CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

VOLUME 3: QUALITY MANAGEMENT	Effective Date: 11/26/12
CHAPTER 7: PATIENT SAFETY	Revision Date(s):
3.7.2: ADVERSE/SENTINEL EVENT REVIEW POLICY	Attachments: Yes ☐ No ☒

I. POLICY

Within the health care industry, it is standard practice to identify and review adverse/sentinel health care events that impact patients or personnel. During the review of adverse/sentinel events, health care staff recognize and address system failures, and use this process to prevent similar events from reoccurring in the future.

California Correctional Health Care Services (CCHCS) maintains a system for identifying, reporting, and reviewing adverse/sentinel health care events in accordance with state law and health care industry best practices, which includes processes for:

- Mitigating risk to patients and staff after an adverse/sentinel event has occurred;
- Reporting adverse/sentinel events;
- Referring professional practice issues and blameworthy or criminal acts;
- Reviewing adverse/sentinel events through root cause analysis;
- Development and implementation of action plans to address system lapses and mitigate risk of events reoccurring in the future;
- Evaluating the effectiveness of action plans;
- Issuing statewide alerts if an adverse/sentinel event reveals a problem or issue that all institutions should immediately address or be aware of;
- Recommending modifications to statewide policies and procedures in accordance with findings from adverse/sentinel event reviews; and
- Aggregate reporting about adverse/sentinel event review findings that may be used to inform performance improvement efforts.

II. PURPOSE

This policy and associated procedures define and standardize the process for identifying, reporting, reviewing, and managing cases determined to be adverse/sentinel events in order to reduce the occurrence of preventable deaths and adverse patient outcomes.

III. DEFINITIONS

Adverse/Sentinel Event: An event or series of events that cause the death or serious disability of a patient, personnel, or visitor. "Serious disability" means a physical or mental impairment that substantially limits one or more of the major life activities of an individual, or the loss of bodily function, if the impairment lasts more than seven days or is still present at the time of discharge, or unintentional loss of a body part. For the purposes of this procedure, adverse events include sentinel events as described in the Health and Safety Code 1279.1 and unusual occurrences as described in Title 22, Division 5, Chapter 1, Article 7, Section 70737, described in Attachment I.

IV. APPLICABILITY

This policy applies to all CCHCS employees. Failure to comply with policy mandates may, in appropriate cases, result in possible adverse action commensurate with the act or omission.

V. RESPONSIBILITIES

Responsibility for implementation of this policy and associated procedure(s) is delegated to the Chair of the Headquarters' Patient Safety Committee, and to the headquarter chief executives in each health care discipline. The Chief Executive Officer at each institution is responsible for implementation of this policy and associated procedures at his or her assigned institution.

VI. REFERENCES

Joint Commission on Accreditation of Health Care Organizations (JCAHCO)

National Commission on Correctional Health Care (NCCHC) 2008 Standards for Health Services in Prisons

California Health and Safety Code Sections 1250 and 1279

California Code of Regulations, Title 22, Division 5, Chapter 1, Article 7, Section 70737

Inmate Medical Services Policies and Procedures (IMSP&P) Volume 3, Chapter 7:

- 3.7.1 Patient Safety Program Policy
- 3.7.3 Death Reporting and Review Policy
- 3.7.4 Patient Safety Program Procedure: Patient Safety Committee
- 3.7.5 Patient Safety Program Procedure: Initial Triage/Assessment of Adverse/Sentinel Events
- 3.7.6 Patient Safety Program Procedure: Institution Response to an Adverse/Sentinel Event
- 3.7.7 Patient Safety Program Procedure: Headquarters Adverse/Sentinel Event Committee
- 3.7.8 Death Reporting and Review Procedure

United States Department of Veterans Affairs - Veterans Affairs National Center for Patient Safety (NCPS) (http://www.patientsafety.gov/); Culture Change: Prevention, Not Punishment (http://www.patientsafety.gov/vision.html)