

Subject: Clinical Crisis Event Management

Originated August 2011 by Risk Management Services

Purpose:

These guidelines apply to critical clinical events, including events involving serious potential or actual serious harm that require medical intervention; which could be defined as either Adverse under PC-196 or Sentinel under PC-233. IHI has defined these critical events as “serious clinical events.”

This document outlines the administrative components of a comprehensive institutional process, supports transparency, safety, new knowledge, error reporting, investigation and analysis; and dissemination of lessons learned.

These tools are to serve as a guideline in response to critical clinical events to mitigate harm, improve communications for patient, family and staff, promote healing after a serious adverse event; and ensure accurate, collaborative flow of information.

The goals of this Crisis Management Toolkit:

- Avoid the crisis

- Prepare to manage the crisis

- Recognize the crisis

- Contain the crisis

- Resolve the crisis

- Learn from the crisis

These guidelines focus on the components below in the management of critical clinical events by the Clinical Crisis Management Team/Adverse Event Task Force or other designated campus individuals:

1. Coordinated and Immediate Action following a serious clinical event.
2. Coordinated follow up steps for Ongoing Event Management.
3. Communication to patients, with emotional support to patients and families. **See also PC-260 and attachment *Nuts and Bolts of Disclosure*.**
4. Support of clinicians and all staff who are involved in serious clinical events.
5. Investigation and Reporting of events meeting reporting requirements.

See Crisis Management Checklist, Flowchart for Immediate Crisis Management, and Flowchart for Ongoing Event Management. (ATTACHMENTS)

ADVERSE EVENT TASK FORCE (AETF): Members of the Core Intensive Assessment Committee who receive the necessary information via phone, meeting or email to determine if a reported event meets the definition of Adverse Event and requires reporting to Department of Health Services. Members consist of Senior Administration, Medical Staff Leaders and Clinical Risk Manager who are designated by each MHS facility.

Adverse Event (PC-196): Defined under Health & Safety Code § 1279.1. See policy for complete list of Adverse Events.

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Sentinel Event (PC-233): An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function or any process variation for which a recurrence would carry a significant chance of a serious adverse outcome either of which need immediate investigation and response (A death or permanent loss of function related to the natural course of the patient's illness or underlying condition is not a Sentinel Event.)

A Serious Clinical Event: Any event causing serious harm, potential serious harm, death, or a clear or present danger to one or more patients and/or to a community (psychological and physical) IHI-“Respectful Management of Serious Clinical Adverse Events.” Jim Conway Senior Fellow, IHI