CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

VOLUME 3: QUALITY MANAGEMENT	Effective Date: 11/26/2012
CHAPTER 7: PATIENT SAFETY	Revision Date: 05/2017
3.7.4: PATIENT SAFETY PROGRAM PROCEDURE: INITIAL REVIEW AND ASSESSMENT OF HEALTH CARE INCIDENTS	Attachments: Yes ☐ No ☒

I. PROCEDURE OVERVIEW

California Department of Corrections and Rehabilitation/California Correctional Health Care Services (CCHCS) staff are required to report all health care incidents to headquarters within 24 hours of occurrence or discovery. This procedure outlines the process and responsibilities of a group of Health Care Incident Review Executives (HCIRE) to perform a review of all reported health care incidents which are deemed potential adverse/sentinel events, medication errors with an assigned severity level 4 through 6, or any anomalous health care incident to ensure that:

- Any immediate danger to patients or staff is resolved quickly and effectively.
- Institution staff is provided with direction as to whether a Root Cause Analysis (RCA) is required.

In the event that a health care incident is discovered by a person or entity not employed at an institution, such as court experts, the HCIRE are responsible for communicating information about the health care incident to the appropriate regional and institution program leads.

II. DEFINITIONS

Adverse/Sentinel Event: An event or series of events that cause the death or serious disability of a patient, personnel, or visitor. "Serious disability" means a physical or mental impairment that substantially limits one or more of the major life activities of an individual, or the loss of bodily function, if the impairment lasts more than seven calendar days or is still present at the time of discharge, or unintentional loss of a body part.

Blameworthy Act/Reckless Behavior: A criminal act, a purposefully unsafe act, act involving patient abuse of any kind, or a situation in which an individual takes a substantial and unjustifiable risk that may result in patient harm.

Health Care Incident: An unusual or unexpected occurrence, such as an error, adverse/sentinel event, near miss, accident, or medication event that has or may have adverse health consequences for patients and/or personnel, and requires submission of a written description of the event to the Statewide Health Care Incident Review Committee. For the purposes of this policy, health care incidents include events as described in the Health and Safety Code Section 1279.1; unusual occurrences as described in Title 22, Division 5, Chapter 12, Article 5, Section 79787; adverse drug reactions submitted to the Food and Drug Administration MedWatch Reporting Program; and Potential Quality Issue Referrals.

Medication Event: A medication-related health care incident resulting in an adverse drug reaction, medication error, near miss, omission error, or sentinel event. Medication events may include, but are not limited to, medication prescribing, verification and dispensing, administration and documentation.

Near Miss: An event or situation that could have resulted in a health care incident but did not, either by chance or through timely intervention.

Root Cause Analysis: A structured and standardized process by which a multidisciplinary team analyzes a health care incident, near miss, or adverse/sentinel event, determines the fundamental reasons why the event occurred, and designs and implements a Plan of Action to prevent similar events from occurring in the future.

III. PROCEDURE

A. Health Care Incident Review Executives

1. Appointment Process
   The CCHCS Statewide Patient Safety Committee shall appoint representatives from health care disciplines (Medical Services, Nursing Services, Pharmacy Services, the Mental Health Program, and Dental Services) at statewide and regional levels to serve as HCIREs.
2. Responsibilities
   a. The HCIREs shall meet each business day to review all reported health care incidents which are deemed potential adverse/sentinel events, medication errors with an assigned severity level 4 through 6, or any other anomalous health care incident, received through the centralized electronic Health Care Incident Reporting system. The HCIREs shall determine the appropriate disposition and document their findings of the health care incident.
      1) Institution staff shall complete assigned RCAs. The HCIREs may recommend that institutions group multiple health care incidents with similar characteristics into one aggregate RCA.
      2) Any possible blameworthy acts or reckless behavior shall be referred to the hiring authority for investigation and response. Health care incidents assigned an RCA where a referral is made to the hiring authority shall have the RCA continue without delay or deferral; however, the staff person(s) referred shall be excluded from the RCA process.
      3) Health care incidents with identified clinical practice concerns shall be referred to the appropriate Peer Review Committee. The HCIREs shall coordinate with peers of the appropriate discipline to determine whether clinical staff involved in the health care incident should be removed from providing patient care pending further analysis of the event. Health care incidents assigned an RCA that result in a peer review referral or temporary redirection of health care staff from direct patient care shall have the RCA continue without delay or deferral.
      4) All patient deaths shall undergo a clinical review conducted by a headquarters primary care provider and nurse team as described in the Inmate Medical Services Policies and Procedures (IMSP&P), Volume 1, Chapter, 29.2 Death Reporting and Review Program Procedure.
      5) If requested or if the health care incident is difficult to address, controversial, and/or likely to attract media coverage, HCIREs shall ensure headquarters staff are available to provide technical assistance, consultation and facilitation to institution staff.

b. The institution Chief Executive Officer shall ensure that institution staff complete a thorough and credible RCA as described in IMSP&P, Volume 3, Chapter 7.5, Institution Response to a Health Care Incident.

IV. REFERENCES

- California Code of Regulations, Title 22, Division 5, Chapter 12, Article 5, Section 79787, Reporting
- California Health and Safety Code, Division 2, Chapter 2, Article 1, Section 1250 and
- California Health and Safety Code, Division 2, Chapter 2, Article 3, Sections 1279, 1279.1, and 1279.2
- California Correctional Health Care Services, Inmate Medical Services Policies and Procedures, Volume 1, Chapters 29.1 and 29.2, Death Reporting and Review Program Policy and Procedure
- California Correctional Health Care Services, Inmate Medical Services Policies and Procedures, Volume 3, Chapter 7:
  - 3.7.1 Patient Safety Program Policy
  - 3.7.2 Health Care Incident Reporting Policy
  - 3.7.3 Patient Safety Program Procedure: Statewide Patient Safety Committee
  - 3.7.5 Patient Safety Program Procedure: Institution Response to a Health Care Incident
  - 3.7.6 Patient Safety Program Procedure: Statewide Health Care Incident Review Committee
- California Correctional Health Care Services, Inmate Medical Services Policies and Procedures, Volume 9, Chapter 27, Reporting of Medication Errors and Adverse Drug Reactions
- California Department of Corrections and Rehabilitation, Mental Health Services Delivery System Program Guide, Chapter 10, Suicide Prevention and Response
- Food and Drug Administration, MedWatch: The FDA Safety Information and Adverse Event Reporting Program (http://www.fda.gov/safety/medwatch/default.htm)
- The Joint Commission (www.jointcommission.org)
- National Commission on Correctional Health Care 2008 Standards for Health Services in Prisons
- National Coordinating Council for Medication Error Reporting and Prevention
- United States Department of Veterans Affairs - Veterans Affairs National Center for Patient Safety (http://www.patientsafety.va.gov/)
- Veterans Health Administration Vision 2020 (http://www.va.gov/healthpolicyplanning/vision2020.pdf)