COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES

Policy Title:	**REPORTING ADVERSE / SENTINAL EVENTS, INCIDENTS AND NEAR MISSES**		
Category:	9 - Leadership	**Policy No.:**	949
Originally Issued:	12/26/1976	**Update (U)/Revised (R):**	5/13/2019
Distribution:	**Hospital-Wide** ☒	**If not Hospital-Wide, Other:**	

PURPOSE:

To establish uniform guidelines for prompt reporting of incidents that harmed or may harm patients, visitors or employees, or which may result in future claims or litigation against the Department and the County. Incidents or near misses identify areas of system vulnerability and system enhancements to minimize safety events. They are an opportunity for learning and afford the chance to develop preventive strategies and actions.

DEFINITION(S):

Sentinel Event: An unexpected occurrence involving death or serious physical or psychological injury.

Serious Disability: A physical or mental impairment that substantially limits one or more life activities of an individual; the loss of bodily function, if the impairment lasts more than seven days; is still present at the time of discharge from an inpatient health care facility; or the loss of a body part.

Datix: University Healthsystem Consortium (UHC) Safety Intelligence (SI):
On-line event/incident reporting system used throughout OVMC.

Unusual Occurrence: An incident that includes not only events that would be perceived as out of the ordinary as well as events that the patient or relatives perceive to be unusual.

Near Miss: An incident or unsafe condition with the potential for injury or property damage.

POLICY:

All employees of Olive View-UCLA Medical Center (OVMC) have a duty to participate in the identification and reporting of occurrences which have caused, or have the potential to cause, harm to a patient, employee, or visitor or which may result in a claim or lawsuit against the County or its employees. All adverse events shall be reported timely to the State Department of Health Services and/or Centers for Medicare and Medicaid Services, as appropriate.

PROCEDURE:

OVMC endorses a non-punitive patient safety culture, which means the major emphasis is to identify system vulnerabilities and opportunities for improvement.

Employees shall report immediately to their supervisors any unusual occurrence or event that does not comply with policy and procedures or that is perceived by the customer to be out of the ordinary.

A. Reportable Adverse Events to California Department of Public Health (CDPH)

1. All Reportable Adverse Events must be reported to the California Department of Public Health (CDPH) within five days of detection, or, if the event is an ongoing urgent or emergent threat to welfare, health, or safety of patient, personnel or visitors, not later than 24 hours after detection. (Reporting is done by OVMC Risk Management at the direction of Hospital Administration.)
2. The event shall be disclosed to the patient or patient's significant other prior to reporting to CDPH.
3. OVMC Risk Management will report the event to the Los Angeles County Department of Health Services' Senior Medical Director concurrently with report to CDPH.
4. The list of reportable adverse events is contained in Attachment I.
5. Reporting of these events shall be followed by an intensive investigation as appropriate by OVMC Risk Management. The investigation will be completed within 45 days from the date of the facility's first notification of the event.

B. Reportable Event to Centers for Medicare and Medicaid Services (CMS)

1. Any death that occurs while a patient is in restraints or seclusion, any death that occurs 24 hours after the patient has been removed from restraints, and any death that occurs within one week after restraint or seclusion, where it is reasonable to assume the use of restraints or placement in seclusion contributed directly or indirectly to the patient's death shall be reported by telephone to the Centers for Medicare and Medicaid Services no later than the close of business the next business day following knowledge of the patient death.
2. Notification to CMS must be documented in the patient's medical record.

C. Joint Commission Reviewable Sentinel Events

1. Joint Commission defines certain events, listed in Attachment II, as events requiring review; some, but not all, of these events are also Reportable Adverse Events to the CDPH.
2. All Reviewable Sentinel Events will undergo a timely, thorough, and credible root cause analysis, development of an action plan designed to implement improvements to reduce risk, implementation of the improvements, and monitoring of the effectiveness of those improvements

D. Incidents involving theft of County, patient, visitor or employee property, suspected drug use, incidents of violence, or threats of violence must be reported to the Los Angeles County Sheriff Department immediately. The County Sheriff will be responsible for collecting and securing all evidence and for documenting these incidents.

E. Any employee, patient, or visitor requiring immediate medical attention shall be brought to the OVMC Emergency Room.

F. Supervisors shall evaluate notifications received via Datix: UHC SI system and follow-up with corrective action as identified in the UHC SI Incident Reporting System, OVMC Policy No. 130.

ATTACHMENTS/FORMS:

Reportable Events Attachment I
Sentinel Events Attachment II

REFERENCE(S)/AUTHORITY:

DHS Policy #932, #934;
Comprehensive Accreditation Manual for Hospitals, Joint Commission: PI.01.01.01; Sentinel Events; Senate Bill 1301;
42 CFR Part 482.13(g)

APPROVED BY:

Bonnie Bilitch (Chief Nursing Officer)
Judith Maass (Chief Executive Officer)
Rima Matevosian (Chief Medical Officer)