

DEPARTMENT OF VETERANS AFFAIRS ILLIANA HEALTH CARE SYSTEM
1900 East Main Street
Danville, IL 61832

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SENTINEL EVENT

- I. **PURPOSE:** To describe how Sentinel Events will be reported to Veterans Integrated Service Network (VISN 12), National Center for Patient Safety (NCPS) and The Joint Commission. In addition, this policy provides a mechanism to facilitate in the identification of Sentinel Events, as well as reporting and appropriate follow up for such events, to assist in the prevention of their reoccurrence and strengthen the quality of care delivered.

- II. **POLICY:** The Joint Commission and National Center for Patient Safety (NCPS) standards state that an organization that experiences a reportable Sentinel Event is required to complete a thorough and credible Root Cause Analysis (RCA) within 45 days from the time that the need for an RCA was identified by the facility. The RCA process identified in the VHA National Patient Safety Improvement Handbook 1050.01 will be followed. Events meeting the Sentinel Event definition will be reported to the VISN 12 Office and the National Center for Patient Safety. To insure uniformity of reporting, the Network Director will be consulted whether to report a Sentinel Event to VA Central Office or to The Joint Commission, as reporting of such an event to the Joint Commission is voluntary.

- III. **DEFINITIONS:**
 - A. **Sentinel Event:** is defined as an unexpected occurrence involving death, serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase “or risk thereof” includes any process variation for which a reoccurrence would carry a significant chance of serious adverse outcomes. These are defined as sentinel because they signal the need for immediate investigation and response. Immediate investigations may include an RCA, or in the case of an intentionally unsafe act, administrative action. Specific events meeting The Joint Commission’s definition of a Sentinel Event are:
 1. Any patient death, paralysis, coma or other major permanent loss of function associated with a medication error.
 2. A patient commits suicide within 72 hours of being discharged from a hospital setting that provided staffed around-the-clock care.
 3. Any elopement, that is, unauthorized departure, of a patient from an around-the-clock care setting resulting in a temporally related death

- (suicide, accidental death or homicide) or major permanent loss of function.
4. A hospital performing the wrong, invasive procedure or operating on the wrong side of the patient's body, on the wrong site of the patient's body or on the wrong patient.
 5. A patient is abducted from the hospital where he/she receives care, treatment or services.
 6. Assault, homicide or other crime resulting in patient death or major permanent loss of function.
 7. A patient fall that results in death or major permanent loss of function as a direct result of the injuries sustained in the fall.
 8. Hemolytic transfusion reaction involving major blood group incompatibilities.
 9. A foreign body, such as a sponge or forceps, that was unintentionally left in a patient after surgery.

Note: This is not an all-inclusive list of events that could constitute a sentinel event.

- B. Root Cause Analysis: is defined as a non-punitive process for identifying the basic or contributing causal factors that underlie variations in performance associated with adverse events or close calls. A Root Cause Analysis (RCA) is a confidential quality assurance (QA) document, and is disclosable only as permitted by Title 38 USC 5705 and 38 CFR 17.500-17.541. An RCA must include:
1. A review of the process and/or systems and the determination of factors most directly associated with the sentinel event.
 2. Analysis of the underlying systems and processes through a series of "why?" questions to determine where redesign might reduce risk.
 3. Potential improvement in processes or systems that would tend to decrease the likelihood of such events in the future.
- C. Sentinel Event Alerts: These are published by the Joint Commission and are reviewed upon receipt to determine if the alert pertains to VAIHCS. If the alert does pertain to the facility, a review of the suggested corrective actions will be completed to determine if they are applicable for local implementation. These alerts are shared with appropriate medical center staff as informational or for action. The alerts and action responses are maintained and tracked through completion by the Patient Safety Program.

IV. PROCEDURES:

A. When a Sentinel Event, as defined above, occurs:

1. Ensure the safety of the patient(s).
2. The employee who discovers the event shall immediately inform his/her supervisor and preserve the integrity of the incident scene.
3. The supervisor will immediately inform the Director (or designee), Chief of Staff (or designee), Associate Director of Patient Care Service (or designee), Quality Management Chief and Chief of Police.
4. The employee who became aware of the Sentinel Event shall initiate an electronic patient incident report (ePIR). Additional steps to completing the patient incident report can be referenced in the Patient Incident & Close Call Reporting Program MCM 00-08.

B. The Patient Safety Program staff will:

1. Review the incident report when received to determine the severity of injury to the patient, and apply the Safety Assessment Code scoring process as defined in the Patient Incident & Close Call Reporting Program MCM 00-08.
2. Review the event with the Executive Management Team and determine if an RCA is appropriate. If an RCA is determined to be appropriate, the Patient Safety Manager or designee will notify the National Center for Patient Safety using the SPOT program and initiate the RCA process.
3. Ensure that the RCA follows the format as described in the VHA National Patient Safety Improvement Handbook 1050.01.
4. Maintain a file containing each RCA report conducted.
5. Be responsible for tracking follow up from actions upon completion of the RCA. Monitoring will be conducted to ensure that there has been sustained improvement.

V. OUTCOMES:

A. Sentinel Events will be identified, reported, evaluated and analyzed in a timely manner to facilitate meeting the following goals:

1. Improving patient care and reducing risks.
2. Focusing on understanding the root causes of the event and/or making changes in the organization's systems and processes to reduce the likelihood of recurrence in the future.
3. Increasing the general knowledge about Sentinel Events, their causes and strategies for prevention.
4. Educating and providing training to staff once the improvement processes have been defined.

VI. RESPONSIBILITIES:

- A. The Director, Chief of Staff or designee assume the responsibility for notification to the VISN Office once an adverse event has been identified as a Sentinel Event.
- B. The Patient Safety Manager is responsible for notifying the National Center for Patient Safety of the Sentinel Event, and ensuring the RCA follows the format described in the VHA National Patient Safety Improvement Handbook 1050.01.
- C. It is the responsibility of each Service to ensure compliance with this policy.

VII. REFERENCES:

VHA National Patient Safety Improvement Handbook 1050.1
Current Joint Commission Hospital Manual
MCM 00-09 Patient Safety Program
MCM 00-08 Patient Incident & Close Call Reporting Program
VHA Directive 2008-077 Quality Management (QM) and Patient Safety Activities That Can Generate Confidential Documents

VIII. RESCISSION: MCM 00-72, Sentinel Event dated February 2012.

/s/

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Preparing Official: Patient Safety Manager