



Sharp HealthCare

Patient Safety Plan CY 2026 - 2027

Our Commitment

At Sharp HealthCare, we are committed to **high reliability** and achieving **zero harm and zero defects** for employees, providers, patients, and their caregivers. We strive to provide **equitable healthcare** and regularly review data to ensure our services are fair and accessible to all.

Definition of Patient Safety Events

- All adverse events or potential adverse events as described in Section 1279.1 that are determined to be preventable, and health-care-associated infections (HAI), as defined by the CDC's National Healthcare Safety Network.
 - All Serious Safety Events as defined by Press Ganey.
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Structure

1. Patient Safety Committees

Patient safety committees have one or more of the following functions:

- Multidisciplinary team (including providers, nurses, pharmacists, administrators)
 - Review and approve the Patient Safety Plan
 - Receive and review patient safety event reports
 - Monitor implementation of corrective actions for patient safety events, including HAIs
 - Make recommendations to eliminate future patient safety events
 - Review and revise the Patient Safety Plan annually, or more often as needed to incorporate advancements in patient safety practices
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2. Voluntary Incident Reporting System

- Allows anyone involved—including health care practitioners, staff, patients, and visitors—to report patient safety events
- Includes anonymous reporting options



- Encourages a **culture of safety** by promoting open reporting without fear of blame or retaliation
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3. Event Analysis Review Process

- Includes a process for conducting analyses, such as apparent cause analysis and root cause analysis
 - Team is composed of interprofessional members tailored to the specific event, with analysis facilitated by an individual trained in the relevant cause analysis methodology
 - Reviews sociodemographic factors (as voluntarily provided by patients):
Age, race, ethnicity, gender identity, sexual orientation, preferred language, disability status, payor, sex
 - Event analysis and resulting action plans are reviewed and monitored by the Patient Safety Event Review Team (PSERT)
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4. Culture of Safety

- Policies and procedures encourage open reporting without fear of retaliation
 - Dedicated to fostering a **Just and Accountable Culture**, embracing continuous learning, and prioritizing system design improvements
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5. Patient Safety Training

- Ongoing patient safety education for all staff, leaders, and Board Members
 - Includes principles of **High Reliability Organizing (HRO)**
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6. Racism & Discrimination

- Sociodemographic disparities in patient safety events are monitored, and customized intervention strategies are developed to address identified disparities
- Voluntary Incident Reporting System includes questions to identify whether racism or discrimination may have contributed to an event encouraging staff to report suspected instances of racism and discrimination
- Policies and procedures promote anti-discrimination and inclusive language