CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

VOLUME 3: QUALITY MANAGEMENT	Effective Date: 11/26/12
CHAPTER 7: PATIENT SAFETY	Revision Date(s):
3.7.5: PATIENT SAFETY PROGRAM PROCEDURE: INITIAL TRIAGE/ASSESSMENT OF ADVERSE / SENTINEL EVENTS	Attachments: Yes ☐ No ☒

I. PROCEDURE OVERVIEW

The California Correctional Health Care Services (CCHCS) staff is required to report adverse/sentinel events to headquarters within 24 hours of occurrence. This procedure appoints a group of Sentinel Event Review Executives (SEREs) to perform an initial review of adverse/sentinel events to ensure that:

- Any immediate danger to patients or staff is resolved quickly and effectively.
- Information about the adverse/sentinel event is referred as appropriate.
- Institution staff is provided with direction as to whether a root cause analysis is required.

In the event that an adverse/sentinel event is discovered by a person or entity not employed at an institution, such as court experts, SEREs are responsible for immediately conveying information about the adverse/sentinel event to institution staff.

II. PROCEDURE DETAILS

A. Sentinel Event Review Executives

1. Appointment Process

   The CCHCS Patient Safety Committee will appoint representatives from multiple health care disciplines to serve as SEREs. Participation in adverse/sentinel event reviews will vary in accordance with the nature of the adverse/sentinel event.

2. Responsibilities

   a. The SEREs will meet daily to review all adverse/sentinel events submitted the business day prior and will determine the appropriate disposition for review.

      1) Any identified allegation of a blameworthy act shall result in coordination with the appropriate investigatory agency for investigation and response. For all adverse events referred to an investigatory agency, root cause analysis shall be deferred until the investigatory agency provides further direction to the institution.

      2) Institution staff will be required to complete a root cause analysis for adverse/sentinel events not referred to an appropriate investigatory agency. The SEREs may recommend that institutions group multiple adverse/sentinel events with similar characteristics at the same institution into one root cause analysis.

      3) Adverse/sentinel events with identified professional practice concerns will be referred to the appropriate Peer Review Committee. The SEREs will coordinate with peers of the appropriate discipline to determine whether clinical staff involved in the adverse event should be removed from providing patient care

pending further analysis of the event. For adverse events that result in peer review referrals or temporary redirection of health care staff from direct patient care, the root cause analysis continues without delay or deferral.

4) All patient-inmate deaths will undergo a clinical review conducted by a headquarters primary care provider and nurse team as described in the Inmate Medical Services Policies and Procedures (IMSP&P) Volume 3, Chapter 7, 3.7.8 Death Reporting and Review Procedure.
5) If requested, or if the adverse event is difficult to address, controversial, and/or likely to attract media coverage, SEREs will link institution staff with headquarters staff to provide technical assistance, consultation, and facilitation.
6) The SEREs will notify clinical executives that provide oversight to the impacted discipline/health care areas.

b. The Chief Executive Officer shall ensure that institution staff completes root cause analysis for identified adverse/sentinel events, including events that have been identified by staff at headquarters or by other stakeholder groups.

III. 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
- 3.7.2 Adverse/Sentinel Event Review Policy
- 3.7.3 Death Reporting and Review Policy
- 3.7.4 Patient Safety Program Procedure: Patient Safety Committee
- 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)