

## HOSPITAL PATIENT SAFETY PROGRAM

Hospitals participating in the Northern Metropolitan Patient Safety Institute (NorMet PSI) will collaborate with other hospitals, their attending physicians and other health care providers with the express goals to meet the following objectives:

- A. Increase patient safety and quality of health care through the collection and analysis of data related to patient care and adverse events from multiple providers.
- B. Gather and analyze data regarding adverse patient events from healthcare providers in a confidential environment that encourages participation and full disclosure of all relevant information.
- C. Promote rapid learning among health care professionals about the underlying causes of risks and harms in the delivery of health care and to share those findings with the healthcare community to improve patient outcomes and increase efficiencies in the region's healthcare systems.

Certain activities are deemed critical in order for participating hospitals and the NorMet PSI to attain the above-mentioned goals. As such, the NorMet PSI and all other participating hospitals will collaborate to:

- Identify, analyze, and reduce the risks and hazards associated with patient care;
- Conduct, coordinate, sponsor and/or assist investigation and activities to increase the knowledge base of hospitals, physicians and other health care providers so that patients may be better served and the quality and safety of healthcare are enhanced;
- Undertake the creation of databases and to promote the exchange of information among hospitals and other health care providers to identify important care processes, interventions and best practices to enhance patient safety;
- Solicit, obtain, spend, grant and dispose of funds in furtherance of its purposes;
- Document and measure the improvements in patient care processes, and resultant impacts on patient quality of life and savings to the healthcare system.

Specific initiatives of the NorMet PSI will be selected annually by the participating hospitals. Initiatives for 2009 and 2010 include, but are not limited to:

- Preparing participating hospitals to meet the proposed January 1, 2010 Joint Commission requirement that “measurement strategies follow evidence-based guidelines, and surgical site infection rates are measured for the first 30 days following procedures that do not involve inserting implantable devices and for the first year following procedures involving implantable devices.”
- Reducing patient falls across participating hospitals.
- Exploring the development and implementation of a confidential, anonymous reporting system for near-misses.

