Quality/Performance Improvement (continued)

Occurrences and Sentinel Events

Policy

- **Employees report as an occurrence any act or omission in the provision of services that is not consistent with acceptable, routine client services and has the reasonable potential to result in an adverse outcome to the client.**
- **Employees report as a sentinel event any unexpected occurrence involving a client that results in actual or risk for unexpected death or serious physical or psychological injury.**
- **The Office analyzes reported occurrences and sentinel events, and takes preventive action, documenting and evaluating the process as a quality/performance improvement activity.**
- **The reporting of occurrences and sentinel events is *in accordance with applicable law or regulation.***

Responsibility

- The Administrator/Manager identifies, analyzes, and tracks any known occurrence or a sentinel event from an employee or external source.
- The Administrator/Manager ensures that reporting of the occurrence or sentinel event occurs in accordance with the organization's provisions for liability insurance, and provides any additional information as required.
- The Administrator/Manager is knowledgeable and complies with any applicable state law or regulation regarding the reporting of sentinel events.

Definitions

Adverse Outcome: Any death or injury or perception of an injury to a client that occurs as a result of an act or omission in the delivery of client services that is not consistent with acceptable, routine services or the client's service plan.

Occurrence: Any act or omission in the provision of services that is not consistent with acceptable, routine client services, and has the reasonable potential to result in an adverse outcome for the client.

Sentinel Event: An unexpected occurrence involving actual or risk for death or serious physical or psychological injury. At a minimum, sentinel events include:

- Unexpected death, or loss of limb or major permanent loss of function that is not related to the normal course of disease; and
- Allegation of physical, psychological or sexual abuse.

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Occurrences and Sentinel Events (continued)

Definition (continued)

Procedure

1. The Administrator/Manager or designee advises in-office and field employees to forward reports of occurrences and sentinel events to the Administrator/Manager or designee.
2. The Administrator/Manager or designee receives and investigates any report of an occurrence or sentinel event Refer to Addendum E - *Occurrence Reporting Decision Tree* in this Chapter).
3. Upon receipt of a report of an occurrence or sentinel event, the Administrator/Manager or designee documents the report - including the date of the report and the reported nature of the occurrence or sentinel event. (Refer to form ***Home Care Confidential Occurrence Report to Attorneys*** **[item # G10000]** or the form supplied by the office's insurance carrier).
4. The Administrator/Manager or designee contacts the employee most familiar with the occurrence or sentinel event and he/she documents the reported facts of the occurrence in the client record including any communication with family/caregivers, emergency response etc..
5. The Administrator/Manager or designee ensures that the responsible family members or other caregivers are advised of the occurrence.
6. Any additional action taken by the Administrator/Manager or designee that is not related to client service (e.g. contact with police or protective services) is maintained in the quality/performance improvement files.
   a) Employee discipline is documented separately from the client record and is maintained in the employee file, (e.g. education, training, counseling, discipline).
7. The Administrator/Manager or designee:
   a) Gathers information leading up to the reported occurrence or sentinel event;
   b) Conducts a root cause analysis of a reported occurrence or sentinel event (refer to Addendum F – *Root Cause Analysis* in this Chapter);
   c) Reports the findings of the investigation to their risk manager or designated insurance as directed; and
   d) Maintains the documentation of the occurrence or sentinel event and the root cause analysis in the quality/performance improvement files.
8. The Administrator/Manager communicates any occurrences and sentinel events, as well as results of any root cause analyses and prevention action taken including quality/performance improvement projects and results to the Owner/governing body.

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Addendum A

The Office Self Audit Tool has been incorporated into the *Comprehensive Review Tool* - worksheets titled Operations, QI and Regulation

The *Comprehensive Review Tool* is located on ORCA under Services>Personal Care and Support Services>Manuals for Personal Care: Policy and Procedure Manual for Personal Care and Support Services – *Policy & Procedures Frequently Used Addendums & Templates.*

The Comprehensive Review Tool *Reference Guide* is located on ORCA/ under Services>Home Care>Quality and Compliance under heading *Quality Improvement Tools.*

The Office self audit represents only one dimension of an office's compliance and should be reviewed in conjunction with the results of the client record audit (refer to Chapter 3 in this Manual – *Periodic Client Record Review*) and the results of an employee record audit (refer to ORCA under Services>Personal Care and Support Services>Manuals for Personal Care: Policy and Procedure Manual for Personal Care and Support Services – *Policy & Procedures Frequently Used Addendums & Templates*). The results will provide an overview of the processes that support your Office's service delivery of personal care and support services. We also encourage you to add any state-specific items that would enhance your understanding of the compliance status of your office (s).

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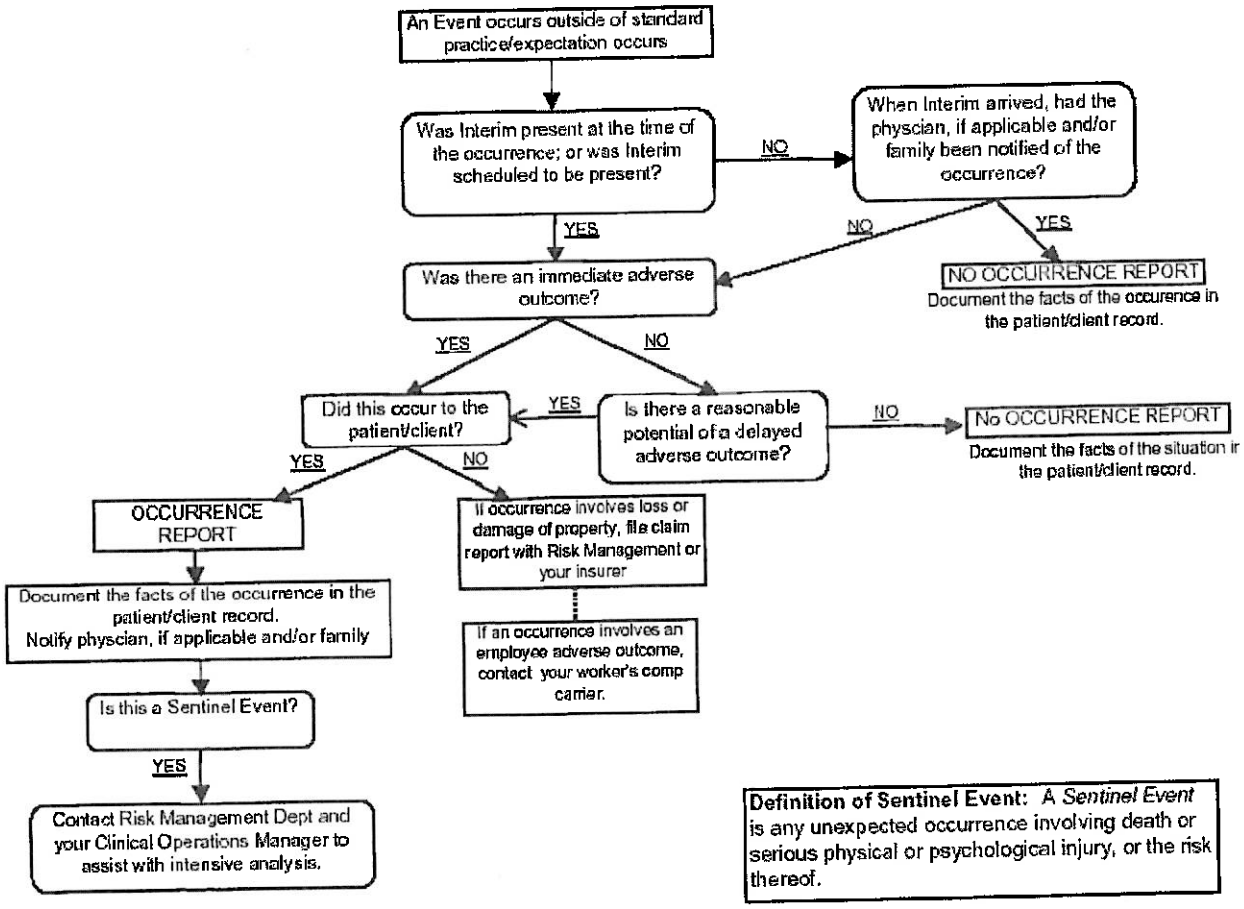
Addendum E

Occurrence Reporting Decision Tree

Definitions:
An *Occurrence* is any act or omission in the furnishing of care/service which is not consistent with routine patient care/client services and which results in or has the reasonable potential to result in an adverse outcome for the patient/client.
An *Adverse Outcome* is any injury or perception of an injury to a patient/client.

OCCURRENCE REPORTING DECISION TREE



Definition of Sentinel Event: A *Sentinel Event* is any unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof.

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SAMPLE
Plan of Action

ACTION	PERSON RESPONSIBLE	DUE DATE
Identify resources on fall prevention • Review Learning Center offerings • Search ORCA • Contact Interim HealthCare's Regional Operations Consultant • Surf internet	Bob, Administrator	10-12-12
Identify a date to meet with all supervisors to collaborate on a fall prevention plan. Send invitations.	Bob, Administrator	10-14-12
Have a meeting to write plan with supervisors: • Explain current problem (trends in client falls) • Share resources regarding fall prevention • Requests ideas for fall prevention • Select the three (3) best ideas • Agree on a plan • Detail each step of the plan • Identify who is responsible for each step • Identify appropriate time frames for each step • Post written plan in the supervisors work place area	Bob, Administrator	10-19-12
Establish clear performance expectations with the supervisors including how this process will be monitored.	Bob, Administrator	10-19-12
Order fall prevention materials from resources identified in meeting	Penelope, Receptionist	10-20-12
Complete fall prevention training materials identified in meeting	Supervisors	11-05-12
Develop content for two one hour presentations for aides regarding fall preventions and tasks that assist in fall prevention	Suzy, Supervisor	11-10-12
Set up staff meeting for two one hour presentations regarding fall preventions and tasks that assist in fall prevention on 11/26 and 12/10	Penelope, Receptionist	11-12-12
Conduct fall prevention training for aides	Suzy, Supervisor	11/26/12
Conduct fall prevention training for aides	Suzy, Supervisor	12/10/12
Monitor fall rate monthly and share on-going feedback monthly for 6 months	Bob, Administrator	1-10-13 2-10-13 3-10-13 4-10-13 5-10-13 6-10-13

Was Targeted Outcome Met? ☒ Yes ☐ No - **If no, begin again.**

Administrator/Manager: *Bob C. Smith-Glondiamond* (Signature) *6-11-13* (Date)

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Root Cause Analysis

Office: _____ **Date:** _____

1. Describe the trend you have identified in your analysis of the variance from expected performance. (e.g., in 9 out of 15 client records, there was evidence the client experiencing a fall).

2. Targeted Outcome ("X" percentage improvement within "X" months):

3. Identify the obvious cause (e.g., the aide did not follow safety precautions):

4. What did the Office (as an organization) do/not do that contributed to the obvious cause (e.g., aides were not trained regarding fall precautions)?

   What factors allowed this to occur:

   What factors allowed **this** to occur:

   What factors allowed **this** to occur:

5. Given the **above** factor, what modifications would prevent this variance from happening again:

(over)

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Plan of Action

ACTION	PERSON RESPONSIBLE	DUE DATE

Was Targeted Outcome Met? ❑ Yes ❑ No - If no, begin again.

Administrator/Manager: _____ _____ _____
Signature Date

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