MAINE DEPARTMENT OF HEALTH
and
HUMAN SERVICES

DIVISION OF LICENSING
and
REGULATORY SERVICES

SENTINEL EVENT

ANNUAL REPORT

to the

STATE LEGISLATURE

CY 2005

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Maine Sentinel Event Reporting
Second Annual Report ▪ February 2006

Events Reported January 2005 through December 2005

"Health care is a decade or more behind other high-risk industries in its attention to ensuring basic safety."

The Institute of Medicine, "To Err is Human"

"Much can be learned from the analysis of errors. All adverse events resulting in serious injury or death should be evaluated to assess whether improvements in the delivery system can be made to reduce the likelihood of similar events occurring in the future."

The Institute of Medicine, "To Err is Human"

"The way to improve safety is to learn about causes of error and use this knowledge to design systems of care so as to prevent error when possible, to make visible those errors that do occur (so they can be intercepted), and to mitigate the harm done when an error dose reach a patient."

The Institute of Medicine, "Crossing the Quality Chasm"

BACKGROUND

The Mandatory Sentinel Event Reporting statute became effective in May of 2003. As many other states, Maine recognized the need to respond to healthcare safety issues by establishing a law that would require hospitals, ambulatory surgical centers, end-stage renal disease facilities and intermediate care facilities for people with mental retardation to report certain serious events (unanticipated death, permanent loss of function, surgery on the wrong body part or patient, hemolytic transfusion reactions, suicide, rape, infant abduction or discharge to the wrong family) to the Division of Licensing and Regulatory Services within the Department of Health and Human Services.

In addition to reporting these events, the facilities must also complete a review and analysis of their findings to identify system weaknesses or failures. Risk reduction measures with resulting action plans must be created and monitored for effectiveness. This information is submitted in writing to the Division within a forty-five (45) day window.

The concept of system failure changes the primary focus from that of individual blame to a broader approach that examines not only the human factors, but also the organizational and technical. It has been concluded that errors are caused by multiple elements and conditions. A systematic analysis of the event provides insight into the most basic causal factors underlying the error, and allows modification to decrease the risk of recurrence.

According to the Institute of Medicine report "*To Err is Human*", "The focus must shift from blaming individuals for past errors to a focus on preventing future errors by designing safety into the system. This does not mean that individuals can be careless. People must still be vigilant and held responsible for their actions. But when an error occurs, blaming an individual does little to make the system safer and prevent someone else from committing the same error". [1]

With staff in place to manage the submission process, Maine began collecting event reports in January of 2004. The Sentinel Event program is under the direction of the Division of Licensing and Regulatory Services but is carried out by non-regulatory Health Services Consultant Registered Nurses (HSCs). As confidentiality is built in to the statute and protects information gathered in sentinel event reports from discovery, it also maintains a firewall between the Sentinel Event program and the regulatory branch of the Division. The intent of the statute is to require facilities to look at the "why" of these serious events and take preventative actions that will promote safer environments in the health care settings.

A "Root Cause Analysis" (RCA) is the process that facilities use to review their events and help to establish their risk reduction measures. All reports submitted to the Division since 2004 have included Root Cause Analysis information.

The RCA has three primary goals:

- What happened
- Why it happened
- What to do to prevent it from happening again

The Joint Commission on Accreditation of Hospital Organizations (JCAHO) and the VA National Center for Patient Safety both require RCA for certain adverse events.

Maine facilities utilize the JCAHO, VA RCA parameters or some variation of them in performing their analysis.

Within those parameters are guidelines to be considered that result in a thorough and credible RCA[2]. They include:

- Determination of human and other factors
- Determination of related processes and systems
- Analysis of underlying cause and effect through a series of "why" questions
- Identification of risks and their potential contribution to the event
- Determination of potential improvement processes or systems
- Participation of leadership
- Be internally consistent (not contradict itself or leave unanswered questions)
- Corrective actions, outcome measures, management approval
- Considering relevant literature

In reviewing Sentinel Events, HSCs look to the statutory requirements and also incorporate many of these guidelines as a tool to determine what constitutes an acceptable report.

These submissions also include a narrative summary of the event that provides additional information to support the RCA findings and to aid in obtaining a more clear understanding of the facts.

All the written reports submitted to the Division for the calendar year (CY) 2005 either met the time frame requirement of forty-five (45) days, or had extensions granted to the facilities in order to obtain consultant/external review information.

While RCA information was provided by all facilities, the extent and quality did vary. Some reports contained extensive detail, while others submitted the minimum required. In those cases where useful data was omitted or not clear, the Division requested additional information. Risk reduction actions should designate who is responsible for that action and a method for evaluating its effectiveness. The absence of this type of data was the primary reason for the additional information requested.

The secondary component of the request was to identify potential causal factors that the HSCs determined were not addressed in the RCA. This was an attempt to promote consistency in the report data. It is the expectation that the written reports will contain common core elements that provide useful information.

ACTIVITIES 2005

By February 1, 2005, the Division had completed and submitted the Annual Report to the State Legislature. The two-member Sentinel Event team conducted onsite visits for all the events reported to the Division in 2005, performed record reviews pertinent to the events, held conference calls, met with facility teams and administration to provide education and help with their decision-making processes.

Submitted written reports were assessed for completeness, findings and the presence of corrective actions. Information was entered into a database for tracking of event activity, follow up, and aggregate purposes.

In April 2005, a review of the findings of the annual report was presented to the Maine Hospital Association. Providers were encouraged to dialogue, pose questions and offer suggestions to the Sentinel Event team.

The Health Services Consultants, in partnership with Goodall Hospital staff, were selected to participate in the Patient Safety Improvement Corps (PSIC) that is sponsored by the Agency for Healthcare Research and Quality (AHRQ) and the Veterans Administration National Center for Patient Safety (NCPS).

This is a three-session training (September 2005, January 2006, May 2006) for the purpose of improving patient safety by providing to State field staff and hospital partners the knowledge and skills necessary to: [3]

- Conduct effective investigations of reports of medical errors (e.g., close calls, errors with and without patient injury) by identifying their root causes with emphasis on underlying system causes.
- Prepare meaningful reports on the findings.
- Develop and implement sustainable interventions based on report findings.
- Measure and evaluate the impact of the safety intervention (i.e., that will mitigate, reduce, or eliminate the opportunity for error or patient injury).
- Ensure the sustainability of effective safety interventions by transforming them into standard clinical practice.

The first two PSIC training sessions have been completed. The State Team project for this program is to create and present sentinel event education sessions to all the Intermediate Care Facilities for Persons with Mental Retardation (ICFs/MR) and End Stage Renal Disease Facilities (ESRDs).

By November 2005, all the state ICF/MR facilities had representatives attend a program to strengthen their knowledge of the regulations and the reporting requirements under the statute. They also received information and instructions on performing root cause analysis activities.

The Sentinel Event team has provided follow up to facilities as needed, shared lessons learned from similar events, and relevant literature. In addition the HSCs have tracked national activities to keep apprised of standards and guidelines and monitored proposed legislation that could impact the statute.

Division administrators have participated in the Maine Quality Forum's (MQF) discussion groups to address issues, provide information and offer recommendations on the sentinel event review process.

Upon request of the MQF, a comparison of Maine Sentinel Events with the National Quality Forum (NQF) core set of 27 reporting standards was done utilizing NQF Serious Reportable Events Criteria. The comparison in Appendix D is interesting in that over the past twenty-three (23) months, use of the Maine Sentinel Events statute, identified forty-seven (47) sentinel events. A crosswalk using the NQF of twenty-seven (27) core standards revealed only twenty-four (24) or 51% of events.

The NQF is an organization created to develop and implement a national strategy for healthcare quality measurement and reporting, whose mission is "to improve American healthcare through endorsement of consensus-based national standards for measurement and public re-

porting of healthcare performance data that provide meaningful information about whether care is safe, timely, beneficial, patient-centered, equitable and efficient".

FINDINGS 2005

There were a total of twenty-eight reportable sentinel events from January 2005 through December 2005. All but one event occurred in a hospital setting. One event was reported by an Intermediate Care Facility for People with Mental Retardation (ICF/MR). Of those twenty-eight, twenty were deaths, five were permanent loss of function, and three were wrong surgery. These numbers are similar to those of 2004. There was an increase of four total reported events. This is not unexpected, as better understanding of the reporting requirements and recent education for ICFs/MR would support greater compliance with the statute and the potential for increased reporting.

Fifty percent of events involved patients over sixty-five years of age and were evenly distributed male to female. Wrong surgery accounted for 11% of the events, loss of function 18%, and unanticipated death 71%. These numbers are similar to those reported by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) for sentinel events from 1994 to 2005.[4] JCAHO also indicated wrong surgery at 12.5%, loss of function at 10%, and death at 74%.

Thirty-five percent of Maine events for calendar year (CY) 2005 involved falls. This was significant compared to the previous reporting year, where no events were fall-related.

HSCs consulted on ten events that were determined to be non-reportable under the statute. Facilities did follow their internal review processes in these cases, and elected to perform Root Cause Analyses as part of their risk management and quality programs.

We should be aware that reported serious events are small in number in relation to the numbers of admissions to facilities and procedures performed over a calendar year. The review of these events, though retrospective, can point to areas for improvement. Events also serve as a guide to certain safety issues and to heighten awareness for caregivers and consumers alike. In this regard, the Agency for Healthcare and Research has published a fact sheet that gives "20 Tips to Prevent Medical Errors".[5] Some of these suggestions include:

- The single most important way you can help to prevent errors is to be an active member of your health care team.
- Make sure that all of your doctors know about everything you are taking. This includes prescription and over-the-counter medicines, and dietary supplements such as vitamins and herbs.
- Make sure your doctor knows about any allergies and adverse reactions you have had to medicines.
- Ask for information about your medicines in terms you can understand—both when your medicines are prescribed and when you receive them.
- If you have a choice, choose a hospital at which many patients have the procedure or surgery you need.
- If you are in a hospital, consider asking all health care workers who have direct contact with you whether they have washed their hands.
- When you are being discharged from the hospital, ask your doctor to explain the treatment plan you will use at home.
- If you are having surgery, make sure that you, your doctor, and your surgeon all agree and are clear on exactly what will be done.
- Make sure that someone, such as your personal doctor, is in charge of your care.
- Make sure that all health professionals involved in your care have important health information about you.
- Ask a family member or friend to be there with you and to be your advocate (someone who can help get things done and speak up for you if you can't).
- Learn about your condition and treatments by asking your doctor and nurse and by using other reliable sources.

This year Health Services Consult-

ants have performed medical record reviews of twenty unanticipated deaths. Of those events, 35% or 7 of 20 were related to injuries secondary to falls. It was noted that the average age was 77 years, and the majority of the patients were female. Root Cause Analyses submitted by various facilities have included risk reductions measures such as revision of fall risk assessments, evaluation of call-bell systems, bed alarm devices, and staff education.

PATIENT FALLS

- ***35% of All Events***
- ***Average Age 77 years***
- ***Majority Females***

The Division has made several recommendations to include:

- Taking a thorough history at the time of presentation to the Emergency Department or during a planned admission.
- Providing accurate documentation of patient medications with special attention to antithrombolytics.
- Obtaining a history of previous falls, and listing dates of prior surgery.
- Performing on admission, a complete fall risk assessment and revising the assessment thereafter on each shift.

Many examples of fall risk assessments are available, e.g., VA National Center for Patient Safety 2004 Toolkit[6] or the Johns Hopkins Hospital Fall Risk Assessment Tool[7]. Both assessments feature important aspects to incorporate: age, fall history, mobility, elimination, mental status changes, medication, and patient care equipment. These tools may require some modification according to the specific population needs of the facility.

Risk for falls can be categorized as low, moderate or high. Approximately 70% of the falls reviewed by HSCs occurred during toileting activities. Interventions specific to this activity can vary. A patient at moderate fall risk may only require supervision or assistance with toileting, while a patient who is at high risk will require someone to remain present while toileting.

Regardless of the level of fall risk, HSCs noted that in some events staff had failed to follow the recommended interventions, even when policies existed. In at least one event, policies were just being developed, but none were in place at the time of the event.

Review of these sentinel events showed that many facilities have alarm systems in place to alert staff when a patient is attempting to get out of bed or chair. However, it was noted these alarms may be selectively turned off.

There should be a clear statement in the facility policy explaining under what conditions alarm systems are deactivated and requiring accurate documentation to support the rationale.

Accurate patient medication history is especially important during the initial and ongoing assessment process. Staff must be aware of a patient's reaction to medications e.g., sleep aids that might contribute to a fall, or anti-thrombolytics that might complicate a fall by causing internal bleeding.

During review of Root Cause Analyses related to fall injuries, it was apparent that many facility policies had no clear guideline to define what should happen after a patient has fallen. Many protocols only included the need to document a set of vital signs and notify the physician at a later time, if there was no obvious patient injury.

Often physicians were not notified of any injury until the patient began to show signs of mental status changes. In some cases, this was too late to intervene and prevent a potentially bad outcome.

Some facilities have established an orientation program designed to familiarize patients with the hospital environment as a way to help them safely cope with this change.

The Division encourages facilities to educate staff on the importance of following existing protocols and not relying on their individual interpretation of the patient's physical or mental status.

In spite of fall interventions, we know that these accidents may still occur. It is the responsibil-

ity of the healthcare facility to create an environment to avert patient injury. Part of this process should be the inclusion of a post fall assessment.

Documentation that describes the patient's explanation of what occurred, along with vital and neurological signs, and an immediate notification to the provider should be present. Those details, as well as the patient assessment and a list of the patient medications, especially if the patient is receiving anticoagulation therapy, should be communicated to the physician. Indication of frequent, ongoing assessments to include any mental status changes, and general physical condition is vital.

In conclusion, lessons learned and recommendations from unanticipated deaths related to falls include:

- accurate documentation of patient history and list of medications.
- initial fall risk assessment and subsequent reassessment documented at the change of each shift during the patient's stay.
- adherence to the hospital protocols specific to risk level.
- performance of a post fall assessment with a policy that clearly establishes a guide for staff to follow.

Most Maine hospitals are aware of the 2006 safety goals (9A, 9B) set by JCAHO[8], one of which is to "reduce the risk of patient harm by: assessing and periodically reassess each patient's risk for falling, and have developed policies and procedures in keeping with these standards".

SYSTEMS INPACTED BY SENTINEL EVENTS

2005

COMMUNICATION	*67.86%*
POLICY/PROCEDURE	*64.29%*
EDUCATION/TRAINING	*60.71%*
DOCUMENTATION	*35.71%*
STANDARDS OF CARE	*28.75%*

2004

COMMUNICATION	*54.55%*
POLICY/PROCEDURE	*31.82%*
EDUCATION/TRAINING	*9.09%*
DOCUMENTATION	*4.55%*
STANDARDS OF CARE	*50.00%*

It is our hope that healthcare facilities will continue to strive towards providing a safe environment for our Maine patients, and in doing so will decrease the unanticipated deaths or loss of function associated with falls.

ROOT CAUSE ANALYSIS FINDINGS

Communication failure was cited in 67.86 percent of the reported events and was similar to the last reporting year with 54.55 percent. Policy and Procedures were indicated as a weak area in 64.29 percent of events, up from 31.82 percent in 2004. Education and Training impacted 60.71 percent of the events and that was an increase from 9.09 percent. Documentation also showed an increase from 4.55 percent to 35.71 percent. Standards of Care had dropped down from 50.00 percent in 2004 to 28.75 percent. In comparison, JCAHO reported Communication and Education/ Training as their top two RCA findings.[9]

These numbers are similar to other national results and other state data.

RISK REDUCTION ACTIONS

Facilities have undertaken various risk reduction measures in response to specific events based on their RCA results.

The following are examples of measures submitted for improvement to:

COMMUNICATION

- Posting of abnormal vital signs on communication board in the Emergency Department (ED).
- ED physicians to acknowledge review of vital signs.
- Nurse to nurse inter-shift report of assessment/ reassessment and implemented interventions.
- Electronic documentation of

fall risk assessment each shift
- Procedure for patient hand-off between departments.
- Policy for the review and follow up of critical lab values in discharged patients

POLICY/PROCEDURE

- Follow up for Code 99 events
- Standing order policy requiring retest for Clostridium Difficile (C Diff) if symptoms change or worsen
- Development of medication reconciliation process
- Revision of telemetry policy to include every 4 hour frequency of vital signs and new alarm limits adjusted to include change in patient's condition
- Development of Falls Risk Policy
- Policy to revise the secure handling/receiving of ambulance run sheets
- Develop ED process for transcription of orders and accountability
- Develop Fall Prevention committee to track, educate, and follow up on falls
- Revision of night access to Pyxis (medication dispensing) system
- Requirement of two nurses to override Dilaudid in Pyxis system

EDUCATION/TRAINING

- Competency training for Clostridium Difficile (C. Diff)
- Pharmacy to educate staff on geriatric drug uses (e.g., Ambien)
- Clostridium Difficile (C. Diff) newsletter
- Falls prevention education to include ancillary staff members
- Retreat/workshop to promote team approach to care
- Staff education on Insulin protocols
- Staff education on proper handling of telemetry strips
- Hands on and written competency for use of Pyxis system (medication dispensing)
- Lab education for critical values reporting
- Staff and Physician education specific to analgesic charts/Meperidine guidelines/medication documentation
- Patient and family education regarding medications brought to hospital

DOCUMENTATION

- Process for documenting medications brought from home
- Physician documentation to verify review of nurse triage data
- Development of standards for discharge documentation for physicians/nurses
- Nurse documentation tool with visual triggers to prompt for reassessment of abnormal findings
- Failure Mode Effects Analysis regarding intravenous documentation

STANDARDS OF CARE

- Critical Troponin level reporting requirements
- Auditing of Peripherally Inserted Central Catheter (PICC) line care
- Pharmacy review of 30 day stop process
- Infectious Disease Committee to focus on CDC (Centers for Disease Control recommendations and provide ongoing education
- Formation of Rapid Response Teams
- Continuous cardiac monitoring for patients transported from OR to post op recovery area
- Review of feasibility of pre-op nasal swabbing for Methicillin Resistant Staphylococcus Aureus (MRSA) in elective cardiac catheter patients

WRONG SURGERY

Wrong surgery contributed to three events for 2005. Actions specific to those events included:

- Second time out to occur after the site prep and drape
- Pre-op checklist to include site marking by patient and policy to address discrepancies
- For operative sites not easily visible to patient, digital cameras will be available to photograph the site for validation
- Verification protocol to include hair clipping to visualize cutaneous lesions be carried out in the pre-anesthesia area
- Brochure for pre-op pa-

tients explaining steps to assure correct patient/site/surgery
- Distribute Universal protocol to surgical services
- Physicians to mark incision
- Method for conflict resolution between team members

EQUIPMENT ISSUES

- Re-evaluate hospital-wide patient call bell system
- Examining technology interventions to detect patient movement
- Added fields to Meditech screen to allow documentation of respiratory rate and level of consciousness
- New cardiac monitors with automated vital signs and oxygen saturation
- Portable suction added to Code cart
- Assess Pyxis system for inventory/overrides
- Use of fall prevention equipment
- Electronic Record to include completed discharge summaries with correct dates
- Utilization of TAB devices for fall prevention (alarms)

Maine facilities are also participating in other initiatives such as the 100,000 Lives Campaign, developed by the Institute for Healthcare Improvement and creating Rapid Response Teams to provide early intervention in potentially critical events. Many providers are moving toward greater "transparency" with quality data, as well as disclosure with medical errors.

ACTION PLANS 2006

At the end of the second reportable year, the Division plans to:

1. Categorize all 2006 sentinel event data utilizing the NQF[10] core set of reporting standards. Include the NQF categories in the *Annual Report to the State Legislature.*

2. Revise *The Governing Board (Chapter VI) Regulations for General and Specialty Hospitals* to include criteria for what is a credible and thorough Root Cause Analysis.

3. Evaluate the need to enhance the regulations for Ambulatory Surgical Centers, End Stage Renal Disease Facilities and Intermediate Care Facilities for People with Mental Retardation.

4. Conduct random follow-up reviews of reported sentinel events to assess implementation of corrective action plans.

5. Conduct follow-up reviews on events identified as having a potential for high risk of recurrence, significant impact on a high volume of healthcare services, or at high risk for death or serious injury if corrective action is not taken.

6. Conduct periodic review of all complaints captured in healthcare entities as defined in statute.

7. Revise the *Governing Board (Chapter VI) Regulations for the Licensure of General and Specialty Hospitals in the State of Maine* to include*: "*The Division may conduct random audits of any and all healthcare facilities, and review facility data/records to assure compliance as outlined in the statute".

8. Revise the *Quality Management Process (Chapter XXI) of the Regulations for General and Specialty Hospitals* to include a requirement regarding Failure Mode and Effects Analysis (FMEA), (1. A prospective assessment that identifies and improves steps in a process thereby reasonably ensuring a safe and clinically desirable outcome; 2. A systematic approach to identify and prevent product and process problems before they occur[11]).

9. Expand education sessions to all the End Stage Renal Dialysis Facilities (ESRDs) as part of the State team project for the Patient Safety Improvement Corps.

10. Continue to offer consultation services to licensed facilities and welcome the opportunity to provide education to staff on the sentinel event reporting process. HSCs have planned presentations for the Perinatal Nurse Managers of Maine, Annual Report overview with the Maine Hospital Association, and a presentation to the Maine Association for Healthcare Quality.

11. Continue to collect, review and analyze reported sentinel events and share aggregated data and risk reduction measures to Maine facilities.
12. Revise the Sentinel Event Reporting form to capture additional information regarding the location where events occurred in the various facilities, diagnosis codes, notification information and also to create a standard review form to help evaluate the information received in the written report.

SENTINEL EVENT TEAM RECOMMENDATIONS

In order to maintain up-to-date information on standards of care, new clinical guidelines, best practices and safety initiatives, the Sentinel Event team requires funding for education. This would also include the authorization to attend training programs, and healthcare quality conferences.

- Part of the responsibility of the HSCs is to promote dialogue and exchange information on quality issues, patient care, and safety with risk managers from Maine and nationally. Conference attendance allows HSCs to network and collaborate with other members with similar responsibilities.

- Access to resource materials, such as professional books, and on-line journals also helps to maintain the high standards necessary to fulfill the review activities of the Sentinel Event team.

- Technical support to establish and maintain a sentinel event database.

- Access to clinical consultative staff as needed.

These recommendations for education, training, technical support, and resources are contingent upon adequate funding.

RESOURCES

www.ahrq.gov/consumer/

www.ihi.org/IHI/Topics/CriticalCare/IntensiveCare/Tools/RapidResponseTeamEducationChecklist(IHITool).htm

www.ismp.org/Pages/Consumer.html

www.jcaho.org/general+public/index/htm

www.leapfroggroup.org

www.maine.gov/dhhs/bms/providerfiles/sentinel_reporting_forms.htm

www.mainequalityforum.gov/

www.nashp.org

www.ncqa.org

www.npsf.org

www.patientsafety.gov

APPENDICES

REFERENCES

[1] Institute of Medicine, To Err is Human: Building a Safer Health System. Linda T. Kohn, Janet M. Corrigan, and Molla S. Donaldson, eds. Washington, D.C.: National Academy Press, 2000

[2] VA National Patient Safety Improvement Handbook 1050.1, January 30, 2002, 4-5.

[3] www.ahcpr.gov/about/psimpcorps.htm

[4] www.jcaho.org/accredited+organizations/sentinel+event/sestats93005.pdf

[5] www.ahrq.gov/consumer/20tips.htm

[6] www.patientsafety.gov/SafetyTopics/fallstoolkit/notebook/05_fallspolicy.pdf

[7] Johns Hopkins Hospital Fall Risk Assessment Tool @ http://www.nursingcenter.com/pdf.asp

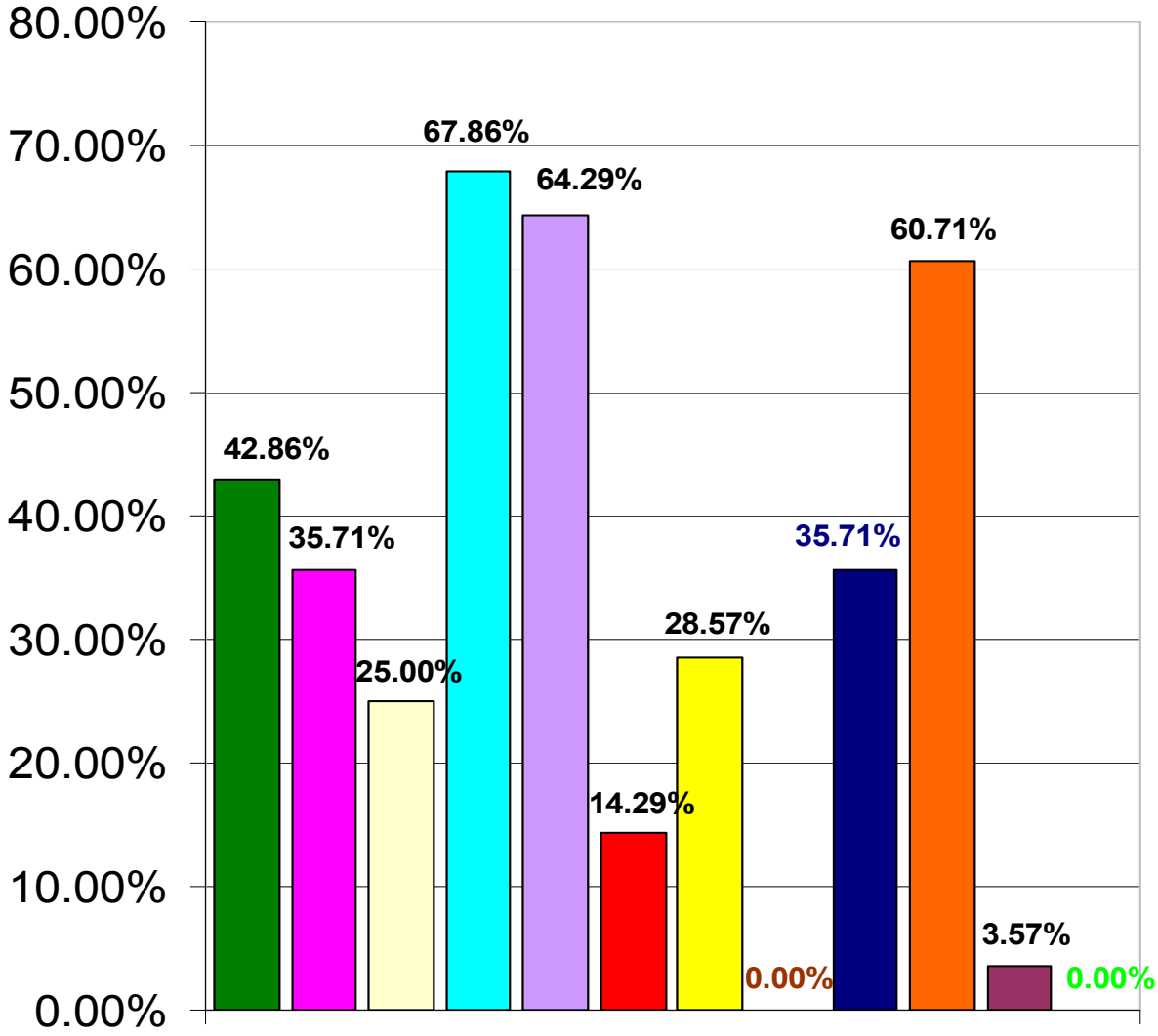
[8] www.jcaho.org/accredited+organizations/patient+safety/06_npsg_cah_hap.htm

[9] www.jcaho.org/accredited+organizations/ambulatory+care/sentinel+events/root+causes+of+sentinel+event.htm

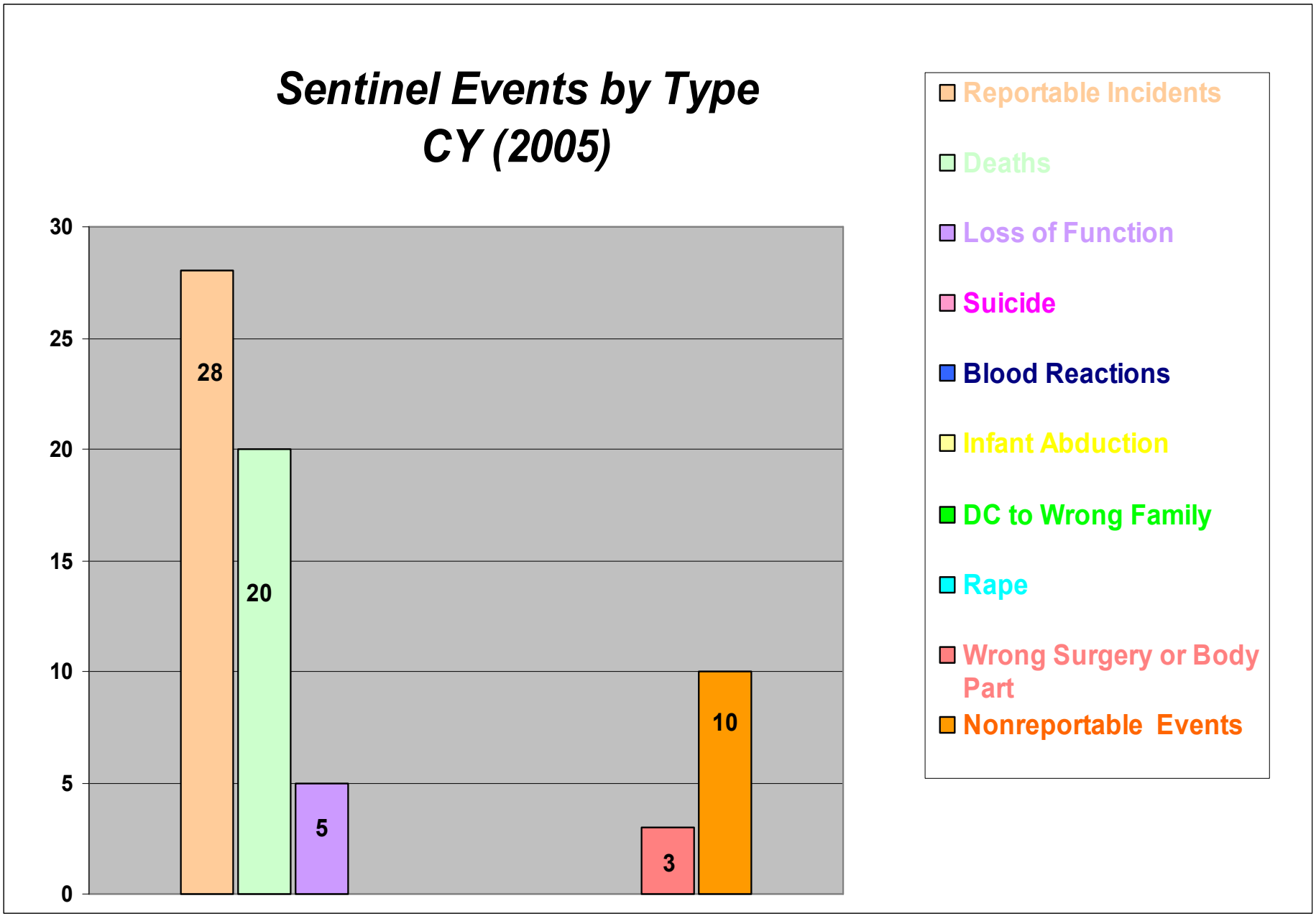
[10] National Quality Forum. *Serious reportable events in healthcare: a consensus report.* Washington, DC: National Forum for Healthcare Quality Measurement and Reporting; 2002

[11] www.patientsafety.gov/HFMEAIntro.doc

Facility Systems Impacting Reported Events by Percentage CY (2005)



- Human Factors
- Equipment
- Availability of Info
- Communication
- Policy/Procedures
- Physical Environment
- Standards of Care
- Leadership
- Documentation
- Education/Training
- None Identified
- Other


Sentinel Events by Type
CY (2005)
30
25
20
15
10
5
0
28
20
5
3
10
Reportable Incidents
Deaths
Loss of Function
Suicide
Blood Reactions
Infant Abduction
DC to Wrong Family
Rape
Wrong Surgery or Body Part
Nonreportable Events

Maine Sentinel Events January 2004-November 2005
Utilizing NQF Serious Reportable Events Criteria

SURGICAL EVENTS	
A. Surgery performed on the wrong body part	**5**
B. Surgery performed on the wrong patient	**0**
C. Wrong surgical procedure performed on a patient	**2**
D. Retention of a foreign object in a patient after surgery or other procedure	**0**
E. Intraoperative or immediately post operative death in an ASA I patient	**3**
PRODUCT OR DEVICE EVENTS	
A. Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the healthcare facility	**0**
B. Patient death or serious disability associated with the use or function of a device in patient care in which the device is used for functions other than is intended	**3**
C. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility	**0**
PATIENT PROTECTION EVENTS	
A. Infant discharged to the wrong person	**0**
B. Patient death or serious disability associated with patient elopement (disappearance) for more than four hours	**0**
C. Patient suicide or attempted suicide resulting in serious disability, while being cared for in a healthcare facility	**0**
CARE MANAGEMENT EVENTS	
A. Patient death or serious disability associated with a medication error (e.g., errors involving wrong drug, wrong dose, wrong patient, wrong rate, wrong preparation or wrong route of administration)	**4**
B. Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO incompatible blood or blood products	**0**
C. Maternal death or serious disability associated with labor and delivery in a low-risk pregnancy while being cared for in a healthcare facility	**0**
D. Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a healthcare facility	**0**

E. Death or serious disability (kernicterus) associated with failure to identify and treat hyperbilirubinemia in neonates	0
F. Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility	0
G. Patient death or serious disability due to spinal manipulation therapy	0
ENVIRONMENTAL EVENTS	
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2. Events that did not meet NQF criteria	21