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| **POLICY TITLE: Sentinel and Critical Events** | |
| **DEPARTMENT:**  Patient Safety/Risk Management, Clinical Effectiveness Department | **ORIGINATION DATE***: 5/1998* |
| **CATEGORY:** | **EFFECTIVE DATE:** *11/30/12* |

SCOPE:

This policy applies to both hospitals, Penrose-Main and St. Francis Medical Center (*hereafter*, PSF)

**PURPOSE:** To provide guidelines for immediate notification and action in the event of a potential sentinel or critical event.

STATEMENT OF POLICY:

An event will be CONSIDERED SENTINEL if Patient Safety/Risk Management and the Chief Medical Officer/Chief Nursing Officer determine that at least two out of the three criteria, below, have been met:

• Unanticipated death; permanent loss of limb or function.

• Significant deviation from usual processes for provision of health care services or managing the organization involved.

• Substantial risk of serious adverse publicity that will undermine the public confidence.

POLICY: When an event occurs, Patient Safety/Risk Management is to be notified immediately by phone or pager. Patient Safety/ Risk Management will do a preliminary investigation, set up an RCA and discuss the findings with the Chief Medical Officer to jointly determine if the event meets the criteria of TJC Sentinel Event. If the criteria are met then Patient Safety/Risk Management is to deem the situation a SENTINEL EVENT.

PROCEDURE:

1. Patient Safety/Risk Management will notify the appropriate department leadership, facility insurance carrier, Clinical Effectiveness Department, Centura VP and administration that an occurrence has been declared a sentinel event. Legal counsel will also be obtained by Patient Safety/Risk Management in conjunction with the hospital insurance carrier.
2. Patient Safety/Risk Management and the Clinical Effectiveness Department will internally assemble a multidisciplinary team with representatives from quality, risk, administration, involved physicians and employees of the department involved in the incident. The team will coordinate the Critical Event Analysis (CEA) or the Root Cause Analysis (RCA) and the preventive action plan.
3. The team will be responsible for monitoring the recommended corrective actions identified by the CEA/RCA.
4. The events, causes and corrective actions will be reported to the appropriate hospital administrative and/or medical staff committees.
5. The CEA/RCA and summary of the events will be classified as confidential. The document and findings will be protected under the Colorado Quality/Risk Management/PEER Review statutes and/or the attorney/client privilege established by Patient Safety/Risk Management.
6. The release of any information of the event or its findings must be approved by Patient Safety/Risk Management and legal counsel.
7. Disclosure of a sSENTINEL EVENT should occur at the time the incident is realized and according to the Disclosure of Adverse Events IDP (A-02-i).

DEFINITIONS:

* ADVERSE PATIENT EVENTS are untoward incidents, therapeutic misadventures, iatrogenic injuries, or other adverse occurrences directly associated with care or services provided within PSF. ADVERSE PATIENT EVENTS may result from acts of commission or omission (e.g., administration of the wrong medication, failure to make a timely diagnosis or institute the appropriate therapeutic intervention, adverse reactions or negative outcomes of treatment), or may not be attributable to any particular act or omission. A determination that an adverse event has occurred is not equivalent to a determination that the event was preventable or that PSF or any provider has acted or failed to act in a negligent manner. Adverse events may include those serious adverse events defined by Centers for Medicare & Medicaid Services (CMS) as not eligible for payment (e.g., certain hospital acquired conditions) or reportable to CMS, and events defined as serious reportable events by the National Quality Forum (NQF) or Leapfrog. A detailed list of such events is in Appendix 1.
* SENTINEL EVENTS are a type of ADVERSE PATIENT EVENT. Sentinel Events, as defined by the Joint Commission, are unexpected occurrences involving death, serious physical or psychological injury, or risk thereof. Serious injury specifically includes permanent loss of limb or function. The phrase “risk thereof” includes any process variation for which a recurrence would carry a significant chance of serious adverse outcomes. SENTINEL EVENTS signal the need for immediate investigation and response in accordance with the facility’s quality management plan. Immediate investigationsmay be a Root Cause Analysis (RCA), or, in the case of an intentionally unsafe act, administrative action.
* A SIGNIFICANT NEAR-MISS EVENT is an incident that could have but didn’t cause injury due to timely intervention, chance, or special circumstances (e.g., a patient with penicillin allergy almost receives penicillin that was ordered for another or a nurse happens to realize that a physician wrote an order in the wrong chart). Significant near misses are those near miss events that could result in the injuries listed in the NQF “Serious Reportable Events” list if not prevented. Sharing near-missdata throughout our system can help protect against future adverse events.
* RCA**:** (Root Cause Analysis) Method used to investigate either a Sentinel or Significant Near Miss Event.

REFERENCES:

The Joint Commission, CAMH 2008 Standards manual

National Quality Forum, 2006 “List of Serious Reportable Events”

Institute for Healthcare Improvement

[When Things Go Wrong: Responding to Adverse Events](http://www.ihi.org/IHI/Topics/PatientCenteredCare/PatientCenteredCareGeneral/Literature/WhenThingsGoWrongRespondingtoAdverseEvents.htm): Patient-Centered Care: Patient-Centered Care: General: Literature …2006.

**Appendix I: Adverse Patient Events Table**

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| **CMS Hospital Acquired Conditions** |
| Catheter Associated Urinary Tract Infection (CAUTI) |
| Pressure Ulcers (Category III and IV, only) |
| Object left in during surgery |
| Air Embolism |
| Blood Incompatibility (i.e., delivery of ABO incompatible blood products) |
| Vascular catheter associated blood stream infections (CLABSI) |
| Surgical Site Infections (SSI) e.g., Mediastinitis after coronary artery bypass graft surgery |
| Falls, resulting in fractures, dislocations, intracranial or crushing injury and burns  Venous thromboembolism (VTE) after hip or knee replacement  Poor Glycemic control (i.e., resulting in ketoacidosis and (hypoglycemic and hypoosmolar) coma) |
| **CMS Reportable Events** |
| Restraint related death |
| **NQF’s Serious Reportable Events** |
| **Surgical Events**   1. Surgery performed on the wrong body part 2. Surgery performed on the wrong patient 3. Wrong surgical procedure performed on a patient 4. Unintended retention of a foreign object in a patient after surgery or other procedure 5. Intra-operative or immediately post-operative death (24hrs) in an ASA Class I patient |
| **Product or Device Events**   1. Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the healthcare facility 2. Patient death or serious disability associated with the use or function of a device in patient care, in which the device is used or functions other than as intended 3. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility |
| **Patient Protection Events**   1. Infant discharged to the wrong person 2. Patient death or serious disability associated with patient elopement (disappearance) 3. Patient suicide, or attempted suicide resulting in serious disability, while being cared for in a healthcare facility |
| **Care Management Events**   1. Patient death or serious disability associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation or wrong route of administration) 2. Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA-incompatible blood or blood products 3. Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a health care facility 4. Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a healthcare facility 5. Death or serious disability (kernicterus) associated with failure to identify and treat hyperbilirubinemia in neonates 6. Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility 7. Patient death or serious disability due to spinal manipulative therapy 8. Artificial insemination with the wrong donor sperm or donor egg 9. Unanticipated death or major permanent loss of function associated with healthcare associated infection |
| **Environmental Events**   1. Patient death or serious disability associated with an electric shock or elective cardioversion while being cared for in a healthcare facility 2. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances 3. Patient death or serious disability associated with a burn incurred from any source while being cared for in a healthcare facility 4. Patient death or serious disability associated with a fall while being cared for in a healthcare facility 5. Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a healthcare facility |
| **Criminal Events**   1. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider 2. Abduction of a patient of any age 3. Sexual assault on a patient within or on the grounds of the healthcare facility 4. Death or significant injury of a patient or staff member resulting from a physical assault (i.e. battery) that occurs within or on the grounds of the healthcare facility |

**POLICY VIOLATION**

Any Centura associate who fails to abide by this policy may be subject to disciplinary action, including termination.

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| **REVIEW/REVISION DATES:** 5/98, 6/01, 5/03, 12/07, 8/09 |  |
| **APPROVAL BODY (IES):** *(will auto-populate)* | **APPROVAL DATE:** *(will auto-populate)* |