

## History and Physical Policy Review

Prior to all procedures/surgeries, our patient's History and Physical must be reviewed with a note documented within 24 hours of the procedure/surgery. (refer to attached Tip Sheet)

### SJHHC Policy Overview:

#### **Workplace Violence, Professional Misconduct, Patient Rights, and Occurrence Reporting** (refer to attached policies)

##### Workplace Violence:

- The purpose of the policy is to facilitate the protection and safety of all patients, employee, visitors, and other individuals while maintaining an orderly working environment.
- Types of Workplace Violence Behaviors include: Threatening, intimidating, abusive, physically/sexually harassing or violent behaviors; these behaviors can be in the form of verbal, written, or physically towards others, including patients, visitors, co-workers, and all others having affiliation with the network operations.

##### Professional Misconduct:

- The organization will report misconduct to the Department of Health and the Department of Education within 30 days of the occurrence.
- Behaviors included: Alleged mental/physical impairment, incompetence, malpractice, misconduct or endangerment of patient safety or welfare; resignation from organization to avoid disciplinary action, receipt of information related to a conviction of a misdemeanor/felony; failure to follow Infection Control Policies; and practicing outside the scope

##### Patient Abuse:

- Definition of Patient Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment, with resulting physical harm, pain, or mental anguish. This includes staff neglect or indifference to infliction of injury or intimidation of one patient by another. Neglect is defined as the failure to provide patient needs and services to avoid physical harm, mental anguish, or mental illness.

○ Procedure for reporting and investigating patient abuse:

1. Complete QATF
2. Contact direct supervisor, corporate compliance; or Administrative Coordinator (AC) when supervisor not available
3. AC or direct supervisor will contact Administrator on Call (AOC)
4. Patient safety should be secured immediately & throughout the investigation
5. Area Manager/Director will investigate incident & report to VP
6. Corporate Compliance & Quality Resources will complete the case review
7. Incidents will be reported monthly at the Quality Management Resource Committee & action plans will be monitored

Occurrence Reporting:

- Every allegation of patient abuse or neglect will be reported to the Administrator on Call (AOC) by the employee's direct supervisor or the Administrative Coordinator in their absence



# History and Physical Notes: Pre-Op and Consult

1. Open the patient's chart; select the **Pre-Op + Consult** activity. The patient must have an up-to-date H&P note.
2. If the patient has a **prior H&P** note in Epic: Click **Update H&P**
  - a. Created within the last **30 days** → + Add Interval to the H&P
  - b. Scanned H&P note attached to current encounter → +Add Interval to the H&P

Update H&P

click to open

Go to Notes

Notes attached to current encounter

Provider, Scanning

Physician

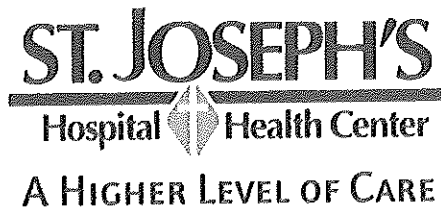


+ Add Interval

3. If no **prior H&P** note is in Epic or H&P note created more than 30 days ago, follow instructions below to **create a new H&P note**.
  - a. Click on the Notes Activity tab.
  - b. Click on All Notes tab and then New Note.
  - c. In the smarttext field that appears, enter "outpt" to bring up Pre-procedure/OP note interval update templates (d).
  - d. Select H&P Update or H&P New>30D smarttext template.
  - e. Enter H and select H&P note type.

The screenshot shows the Epic Notes interface. On the left, the 'Notes' activity is selected. The 'All Notes' tab is active, and a search for 'outpt' has been performed. The search results show three templates: 'SIH OUTPT PRE-PROCEDURE H&P NEW >30D', 'SIH OUTPT PRE-PROCEDURE H&P UPDATE', and 'SIH OUTPT UPDATE OR NEW PRE-PROCEDURE H&P'. The 'New Note by INPATIENT' button is also visible. The 'Match' field contains 'outpt'. The 'Title' field is empty. The 'Service' field is set to 'Internal Medicine'. The 'Type' field is set to 'C'. The 'Cosign Required' checkbox is unchecked. The 'SmartText' field is empty.

4. Complete the template for the new H&P note using F2 key.
5. Sign the Note.



## WORKPLACE VIOLENCE PREVENTION

### **Policy:**

It is the policy of St. Joseph's Hospital Health Center to keep the workplace free from acts or threat of violence. Threats, threatening behavior, or acts of violence against employees, visitors, or other individuals by anyone on St. Joseph's Hospital Health Center property is prohibited. (Refer to *Patients Rights* policy for patient safety) This includes the following types of behaviors:

- Threatening, intimidating, abusive, physically/sexually harassing or violent behaviors. These behaviors can be in the form of verbal, written, or physical towards others, including patients, visitors, co-workers, and all others having affiliation with the network operations.

### **Purpose:**

To facilitate the protection and safety of all patients, employees, visitors and other individuals while maintaining an orderly working environment.

### **General Information:**

All reported allegations of threats or actual violent behavior will be immediately investigated and the hospital may choose to remove any involved individuals to ensure both their safety and the safety of others. All hospital employees are responsible for completing the appropriate Quality Assessment Tracking Form in Midas – RDE and notifying their immediate supervisor of any threats they have witnessed, received, or has been informed about. Employees should report these incidents regardless of the relationship between the individual who has initiated the threat or threatening behavior and the person or persons who were threatened.

Violation of this policy will elicit an immediate and firm response that could include dismissal from employment or criminal prosecution.

### **Hazard Prevention and Control:**

The hospital maintains several hazard prevention controls that include, but are not limited to the following:

- Directed Security patrols and post assignments
- Personal safety escorts
- CCTV
- Panic alarm devices
- Locking door hardware on exterior doors
- Follow up investigations
- Patient watches
- Visitor pass distribution
- Card reader application
- Patient Watch Policy
- Preventing & Managing Crisis Situation training for Security, Psych, and Clinical Services staff

**Education:**

All employees receive information regarding this policy during hospital orientation and their annual Mandatory In - service.


**Documentation:**

The Employee Health Office trends all reports of employee injuries related to violence in the work place and are required to document injuries that have incurred medical and/or lost work time, on the OSHA 300 Log. Methods for documenting workplace violence incidents occur by utilizing the following:

- Employee/Affiliate Occurrence Reports
- Security Incident Reports
- Human Resources Reports
- Midas (Electronic occurrence reporting system)
- Hospital reporting system

**Evaluation of program:**

Reports of workplace will be submitted to the hospital Patient & EC Safety Committee at least quarterly. Trends can be identified and solutions explored.

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**PROFESSIONAL MISCONDUCT**

Policy:

- 1.0 The hospital shall furnish to the appropriate office or department, a written report of any denial, withholding, curtailment, restriction, suspension or termination of any membership or professional privileges in, employment by or any type of association with a hospital relating to a professional or an individual who is a health profession student serving in a clinical clerkship, an unlicensed health professional serving in a clinical fellowship or residency; or an unlicensed health professional practicing under a limited permit or state license, such as an audiologist, certified social worker, licensed master social worker (LMSW), dental hygienist, dentist, medical laboratory technologist, nurse, occupational therapist, pharmacist, physical therapist, podiatrist, psychologist, radiologic technologist, radiologist assistant, respiratory therapist, respiratory therapy technician or speech-language pathologist for reasons related in any way to any of the following:
  - 1.1 Alleged mental or physical impairment, incompetence, malpractice, misconduct or endangerment of patient safety or welfare;
  - 1.2 Voluntary or involuntary resignation or withdrawal of association, employment or privileges with the hospital to avoid imposition of disciplinary measures;
  - 1.3 The receipt of information concerning a conviction of a misdemeanor or felony;
  - 1.4 Failure to follow established Infection Control policies
  - 1.5 Practicing outside of scope
- 2.0 Physicians/Clinical Affiliates:
  - 2.1 If any acts or behaviors of physicians/clinical affiliates practicing at the Hospital become known to the Chief Executive Officer, the Chief of the Medical Staff, the Chairperson of any Department at the Hospital, or the Vice President For Medical Affairs, , and such acts or behavior are determined to constitute professional misconduct as defined in Sections 6530 and 6531 of The Education Law of the State of New York, then such persons shall report those acts or behaviors as promptly as possible to the Board of Professional Conduct ("the Board").
  - 2.2 Such reporting shall be in writing and shall be sent to the Board, together with all available information pertaining to the acts or behavior.
  - 2.3 If it is unclear whether the acts or behaviors in question constitute unprofessional conduct, the Hospital's General Counsel or Vice President for Medical Affairs shall call the counsel for the Board and seek guidance on whether the acts or behaviors in question constitute professional misconduct and should be reported.

- 2.4 No physician/clinical affiliate shall be responsible to report information obtained from a properly conducted mortality and or morbidity conference or departmental meeting, as specified in Public Health Law Section 230, paragraph 11(c)(i).
- 2.5 The Chief Executive Officer shall also report to Office of Professional Medical Conduct, with a copy to the appropriate area administrator of the Office of Health Systems Management, any denial, suspension, restriction, termination, or curtailment privileges, or termination of employment occurring for any of the following reasons, as set forth in 10 NYCRR 405.3e
  - a. Alleged mental or physical impairment, incompetence, malpractice, misconduct, or endangerment of patient safety or welfare;
  - b. Voluntary or involuntary resignation or withdrawal of privileges to avoid imposition of disciplinary measures; or
  - c. Receipt of information concerning a misdemeanor or felony.
- 3.0 All reports shall be sent in writing within 30 days of the occurrence of the event causing the obligation to report.
- 4.0 The report shall contain:
  - 4.1 The name and address of the individual
  - 4.2 The profession and license number
  - 4.3 The date of the hospital's action
  - 4.4 A description of the of the action taken
  - 4.5 The reason for the hospital's action or the nature of the action or conduct which lead to the resignation or withdrawal and date thereof.
- 5.0 Disciplinary action against the professional license is determined by the New York State Education Department.

The New York State Board of Regents may be accessed at <http://www.op.nysed.gov/title8/part29.htm>

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**PATIENT'S RIGHTS**

**Definition of Patients Rights, Distribution and Review of Notice**

**Purpose:**

1. To ensure patients rights are protected, the organization will have methods in place that provide patients with an environment free of all forms of abuse, neglect, or harassment.
2. To ensure every patient is given a copy of the NYS Patient's Rights and Notice of Privacy Practices

**Definition of Patient Abuse:**

Patient abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment, with resulting physical harm, pain, or mental anguish. This includes staff neglect or indifference to infliction of injury or intimidation of one patient by another. Neglect is defined as the failure to provide patient needs and services to avoid physical harm, mental anguish, or mental illness.

All violations of patient's rights must be investigated for the following:

1. There must be adequate staffing to ensure individual patient's needs are assessed, safe plans of care are established and carried out by the right number of qualified, competent (trained), and experienced employees.
2. Human Resources screens all potential employees and ensures persons with a record of abuse or neglect are not hired or retained.
3. The organization creates and maintains investigation processes that identify patient abuse events.
4. Training related to patient abuse is completed in orientation and annually through the annual inservice.
5. The organization ensures patients are protected during abuse investigations.
6. The organization ensures a timely and thorough investigation of all allegations of abuse, neglect, or mistreatment.
7. All incidents of patient abuse, neglect, or harassment are reported, analyzed, and appropriate corrective, remedial, or disciplinary action occurs in accordance with applicable local, state, and federal laws.

**Procedure for Reporting and Investigation of Patient Abuse:**

1. Complete a Quality Assessment Tracking Form (QATF) in MIDAS-RDE and report incident to direct supervisor, corporate compliance, or administrative coordinator (who must notify the Administrator on Call) when direct supervisor is unavailable.
2. Patient safety during alleged abuse events should be secured immediately, and throughout the investigation period.



3. The service area manager and director will complete initial investigation, by collecting materials and information regarding the event, and report to the service vice president.
4. All allegations of patient abuse or neglect will be reviewed by corporate compliance and the Quality Resources Department to determine if allegation is substantiated or unsubstantiated.
5. Allegations of patient abuse or neglect will be reviewed monthly at Quality Management Resource Committee and corrective and preventative action plans will be established and monitored.

#### **Distribution of Review of Notice:**

##### **1. Inpatient**

Upon arrival of a patient to registration the patient will be given a "Patient Handbook", Notice of Privacy Practices and the NYS publication "Your Rights as a Hospital Patient in NYS" form#20050 COPY CENTER: YOUR RIGHTS AS A HOSPITAL PATIENT IN NYS. The patient is encouraged to read them. The receipt of these documents by the patient will be documented on the Admission Auth and Consent Form. Pre-registered inpatients will be given the above documents s at the time of pre-testing by the PAT lab. The patient is encouraged to read them.

Upon admission, if the pre-registered inpatient indicates that they have previously received these documents at PAT testing, it will be documented on the Authorization and Consent form by the person admitting the patient.

An ED outpatient who is converted to inpatient or observation status will receive the Patient Handbook and the NYS publication "Your Rights as a Hospital Patient in NYS" form # 20050.

The patient will also be instructed that if he/she has any issues/problems regarding his/her rights, to ask the nurse in charge of his/her care. If the nurse is unable to answer the patient's questions, the nurse will contact the Unit Manager/Administrative Coordinator. In turn, if the Unit Manager/Administrative Coordinator is unable to answer the question, he/she will contact the Administrator on-call.

Any concerns the patient may have in regard to Patients' Rights should also be documented in the Clinical Progress Record along with the action taken in response to those concerns.

##### **2. Outpatient**


Upon arrival of a patient to any outpatient service registration office the patient will be given an "Outpatient Information" handbook (form # 12667), the Notice of Privacy Practices and the NYS publication "Health Care Proxy-Appointing your Health Care Agent in NYS form #16348 NEW YORK STATE'S PROXY LAW". The patient is encouraged to read them. The receipt of these documents by the patient will be documented on the Admission Authorization and Consent Form. Pre-registered outpatients arriving directly to their point of service will be given the "Outpatient Information" handbook, the "Health Care Proxy-Appointing Your Health Care Agent in NYS and the Notice of Privacy Practices. The patient is encouraged to read them by the clinical service to which they arrive.

Primary Care Patients and recurring therapy patients (PT, OT, ST, cardiac and pulmonary rehab, diabetic teaching, OP Behavioral Health) will be given the "Outpatient Information" handbook, the Notice of Privacy Practices and the "Health Care Proxy-Appointing Your Health Care Agent in NYS" once, at the onset of their course of treatment. The receipt of both documents will be documented on the Authorization and Consent Form.

Patients will also receive a "Notice of Privacy Practices" and sign the "Notice of Privacy Practices Acknowledgement Form" on the reverse side of the "Admission Authorization and Consent Form". The "Notice of Privacy Practices" needs to be given to each patient on their first point of contact. It only needs to be provided to the patient one time.

It will be the responsibility of the hospital employee attending the patient to answer any questions the patient may have regarding his/her rights. If the patient has any concerns the staff member is unable to resolve, they will contact the Unit Manager/Administrative Coordinator. The Unit Manager/Administrative Coordinator will contact the Administrator on-call if unable to answer the concerns.

The NYS Patient Rights are outlined in both the Patient Handbook and the Outpatient Information Handbook. The NYS Patient Rights (form# 11003) is available in multiple languages under governmental forms on the St Joseph's Intranet-Forms.

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**OCCURRENCE REPORTING**

Defintions (Attachment G)

Serious Reportable Events/Never Events List (Table 1)

NYPORIS Reportable List (Table 2)

Sentinel Event List (Table 3)

Unexpected and NEAR MISS Event Reporting Flowchart (Attachment A)

Securing Equipment Flowchart (Attachment D)

Root Cause Analysis Form (Attachment F)

Administrator on Call (AOC) Flowchart (Attachment B)

Guidelines for completion of downtime paper QATF (Attachment C)

Near Miss Reporting Flowchart (Attachment E)

**1.0 Purpose:**

To ensure that an appropriate report is made and maintained regarding ANY unusual or unexpected event involving a patient, visitor, staff, affiliate or other non patient issue so that:

- the correct hospital personnel are informed
- disclosure has been made to patient and/or family as indicated
- appropriate review is conducted
- risk reduction strategies are system based to prevent recurrence and
- reporting requirements are met for appropriate state and federal statutes
- occurrences can be trended and analyzed

**2.0 Policy:**

All employees, medical staff and affiliates are responsible to report any unexpected event, whether actual or a near miss, involving a patient, visitor, staff member, affiliate or non- patient issue that they identify or observe using the appropriate Quality Assessment Tracking Form (QATF) in the electronic reporting system MIDAS or a Near Miss Reporting form # 20186 NEAR MISS NO HARM EVENT REPORTING

**Definitions:** Defintions (Attachment G).

**3.0 Structure/Process**

**3.1** Every unexpected event, actual or near miss is to be promptly reported by the individual who identified or observed the event regardless of whether or not there was harm or injury to the patient. See Attachment A. Narrative descriptions of the unexpected events on the QATF should:

- be objective
- be clear and concise
- avoid use of staff name(s) in narrative
- relay only the detailed, factual, circumstances of the event
- the narrative must provide the reader with a clear description of what happened

3.2 Patients involved in unexpected occurrences are to be assessed by the RN in charge immediately following identification that an event has occurred. Safety measures are to be implemented as appropriate given the patient's clinical situation. Similarly, action must be taken to ensure a safe environment for non-patient events. Notify appropriate personnel.

3.3 See Serious Reportable Events/Never Events List (Table 1)  
NYPORTS Reportable List (Table 2)  
Sentinel Event List (Table 3)

for events that require reporting. Other occurrences that require reporting include but are not limited to:

- Iatrogenic complications such as pneumothorax, hemorrhage or hematoma
- Return to the operating room related to a primary procedure
- Unplanned operative procedure related to another procedure i.e., colon surgery due to perforated bowel during colonoscopy
- Hospital acquired infections
- Hospital acquired pressure ulcers
- DVT while hospitalized or within 30 days of hospitalization
- Pulmonary embolus while hospitalized or within 30 days of hospitalization
- Complications of IV therapy such as phlebitis, infiltration or extravasation
- Unexpected death
- ALL FALLS

3.4 Immediately notify Risk Management staff at 448-5157 for any occurrence where the patient has sustained a serious injury or unexpected death. During normal business hours, Monday through Friday from 0700 – 1600, a voice mail message may be left. The message must include: date and location of event, medical record number and a brief description of the event. A Risk Management staff member will notify the Director of Quality Resources. After hours, or when a Patient Safety and Risk Management staff member is not available, the Director of Quality Resources must be contacted using the phone number provided on the message.

3.5 Occurrences to be reported to the Administrator on Call (AOC) include but are not limited to:

- Patient deaths or impairments of bodily function in circumstances other than those related to the natural course of illness, disease or proper treatment, in accordance with generally accepted medical standards.
- All allegations of patient abuse or neglect.
- Fires in the facility which disrupt the provision of patient care services or cause harm to patients or staff.
- Major equipment malfunction during treatment or diagnosis that affected a patient or health care staff member.
- Poisoning occurrence within the facility.
- disasters or other emergency situations external to the hospital environment which affect health facility operations.
- Termination of any service vital to the continued safety of its' patients and personnel, including but not limited to: the anticipated or actual termination of telephone, electric, gas, fuel, water, heat, air conditioning, rodent or pest control, laundry service, food or contact services.
- Serious reportable events (refer to Tables 1, 2 and 3).
- Serious events reportable to the Justice Center: Protection of People with Special Needs (Justice Center)

3.6 Refer to the attached "Flowchart for Administrator on Call (AOC): What to Do if an Unexpected Serious Event Occurs" Administrator on Call (AOC) Flowchart (Attachment B)

3.7 All occurrences involving drugs are to be reported and are reviewed. Refer to the *Medication Related Occurrence Reporting* policy: Medication Related Occurrence Reporting

3.8 Instructions for securing equipment after an occurrence that involves harm or potential harm is attached to this policy (see Securing Equipment Flowchart (Attachment D) If the equipment involves a medication, report the event using the Medication QATF (MED-QATF).

3.9 The QATF /Near Miss Reporting form is the property of the facility and is specifically for the purpose of evaluating and managing risk and quality and as such is protected under NYS Public Health Law § 2805-m and NYS Education Law § 6527.

3.10 The QATF via MIDAS-RDE or a paper QATF/ Near Miss Reporting form is not a patient record and must NOT be included as part of the patient record. Do not document or discuss with a third party that a QATF was generated. Do not file in the medical record. The circumstances, follow up, and outcome of the event should be described in the patient record in a factual, objective manner.

#### 4.0 General Guidelines/Information:

4.1 The electronic reporting system, MIDAS-RDE, can be accessed by all staff, employees, medical staff, and affiliates via the hospital intranet (SJEN under Work Tools). Select the appropriate QATF under Risk Form and complete all fields. Refer to Guidelines for Completion of a Quality Assessment Tracking Form (QATF), Attachment C. Near Miss Reporting forms are available in all departments/services including the forms catalog form # 20186 NEAR MISS NO HARM EVENT REPORTING.

4.2 The saved QATF in MIDAS-RDE will be automatically forwarded electronically to Risk Management and to the manager for the unit or service where the event was reported to have occurred. If an update needs to be made after the QATF has been submitted, please notify your manager to update. DO NOT enter a second MIDAS QATF on the same event for the purpose of entering additional information.

For Near Miss events see Near Miss Reporting Flowchart (Attachment E).

4.3 Paper QATFs are available for computer downtime use and can be printed from the online forms catalog:

- Medication QATF form #12025 MEDICATION Q&A TRACKING FORM
- Patient Fall QATF form #16767 FALL/QUALITY ASSESMENT TRACKING FORM
- Generic QATF form #18654 is used to report all other event types QUALITY ASSESMENT TRACKING FORM

**NOTE: Any event that is bolded on the Generic QATF, form #18654, requires a phone call reporting the event to Risk Management at 448-5157.**

When a downtime form is used, enter the event into MIDAS-RDE when it becomes available. If downtime extends beyond 24 hours, send the original paper form to the Risk Management office either by interdepartmental mail or fax within 24 hours of the occurrence. Risk Management fax: 448-5719.

4.4 For a non-patient fall, call **Security** to complete a security non-patient fall report.

4.5 For thefts, lost items, property damage or other related occurrences, call **Security** to complete the appropriate security report.

**TABLE 1:**

**NEVER EVENTS / SERIOUS REPORTABLE EVENTS**

Applicable in hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

Source: [www.qualityforum.org](http://www.qualityforum.org) Accessed: October 4, 2013

1. Surgical or Invasive Procedure Events

- 1A. Surgery or other invasive procedure performed on the wrong site (body part)
- 1B. Surgery or other invasive procedure performed on the wrong patient
- 1C. Wrong surgical or other invasive procedure performed on a patient
- 1D. Unintended retention of a foreign object in a patient after surgery or other invasive procedure
- 1E. Intra-operative or immediately postoperative/ post procedure death in an ASA Class I patient

2. Product or Device Events

- 2A. Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting
- 2B. Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended
- 2C. Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting

3. Patient Protection Events

- 3A. Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person
- 3B. Patient death or serious injury associated with patient elopement (leaving the facility without permission) or disappearance
- 3C. Patient suicide, attempted suicide, or self harm that results in serious injury, while being cared for in a healthcare setting

4. Care Management Events

- 4A. Patient death or serious injury associated with a medication error (e.g. errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)
- 4B. Patient death or serious injury associated with unsafe administration of blood products, such as a hemolytic reaction (abnormal breakdown of red blood cells) due to the administration of ABO/HLA – incompatible blood or blood products
- 4C. Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting \*\*
- 4D. Death or serious injury of a neonate associated with labor or delivery in a low risk pregnancy \*\*

- 4E. Patient death or serious injury associated with a fall while being cared for in a healthcare setting
- 4F. Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting ◇
- 4G. Artificial insemination with the wrong donor sperm or wrong egg ■
- 4H. Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen
- 4I. Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results

5. Environmental Events

- 5A. Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting
- 5B. Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances
- 5C. Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting
- 5D. Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting

6. Radiologic Events

- 6A. Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area

7. Potential Criminal Events

- 7A. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider
- 7B. Abduction of a patient/resident of any age
- 7C. Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting
- 7D. Death or serious injury of a patient or staff member resulting from a physical assault (i.e. battery) that occurs within or on the grounds of a healthcare setting

**\*\* Applicable in hospitals, outpatient/office-based surgery centers**

◇ **Applicable in: hospitals, outpatient/office-based surgery centers, long-term care/skilled nursing facilities**

■ **Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices**

**TABLE 2:**

New York State Department of Health  
**NQF/NYPORTS HOSPITAL REPORTING GUIDE**  
 (Effective 7/15/2013)

Source: [http://commerce.health.state.ny.us/hesportal/hes\\_home](http://commerce.health.state.ny.us/hesportal/hes_home) Retrieved 7/13

<b>NQF/NYPORTS EVENT</b>
<b>Level 1 Events - RCA REQUIRED</b>
<b>701</b> Patient or staff death or serious injury associated with a <b>burn</b> incurred from any source in the course of a patient care process in a healthcare setting
<b>911</b> Surgery or other invasive procedure performed on the wrong site, side, level or digit
<b>911</b> Surgery or other invasive procedure performed on the wrong patient
<b>911</b> Wrong surgical or other invasive procedure performed on a patient
<b>913</b> Unintended retention of a foreign object in a patient after surgery or other invasive procedure
<b>915</b> Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biologic specimen
<b>915</b> Patient death or serious injury associated with a fall while being cared for in a healthcare setting
<b>915</b> Patient death or serious injury associated from failure to follow up or communicate lab, pathology, or radiology test results
<b>915</b> Patient death or serious injury of patient or staff associated with the introduction of a metallic object into the <b>MRI</b> area
<b>915</b> Maternal death or serious injury associated with labor or delivery while being cared for in a healthcare setting
<b>915</b> Death or serious injury of a neonate associated with labor or delivery
<b>915</b> Patient death or serious injury in circumstances other than those related to the natural course of illness, disease or proper treatment in accordance with generally accepted medical standards
<b>915</b> Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting
<b>915</b> Patient death or serious injury associated with a <b>medication error</b> (i.e. errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation or wrong route of administration), and omissions
<b>915</b> Intraoperative or immediately post-operative/post procedure (within 24 hrs) death in an ASA (American Society of Anesthesiology) Class 1 or Class 1E patient
<b>921</b> Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting
<b>922</b> All patient <b>suicides</b> and attempted suicides, regardless of level of injury; and self harm that results in serious injury, while being cared for in a healthcare setting
<b>923</b> Patient death or serious injury associated with patient elopement (disappearance)
<b>938</b> Patient death or serious injury associated with the use or function of a device in patient care in which the device is used or functions other than as intended
<b>961</b> Abduction of a patient of any age
<b>962</b> Discharge or release of a patient of any age, who is unable to make decisions, to other than an authorized person
<b>963</b> Sexual abuse/Sexual assault on a patient or staff member within or on the grounds of a healthcare setting
<b>Level 2 Events - No RCA required</b>
<b>914</b> Misadministration of radiation or radioactive material (as defined by BERP, Section 16.25, 10 NYCRR)
<b>931</b> Strike by hospital staff
<b>932</b> External disaster outside the control of the hospital, which effects facility operations (natural or catastrophic disasters)
<b>933</b> Termination of any services vital to the continued safe operation of the hospital or to the health and safety of its patients and personnel (ie, telephone, electric, gas, fuel, water, heat, air conditioning, food, pest control etc)
<b>934</b> Poisoning occurring within the hospital. (water, air, food)
<b>935</b> Hospital fire or other internal disaster disrupting patient care or causing harm to patients or staff.
<b>Other</b>
Patient death or serious injury associated with unsafe administration of blood products



**TABLE 3:**

**SENTINEL EVENT LISTING**

Source: CAMH March 1, 2013

[www.jointcommission.org](http://www.jointcommission.org)

Accessed October 2, 2013

Any event that results in unanticipated death or major permanent loss of function not related to the natural course of the patient's illness or underlying condition

The event is one of the following (even if the outcome was not death or major permanent loss of function not related to the natural course of the patient's illness or underlying condition):

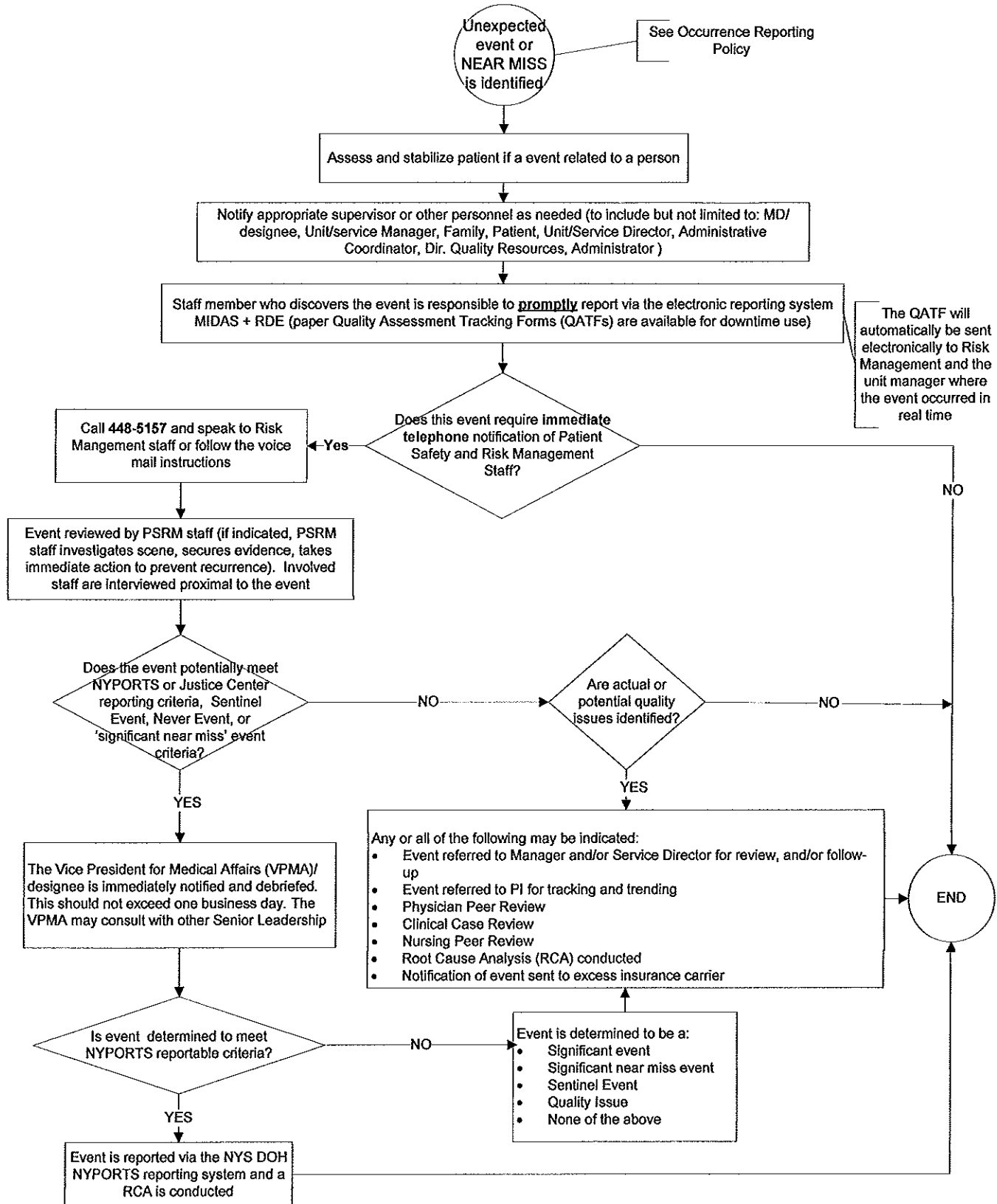
- Suicide of any patient receiving care, treatment and services in a staffed around-the-clock care setting or within 72 hours of discharge
- Unanticipated death of a full-term infant
- Abduction of any patient receiving care, treatment, and services
- Discharge of an infant to the wrong family
- Rape, assault (leading to death or permanent loss of function) or homicide of any patient receiving care, treatment and services. Further defined as unconsented sexual contact involving a patient and another patient, staff member or other perpetrator while being treated or on the premises of the hospital.
- Rape, assault (leading to death or permanent loss of function) or homicide of a staff member, licensed independent practitioner, visitor or vendor while on site at the health care organization
- Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities (ABO, Rh, other blood groups)
- Invasive procedure, including surgery on the wrong patient, wrong site, or wrong procedure
- Unintended retention of a foreign object in a patient after surgery or other invasive procedures
- Severe neonatal hyperbilirubinemia (bilirubin >30 milligrams/deciliter)
- Prolonged fluoroscopy with cumulative dose >1500 rads to a single field, or any delivery of radiotherapy to the wrong body region or > 25% above the planned radiotherapy dose

Examples include the following:

- Any patient death, paralysis, coma, or other major permanent loss of function associated with a medication error
- A patient commits suicide within 72 hours of being discharged from a hospital setting that provides staffed around-the-clock care
- Any elopement, that is, unauthorized departure, of a patient from an around-the-clock care setting resulting in a temporally related death (suicide, accidental death, or homicide) or major permanent loss of function
- A hospital performing the wrong invasive procedure or operating on the wrong side of the patient's body, on the wrong site on the patient's body, or on the wrong patient
- Any intrapartum (related to the birth process) maternal death
- Any perinatal death unrelated to a congenital condition in an infant having a birth weight greater than 2,500 grams

- A patient is abducted from the hospital where he or she received care, treatment or services
- Assault, homicide, or other crime resulting in patient death or major permanent loss of function
- Assault, homicide, or other crime resulting in patient death or major permanent loss of function of a staff member, licensed independent practitioner, visitor or vendor
- A patient fall that results in death or major permanent death, or major permanent loss of function
- Hemolytic transfusion reaction involving major blood group incompatibilities
- A foreign body, such as a sponge or forceps, that was left in a patient after surgery

# St. Josephs Hospital Health Center Unexpected and NEAR MISS Event Reporting

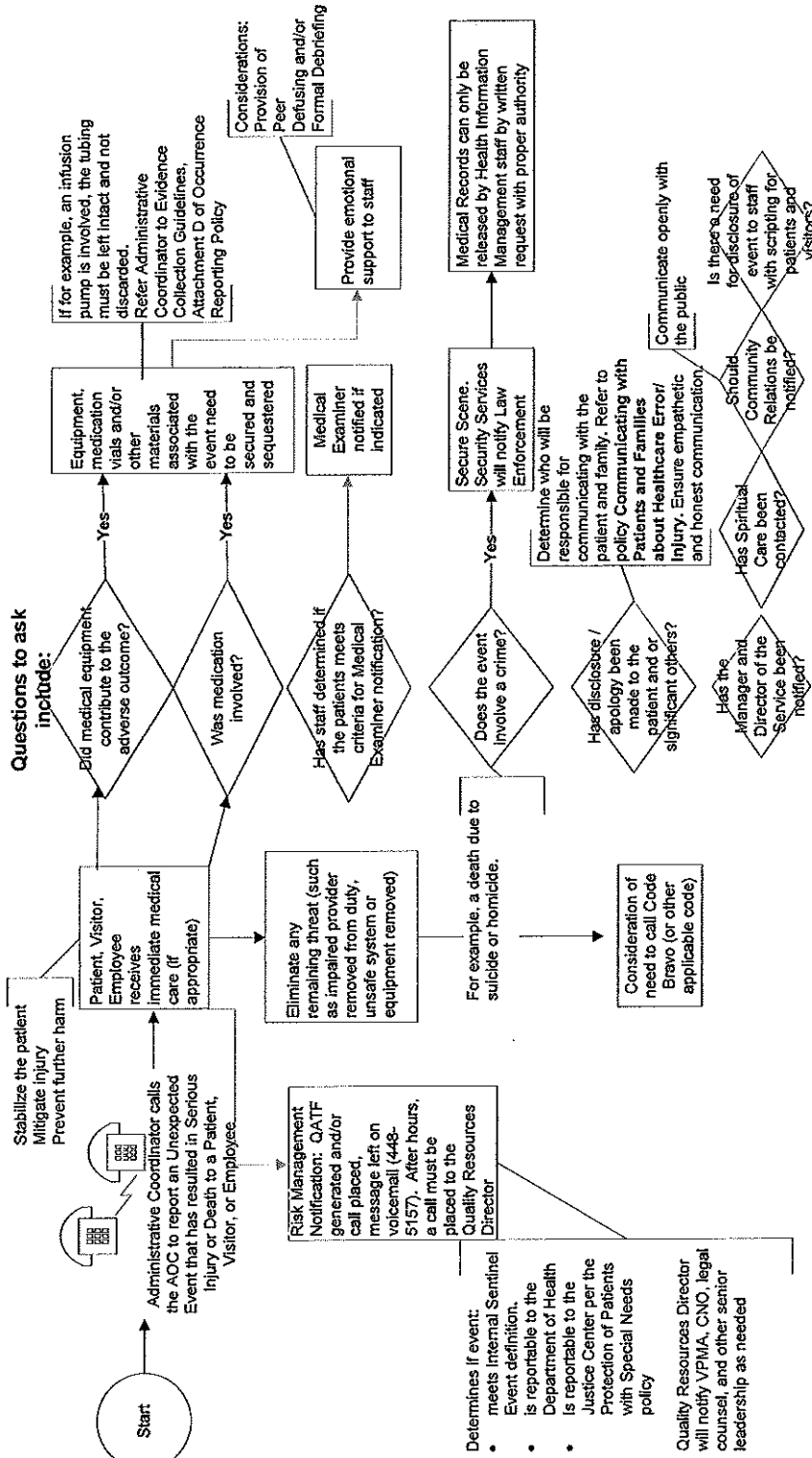


Original: Jan 2013    Revised: Apr 2013  
VisioDocument

**ATTACHMENT B:**

**Flowchart for Administrator on Call (AOC): What to Do if an Unexpected Serious Event Occurs**  
*(Unexpected events may include those resulting in serious physical or psychological injury or death to a patient, visitor, or employee)*

10/7/2013



Reference:  
 2006 Massachusetts Coalition for the Prevention of Medical Errors.  
 When things go wrong. Responding to adverse events. A consensus statement of the Harvard Hospitals. Massachusetts: Author.  
 Original: June 20, 2008 Revised: June 23, 2008; June 24, 2008; January 8, 2009; January 22, 2009; January 2010, October 2011, April 2013, May 2013, October 2013


## ATTACHMENT C:

### Guidelines for Completion of a Quality Assessment Tracking Form (QATF)

#### MIDAS-RDE:

NOTES: A **bold** field indicates a required field.

Any item that requires a selection from the dictionary or drop down menu does not allow you to free text.

- a. Access the hospital internet (SJEN, WORK TOOLS), and then click on the selection MIDAS-RDE.
- b. Select the appropriate Risk Form (QATF).
- c. When you have selected the appropriate Risk form, a screen appears with the Facility name. You are prompted to enter the event date in the mm/dd/yyyy format, or use the calendar button to the right of the field. Hint: Enter the letter T and hit the tab key and today's date will populate automatically.
- d. The next selection is patient or non-patient, and then click next.
- e. The next screen assists you in identifying an individual patient. It is recommended that the search is by account number, a 10 digit number beginning with 300...because it is unique to the current patient and current visit. When you search by patient name, you may have multiple same name patients and you must select the correct patient as well as the correct visit for that patient. If you search by medical record number you will get the correct patient but still must ensure you select the correct encounter for your entry. Once a patient name and encounter appears in the Encounter window, ensure you have the correct patient AND correct encounter then: **click ok**.
- f. Complete all the fields in the MIDAS-RDE form.
  - Remember **bold** fields are mandatory. You must enter data in this field to successfully save the event.
  - You have 20 minutes to complete the form before timing out. You can see the clock in the lower left hand corner of the form. Hint: if you need more time, make a selection in a dictionary field and the clock will reset.
  - Fields followed by an *ellipsis* button  must be completed by selecting from the drop down box.
  - For many fields, help notes are available to assist the user. If you right click on the field, check the screen; if help is available for that field, the text will be visible.
  - The narrative box is a free text field. This should be a detailed, objective description of what happened. It should be as brief as possible but contain the necessary, accurate, and objective details of the event.
- g. When you have completed your data entry, before clicking on the submit button, review the information entered and make changes as necessary. You may want to note the event number which is auto-assigned by the system in case you need to update later or give information to your manager. The event number starts with the last two digits of the year, followed by a hyphen and an auto assigned consecutive number (i.e.; 13-1123). When you are satisfied that your entry is complete, click on the Submit button.
- h. If any of the mandatory fields have not been answered, when you click the submit button you will see a window indicating the fields not completed, otherwise, you will see a new screen and the words "Remote Data Entry Saved Successfully."
- i. If no other entry is to be made at this time, close out of MIDAS-RDE by clicking on the X to close the program.

#### PAPER QATFS:

##### 1.0 Generic QATF - form #18654 QUALITY ASSESSMENT TRACKING FORM

- a. Affix patient identification label to both copies of form.
- b. Complete all of the blanks/demographic information on the upper third of the form.
- c. Check the occurrence category that best fits the event.

- d. If equipment is involved in the event, be sure to obtain and document the asset #, model, serial number and manufacturer as requested. Also remember to notify Clinical Engineering by pager or telephone if MIDAS is not available. Please review the back of the form for securing equipment if indicated or see flowchart, Attachment D, attached to this policy.
- e. Please completely fill in the blanks on the lower third of the form and have it signed by the supervisor prior to submitting to Risk Management via interdepartmental mail or fax to 448-5719. The yellow copy should be retained for the service manager.
- f. Immediately notify Risk Management staff at **448-5157** for all events that are **bolded**. Voice mail messages must include: date and location of event, medical record number, and a brief description of the event.

2.0 Medication QATF - form #12025 MEDICATION Q&A TRACKING FORM

- a. Affix patient identification label to both pages of the form.
- b. Complete all sections of the form.
- c. If equipment is involved in the event, be sure to obtain and document the asset #, model, serial number and manufacturer as requested. Also remember to notify Clinical Engineering by pager or telephone if MIDAS is not available. Please review the flow chart attached to this policy for securing equipment if indicated.

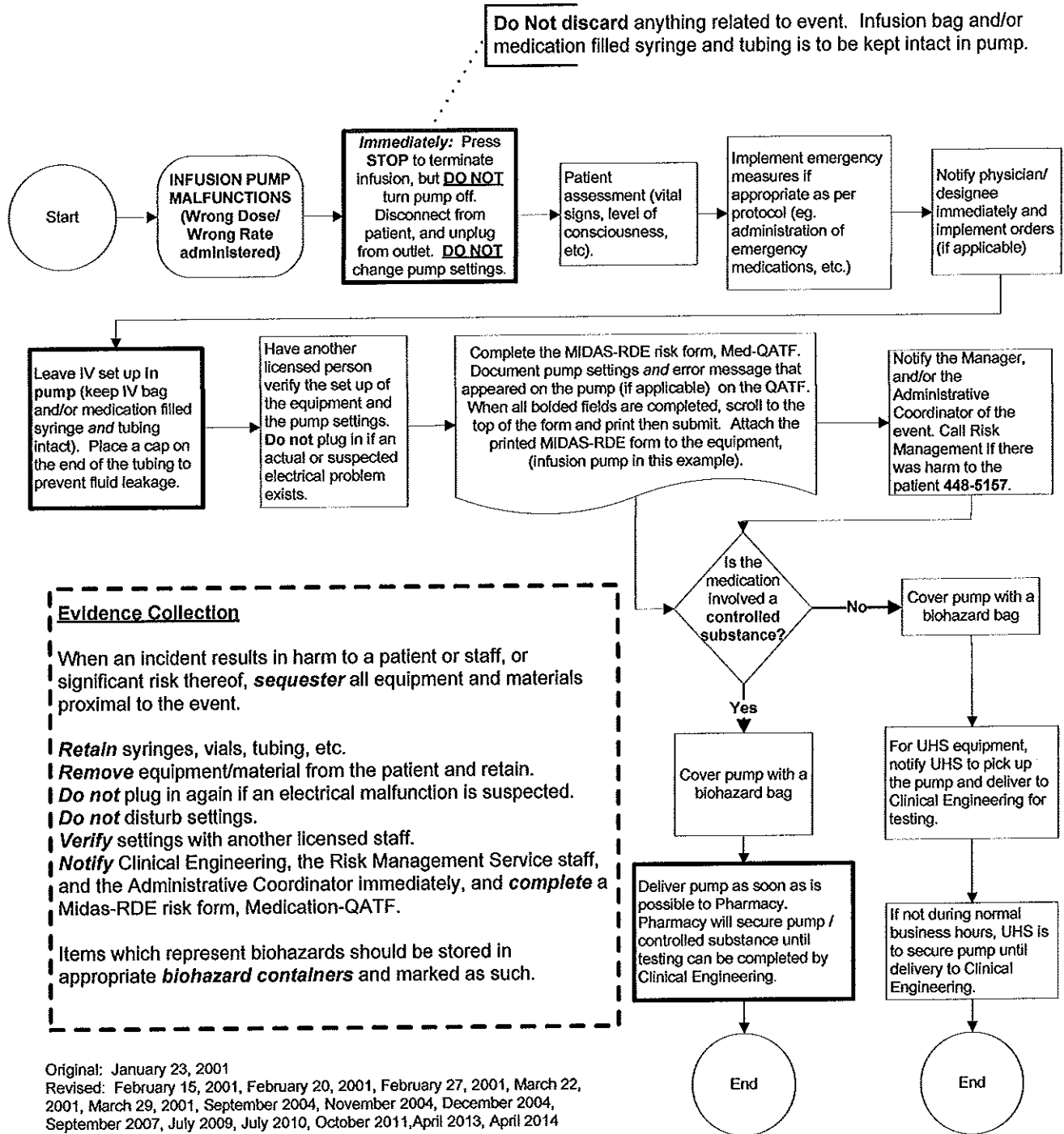
**Reminder: If a controlled substance is involved, secure the device until testing can be completed by Clinical Engineering. When clinical engineering staff is not immediately available, the device is to be secured in the Pharmacy.**

- d. Immediately notify Risk Management staff at **448-5157** for any event where the patient has sustained harm related to the occurrence. Voice mail messages left must include: date and location of event, medical record number, and a brief description of the event.

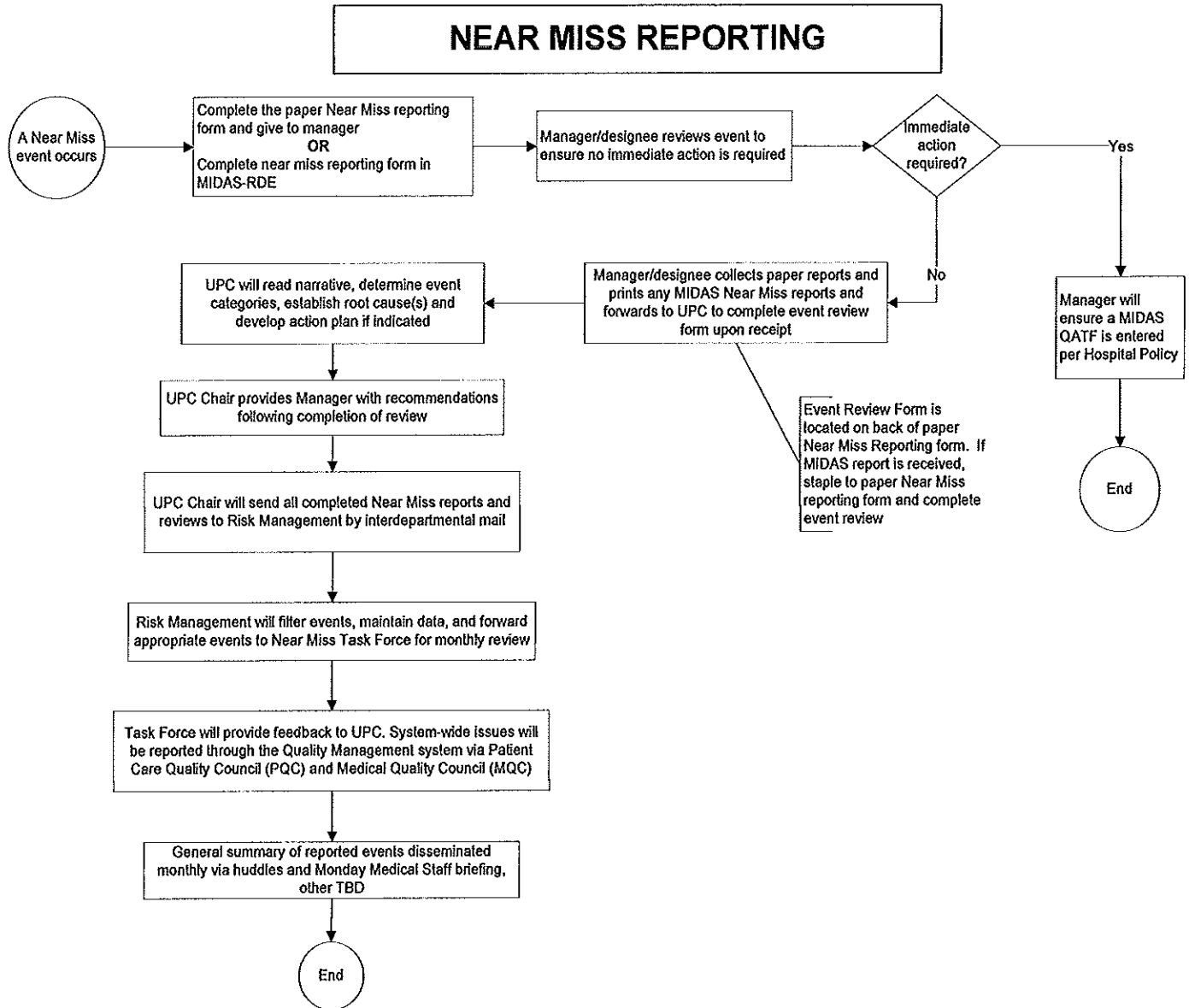
3.0 Fall QATF - form #16767 FALL/QUALITY ASSESMENT TRACKING FORM

- a. Affix patient identification label to both pages of the form.
- b. Complete all of the blanks/demographic information on the upper third of the form.
- c. Check the Incident Type that best fits the event.
- d. Complete all sections of the form.
- e. Immediately notify Risk Management staff at **448-5157** for any occurrence where the patient has sustained a serious injury (head injury, fracture, etc.). Voice mail messages left must include: date and location of event, medical record number, and a brief description of the event.
- f. Call security to complete a report if a non-patient or visitor fell.

## Securing Equipment After An Occurrence That Involves Harm or Potential Harm Infusion Pump Malfunction (Example)



**ATTACHEMENT E:**



Original: June 2013  
Lucrilia Pine



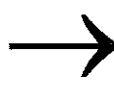
**ATTACHMENT F:**


**A Framework for a Root Cause Analysis and Action Plan in Response to an Unexpected Event**

**Event:**  
**Risk #:**

Non-NYPORTS Event

Sentinel Event

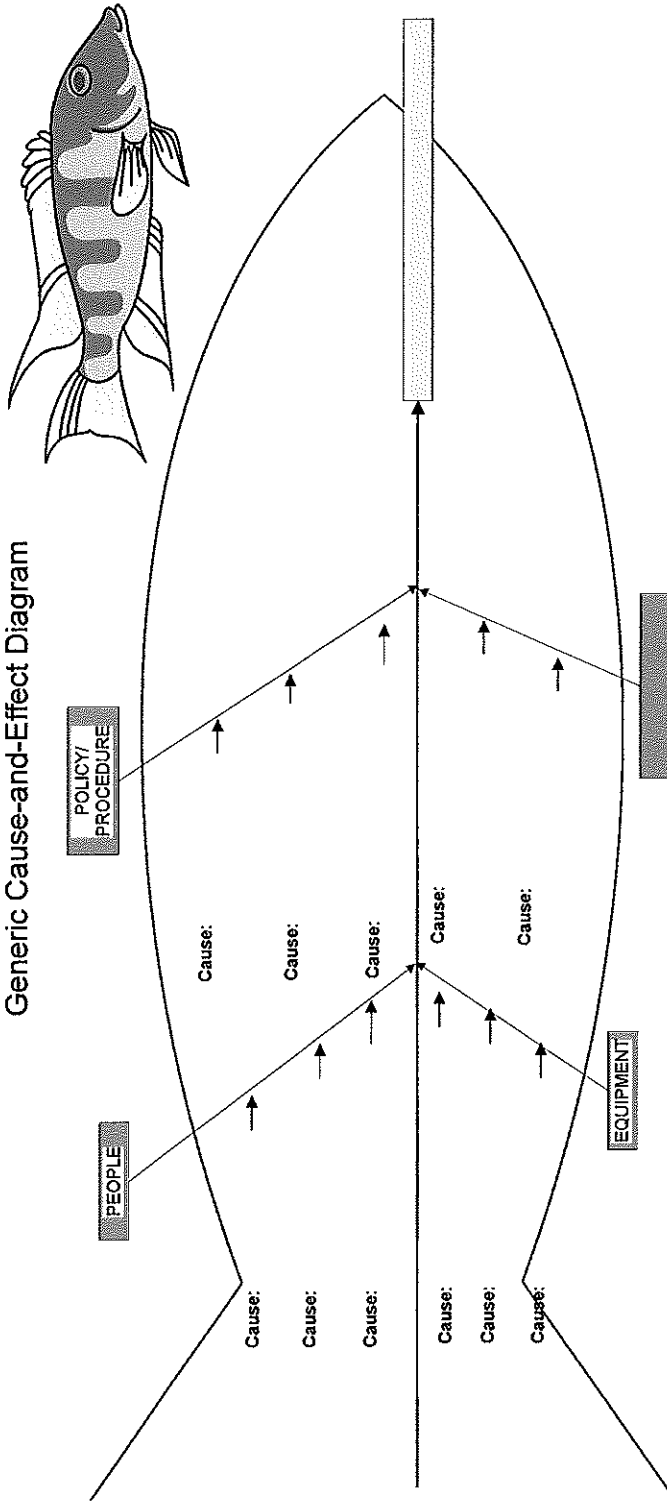
<u>Level of Analysis</u>	<u>Questions</u>	<u>Findings</u>	Root cause?	Ask "Why?"	Take action?
What happened? 	What are the details of the event? (Brief description) When did the event occur? (Date, day of week, time) What area/service was impacted?				

<p><b>Why did it happen?</b></p> <p><b><u>What</u></b> <b><u>were the</u></b> <b><u>most</u></b> <b><u>proximate</u></b> <b><u>factors?</u></b> (Typically "special cause" variations)</p> 	<p>The process or activity in which the event occurred</p>	<p>What are the steps in the process, as designed? (A flow diagram may be helpful here)</p>			
--	--	---	--	--	--

Is the system in place related to the event effective?  
*Was the system in place related to the event carried out as intended?*  
*Is an effective policy in writing?*  
*Was the policy effectively communicated?*  
*Is an effective procedure in place?*

What steps were involved in (contributed to) the event?

## Generic Cause-and-Effect Diagram




### How to construct a Cause-and Effect Diagram (see Figure 1):

1. Summarize your effect or problem statement in as few words as possible (the so-called spine of the fish) .
2. Determine headers for each category. These categories trigger thinking about possible causes (between 3 and 6 categories). Connect these to the spine with arrows (called bones or branches). Use these versatile categories to trigger possible causes of the effect you're trying to improve. Ishikawa suggested using generic headers such as: material, machine, measurement, man (people), and methods. Other generic possibilities include: Equipment, people, materials, methods, money OR Policies, people, paper, technology, and methods.
3. Determine what elements of each category are contributing to the effect. These elements are the subsidiary causes that influence the effect in question. Write those answers on lines or bones branching off the category lines.
4. Continue to dig for the causes in each branch of your chart until you reach what you believe to be the root cause of each bone. A good rule of thumb is to ask why 5 times to ferret out root causes.
5. Clean out the diagram before testing the theories reflected within it. Because brainstorming is used along the way and it produces freewheeling thinking, not all causes generated will turn out to be pertinent. Thus, the logic for each cause should be checked. For each set of bones, work both forward and backward to double check the validity of the causal links.
6. Narrow down your theories. Show the chart to people close to the causes identified and invite their views about the most powerful ones. Vote to select key causes worthy of further investigation (ie. nominal group voting).

Reference:  
 Leebow, W., & Esocz, C.J. (1981). The Health Care Manager's guide to continuous quality improvement. USA: American Hospital Publishing, Inc.  
 Original: April 30, 1998, Revised April 2013  
 water/rela/rla/hp/lec3.vcd

		<p>Human factors</p> <p>Equipment factors</p> <p>Controllable environmental factors</p> <p>Uncontrollable external factors</p> <p>Other</p>	<p>What human factors were relevant to the outcome?</p> <p>How did the equipment performance affect the outcome?</p> <p>What factors directly affected the outcome?</p> <p>Are they truly beyond the organization's control?</p> <p>Are there any other factors that have directly influenced this outcome?</p> <p>What other areas or services are impacted? Question: Are there any other areas in the Health Care Organization where this could happen?</p>	<p><b><u>Why did that happen? What systems and processes underlie those proximate factors?</u></b> (Common cause variation here may lead to special cause variation)</p>	<p>Human resource issues</p>	<p>To what degree are staff properly qualified and currently competent for their responsibilities?</p> <p>How did actual staffing compare with ideal levels?</p> <p>What are the plans for dealing with contingencies that would tend to reduce effective staffing levels?</p>	<p><i>Did human factors contribute to the outcome?</i></p> <p>Did controllable equipment factors contribute to event?</p> <p>Did controllable environmental factors contribute to the event?</p> <p>Were uncontrollable external factors (natural disasters, power outages) a factor in this case?</p> <p><i>Are staff properly qualified?</i> <i>Are staff currently assessed as competent to carry out their responsibilities?</i></p> <p>All licensed staff are graduates of approved training programs and are properly certified or licensed to perform their job functions. All staff participate in general hospital orientation as well as department specific orientation. Specialized training or certification is obtained as necessary. Staff are required to complete annual competencies and have satisfactory performance evaluations annually.</p> <p>Were staffing level plans in place? Were staffing level plans appropriate? Were staffing levels appropriate? If applicable, how many hours has the staff member worked prior to the event? (Are they working other jobs?)</p> <p>Were staffing level plans implemented?</p>	
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<p>in dependent processes)</p> 		<p>To what degree is staff performance in the operant process(es) addressed?</p> <p>How can orientation &amp; inservice training be improved?</p>	<p>Is staff performance in the relevant processes evaluated? All staff are evaluated annually and have required competences that must be achieved for a satisfactory performance review.</p>				
<p>Information management issues</p>	<p>To what degree is all necessary information available when needed? accurate? complete? Unambiguous?</p> <p>To what degree is communication among participants adequate?</p>	<p>Is orientation and inservice training in place? All staff participate in general hospital orientation as well as department specific orientation. Additional educational opportunities are identified in multiples ways: 1. Formal needs assessment 2. Based on an occurrence or trend 3. Employee request 4. Requirement of governing body 5. Identified by management staff</p>	<p>Was necessary information: Available? Accurate? Complete? Was necessary information clear and unambiguous? 11/05 - Do documentation deficiencies exist (such as unapproved abbreviation use, inadequate vital sign documentation, lack of documentation regarding change in condition)? 11/03/08 - Was the patient and / or family notified of the event? Are the event details documented in the medical record?</p>				
<p>Environmental management issues</p>	<p>To what degree was the physical environment appropriate for the processes being carried out?</p> <p>What systems are in place to identify environmental risks?</p> <p>What emergency and failure-mode responses have been planned and tested?</p>	<p>A system is in place to identify environmental risk. Patient Care Enhancement Team Rounds are conducted on a routine basis and data is collected based on observations made regarding the Environment of Care, Safety, Infection Control and employee safety. An Emergency Preparedness Plan is in place. Have emergency and failure-mode responses been planned and tested? See risk reduction strategies.</p>	<p>Was communication among participants effective? Were barriers to communication identified?</p> <p>Was the physical environment appropriate for the processes/treatment being carried out?</p>				

RISK ASSESSMENT		<p><i>Is there immediate threat to life or limb in which a temporary plan or alert should be implemented while a more comprehensive action plan is developed? If yes, What? When? By Whom?</i></p> <p><i>Does this event meet the serious adverse event criteria? If yes, has appropriate personnel been notified?</i></p>		
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This template is provided as an aid in organizing the steps in a root cause analysis. Not all possibilities and questions will apply in every case, and there may be others that will emerge in the course of the analysis. However, all possibilities and questions should be fully considered in your quest for "root cause" and risk reduction.

As an aid to avoiding "loose ends," the three columns on the right are provided to be checked off for later reference:

"Root cause?" should be answered "yes" or "no" for each finding. A root cause is typically a finding related to a process or system that has a potential for redesign to reduce risk. If a particular finding that is relevant to the event is not a root cause, be sure that it is addressed later in the analysis with a "Why?" question. Each finding that is identified as a root cause should be considered for an action and addressed in the action plan.

"Ask 'Why?'" should be checked off whenever it is reasonable to ask why the particular finding occurred (or didn't occur when it should have)- - in other words, to drill down further. Each item checked in this column should be addressed later in the analysis with a "Why?" question. It is expected that any significant findings that are not identified as root causes themselves have "roots."

"Take action?" should be checked for any finding that can reasonably be considered for a risk reduction strategy. Each item checked in this column should be addressed later in the action plan. It will be helpful to write the number of the associated Action Item on the last page in the "Take Action?" column for each of the findings that require an action.

Conclusion/summary:

**Framework for an Action Plan in Response to an Unexpected Event**

	<u>Risk Reduction Strategies</u>	<u>Measure of Effectiveness</u>
<p>For each of the findings identified in the analysis as needing an action, indicate the planned action, expected implementation date, and associated measure of effectiveness, OR...</p>	<p><b>Action item #1:</b> Determined to require Root Cause analysis</p>	<p><b>Measure:</b></p>
<p>If, after consideration of such a finding, a decision is made not to implement an associated risk reduction strategy, indicate the rationale for not taking action at this time.</p>	<p><b>Action item #2:</b></p> <p><b>Follow-up:</b> <b>Individual Responsible:</b> <b>Target date for completion:</b></p>	<p><b>Measure:</b></p>
<p>Check to be sure that the selected measure will provide data that will permit assessment of the effectiveness of the action.</p>	<p><b>Action item #3:</b></p> <p><b>Follow-up:</b> <b>Individual Responsible:</b> <b>Target date for completion:</b></p>	<p><b>Measure:</b></p>
<p>Consider whether pilot testing of a planned improvement should be conducted.</p>	<p><b>Action item #4:</b></p> <p><b>Follow-up:</b> <b>Individual Responsible:</b> <b>Target date for completion:</b></p>	<p><b>Measure:</b></p>
<p>Improvements to reduce risk should ultimately be implemented in all areas where applicable, not just where the event occurred. Identify where the improvements will be implemented.</p>	<p><b>Action item #5:</b></p> <p><b>Follow-up:</b> <b>Individual Responsible:</b> <b>Target date for completion:</b></p>	<p><b>Measure:</b></p>
	<p><b>Action item #6:</b></p> <p><b>Follow-up:</b> <b>Individual Responsible:</b> <b>Target date for completion:</b></p>	<p><b>Measure:</b></p>



<p><b>Action item #7:</b></p> <p><b>Follow-up:</b></p> <p><b>Individual Responsible:</b> <b>Target date for completion:</b></p> <p><b>Action item #8:</b></p> <p><b>Follow-up:</b></p> <p><b>Individual Responsible:</b> <b>Target date for completion:</b></p> <p><b>Action item #9:</b></p> <p><b>Follow-up:</b></p> <p><b>Individual Responsible:</b> <b>Target date for completion:</b></p> <p><b>Action item #10:</b></p> <p><b>Follow-up:</b></p> <p><b>Individual Responsible:</b> <b>Target date for completion:</b></p>	<p><b>Measure:</b></p> <p><b>Measure:</b></p> <p><b>Measure:</b></p> <p><b>Measure:</b></p>
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Cite any books or journal articles that were considered in developing this analysis and action plan: Refer to Reference List.

**RCA Team Members**

**Event:**  
**Risk #:**

Name	Title / Position

**RCA Team Members (Title Only)**

**Event:**

**Risk #:**

Title / Position

**RCA Team Members**

**Event:**

**Meeting Date:**

**Risk #:**

<b>Team Member</b>	<b>Signature</b>

## **ATTACHMENT G: Definitions**

1. *Healthcare error*: Synonymous with medical error.
2. *Medical error*: The failure of a planned action to be completed as intended (i.e., an error of execution) or the use of a wrong plan to achieve an aim (i.e., an error of planning). [1]
3. *Medical error reporting*: A process in which an adverse event or near miss that is preventable given the current state of medical knowledge, is reported.
4. *Near Miss*: An event that **did not** reach the patient. The event **almost happened** but was intercepted (or caught) before it had the chance to reach the patient. A near miss could be a warning sign of a significant system problem. [3]
5. *Non-patient*: A visitor, or an outpatient who is **not** under the care of hospital staff at the time of the occurrence. It could also refer to occurrences involving equipment, environment, narcotic discrepancies etc.
6. *Never Event / Serious Reportable Event*: Error in medical care that is clearly preventable, identifiable and serious in its consequences for the patient. For listing, see Table 1.
7. *NYPORTS Reportable Event*: Those events as prescribed by the New York State Department of Health under Public Health Law Section 2805-I. These events require a root cause analysis and may also be a Never Event/ Serious Reportable Event and/or a sentinel event. For NYPORTS event listing, see Table 2.
8. *Occurrence*: An occurrence is any event that is not consistent with the routine operation of the hospital or the routine care of a particular patient. It may be an accident or an event which has caused physical or emotional harm to a patient, or has the potential risk thereof.
9. *Root Cause Analysis*: Root cause analysis is a process for identifying the factors that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event. A root cause analysis focuses primarily on systems and processes, not on individual performance. The analysis progresses from *special causes* in clinical processes to *common causes* in organizational processes and systems and identifies potential improvements in these processes or systems that would tend to decrease the likelihood of such events in the future or determines, after analysis that no such improvement opportunities exist.
  - i. *Common cause* is a factor that results from variation inherent in the process or system. The risk of a common cause can be reduced by redesigning the process or system.
  - ii. *Special cause* is a factor that intermittently and unpredictably induces variation over and above what is inherent in the system. It often appears as an extreme point (such as a point beyond the control limits on a control chart) or some specific, identifiable pattern in data.

Source: Comprehensive Accreditation Manual for Hospitals (CAMH). March 2012.
10. *Sentinel Event*: A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or the risk thereof" includes any process for which a recurrence would carry a significant chance of a serious adverse outcome.
  - iii. Such events are called "sentinel" because they signal the need for immediate investigation and response.
  - iv. The terms "sentinel event" and "medical error" are not synonymous; not all sentinel events occur because of an error and not all errors result in sentinel events.

These events require a root cause analysis and may also be a Never Event/ Serious Reportable Event and/or NYPORTS reportable. For a sentinel event listing, see Table 3.
11. *Unanticipated Outcome*: A result that differs significantly from what was anticipated to be the result of the treatment or procedure. [2]
12. *Unexpected Event*: Any happening or occurrence that is not part of the routine care of a particular patient or the routine operation of the healthcare entity. [2]

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