South Metro Fire Department

Clinical Policies and Procedures

Title:	Patient Safety Event Reporting
Effective Date:	December 15, 2015
Authorized By:	Keith Wesley, MD Medical Director
Standard:	Patient Care and Transport
Policy:	All adverse or potentially adverse events occurring during the care of a patient will be reported by the established mechanism. • Reporting **must occur** when a staff member, provider, or leader identifies any Sentinel Event. • Reporting **should occur** when a staff member, provider, or leader identifies a Serious Event.

I. Purpose

This policy serves to support a culture of safety in which individuals submitting reports related to events involving patient safety are held accountable for decisions impacting patient care, but without punitive action, when circumstances of human error or poorly designed systems of care delivery are involved.

II. Definitions

A. Sentinel Event: An accident, occurrence, or safety event in the course of care delivery **that results** in patient harm, injury, complication, or death. Examples include, but are not limited to;

- Medication administration errors that require immediate intervention.
- Multiple failed advanced airway attempts.
- Unrecognized esophageal intubation.
- Failure of equipment required to sustain life.
- Physical injury to a patient during care delivery and/or transport.

B. Serious Event: A safety hazard, near/miss, good catch, or other issue **that could have** potentially resulted in patient harm, or was caught before it reached the patient but could have caused harm to the patient. Examples include, but are not limited to;

- Incorrect medication prepared, but not given.
- Dispatch error causing prolonged response time to high priority call (Charlie, Delta, Echo).
- Vehicle failure after initiating response or during transport that prolongs response time or transport time of high priority call.
- Near elopement of a patient.
- Delivery of a patient to the wrong address.

- Unexpected deterioration of a patient that requires diverting to a closer hospital than originally planned.

III. Procedure

A. Sentinel Events

1. If patient is transported, report Sentinel Event to the physician assuming care at the destination facility.
2. Whether transported or not, report all Sentinel Events to a Supervisor or Chief Officer as soon as possible. Preferably, immediately following conclusion of the call.
3. Complete QA Report using the established mechanism. (Currently 9th Brain)

B. Serious Events

1. Complete a QA Report using the established mechanism. (Currently9th Brain)
2. Report event to a Supervisor or Chief Officer no later than the end of the shift.