Sentinel/Serious Event Coordination Process Flow

Serious Adverse Event Detected

Clinical Chair notified

Immediate management and rapid mitigation if possible by Frontline Staff

Post Event Debrief Coordinated by Event Response Team

Emotional support for clinical staff

Emotional support for patient/family members

Event Response Team (Coordination of Facts)

Disclosure with patient/family Directed by Clinical Chair

Offer service recovery

Risk/Claims Analysis & Consideration of Compensation with Clinical Chair

Authorization Policy?

Preliminary Determination

Meeting with patient/family to share strategies Directed by Clinical Chair

Case/Peer Review Directed by Clinical Chair

Directed by Clinical Chair

Preliminary Determination

Authorization Policy?

Case/Peer Review Directed by Clinical Chair

Christiana Care Health System
## Coordination of Sentinel or Serious Event Checklist

### Immediate Management

**Frontline Staff & Manager Involved**
- Provide immediate intervention to patient to minimize harm
- Secure equipment or medical devices, supplies agent and medications
- Notify Risk Management
- Notify attending physician
- Complete SFLR on portal
- Document facts in medical record
- Notify immediate supervisor/manager, Clinical Chair, & Leadership hierarchy
- Notify Public Safety, if non-patient
- Notify Event Response Team

**Event Response Team (PI, Risk & Medical Director PI, Clinical Chair)**
- Verifies notification of Clinical Chair
- Investigate, prepare timeline & Expedited Clinical Abstract (within 24 hours) for review by Clinical Chair (see Clinical Chair Review)
- Identify patient/family spokesperson & determine if support is needed
- Identify if defusing or staff support needed
- Evaluate if Debrief indicated
- Involve Patient Relations as needed

### Process

**Event Response Team (PI, Risk & Medical Director PI, Chair)**
- Hold Initial Multidisciplinary Post Event Debrief
- Confirm status of disclosure by attending
- Provide Clinical Chair and Senior Leadership update
- Review Expedited Clinical Abstract with Clinical Chair/Designee and Executive Team

**Disclosure and Ongoing Patient/Family Support Chair & Attending Physician**
- Support and provide ongoing Patient/Family communication

**Clinical Chair Review and Input**
- Review facts and make recommendation for sentinel event
- Peer Review and M & M
- Ongoing Involvement and direction
- Direct disclosure process
- Direct Patient/Family Meetings
- Implement Authorization Policy

### Responsibilities

**Supervisor/Manager Follow-up**
- What happened, need facts & early evaluation?
- Why did it happen?
- How to prevent?

**Executive Team* & Clinical Chair (s)**
- Determine if event meets sentinel event criteria within 5 business days
- Evaluate need for Safety First Alert
  * (Executive Team: James Newman MD, Kathleen McNicholas MD, Sharon Anderson RN, Michele Campbell RN, Susan Perna RN, & Clinical Chair)

**Patient Safety Analysis & Clinical Chair (s)**
- Perform Sentinel Event Root Cause Analysis (RCA), Intensive Review (IR) Departmental Review

**Risk Analysis & Clinical Chair (s)**
- Notify Insurance Carrier and implement Claims process, if deemed appropriate
- Collaborate with Clinical Chair as needed
Initial Multidisciplinary Post Event Debrief Process
Guidelines
(Working Document)

**Purpose:** Initial discussion of what happened and debriefing of involved staff that allow staff to express themselves in a safe supportive and learning environment.

**Recommended Criteria:**
- **Unexpected or totally unanticipated** complication, death or harm to a patient
- Staff request due to the potential emotional impact on the well being of our staff

2. **Identify Participants who were involved in the care of the patient:**
   - Anesthesiologist /CRNA
   - Administrative personnel
   - Nurses
   - Pharmacist
   - Physician(s)
   - Performance Improvement nurse
   - Reporting individual or who completed the SFLR
   - Resident(s)
   - Technicians
   - Lab Personnel
   - Respiratory Therapist
   - Risk Management
   - If potential for IR or RCA, project manager
   - Others as needed

3. **Notify Clinical Chair, Administrative Leaders including the Vice President and participants.**

4. **Identify Debrief Leader to lead debrief.**

5. **Utilize Post Event Debrief Checklist to guide the discussion and process.**

6. **Thank all participants for their contributions to Patient Safety.**
**Initial Post Event – Debrief**

- Introduce participants and **Purpose of Post Event Debrief**: Allow staff to express themselves in a safe, support and learning environment
- Engage all participants in the Debrief
- Review Ground Rules

**Ground Rules:**
- Maintain non-judgmental and open discussion
- Examine existing processes & systems, not individuals

*Never doubt the ability of a small group of dedicated people to change the world. Indeed, they are the only ones who ever have.*

*Margaret Meade*

<table>
<thead>
<tr>
<th>✓ Prompts for Discussion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describe what happened?</td>
</tr>
</tbody>
</table>

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>What normally happens?</td>
</tr>
<tr>
<td>What went well, what should we change, what can we improve?</td>
</tr>
<tr>
<td>Do you have any other concerns?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>✓ Other Considerations for Discussion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any staff not present for Debrief, need support, defusing or should be recognized?</td>
</tr>
</tbody>
</table>

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Any patient or family support needed?</td>
</tr>
<tr>
<td>Is there a need for disclosure? Identify patient/family spokesperson</td>
</tr>
<tr>
<td>Is there a need to secure equipment?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>✓ Feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td>Share any Actions Plans as a result of this Debrief</td>
</tr>
</tbody>
</table>

*Thank you for your efforts to improve Patient Safety*