Richard L. Roudebush VA Medical Center
Indianapolis, Indiana
Medical Center Memorandum

| MCM Number: 11-08 | Service: Chief of Staff |
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| Effective Date: 5/28/2013 | Review Date: 5/28/2016 |

# Sentinel Event Reporting

I. **Purpose:** To establish a program for the reporting and management of sentinel events. This policy provides a mechanism for the identification and reporting of sentinel events and for the investigation of such events. It aims to prevent their recurrence and seek opportunities to improve the quality of care delivered.

II. **Policy:** This medical center will promptly document by entering an ePIR (Electronic Patient Incident Report) for all instances in which there is reason to believe -a sentinel event has occurred. A sentinel event requires immediate reporting to the Medical Center Director and Patient Safety Manager and/or designee. Upon confirmation a sentinel event has occurred, an immediate investigation and response through the review process called Root Cause Analysis (RCA) or Administrative Investigative Board (AIB) (in the case of an intentionally unsafe act), is conducted Keys to accomplishing this include:

A. Identifying and reporting sentinel events immediately.

B. Conducting a timely and thorough RCA or AIB after the event is verified as a sentinel event.

III. **Implementation:**

A. Definitions:

1. *Sentinel event*: is an unexpected occurrence involving death or 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 recurrence would carry a significant chance of a serious adverse outcome. The terms “sentinel event” and “error” are not synonymous; not all sentinel events occur because of an error, and not all errors result in sentinel events.

The event has resulted in death or major permanent loss of function not related to the natural course of the patient's illness or underlying condition, OR:

a. Suicide of any patient receiving care, treatment and services in a staffed around-the-clock care setting or within 72 hours of discharge.
b. Abduction of any patient receiving care, treatment, and services.
c. Rape (defined as unconsented sexual contact involving a patient, staff member, licensed independent practitioner, visitor, or vendor while being treated or on the premises of the health care organization, including oral, vaginal or anal penetration or fondling of the patient's sex organ(s) by another individual's hand, sex organ or object.
d. Assault of a patient, staff member, licensed independent practitioner, visitor, or vendor while on site (leading to death or permanent loss of function).
e. Homicide of a patient, staff member, licensed independent practitioner, visitor, or vendor while on site.
f. Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities (ABO, Rh, other blood groups).
g. Invasive procedure, including surgery, on the wrong patient or wrong body part or wrong procedure.
h. Unintended retention of a foreign object in a patient after surgery or other invasive procedure.
i. 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.
j. Any patient death, coma, or other major permanent loss of function associated with a medication error.

2. *Root Cause Analysis:* a process for identifying the factors that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event. A RCA focuses primarily on systems and processes, not on individual performance. The analysis progresses from special causes in clinical process to common causes in organizational processes and systems and identifies potential improvements in these processes or systems that would tend to decrease the likelihood of such events in the future or determines, after analysis that no such improvement opportunities exist.

3. *Administrative Investigative Board (AIB):* Is a review process that may be used if the event involves what appears to be an intentionally unsafe act. Its focus is answering the question of what happened, why, and what can be done to prevent it from happening again. AIBs can result in individually directed action in addition to system improvement.

B. Reporting:

1. Reporting of events will be made in ePIR. according to the MCM CES-16 Incident Report (ePIR) Program**.**

2. The first employee to be aware of a sentinel event is responsible for initiating the ePIR. The patient's nurse is responsible for informing the physician caring for the patient and/or the attending physician, if applicable, of the sentinel event.

3. The Patient Safety Manager and/or the designee should be notified immediately of any sentinel event. The Patient Safety Manager and/or the designee will verify that the attending physician, appropriate Service Chief, and the Chief of Staff have been notified.

4. The Patient Safety Manager and/or designee will ensure any immediate threats to patient safety are identified and mitigated, sequester evidence, and begin investigation of the sentinel event as soon as possible.

5. The Patient Safety Manager and/or designee will initiate an Urgent Notification "Heads-Up" and notify the Executive Management Team, and the VISN 11 Urgent Notification group of the sentinel event. If an Issue Brief is required by VISN, the Patient Safety Manager will prepare and send an Issue Brief per VISN Facility Guidance.

6. The Patient Safety Manager and/or designee will notify the Risk Manager and the Chief of Clinical Excellence of the event.

7. Nursing managers or supervisor will conduct immediate interviews with appropriate staff and assist the Patient Safety Manager and/or designee with investigation of the sentinel event

C. Review and Analysis:

1. For all sentinel events, a RCA will be conducted.

2. The Patient Safety Manager and/or designee will recommend team members to participate in the RCA to the Chief of Staff and/or Medical Center Director.

3. The RCA process will be completed according to the VHA National Patient Safety Improvement Handbook.

4. The Patient Safety Manager and/or designee will track and trend all sentinel events to include, at least, a yearly report to leadership: The report should include:

    a. The number and type of sentinel events.
    b. The system or process failures.
    c. Whether the patients and families were informed of the event
    d. All actions taken to improve safety, both proactively and in response to actual occurrences.
    e. The results of the analyses related to the adequacy of staffing.

D. Confidentiality: All reports are confidential and protected by the provisions of 38 United States Code 5705, governing VHA performance and quality improvement programs.

E. Informing Patients and/or Families of Sentinel Events:

1. The Veterans Health Administration is obligated to inform patients and their families about injuries resulting from sentinel events.

2. This will be completed according to MCM CES-12 Disclosure of Adverse Events to Patients

IV. **References:**

A. VHA Handbook 1050.01, VHA National Patient Safety Improvement Handbook

VHA Handbook 1050.01 NPS.pdf

B. MCM CES-12 Disclosure of Adverse Events to Patients

C. MCM CES-16 Incident Report (ePIR) Program.

D. The Joint Commission Hospital Accreditation Standards Manual, current edition (Link through the VHA Office of Quality, Safety & Value)

V. **Rescission:** MCM 11-08, Dated; 2009/12/29

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