TITLE	NQF Serious Reportable Events (Leapfrog)		
NUMBER	NH-LD-PS-001	**Last Revised/Reviewed Effective Date:**	Aug 31, 2018
TJC FUNCTIONS	LD, PS		
APPLIES TO	Novant Health: Hospitals, Free standing Ambulatory Surgical Center, NH Imaging, Rehabilitation centers, NHMG NH UVA: Hospitals		

I. SCOPE / PURPOSE

Novant Health (NH) deeply cares about our patients. When unexpected events happen, NH is committed to taking steps to learn from incidents to prevent future events or harm.

II. POLICY

1. When a safety event as defined by the National Quality Forum (NQF), The Joint Commission (TJC) or Novant Health safety program occurs, an explanation of the known circumstances with an appropriate verbal empathetic apology will be provided to the patient and/or family/support person/legally authorized representative affected.
2. Safety events will be reported to the designated Patient Safety Organizations (PSOs) and/or The Joint Commission (TJC) within 15 business days of becoming known or recognized as a safety event.
3. A comprehensive systematic (root cause) analysis (CSA) of how and why the event occurred will be conducted.
4. Patients and/or family (or support person/legally authorized representative) affected will be interviewed, if willing and able, to gather information for the CSA analysis.
5. Appropriate leaders, with the support of the Risk Management and Patient Partnership departments, will inform the patient and/or legally authorized representative of the action(s) that the hospital will take to prevent future recurrences of similar events based on the findings from the CSA.
6. Support for team members involved in NQF safety events will be provided through the NH Employee Assistance Program and by NH Spiritual Care Services through caregiver support protocols. Availability of these resources will be generally communicated and will be specifically offered at the time of the event.
7. The Clinical Improvement directors will facilitate an annual review to ensure compliance with elements of this policy for each NQF safety event that is reported.
8. Costs directly related to the NQF safety event will be evaluated and written off as appropriate.
9. A copy of this policy will be provided to patients and/or family and/or payors upon request.

III. QUALIFIED PERSONNEL

Team members in accordance with roles and functions outlined in job descriptions.

IV. EQUIPMENT

N/A

V. PROCEDURE

The procedure serves as a guideline to assist personnel in accomplishing the goals of the policy. While following these procedural guidelines personnel are expected to exercise judgment within their scope of practice and/or job responsibilities.

N/A

VI. DOCUMENTATION

N/A

VII. DEFINITIONS

Apology to the Patient – While events can occur that are not the fault of care systems or team members, given the high level of trust patients place in health care providers, Novant Health deems it appropriate for caregivers to apologize (or apologetically recognize) when a patient within their care setting suffers a serious event.

National Quality Forum safety event – In 2011, the National Quality Forum released a list of events that they termed “serious reportable events,” medical incidents that would not be expected to happen to a patient.

Patient Safety Organization (PSO) – Patient safety organization (PSO) means a private or public entity or component thereof that is listed as a **PSO** by the Secretary of Health and Human Services and any other officer or employee of that Department to whom the authority involved has been delegated.in accordance with subpart B.

VIII. RELATED DOCUMENTS

N/A

IX. REFERENCES

N/A

X. SUBMITTED BY

Clinical Improvement, Risk Management, Patient Partnership

XI. KEY WORDS

Leapfrog, disclosure, event, root cause, RCA, CSA, apology, safety, comprehensive systematic analysis, PSO

XII.	**INITIAL EFFECTIVE DATE**	Aug 31, 2018
	DATES REVISIONS EFFECTIVE	
	DATES REVIEWED (No changes)	
	Date Due for Next Review	Aug 2021