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| Serious Adverse Events | **Last Revision:** | November 2017 |
| **Last Reviewed:** | November 2017 |
| **Applies to the following THA Group of Companies:** | * Island Health Care * Island Hospice * Independent Life at Home * RightHealth® |
| **Included in the following THA Manuals:** | Administrative Policies & Procedures  Risk Management |

### POLICY

All unanticipated adverse events such as occurrences resulting in death or serious physical injury or psychological injury are thoroughly investigated and analyzed by staff having direct contact or involvement in the events, as well as by Senior Management, and are classified as Serious Adverse Events. A Serious Adverse Event is an unexpected event or occurrence that results in death or serious physical or psychological injury. Adverse Events that are defined as Serious Adverse Events are:

1. Unexpected death not resulting from the client's medical condition
2. Loss of body parts
3. Permanent or partial loss of body function
4. Blindness
5. Rape
6. Injury by violence

**PURPOSE**

1. To develop strategies that have a positive impact on improving patient care, treatment, services and preventing serious adverse events.
2. To focus the attention of the organization on understanding the underlying factors causing a serious adverse event in order to change systems and processes to reduce the probability of such an event in the future.

### PROCEDURE

1. The clinician or manager receiving information that a serious adverse event has occurred immediately begins the reporting process (see [Patient Adverse Events policy](file:///\\Tha-fs1\2006\Policies%20and%20Procedures%202016\Administrative%20Policies%20and%20Procedures%20Manual\06%20Risk%20Management\Adverse%20Events.doc) and [report](https://thagroup.wufoo.com/forms/ziv6ql10faixg9/)).
2. A [Patient Adverse Event Report](https://thagroup.wufoo.com/forms/ziv6ql10faixg9/) is completed within 24 hours and discussed with the Assistant Vice President of Performance Excellence, who also notifies the Chief Executive Officer (CEO) upon learning about the serious adverse event.
3. The Assistant Vice President of ome HEalth, Home Care and HOscpPerformance Excellence, Director of Patient Centered Care (DPCC) and Vice President of Talent Management begin the in-depth investigation by discussing the event with the clinician involved and by reviewing the patient care record, including vital sign trends, face-to-face visit and telephonic visit notes, in order to gather all clinical and statistical data and information possible about the patient care plan and care process.
4. The Assistant Vice President of Performance Excellence reports the progress of the actions taken to investigate the event to the CEO within 24 hours of the serious adverse event.
5. The Assistant Vice President of Performance Excellence initiates a formal written root cause analysis of the serious adverse event, in collaboration with the DPCC responsible for the care provided.
6. The Assistant Vice President of Performance Excellence is responsible for the direction and oversight of the development of an action plan to address areas in the underlying process identified by the root cause analysis as potential areas of failure or weakness.
7. The Assistant Vice President of Performance Excellence, in coordination with the CEO, select process improvement team(s) to address specific areas for improvement that may be identified through the findings of the root cause analysis.
8. The CEO determines the process for reporting any serious adverse events to accrediting and/or regulatory agencies on a case by case basis in accordance with standards and regulations.
9. A full report of the serious adverse event, including the root cause analysis findings and actions taken as a result of the process improvement team(s), is provided to the Coordinating Council.
10. Action is taken to implement recommendations made by the process/performance improvement team(s) upon direction from the Coordinating Council.

**STAFF EDUCATION**

1. Employees are educated about reporting adverse events at the time of new-hire orientation.
2. After any serious adverse event has occurred and a root cause analysis is conducted, the findings are used as an educational tool for all staff. In-service education about the general circumstances of such an event is used for training purposes, while maintaining confidentiality of the patient/client and specific details of the actual event.
3. If investigation yields negligence on the part of the responsible clinician, any necessary disciplinary action will be address by the Vice President of Talent Management and applicable supervisor.