RANCHO LOS AMIGOS
NATIONAL REHABILITATION CENTER

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Patient Safety Plan

2026-2027

Reviewed and approved by

Patient Safety Council:
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Medical Executive Committee:

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Hospital Wide Patient Safety Plan for 2026-2027

I. PURPOSE

The purpose of the Patient Safety Program at Rancho Los Amigos National Rehabilitation Center ("Rancho") is to enhance and promote **its commitment to** patient safety throughout the organization **as a core value**. This program implements structured measures, protocols, and practices designed to prevent medical errors with a goal of **zero preventable harm** and improve the overall quality of care.

The Patient Safety Program fosters a culture of safety, supports continuous learning, and ensures that all workforce members prioritize patient well-being, workforce safety, and risk reduction throughout all aspects of care delivery.

II. HIGH RELIABILITY ORGANIZATION (HRO)

Rancho Los Amigos National Rehabilitation Center is committed to operating as a High Reliability Organization (HRO). In alignment with healthcare HRO principles, Rancho strives to achieve zero harm in complex, high-risk clinical environments by emphasizing three foundational domains:

- Leadership commitment
- A strong culture of safety
- Continuous process improvement

The five core principles of high reliability guide the design, implementation, and evaluation of Rancho's Patient Safety Program:

1. **Preoccupation with Failure**
   Actively identifying errors, near misses, and system vulnerabilities and treating them as learning opportunities.
2. **Reluctance to Simplify**
   Recognizing the inherent complexity of healthcare systems (number of teams, processes, and relationships) while balancing standardization with situational awareness.

3. **Sensitivity to Operations**
   Maintaining real-time awareness of frontline operations and ensuring bidirectional communication between staff and leadership.
4. **Commitment to Resilience**
   Developing the capacity to anticipate, respond to, and recover from unexpected events through training and preparedness.
5. **Deference to Expertise**
   Valuing frontline expertise regardless of hierarchy and empowering staff closest to the work to inform decision-making.

Source: AHRQ PSNet, High Reliability, 2019.

III. COMMITMENT TO SAFETY

Rancho is committed to delivering safe, compassionate, equitable, and high-quality care. This Patient Safety Plan is aligned with Rancho's mission, vision, values, strategic priorities, and philosophy of patient- and family-centered care. Continuous quality improvement efforts are informed by feedback from staff, physicians, volunteers, patients, families, and the community.

Given Rancho's diverse patient population, patient safety initiatives are implemented through an equity-focused lens that considers disparities related to age, race, ethnicity, gender identity, sexual orientation, preferred language, disability status, payor, sex, and other social determinants of health. Safety at Rancho encompasses physical, emotional, spiritual, cultural, and psychological well-being.

Rancho aims to foster a culture of safety that spans the entire continuum of care and benefits patients, visitors, volunteers, and workforce members alike.

The Patient Safety Plan will be reviewed at least annually and updated more frequently as needed to ensure continued effectiveness and alignment with organizational priorities and regulatory requirements by the Patient Safety Council.

Eliminating preventable harm requires equipping workforce members with standardized tools, evidence-based protocols, and ongoing education. Rancho also recognizes that patient safety cannot be achieved without workforce safety and promotes programs addressing:

- Slip, trip, and fall prevention

- Safe patient handling
- Sharps and exposure prevention
- Workplace violence prevention
- Fire and electrical safety
- Psychological safety

Rancho participates fully in the DHS-wide **Safe and Just Culture Program**, promoting transparency, accountability, and learning through the distinction between human error, at-risk behavior, and reckless behavior.

IV. ALIGNMENT AND GOVERNANCE

The Patient Safety Plan aligns with evidence-based standards and best practices established by:

- Institute for Healthcare Improvement (IHI)
- The Joint Commission (TJC)
- Agency for Healthcare Research and Quality (AHRQ)
- Centers for Medicare & Medicaid Services (CMS)
- Commission on Accreditation of Rehabilitation Facilities (CARF)

The Patient Safety Program is supported through the following governance structures:

- Mission, Vision, and Values
- 2026 Strategic Plan
- Annual Quality Improvement Plan
- Executive Council
- Quality, Risk, and Safety (QRS) Council
- Patient Experience Council (PEC)
- Patient Family Advisory Council (PFAC)

Patient and family engagement is integral and informed through patient experience data, survey feedback, and workforce culture of safety survey results.

V. ROLES AND RESPONSIBILITIES

Leadership Oversight

Oversight of the Patient Safety Plan resides with the **Patient Safety Officer (PSO)**, who reports to the **Chief Medical Officer (CMO).** Upon a CMO vacancy the **Chief Executive Officer (CEO)** is reported to. Organizational leaders at all levels are accountable for advancing patient safety practices.

Hospital quality and safety leaders are responsible for:

1. Integrating patient safety into strategic planning
2. Overseeing compliance on the National Performance Goals
3. Analyzing safety trends and data
4. Ensuring credible Root Cause Analyses (RCAs)
5. Monitoring corrective action plans
6. Supporting bidirectional communication
7. Advancing health equity in patient safety
8. Approving proactive risk assessments utilizing Failure Mode and Effects Analysis (FMEA) methodology) every 18 months
9. Distributing Joint Commission Sentinel Event Alerts
10. Reviewing Patient Safety Indicators (PSIs)
11. Notifying Executive Leadership of serious reportable events (SREs) within 3 days
12. Monitoring socioeconomic disparities and developing interventions to address them.
13. Reporting suspected instances of racism and discrimination through SI events and patient advocacy.

All workforce members participate in a biennial Culture of Safety Survey. Results are shared broadly as feedback on the effectiveness of the Executive Leadership Team and hospital quality and patient safety leaders in promoting the culture and building the infrastructure to achieve Rancho's patient safety goals.

VI. PATIENT SAFETY COUNCIL

The Patient Safety Council provides oversight, strategic direction, and guidance for patient safety initiatives. The Council:

- Reviews, revises, discusses and approves the Patient Safety Plan annually
- Identifies and prioritizes safety risks
- Reviews patient safety event reports and disseminates a dashboard to all units
- Recommends interventions to prevent future safety events
- Promotes transparency and accountability
- Ensures timely event review
- Supports evidence-based practices
- Encourages innovation and improvement
- Supports staff education

The Council is co-chaired by the **PSO** and **Associate Nursing Director of Patient Safety.**

VII. QUALITY, RISK & SAFETY (QRS) COMMITTEE

The QRS Committee ensures execution of the Patient Safety Program and is chaired by the CQO. Responsibilities include:

- Monitoring safety initiatives
- Reviewing performance reports
- Facilitating communication
- Supporting organizational learning
- Embedding safety into process design

Reporting committees include Falls, Medication Safety, Interprofessional Pressure Injury Prevention (IPIP), Environment of Care, Behavioral, Nursing Executive Council, and Patient Safety Council.

VIII. PATIENT SAFETY EVENTS

We define a patient safety event as an unintended or unexpected (i.e., not primarily related to the natural course of the patient's illness or underlying condition) event, incident, or condition that could have resulted ("near miss," "close call," or "good catch") or did result in harm to a patient resulting from the care that is intended to help them ("adverse event"). Patient safety events may or may not be related to human error.

Patient safety events include near misses, hazardous conditions, adverse events, and sentinel events. Events are reviewed to identify facility specific and/or system-level opportunities to prevent recurrence through redesign and safeguards.

The safety event system automatically notifies the Executive Leadership Team within 3 days of a confirmed serious patient safety event that results in morbidity, mortality, or other harm – otherwise known as sentinel events. Patients family members, and visitors may report events by notifying clinical care providers, contacting Patient Relations, or calling the DHS Patient Safety hotline or the The Joint Commission complaint hotline.

Definitions

Near Miss: An act of commission or omission that could have resulted in harm but did not, either by chance or through timely prevention or mitigation. An error intercepted before reaching the patient.

Hazardous Condition: A circumstance with the potential to cause injury, harm, or adverse health effects.

Sentinel Event/Serious Reportable Events: A patient safety event resulting in death, permanent harm, or severe temporary harm.

Harm: Injury or adverse outcome resulting from medical care or the failure to provide appropriate care.

Immediate Response to Patient Safety Events

Upon identification or notification of a patient safety event, including near misses, Rancho staff shall take the following immediate actions:

A. Clinical Response

1. Provide prompt and appropriate clinical interventions to protect and stabilize the affected patient.

2. Notify the patient's attending physician(s) without delay.
3. Implement and document all physician orders as indicated.
4. Document objective facts related to the event in the patient's medical record.

B. Preservation of Evidence

Relevant equipment, products, and information associated with the event shall be secured and preserved as appropriate. Examples include, but are not limited to:

1. Blood product unit(s) involved in a suspected transfusion reaction
2. IV tubing, fluid bags, and/or infusion pumps involved in a suspected medication reaction
3. Medication labels, ventilators, monitors, or other devices implicated in an adverse event
4. Event details can be entered and submit an event report pertaining to patient, staff, and visitors in the Vizient Safety Intelligence™ (SI) event reporting system which has an anonymous reporting option available if preferred.
5. Timely notification of the immediate supervisor

C. Attending Physician Responsibilities

The attending physician shall:

1. Inform the patient—and when appropriate, the patient's family—regarding outcomes of care, including unanticipated events or significant deviations from expected outcomes.
2. Submit an SI event report if one has not already been completed by another staff member.

D. Root Cause Analysis (RCA) Process

The RCA process adheres to the following principles:

- The RCA team consists of collaborative, multidisciplinary members who value diverse expertise and perspectives.
- The team reviews event data, evaluates contributing factors, assesses related quality improvement activities, and evaluates timeliness of response.

- Structured analytic tools (e.g., fishbone diagrams, cause-and-effect analysis) are utilized to identify contributing factors and system vulnerabilities.
- Corrective actions are developed and recommended to mitigate identified risks.
- Discussions are fact-based, objective, and transparent.
- A comprehensive Corrective Action Plan (CAP) is developed and monitored.
- The team leader reports progress, identified barriers, and finalized plans to the QRS Committee.
- Ongoing monitoring and structured follow-up ensure accountability and effectiveness of corrective actions.

E. Communication About Patient Safety

I. Communication with Patients

1. Patient Rights are incorporated into the General Consent form and provided upon hospital admission and renewed annually in ambulatory settings.
2. Patient Rights posters are displayed throughout the facility.
3. Patients and, when appropriate, their families are informed about care outcomes, including unanticipated outcomes.
4. Key patient safety metrics (e.g., Falls, HAPI, CLABSI, CAUTI) are publicly displayed.
5. Patient Safety Hotline posters provide contact information for Rancho, DHS, and The Joint Commission for reporting safety or quality concerns.

II. Communication with Staff

Patient safety information is disseminated through:

1. QRS Committee members reporting to their respective departments
2. Safety posters in key locations
3. DHS e-Newsletters and Quality, Risk, Safety communications
4. Patient Safety Awareness Week Activities
5. National Patient Safety Week activities
6. Town Hall meetings

7. Educational activities (continuing medical education (CME), nursing competencies, staff meetings)
8. Executive Council, Management Staff, Professional Staff Association (PSA), and departmental meetings

F. Ongoing Employee Education

I. New Hire Orientation

New employees receive education on:

1. Organizational Mission, Vision and Values
2. Rancho Orientation/Reorientation Handbook
3. Joint Commission's National Performance Goals
4. Reporting processes for errors, near misses, SREs, and critical events
5. Relevant patient safety policies and procedures (e.g., DHS Safe and Just Culture 311.4; Rancho Administrative Policy B704; Infection Control A128.1)

II. Ongoing Education for All Staff

Staff are encouraged to:

1. Participate in Patient Safety quizzes
2. Engage in National Patient Safety Week activities
3. Review the DHS Patient Safety Employee Handbook
4. Review DHS Med Safety Blast communications
5. Attend the annual DHS Patient Safety Conference
6. Participate in in-service trainings
7. Engage in continuing professional education activities
8. Annual Infection Control Training
9. Rancho Orientation/Reorientation Handbook

III. Required Education

Staff periodically complete:

1. Monthly Safety in-service modules

2. DHS annual core competency assessments
3. Hospital-wide survey readiness activities

IX. STAFF SUPPORT

Rancho provides psychological, emotional, and pastoral support to our county staff involved in serious events through:

- Human Resources
- Employee Assistance Program (EAP)
- Social Work
- Chaplaincy
- Bioethics Committee
- Medical Staff Aid Committee
- Helping Healers Heal (H3)
- Staff Wellness Program

X. Key Terms

Patient Safety Event – an unintended or unexpected (i.e., not primarily related to the natural course of the patient's illness or underlying condition) event, incident, or condition that could have resulted or did result in harm to a patient.

Adverse Event – a patient safety event that resulted in harm to a patient. Adverse events should prompt notification of organization leaders, investigation, and corrective actions. Adverse events may or may not result from an error.

Sentinel Event – a patient safety event that reaches a patient and results in death, severe harm (regardless of duration of harm), or permanent harm (regardless of severity of

harm). Sentinel events are a subcategory of adverse events.

Close Call – a patient safety event that did not cause harm but posted a risk of harm. Also called near miss or good catch.

Hazardous Condition – a circumstance (other than a patient's own disease process or condition) that increases the probability of an adverse event. Also called unsafe condition