Patient Safety/Risk Management Information Physicians Need to Know:

Sentinel Events:

The Joint Commission requires hospitals to conduct a through investigation and analysis when unexpected occurrences involve serious injury, death of a patient, or the risk thereof. These unexpected serious outcomes are called Reviewable Sentinel Events. You should notify the Risk Manager if your patient is involved in a Sentinel Event. Examples of Sentinel Events include but are not limited to the following:

1. An unanticipated death or major permanent loss of function not related to the natural course of the patient's illness or underlying condition.
2. Any patient death, paralysis, coma, or other major permanent loss of function associated with a medication error.
3. Abduction of any patient receiving care, treatment, and services.
4. Infant discharge to the wrong family.
5. Rape is defined as unconsented sexual contact involving a patient and another patient, staff member, or other perpetrator while being treated on the premises of the health care organization, including oral, vaginal or anal penetration or fondling of the patient's sex organ(s) by another individual's hand, sex organ or object. One or more of the following must be present to determine reviewability:
   - Any staff witnessed sexual contact as described above;
   - Sufficient clinical evidence obtained by the hospital to support allegations of unconsented sexual contact; and
   - Admission by the perpetrator that sexual contact, as described above, occurred on the premises.
6. Unanticipated death of a full-term infant.
7. Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities.
8. Surgery or invasive procedure performed on the wrong patient, wrong side of the body, or wrong part.
9. Suicide of a patient receiving care, treatment and services in a staffed around the clock care setting or suicide of a patient within 72 hours of discharge.
10. Any elopement, that is, unauthorized departure, of a patient from an around the clock setting resulting in a temporally related death (suicide, accidental death, or homicide) or major permanent loss of function.
11. Any intrapartum (related to the birth process) maternal death.
12. Any perinatal death, unrelated to a congenital condition, in an infant having a birth weight greater than 2500 grams.
13. Any assault, homicide, or other crime resulting in patient death or major permanent loss of function.

14. A patient fall that results in death or major permanent loss of function as a direct result of the injuries sustained in the fall.
15. Death of a patient as a result of the patient being restrained.
16. Death or major permanent loss of function associated with a health care-acquired infection.
17. Unintended retention of a foreign object in a patient after surgery or other procedure.
18. Severe neonatal hyperbilirubinemia (bilirubin more than 30 milligrams/deciliter).
19. Prolonged fluoroscopy with cumulative dose more than 1500 rads to a single field, or any delivery of radiotherapy to the wrong body region or more than 25% above the planned radiotherapy dose.

Please inform the hospital Risk Manager regarding any of these events.

Unplanned Occurrence Reporting System:

Mercy Medical Center staff use a computerized system called PEERS (Potential Error/Event Reporting System) to report unplanned incidents involving patients, visitors and physicians.

Serious Reportable Events or Never Events:

Similar to Reviewable Sentinel Events, Mercy Medical Center has a process for reviewing these events by conducting a root cause analysis of the event to assist with identifying patient care improvement opportunities. Below is a listing of events that may be considered a Serious Reportable Event and should be reported to the hospital Risk Manager.

Surgical Events

1. Surgery on wrong body part
2. Surgery on wrong patient
3. Wrong surgery on a patient
4. Unintended retention of a foreign object left in patient after surgery or other procedure
5. Intra-operative or immediately post-operative death in an ASA Class 1 patient

Product or Device Events

6. Patient death or serious disability associated with use of contaminated drugs, devices, or biologics provided by the healthcare facility
7. Patient death or serious disability associated with use or function of a device other than as intended
8. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility

Patient Protection Events

9. Infant discharged to wrong person
10. Patient death or serious disability due to patient elopement (disappearance)
11. Patient suicide or attempted suicide resulting in serious disability while being cared for in a healthcare facility

Care Management Events

12. Patient death or serious disability associated with medication error (errors involving wrong drug, wrong dose, wrong patient, wrong time, wrong preparation, or wrong route of administration)

13. Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA-incompatible blood or blood products
14. Maternal death or serious disability associated with labor or delivery in a low risk pregnancy while being cared for in a healthcare facility
15. Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being treated in a healthcare facility
16. Patient death or serious disability (kernicterus) associated with failure to identify and treat hyperbilirubinemia in neonates
17. Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility
18. Patient death or serious disability due to spinal manipulative therapy

Environmental Events

20. Patient death or serious disability associated with electric shock while being cared for in a healthcare facility
21. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances
22. Patient death or serious disability associated with a burn incurred from any source while being cared for in a healthcare facility
23. Patient death or serious disability associated with a fall while being cared for in a healthcare facility

24. Death/disability associated with use of restraints or bedrails while being cared for in a healthcare facility

Criminal Events

25. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist or other licensed healthcare provider
26. Abduction of a patient of any age
27. Sexual assault of a patient within or on facility grounds
28. Death or significant injury of a patient or staff member resulting from physical assault within or on facility grounds

Other

29. Any unanticipated death or serious disability or near miss/event that would likely cause death or serious disability.

Disclosing Adverse Outcomes to Patients/Families:

Mercy has a policy and procedure in place to guide physicians and staff in collaborating in disclosing adverse events or unanticipated outcomes.

Please see the attached decision tree for a summary of considerations and steps.