JUVENILE COURT HEALTH SERVICES

Subject:	Original Issue Date: 4/02/85	Policy # F-201
EVENT NOTIFICATION GUIDELINES	Supersedes: 6/1/18	Effective Date: 6/7/2021

Departments Consulted:	Approved By:	Approved by:
	(Signature on File) Health Services Administrator (Signature on File) Nursing Director	(Signature on File) Medical Director

PURPOSE

To establish uniform guidelines for prompt reporting of all incidents, events, or injuries that may result in harm or future claims or litigation against JCHS or their employees.

POLICY

In support of its commitment to improve continuously the safety and quality of care, JCHS requires that any employee who becomes aware of an incident, event, or injury (referred to as an "event") involving a youth, visitor, or non-County employee immediately notify his or her direct supervisor.

JCHS uses the UHC Safety Intelligence (SI) program to document all event notifications. SI is accessible via the DHS Intranet. Event notifications can be entered into SI anonymously. All events, even those that do not result in harm (near-miss), should be entered into SI because each event provides an opportunity to improve care.

An Event Notification Report should be entered into SI by the end of the shift of occurrence or when becoming aware of the event. All events shall be reported even if only partial statements of fact are available at the time the report is entered.

Events are reviewed and the responsible manager initiates follow-up following submission of the event into SI. Other reviews (Pharmacy, Ancillary, Consultations) shall be completed following submission of the event if applicable.

If the reporter requests feedback regarding the event report, it is the manager that is responsible for providing that feedback. In special circumstances, the manager may request the feedback to be given by an alternate administrator or a risk manager.

Sentinel/Critical clinical incidents resulting in severe injury or death shall be reported immediately to Department of Health Services Risk Management and/or Intercare, County's contractor.

DEFINITIONS

Event Notification Reports are privileged, confidential communication between the Department, County Counsel, and Intercare, County's contractor.

TYPES OF EVENTS TO BE REPORTED:

An Event Notification Report shall be submitted to report incidents that may include, but are not limited to, the following:

- Youth, visitor, employee, or volunteer sustains an injury or a near miss which has the potential for injury;
- A youth or relative seems dissatisfied or unhappy about the treatment or results of a treatment provided;
- An unforeseen result occurs whether or not the treatment has been proper or improper;
- A therapeutic mishap occurs

EVENT NOTIFICATION REPORTING PROCEDURE

- An event occurs and the immediate needs of the youth are addressed.
- Nurse, physician, or other staff notify his/her immediate supervisor and submit an Event Notification report via the SI system by the end of the shift of occurrence or when becoming aware of the incident. Events shall be reported even if only partial statements of facts can be made. At no time should the entry of an event be delayed more than 24 hours after the occurrence or awareness of an event.
- If access to SI is not available, reports are to be manually generated, but must be subsequently entered into SI by the reporter or manager. Forward all manual reports to Risk Management within 3 business days.
- At no time should event reports be referenced in the youth's medical record, printed, or copied.
- Reports shall be reviewed by the appropriate manager for completeness and the need to initiate the sentinel/critical clinical event reporting process. The manager may contact the employee(s) involved in the event if additional information and/or follow-up are required.
- If a sentinel/critical event occurs, notify the Nursing Director, Medical Director and Risk Management immediately.

- DHS Risk Management will review all events with harm scores greater than or equal to category 6 (The individual experienced temporary harm and required treatment or intervention).

MAJOR UNUSUAL EVENTS

Major unusual events include but not limited to: epidemic outbreaks, poisonings, fires, and major accidents, deaths from unnatural causes or other catastrophes and unusual occurrences which threaten the welfare, safety or health of youths, personnel or visitors.

Whenever major unusual occurrences occur, the Event Notification Procedure will be followed. In addition, staff shall notify the Juvenile Court Health Services' Administrator, Medical Director, and Nursing Director. JCHS Leadership will notify Los Angeles County Department of Public Health when applicable.

DISCLOSURE OF OUTCOMES

Youth's parents/legal guardians are informed of an unanticipated outcome that is injurious or potentially injurious as a result of care or treatment rendered. They are entitled to information about the outcomes of diagnostic tests, medical treatment, and surgical intervention regardless of whether the outcomes were anticipated or unanticipated.

The responsible physician should clearly explain the outcome of any treatment or procedure to the patient and must explain unanticipated outcomes. The discussion should clearly explain results of any additional treatment plans. If more than one clinical service is involved, collaboration should occur when appropriate. The Risk Manager is available to assist in the development of a plan of disclosure.

- Disclosure shall be made in a timely manner.
- The youth's parents/legal guardians shall be informed about the outcomes of care, including unanticipated outcomes.
- If the cause of an unanticipated outcome is under investigation, the investigation process may not delay the timely disclosure of necessary information to the patient or the patient's legal/surrogate representative.
- The youth's provider or designee, when reasonable, shall make the disclosure of an unanticipated outcome. In all cases, the designee must have the appropriate medical knowledge and be sufficiently familiar with the patient's care to answer questions regarding the patient's care and the unanticipated outcome.
- Providers or other healthcare personnel with concerns about disclosure may discuss their concerns with their supervisors and Risk Manager, to clarify the appropriate approach.
- Disclosure of an unanticipated outcome does not necessarily constitute an admission of liability.

- Disclosing personnel should not assume fault or error was involved in the unanticipated outcome.
- Disclosing personnel must avoid conveying that error or fault caused the unanticipated outcome until an investigation is complete.
- A disclosure should contain the following elements as applicable:
    a. Acknowledgement of the unanticipated outcome;
    b. Data known to date;
    c. How the unanticipated outcome will affect patient care and actions taken to treat the patient;
    d. A statement that a full analysis will take place; and
    e. An expression of concern, sympathy, compassion

Documenting Disclosure

Whenever a provider discloses an unanticipated outcome to a youth or youth's parent/legal guardian, the provider shall document in the youth's healthcare record that the discussion occurred and the contents of that discussion. The documentation should include the following elements:

- Documentation of the time and date of disclosure;
- List of names and relationship to patient of those present;
- Documentation that there was a discussion of the unanticipated outcome and the contents of that discussion; and
- A brief, factually based description of the unanticipated outcome

REFERENCES

NCCHC Standard Y-B-03
DHS Policy #311, Incidents Involving Potential Claims Against the County

REVIEW DATES

December 31, 2007; February 7, 2013; June 1, 2018