

Patient Safety Strategies

Initiatives and Metrics to Achieve Success

Fairfield Medical Center is a not-for profit health system offering vital access to advanced specialties and primary care services in Southeastern Ohio. We are driven by our mission to deliver outstanding healthcare for our patients, their families and our communities, and safety is our number one service standard. The following overview outlines initiatives and organizational tools to achieve our goal of zero preventable harm.

Pillars of Safety Culture of Safety

Fostering a culture of safety across the organization empowers staff to prioritize the well-being of patients and teammates, uphold quality standards and champion compliance through accountability and shared responsibility. Components of Fairfield Medical Center's safety culture include:

- · Just culture Staff feel safe raising questions and concerns and reporting safety events in an environment that emphasizes a non-punitive response
- · Reporting culture Staff are encouraged to advocate for patients and speak up for safety by reporting all errors and near misses
- · Learning culture Staff learn from reports and successes, openly share information and data and apply best evidence to improve patient outcomes
- Collaborating culture Staff at all levels work together to solve and improve safety issues

Event Reporting

Providing 24/7 access to an event reporting system allows for increased awareness of incidences that signal harm or potential harm within the organization, ultimately leading to process improvements and a safer environment of care for patients, staff and visitors.

- Types of events reported include errors, near misses, hazardous conditions and sentinel events impacting patients, visitors or employees
- Upon completion, reports are reviewed and investigated, assigned a severity score and submitted for root cause analysis if indicated
- Data from analyzed reports are shared with leadership and appropriate committees to improve safety

Policies and Protocols

Establishing policies, procedures, protocols and best practices reduces adverse events and supports patient safety goal of zero preventable harm; policy development, implementation and monitoring are supported by dedicated committees of clinical and leadership staff, including*:

- Fall Prevention (Policy No. POC-02-032)
- Medication Errors (WI No. AHR-19-006-001)
- Pre-op Work Flow (WI No. SOS-063-038)
- Infection Control Program (Policy No. CD-19-001)
 Handoffs and Transitions (Policy No. POC-02-089)
- Pressure Injury Prevention (WI No. POC-02-092-002)
- Two Patient Identifiers (Policy No. AHR-18-035)
- Transfusion of Blood (Policy No. POC-02-020)

Metrics of Safety

Corporate Scorecard

Creation of a balanced corporate scorecard with designated focus on safety and quality promotes routine analytics, reporting, investigation and process improvement of key patient safety indicators. Components related to quality, safety and patient care include*:

- CLABSI Event/Catheter Days Number of patients with CLABSI observed divided by number of central line days multiplied by 1,000 (Threshold: 0.8 | Target: 0.2 | Actual: 0.2 | Achieved)
- Sepsis Number of diagnosed sepsis patients who received appropriate bundle care within the designated time frame divided by total number of patients diagnosed with severe sepsis or septic shock multiplied by 100 (Threshold: 53% | Target: 57% | Actual: 70.2% | Achieved)
- Left without being seen Percent FMC Emergency Department patients who left before being seen by a provider. This included those patients who are classified as "Left without Triage" or "Left without Being Seen"; reported separately for two emergency care facilities (Main Campus, Threshold: 2% | Target: 1.5% | Actual: 0.94% | Achieved) | (RVC, Threshold: 2% | Target: 1.5% | Actual: 0.67% | Achieved)
- * Based on 2024 data; metrics reported to leadership on a monthly basis; categories do not represent totality of balanced corporate scorecard

Desired Outcomes

Goals of Fairfield Medical Center's multi-faceted focus on safety include:

- Utilize accurate quality data to create and assess improvement plans
- Implement risk reduction strategies led by didactic healthcare leadership
- Reduce incidence of hospital-acquired infections
- Zero preventable harm to promote positive patient outcomes

^{*} This is not an exhaustive list of safety policies, work instructions or safety initiatives