Measurable Elements of QPS.03.04

1. The hospital implements data collection processes to ensure that risks to patient safety are identified.
2. Ⓓ The hospital conducts an intensive analysis, or a comprehensive systematic analysis, of data when adverse events, patterns, or undesirable trends occur.
3. Ⓓ The hospital performs data collection and analysis for all of the following, at minimum, when applicable:
   - All confirmed transfusion reactions
   - All serious drug reactions or drug-related patient safety events as defined by the hospital or laws and regulations
   - All medication errors and near misses, as defined by the hospital (*See also* MMU.07.01, ME 2)
   - All major patient safety events or errors related to surgical procedures
   - All major discrepancies between preoperative and postoperative diagnoses; for example, a preoperative diagnosis of intestinal obstruction and a postoperative diagnosis of ruptured abdominal aortic aneurysm (AAA)
   - Patient safety events or patterns of events during procedural sedation regardless of administration route
   - Patient safety events or patterns of events during anesthesia regardless of administration route
   - Patient safety events or errors related to patient identification
   - Patient safety events or errors related to pathology samples, such as biopsy or other tissue specimens

   (*See also* AOP.04.00, ME 6)
4. The hospital uses the results of analyses to implement actions that improve the quality and safety of the service, treatment, or function.
5. Ⓓ The hospital reports data for identified risks to patient safety to the governing entity as part of the quality and patient safety program.
6. The hospital implements measures designed to encourage patient safety events incident reporting by hospital staff.

Gaining and Sustaining Improvement

Standard QPS.04.00

The hospital achieves and sustains improvement in quality and safety.

Intent of QPS.04.00

Information from data analysis is useful to identify potential improvements or to reduce (or prevent) patient safety events and is a critical element of hospital quality and patient safety programs. Routine measurement data, as well as data from intensive analyses, contribute to the understanding of where improvement is needed and how improvement efforts should be prioritized. Improvements are planned for the priority data collection areas identified by hospital leaders.

After an improvement(s) is planned, data are collected during a test period to demonstrate that the planned change was actually an improvement. To ensure that the improvement is sustained, measurement data are then collected for ongoing analysis. Effective changes are incorporated into standard operating procedures, and any necessary staff education is carried out. The hospital documents those improvements achieved and sustained as part of its continuous quality improvement program. The hospital should reevaluate goals at defined intervals to when a successful goal has been achieved and sustained, and whether it should be retired in favor of identifying a new focus for improvement.

Measurable Elements of QPS.04.00

1. The hospital plans, tests, and implements improvements in quality and patient safety. (*See also* GLD.04.02, ME 1)
2. Ⓓ Data are available to demonstrate that improvements are effective and sustained. (*See also* GLD.06.01, ME 3)
3. The hospital makes policy changes when necessary to plan, to carry out, and to sustain the improvement.
4. Ⓓ Successful improvements are documented and reviewed by the quality and patient safety program and hospital leaders to understand why efforts were or were not successful. (*See also* GLD.04.00, ME 2)

Standard QPS.04.01

The hospital uses an ongoing program of risk management, overseen by qualified individuals with the appropriate experience, knowledge, and skills, to identify and proactively reduce unanticipated adverse events, and other safety risks to patients and staff.

Intent of QPS.04.01

Proactive risk management is essential to the quality and safety of patient care, treatment, and services within a hospital.

There are many types of risks in a hospital setting; for example, risks can include those associated with clinical care and patient safety, such as diagnostic, surgical, or medication errors; risks associated with the environment, such as hazardous conditions; risks associated with operations, such as plans for achieving the hospital's goals; or risks associated with compliance to standards of care and adherence to laws and regulations. Other risks can be associated with finances and strategic planning. Hospitals must adopt a proactive approach to risk management that includes implementing risk mitigation strategies, with the goal being to reduce or eliminate the potentially harmful impact of known or possible risks. One such way is a formalized risk management program.

An important element of risk management is risk analysis, such as a process to evaluate near misses and other high-risk processes for which a failure would result in a sentinel event. There are multiple tools that can provide a proactive analysis of the consequences of an event that could occur in critical, high-risk processes, such as prevention of wrong-site surgery, the care of patients at high risk for suicide, or emergency management of natural disasters. For example, failure mode and effects analysis (FMEA) and hazard vulnerability analysis (HVA) are two common tools.

To use these or similar tools effectively, leaders must identify and prioritize the potential risks that could have the greatest impact on patient and staff safety as well as on the quality and safety of patient care, treatment, and services. This information should be used to prioritize resource allocation to analyze the areas of highest risks and redesign the process or similar actions to reduce the risk in the process. This risk reduction process is carried out at least once per year and is documented.