OREGON STATE HOSPITAL

POLICY

SECTION 2:	Clinical Support	**POLICY: 2.012**
SUBJECT:	Sentinel Events	
POINT PERSON:	Director of Quality Management	
APPROVED:	Dolores Matteucci *Dolores Matteucci* Superintendent	**DATE: FEBRUARY 16, 2024**

SELECT ONE:

- ○ New policy
- ○ Minor/technical revision of existing policy
- ○ Reaffirmation of existing policy
- ◉ Major revision of existing policy

I. PURPOSE AND APPLICABILITY

A. Oregon State Hospital (OSH) promotes an organizational culture conducive to identifying, reporting, analyzing, and preventing patient safety events, including sentinel events. This policy establishes OSH's response to patient safety events, including sentinel events.

B. This policy applies to all staff.

II. POLICY

A. OSH reviews patient safety events through established review processes to understand the contributing factors that resulted in the event occurrence.

B. Patient safety events that are not considered sentinel may be reviewed through a process which may include risk identification and corrective action plan implementation or sustainment.

1. Investigation actions for patient safety events shall be assigned per OSH policy 1.003 "Incident Reporting" and Incident Reporting Systems Investigation (IRSI) team protocols.

C. This policy must be read in conjunction with other patient safety event-related policies, including:

1. OSH policy 1.003, "Incident Reporting";
2. OSH policy 6.005, "Deceased Patient";
3. OSH policy 6.016, "Sexual Activity Involving Patients";

4. OSH policy 6.046, “Fall Prevention Program”;
5. OSH policy 7.008, “Patient Abuse or Mistreatment Allegation Reporting”;
6. OSH policy 8.018, “Unauthorized Leave”;
7. OSH policy 8.019, Staff Response to Alleged Criminal Acts”; and
8. OSH policy 8.038, “Code Blue Medical Emergency”.

D. When the hospital is uncertain that a patient safety event is a sentinel event, the event will be presumed not to be a sentinel event unless determined otherwise through further investigation or presentation of relevant information.

E. When a potential sentinel event has occurred, OSH staff must do the following:

1. Stabilize of the involved patient, notify the patient and patient’s contacts (if applicable per ORS 192.567**)** of the event, and complete proper documentation per Procedures A;
2. Identify short term actions to mitigate the risk of a similar event occurring again per Procedures B;
3. A complete comprehensive systemic analysis resulting in a corrective action plan per Procedures C and D;
4. Implement improvements to reduce risk; and
5. Monitor the effectiveness of the improvements as part of its ongoing performance improvement efforts.

F. OSH follows all applicable regulations, including federal and state statutes and rules; Oregon Department of Administrative Services (DAS), Shared Services, and Oregon Health Authority (OHA) policies; and relevant accreditation standards. Such regulations supersede the provisions of this policy unless this policy is more restrictive.

G. Staff who fail to comply with this policy or related policy attachments or protocols may be subject to disciplinary action, up to and including dismissal.

III. DEFINITIONS

A. “After surgery” is defined as any time after completion of final skin closure, even if the patient is still in the procedural area or in the operating room under anesthesia.

B. “Adverse event” means a patient safety event that resulted in harm to a patient. Adverse events should prompt notification of organization leaders, investigation, and corrective actions. An adverse event may or may not result from an error.

C. “Clinical/Administrative Debrief Meeting” (CADM) Is an OSH internal process that is directed by the Superintendent and occurs directly after the report of an adverse patient event has been triaged by IRSI. A CADM team conducts staff interviews and documentation review to identify initial actions that may be taken quickly to mitigate the risk of a similar event occurring again. (Please see Procedure B for Policy 2.012)

D. “Comprehensive systemic analysis” is a process for identifying the causal and contributing factors that underlie variations in performance.

E. “Close call” means a patient safety event that did not cause harm but posed a risk of harm to the patient. Also called a near miss or good catch.

F. “Hazardous condition” means a circumstance (other than a patient’s own disease process or condition) that increases the probability of an adverse event. Also called “unsafe condition.”

G. “Invasive procedure” is defined as a procedure in which skin or mucous membranes and/or connective tissue are incised or punctured, an instrument is introduced through a natural body orifice, or foreign material is inserted into the body for diagnostic or treatment-related purposes. Venipuncture is not considered an invasive procedure for the purposes of this policy.

H. “No-harm event” means a patient safety event that reaches the patient but does not cause harm.

I. “Patient safety event” means an event, incident, or condition that could have resulted or did result in harm to a patient. Patient safety events include adverse events, no-harm events, close calls, hazardous conditions, and sentinel events.

J. “Permanent harm” means an event or condition that reaches the individual, resulting in any level of harm that permanently alters and/or affects an individual’s baseline.

K. “Root Cause Analysis” (RCA) is a process OSH completes after commission by the Superintendent in partnership with The Joint Commission (TJC). It is conducted by an internal team of subject matter experts (SMEs) over the course of 4 days. An RCA may consist of interviewing staff, reviewing policy/procedure/protocol, and reviewing documentation. The goal is to identify system gaps and corrective action plans (CAPs) to mitigate the identified gaps

and prevent reoccurrence of similar events from happening. This is an in-depth process that takes from one to three months to complete and submit to TJC. Ongoing measures of success are submitted to TJC as requested. (Please see Procedure TBD for Policy 2.012)

L. “Sentinel event” (SE) is a subcategory of adverse events. A sentinel event is a patient safety event (not primarily related to the natural course of the patient’s illness or underlying condition) that reaches a patient and results in death, severe harm (regardless of duration of harm), or permanent harm (regardless of severity of harm).

Please see Attachment A for specific examples of sentinel events more apt to happen in a Behavioral Healthcare Inpatient Hospital setting and sentinel events that are unlikely to occur in a Behavioral Healthcare Inpatient Hospital setting.

M. “Severe harm” an event or condition that reaches the individual, resulting in life-threatening bodily injury (including pain or disfigurement) that interferes with or results in loss of functional ability or quality of life that requires continuous physiological monitoring and/or surgery, invasive procedure, or treatment to resolve the condition.

N. “Sexual abuse” is as defined by ORS 430.735(13). The definition of sexual abuse includes any incident which meets the definition of sexual assault, as well as incidents of non-consensual sexual behavior without sexual contact. An example of this includes but is not limited to exposing one’s genitals to someone else without their consent. (If any sexual behavior occurs in which one party is a staff and the other is a patient, it is always considered assault or abuse, even if the patient asserts that they consented.)

O. "Sexual assault” means an incident of sexual contact between patients, patient to staff, staff to patient or non-consensual staff to staff where criminal activity is alleged to have occurred as defined by Oregon Criminal Code, including, but not limited to, non-consensual sexual intercourse or penetration, and those acts involving an alleged victim who lacks capacity to consent to sexual contact.

P. “Sexual contact” is defined by ORS 163.305 and means any touching of the sexual or other intimate parts of a person or causing such person to touch the sexual or other intimate parts of the actor for the purpose of arousing or gratifying the sexual desire of either party.

"NOTE: Organizations are required to conduct an investigation and protect an individual(s) from non-consensual sexual relations any time the organization has reason to suspect that the individual(s) does not wish to engage in sexual activity or may not have the cognitive or legal ability to consent.

Q. "Significant attempt of unauthorized leave" means a patient tried an unauthorized leave and had the means and capability to be successful but was not successful. Examples of a significant attempt of unauthorized leave include, but are not limited to:

1. A patient attempts to depart the secure perimeter and makes it inside a sallyport but does not depart OSH secure perimeter.
2. A patient is physically restrained while attempting to leave OSH property boundary when outside the secure perimeter.
3. A patient attempts to scale a secure perimeter wall but does not exit the secure perimeter.

R. "Staff" includes employees, volunteers, trainees, interns, contractors, vendors, and other state employees assigned to work at OSH.

S. "Unanticipated death" a patient death that could not be reasonably predicted based on known medical conditions, as determined by the Chief of Medicine or designee.

T. Unauthorized leave" means a patient:

1. Successfully leaves OSH boundaries without reasonable ability for staff to pursue the patient, or
2. Leaves the supervision of staff without authorization and is out of the line of sight while outside the secure perimeter (this includes a patient overstaying an off-grounds pass).

IV. PROCEDURES

Procedures A	Required Response to a Sentinel Event or other Qualifying Event
Procedures B	Clinical/Administrative Debrief Meeting (CADM) Process
Procedures C	Root Cause Analysis (RCA) Process
Procedures D	IRSI Investigation Process

V. ATTACHMENTS

Attachment A Qualifying Sentinel Events

VI. RELATED OSH POLICIES AND PROTOCOLS

1.001 Policy System at Oregon State Hospital

1.003 Incident Reporting

6.003 Seclusion and Restraints

6.005 Deceased Patient

6.016 Sexual Activity Between Patients

6.046 Fall Prevention Program

6.059 Animals at Oregon State Hospital

7.008 Patient Abuse or Mistreatment Allegation Reporting

8.001 Video Surveillance

8.004 Criminal Offender Information Access

8.018 Unauthorized Leave

8.019 Staff Response to Alleged Criminal Acts and Contraband

8.038 Code Blue Medical Emergency

Medical Department Protocol 1.003 Psychiatry Notes

Safety and Security Department Protocol 3.012 OSH Notifications and Critical Incident Process

Safety and Security Department Protocol 5.007 Communications Log

VII. REFERENCES

Condition of Participation: *Patient's Rights*, 42 CFR §482.13.

(CMS) 482.21(a)(2)

Condition of Participation: *Physical Environment*, 42 CFR §482.41.

Condition of Participation: *Quality Assessment and Performance Improvement Program*, 42 CFR §482.21.

Condition of Participation: *Radiologic Services*, 42 CFR §482.26.

Joint Commission Resources, Inc. (2021). *The joint commission comprehensive accreditation manual for hospitals*, EC.02.01.01. Oakbrook Terrace, IL: Author.

Joint Commission Resources, Inc. (2021). *The joint commission comprehensive accreditation manual for hospitals*, LD.03.02.01. Oakbrook Terrace, IL: Author.

Joint Commission Resources, Inc. (2021). *The joint commission comprehensive accreditation manual for hospitals*, LD.03.09.01. Oakbrook Terrace, IL: Author.

Joint Commission Resources, Inc. (2021). *The joint commission comprehensive accreditation manual for behavioral healthcare*, PI.01.01.01 Oakbrook Terrace, IL: Author.

Joint Commission Resources, Inc. (2021). *The joint commission comprehensive accreditation manual for behavioral healthcare*, PI.02.01.01 Oakbrook Terrace, IL: Author.

Oregon Administrative Rules §§ 325-010-0025— 325-010-0050
Oregon Administrative Rule § 943-0450-0260.

Oregon Revised Statute 192.567

Oregon Revised Statute 442.837

Oregon Revised Statute 442.844.

Oregon Revised Statute 442.846

The Joint Commission Sentinel Event policy (hospital)

The Joint Commission Sentinel Event policy (Behavioral Health)

The Joint Commission Sentinel Event policy (Lab)