

DEPARTMENT OF THE ARMY
U.S. ARMY MEDICAL DEPARTMENT ACTIVITY
FORT HUACHUCA, ARIZONA 85613-7079

MEDDAC PAMPHLET
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Medical Services
SENTINEL EVENT (SE) POLICY

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1. HISTORY. This issue publishes a revision of this publication.

2. PURPOSE. To define and delineate responsibilities regarding SEs.

3. REFERENCES.

3.1 Memorandum, Assistant Secretary of Defense (Health Affairs), subject: Reporting Sentinel Events to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

3.2 Joint Commission on Accreditation of Healthcare Organizations (JCAHO), current edition.

3.3 AR 40-68, Quality Assurance Administration with Interim Change IO3.

4. SCOPE. This policy applies to all assigned staff, including contractors and all others involved in patient care at Raymond W. Bliss Army Health Center (RWBAHC).

5. RESPONSIBILITIES.

5.1 Staff Members.

5.1.1 Report to their immediate supervisor that a significant adverse event in which he/she has first-hand knowledge has occurred. The DCCS and Risk Management Coordinator (RMC) will be immediately notified.

*This PAM supersedes MEDDAC memo 40-159, 18 January 2001

5.1.2 Upon supervisor review, hand-carry DA Form 4106, Incident Report to the RMC, Quality Management Division, within 24 hours (or next duty day).

5.1.3 Be alert to preventing accidents; perform duties as safely as possible.

5.1.4 Report potential safety hazards or procedure problems to supervisor and Safety NCO.

5.1.5 Participate in any team performing a root cause analysis (RCA) to which they have been appointed.

5.2 Officer-In-Charge/Supervisor:

5.2.1 Review significant adverse events then evaluate and make recommendations for any corrective action that may be required.

5.2.2 Ensure the event is recorded on the Commander's Report.

5.2.3 Be alert to potential safety hazards and procedural problems.

5.2.4 Ensure that subordinates perform tasks safely using proper procedures and safe equipment and remain fully trained in their duties and recognition of sentinel events.

5.2.5 Secure all equipment and records involved to ensure all data is available for analysis.

5.2.6 Participate in teams performing an RCA to which they have been appointed.

5.3 Risk Manager (Deputy Commander for Clinical Services (DCCS):

5.3.1 Screen all significant adverse events to determine whether or not they require physician intervention, ensure that an RCA is being done, and reported to Great Plains Regional Medical Command (GPRMC) and U.S. Army Medical Command (MEDCOM).

5.3.2 Identify participants of RCA teams. Core members are personnel with training or expertise in the area the SE occurred, i.e., in the OR the team should consist of a surgeon, OR Nurse or Nurse Anesthetist, and an OR tech. Other individuals may be asked to participate, depending on the nature of the incident.

5.3.3 If warranted, convene a meeting of the Risk Management Committee, as soon as possible after the event, ensuring that all personnel having knowledge of the event are present.

5.4 Risk Management Coordinator:

5.4.1 Promptly investigate all significant adverse events and ensure that investigation is completed.

5.4.2 Obtain written statements from all individuals having knowledge of the event, when appropriate.

5.4.3 Identify any actions needed to preclude recurrence of the incident.

5.4.4 Notify the Claims Judge Advocate within 24 hours of identifying a potentially compensable event and coordinate further review.

5.4.5 Coordinate with the Chief, Logistics Division for quality control procedures for medical material. For incidents involving medical equipment or material, every effort will be made to secure actual materiel (i.e., needles, drugs, packages, along with manufacturer's literature).

5.4.6 Maintain data on adverse events and claims to include clean copies of all medical records, and quality improvement investigative reports and peer review data. Data files will be maintained IAW MEDCOM guidance for risk management files.

5.4.7 Ensure medical records involved in litigation or those where potential litigation has been identified are placed in special handling and released only at the direction of the RMC.

5.4.8 Compile data to identify trends and report to the Executive Committee. Recommend action to correct undesirable trends.

5.5 Chief, Patient Administration Division:

5.5.1 Determine the completeness of medical records involved in the incident prior to any actions. Each record will be assembled in the proper order and each page numbered in ink.

5.5.2 Provide official photocopies of records to the RMC, upon request.

5.5.3 Secure original copies of all medical records identified by the RMC in a locked filing cabinet and release such records only under direction of the RMC.

5.6 Commander: In serious incidents of death or serious bodily injury resulting from potentially substandard care, the commander will:

5.6.1 Determine if the health care provider (HCP) involved needs to be detailed to administrative duties. The HCP's privileges will be placed in abeyance until the incident has been reviewed.

5.6.2 Final authority for JCAHO notification. All SEs must be reported through channels (GPRMC, MEDCOM, and JCAHO).

6. DEFINITIONS.

6.1 Adverse Events. Untoward incidents, therapeutic misadventures, iatrogenic injuries or other occurrences or conditions in the provision of care or services, causing, or threatening to cause, unexpected harm to a patient. Adverse events include 'near misses' that do not cause harm because of chance or fortuitous intervention. Adverse events do not include mortality and morbidity resulting from the natural course of the patient's illness or underlying condition that was not expected to be ameliorated by diagnosis and appropriate treatment consistent with the applicable standard of care.

6.2 Sentinel Events (SE): As defined by JCAHO, an SE is 'an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof.' Serious injury specifically includes loss of limb or function. The phrase, 'or the risk thereof' includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called 'sentinel' because they signal the need for immediate investigation and response.

6.3 Root Cause Analysis. An RCA is the process for identifying the basic or causal factor(s) that underlies variation in performance, including the occurrence or possible occurrence of an SE. An RCA focuses primarily on systems or processes, not individual performance. It progresses from special causes in clinical processes to common causes in processes or systems that would tend to decrease the likelihood of such events in the future, or determines, after analysis, that no such improvement opportunities exist.

6.4 Action Plan. The end product of an RCA, which identifies the risk reduction strategies the MTF, intends to implement to prevent recurrence of similar events in the future. The Action Plan should address responsibility for implementation, oversight, pilot testing if appropriate, timelines and strategies for measuring the effectiveness of the actions.

6.5 Sentinel Event Response Team (SERT). The group identified by the MTF commander to develop the RCA and Action Plan. The SERT may include leaders of performance improvement/quality management, risk management, nursing and patient care services, the medical staff, the department head or supervisor of the area in which the event occurred, administrative staff (Deputy Commander for Administration, Risk Manager, Safety, etc), a Staff Judge Advocate representative, and others as necessary depending on the event. The SERT members will be trained and knowledgeable in the SE process.

7. GOALS.

7.1 Have a positive impact on improving patient care.

7.2 Focus the attention of RWBAHC in the event an SE occurs, the understanding of the causes that underlie that event, and on making changes in the organization's systems and processes to reduce the probability of such an event in the future.

7.3 To increase the general knowledge about SE's, their causes and strategies for prevention.

7.4 To maintain the confidence of the public in the accreditation process.

7.5 To bring to the forefront those unexpected events in the RWBAHC that result in the loss of life or serious physical or psychological injury (such as the loss of limb or function), or the risk thereof. The phrase, "or risk thereof" is commonly called the "near miss" provision and includes "any process variation for which a recurrence would carry a significant chance of a serious adverse outcomes."

7.6 Reportable incidences include:

7.6.1 An unexpected occurrence resulting in an unanticipated death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition or the event is one of the following, even if the outcome was not death or major permanent loss of function unrelated to the natural course of the patient's illness or underlying condition.

7.6.2 Abduction of any individual receiving care, treatment or services.

7.6.3 Rape by another patient, staff member or unknown perpetrator while being treated or on the premises of the health care organization.

7.6.4 Assault, homicide or other crime resulting in patient death or major permanent loss of function.

7.6.5 A patient fall that results in death or major permanent loss of function as a direct result of the injuries sustained in the fall.

7.6.6 Surgery on the wrong patient or wrong body part.

7.6.7 Unintended retention of a foreign object in an individual after surgery or other procedure.

8. PROCEDURES.

8.1 Notification to GPRMC and MEDCOM by the commander. All SEs must be reported to GPRMC and MEDCOM QMD within 72 hours of their identification. This reporting requirement can be accomplished through the use of a MEDCOM SE Worksheet (in Risk Management Coordinator's office), which will be completed and sent, by facsimile, Outlook electronic mail, or other electronic means of communication to the GPRMC.

8.2 Upon determination that an SE has occurred, the commander is contacted by MEDCOM to initiate an RCA. MEDCOM will notify JCAHO that an SE has occurred.

8.3 The organization will prepare/submit to JCAHO a thorough and credible RCA and action plan within 45 days of the event or of becoming aware of the event.

8.4 The JCAHO will determine whether the root cause analysis and action plan are acceptable.

8.5 If the RCA is unacceptable, an additional 15 days will be allowed for revision before bringing a recommendation for Accreditation Watch to the Accreditation Committee.

8.6 Loss of accreditation may result if the health care organization does not provide an RCA after 15-day time period permitted after assignment of Accreditation Watch.

The proponent of this publication is the Chief, Quality Management Division. Users are invited to send their comments and suggestions on DA 2028, to MCXJ-QM, Ft Huachuca, AZ 85613-7079.

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