OREGON STATE HOSPITAL

POLICY ATTACHMENT

PROCEDURE A:	Required Response to a Sentinel Event or Other Qualifying Event	**POLICY: 2.012**
POINT PERSON:	Director of Quality Management	
APPROVED:	Superintendent	**DATE: FEBRUARY 16, 2024**
SELECT ONE:	(●) New policy attachment ( ) Reaffirmation of existing policy attachment	( ) Minor/technical revision of existing policy attachment ( ) Major revision of existing policy attachment

PLEASE NOTE THAT ALL CHANGES WILL BE MADE AS TRACK CHANGES. TO CLEAR AND ACCEPT

RESPONSIBLE PERSON/GROUP	PROCEDURES
Staff	**Response to a potential sentinel event:** 1. Ensure all individuals involved are safe and/or moved into a safe area (staff and patients included) 2. Staff must follow incident reporting policy 1.003, "Incident Reporting," refer to 1.003 Procedures A for code specific reporting. 3. If staff are injured as a result of a sentinel event, complete an injury and illness report in workday.
Immediate Supervisor or Manager	1. If indicated per ORS 192.567 or at the request of the patient, notify the patient's contacts of the event and support individuals involved and staff as needed. 2. If staff is injured and cannot complete an injury and illness report in Workday, submit a report on the staff's behalf as outlined in OSH Policy & Procedure, 5.012, "Injury or Illness Reporting." 3. If staff is unable to complete an incident report, submit a report on the staff's behalf as outlined in OSH Policy & Procedure, 1.003, "Incident Reporting." 4. Provide staff with Employee Assistance Program resources, upon request.
Incident Reporting Systems	1. Prioritize and immediately screen all patient safety events; 2. Determine, based on screening, what may be an adverse event; 3. Send incident reports that may be considered sentinel to the Superintendent or designee for review.

Investigation (IRSI) Team	**If the patient safety event is determined to be a sentinel event:** 4. Begin IRSI investigation per the Superintendent or designee's direction
Superintendent or Designee	1. Consult with clinical leadership and other staff to determine the action to be taken in response to a patient safety event, including whether a comprehensive systemic analysis is required. The Superintendent may delegate this authority as needed. NOTE: OSH may contact the Department of Justice to establish attorney/client privilege. 2. The use of this workflow outside of a sentinel event is at the discretion of the Superintendent or Designee. 3. Notify IRSI of the patient safety event determination (sentinel or not sentinel) and any follow up action requirements, such as a corrective action plan. **Reporting:** 4. Ensure timely completion of all patient safety event reviews. 5. The Superintendent or designee may choose to self-report the sentinel event to The Joint Commission by completing the required forms and following procedures outlined in The Joint Commission Sentinel Events (SE) policy. a. Self-reporting a sentinel event to The Joint Commission is not required. There is no difference in the expected response, time frames, or review procedures whether the hospital voluntarily reports the event, or The Joint Commission becomes aware of the event by some other means.
IRSI Director	**If the patient safety event is determined to be a sentinel event:** 1. Assign the director for the program in which the event occurred to begin coordination of the Clinical/Administrative Debrief Meeting (CADM) process per Procedures B; and 2. Assign the Director of Standards & Compliance to begin coordination of a comprehensive systemic analysis, such as a Root Cause Analysis (RCA), per the Superintendent or designee's direction. 3. Assign investigation to an IRSI investigator. 4. Based on severity of event, CIR may assign a lead and direct other staff to help complete the work using an internal team approach 5. See Procedures D for IRSI Investigative process
Director of Standards &	**If the patient safety event is determined to be a sentinel event and an RCA is conducted:**

Compliance or Designee	1. With direction from the Superintendent, report the event to TJC. a. This report must include i. What happened, including the time, date, and location, ii. Extent of injury, iii. Role(s) of individuals involved, iv. Ethnicity of individual(s) involved, v. Race of Individual(s) involved, vi. Primary language of individual(s) involved, vii. Gender of individual(s) involved, viii. Age of individual(s) involved. 2. Complete the comprehensive systemic analysis and corrective action plan for sentinel event within 45 business days of the known occurrence of the event. 3. Share results of the comprehensive systemic analysis for sentinel events and recommendations with hospital executive leadership or designee. 4. Responsible to input the notification and follow up communications into TJC portal. 5. Monitor TJC communications under continuous compliance until the case is deemed closed by The Joint Commission. Follow up Actions 6. OSH must track the completion of the risk reduction strategies and action steps outlined in the corrective action plan 7. If The Joint Commission assigns a follow-up activity, the Director of Standards & Compliance or Designee must add the activity to the internal tracker and notify the item owner and other appropriate staff for completion and reporting of the activity.