CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

VOLUME 3: QUALITY MANAGEMENT	Effective Date: 11/26/12
CHAPTER 7: PATIENT SAFETY	Revision Date(s):
3.7.7: PATIENT SAFETY PROGRAM PROCEDURE: HEADQUARTERS ADVERSE/SENTINEL EVENT COMMITTEE	Attachments: Yes ☐ No ☒

I. PROCEDURE OVERVIEW

This procedure establishes a headquarters Adverse/Sentinel Event Committee to:

- Provide oversight and support to the root cause analysis process at institutions;
- Review Adverse/Sentinel Event Reports submitted by institutions to ensure that the analysis is thorough and credible, and that action plans adequately address the system lapses that led to the adverse/sentinel event, and provide guidance to institutions as necessary;
- Monitor implementation of action plans and provide assistance as required;
- Issue statewide alerts if an adverse/sentinel event reveals a problem or issue that all institutions should immediately address or be aware of;
- Advocate for changes to statewide policies and procedures in accordance with findings from adverse/sentinel event reviews; and
- Issue an aggregate report about adverse/sentinel event review findings that may be used to inform performance improvement efforts.

II. 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 California Health and Safety Code 1279.1 and unusual occurrences as described in Title 22, Division 5, Chapter 1, Article 7, Section 70737.

Hiring Authority: Entity with the power to make personnel decisions, such as appointing new staff or taking other personnel action, including employee discipline. Different staff may assume this authority, depending on the level of the organization. For example, the hiring authority for institution health care staff is generally the institution's Chief Executive Officer (CEO). At headquarters, the hiring authority may be a manager or executive over a specific program area.

III. RESPONSIBILITIES

Responsibility for implementation of this policy and associated procedure(s) is delegated to the Chair of the Patient Safety Committee, and to the chief executives in each health care discipline (Medical, Nursing, Mental Health, Dental, and Allied Health) . The CEO at each institution is responsible for implementation of this policy and associated procedures at his or her assigned institution.

IV. PROCEDURE DETAILS

A. Headquarters Adverse/Sentinel Event Committee

1. Committee Purpose
   a. California Correctional Health Care Services (CCHCS) will maintain an Adverse/Sentinel Event Committee at headquarters as an inter-disciplinary forum to promote patient safety and improvements to the health care services delivery system by:
      - Taking action to address immediate patient safety concerns through the Initial Review process, and making referrals to the hiring authority (for investigation by an investigatory agency) and the appropriate peer review process in accordance with current policy;
      - Ensuring that institutions complete root cause analyses for identified adverse/sentinel events, including events that have been identified by staff at headquarters or by other stakeholder groups;
      - Ensuring that institutions receive consultation, facilitation, and other types of technical assistance as requested or needed during the root cause analysis process;
      - Reviewing and approving Adverse/Sentinel Event Reports and associated action plans;
      - Monitoring the implementation of action plans to ensure that identified institution level system or process issues are resolved and similar adverse/sentinel events are prevented in the future, and providing additional support to institution implementing action plans as necessary;
      - Identifying system or processes lapses that may have impact statewide and issuing Patient Safety Alerts;
      - Communicating adverse event information to health care staff executives and other committees and program areas and coordinating committee activities with the activities or initiatives of other health care committees and programs;
      - Producing an annual report of adverse/sentinel event information for the Patient Safety Committee; and
      - Supporting an organizational culture of continuous learning and improvement.
2. Committee Membership, Meeting Frequency, and Quorum Requirements
   a. The CCHCS Patient Safety Committee will appoint the members of the headquarters Adverse/Sentinel Event Committee as appropriate from each respective health care discipline (Medical, Nursing, Mental Health, Dental and Allied Health).
   b. Committee members will nominate and elect one committee member to serve one year as Chairperson. The Chairperson is responsible for ensuring that the headquarters Adverse/Sentinel Event Committee meets regularly, the committee agenda reflects the responsibilities and actions described in this procedure, and committee decisions are appropriately documented.

c. All members may choose a designee to serve in their stead, subject to approval by the full committee.

d. The headquarters Adverse/Sentinel Event Committee will meet at least monthly, and more often as necessary. Each members has one vote, and a quorum exists when one-half of the voting members are present.

3. Reporting Structure

The headquarters Adverse/Sentinel Event Committee reports to the CCHCS Patient Safety Committee.

4. Committee Responsibilities

a. Oversight and Support of Institution Adverse/Sentinel Event Review Process.

Most adverse/sentinel events will be discovered at the point of care by institution staff. However, some adverse/sentinel events may be identified by a person or entity not employed at an institution, such as other stakeholder groups. Upon notification that an adverse/sentinel event has occurred, the headquarters Adverse/Sentinel Event Committee will ensure that:

1) Information about the adverse/sentinel event is entered into a tracking system or database;

2) Institutions that have requested assistance with root cause analysis receive support as appropriate;

3) Institutions submit root cause analysis reports and corrective action plans per procedure timeframes and requirements in state law; and

4) Referrals to the hiring authority (for investigation by an investigatory agency), the appropriate peer review process, or other program areas have been communicated as appropriate

b. Review and Approval of Adverse/Sentinel Event Reports

1) The headquarters Adverse/Sentinel Event Committee will review all Adverse/Sentinel Event Reports to ensure that:

- All necessary actions have been taken to stabilize the patient, support the health care staff involved, and communicate the event;
- Appropriate referrals have been made to the hiring authority (for investigation by an investigatory agency), appropriate peer review bodies, and other program areas;
- The root cause analysis conducted was thorough and credible, per criteria specified in the CCHCS Root Cause Analysis Procedure; and
- The action plan adequately addresses local system and process lapses.

2) The headquarters Adverse/Sentinel Event Committee will request revisions and clarification to Adverse/Sentinel Event Reports as appropriate.

3) Upon approving an Adverse/Sentinel Event Report, the headquarters Adverse/Sentinel Event Committee will begin a four-month monitoring period to provide oversight and support to institutions implementing action plans.

c. Action Plan Monitoring

1) For four months following the approval of an Adverse/Sentinel Event Report, the headquarters Adverse/Sentinel Event Committee will review status reports from the institution regarding action plan implementation and data measuring the success of system changes.

2) If required, institutions will be provided with technical assistance, including on-site support, partnership with institutions that have faced similar issues, and information about best practices within CCHCS and at other health care organizations.

3) At the end of the monitoring period, the headquarters Adverse/Sentinel Event Committee will assess whether system or process issues have been adequately addressed and, if appropriate, close the case.

4) In some instances, the committee will provide additional feedback and support to the institution, and extend the monitoring period to allow the institution more time to address system or process issues.

d. Patient Safety Alerts

If an adverse/sentinel event raises an issue that has statewide implications, such as a problem with commonly used equipment or medication, the headquarters Adverse/Sentinel Event Committee will coordinate with the appropriate health program area to issue a statewide Patient Safety Alert to all facilities, with a description of the problem and recommendations or instructions for mitigating risk to patients and staff.

e. Recommendations for Changes to Statewide Processes, Policies, Etc

1) In the course of reviewing adverse/sentinel events, the headquarters Adverse/Sentinel Event Committee will consider whether changes to statewide policy, procedures, processes, information systems, or other systems might improve patient safety.

2) The headquarters Adverse/Sentinel Event Committee will elevate all recommended changes to statewide systems or processes to the CCHCS Patient Safety Committee for consideration.

f. Coordination with Other Committees and Program Areas

In compliance with relevant confidentiality provisions, the headquarters Adverse/Sentinel Event Committee will collaborate with other standing committees and program areas to complete adverse/sentinel event reviews and share information related to adverse/sentinel events, including, but not limited to:

- Sharing the disposition of adverse/sentinel events with relevant committees or program areas;
- Providing information about trends in certain categories with relevant stakeholders, such as reporting medication error trends and system and process concerns to the Pharmacy and Therapeutics Committee;
- Referring information or making recommendations for program changes to other committees and program areas; and

- Coordinating with other committees or program areas when an initiative under the committee or program's purview relates to an individual adverse event or a trend in adverse events.

g. Statewide Adverse Event Reporting

At least annually, the headquarters Adverse/Sentinel Event Committee will issue a report that aggregates information about all adverse/sentinel events that occurred during the reporting period. Adverse/sentinel event data will be analyzed and, where possible, trended over time. Statewide adverse/sentinel event reports will include, but are not limited to, the following information:

- Number of adverse/sentinel events reported by event type;
- Most common root causes identified during root cause analysis;
- Actions by individual institutions and organization-wide to address common root causes; and
- Identified best practices.
- Summary of Patient Safety Alerts issued during the reporting period
- Recommendations from the headquarters Adverse/Sentinel Event Committee for further activities to improve patient care

B. Confidentiality

1. Protected Proceedings and Records

a. It is critical that the proceedings and records of the adverse/sentinel event review process be maintained as confidential and not be available to unauthorized persons or organizations.

b. All staff participating in the adverse/sentinel event review process discussed in this procedure shall adhere to these provisions regarding confidentiality.

c. The records of the committees and staff responsible for the evaluation and improvement of the quality of patient care shall be maintained as confidential where required by California law.

V. 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

- 3.7.5 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
- 3.7.8 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)