I. PURPOSE

To define the scope of what constitutes a potential or actual sentinel event. Those events not meeting the definition of an actual sentinel event will be considered adverse events.

II. DEFINITION

**Adverse Event:** An outcome resulting in an undesirable or unanticipated patient outcome that is not directly related to the natural course of the patient’s illness or underlying condition and may affect the quality of care or environment for patients.

**Root Cause Analysis:** A process for identifying the basic or causal factors that underlie variation in performance. The process focuses primarily on systems and processes, not individual performance, progressing from special causes in clinical processes to common causes in organizational processes and identifies potential improvements in processes or systems that would tend to decrease the likelihood of such events occurring in the future. The outcome of the Root Cause Analysis will be an action plan that will identify the improvement strategies the medical center elects to implement in order to reduce the risk of a similar event occurring in the future.

**Sentinel Event:** Defined as “an event which has resulted in an unanticipated death or major permanent loss of function not related to the natural course of the patient’s illness or underlying condition.” An “event” may also be one of the following, even if the outcome was not death or major permanent loss of function unrelated to the natural course of the patient’s illness or underlying condition:

- Suicide of a patient in a setting where the patient receives around-the-clock care, treatment or services, or within 72 hours of discharge
- Unanticipated death of a full-term infant
- Abduction of any patient receiving care, treatment, or services
- Infant discharge to the wrong family
- Rape
- Surgery on the wrong patient or body part
- Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities
- Unintended retention of a foreign object (sponge, forceps) in a patient after surgery or other procedure

---

1 A distinction should be made between an adverse outcome that is primarily related to the natural course of the patient’s illness/underlying condition and death/loss of function not clearly or primarily related to the natural course of the patient’s illness/underlying condition.

2 Major permanent loss of function means sensory, motor, physiologic or intellectual impairment not present on admission requiring continued treatment of life-style change.

3 Defined as unconsented sexual contact involving a patient and another patient, staff member or unknown perpetrator.
• 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

Examples of events that are reviewable:

• Any patient death, paralysis, coma, or other major permanent loss of function not
related to the natural course of the patient’s illness or underlying condition, including
but not limited to, death associated with a medication error or death attributable to a
health-care associated infection
• Any suicide of a patient in a setting where the patient is housed around the clock,
including suicides following elopement from such a setting
• Any elopement of a patient resulting in a temporally related death (suicide or
homicide) or major permanent loss of function
• Any intrapartum (related to the birth process) maternal death
• Any perinatal death unrelated to a congenital condition in an infant having a birth
weight greater than 2500 grams
• Assault, homicide, or other crime resulting in patient death or major permanent loss
of function
• A patient fall that results in death or major permanent loss of function as a direct
result of injuries sustained in the fall

Examples of events that are NOT reviewable:

• Any “near miss”
• Full return of limb or bodily function to the same level as prior to the adverse event by
discharge or within two weeks of the initial loss of function
• Medication errors that do not result in death or major permanent loss of function
• Unsuccessful suicide attempts
• A death or loss of function following a discharge “Against Medical Advice”
• Unintentionally retained foreign body without major permanent loss of function
• Minor degrees of hemolysis with no clinical sequelae

III. POLICY

A. Sentinel events will be evaluated by an interdisciplinary team of physicians and hospital staff
within fifteen (15) working days of the discovery of the event as delineated in the Intensive
Review policy. An event not meeting the criteria for Sentinel Event will be considered an
Adverse Event and may be reviewed using the same intensive review process in order to
proactively identify risk reduction strategies in patient quality and safety.

B. Sentinel Events, as defined above, may be reported to the Joint Commission on a voluntary
basis within forty-five (45) calendar days of the occurrence, or upon becoming aware of its
occurrence. All Sentinel Events are reported to the Director of Risk Management upon
confirmation from the Chief Executive Officer and/or Chief Medical Officer that the event
met the above definition. The Director of Risk Management will report the Sentinel Event to
Office of the President.
C. A Root Cause Analysis will be completed in accordance with JCAHO reporting criteria (see Intensive Review Policy).

D. Interdisciplinary teams will develop a Root Cause Analysis and Action Plan to address identified issues. This process is delineated in the Intensive Review Policy.

E. In indeterminate cases where there is a question regarding whether a case is an Adverse Event or Sentinel Event, the event will be presumed reviewable as delineated in the Intensive Review Policy.

F. Individual clinical practice issues identified in the intensive review process will be referred to the clinical chief of the appropriate clinical department (physician issues), Chair of the Credentials Committee (physician issues) or the department director (employee issues).

III. CONFIDENTIALITY

No copies of the online Incident Report or Sentinel Event investigational reports are to be made for any reason. All follow-up analysis reports are maintained for Performance Improvement review purposes and are protected from disclosure. The sole purpose of these reports is for improvement of quality of care.

IV. REFERENCES

2005 JCAHO Standards
Performance Improvement Plan
General Administrative: Intensive Review Policy

Author: Mary Owen, Director, Performance Improvement
        Nance Hove, Director, Risk Management

Approvals: Policy Review Committee February 7, 2006
          Performance Improvement Committee February 8, 2006
          Med Exec Committee February 27, 2006
          Governing Body February 27, 2006