PURPOSE:

To develop a mechanism of reporting sentinel events in the clinical area. This mechanism is important. Sentinel policy provides DPOTMH opportunities to create positive impact on the care provided, treatment, and services by changing culture, systems, and processes to prevent unintended harm (JCI, 2022).

LEVEL:

All patient care area

DEFINITION OF TERMS:

Sentinel Events. A patient safety event (not primarily related to the natural course of a patient's illness or underlying condition) that reaches a patient and results in death, severe harm (regardless *of duration of harm),or permanent harm (regardless of severity of harm).*

Permanent harm. An event or condition that reaches the individual, resulting in any level of harm that permanently alters others and/or affects an individual's baseline.

Severe harm. An event or condition that reaches the individual, resulting in life-threatening bodily injury (including pain or disfigurement) that interferes with or results in loss of functional ability or quality of life that requires continuous physiological monitoring or a surgery, invasive procedure, or treatment to resolve the condition.

POLICY:

1 Dr. Pablo O. Torre Memorial Hospital (DPOTMH) advocates safe and quality care and services.

2 A sentinel event shall be considered as a Patient Safety Event that reaches a patient and results in any of the following:

- 2.1 Death
- 2.2 Permanent harm
- 2.3 Severe temporary harm and intervention required to sustain life

3 An event can also be considered sentinel event even if the outcome was not death, permanent harm, severe temporary harm and intervention required to sustain life.

4 All documents generated as a result of a Sentinel Event, an Adverse Event or a Near Miss, including but not limited to the initial report, the findings of the Root Cause Analysis forms shall be considered as confidential, and privilege by all parties who receive the document.

5 The following events are considered as sentinel events under the Joint Commission International:

- 5.1 Suicide during treatment or within 72 hours of discharge (Patra, 2021)
- 5.2 Unanticipated death during care of an infant
- 5.3 Abduction while receiving care
- 5.4 Discharge of an infant to the wrong family
- 5.5 Hemolytic transfusion reaction due to blood transfusion with major blood group incompatibilities
- 5.6 Surgery on the wrong individual or wrong body part
- 5.7 Retained foreign body after surgery
- 5.8 Severe neonatal jaundice (bilirubin >30 mg/dl)
- 5.9 Prolonged fluoroscopy with very high or inappropriate dose or to the wrong site
- 5.10 Fire during direct patient care caused by hospital equipment
- 5.11 Intrapartum maternal death
- 5.12 Unanticipated severe maternal morbidity resulting in permanent or severe temporary harm
- 5.13 Rape
- 5.14 Falls
- 5.15 Delay in treatment
- 5.16 Medication error
- 5.17 Criminal event

RESPONSE TO SENTINEL EVENTS

1. Stabilize the patient
2. Disclose the event to the patient and family
3. Provide support for the family and staff involved
4. Notification to the hospital leadership
5. Immediate investigation
6. Comprehensive systematic review
7. Root cause analysis (RCA) for identifying the causal and contributory factors
8. Strong corrective actions to eliminate the root cause and prevent similar future events
9. Establish a timeline for the implementation of corrective actions
10. System improvement

5. A Root Cause Analysis shall be considered acceptable if it has the following characteristics

The analysis:

1. Focuses primarily on systems and processes, not individual performance
2. Progresses from special causes in clinical processes to common causes in organizational processes
3. Repeatedly digs deeper by asking "Why?" then, when answered, "Why?" again, and so on.
4. Identifies changes, which could be made in systems and processes---that would reduce the risk of such events occurring in the future.
5. Is thorough and credible

To be thorough, the root cause analysis shall include:

1. A determination of the human and other factors most directly associated with the sentinel event, and the process(es) and systems related to its occurrence;
2. Analysis of the underlying systems and processes through a series of "Why?" questions to determine where redesign might reduce risk.
3. Inquiry into all areas appropriate to the specific type,
4. Identification of risk points and their potential contributions to this type of event;
5. A determination of potential improvement in processes or systems that would tend to decrease the likelihood of such events in the future, or a determination, after analysis, that no such improvement opportunity exist.

To be credible, the root cause analysis shall:

1. Include participation by the leadership of the organization and by the individuals most closely involved in the processes and systems under review;
2. Be internally consistent, i.e. not contradict itself or leave obvious questions unanswered;
3. Include patients, family, or patient representatives when appropriate to ensure thorough understanding of the facts;
4. Include individuals most closely involved in the process and systems under review
5. Provide an explanation for all findings of "not applicable" or "no problem", and
6. Include consideration of any relevant literature

A corrective action plan shall be considered acceptable if it:

1. Identifies and implements actions to eliminate or control systems hazards or vulnerabilities.
2. It is recommended but not required that review teams should attempt to identify actions that are likely to reduce the risk or prevent the event from recurring and if that is not possible reduce the severity or consequences if it should recur.
3. Identifies, in situations in which improvement actions are planned, who is responsible for implementation, when the action will be implemented, how the effectiveness of the actions will be evaluated, and how the actions will be sustained.
4. Identifies at least one stronger or intermediate strength action for each comprehensive systemic analysis.

REFERENCES:

Floyd medical center policy and procedure manual. Joint Commission Standards ~ LD.04.04.05, DCH Rules and Regulations for Hospitals, CMS Conditions of Participation. **file:///C:/Users/006571/Downloads/AD-01-060%20Sentinel%20Events.pdf**. Retrieved: June 1, 2022

Patra KP, De Jesus O. Sentinel Event. [Updated 2021 Oct 7]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2022 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK564388/

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