Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner

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July 16, 2021

Senator Ned Claxton, Chair
Representative Michele Meyer, Chair
Members, Joint Standing Committee on Health and Human Services
100 State House Station
Augusta, ME. 04333-0100

Dear Senator Claxton, Representative Meyer and members of the Joint Standing Committee on Health and Human Services:

Enclosed is the *Sentinel Events Annual Report for calendar year 2020.* The Sentinel Events Reporting statute (22 M.R.S.A. §8754) directs the Department of Health and Human Services to submit an annual report to the Legislature, healthcare facilities and the public that includes summary data of the number and types of sentinel events reported during each calendar year.

If you have any questions or would like further information, please feel free to contact Bill Montejo, Director, Division of Licensing and Certification at 207-287-9338.

Sincerely,

Jeanne M. Lambrew

Jeanne M. Lambrew, PhD
Commissioner

JML/klv

Enclosure

cc: Bill Montejo, Director, Division of Licensing and Certification

Sentinel Events

CY2020

Annual Report to the Maine State Legislature

Sentinel Event Annual Report prepared by:
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Executive Summary

In 1999, the Institute of Medicine published To Err is Human, a report that brought attention to the prevalence of medical errors and underscored the importance of patient safety. In the years since then, there have been many important changes, including patient safety research and hospital programs focused on measurement and accreditation.[1] Maine has taken an active role in the promotion of patient safety through its requirement for mandatory reporting of sentinel events (22 M.R.S.A. §§8751-8756) for hospitals, ambulatory surgical centers (ASC), end stage renal disease facilities (ESRD), and intermediate care facilities for individuals with intellectual disabilities (ICF/IID). Since 2004, these facilities have been required to report all sentinel events to the Sentinel Events Team (SET), with the goal of improving the quality of healthcare and increasing patient safety throughout the state. The Sentinel Event Program provides a structure that promotes understanding of the causes that underlie sentinel events which can lead to system and process changes that will reduce the probability of future events. The SET, part of the Division of Licensing and Certification (DLC), is responsible for overseeing the Sentinel Event Program.

The Sentinel Event Statute and Rules have a number of requirements, including the collection of data regarding sentinel events and sharing aggregated data with the Legislature and the public. This annual report provides information related to the number and types of sentinel events that were reported in 2020, as well as the actions taken by facilities to prevent future occurrences and to mitigate the harm caused by similar events. However, the work of the SET goes well beyond these data collection and reporting requirements. The SET provides extensive technical assistance to covered facilities, providing guidance on understanding sentinel events and identifying their root causes. The SET has established relationships with covered facilities, which promotes communication and interactions related to serious adverse events. A key feature of the Sentinel Events Program is the confidentiality outlined by statute, which protects sentinel event information from discovery, allowing covered facilities to complete the system-wide investigations necessary to truly understand the causal factors of sentinel events.

The SET continues to publish a quarterly newsletter that focuses on key patient safety issues identified by covered facilities in the state, as well as those issues that have been identified nationally. The newsletters include information and links to tools that are available to facilities as a means of assisting in the promotion of their patient safety programs.

[1] Two Decades Since To Err is Human: An Assessment of Progress and Emerging Priorities in Patient Safety, Bates and Singh, Health Affairs, November 2018

How to Use this Report

The Maine Sentinel Event Annual Report is one of many sources of information available to the public related to health care quality and patient safety. It is designed to provide an overview of the Sentinel Event Program, including background information regarding the program, review of SET activities, reporting of aggregated data and trends, and plans for the upcoming year.

The fact that health care providers are identifying and reporting potential adverse events in order to learn and prevent harm to patients is a positive step in the work of improving patient safety. The sentinel event data listed in this report reflects organizational transparency in addressing patient safety issues. Consumers are discouraged from reaching conclusions about the safety of patient care in Maine health care facilities based only on the data included in this report. Consumers are encouraged to talk with their healthcare providers about questions or concerns related to patient safety, and to be active participants in their own health care.

The events listed in this report represent a very small fraction of all the health care services performed in Maine facilities. The number of reported events can fluctuate at a facility for a variety of reasons. The size of the facility, the volume of services, and the type and complexity of procedures will influence the number of events. The number of reported events will also be higher from facilities that are especially vigilant about identifying and reporting errors. This heightened vigilance helps foster an organizational culture wherein staff members feel comfortable reporting patient safety concerns without fear of reprisal. Health care facilities that embrace this safety-focused culture look at adverse events as opportunities to learn and improve.

Information regarding health care quality and safety is available from several organizations dedicated to promoting patient safety. A listing of some of these resources is provided in Appendix D of this report.

Background

Maine's Sentinel Event Program was established in 2002 with enactment of Public Law 2001, Chapter 678 to create a system for reporting all sentinel events, with the goal of improving the quality of health care and increasing patient safety throughout the state. Beginning in 2004, mandated reporting of sentinel events has been required of hospitals and ASC, ESRD, and ICF/IID facilities.

This report is submitted in accordance with Maine law (22 M.R.S.A. §§8751-8756) that requires that an annual report be provided to the Legislature, health care facilities, and the public on the aggregate number and type of sentinel events for the prior calendar year, rates of change, causative factors, and activities to strengthen patient safety in Maine.

This report is designed to:

- Build awareness of Maine's sentinel event reporting requirements and the follow-up process used by facilities and the SET when events occur;
- Provide aggregated data and information about the number and nature of sentinel events reported;
- Identify patterns and make recommendations to improve the quality and safety of patient care;
- Describe efforts to address underreporting;
- Review efforts to enhance the role of sentinel event reporting in improving patient safety; and
- Maintain best practice reporting by updating event criteria to current national standards.

Maine, along with all other New England states, is among the 28 states and the District of Columbia, that have prioritized improvements in patient safety by implementing a mandatory sentinel event reporting program. As with most reporting states, Maine uses state-identified sentinel event criteria as well as the National Quality Forum's (NQF) list of serious reportable events. Appendix A contains the Maine-specific and NQF definitions of mandatory reportable sentinel events. The Joint Commission, a health care accrediting agency for many hospitals, has been collecting sentinel event reports since 1995. This is a voluntary reporting program, however, so facilities are not compelled to report sentinel events.

There are other entities that collect information related to safety and quality of healthcare. One of these, the Leapfrog Group, is a voluntary program, "aimed at mobilizing employer purchasing power to alert America's health industry that big leaps in health care safety, quality and customer value will be recognized and rewarded." The Leapfrog Hospital Survey compares hospitals' performance on the national standards of safety, quality, and efficiency that are deemed most relevant to consumers and purchasers of care. The survey is the only nationally standardized and endorsed set of measures that captures hospital performance in patient safety, quality and resource utilization. Leapfrog's Hospital Safety Score® assigns A, B, C, D and F grades to more than 2,600 U.S. hospitals based on their ability to prevent errors, accidents, injuries, and infections. The Hospital Safety Score is calculated by top patient safety experts, peer reviewed, fully transparent, and free to the public.

Participation in the Leapfrog Group surveys is not related to the Sentinel Event Program. It is, however,

an indication of the importance hospitals place on patient safety and their willingness to be transparent regarding their performance. In 2020, 32 of Maine's acute and critical access hospitals submitted data to the Leapfrog Group. For the second year in a row Maine is the top-rated state for patient safety. This number is based on the number of A-grade hospitals they have, compared to the number of graded hospitals on the Fall 2020 Leapfrog Hospital Safety Grade. 62.5% of Maine hospitals that participate in Leapfrog received an A grade.

Five Maine hospitals were included in the Leapfrog Top Hospitals lists, as announced in December 2020:

- Blue Hill Memorial Hospital
- LincolnHealth
- Pen Bay Medical Center
- Stephens Memorial Hospital
- Waldo County General Hospital

The Centers for Medicare and Medicaid Services (CMS) has a consumer-oriented website that helps individuals learn about hospital quality and safety measures. There are 57 quality measures used to generate an overall score or "star rating". In addition to patient satisfaction, these measures include information about patient safety, including complications and deaths and unplanned returns to the hospital.

Reporting Requirements

The Maine Sentinel Event Program receives the authority to carry out its activities in MRSA Title 22, Chapter 1684, §8754, Division Duties. This statute establishes a system for reporting sentinel events for the purpose of improving the quality of health care and increased patient safety.

Notification: Facilities must notify the SET within one business day of discovering a possible sentinel event. The SET determines whether the incident conforms to the statutory definition of a sentinel event. Upon confirmation by the SET that the event meets the sentinel event criteria, the facility is required to submit a brief description of the incident to the SET. A copy of the notification form used by facilities can be found in Appendix A.

Root Cause Analysis: Facilities are required to conduct a root cause analysis after every sentinel event. A root cause analysis is a systematic approach to problem solving that identifies the causal factors related to an adverse event. The SET does not dictate how facilities conduct or record root cause analyses. The Joint Commission and the Veterans Administration have developed root cause analysis forms and processes that are available for healthcare facilities to use, without charge.

To be acceptable to the SET, root cause analyses must be both *thorough* and *credible*. For purposes of the Sentinel Event Program, these terms are defined as follows:

A *thorough* root cause analysis includes at least the following information:

- An analysis of the underlying systems and processes to determine where redesign might reduce risk;
- An inquiry into all areas appropriate to the specific type of event;
- A determination of the human and other factors most directly associated with the sentinel event, and the processes and systems related to its occurrence;
- An identification of risk points and their potential contributions to the event;
- A determination of potential improvement in processes or systems that would tend to decrease the likelihood of such an event in the future or a determination, after analysis, that no such improvement opportunities exist;
- An action plan that identifies changes that can be implemented to reduce risks or formulates a rationale for not undertaking such changes; and
- Where improvement actions are planned, an identification of who is responsible for implementation, when the action will be implemented and how the effectiveness of the action will be evaluated.

A *credible* root cause analysis meets the following criteria:

- It includes participation by the leadership of the healthcare facility and by the individuals most closely involved in the processes and systems under review;
- It is internally consistent (that is, it does not contradict itself or leave obvious questions unanswered);
- It provides an explanation for all findings, including those identified as “not applicable” or “no problem;” and
- It includes the consideration of any relevant literature.

The root cause analysis report, including action plans, must be sent to the SET within 45 days of discovery of the sentinel event. The facility’s Chief Executive Officer (CEO) is required to sign this report to assure their active engagement in understanding factors leading to the event and plans for mitigating its recurrence.

Once received, the SET reviews the report to determine that a thorough and credible evaluation was performed, and that appropriate action plans were developed with assigned responsibilities and timelines for their implementation. Reports that are incomplete are returned to the facility by the SET. The SET may provide technical assistance to facilities in discussing sentinel events, but it is the responsibility of the facility to conduct a thorough and credible root cause analysis. Once an acceptable report is received, the SET sends an acceptance letter to the facility’s CEO. A flow chart diagramming the sentinel event case review process can be found in Appendix B.

A facility that knowingly violates any provision of the notification and/or the reporting requirements is subject to a civil penalty of up to $10,000.

The SET utilizes a confidential, secure database to gather and track information collected on reported events, their associated root causes, and applicable action plans. This database provides a

management system for tracking events and incoming reports and is the primary source for the SET's data and reports. The sentinel event management system helps the SET identify patterns or trends in the frequency of sentinel events and common factors associated with events.

The SET provides facilities with facility-specific sentinel event data, which can be helpful in identifying ongoing issues. Aggregated data is made available in the Sentinel Event Annual Report. Deidentified root causes and action plans may be used by the SET for educational purposes.

Not all events reported to the SET fit the definition of a sentinel event. The SET will notify a facility if the reported event does not constitute a sentinel event. Facilities are encouraged, although not required, to report "near misses". Conducting a root cause analysis of a near miss can help identify systems issues that, if not addressed, could result in a sentinel event in the future. The root cause and action plans from these near-miss reviews are entered into the database for educational purposes.

Annually, all covered facilities must provide the SET with a written attestation that contains an affirmative statement that it reported all sentinel events that occurred in the prior calendar year.

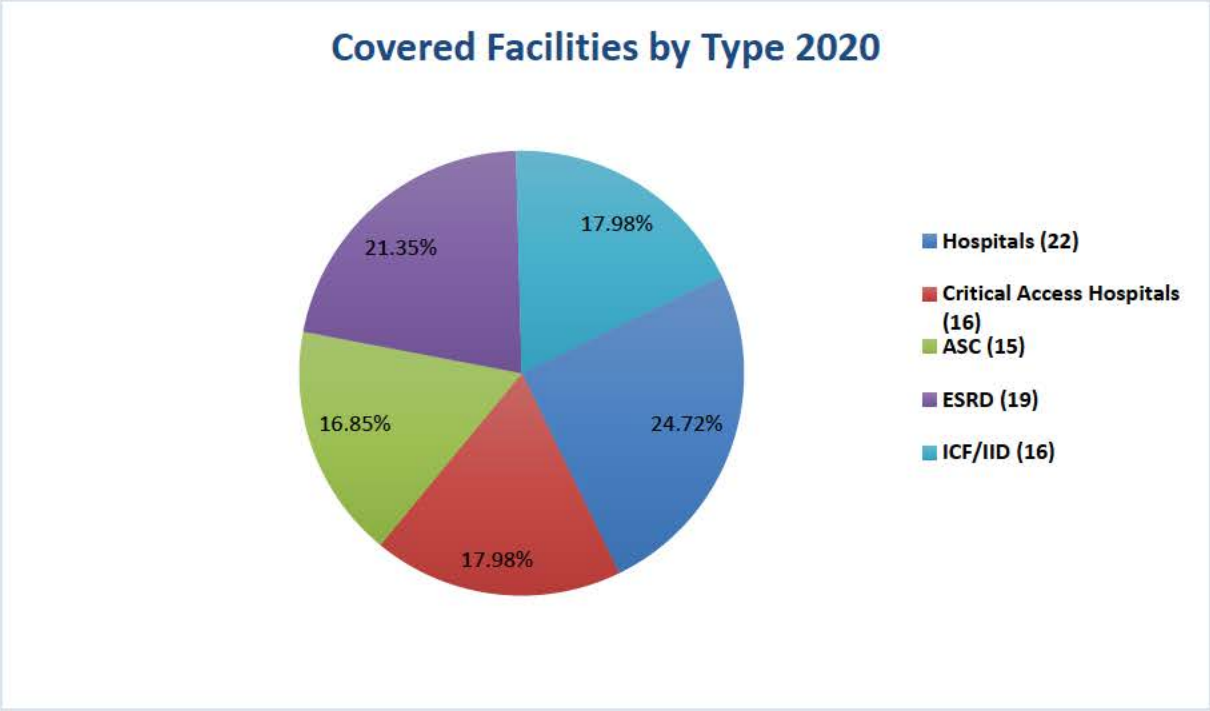
Confidentiality Provisions

By law, all sentinel event information submitted to the SET is considered privileged and confidential. No information about reporting facilities or providers is discoverable or made public. A firewall is maintained between the sentinel event program and the DLC licensing and certification unit. The only time that the SET is permitted to share information with DLC licensing and certification staff is when a reported sentinel event represents immediate jeopardy to the public. Immediate jeopardy is defined as a failure on the part of a healthcare facility and/or provider to comply with the Conditions of Participation for the Medicare and Medicaid certification program that has caused, or is likely to cause, serious injury, harm, impairment, or death to a patient.

Covered Facilities

In 2020, Maine had 89 health care facilities that were responsible for reporting sentinel events. Table 1 shows the distribution of covered facilities by type.

Table 1 Distribution of Covered Facilities in 2020

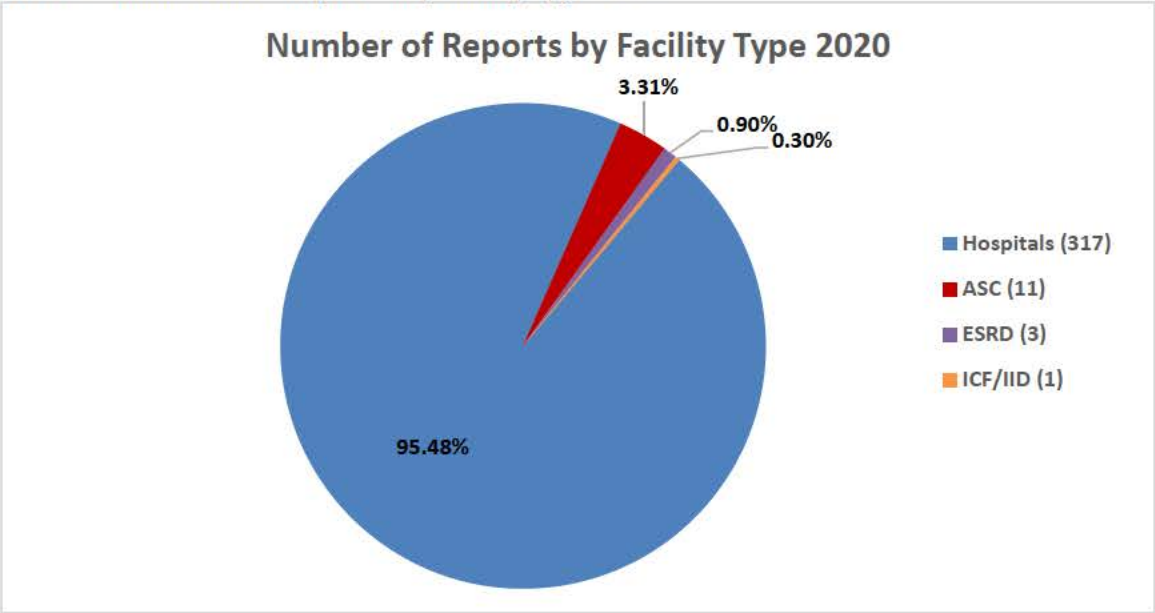


Reports by Facility Type

Of the 89 facilities covered by the law, 48 (54%) reported sentinel events during 2020. Event reports were received from 37 (97%) Maine hospitals. An additional nine facilities did report near miss and/or non-reportable cases. Including these reports, 65% of all covered facilities reported activity to the SET in 2020.

There were 332 sentinel events reported in 2020. 317 were reported by hospitals, 11 were reported by ASCs and three were reported by ESRDs. ICF/IID facilities reported one sentinel event for 2020.

Table 2. Sentinel Events Reported by Facility Type 2020



Sentinel Events

A total of 2,666 sentinel events have been reported to the SET since 2004, when covered facilities began reporting. As illustrated in Table 4, few facilities reported sentinel events between 2004 and 2008. The SET engaged in outreach efforts to ensure that all facilities had a heightened awareness of the requirement to report, resulting in some increase in reporting, starting in 2008.

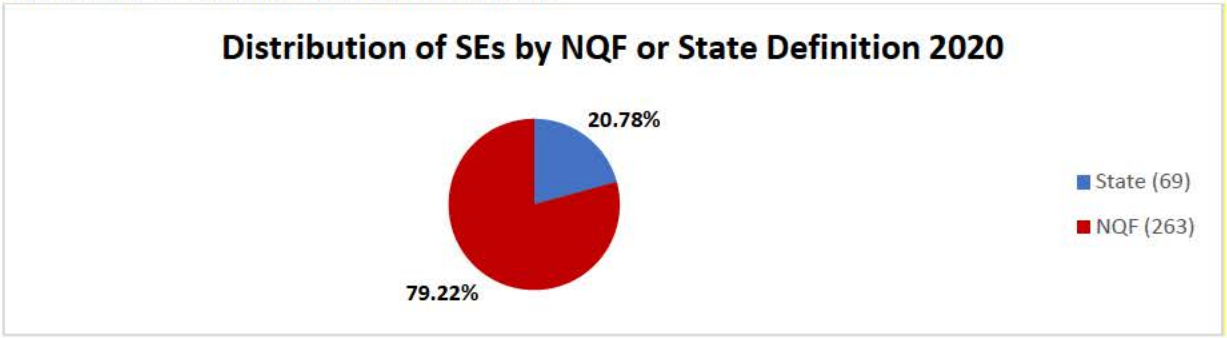
In 2010 the entire list of the NQF Serious Reportable Events was formally adopted as part of statutory changes. These events are sometimes referred to as "never events" because they represent situations that should never occur in healthcare facilities. The NQF Serious Reportable Events are structured around seven categories: Surgical, product or device, patient protection, care management, environmental, radiologic, and potentially criminal. This expansion of reporting requirements to include additional types of events resulted in a significant increase in the volume of reporting in 2010.

The inclusion of the NQF list was significant in that Maine providers were then required to utilize nationally recognized definitions for reportable events. The NQF is a consensus-driven, public-private partnership aimed at developing common approaches to identification of events that are serious in nature and have been determined to be largely preventable. The NQF list increasingly has become the basis for states' mandatory reporting systems. The list of NQF Serious Reportable Events is intended to capture events that are clearly identifiable, measurable, largely preventable, and of interest to the public and other stakeholders.

Comparability of definitions enhances clarity about what must be reported and provides benchmarks

for comparing experiences across states. The primary goals are to prevent harm and enhance public trust. In 2020, 79.22% of the sentinel events reported conformed with the NQF definitions and 20.78% were based on State definitions.

Table 3. NQF or State Definition Distribution 2020

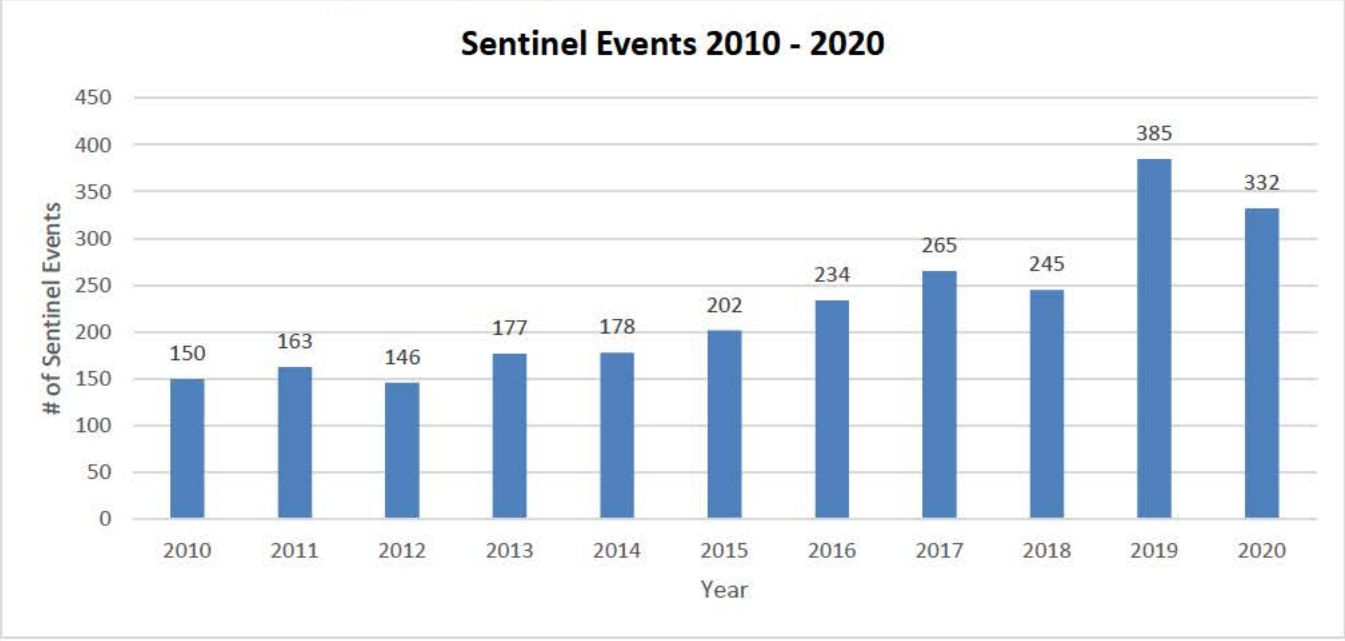


2020 Reported Events

There were 406 event notifications in 2020. Of those, 72 events did not meet the criteria of a sentinel event, and an additional two events were determined to be "near misses," bringing the total number of actual sentinel events to 332.

14.03% of sentinel events occurred either on a holiday (zero) or a weekend (57). The SET encourages facilities to identify the day of the week, time of day, and if the event occurred on a holiday as there is research that shows that more adverse events occur outside of regular business hours

Table 4 Sentinel Events Reported by Year, 2010-2020

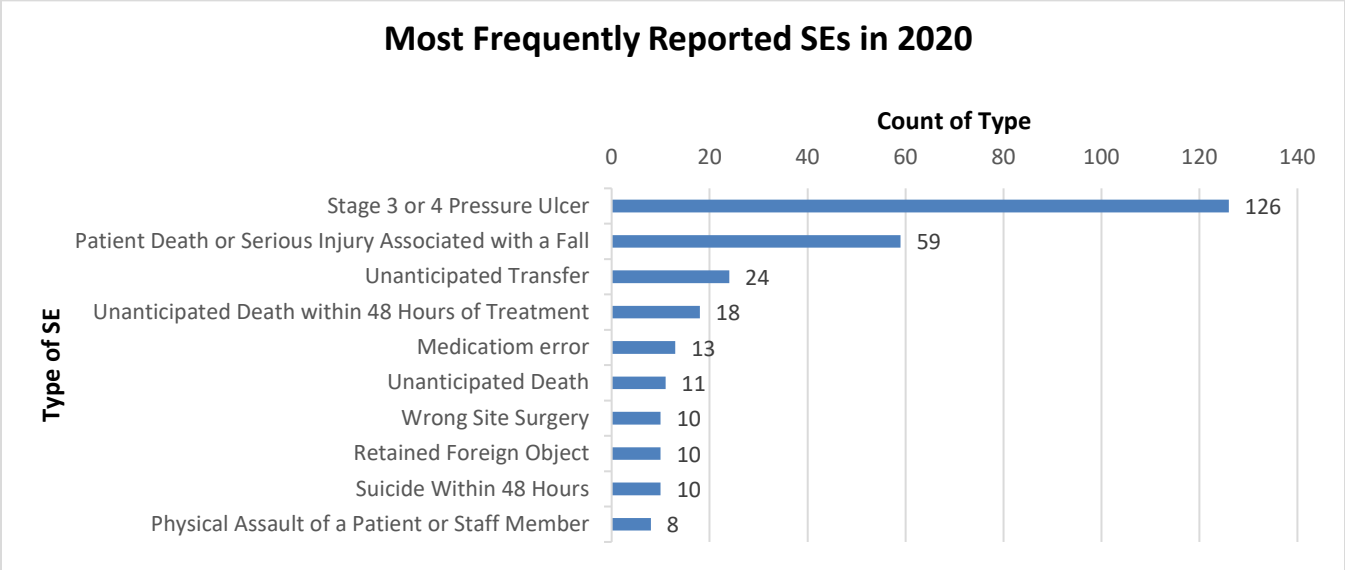


Types of Sentinel Events Reported

A listing of all sentinel events can be found in Appendix C. Of the 27 different categories of sentinel events in 2020, 10 categories made up 87% of the total sentinel events reported, as listed below:

- Stage 3 or 4 pressure ulcer: 126 (43.60%)
- Patient death or serious injury associated with a fall: 59 (20.42%)
- Unanticipated transfer: 24 (8.30%)
- Unanticipated death within 48 hours of treatment: 18 (6.23%)
- Medication error: 13 (4.50%)
- Unanticipated death: 11 (3.81%)
- Wrong site surgery: 10 (3.46%)
- Retained foreign object: 10 (3.46%)
- Suicide within 48 hours: 10 (3.46%)
- Physical assault of a patient or staff member: 8 (2.77%)

Table 5 Most Frequently Reported Sentinel Events in 2020



Key Findings

- Pressure ulcers have been the most frequently reported sentinel events over the past five years.
- Falls with patient death or serious injury continue to remain the second most reported sentinel event. Reported events show that falls frequently occur when the patient is getting up to use the bathroom.
- Surgical-related cases continue to be identified. While these type of sentinel events would seem to be more easily preventable due to the nature of surgeries being planned and many tools available to help mitigate harm and risk, the SET continues to see issues. This includes wrong site surgery, retained foreign objects, wrong surgical procedures, and surgery performed

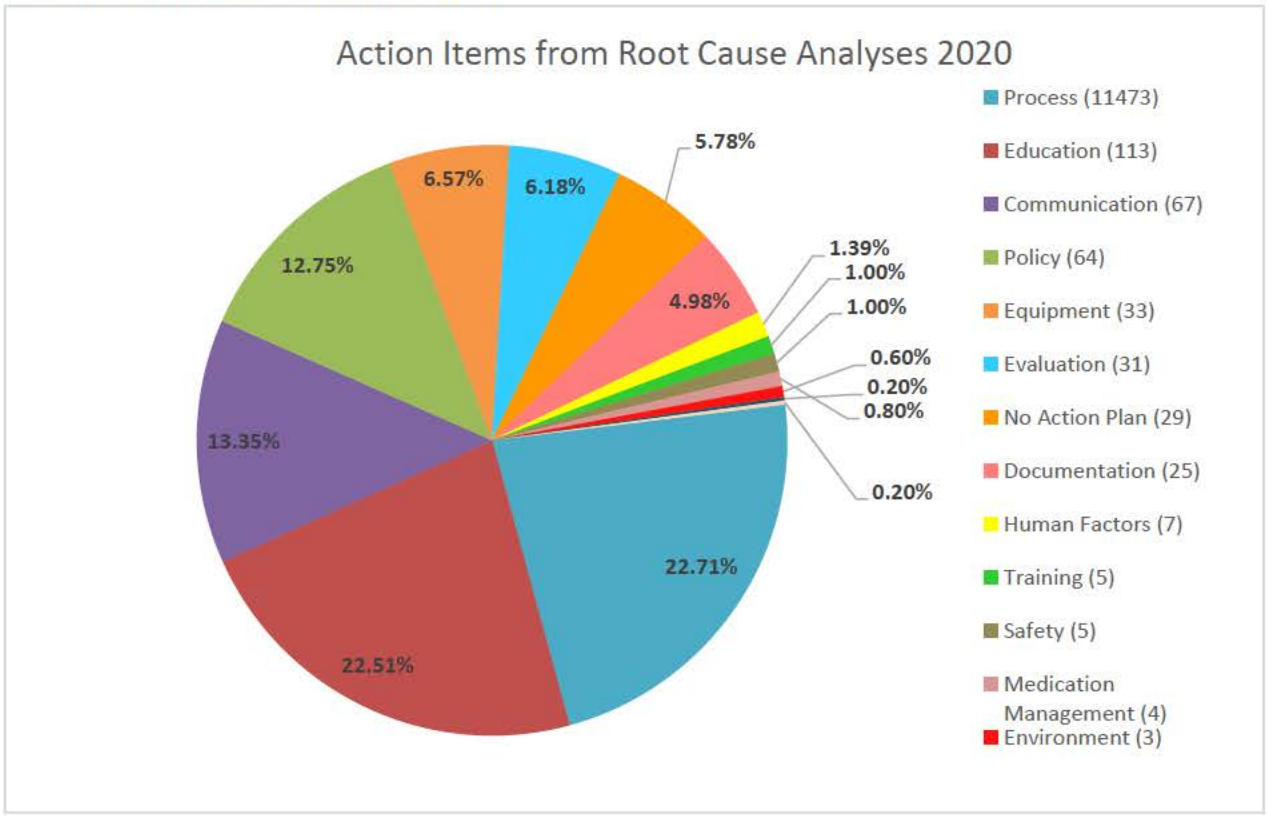
on the wrong patient.

- Unanticipated deaths, including those that occur within 48 hours of treatment, also remain elevated. While it is not clear that there is a pattern or trend related to these events, assessments and discharge planning are two areas that could be reviewed as areas for improvement. This category can be challenging for facilities as sometimes the cause of death is not known.

Root Cause Analysis: Action Items

When an adverse event occurs, facilities are required to conduct a root cause analysis. Action items that were implemented as a result of root cause analyses are categorized by type. As can be seen in Table 6, the most common action item categories were process, education, and communication.

Table 6. Action Items Identified 2020



Opportunities for Improvement

The SET notes that the evaluation of the effectiveness of Root Cause Analysis action items continues to be the biggest challenge for facilities. To be effective, action items must be evaluated to determine if the intended outcome has been achieved, and if the outcome has not been achieved, to identify possible modifications to support achievement. Additionally, the SET continues to receive notification of events that were only identified weeks or months after the event actually occurred, indicating that there are insufficient surveillance mechanisms in place. The importance of identifying and reporting all events at the time they occur cannot be stressed enough. The SET strongly encourages facilities to contact the team directly when there is any question about whether an event meets the sentinel event

reporting criteria.

Reviews

The SET did not conduct any on-site reviews in 2020 due to COVID 19. The SET is developing procedures for remote reviews, as well as plans for resumption of partial on-site reviews as conditions related to COVID 19 change.

When they can be conducted, reviews enable the SET to identify not only noncompliance, but also best practices for improving patient safety. When SET identifies best practices, the team will share them in the quarterly newsletter with the permission of the facility.

Examples of best practices:

Education and training

- Sharing sentinel event educational content with staff, directors, and board members.
- Distributing sentinel event newsletters with managers and directors.
- Expanding daily patient-safety huddles.

Analysis and tools

- Assessing patient safety culture through use of the AHRQ patient safety culture survey.
- Implementing a "Great Catch" program.
- Sending Patient Safety Alerts to all staff and publishing alerts on the hospital portal to publicize action items and Root Cause Analysis findings.
- Using the IHI tool to complete death reviews.

Leadership Involvement

- Establishing a process for the disclosure of unanticipated outcomes and involving the family in the information gathering portion of an Root Cause Analysis.
- Convening a Quality Council & Patient First Committee to address common themes or areas that require improvement.
- Looking at equipment and vendor difficulties in meeting identified needs.

Sentinel event policy

- Developing a comprehensive sentinel event policy that includes a section on performance improvement tools, as well as information on root cause analysis.
- Ensuring the sentinel event policy clearly addresses the requirements of the Maine Sentinel Event Program, provides direction to staff, and is carried over to orientation for staff.

Progress on Goals

During calendar year 2020, the SET continued to work with covered facilities and other agencies to enhance understanding of the Sentinel Event Program and the importance of patient safety. The following represents progress on the goals set for 2020:

1) *Goal*: Continue to provide technical assistance and consultations, as requested, to facilities covered under the sentinel event rules.

    - *Actions*: The SET continues to provide technical assistance in understanding the requirements of the Sentinel Event Program. The SET also continues to receive phone calls and emails from facilities seeking clarification on topics.

2) *Goal*: Continue to assess facilities' compliance with MRSA Title 22, Chapter 1684, §8754, *Division Duties* by performing on-site reviews for covered facilities.

    - *Actions*: The SET was unable to conduct on-site reviews in 2020 due to COVID 19. We are working on a hybrid process for future reviews.

3) *Goal*: Initiate on-site revisits for facilities at which there were previous deficiencies noted.

    - *Actions*: The SET was unable to conduct any on-site revisits due to COVID. SET provided technical assistance and education to facilitated with repeat events in order to reduce the occurrence of reported events.

4) *Goal*: Continue to produce the quarterly SE Newsletter focused on trends noted in Maine sentinel event data and patient safety issues identified nationally.

    - *Actions*: Newsletters were distributed in March; September and December were distributed late due to COVID-19. Newsletters are distributed via email and available on the DHHS website. Recent Topics included:
        - Human Factors for Root Cause Analysis
        - Risks in Outpatient Care
        - Communication and the Impact on Patient Safety
        - Efficacy of Root Cause Analysis
        - Preventing Medication Errors during Surges in Care

5) *Goal*: Review and revise the sentinel event rules to clarify reporting criteria and other modifications.

    - *Actions*: The SET continues to evaluate the sentinel event rules with a focus on sentinel event reporting categories and criteria specific to specialized

environments. The SET remains in contact with other states regarding sentinel event reporting. Based on information obtained from other states, reporting facilities, health care systems, and other agencies, the SET is preparing a revision packet for approval.

Program Goals 2021

In 2021, the SET will continue to enhance the Sentinel Event Program in the following areas:

1) Continue to provide technical assistance and consultations, as requested, to facilities covered under the sentinel event rules.
2) Develop a schedule to assess facilities' compliance with MRSA Title 22, Chapter 1684, §8754, *Division Duties* by developing a hybrid process to perform reviews for covered facilities, which will consist of remote activities and on-site follow up as needed.
3) Continue to produce the quarterly SE Newsletter focused on trends noted in Maine, sentinel event data, and national patient safety issues.
4) Review and revise sentinel event rules to clarify reporting criteria and other modifications.

Conclusion

The Sentinel Event Program provides valuable oversight of, and technical support to, hospitals, ASCs, dialysis centers, and ICF/IIDs. The Sentinel Event Program continues to balance accountability with education, while supporting facilities in developing and sustaining safer practices to enhance patient care in Maine. 2020 saw an increase in communication about sentinel events, indicating that facility surveillance is successfully identifying such events. Virtual meetings and telephone calls reveal that Maine facilities are actively working to identify both best practices, and continued areas for improvement. The SET continues to focus on providing educational opportunities for facilities that are relevant to both state-specific and national trends.

Appendix A – Reporting Form

Maine Sentinel Event Notification and Near Miss Reporting Form

This form is required pursuant to 22 MRSA, Chapter 1684, and 10-44 CMR Chapter 114, Rules Governing the Reporting of Sentinel Events

State notification of a Sentinel Event is required within one (1) business day of discovery.
Do not delay notification, for any reason, including Medical Examiner results or internal discussions.

1. **What is being reported?**
☐ **Sentinel Event**
☐ **Near Miss**

2. **Today's Date:** _____
Date of Discovery: _____
Date of Event: _____
Time of Event: _____**AM/PM**
Date of Death (if applicable): _____

3. **Facility Name:** _____

Reporter's Name: _____ **Title:** _____

Telephone Number: _____ **E-mail Address:** _____

4. **Briefly describe the event including location:** _____
_____
_____
_____
_____

5. **Patient Age:** _____ ☐ **M** ☐**F** **Admitting Diagnosis:** _____

6. **Does this event meet NQF criteria?** ☐**Y** ☐ **N**
(*If yes, continue on the back – check appropriate box. If no, continue to question 7*)

7. **What type of event is being reported?**
☐ **Unanticipated Death** unrelated to the natural course of the patient's illness or underlying condition, or proper treatment of that underlying condition.
☐ **Major permanent loss of function** present at discharge, unrelated to the natural course of the patient's illness.
☐ **Major Permanent loss of function**, within 48 Hrs., unrelated to the natural course of the patient's illness.
☐ **Unanticipated Death** within 48 Hrs. of Treatment
☐ **Suicide** within 48 hours of discharge
☐ **Major Permanent Loss of Function in perinatal infant** with a birth weight over 2,500 grams, unrelated to the natural course of the mother or patient's illness or underlying condition.
☐ **Unanticipated Perinatal Death** with a birth weight over 2,500 grams, unrelated to the natural course of the mother or patient's illness or underlying condition
☐ **Unanticipated Transfer** to another facility

Submission by secure email jessica.levesque@maine.gov and elizabeth.church@maine.gov
or Confidential Fax (207) 287-3251
Sentinel Event Hotline (207)287-5813

This information is protected from public disclosure
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Revised February 2021

NATIONAL CONSENSUS EVENTS
NATIONAL QUALITY FORUM SERIOUS REPORTABLE EVENTS

Surgical or Invasive Events

- ☐ Surgery or other invasive procedure performed on the wrong s te
- ☐ Surgery or other invasive procedure performed on the wrong patient
- ☐ Wrong surgical or other invasive procedure performed on a patient
- ☐ Unintended retention of a foreign object in a patient after surgery or other invasive procedure
- ☐ Intraoperative or immediately postoperative/post-procedure death in an American Society of Anesthesiologists Class I patient

Product or device events

- ☐ Patient death or serious injury associated w th the use of contaminated drugs, devices, or biologics prov ded by the healthcare setting
- ☐ Patient death or serious injury associated w th the use or funct on of a device in patient care, in wh ch the device is used or functions other than as intended
- ☐ Patient death or serious injury associated w th intravascular air embolism that occurs while being cared for in a healthcare setting

Patient Protection Events

- ☐ Discharge or release of a patient of any age, who is unable to make decisions, to other than an authorized person
- ☐ Patient death or serious injury associated w th patient elopement (disappearance)
- ☐ Patient suicide, attempted su cide or self-harm resulting in serious injury, while being cared for in a healthcare setting

Care management events

- ☐ Patient death or serious injury associated w th a medication error (eg, errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparat on, or wrong route of administrat on)
- ☐ Patient death or serious injury associated w th unsafe administration of blood products
- ☐ Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting
- ☐ Death or serious injury of a neonate associated w th labor or delivery in a low-risk pregnancy
- ☐ Patient death or serious injury associated w th a fall while being cared for in a healthcare setting
- ☐ Stage 3 or 4 pressure and unstageable pressure ulcers acquired after admiss on/presentation to a healthcare setting
- ☐ Artificial insemination with the wrong donor sperm or wrong egg
- ☐ Patient death or serious injury resulting from the irretrievable loss of an irreplaceable b ological specimen
- ☐ Patient death or serious injury resulting from failure to follow up on or communicate laboratory, pathology or rad ology test results

Environmental Events

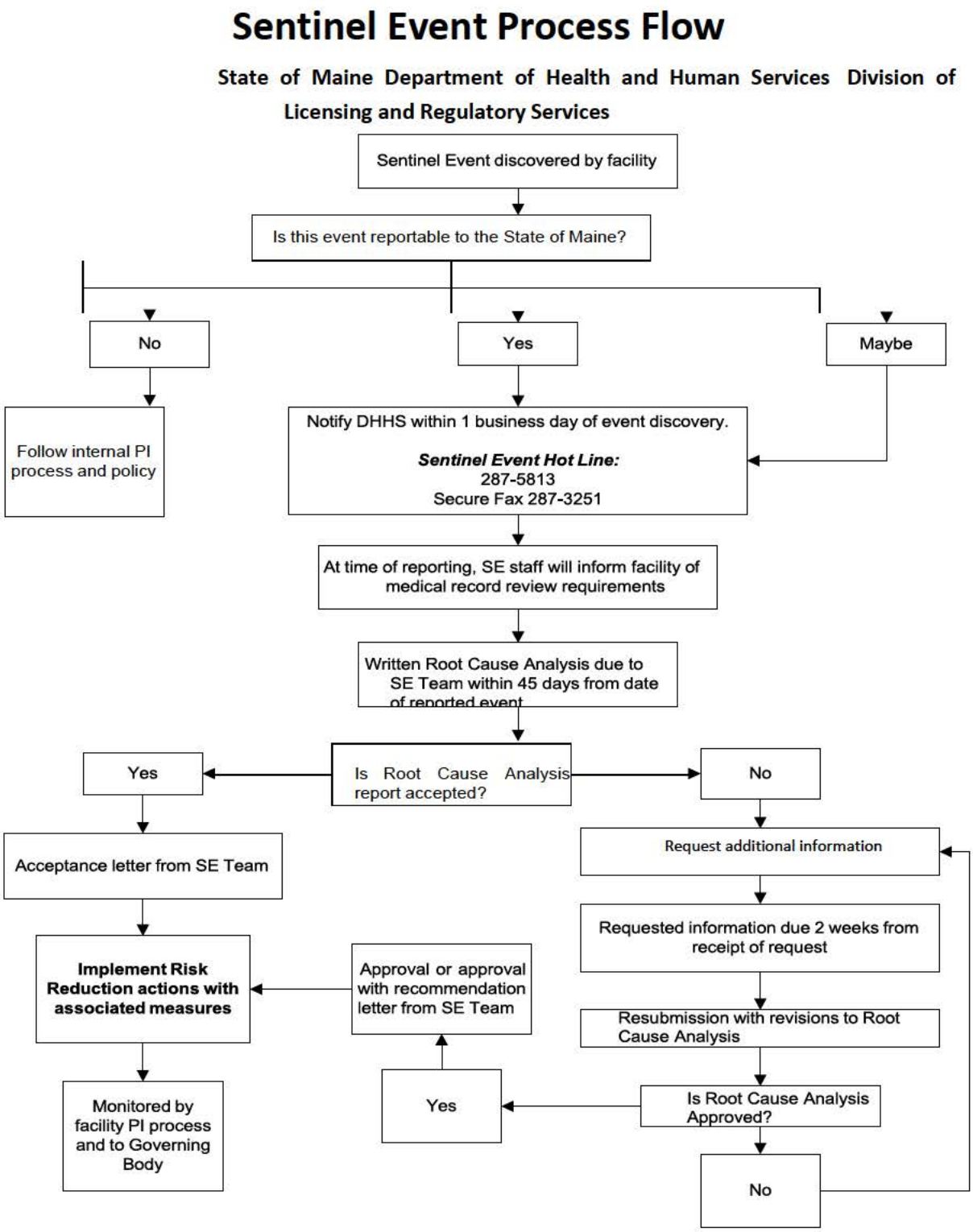
- ☐ Patient or staff death or serious injury with an electric shock in the course of a patient care process in a healthcare setting
- ☐ Any inc dent in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas or is contaminated by toxic substances
- ☐ Patient or staff death or serious injury associated with a burn incurred from any source while being cared for in a healthcare setting
- ☐ Patient death or serious injury associated w th the use physical restraints or bedrails while being cared for in a healthcare setting

Radiologic Events

- ☐ Death or serious injury of a patient or staff associated with the introduct on of a metal object into the MRI area

Potential Criminal Events

Appendix B – Sentinel Event Process Flow



Appendix C – Sentinel Events Reported by Type

Table 2. Sentinel Events Reported by Event Type, 2020

			Gender			Age		
Scope	Event Description	Total	Male	Female	Infant	<= 18	19-64	>= 65
NQF	Stage 3 or 4 pressure ulcers acquired after admission to a health care setting	126	75	51	0	1	40	85
NQF	Patient death or serious disability associated with a fall while being cared for in a health care setting	59	18	41	1	0	13	45
State	Unanticipated patient transfer to another facility	24	9	14	1	0	14	9
State	Unanticipated death within 48 hours of treatment	18	9	9	0	0	12	6
NQF	Patient death or serious disability associated with a medication error (e g. errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)	13	4	9	0	2	3	8
State	Unanticipated death	12	7	5	0	0	1	11
NQF	Surgery or other invasive procedure performed on the wrong site	10	5	5	0	0	4	6
NQF	Unintended retention of a foreign object in a patient after surgery or other invasive procedure	10	3	7	0	0	6	4
NQF	Death or significant injury of a patient or staff member resulting from a physical assault (i.e. battery) that occurs within or on the grounds of the health care setting	8	5	3	0	1	4	0
State	Permanent loss of function within 48 hours of treatment	6	4	2	0	0	5	1
State	Major permanent loss of function present at discharge	6	2	3	0	0	4	2
NQF	Sexual assault on a patient within or on the grounds of the health care setting	6	4	2	0	1	4	1
NQF	Patient suicide or attempted suicide resulting in serious disability while being cared for in a health care setting	5	1	4	0	2	3	0
NQF	Patient death or serious injury resulting from failure to follow up on or communicate laboratory, pathology, or radiology test results	5	4	1	0	0	4	1
NQF	Discharge or release of a patient of any age, who is unable to make decisions, to other than an authorized person	5	2	3	1	0	4	0
NQF	Patient death or serious disability associated with the use or function of a device in patient care, in which the device is used for function other than as intended	4	2	2	0	0	2	2
NQF	Death or serious injury of a neonate associated with labor or delivery in a low risk pregnancy	3	2	1	3	0	0	0
NQF	Patient or staff death or serious injury associated with a burn incurred from any source while being cared for in a health care setting	2	0	2	0	0	1	1
State	Unanticipated perinatal death	2	1	0	2	0	0	0
NQF	Wrong surgical or other invasive procedure performed on a patient	2	1	1	0	0	0	2
NQF	Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas or is contaminated by toxic substances	1	0	1	1	0	0	0
NQF	Surgery or other invasive procedure performed on the wrong patient	1	0	1	0	0	1	0
NQF	Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the health care setting	1	0	1	1	0	0	0
NQF	Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider	1	0	1	0	0	1	0
State	Suicide within 48 hours	1	1	0	0	0	0	1
NQF	Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a health care setting	1	0	1	0	0	1	0

Appendix D Resources

The following represent additional resources from organizations that support healthcare quality and safety:

Maine Quality Counts: An independent, multi-stakeholder, regional healthcare collaborative dedicated to transforming health and healthcare in Maine.

Hospital Safety Score: A public service provided by The Leapfrog Group, a nonprofit organization committed to driving quality, safety, and transparency in the U.S. health system.

The Maine Health Management Coalition: A charitable organization whose mission is to bring the people who get care, pay for care and provide care together in order to measure and improve the quality of health care services in Maine. By publicly reporting quality information on Maine doctors and hospitals, the MHMC hopes to empower the public to make informed decisions about the care they receive.

Maine Hospital Association: The Maine Hospital Association represents 36 community-governed hospitals in Maine. Formed in 1937, the Augusta-based non-profit Association is the primary advocate for hospitals in the Maine State Legislature, the U.S. Congress and state and federal regulatory agencies. It also provides educational services and serves as a clearinghouse for comprehensive information for its hospital members, lawmakers and the public. MHA is a leader in developing health care policy and works to stimulate public debate on important health care issues that affect all of Maine's citizens.

WhyNotTheBest.org: WhyNotTheBest.org was created by The Commonwealth Fund, and in January 2015, was transferred to IPRO, a national organization providing a full spectrum of healthcare assessment and improvement services. It is a free resource for health care professionals interested in tracking performance on various measures of health care quality. It enables organizations to compare their performance against that of peer organizations, against a range of benchmarks, and over time. Case studies and improvement tools spotlight successful improvement strategies of the nation’s top performers. A regional map shows performance at the county, HRR, state, and national levels.

Maine Quality Forum: In 2003, the Maine Quality Forum was created as an independent division of Dirigo Health, to continue Maine's leadership in assuring high quality healthcare for its citizens. The Maine Quality Forum's mission is to advocate for high quality healthcare and help each Maine citizen make informed healthcare choices.

Maine Health Data Organization: A State agency that collects health care data and makes those data available to researchers, policy makers, and the public while protecting individual privacy. The purpose of the organization is to create and maintain a useful, objective, reliable and comprehensive health information database that is used to improve the health of Maine citizens.

The Agency for Healthcare Research and Quality: AHRQ’s mission is to produce evidence to make

health care safer, higher quality, more accessible, equitable, and affordable, and to work within the U.S. Department of Health and Human Services and with other partners to make sure that the evidence is understood and used.

The National Academy for State Health Policy: A non-profit that helps "states achieve excellence in health policy and practice" by working with each other. The organization is based in Portland, ME and Washington, DC, and they provide a "forum for constructive work across branches and agencies of state government on critical health issues."

The National Patient Safety Foundation-Institute of Healthcare Improvement: NPSF-IHI's vision is to create a world where patients and those who care for them are free from harm. A central voice for patient safety since 1997, NPSF partners with patients and families, the health care community, and key stakeholders to advance patient safety and health care workforce safety and disseminate strategies to prevent harm. NPSF merged with the Institute for Healthcare Improvement in May 2017.

The VA National Center for Patient Safety: Established in 1999 to develop and nurture a culture of safety throughout the Veterans Health Administration. We are part of the VA Office of Quality, Safety and Value. Our goal is the nationwide reduction and prevention of inadvertent harm to patients as a result of their care.

The Pennsylvania Patient Safety Authority: An independent state agency charged with taking steps to reduce and eliminate medical errors by identifying problems and recommending solutions that promote patient safety.

Maine DHHS Online Sentinel Event Resources

- Sentinel Event Annual Report
- Maine Sentinel Event Reporting Statute
- Rules Governing the Reporting of Sentinel Events

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