1.0 PURPOSE

The purpose of this policy is to reduce risk and harm to patients through a safety system focused on strategies that improve clinical practice.

2.0 SCOPE

This policy and procedure applies to all correctional facilities and their assigned personnel.

3.0 REFERENCES, DEFINITIONS & FORMS

.1 References

a. Hawaii Revised Statutes, Section 26-14.6, Department of Corrections and Rehabilitation; Section 353C-2, Director of Corrections and Rehabilitation, Powers and Duties.

b. Standards for Health Services in Prisons. National Commission on Correctional Health Care, (2018).

c. Standards for Health Services in Jails. National Commission on Correctional Health Care, (2018).

d. Standards for Mental Health Services in Correctional Facilities. National Commission on Correctional Health Care, (2015).

.2 Definitions

a. Adverse Clinical Event: injury or death caused by medical management rather than by the patient's underlying disease or condition.

b. Error Reporting System: includes policies and procedures that outline how health care staff voluntarily identify and report all clinical errors, whether the error occurs by omission or commission.

c. Near Miss Clinical Event: an error in clinical activity without a consequential adverse patient outcome.

d. Patient Safety Systems: practices and/or interventions designed to prevent adverse or near miss-clinical events.

.3 Forms

a. DCR 0428, Medication Error Report

4.0 POLICY

.1 The Health Care Division shall, in conjunction with the facility Clinical Section Administrators, proactively implement patient safety systems to prevent adverse and near-miss clinical events.

.2 The Health Care Division in conjunction with the facility Clinical Section Administrators shall implement an error reporting system for health staff to voluntarily report, in a non-punitive environment, errors that affect patient safety.

5.0 PROCEDURES

.1 All newly hired nursing staff shall undergo a thorough orientation including the successful passing of a medication administration skills test, a complete review of all nursing procedures, departmental policies, and procedures per the orientation policy.

.2 All nursing staff shall undergo an initial and then annual review of Core Competency skills necessary to perform within a correctional setting.

.3 All nursing and provider staff shall receive education on the use and completion of the Clinical Event Report and Medication Error Report [DCR 0428].

.4 All errors and near misses shall be confidentially reported to the responsible health authority (RHA). The RHA shall review each event analyzing what happened during the event and any contributory factors to determine causation. The RHA shall submit a narrative report indicating the results of their analysis and actions or initiatives under taken to address the incident. This data shall be used for event trending, identifying the need for retraining, and formulation of quality improvement initiatives.

a. Incidents involving all other aspects of clinical care including but not limited to nursing, medical records, and dental services shall be routed to the Clinical Services Branch Administrator for review, identification of needed system-wide organizational structure and function improvements, trending and reporting to the QI Committee.

b. Incidents involving mental health staff shall be routed to the Mental Health Branch Administrator for review, identification of needed system-wide organizational structure and function improvements, trending and reporting to the QI Committee.

c. Incidents involving provider practice shall be routed to the Medical Director for review, identification of needed system-wide organizational structure and function improvements, trending and reporting to the QI Committee.

.5 All errors and near misses shall be reported in a non-punitive, supportive environment. Data is used to evaluate for trends, review current practice patterns and ultimately improve patient practice through incorporation into the facility CQI process.

.6 All patients shall present either a picture or picture ID wrist which shall be used for patient identification during medication administration to decrease medication administration errors.

APPROVAL RECOMMENDED:

JAN 0 1 2024

Deputy Director for Corrections Date

APPROVED:

JAN 0 1 2024

DIRECTOR Date

NOT CONFIDENTIAL