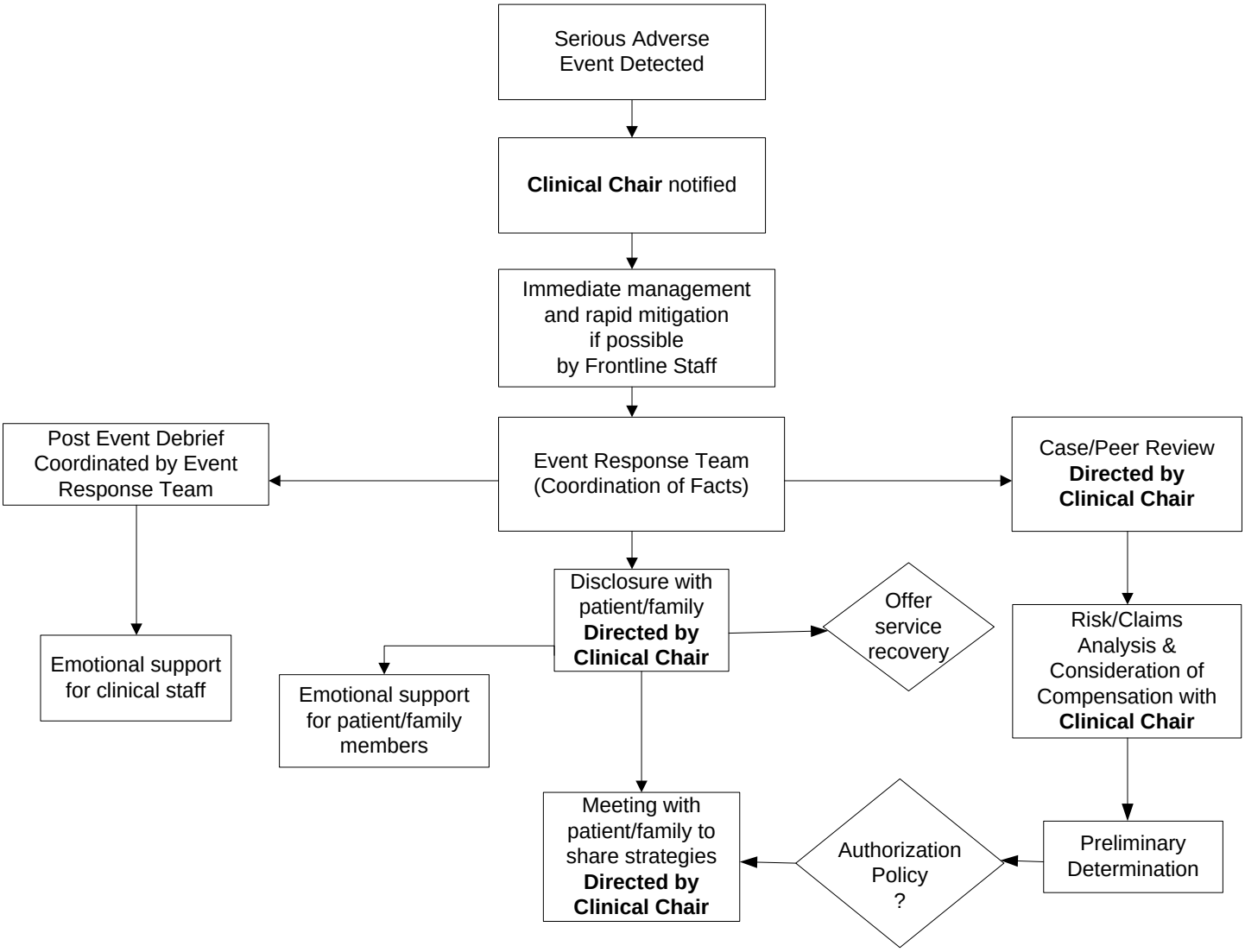
Sentinel/Serious Event Coordination Process Flow



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 24hours) 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/Desingee** 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 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

✓	**Prompts for Discussion**
	Describe what happened?
	What normally happens?
	What went well, what should we change, what can we improve?
	Do you have any other concerns?
✓	**Other Considerations for Discussion**
	Any staff not present for *Debrief*, need support, defusing or should be recognized?
	Any patient or family support needed?
	Is there a need for disclosure? Identify patient/family spokesperson
	Is there a need to secure equipment?
✓	**Feedback**
	Share any Actions Plans as a result of this Debrief

Thank you for your efforts to improve Patient Safety