POLICY OF STATE OF DELAWARE DEPARTMENT OF CORRECTION	POLICY NUMBER B-08	TOTAL PAGES 4
	RELATED NCCHC / ACA STANDARDS: NCCHC: P-B-08 (important); J-B-08 (important), MH-B-02 (important), O-B-02	
CHAPTER: 11 BUREAU OF HEALTHCARE, SUBSTANCE ABUSE, AND MENTAL HEALTH SERVICES	**SUBJECT: Patient Safety**	
APPROVED BY THE BUREAU CHIEF: Deputy Chief, Michael Records (signature on file with BHSAMH)		
APPROVED BY THE COMMISSIONER AND EFFECTIVE THIS DATE Commissioner Monroe B Hudson Jr. October 20, 2021 (signature on file with BHSAMH)		
APPROVED FOR PUBLIC RELEASE		

I. AUTHORITY: 11 *Del. C.* §6536 Medical Care

II. PURPOSE: To ensure there is a system in place to reduce risk and prevent harm to offenders receiving medical, dental, and/or behavioral health services.

III. APPLICABILITY: All Delaware Department of Correction (DDOC) employees and Contract Provider staff, offenders, and any outside healthcare provider servicing DDOC offenders.

IV. DEFINITIONS: See Glossary

V. SUMMARY OF CHANGES: This policy has not changed significantly. An additional NCCHC standard was added to the related standards box at the top of this page.

VI. POLICY:

A. It is the policy of the DDOC that the Responsible Health Authority (RHA) proactively implements a reporting and reviewing system of patient safety for all DDOC facilities. All healthcare staff are encouraged to voluntarily report, in a non-punitive environment, adverse, near-miss, and/or sentinel events that affect patient safety in order to reduce risk and prevent harm. This is accomplished in the following ways:

1. Patient Safety Systems are practice interventions designed to prevent adverse or near-miss clinical events. Patient Safety Systems include, but are not limited to the following:
    a. Patient identification prior to medication administration (e.g. use of photo identification during medication pass).
    b. Establishment of a medication error reporting system
    c. Crushing and floating oral medications that are subject to diversion and/or misuse
2. Near-miss clinical events occur when there is an error that does not result in a consequential adverse patient outcome (e.g., wrong drug dispensed but not administered). These events must be reported and reviewed as follows:
    a. A near miss clinical event may be identified by anyone in DDOC or within the contract provider staff. The staff member identifying the event must immediately notify the site Medical Director, or site Mental Health Director if the event involves a behavioral health event, and the Health Services Administrator (HSA).

b. Notification of the event should include sufficient details of the event being reported.
c. The site Medical Director, or site Mental Health Director will review the event and determine what corrective action is needed.
    i. The site HSA will track and maintain a log of all near-miss clinical reviews at that site. This log must include, at a minimum, the following:
        a) Offender demographics
        b) Date of event
        c) Type of event
        d) Short synopsis of event
        e) Staff involved in event
        f) Recommendations
        g) Date review conducted
        h) Date of final resolution
    ii. The site Medical Director, HSA and MH Director should review the log at least quarterly to identify any potential trends or patterns. Once this review has been completed, the log shall be annotated as such and forwarded to BHSAMH.
d. Information regarding these reviews should be reviewed by the site CQI committee at least quarterly to identify potential opportunities for the formulation of appropriate quality improvement plans.
e. The results of this review shall be shared during quarterly Healthcare Advisory Committee (HAC) Meetings in accordance with BHSAMH policy A-06 Continuous Quality Improvement Program.

3. Adverse clinical events occur when an offender is injured, misdiagnosed, and/or experiences a negative outcome resulting in injury or psychological harm, or if there was potential for injury, or psychological harm to the offender. These events must be reported and reviewed anytime a physical or psychological injury is caused by medical management rather than a patient's disease or condition (e.g., administering the wrong medication) or if there was potential for injury, or psychological harm to the offender. A sizable proportion of adverse events are the result of human error, whether by omission or commission.
    a. An adverse clinical event may be identified by anyone in DDOC or within the contract provider staff. The staff member identifying the event must immediately notify the Bureau of Healthcare, Substance Abuse, and Mental Health Services (BHSAMH), site Medical Director, and the site HSA (and the site Mental Health (MH) Director if the event is behavioral health related). Notification of the event should include sufficient details of the event being reported.
    b. The Site Medical Director and/or Site Mental Health Director shall complete the State of Delaware, Department of Correction, Adverse Clinical Event Report (Attachment 1) outlining the pertinent facts of the case and send a copy to the BHSAMH Bureau Chief, DDOC Medical Director, BHSAMH BH Director, BHSAMH Compliance Director, BHSAMH Quality Assurance Administrator, and the BHSAMH Site Liaison within 7 calendar days of notification of Adverse Clinical event review.
    c. Each adverse clinical event will be investigated and reviewed within 30 days of the occurrence.
        i. The narrative of the event should provide insight into the event and drive changes or adjustments to the current system.

ii. A review of the clinical record, incident reports, video surveillance, and/or other available resources should be utilized as part of the investigation and review as needed or necessary.

iii. If necessary, a Root Cause Analysis (RCA) can be utilized as an effective tool that utilizes a retrospective approach to identify what happened during an adverse event and the contributing factors that lead to its occurrence.

a) An RCA identifies system factors that contributed to an event and determines underlying causation.

b) The results of an RCA, along with information gathered from the report narrative, can be utilized in formulating quality improvement plans (the effectiveness of which can be studied through the Continuous Quality Improvement (CQI) Program – see DDOC Policy *A-06 Continuous Quality Improvement Program*).

c) Most adverse events have multiple root causes.

d) RCA's can improve the safety of the system by highlighting underlying causes of poor performance.

d. Conducting the review

i. The site HSA or the site Mental Health (MH) Director (based on whether the event is medical or behavioral health related) shall chair the review committee.

ii. The committee shall have at least four members present for the review. These members shall include, at a minimum, the following:

a) Site HSA or site MH Director

b) BHSAMH Medical Director, or designee

c) BHSAMH Behavioral Health Director, or designee (if the event is a behavioral health event)

d) Director of Nursing (DON) or designee

e) MH Clinical Supervisor or designee

f) A Registered Nurse (RN)

g) A licensed MH clinician (if the event is a behavioral health event)

h) A security representative as designated by the warden (if there are security related implications)

iii. The Site HSA shall maintain on file sign in sheets and copies of reviews for future reference. Copies shall be forwarded to the BHSAMH Quality Assurance Administrator who will monitor, track, and review all documents for completeness and ensure recommendations are followed.

iv. The BHSAMH Quality Assurance Administrator will track and maintain a log of all reviews for each site. This log must include, at a minimum, the following:

a) Offender demographics

b) Date of event

c) Type of event

d) Short synopsis of event

e) Staff involved in event

f) Recommendations

g) Date review conducted

h) Date of final resolution

v. After each meeting, the site HSA or site MH Director shall summarize the discussion and outline any corrective action plans as agreed upon during the meeting. This report with the Corrective Action Plan is due to the BHSAMH within thirty (30) calendar days following the review meeting.

vi. If there are unresolved questions, a follow-up meeting may be reconvened within 30 days. The BHSAMH Quality Assurance Administrator has the authority to schedule the 30 calendar day meetings as necessary.

vii. The BHSAMH site liaison will be responsible to ensure that the plans have been acted upon through review of the HAC meeting minutes and provide appropriate documentation to the Quality Assurance Director.

4. Sentinel events are called "sentinel" because they signal the need for immediate investigation and response. A sentinel event is a patient safety event that reaches a patient and results in death, permanent harm, or severe temporary harm and intervention is required to sustain life.
    a. All sentinel events must be reported and reviewed.
    b. If the event results in a death, BHSAMH Policy *A-09 Procedure in the Event of an Offender Death or Serious Suicide Attempt* shall take precedence. Otherwise, a sentinel event is initiated and will follow the same process as an Adverse Clinical Event as outlined above.

B. Medication related Adverse Clinical, or Near-Miss events shall be reviewed through the process in DDOC Policy *D-02 Medication Services* unless the event results in the offender being injured physically or psychologically.

C. In most cases, the affected patient should be informed when an adverse event has occurred. However, patient competence, the significance of the event, and/or security concerns may determine the appropriateness of the disclosure.

D. The contract provider should foster a patient safety culture at each site that encourages staff to identify opportunities to reduce harm or potential harm to patients. This can be done through the following:
    1. Initial staff orientation
    2. In-service trainings
    3. Reviewing and incorporating policy and procedure reviews that may guide staff in identifying and reporting problem areas as well as suggesting patient safety system improvements.
    4. Encouraging healthcare staff to be attentive to what is being done (or not done).
    5. Encouraging staff to openly report and address problems and offer solutions.

E. Confidentiality
    1. The processes described in this policy is a peer review process pursuant to Title 24, Delaware Code § 1768. These processes may also be covered by other state and federal laws, such as the quality assurance privilege. Accordingly, the records and proceedings of the committee are confidential and may be used by the committee and the members thereof only in the exercise of the proper functions of the committee. Confidentiality of information will be consistent with Title 16, Delaware Code § 1210, 1211 and 1212, and any other applicable state and federal laws

F. The Contracted Medical Provider shall develop within 30 days of the effective date of this policy, a site-specific procedure for each Level 4 and Level 5 facility implementing this policy and coordinating the procedure with the BHSAMH.

Adverse Clinical/Sentinel Event Report

Delaware Department of Correction
Bureau of Healthcare, Substance Abuse, and Mental Health Services
245 McKee Road
Dover, DE 19904

Type of Event: ☐ Adverse Clinical Event ☐ Sentinel Event	Date of Report:	Date of Event:
Location: Level 5: ☐ HRYCI ☐ BWCI ☐ JTVCC ☐ SCI Level 4: ☐ PCCC ☐ HD Plant ☐ CVOP ☐ MCCC ☐ SWRC ☐ SVOP		Housing Location:
I/M Name:	SBI#:	DOB:
Gender: ☐ Male ☐ Female ☐	Race/Ethnicity: ☐ White ☐ Black ☐ Hispanic ☐ Asian/Indian ☐ Native American ☐ Pacific Islander ☐ Other _____	
Provide a synopsis of the event (synopsis should include who and how the event was discovered):		

Medical Staff involved	Behavioral Health Staff involved	Security Staff involved

This document is protected from disclosure pursuant to state and federal peer review and quality assurance privileges.

Date Review conducted:
Review findings:

Recommendations for Action - must follow S.M.A.R.T. format and include specific documentation to be submitted as proof of completion of recommended action and the specific person responsible for implementing the action.

	Description of recommendation	Date Due	Documentation to be submitted as proof	Person Responsible
A				
B				
C				
D				

Approval for closure

Title	Printed Name	Signature	Date
Contract Site Medical Director			
Contract Mental Health Site Director			
BHSAMH Medical Director			
BHSAMH Behavioral Health Director			
BHSAMH Bureau Chief			