**PURPOSE**

For Ohio Living Home Health & Hospice’s understand the root cause of a serious or adverse event and to reduce the probability of such an event in the future.

**POLICY**

1. Incidents that conform to Ohio Living Home Health & Hospice’s definition of serious or adverse events will be immediately reported to the Executive Director/Administrator or designee. Any member of the staff may report the incident.
2. Under the guidance of the Executive Director/Administrator, the Clinical Team Leader will conduct a root cause analysis of the serious or adverse event.
3. Undesirable patterns or trends in performanceand serious or adverse events will be analyzed.
4. At a minimum, performance measures will be selected related to the following processes as appropriate to care and services:
   1. Medication use
   2. Use of blood and blood components
   3. Equipment malfunction
   4. Oxygen use
   5. Care or services provided to high-risk populations

***Definitions***

1. *Serious Adverse Event (Sentinel Event):* An unexpected occurrence involving death or serious physical or psychological injury.
   1. Serious adverse event injury includes but is not limited to:
      1. loss of limb or function
      2. severe head trauma causing permanent alteration in consciousness
      3. Major permanent loss of function
2. *Adverse Event:* Is an unexpected occurrence involving a serious physical injury requiring emergency hospitalization. These may include, but are not limited to:
   1. Fracture
   2. Dislocation
   3. Major cut or laceration with uncontrolled bleeding
3. *Root Cause Analysis:* A process for identifying the basic or causal factors that underlie variation in performance, including the occurrence or possible occurrence of a serious adverse event. A root cause analysis focuses primarily on systems and processes, not individual performance.
4. *Action Plan*: The product of the root cause analysis is an action plan that identifies the strategies that Ohio Living intends to implement to reduce the risk of similar events occurring in the future.

**PROCEDURE**

1. Inform the Executive Director/Administrator or designee so he/she can provide information to any appropriate outside parties.
2. Ensure that Ohio Living is doing everything possible to provide follow-up care/services to ensure the best possible outcomes for injured parties/property and/or personnel.
3. Follow any immediate regulatory and/or payer reporting requirement.
4. Document appropriate information in occurrence reports and other risk management forms and submit to the Executive Director/Administrator or designee and the Clinical Team Leader. Document objective clinical findings in the clinical record as necessary.
5. Gather detailed information about the event.
6. Remind personnel of the confidentiality surrounding the event and the patient. Assure that personnel are aware of and communicate with the identified spokesperson/liaison, as appropriate.
7. The Clinical Team Leader or designee interviews all parties to the event, obtains written statements to gather an accurate description of the sequence of events.
8. Determine the root cause(s) of the event, including an analysis of all processes and systems related to its occurrence. Involve all appropriate personnel, as determined by the Executive Determine potential improvements in processes or systems that would tend to decrease the likelihood of such events occurring in the future. Examples may include a change in communication, forms, training, equipment, policies, and procedures. If none exist, indicate in the conclusion of the analysis the determination that no such opportunities exist.
9. Establish a plan to address identified opportunities for improvement or formulation of a rationale for not undertaking such changes. Indicate time frame, person responsible, and criteria to evaluate effectiveness of the actions.
10. Director/Administrator or designee in this analysis.
11. The Clinical Team Leader or designee will create a summary of all incidents managed through the serious adverse event intervention action plan.
12. The Executive Director/Administrator will review the summary and forward report recommendations to the Quality Assessment and Performance Improvement Committee.