XYZ HHA
Sentinel Event Model Policy

1. Definition
A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof, to patients and/or employees. Serious injury specifically includes loss of limb or function. The phrase, "or risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.

The event of one of the following (even if the outcome was not death or major permanent loss of function) also constitutes a sentinel event:

A. Suicide attempt of a patient in a setting where the patient is receiving around-the-clock services;
B. Rape;
C. Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incapabilities.

A distinction is made between an adverse outcome that is related to the natural course of the patient's illness or underlying condition (not reportable) and a death or major permanent loss of function that is associated with the treatment, or lack of treatment, of that condition (voluntarily reportable).

A major permanent loss of function means sensory, motor, physiological, or intellectual impairment, not present at admission, requiring continued treatment or life-style change. When a major permanent loss of function cannot be immediately determined, reporting is not expected until either the patient is discharged with continued major loss of function, or two weeks have elapsed with persistent major loss of function, whichever occurs first.

The determination of a rape is to be consistent with applicable law and regulation. Reporting of a mere allegation of rape, without more, is not expected. The five-day time frame for voluntarily reporting begins when a determination is made that a rape has occurred. Reporting of a rape is not expected where law prohibits such reporting.

2. Process
When a sentinel event is identified, either by family or staff, the following process will be followed:

A. The individual most directly involved in finding an incident will be responsible for reporting the event to the Administrator and will complete an incident report.
B. The Administrator shall screen the event against the sentinel event criteria. If the event meets the criteria above, or is in question as to sentinel event status, the Administrator will notify the Executive Management Team, the Board of Directors and, on a need-to-know-basis, Agency staff.
C. Staff will implement an investigation within 24 hours of notification of the sentinel event.
D. Staff members are expected to do all within reason to provide follow-up care/services to ensure the best possible outcomes for involved parties.
E. Regulatory reporting requirements are performed, in a timely fashion, in the event of patient, or employee, death.
F. Staff shall obtain, sequester, or preserve appropriate evidence (for example, photographs of the location of the injury or equipment that malfunctioned).
G. If a root-cause analysis needs further discipline representatives, they will be added. Agency staff will determine the root cause of the event, including analysis of all processes and systems related to its occurrence.
H. Risk reduction strategies will be formed within a week of the analysis. Potential improvements in processes or systems that would tend to decrease the likelihood of such events occurring in the future will be determined. Examples may include a change in communication, forms, training, equipment, policies and procedures. If no potential improvements exist, the analysis will indicate that no such opportunities exist. Agency will track implementation of the risk reduction strategies for the Agency.
I. Results of the above will be reported to the Board of Directors and Executive Management Team as needed.

Written by:
Approved by:
Effective Date: