Preventable Patient Error Policy	Department: Clinical Operations	
Origination Date: 03/2020	**Effective Date:** 03/2020	**Next Review Date:** 03/01/2026
Policy Contact: Rebecca Kruse-Jarres, rkj@wacbd.org	**Version:** #3	
Written By: Savannah Simmons, Savannah.simmons@wacbd.org		

PURPOSE: Washington Center for Bleeding Disorders (WACBD) has an ongoing effort to identify and reduce preventable medical errors for better patient care. Medical errors are a serious occurrence that is a leading cause of death in the United States. Creating, implementing, and following consistent guidelines can help reduce preventable medical errors. A part of creating these guidelines, is creating a culture that works towards recognizing potential harmful situations and implementing solutions. Employees providing patient care use these guidelines daily and have the advantage of identifying challenges presented to them. These employees are encouraged to speak up and aide in enhancing WACBD's patient care and safety, as communication breakdowns are the most common cause of medical errors.

SCOPE: The scope of this policy applies to all WACBD employees providing direct patient care.

POLICY STATEMENT: WACBD will identify errors, incidents, and event types to help create workflows that provide guidance and instruction to better prevent medical errors.

DEFINITIONS:

Term	Definition
Adverse Event	A type of injury that most frequently is due to an error in medical or surgical treatment rather than the underlying medical condition of the patient. Adverse events may be preventable when there is a failure to follow accepted practice at a system or individual level.
Error	Preventable adverse effect of care, whether or not it is evident or harmful to the patient.
Near Miss	A potential harm event that did not reach a patient.
Patient Safety	The process of amelioration, avoidance, and prevention of adverse injuries or outcomes that arise as a result of the healthcare process.
Unsafe Condition	A patient safety hazard – a circumstance or physical place, that increases the risk or probability of a future patient safety event. An unsafe condition exists until it is eliminated.

PROCEDURES:

Procedure 1—Identifying Errors, Incidents, and Events	
Types of Errors	There are two major types of errors: • **Errors of omission occur as a result of actions not taken.** Examples are not strapping a patient into a wheelchair or proper preparation of an exam room. • **Errors of commission occur as a result of the wrong action taken.** Examples include administering a medication to which a patient has a known allergy or not labeling a laboratory specimen that is subsequently prescribed to the wrong patient.

Non-preventable vs. preventable Incidents	Incidents are not always preventable, as they do not necessarily reflect an error in care, negligence, or poor quality. • Non-preventable incidents can occur despite proper assessment and treatment. A patient may have been highly susceptible to an event because of their health status, a complex diagnosis, or lack of available information. In some situations, harm from treatment may have been anticipated, but the risk of harm was considered more acceptable than risk of failing to treat. • However, a significant number of harmful events are preventable. These incidents are related to errors in medical judgment or skill, provision of substandard care, and inadequate monitoring or assessment of monitoring or assessing patients. Examples include prescribing the wrong medication for the condition, or delay in treatment due to failure to recognize and monitor signs and symptoms.
Event Types	WACBD acknowledges that as a specialty healthcare provider, there are event types, as defined by CMS, that apply and are acknowledged: <u>Procedure Events:</u> 1. Incorrect procedure performed 2. Procedure performed on the wrong body part 3. Procedure performed on the wrong patient <u>Product or Device Events</u> 1. Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the healthcare facility 2. Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended 3. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility <u>Patient Protection Events</u> 1. Patient death or serious disability associated with patient elopement (disappearance) when receiving care in the healthcare facility 2. Patient suicide, or attempted suicide resulting in serious disability, while being cared for in a healthcare facility <u>Care Management Events</u> 1. Patient death or serious disability associated with a medication error (e.g., error involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration) <u>Environmental Events</u> 1. Patient death or serious disability associated with an electric shock while being cared for in a healthcare facility 2. Patient death or serious disability associated with a burn incurred from any

	source while being cared for in a healthcare facility 3. Patient death associated with a fall while being cared for in a healthcare facility <u>Criminal Events</u> 1. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider 2. Abduction of a patient of any age 3. Sexual assault on a patient within or on the grounds of a healthcare facility 4. Death or significant injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare facility

Procedure 2- Strategies to Preventing Errors	
Strategies to Preventing Errors	<u>Prevention of Procedure Related Events</u> 1. Prior to procedures take a time out and confirm that consent has been obtained from the patient, that you have the correct patient, the correct site/location/limb, the correct equipment/drug 2. Prior to any invasive procedures, verify that the patient had adequate hemostatic prophylaxis <u>Prevention of Product or Device Related Events</u> 1. Prior to applying or administering any device or product, assure that the device or product is operating appropriately 2. Prior to applying device or product, assure that you have the correct patient, correct location, and correct device or product. 3. Prior to administering a drug, assure that it is the right patient, the right drug, the right dose, the right route, and the right time. <u>Prevention of Patient Protection Events</u> 1. Patient will not be admitted to clinic without the presence of clinic personnel 2. We will follow our suicide prevention policy <u>Prevention of Care Management Events</u> 1. Prior to administering drugs confirm that you have the correct patient, the correct drug, the correct route, correct rate, the correct dose, the correct preparation, and the correct time to drug is supposed to be administered <u>Prevention of Environmental Events</u> 1. Electrical medical equipment is inspected at least annually for proper function 2. Wheelchairs and other assistive devices are utilized to prevent falls <u>Prevention of Criminal Events</u> 1. ID badges are work by all personnel at all times 2. Security doors are activated at all times to limit access to the clinic 3. The clinic is locked after hours

Procedure 3- Responsibilities	
Employee Responsibilities	Upon identifying an "event," preventable patient errors in medical care, providers will do the following: • Immediately report "event" to immediate supervisor and medical director • Alert and send completed incident report to the Compliance Committee and Medical Director immediately no later than within 12 hours. • If medical error involves the Medical Director- send incident report to the Compliance committee only (Medical director will recuse themselves from discussion).
Medical Director/ Compliance Committee	Once an incident report has been submitted, both the Medical Director and Compliance Committee will: • Investigate the event within 24 hours • Secure equipment/ evidence • Remove any faulty equipment involved in event • Follow up and implement system changes as warranted • Document investigation and follow up

RELEVANT REFERENCES:

- ELIMINATING SERIOUS, PREVENTABLE, AND COSTLY MEDICAL ERRORS - NEVER EVENTS | CMS
- Medical Error Reduction and Prevention - StatPearls - NCBI Bookshelf (nih.gov)
- https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-13-19.pdf
- https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures

APPROVING COMMITTEE(S):

Policy and Compliance Committee (PCC)

REVISION HISTORY

	Final Approval by	Date	Brief description of change/revision
Revision	PCC	11/24/21	Updated language, information, incident report form, and outline
Revision	PCC	4/19/23	Added #3 under Prevention of Product or Device Related Events

WACBD Incident Report Form

Name of Person(s) Involved: _____

Employee Involved (If any): _____

Date of Event: _____ Location of Event: _____

Description of Event:

_____

_____

_____

_____

Description of Injury:

_____

_____

Actions Taken by Employee(s):

_____

_____

Follow up Actions Required:

_____

_____

Name of Employee: _____ Date: _____

****Once Investigation and Follow Up are Completed- Attach Documentation with this Report****