

COMAR 10.07.06 Hospital Patient Safety Program

Authority: Health-General Article, §§19-308 and 19-319,

Annotated Code of Maryland

.01 Definitions.

A. In this chapter, the following terms have the meanings indicated.

B. Terms Defined.

(1) “Action plan” means a written document that includes:

(a) Specific measures to correct problems or areas of concerns;

(b) Specific measures to address areas of system improvement;

(c) Time frames for implementation of any specific measures; and

(d) Title of responsible individual to monitor implementation and effectiveness.

(2) “Adverse event” means an unexpected occurrence related to an individual’s medical treatment and not related to the natural course of the patient’s illness or underlying disease condition.

(3) “Department” means the Department of Health and Mental Hygiene.

(4) “Level 1 adverse event” means an adverse event that results in death or serious disability.

(5) “Level 2 adverse event” means an adverse event that requires a medical intervention to prevent death or serious disability.

(6) “Level 3 adverse event” means an adverse event that does not result in death or serious disability and does not require any medical intervention to prevent death or serious disability.

(7) “Medical review committee” has the meaning stated in Health Occupations Article, §1-401 et seq., Annotated Code of Maryland.

(8) “Near-miss” means a situation that could have resulted in an adverse event but did not, either by chance or through timely intervention.

(9) “Patient safety program” means an ongoing, proactive program for identifying risks to patient safety and reducing medical errors which is one component of the hospital-wide risk management program.

(10) “Root cause analysis” means a medical review committee process as defined under Health Occupations Article, §1-401 et seq Annotated Code of Maryland, for identifying the basic or contributing causal factors that underlie variations in performance associated with adverse events or near-misses.

(11) “Serious disability” means a physical or mental impairment that substantially limits one or more of the major life activities of an individual lasting more than 7 days or still present at the time of discharge.

.02 Patient Safety Program.

A. General.

(1) On or before January 1, 2004, a hospital shall have in effect a patient safety program that meets the requirements of this chapter.

- (2) The purpose of this chapter is to provide a safe environment for patients by requiring hospitals to:
- (a) Identify adverse events;
 - (b) Encourage reporting of near-misses;
 - (c) Assess and prioritize near-misses and adverse events based on level of disability or potential disability to patients;
 - (d) Determine the appropriate hospital response based on level of disability or potential disability;
 - (e) Conduct a root cause analysis on:
 - (i) All level 1 events;
 - (ii) All level 2 events; and
 - (iii) Any near-miss or other adverse event if warranted;
 - (f) Conduct an appropriate investigation on adverse events and near-misses that do not require or warrant a root cause analysis;
 - (g) Provide for a process by which the concerns of patients can be addressed; and
 - (h) Provide for a process to notify a patient or, if appropriate, a patient's family, whenever an outcome of care differs significantly from an anticipated outcome.

B. Duties of the Hospital.

- (1) The hospital shall identify an individual as patient safety coordinator who shall:
- (a) Coordinate patient safety activities;

(b) Facilitate assessment and determination of the appropriate response to reported near-misses and adverse events related to patient care;

(c) Monitor root cause analyses and any actions resulting from a root cause analysis; and

(d) Provide for flow of information among quality assurance, credentialing, peer review, and any patient safety committee.

(2) The hospital shall establish:

(a) Patient safety education programs for all staff; and

(b) An internal staff committee structure in accordance with Health Occupations Article, §1-401, Annotated Code of Maryland to conduct a review and evaluation of patient safety activities in accordance with this chapter.

(3) The governing board of a hospital shall develop a process to review the hospital's patient safety program and to determine the effectiveness of the hospital's patient safety program.

(4) Before a committee can operate or review patient safety activities under this chapter, a hospital shall require that the committee meet the requirements for a medical review committee under Health Occupations Article, §1-401 et seq., Annotated Code of Maryland.

.03 Near-miss and Adverse Event Reporting and Determination of Appropriate Response.

A. The hospital shall develop and encourage a supportive environment that permits spontaneous identification, open discussion, and timely and accurate reporting of near-misses and adverse events.

B. The hospital shall establish a clear and well-defined near-miss and adverse event identification and reporting process that shall:

(1) Encourage reporting of near-misses and require reporting of adverse events;

(2) List and describe examples of adverse events that shall be reported;

(3) Designate a hospital representative to whom a near-miss is encouraged to be reported or to whom an adverse event shall be reported;

(4) Provide a time frame within which the near-miss is encouraged to be reported or within which an adverse event shall be reported;

(5) Require that an individual employed by the hospital or appointed to the medical staff and who is aware of an adverse event shall report the adverse event in accordance with this chapter;

(6) Develop a procedure to coordinate receipt of all adverse events and near-misses and to prioritize adverse events and near-misses based on level of disability or potential disability; and

(7) Develop a procedure to assign an appropriate response to level 1 and level 2 adverse events, other adverse events, and near-misses.

.04 Investigation Of Level 1 and 2 Adverse Events And Near-misses that Warrant a Root Cause Analysis to be Conducted.

A. When a level 1 or 2 adverse event or near-miss that warrants a root cause analysis occurs, the hospital shall:

(1) Provide immediate care to the patient;

(2) Identify any immediate corrective action to prevent reoccurrence;

- (3) Identify and report the event in accordance with the hospital's reporting process;
- (4) Complete a root cause analysis within 60 days of the time that the hospital has knowledge of the occurrence;
- (5) Develop and implement an action plan to correct any systems problems;
- (6) Share any pertinent information with quality assurance or other medical review committees; and
- (7) Aggregate data to determine patterns or trends.

B. All patient safety activities shall be conducted by a medical review committee established under Health Occupations Article, §1-401, Annotated Code of Maryland.

.05 Root Cause Analysis.

A. The hospital shall appoint an interdisciplinary root cause analysis team that shall include:

- (1) Individuals who have knowledge of the event or near-miss;
- (2) Representatives of hospital leadership; and
- (3) Individuals with expertise in the subject matter of the event.

B. The root cause analysis team shall interview and permit participation of individuals who were directly involved in the event or near-miss and allow the individual to participate in the root cause analysis as appropriate.

C. The root cause analysis shall examine the cause and effect of the event through an impartial process through:

- (1) Analysis of human and other factors;

- (2) Analysis of related processes and systems;
- (3) Analysis of underlying cause and effect systems through a series of “why” questions;
- (4) Identification of risks and possible contributing factors; and
- (5) Determination of improvement in processes or systems.

D. A root cause analysis shall:

- (1) Be internally consistent; and
- (2) Include consideration of relevant literature and best practices.

E. The hospital shall provide feedback including changes to hospital policy or procedure resulting from the root cause analysis to hospital employees and staff who were involved in the event or near-miss and to other employees or staff who would benefit from the feedback.

.06 Level 3 Adverse Event Or Near-Misses that Do Not Warrant Root Cause Analysis.

A. If the event is not a level 1 or 2 event or near-miss that warrants a root cause analysis, the hospital shall conduct an evaluation of the event to determine any problem area and corrective action.

B. All events shall be aggregated by type and level to determine any patterns or trends.

C. The hospital is encouraged to evaluate and trend all near-misses to determine any system problems.

D. The hospital shall monitor the results and effectiveness of all action plans.

.07 Information Sharing.

The patient safety program shall require that the quality assurance, and other medical review committees share information and take any appropriate action concerning near-misses and adverse events.

.08 Reports To the Department.

A. A hospital shall report any level 1 adverse event to the Department within 5 days of the hospital's knowledge that the event occurred.

B. A hospital shall submit the root cause analysis and action plan for the level 1 adverse event to the Department within 60 days of the hospital's knowledge of the occurrence.

C. Any root cause analysis and any other medical review committee information submitted to the Department and the identity of individuals appointed to the interdisciplinary root cause analysis team are confidential under Health Occupations Article, §1-401, Annotated Code of Maryland and may not be discoverable, disclosable, or admissible as evidence in any civil action or available under the Maryland Public Information Act.

D. If the Department receives a complaint alleging a level 1 adverse event, the Department may accept the root cause analysis as a hospital's internal investigation under Health-General Article, §19-309(b), Annotated Code of Maryland.

.09 Documentation.

Actions taken by the quality assurance and medical staff credentialing and peer review committees shall be documented in committee minutes.

.10 Patient Complaint Program.

A. In accordance with this regulation, the patient safety program shall include a formal written program for addressing patient complaints.

B. The hospital shall provide patients with information regarding the hospital's patient complaint program including:

(1) The name of the hospital's representative that the patient may contact if the patient wishes to make a complaint; and

(2) The hospital representative's phone number or address.

C. The hospital's representative shall treat the complainant with dignity and courtesy and due regard for the individual's privacy.

D. The hospital's representative shall provide the complainant with information about the complaint including:

(1) The hospital representative that the patient may contact for information regarding the complaint;

(2) The procedure for investigating the complaint;

(3) The length of time in which the complainant can expect a response or resolution to the complaint; and

(4) Notice that the patient may contact the Department at a specified telephone number or address with any complaint.

E. The hospital's representative shall document the complaint and any action taken concerning the complaint or the hospital function complained about.

F. Patient Safety Program Requirement- Notice to Patients and Families of Unanticipated Outcomes. The hospital shall inform the patient and, when appropriate,

the patient's family whenever a final outcome of care differs significantly from an anticipated outcome.

.11 Inter-hospital Notification Of Level 1 or Level 2 Adverse Events.

A. A hospital that admits a patient with a condition resulting from an adverse event that the hospital perceives may be related to care that was provided at another Maryland hospital and that appears to be unknown to the other hospital at the time of discharge shall notify and provide any necessary information to the appropriate medical review committee at the hospital where the adverse event allegedly occurred.

B. The hospital where the event allegedly occurred shall conduct a root cause analysis and provide notice to the Department in accordance with this chapter.

C. The hospital where the event allegedly occurred shall notify the patient or the patient's family in accordance with this chapter.

D. All communication that occurs in accordance with this provision is confidential under Health Occupations Article, §1-401, Annotated Code of Maryland.

.12 Records.

The hospital shall maintain records that document the operation of its patient safety program.

.13 Documentation.

A. On or before January 1, 2004, the hospital shall send to the Secretary a written description of its patient safety program that includes:

- (1) The name of the patient safety coordinator;
- (2) The board policy statement relevant to patient safety activities;

(3) A description of the near-miss and adverse event identification and reporting process;

(4) A list of examples of adverse events that shall be reported;

(5) A description of the process for determining which near-misses warrant a root cause analysis to be conducted;

(6) A description of the near-miss and adverse event review, prioritization, evaluation, and root cause analysis process;

(7) A description of the process used to provide notification to a patient, and, when appropriate, to a patient's family whenever an outcome of care differs from an anticipated outcome; and

(8) A description of the formal written patient complaint process.

B. The hospital shall notify the Secretary of any change in its patient safety program related to the description required by this regulation within 30 days of the effective date of the change.

.14 Plan of Correction.

A. If the Department notifies a hospital that the patient safety program of the hospital does not meet the requirements of this chapter, the hospital shall submit a plan indicating the steps the hospital shall take to meet the requirements of this chapter.

B. The plan shall be sent to the Secretary within 30 days after the Department notifies the hospital that the hospital does not meet the requirements of this chapter.

.15 Penalties.

If a hospital fails to have in effect a patient safety program in accordance with this chapter, then the Secretary may impose on the hospital the following penalties:

A Delicensure of the hospital; or

C. A fine of \$500 for each day that the hospital is in violation of this chapter.

END ALL NEW MATERIAL

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