RIVERSIDE MEDICAL CENTER, INC.

DR. PABLO O. TORRE MEMORIAL HOSPITAL

METRO PACIFIC HEALTH
THE HEART OF FILIPINO HEALTHCARE

DEPARTMENT: Total Quality Division		**POLICY NUMBER:** DPOTMH-APP-QA- P006 (01)	
TITLE/DESCRIPTION: **SENTINEL EVENTS**			
EFFECTIVE DATE: November 14, 2025	**REVISION DUE:** November 13, 2028	**REPLACES NUMBER:** N/A	**NO. OF PAGES:** 1 of 5
APPLIES TO: All Patient Care Areas		**POLICY TYPE:**	

PURPOSE:

To develop a mechanism of reporting sentinel events in the clinical area. Sentinel events policy provides The Riverside Medical Center, Inc. opportunities to create positive impact on the care provided, treatment, and services by changing culture, systems, and processes to prevent unintended harm.

DEFINITIONS:

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.

RESPONSIBILITY:

Total Quality Division,

POLICY:

1. The Riverside Medical Center, Inc. advocates safe and quality care 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. All documents generated as a result of a Sentinel Event, an Adverse Event, or a Near Miss—this includes, but is not limited to, the initial report and the findings from the Root Cause Analysis—shall be considered confidential and a privilege to all parties who receive these documents.

4. The following events are also considered as sentinel events:
   - 4.1 Suicide during treatment or within 72 hours of discharge (Patra, 2021)
   - 4.2 Unanticipated death during care of an infant
   - 4.3 Abduction while receiving care

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4.4 Discharge of an infant to the wrong family
4.5 Hemolytic transfusion reaction due to blood transfusion with major blood group incompatibilities
4.6 Surgery on the wrong individual or wrong body part
4.7 Retained foreign body after surgery
4.8 Prolonged fluoroscopy with very high or inappropriate dose or to the wrong site
4.9 Fire during direct patient care caused by hospital equipment
4.10 Intrapartum maternal death
4.11 Unanticipated severe maternal morbidity resulting in permanent or severe temporary harm
4.12 Rape
4.13 Criminal event

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Response to Sentinel Events

Key Tasks	KEY PERSON/S RESPONSIBLE
1. Remove the patient from harm	Attending Physician / Nurse-in-charge
2. Stabilize the patient	Attending Physician / Emergency Team
3. Disclose the event to the patient and family	Attending Physician (with support from Client Relations / Patient Experience Team if needed)
4. Provide support for the family and staff involved	Client Relations & Corporate Communications Manager / Patient Experience Team/ HR Representative / Head Nurse
5. A Non-Conformity Report (NCR) Form shall be filled-out and submitted to the Total Quality Division in less than 24 hours	Witness or person/s involved/ Unit Head
5. Conduct immediate investigation	Quality Improvement Team/ Unit Head/ Client Relations & Corporate Communications Manager
6. Notify hospital leadership	Unit Head / Quality Improvement Team/ Client Relations & Corporate Communications Manager
7. Perform Root Cause Analysis (RCA)	RCA Team (led by Quality Improvement Team, including relevant department heads)
8. Implement strong corrective actions	Unit or Department Head / MANCOM
9. Establish timeline for implementation of corrective actions	Quality Improvement Team/ Client Relations (in coordination with Department Heads and MANCOM)

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PROCEDURE (SOP): N/A
WORK INSTRUCTION: N/A
WORK FLOW: N/A
FORMS:
EQUIPMENT:
REFERENCES:

1. 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
2. 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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APPROVAL:				
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