OREGON STATE HOSPITAL

PORTLAND – SALEM

POLICIES AND PROCEDURES

SECTION 2:	Clinical Support	**POLICY: 2.012**
SUBJECT:	**Sentinel Events**	
POINT PERSON:	TED FICKEN DIRECTOR STANDARDS & COMPLIANCE	
APPROVED:	GREGORY P. ROBERTS SUPERINTENDENT	**DATE: JUNE 11, 2012**

I. POLICY

Oregon State Hospital shall review all Sentinel Events and implement a process to understand and address the factors that contribute to the events.

Oregon State Hospital shall ensure an organizational culture conducive to identification, reporting, analysis, and prevention of Sentinel Events. Oregon State Hospital shall ensure the consistent and effective implementation of a mechanism to accomplish these activities. Any time a Sentinel Event occurs, or when otherwise directed by the Superintendent for serious incidents that do not meet the definition of a Sentinel Event, Oregon State Hospital shall complete a thorough and credible Root Cause Analysis (RCA), implement improvements to reduce risk, and monitor the effectiveness of the improvements, as part of its ongoing performance improvement efforts.

II. DEFINITIONS

A. "Sentinel Event" means an unexpected occurrence involving death, serious physical or psychological injury, or risk thereof. Serious injury includes loss of limb or function. The phrase, "or the risk thereof," includes any process variation for which a reoccurrence would carry a significant chance of a serious adverse outcome. Such events are called "sentinel," because they signal the need for immediate investigation and response. The terms "sentinel event" and "error" are not synonymous: not all sentinel events occur because of an error, and not all errors result in sentinel events. The subset of sentinel events that is subject to review by the Joint Commission includes any occurrence that meets the following criteria:

1. The event has resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition.

2. The event is one of the following, even if the outcome was not death or major permanent loss of function unrelated to the natural course of the patient's illness or underlying condition.

   a. Suicide of any patient receiving care, treatment and services in a staffed around-the-clock setting, or within 72 hours of discharge.

   b. Elopement (unauthorized leave) of a patient resulting in a temporally related death (suicide or homicide) or major permanent loss of function.

   c. A patient fall that results in death or major permanent loss of function as a direct result of the injuries sustained in the fall.

   d. Abduction of any patient receiving care, treatment and services.

   e. Sexual abuse/assault (including rape) is defined as unconsented sexual contact involving a patient and another patient, staff member, or unknown perpetrator while being treated or on the premises of the organization, including oral, vaginal or anal penetration or fondling of the patient's sex organ(s) by another individual's hand, sex organ, or object. One or more of the following must be present to determine reviewability:

      1. Any staff-witnessed sexual contact as described above.

      2. Sufficient clinical evidence obtained by the organization to support allegations of unconsented sexual contact.

      3. Admission by the perpetrator that sexual contact, as described above, occurred on the premises.

   f. All identified cases of unanticipated death or major permanent loss of function associated with a healthcare-associated infection, assault, homicide, or other crime.

   g. Any patient death, paralysis, coma, or other major remnant loss of function associated with a medication error.

B. "Major permanent loss of function" means sensory, motor, physiologic, or intellectual impairment not present on admission requiring continued treatment or lifestyle change. When a major permanent loss of functioning cannot be immediately determined, reporting is not expected until either the patient is discharged with continued major loss of function, or two weeks have elapsed with persistent major loss of function, whichever is the longer period.

C. "Root Cause Analysis (RCA)" is a process for identifying the basic or contributing factors that underlie variations in performance associated with Sentinel Events. An RCA is a specific type of focused review that may be used for Sentinel Events that require further analysis.

III. PROCEDURES

A. The following incidents are considered serious and require immediate notification of the Communications Center, whether occurring on or off campus. The Communications Center shall then notify all required management and administrative personnel as indicated on the Critical Incident Contact Grid. If a Sentinel Event occurs with a patient from the Portland campus, the Program Nursing Supervisor (PNS) or lead Registered Nurse (RN) is to be immediately notified, and shall make the call to the Communications Center.

1. Any unexpected death, including any that result from seclusion or restraint use, or during an elopement.

2. The suicide of any patient receiving care, treatment and services in a staffed around-the-clock setting or within 72 hours of discharge.

3. The elopement (unauthorized leave) of a patient resulting in a temporally related death (suicide or homicide) or major loss of function.

4. A patient fall resulting in death or major permanent loss of function as result of the injuries sustained in the fall.

5. The abduction of any patient receiving care, treatment, and services.

6. Rape

7. All identified cases of unanticipated death or major permanent loss of function associated with a health care associated infection.

B. Employees are to report any unsafe conditions of which they are aware to their immediate supervisor, even if the conditions have not yet resulted in a Sentinel Event.

C. The Superintendent shall determine the action to be taken, and whether or not a Root Cause Analysis is required. If it is determined that a reviewable Sentinel Event has occurred, the Director of Standards & Compliance shall report the Sentinel Event to The Joint Commission.

D. All Root Cause Analyses undertaken at Oregon State Hospital are to be done in consultation with the Standards & Compliance Department. A Root Cause Analysis assigned by the Superintendent shall be completed within 45 calendar days.

E. Completion of the RCA is the responsibility of the Director of Standards & Compliance, Chief Medical Officer, Director of Nursing Services, and assigned Program Director. The Standards & Compliance Department shall coordinate the completion of the RCA.

F. All Oregon State Hospital employees have the option of reporting quality of care or safety concerns directly to the Joint Commission, even if those concerns do not rise to the level of being Sentinel Events.

G. Characteristics of a Root Cause Analysis (RCA) include:

1. A Root Cause Analysis is a process for identifying the basic or contributing causal factors that underlie variations in performance associated with Sentinel Events.

2. A RCA review is interdisciplinary in nature, with involvement of those knowledgeable about the processes involved in the event.

3. The analysis focuses primarily on systems and processes rather than individual performance.

4. The analysis repeatedly digs deeper by asking "What?"" and "Why?" until all aspects of the process are reviewed and contributing factors are considered.

5. The analysis identifies changes that could be made in systems and processes through either redesign or development of new processes, or systems that would improve performance and reduce the risk of a Sentinel Event.

6. To help adhere to these characteristics, the following five guidelines need to be considered when developing root cause statements:

a. Root cause statements need to include the cause and effect.

b. Negative descriptions are not to be used in root cause statements.

c. Each human error has a preceding cause.

d. Violations of procedure are not root causes, but must have a preceding cause.

e. Failure to act is only a root cause when there is a pre-existing duty to act.

7. To be thorough, a Root Cause Analysis is to include:

a. A determination of the human and other factors most directly associated with the Sentinel Event and the processes and systems related to its occurrence.

b. Analysis of the underlying systems through a series of "Why?" questions to determine where redesign might reduce risk.

c. An inquiry into all areas appropriate to the specific type of event as described in the Comprehensive Accreditation Manual for Hospitals (SE-11, Table 3).

d. Identification of risks and their potential contributions to the Sentinel Event.

e. Determination of potential improvement in processes or systems that would tend to decrease the likelihood of such events in the future, or a determination, after analysis, that no such improvement opportunities exist.

8. To be credible, a Root Cause Analysis must:

a. Include participation by the leadership of the organization. This participation can range from chartering the RCA team, to direct participation on the RCA team, to participation in the determination of the corrective action plan. The RCA is to include individuals most closely involved in the processes and systems under review.

b. Be internally consistent, not contradict itself, and not leave obvious questions unanswered.

c. Provide an explanation for all findings of "not applicable" or "no problem".

d. Cite any books or journal articles that were considered in developing the analysis and action plan.

9. At the completion of a Root Cause Analysis, an action plan shall be generated that identifies strategies to reduce the risk of similar events occurring in the future. The results shall be shared with all affected employees. Copies of the final RCA shall be sent to the Program Directors. The action plan shall include actions to be taken, responsible staff, target dates for implementation, and measurement strategies to determine the effectiveness of the actions. Required reports to the Joint Commission shall be made by the Standards & Compliance Department. Oregon State Hospital shall track the completion of the risk reduction strategies and action steps via the monthly Quality Council meetings and shall document those in the meeting minutes.

V. REFERENCES

Joint Commission Comprehensive Accreditation Manual for Hospitals and for Behavioral Health, January 2009.

Department of Human Services (DHS) Administrative Rules, April 2007:

1. Reporting Serious Adverse Events (325-010-0025)
2. Hospital Reporting of Less Serious Adverse Events or Close Calls (325-010-0030.
3. Commission Review of Reports (325-010-0035).
4. Patient Notification of Reportable Serious Adverse Events (325-010-0045).
5. Extensions And Waivers (325-010-0050).

Replaces OSH Policy and Procedure 2.012, *Sentinel Events,* dated 2/24/2009.