Hennepin Healthcare System	
Title: 2026 Patient Safety Plan	**Plan #** 010720
Policy Sponsor: Patient Safety Manager	
Review Body(s): Quality and Safety Management Committee	
Approval Body: Hennepin Health System Board	
Original Approval Date: 08/27/08	
Reviewed/ Revised: 2026	

OVERVIEW

The Patient Safety Plan describes Hennepin Healthcare System's (HHS) Patient Safety Program which supports and promotes the mission, vision, and values through the continuous improvement of patient safety. This program centers on the establishment of mechanisms that support effective responses to actual occurrences and hazardous conditions; ongoing proactive risk assessment and prevention of medical/health care errors; and integration of patient-safety principles in the design of all relevant organizational processes, functions, and services.

OBJECTIVE

The organization-wide Patient Safety Plan is designed to reduce medical errors and hazardous conditions by utilizing a systematic, coordinated, and continuous approach to the improvement of patient safety.

SCOPE OF ACTIVITIES

This plan is applied to all HHS programs and HHS owned or leased areas, including clinical research, administrative, and areas where HHS employees work.

ROLES AND RESPONSIBILITIES

A. Hennepin County Board of Commissioners
The parent body for Hennepin Healthcare System Inc. has ultimate responsibility for the Hennepin Healthcare System mission.

B. Hennepin Healthcare System (HHS) Board
The governing body is responsible for guiding Hennepin Healthcare System.

C. HHS Quality, Safety, Audit and Compliance committee.
This committee is a subcommittee of the HHS Board. The purpose of the HHS Quality, Safety, Audit and Compliance Committee is:

1. To ensure patient care services and processes of care are designed to continuously improve the quality of care.
2. To provide adequate time and consideration of the plans and work being performed.
3. To provide for a broader base of regular input from the various parties involved in performing the work on behalf of the Hennepin Healthcare System.
4. To make recommendations to the Board based upon deliberation within the Committee's scope of assignment.

D. Quality and Safety Management Committee

The primary responsibility of this committee is to prioritize, direct, implement, and evaluate organizational improvement and safety initiatives. The work of this committee needs to meet the requirements of the governing board and external regulatory agencies. This committee also ensures integration of strategic goals with safety management, performance improvement, and accreditation readiness for the medical center. The Quality and Safety Management Committee allocates/assigns resources as needed for performance improvement initiatives identified by patient safety work/data. This committee reports to the HHS Board Quality and Safety Committee.

E. Clinical Safety Practices Committee

The Clinical Safety Practices Committee provides leadership and oversight to patient safety with the goal of achieving continuous improvement of prioritized patient safety initiatives. The Clinical Safety Practices Committee is directly accountable to the Quality and Safety Management Committee.

F. Medical Staff Quality Committee (MSQC): Peer Review

The MSQC ensures that the hospital, through the activities of its medical staff, assesses the performance of individuals granted clinical privileges and uses the results of such assessments to improve patient care. The MSQC reports to the Medical Executive Committee and has an indirect reporting relationship with QSMC as it relates to system issues identified within its review activities.

G. Medication Safety Committee

The Medication Safety Committee is an interdisciplinary committee that coordinates the ongoing evaluation and improvement of medication processes and works to continuously improve and promote safe, effective, and compliant medication use. This committee addresses medication safety, medication management, and nursing-pharmacy issues. The Medication Safety Committee oversees medication practices at all inpatient and outpatient facilities within the Hennepin Healthcare System (HHS).

H. Administrative and medical department leaders

Administrative and medical department leaders set expectations for a culture of safety and ensure patient safety principles are included in process design.

I. Performance Measurement and Improvement (PM&I)

PM&I supports organizational and patient safety improvement by providing data, tools, knowledge, skills, and expertise needed to assess and improve processes, outcomes, patient safety, customer service and continual survey readiness.

J. Employees

Employees report events, near misses and unsafe conditions and when requested participate in event reviews and other improvement activities that promote patient safety.

COMPONENTS

A. Proactive risk assessment and risk reduction: Activities using internal and external knowledge and experience to prevent errors and maintain and improve the quality and safety of the care provided. This includes a selection of a high risk or error prone process at least every 18 months for a Failure Mode Effects Analysis. The selection may be based on information published by Joint Commission Sentinel Event Alerts, and/or other sources of information including Minnesota Adverse Healthcare Events data sharing reports, risk

management, performance improvement, quality assurance, infection prevention, research, patient/family suggestions or process outcomes.

B. **Effective responses to events:** The mechanism for identification, reporting and responding to events that range in harm from near misses to sentinel events is described in the "Response to Events at Hennepin Healthcare System" policy. This describes reporting and investigation done in response to events and near misses including a focus on system and process issues. Leader standard work includes an expectation that leaders investigate and respond to events in a timely manner. Sentinel events and events reported under the Minnesota Adverse Healthcare Reporting law have credible and thorough root cause analyses.
C. **Communication of unanticipated outcomes (Disclosure):** The attending physician will explain the outcome of treatments or procedures, including unanticipated outcomes of care, treatment, and services that relate to events when the patient is not already aware of the occurrence or when further discussion is needed to patient and/or family. The Patient & Staff Support Team (PSST) provides support to staff and patients/families. PSST provides communication guidance as needed.
D. **Data tracking and Analysis**: Event data is tracked and analyzed for trends that indicate the need for process improvement. This data is available in event system dashboards.
E. **Process Improvement:** Both event investigation and proactive risk assessment identify opportunities for system and process improvements. Mistake proofing is an emphasis in these system and process improvements. Root Cause Analysis, System Reviews, and Failure Mode Effects Analysis include action plans outlining actions that will be implemented to reduce the risk of future occurrences. Results of action plans are tracked. Whenever applicable, observational audits are included in the action plan to ensure desired process and/or behavioral changes have been implemented.
F. **Just Culture:** An environment of trust and fairness where it is safe to report and learn from events and system flaws and where there is a clear difference between human error in an unreliable system and intentional unsafe acts. Culture is assessed through an employee engagement survey administered by a third party.
G. **Dissemination of lessons learned:** Lessons learned from root cause analyses, system reviews, and Failure Mode Effects Analyses are communicated to team members that provide services for specific situations. In addition, lessons learned will be shared broadly with the organization on a regular basis.
H. **Staff education:** Education is critical to creating a culture of safety in health care organizations. Multiple strategies are utilized to weave safety education and outcomes into the life of the organization. This education includes:
    1. New Employee Orientation, which emphasizes organizational processes related to patient safety, as well as specific job-related aspects of patient and employee safety. Annual Required Training (ART): All employees complete mandatory annual training to maintain a safe and healthy environment.
    2. ART also includes education about patient safety topics.
    3. Simulation Training: In situ (in the actual clinical care environment) training provides a method of education to improve teamwork, communication, and patient safety in patient care areas. Education identifies and mitigates latent hazards, knowledge gaps, and provides opportunities for clinical teams to rehearse infrequent and/or high-risk clinical scenarios.

I. **Solicitation of input and participation from patients and families in improving patient safety:** This is accomplished by:
   1. Patient and Family Advisory Council (PFAC)
   2. Conversations with patients and families/care givers during nurse manager, patient representative, or administrative rounds.
   3. Comments from Patient Satisfaction surveys.
   4. Information from Patient Complaints.
   5. Discussions with the patient/family/caregivers regarding adverse outcomes.

J. **Staff Support for those involved in events:**
   1. Managers are trained in Psychological First Aid (PFA)
   2. Critical Incident Support (CIS) is available for those involved in events as needed.
   3. Employee Assistance Program (EAP) is available to all staff and recommended as needed.
   4. The Patient & Staff Support Team (PSST) provides support to staff and guidance for communication with patients and families as needed.

K. **External required and voluntary reporting:** Includes but is not limited to the Minnesota Patient Safety Registry, The Federal Drug Administration via MedSun, Minnesota Department of Health, and the Office of the Ombudsman.

L. **Annual report to the Board:** At least once per year, the following will be reported to the Board in written reports: all system or process failures; the number and type of sentinel events; whether the patients and the families were informed of the event; all actions taken to improve safety, both proactively and in response to actual occurrences; the determined number of improvement projects to be conducted annually; and all results of the analyses related to the adequacy of staffing.

EVALUATION/APPROVAL

The Patient Safety Plan will be reviewed annually with the Quality and Safety Management Committee and revised as necessary. Annual evaluation of the plan's effectiveness will be documented in a report to the board.