

**CENTRAL IOWA HEALTH SYSTEM
GRADUATE MEDICAL EDUCATION COMMITTEE**

POLICY ON SENTINEL EVENT

The Graduate Medical Education Committee has adopted the UnityPoint Health - Des Moines Sentinel Event Policy (Policy: UPHDM091) as the Graduate Medical Education Committee policy on sentinel event. The most current copy of this policy can be found on the intranet under the DocuCenter link.



I. POLICY

Sentinel events will be promptly identified, reported, and investigated internally within 45 days after the occurrence or discovery of the occurrence as a fundamental process to help reduce morbidity and mortality. Outside consultants or agencies may be utilized to assist with the investigation or to review the data and reports. A root cause analysis is completed on all cases which fit the definition of a sentinel event.

This process may also be used to identify and investigate events which are determined not to be sentinel events, however the identification, investigation and learning process which may also help to reduce morbidity and mortality in the hospitals.

II. DEFINITION

A. An “event” is an occurrence which, pending the results of investigation, is identified as a potential sentinel event or as an occurrence warranting investigation under the sentinel event policy.

A sentinel event is an event that results in an unanticipated death or major permanent loss of function, not related to the natural course of the patient’s illness or underlying condition or the event is one of the following (even if the outcome is not death or major permanent loss of function):

- Suicide of any individual receiving care, treatment or services in a staffed round-the-clock setting or within 72 hours of discharge.
- Unanticipated death of a full-term infant.
- Abduction of any individual receiving care, treatment or services.
- Discharge of an infant to the wrong family.
- Rape.
- Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities.
- Surgery or other invasive procedure on the wrong patient or wrong body part.
- Unanticipated death or major permanent loss of function associated with a health care-acquired infection.

- Unintended retention of a foreign object in a patient after surgery or other procedure.
- Severe neonatal hyperbilirubinemia (bilirubin >30 milligrams/deciliter).
- Prolonged fluoroscopy with cumulative dose > 1500 rads to a single field, or any delivery of radiotherapy to the wrong body region or > 25% above the planned radiotherapy dose.

Such events are called “sentinel” because they signal the need for immediate investigation and response.

Major permanent loss of function is defined as sensory, motor, physiologic, or intellectual impairment not present on admission that requires treatment or lifestyle change.

In addition, events described as “never events” by National Quality Forum will also be considered sentinel and be addressed in this same manner. Never events include:

SURGICAL OR INVASIVE PROCEDURE EVENTS

- Wrong surgical or other invasive procedure performed on a patient
Intraoperative or immediately postoperative/post-procedure death in an ASA Class 1 patient.

PRODUCT OR DEVICE EVENTS

- Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting.
- Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended.
- Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting.

PATIENT PROTECTION EVENTS

- Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person.
- Patient death or serious injury associated with patient elopement (disappearance).
- Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting.

CARE MANAGEMENT EVENTS

- Patient death or serious injury 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).
- Patient death or serious injury associated with unsafe administration of blood products.

- Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting.
- Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy.
- Patient death or serious injury associated with a fall while being cared for in a healthcare setting.
- Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting.
- Artificial insemination with the wrong donor sperm or wrong egg.
- Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen.
- Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results.

ENVIRONMENTAL EVENTS

- Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting.
- Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances.
- Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting.
- Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting.

RADIOLOGIC EVENTS

- Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area.

POTENTIAL CRIMINAL EVENTS

- Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider.
- Abduction of a patient/resident of any age.
- Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting.
- Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting.

- B. Root cause analysis is defined as a process for identifying the most basic causal factor or factors that underlie variation in performance, including the occurrence of a sentinel event.

III. INTERNAL REPORTING

- A. Any member of the medical or hospital staff may identify an event. Events are also identified by reviewing internal and external reports.
- B. An occurrence report is completed within 24 hours after the identification of an event. Occurrence reports are routed to Clinical Quality Department.
- C. The following persons are notified that an event has occurred:
 - 1. Executive Director of the affected Service or Department
 - 2. Senior Vice President, Medical Education and research if a resident physician is involved in the event
 - 3. Program Director if a resident physician is involved in the event
 - 4. Executive Director of Clinical Quality
 - 5. Quality Partner
 - 6. Chief Nurse Executive
 - 7. Vice President of Medical Affairs
 - 8. Chief Operating Officer
 - 9. Clinical Risk Manager
- D. Updates on sentinel event action plans are reported semi-annually to the UPHDM Quality and Safety Committee of the Board and to the UPHDM Clinical Quality Improvement Committee.

IV. INVESTIGATION OF THE EVENT

- A. Investigation of events is initiated by the Clinical Quality Department.
- B. The event is reviewed by the Morbidity and Mortality (M&M) Subcommittee of the UPHDM Clinical Quality Improvement Committee and other physicians and hospital staff closely involved in the event. If a resident physician is involved with the event, the resident physician and his/her program director or designee will be included on the interdisciplinary team.
- C. The purpose of this review is to reduce the morbidity or mortality at UPHDM and to provide education to the medical and hospital staff.
- D. The Chair of the UPHDM Clinical Quality Improvement Committee, the Vice President of Medical Affairs, or a member of the Clinical Quality Department will act as the review team facilitator.
- E. The interdisciplinary task force reviews the case, conducts interviews, prepares records of findings, determines root cause(s), develops an action plan, assigns responsibilities for action steps to clinical or hospital departments, sets deadlines for completion, refers systems issues or hospital-wide issues to the Clinical Quality Department for further

review, insures the reporting of action plan results, and reports findings and actions taken as a result of the sentinel event evaluation/root cause analysis.

- F. The M&M Subcommittee or the UPHDM Clinical Quality Improvement Committee may seek review of the root cause analysis from an outside body for the purpose of assessing the adequacy of the evaluation process.
- G. The analysis focuses primarily on systems and processes, not individual performance. The investigation progresses from special causes in clinical processes to common causes in organizational processes, with a series of “Why?” questions. The analysis identifies changes which should be made in systems and processes, either through redesign or development of new systems or processes, that would reduce the risk of such events occurring in the future.
- H. The Clinical Quality Department will track resolutions based on clinical and hospital department action plans. If the desired outcomes are not obtained by the action plan or within a specified time frame, the Clinical Quality Department will work with the Executive Director of the appropriate department(s).
- I. The Clinical Quality Department maintains the record of the review including the resolution and action plan. This record is accessible to designated hospital staff physicians and M&M Subcommittee members.
- J. Physician-specific performance issues identified in sentinel event evaluations/root cause analysis will be referred to the Department Chair/Section Designee/Director of the Medical Staff to be evaluated using the peer review process.
- K. Employees who have been involved in a sentinel event may access support services available through the Employee Assistance Center and/or Pastoral Care.

References:

UPHDM105 Occurrence Reporting
Medical Staff policy 12 Peer Review: Informal Corrective Action