Memorandum of Understanding (MOU) for the
VA Portland Health Care System between
Department of Veterans Affairs, (VAPORHCS) and
American Federation of Government Employees (AFGE), AFL-CIO
National VA Council 53, AFGE Locals 2157 and 2583

The following constitutes an agreement between The VAPORHCS within VISN 20, and the American Federation of Government Employees (AFGE), AFL-CIO, National VA Council #53 (NVAC), AFGE Local 2157 & AFGE Local 2583, the parties have reviewed and agreed upon the appropriate arrangements and procedures regarding the MCP 00-71 Sentinel Events

- The *parties* met on March 11, 2024, and agreed to MCP 00-71. The agreed upon document will be attached to this MOU.

Denise L Lieb
NVAC 11th District Representative
President AFGE Local 2583
Chief Negotiator, Labor

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Date: ____________________

Marcy Polk
Director QSV, VAPORHCS
Chief Negotiator, Management

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Date: 2024.03.11 14:39:48 -07'00'

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Yvonne Angel
President AFGE Local 2157

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Date: 2024.03.12 09:03:29 -07'00'

Date: ____________________

SENTINEL EVENTS

MCP 00-71

VA Portland Health Care System
Portland, OR 97239

Rescinded Document:
See paragraph 7.

Signatory Authority:
Medical Center Director

Effective Date:
March 11, 2024

Responsible Owner:
Medical Center Director

Recertification Date:
March 11, 2029

1. POLICY

This medical center policy (MCP) establishes the definition of a sentinel event and the process that is performed when a sentinel event occurs to ensure a safe environment for patients, families, staff and visitors. This MCP is designed to ensure maximum risk-prevention and loss-reduction activities on the part of the VA Portland Health Care System (VAPORHCS) in response to a sentinel event.

2. JUSTIFICATION

This policy exists to establish standards and to meet requirements and responsibilities described in:

a. The Veterans Health Administration (VHA) Directive 1050.01, VHA Quality and Patient Safety Programs, dated March 24, 2023

b. VHA National Center for Patient Safety (NCPS) Guidebook for Assessing Reported Adverse Events, current version.

c. VHA NCPS Joint Patient Safety Reporting (JPSR) Guidebook, current version.

d. VHA NCPS Guide to Performing Root Cause Analysis (RCA) Guidebook, current version.

e. The Joint Commission Leadership (LD) Standard LD.03.09.01

f. The Joint Commission Sentinel Event (SE) Policy, current version.

3. RESPONSIBILITIES

a. **VA Medical Facility Director.** The VA medical facility Director is responsible for ensuring overall VA medical facility compliance with this policy, and appropriate corrective action is taken if non-compliance is identified.

b. **Managers and Supervisors.** Managers and supervisors

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(1) Encourage staff to report all sentinel, adverse and close call events that involve patients.

(2) will support the sentinel event process and provide staff to participate in the multidisciplinary process as requested.

(3) Local VAPORHCS leadership and the Quality, Safety and Value service will be notified directly (e.g., by email @VHAPOR-EventNotification@va.gov) about any potential or suspected SE as soon as the event is discovered.

c. **Patient Safety Manager.** The Patient Safety Manager is responsible for:

(1) Determine if patient safety events meet SE criteria.

(2) Ensuring Risk Management, Quality, Safety and Value Leadership, Executive Facility Leadership, Veterans Integrated Service Network (VISN) 20 and NCPS have been notified of the Sentinel Event.

(3) RCA completion in accordance with VHA NCPS Guidebook for Assessing Reported Adverse events, JPSR Guidebook, and RCA Guidebook.

d. **All Staff.** All staff are responsible for reporting sentinel, adverse and close call events that involve patients into the JPSR system or the use of JPSR downtime contingency plans.

(1) Staff members will utilize the chain of command to actively alert their immediate supervisor about a potential or suspected SE. This is in addition to submitting a JPSR (refer to the Joint Patient Safety Reporting (disa.mil)).

4. OTHER PARAGRAPHS

None.

5. DEFINITIONS

a. **Adverse Events.** Adverse events are untoward diagnostic or therapeutic incidents, Iatrogenic injuries, or other occurrences of harm directly associated with care or services delivered by VA providers.

b. **Aggregate Review.** An aggregated review is a process outlined by NCPS to assess organization risks which can include the completion of an Aggregate RCA, PSAT or some other methodology.

c. **Close Call.** Close calls are events or situations that could have resulted in an adverse event but did not, either by chance or through timely intervention.

d. **Intentional Unsafe Acts.** An intentionally unsafe act is an action that involves reckless behavior done with the knowledge that it poses risk to patient safety.

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Intentionally unsafe acts in health care include, but are not limited to, criminal acts, acts related to alcohol or substance abuse by an impaired provider or staff member, and acts involving patient abuse.

NOTE: Any event or close call that is determined to be caused by an intentional unsafe act will not result in a root cause analysis. Rather, an Administrative Investigation or other administrative channels as directed by the VA Medical Center Director or designee and by applicable regulations and VHA Directives.

e. **Joint Patient Safety Reporting System (JPSR).** JPSR is a web-based, patient safety event reporting system that can be used by any VHA employee with an active Personal Identity Verification (PIV) card to report patient safety concerns.

f. **Root Cause Analysis.** Root Cause Analysis (RCA) is a comprehensive team-based, systems-level investigation with a formal charter for review of health care adverse events and close calls.

g. **Sentinel Event.** Sentinel events are a type of adverse event. Sentinel events, as defined by TJC, are any patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that results in death, severe harm (regardless of duration of harm), or permanent harm (regardless of severity of harm). VHA defines harm events utilizing the Safety Assessment Code.

NOTE: This includes any process variation for which a recurrence would carry a significant change of serious adverse outcomes. Sentinel events signal the need for immediate investigation and response.

h. **Safety Assessment Code.** A Safety Assessment Code (SAC) is a score assigned to a patient safety event utilizing a matrix that takes into account both the severity and probability of harm. The matrix is used to generate a risk score of 1, 2, or 3 (1 = lowest risk; 2 = intermediate risk; 3 highest risk).

6. REFERENCES

a. VHA Directive 1050.01, VHA Quality and Patient Safety Programs, dated March 24, 2023

b. VHA Directive 1004.08, subject: Disclosure of Adverse Events to Patients, dated October 31, 2018

c. VHA Directive 1320, Quality Management and Patient Safety Activities that Can Generate Confidential Records and Documents, dated July 10, 2020

d. VHA NCPS Guidebook for Assessing Reported Adverse Events, current version.

e. VHA NCPS Joint Patient Safety Reporting (JPSR) Guidebook, current version.

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f. VHA NCPS Guide to Performing Root Cause Analysis (RCA) Guidebook, current version.

g. The Joint Commission Hospital Accreditation Standards Manual, current edition.

7. RESCISSION

None.

8. REVIEW

This policy must be reviewed, at minimum at recertification and including when there are changes to the governing document and any regulatory requirement for more frequent review.

9. RECERTIFICATION

This MCP is scheduled for recertification on or before the last working day of March 2024. This MCP will continue to serve as local policy until it is recertified or rescinded. In the event of contradiction with national policy, the national policy supersedes and controls.

10. SIGNATORY AUTHORITY

David L. Holt
Medical Center Director
Date Approved: March 11, 2024

NOTE: *The signature remains valid until rescinded by an appropriate administrative action.*

DISTRIBUTION: MCPs are available at: Quality, Safety, & Value - Medical Center Memorandums - Standard MCM (sharepoint.com)

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