# Sentinel Events

## CY2021

*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 2021, 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 to 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.

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.

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 from 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.

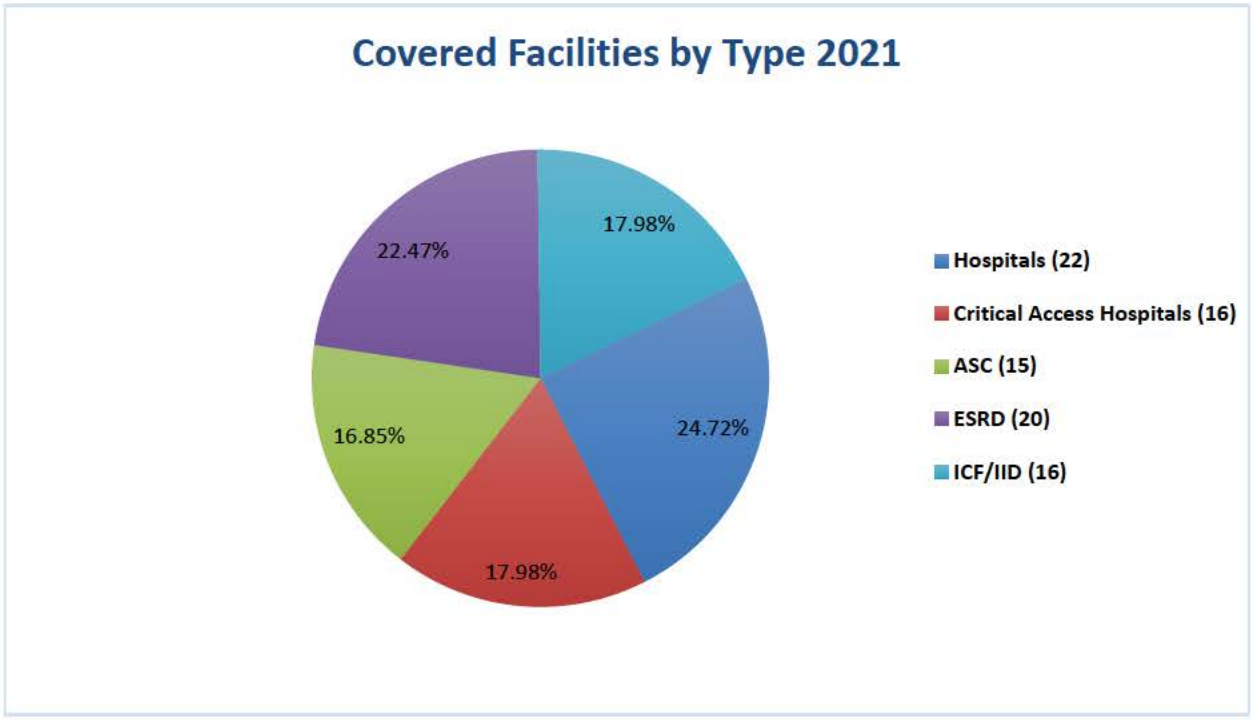
## Confidentiality Provisions

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 2021, 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 2021**

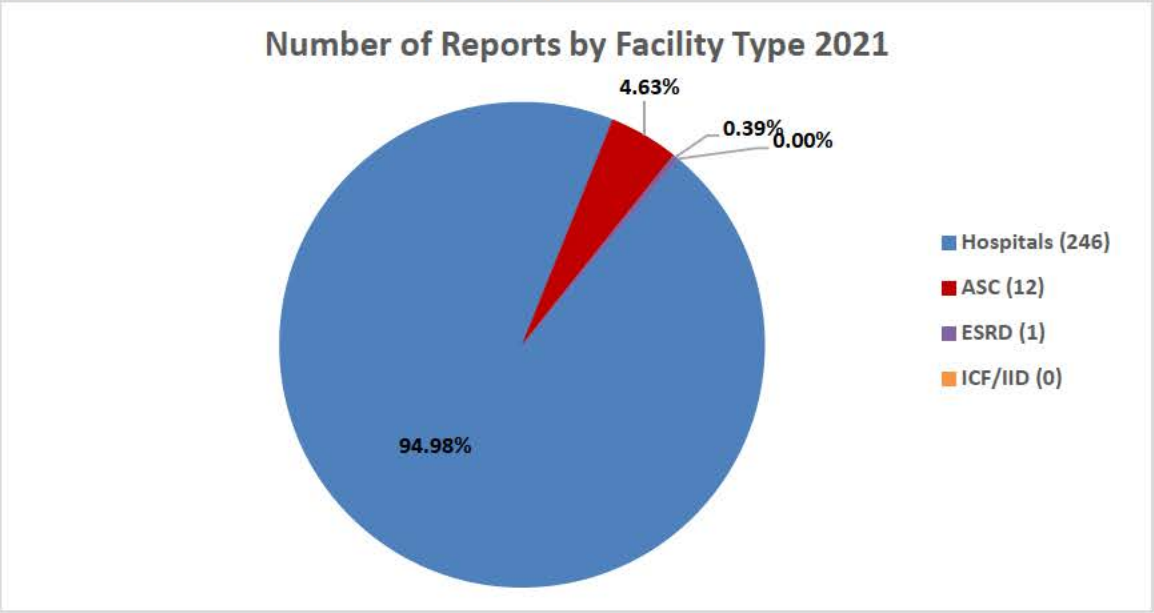



## Reports by Facility Type

Of the 89 facilities covered by the law, 44 (49%) reported sentinel events during 2021. Event reports were received from 37 (97%) Maine hospitals. An additional seven facilities did report near miss and/or non-reportable cases. Including these reports, 57% of all covered facilities reported activity to the SET in 2021.

There were 259 sentinel events reported in 2021. 246 were reported by hospitals, 12 were reported by ASCs, 1 was reported by an ESRD and 0 reported by ICF/IID facilities.

**Table 2. Sentinel Events Reported by Facility Type 2021**




## Sentinel Events

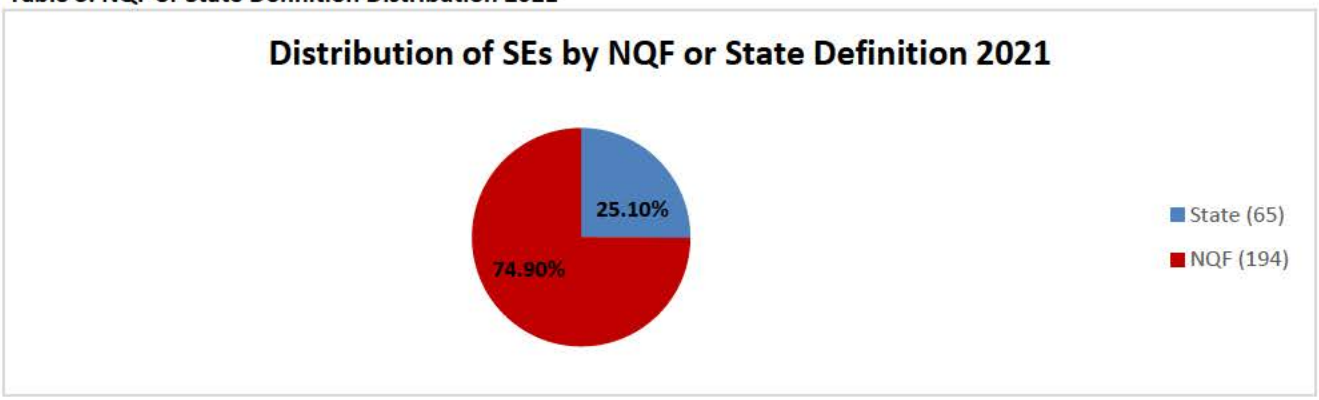
A total of 2,924 sentinel events have been reported to the SET since 2004, when covered facilities began reporting. As illustrated in Table 4, few facilities reported sentinel events between 2004 and 2008. The SET engaged in outreach efforts to ensure that all facilities had a heightened awareness of 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 2021, 74.90% of the sentinel events reported conformed with the NQF definitions and 25.09% were based on State definitions.

**Table 3. NQF or State Definition Distribution 2021**

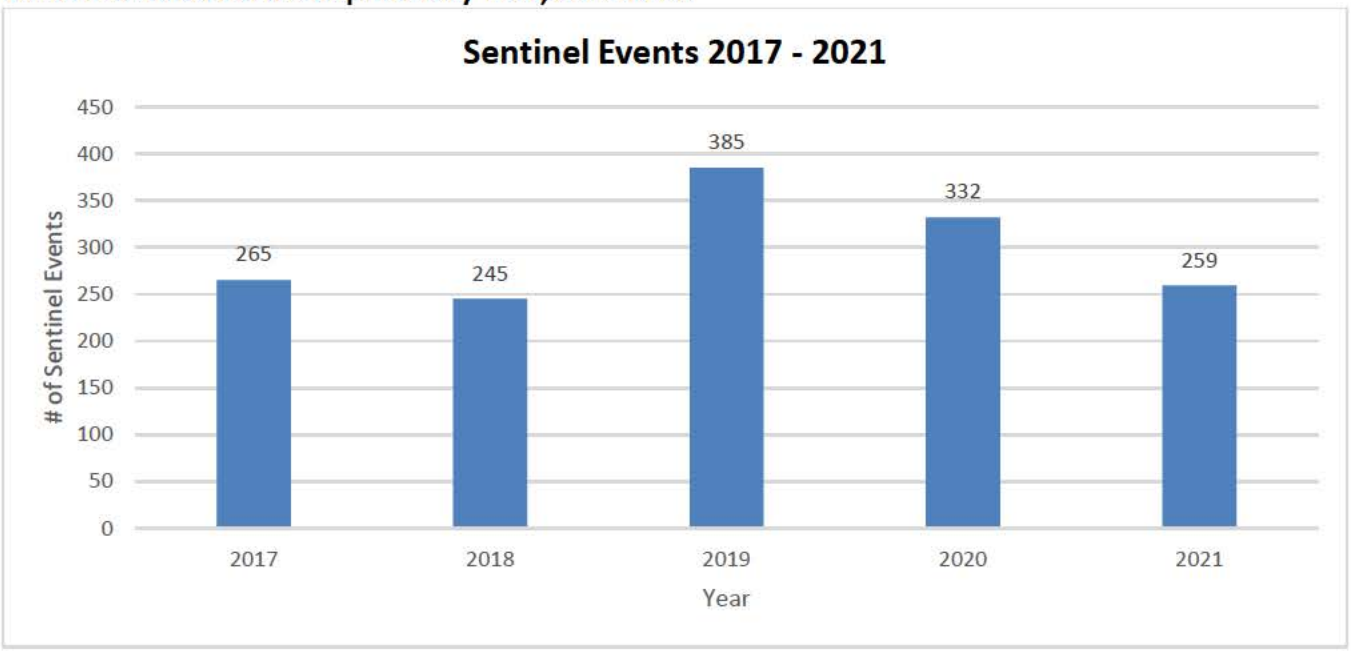



## 2021 Reported Events

There were 329 event notifications in 2021. Of those, 59 events did not meet the criteria of a sentinel event, and an additional 11 events were determined to be "near misses," bringing the total number of actual sentinel events to 259.

13.51% of sentinel events occurred either on a holiday (1) or a weekend (34). 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, 2017-2021**

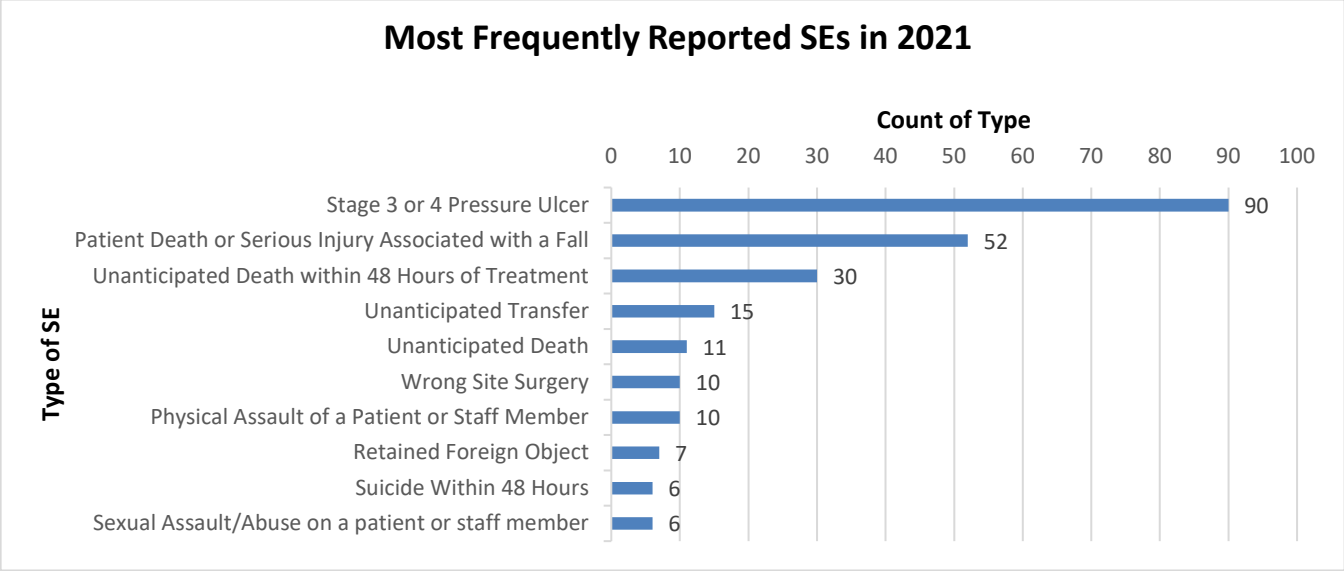


## Types of Sentinel Events Reported

A listing of all sentinel events can be found in Appendix C. Of the 23 different categories of sentinel events in 2021, 10 categories made up 91% of the total sentinel events reported, as listed below:

- Stage 3 or 4 pressure ulcer: 90 (34.74%)
- Patient death or serious injury associated with a fall: 52 (20.07%)
- Unanticipated death within 48 hours of treatment: 30 (11.58%)
- Unanticipated transfer: 15 (5.79%)
- Unanticipated death: 11 (4.24%)
- Wrong site surgery: 10 (3.86%)
- Physical assault of a patient or staff member: 10 (3.86%)
- Retained foreign object: 7 (2.70%)
- Suicide within 48 hours: 6 (2.31%)
- Sexual assault/abuse on a patient or staff member: 6 (2.31%)

**Table 5 Most Frequently Reported Sentinel Events in 2021**



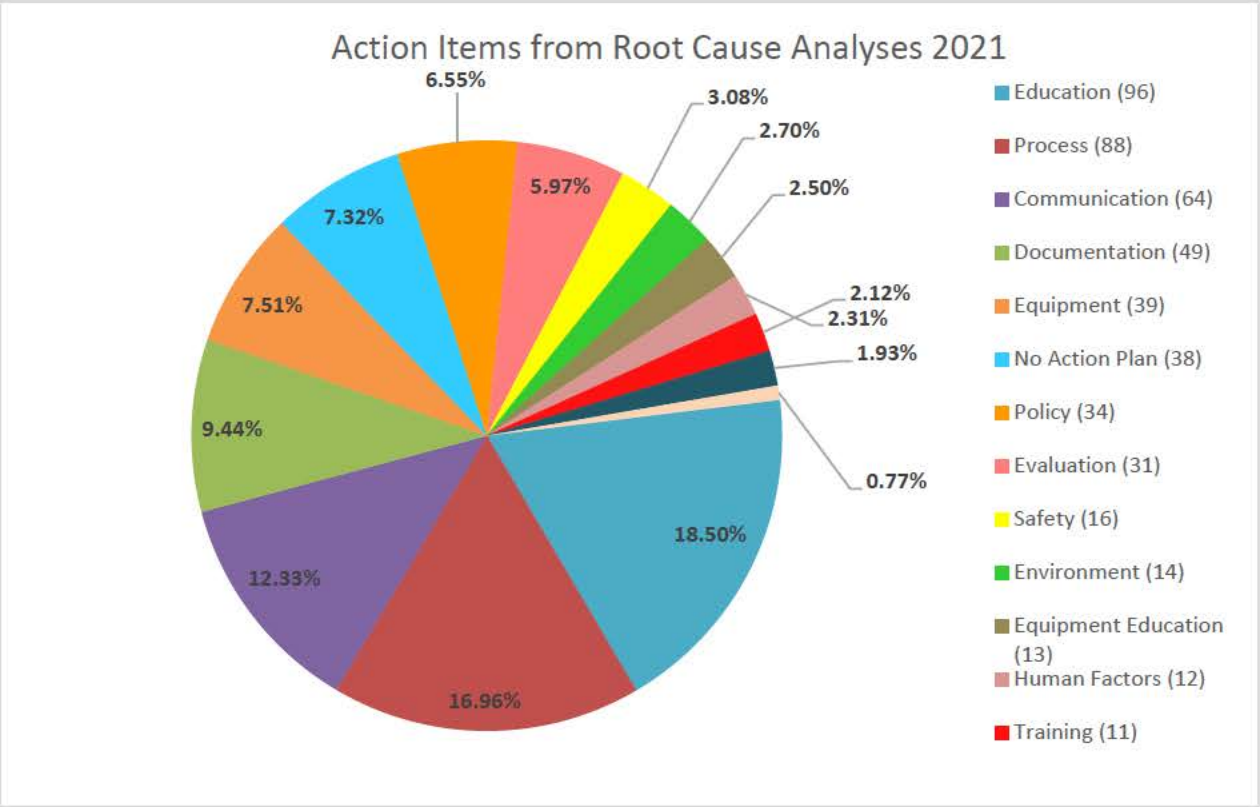

## Key Findings

- 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.
- Unanticipated deaths, including those that occur within 48 hours of treatment, also remain elevated. This category can be challenging for facilities as sometimes the cause of death is not known.
- Wrong site surgeries and retained foreign objects are two surgical categories that remain in the top ten events.
- Suicides, sexual and physical assaults along with unanticipated transfers comprise the rest of the top ten events in 2021 and will be monitored.

## 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 2021**




## 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. 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

With the limitations of COVID 19, the SET did not conduct any on-site reviews in 2021. The SET is evaluating the best process to complete audits of facilities to see if they are meeting regulatory requirements.

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.

In reviewing RCAs during the pandemic, some correlations can be made as to COVID's impact on sentinel events. This was evident by the causal factors identified by facilities. Examples included: staffing, equipment, bed availability/overcrowding, standard operating procedures and donning PPE before entering isolation rooms in urgent times.

## Progress on Goals

During calendar year 2021, 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 2021:

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 2021 due to COVID 19. We are working on a hybrid process for future reviews.

3) *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 via email in March, June, September, and December and are available on the DHHS website.
    - Recent Topics included:
        - The Joint Commission Post Suicide Themes
        - CDC Conversation Starter for Dialysis Patients
        - Safe Ambulatory Care
        - By the Numbers: Sentinel Events associated with Medication errors
        - Top Ten Patient Safety Issues for 2021

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

    - *Actions*: The SET continues to revise 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 2022

In 2022, 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) Propose a schedule and format to assess facilities' compliance with MRSA Title 22, Chapter 1684, §8754, *Division Duties. A tentative schedule will be ready to launch when the pandemic related restrictions are lifted. D*evelop a hybrid process to perform reviews for covered facilities, which will consist of remote assessments 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 better align definitions with other related safety entities.

## 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. 2021 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: _____**

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

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**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

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**or Confidential Fax (207) 287-3251**

**Sentinel Event Hotline (207)287-5813**

*This information is protected from public disclosure*



Revised July 30 2021

## NATIONAL CONSENSUS EVENTS
## NATIONAL QUALITY FORUM SERIOUS REPORTABLE EVENTS

**Surgical or Invasive Events**

- ☐ Surgery or other invasive procedure performed on the wrong site
- ☐ 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 with the use of contaminated drugs, devices, or biologics provided by the healthcare setting
- ☐ Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended
- ☐ Patient death or serious injury associated with 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 with patient elopement (disappearance)
- ☐ Patient suicide, attempted suicide or self-harm resulting in serious injury, while being cared for in a healthcare setting

**Care management events**

- ☐ Patient death or serious injury associated with a medication error (eg, errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)
- ☐ Patient death or serious injury associated with 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 with labor or delivery in a low-risk pregnancy
- ☐ Patient death or serious injury associated with a fall while being cared for in a healthcare setting
- ☐ Stage 3 or 4 pressure and unstageable pressure ulcers acquired after admission/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 biological specimen
- ☐ Patient death or serious injury resulting from failure to follow up on or communicate laboratory, pathology or radiology test results

**Environmental Events**

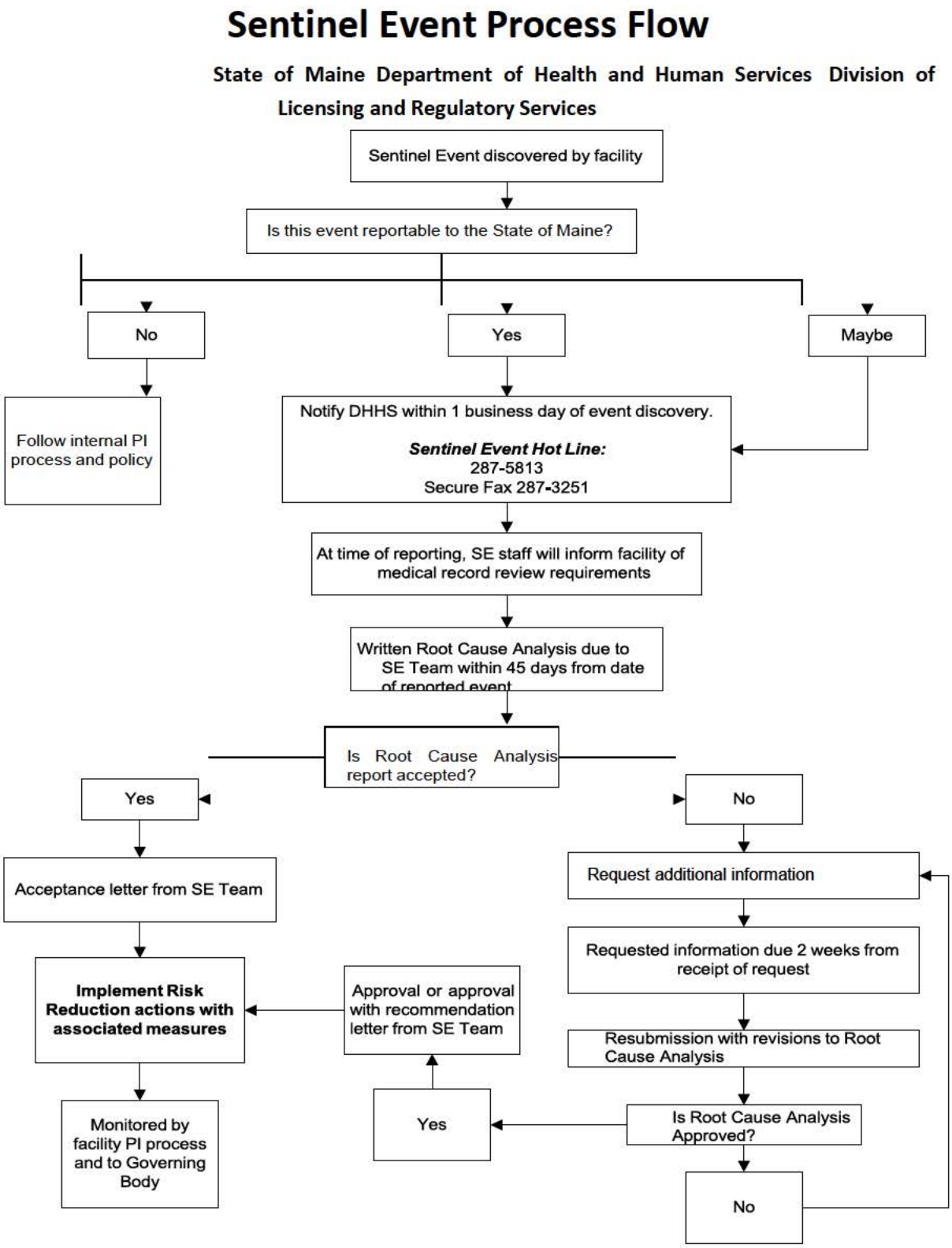
- ☐ Patient or staff death or serious injury with an electric shock in the course of a patient care process in a healthcare setting
- ☐ Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas or is contaminated by toxic substances
- ☐ 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 with 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 introduction 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, 2021

| | | | 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 | 90 | 58 | 32 | 0 | 2 | 37 | 51 |
| NQF | Patient death or serious disability associated with a fall while being cared for in a health care setting | 52 | 21 | 31 | 0 | 0 | 12 | 40 |
| State | Unanticipated patient transfer to another facility | 15 | 5 | 10 | 0 | 0 | 11 | 4 |
| State | Unanticipated death within 48 hours of treatment | 30 | 21 | 9 | 0 | 0 | 14 | 16 |
| 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) | 3 | 2 | 1 | 0 | 0 | 1 | 2 |
| State | Unanticipated death | 11 | 7 | 4 | 0 | 0 | 4 | 7 |
| NQF | Surgery or other invasive procedure performed on the wrong site | 10 | 7 | 3 | 0 | 0 | 4 | 6 |
| NQF | Unintended retention of a foreign object in a patient after surgery or other invasive procedure | 7 | 2 | 5 | 0 | 1 | 4 | 2 |
| 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 | 10 | 7 | 3 | 0 | 0 | 10 | 0 |
| State | Permanent loss of function within 48 hours of treatment | 1 | 0 | 1 | 0 | 0 | 1 | 0 |
| State | Major permanent loss of function present at discharge | 1 | 1 | 0 | 0 | 0 | 1 | 0 |
| NQF | Sexual assault on a patient within or on the grounds of the health care setting | 6 | 4 | 2 | 0 | 1 | 5 | 0 |
| NQF | Patient suicide or attempted suicide resulting in serious disability while being cared for in a health care setting | 2 | 1 | 1 | 0 | 2 | 0 | 0 |
| NQF | Patient death or serious injury resulting from failure to follow up on or communicate laboratory, pathology, or radiology test results | 3 | 2 | 1 | 0 | 0 | 3 | 0 |
| NQF | Discharge or release of a patient of any age, who is unable to make decisions, to other than an authorized person | 1 | 1 | 0 | 0 | 1 | 0 | 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 | 2 | 1 | 1 | 1 | 0 | 0 | 1 |
| NQF | Patient death or serious disability associated with patient elopement (disappearance) | 2 | 2 | 0 | 0 | 0 | 2 | 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 | 1 | 1 | 0 | 1 | 0 | 0 | 0 |
| State | Unanticipated perinatal death | 1 | 0 | 1 | 1 | 0 | 0 | 0 |
| NQF | Surgery or other invasive procedure performed on the wrong patient | 1 | 0 | 1 | 0 | 0 | 0 | 1 |
| | Wrong surgical or other invasive procedure performed on a patient | 3 | 1 | 2 | 0 | 1 | 2 | 0 |
| State | Suicide within 48 hours | 6 | 4 | 2 | 0 | 0 | 5 | 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 |
| | Totals | 259 | 148 | 111 | 3 | 8 | 117 | 131 |

## 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.

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.

Centers for Medicare & Medicaid Services | CMS: A consumer-oriented website that helps individuals learn about hospital quality and safety measures.

**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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