Minnesota Hospital Association

MHA Patient Safety Policy Statements

All approved by MHA Patient Safety Committee, 5-2-01

Leadership Policy
Patient safety is a foremost responsibility of the leaders within each health care organization. Health care executives and boards of trustees must pronounce patient safety a high priority, incorporate into their organizational infrastructure, and allocate resources required to initiate and sustain safety programs. Leaders will be accountable to initiate, lead, and oversee patient safety programs. They will champion a 'beyond blame' culture through demonstration and effective communication throughout all levels of their organization. Leaders will establish appropriate policies and procedures that reflect a full disclosure policy. It is recommended that members consider the language from the National Patient Safety Foundation Statement of Principle when developing these policies and procedures, which can be viewed at http://www.npsf.org/statement.htm.

Management Policy
Managers will take an active role in implementing and disseminating 'best practices.' Clinical leaders will provide a safe environment for staff to work in addition to providing a safe environment for patients and their families to receive care, they will encourage staff and patients/family input on ways to improve safety. They will encourage staff and patient/family input on ways to improve safety. Managers will be supportive, in every way possible, to their employees and consumers after a medical accident or 'near accident' occurs and implement processes to prevent replication of the same situation.

Staff Policy
Health care staff including anyone that provides patient care in a facility such as employees, medical staff, and contracted staff will actively take a role in creating a safe environment for themselves, peers, and patients and families through meeting organizational and professional standards, following 'best practices,' proactively intercepting unsafe conditions, and voluntarily reporting accidents and near misses according to policy. Staff will take the responsibility to keep informed of recommended successful practices and safety alerts. They will welcome input from, and involve peers and patients and their families to provide the safest possible care.

(more)

Reporting Systems

- Patient safety reporting systems should be standardized across hospitals and they should leverage existing databases. As the tort system allows, aggregate data should be shared among peers to prevent similar occurrences. Changes to the existing law should be made to allow sharing of information without incurring additional liability.
- Reporting systems should capture events, including “near-misses.” Reporting should be voluntary to encourage a robust reporting system and avoid punitive repercussions.
- Policies should encourage reporting. Reporting systems should focus on all components leading to the event, rather than on the individual at the sharp end. Individuals should not be penalized for reporting, however will be held accountable to professional standards and training.
- The output of reporting systems, aggregate data, will yield information for professionals and consumers.
- Internal reporting processes will encourage open communication to the patient and family following an event, guided by peer review statutes and internal processes.