

ADMINISTRATIVE POLICY AND PROCEDURE MANUAL**Subject: Sentinel Event****I.43****Purpose**

The Joint Commission has incorporated into its accreditation decision process a formal approach for addressing "Sentinel Events." The following guidelines have been prepared to facilitate prompt root cause analyses of these events.

Policy

All Sentinel Events require an immediate "root cause" analysis by the organization which is an in depth analysis as to why the incident occurred. The occurrence of a Sentinel Event sends a signal that immediate attention is required and process improvement may be indicated. By immediately conducting a root cause analysis along with identification and implementation of targeted performance improvement techniques, the organization may improve patient safety and the quality of patient care, prevent the likelihood of similar events occurring in the future, reduce the number of any serious events, and minimize loss exposure and liability.

Definitions**1. Sentinel Event**

An unexpected occurrence involving death or serious physical or psychological injury, or risk thereof. Such events are called sentinel because they signal the need for immediate investigation and response.

A Sentinel Event includes any event that meets the following criteria:

- a. Unexpected death or major permanent loss of function not associated with the patient's condition, includes nosocomial infections.
 - 1) Death: includes death due to fall, intrapartum maternal death, and perinatal death, unrelated to congenital condition in an infant > 2500 gms. Deaths associated with behavior restraint/seclusion must be reported to CMS.
 - 2) Major permanent loss of function: includes medication errors and falls.
- b. Infant abduction/discharge to wrong family
- c. Surgery on wrong patient/body part, regardless of magnitude.

- d. Rape on hospital grounds (includes rape of patient/visitor/staff)
One or more of the following must be present to determine review:
 - 1). witnessed sexual contact
 - 2). sufficient clinical evidence obtained to support allegation
 - 3). admission by the perpetrator
- e. Hemolytic Transfusion reaction due to mismatched blood
- f. Suicide of any individual receiving care, treatment or services in a staffed round-the-clock setting or within 72 hours of discharge
- g. Abduction of any individual receiving care, treatment or services
- h. Unintended retention of a foreign object in a patient after surgery or other procedure.
- i. Neonatal Hyperbilirubinemia (> 30 mg/deciliter)
- j. Radiation overdose (involving prolonged fluoroscopy with cumulative dose more than 1500 rads to a single field or any delivery of radiotherapy to the wrong body region or more than 25 percent above the planned radiotherapy dose).

2. Root Cause Analysis

A process for identifying the basic or causal factors that underlie the event. In particular, a root cause analysis: (I) focuses on systems and processes, not individual performance; (ii) analyzes particular events then extrapolates potential process improvement opportunities for the entire organization, if any, that would tend to decrease the likelihood of such events occurring in the future; (iii) continues asking "Why?" to ensure meaningful in depth analysis.

3. Action Plan

The product of a root cause analysis that identifies the strategies that an organization plans to implement to reduce the risk of similar events occurring in the future. The plan should address responsibility for implementation, oversight, pilot testing if appropriate, time lines and strategies for measuring the effectiveness of the actions.

4. Events not reviewable as Sentinel may included: Full return of limb or bodily function to the same level as prior to the adverse event by discharge or within two weeks of the initial loss of said function.; Any sentinel event that has *not* affected a recipient of care (patient, client, resident); Medication errors that do *not* result in death or major permanent loss of function.; Suicide *other than* in an around-the-clock care setting or following elopement from such a setting; Unsuccessful suicide attempts; A death or loss of function following a discharge against medical advice (AMA); Unintentionally retained foreign body without major permanent loss of function; Minor degrees of hemolysis after transfusion with no clinical sequelae.

Procedure

- I. Reporting the Event: Individual involved in or aware of the event should complete an event report and immediately notify Hospital Risk Manager (RM) via phone or beeper.
- II. The RM will initiate an investigation under the direction of Main Line Health Legal Counsel and the PSO as well as notify other appropriate individuals.
 - CMO

- CEO who will, at his discretion, notify the Joint Conference Committee chair.
 - Hospital President, who will determine, in consultation with other key individuals, whether notification of the Public Relations Department is warranted.
 - Administration on call, evenings, weekends and nights (when applicable)
 - System Chair of involved physician department
 - Hospital Chief of involved physician department
 - Hospital VP of Nursing, if applicable
 - Department Manager or Supervisor (if event involves patient care)
 - Attending Physician
 - Director, Quality and Regulatory Affairs, Patient Safety Officer (PSO)
 - Other appropriate individuals
- III. The RM will gather facts and collect pertinent data on the event including contacting key individuals, as appropriate, to determine if the event is truly a Sentinel Event. This will be accomplished as soon as reasonably possible.
- IV. The RM, will establish a sentinel safety patient event team in order to initiate the root cause analysis process. The team may include, the CMO, Main Line Health Legal Counsel, PSO, and those individuals, supervisors, administrators and/or Medical Staff Department Chairs most closely involved in the processes/systems under review.
- V. Within **45** business days of the sentinel event, a root cause analysis and action plan will be completed.
- VI. The peer review sentinel event team will report its activities to the Patient Safety Committee (PSC).
- VII. If as a result of the root cause analysis, a process(es) for improvement is identified, the RM will report the activities and recommendations to the PSC.
- VIII. All information and documentation developed in connection with a sentinel event, including the root cause analysis and action plan, are confidential and peer review privileged.
 All folders dealing with investigation/management of **Sentinel Events, Serious Events, Incidents and Infrastructure Failures** should be labeled
 - **“Confidential – Patient Safety and Peer Review Privileges Apply”** (through May 19, 2002);
 - **“CONFIDENTIAL PURSUANT TO PA MCARE”** from May 20, 2002 forward.
 No material marked as Peer Review or Attorney-Client Privileged should be copied or distributed without the advice of Main Line Health Legal Counsel.
- IX. The Risk Department will maintain Sentinel Event files for seven (7) years following the completion of the **45** day root cause analysis period or submission of the final follow-up report (see #10 below), whichever occurs later.
- X. The Risk Management Department will prepare “CONFIDENTIAL/PEER REVIEW PRIVILEGED” Sentinel Event follow-up reports for the Chair of Main Line Quality Council on a monthly basis. The Chair of the Quality Council will give a verbal report of

these events on a quarterly basis to the Joint Conference Committee, a sub-committee of the Governing Board.

- XI. In consultation with, and pursuant to the advice of, Main Line Health Legal Counsel, and under the direction of the PSO, the RM will ensure proper notification of government agencies. (See Main Line Health Administrative Policy No. I.42 in the Administrative Policy and Procedure Manual).

References

Joint Commission on the Accreditation of Healthcare Organizations, Hospital Accreditation Standards, (CAMH, CAMBHC, CAMHLTC) 2006 OR current edition.

Joint Commission Perspectives; Vol. 16, No. 1 – Policy for Evaluating Occurrence of Sentinel Events Established

Joint Commission Perspectives; Vol. 16, No. 3 – Rationale Guiding the Evaluation of Sentinel Events

Sentinel Event Policy and Procedures, Updated: June 2005, www.jcaho.org

Frequently Asked Questions Radiation Overdose as a Reviewable Sentinel Event, 2006, www.jcaho.org

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