CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

VOLUME 3: QUALITY MANAGEMENT	Effective Date: 11/26/12
CHAPTER 7: PATIENT SAFETY	Revision Date(s):
3.7.4: PATIENT SAFETY PROGRAM PROCEDURE: PATIENT SAFETY COMMITTEE	Attachments: Yes ☐ No ☒

I. PROCEDURE OVERVIEW

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

Among other activities, the Patient Safety Committee establishes an annual Patient Safety Plan, designs a data collection and reporting system to identify patient safety issues, and provides training and decision support materials to help staff perform root cause analysis and redesign health care processes. The Patient Safety Committee shall encourage staff to proactively identify and mitigate risk to patients and emphasizes continuous learning and improvement.

II. DEFINITIONS

Patient Safety Alert: A bulletin issued to all institutions informing them of a patient safety issue with statewide ramifications. For example, a patient safety alert might be issued when an adverse event is linked to a malfunctioning piece of medical equipment used by several institutions.

III. HEADQUARTERS PATIENT SAFETY COMMITTEE

A. Responsibilities

1. The CCHCS Patient Safety Committee promotes patient safety and improvements to the health care services delivery system by:
   a. Designing a surveillance system for the collection and review of data pertinent to patient safety;
   b. Reviewing program data, including appeals, death review, utilization management, litigation and correspondence, and reports from external stakeholders, to identify and mitigate risk to patients;
   c. Ensuring that CCHCS maintains an effective process for initial assessment, appropriate referral, and timely conclusion of adverse/sentinel events;
   d. Establishing annual patient safety priorities and objectives;
   e. Working with other program areas to redesign health care processes when required to improve patient safety;
   f. Assisting in developing and implementing statewide initiatives to protect patient safety;
   g. Assisting in developing statewide training programs and decision support tools, such as forms, checklists, and flowcharts, to support root cause analysis and process redesign;

h. Identifying system or process lapses that may have impact statewide and issuing Patient Safety Alerts;

i. Communicating patient safety findings and recommendations to health care staff executives and other committees and program areas;

j. Coordinating committee activities, including but not limited to Death Review Committee and the recommendations there from, with the activities or initiatives of other health care committees and programs;

k. Documenting recommendations related to identified problems and completion of such recommendations, or other actions taken in response thereto, within appropriate timeframes determined by the Patient Safety Committee;

l. Producing an annual report of patient safety information for all health care staff; and

m. Supporting initiatives to encourage reporting of "near misses" and adverse/sentinel events.

2. The CCHCS Patient Safety Committee will designate staff as Sentinel Event Review Executives (SEREs) to review all incoming reports of adverse/sentinel events, and provide direction regarding peer review referrals, referrals to an investigatory agency, and institution-level review and follow-up activities. This triage group will meet every business day.

B. Committee Membership

1. The Chief Quality Officer or designee will serve as chairperson for the CCHCS Patient Safety Committee. The chairperson is responsible for ensuring that the Patient Safety Committee meets regularly, the committee agenda reflects the responsibilities and actions described in this procedure and committee decisions are appropriately documented.
2. The headquarters chief executive in each respective health care discipline (Medical, Nursing, Mental Health, Dental and Allied Health) will select a designee to serve on the Patient Safety Committee. One or more institution Chief Executive Officers may also be appointed to the Patient Safety Committee, as well as one or more custody representatives.
3. All voting members may choose a designee to serve in their stead. Non-voting members, such as presenters and guests, may attend as appropriate and approved by the committee.
4. Each member has one vote, and a quorum exists when one-half of the voting members are present.

C. Meeting Frequency

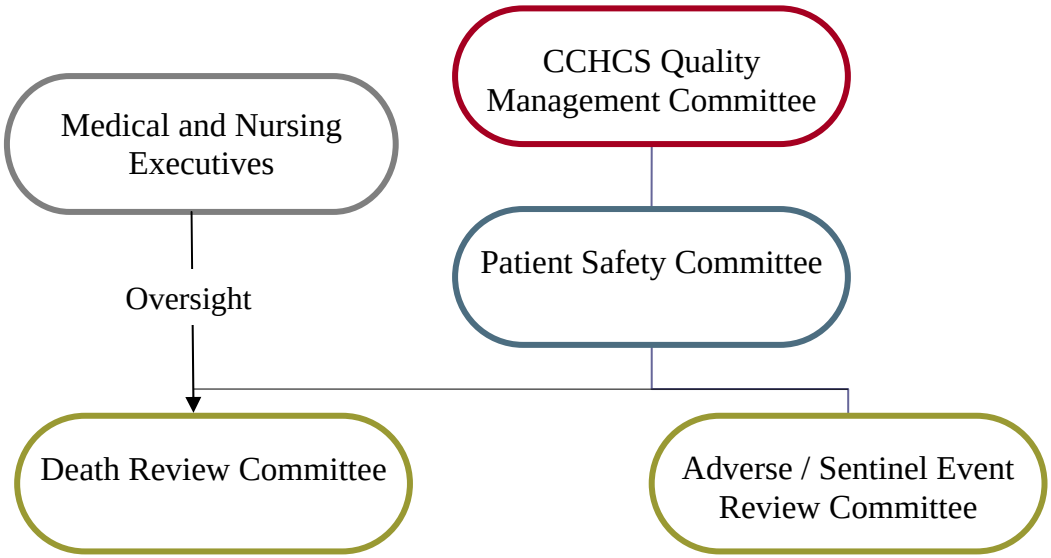
The Headquarters Patient Safety Committee will meet at least monthly, and more often as necessary.

D. Reporting Relationships

The CCHCS Patient Safety Committee reports to the CCHCS Quality Management Committee, and provides oversight to the Adverse/Sentinel Event Review Committee. In

addition, the Headquarters' CCHCS Death Review Committee reports on their activities to the Patient Safety Committee. Refer to Figure 1.

Figure 1. Reporting Relationships: Patient Safety Committee



IV. 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:

- 3.7.1 Patient Safety Program Policy
- 3.7.2 Adverse/Sentinel Event Review Policy
- 3.7.3 Death Reporting and Review Policy
- 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
- 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)