within HHSC shall implement an integrated patient safety program.

III. POLICY:

A. Each facility within HHSC will designate a multidisciplinary team to manage the facility-wide patient safety program.

B. Medical healthcare errors which fall within the scope of this patient safety program include but should not be limited to the following:

- Near misses
- Medication errors
- Falls
- Wrong surgical site
- Sentinel events (reference facility specific sentinel event policy)
- Sentinel events with adverse outcomes

C. Each facility will develop mechanisms for all components (i.e., nursing, occupational therapy, respiratory care, etc.) within the facility to be integrated into and participate in the facility wide program.

D. Each facility will develop procedures for immediate response to medical/health care errors, including care of the affected patient(s), containment of risk to others, and preservation of factual information for subsequent analysis.

E. Each facility will have a clear system for internal and external reporting of information relating to medical/health care errors.

F. Each facility will report on a quarterly basis to the HHSC Quality Council on the occurrence of medical/health care errors.

G. Each facility will report annually to the HHSC Board of Directors on the occurrence of medical/health care errors and actions taken to improve patient safety, both in response to actual occurrences and actions taken proactively to improve patient safety.

H. Each facility will have defined mechanisms for responding to the various types of occurrences, e.g., root cause analysis in response to a sentinel event, or for conducting proactive risk reduction activities.

I. Each facility will have defined mechanisms for support of staff who have been involved in a sentinel event.