Sample

TITLE: Sentinel Events

POLICY: The purpose of this policy is to improve the quality of patient care by identifying and appropriately responding to all suspected sentinel events. An appropriate response includes completing a root cause analysis of the event, developing and implementing an action plan to reduce associated risks, and monitoring the effectiveness of the improvements to prevent its recurrence.

DEFINITIONS: A sentinel event is an unexpected adverse event, involving an unanticipated death or major permanent loss of function, “or risk thereof” and not related to the natural course of the patient’s underlying condition. “Or risk thereof” refers to any process variation which could lead to a serious adverse outcome if not prevented.

Criteria:
- Suicide of a patient in a setting where the patient receives around-the-clock care (e.g. hospital, residential treatment center, crisis stabilization center) or within 72 hours of discharge;
- Unexpected death of a full term infant;
- Abduction of any patient receiving services and care;
- Discharge of an infant to the wrong family;
- Rape;
- Hemolytic transfusion reaction involving major blood group incompatibilities;
- Surgical or nonsurgical invasive procedure on the wrong patient, wrong body part, or wrong procedure;
- Unintended retention of a foreign object in a patient after surgery or procedure;
- Severe neonatal hyperbilirubinemia (bilirubin>30 milligrams/deciliter); or
- Prolonged fluoroscopy with cumulative dose >1,500 rads to a single field or any delivery of to the wrong body region or >25% above the planned radiotherapy dose.

“Major permanent loss of function” refers to diminished sensory, motor, physiologic, or intellectual impairment that was not present on admission that will require continued treatment or a change in life-style. If “major permanent loss of function” cannot be immediately determined, applicability of the policy is not established until either the
patient is discharged with continued major loss of function, or two weeks have elapsed with persistent major loss of function, whichever occurs first.

PROCEDURE:

1. When a potential sentinel event occurs, the staff member most directly involved in the event will contact the Risk Manager and/or the Administrator-on-call immediately and complete an occurrence report.
2. The Risk Manager and/or the Administrator-on-call will begin an investigation of the event.
3. The potential sentinel event will be referred to a review committee consisting of Leadership and designated staff (name of departments), who will determine as to whether the occurrence was a sentinel event.¹
4. If the occurrence is designated as a true sentinel event, appropriate leadership including e.g. CEO, and (name of personnel) will be notified by Risk Management.
5. The review committee will then convene a Root Cause Analysis (RCA) team to complete a root cause analysis in accordance with the Joint Commission framework.² The RCA team will complete its analysis and action plan within 45 days of the event or discovery of the event.
6. The review committee will examine the findings and recommendations of the RCA team and make further recommendations as necessary. They will be responsible to ensure that measures are put in place to monitor the effectiveness of the changes in their systems and processes. The review committee will provide reports on a regular basis to validate this performance improvement to the CEO and other hospital leadership.
7. The RCA team shall follow the recommendations from the review committee. It will be responsible to complete the final root cause analysis and action plan within 45 days of the event or discovery of the event.
8. Risk Management department will determine and complete any required external reporting notifications.
9. All work products from the review of an event are treated as confidential.

¹ Personnel recommended to serve on this review committee include the following: Chief of Staff, Chief Medical Officer, Chief Nursing Officer, Vice President /Director of Risk Management and Quality, and the Department Director responsible for the involved area.

² Root Cause Analysis team members should include some personnel involved in the event, administrators, and representatives from quality management and/or patient safety and risk management.
The sample policy is provided as a source of information and is to be modified to fit the needs of your medical practice. It is not intended as legal advice. If legal advice is required, please contact an attorney.

References