

El Paso - Ambulatory Clinic Policy and Procedure

Title: MANAGEMENT OF A SENTINEL EVENT (PATIENT SAFETY EVENT)	Policy Number: EP 8.2
Regulation Joint Commission Reference:	Effective Date: 1/2015

Policy Statement:

It is the policy of the Texas Tech University Health Sciences Center El Paso (TTUHSC El Paso) to identify and manage patient safety events, such as sentinel events in order to measure, assess, and improve the organization's performance.

Scope and Distribution:

This policy applies and will be distributed to all TTUHSC El Paso ambulatory clinics.

Procedure:

1. Sentinel Event: A "Sentinel Event" is a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in any of the following: death, permanent harm, severe temporary harm.
2. Events To Be Reported: Reports should be submitted whenever TTUHSC El Paso staff receives or otherwise becomes aware of information, from any source, that reasonably suggests that a Sentinel Event has occurred at a TTUHSC El Paso facility. The following is a non-inclusive list of events, identified by the Joint Commission for Sentinel Events in the Ambulatory Clinic setting that should be reported.
 - a. The event has resulted 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
 - b. 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):
 - i. Surgical and nonsurgical invasive procedures on the wrong patient, wrong site, or wrong procedure.
 - ii. Unintended retention of a foreign object in a patient after surgery or other procedure
 - iii. Prolonged fluoroscopy with cumulative dose >1,500 rads to a single field or any delivery of radiotherapy to the wrong body region or >25% above the planned radiotherapy doses.
 - iv. Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities (ABO, Rh, other blood groups)
 - v. Abduction of any patient receiving care, treatment, or services.
 - vi. Fire, flame, or unanticipated smoke, or unanticipated smoke, heat, or flashes occurring during an episode of patient care.
3. Reporting Procedure:
 - a. Any TTUHSC El Paso staff who witnesses, discovers or otherwise becomes aware of information that reasonably suggests that a Sentinel Event has occurred is responsible for immediately reporting the incident to his/her Supervisor, Department Head or directly to the

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Director of Quality Improvement or Risk Manager.

4. Root Cause Analysis: A root cause analysis and action plan will be performed within 45 business days to identify basic or causal factors (see 8.2.A, Sentinel Event Root Cause Analysis and Action Plan). The root cause analysis team should be comprised of the Quality Improvement Director, Risk Manager, and clinical leadership as appropriate.
 - a. If a Sentinel Event occurs at a teaching hospital or other facility, and is determined to be directly related to a TTUHSC El Paso Provider, the event will be reviewed as outlined in paragraph 3 above.
 - b. An action plan will be developed as warranted. Improvement actions will be monitored for effectiveness by the Quality Improvement Director, and may include the Root Cause Analysis Team. As “Sentinel Event Alerts” become available from the Joint Commission, they will be reviewed in the Clinic Operations Committee and forwarded to the appropriate clinical staff. Clinicians will be requested to implement the Joint Commission recommendations when applicable.

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Signatory approval on file by: Michael J. Romano, M.D. Associate Dean of Clinical Affairs Clinic Operations Committee, Chair Texas Tech University Health Sciences Center El Paso	