

[Facility Logo]	[Facility Name] Patient Safety Policy	No. CQ-2.010
	Title: SENTINEL EVENT RESPONSE AND REPORTING POLICY	Page: 1 of 8
		Origination Date: 10-01-96
		Previous Policy Dated: 07-22-05 8-15-02; 8-28-00
		Effective Date: 06-01-08
		Hospital Governing Board Approval Date:

I. SCOPE:

This policy applies to _____ (“Facility”), its employees, medical staff, contractors, patients and visitors regardless of service location or category of patient. This policy should not be used in isolation but as a supplement to the Facility’s overall Clinical Risk Management/Patient Safety Plan.

II. PURPOSE:

The purposes of this policy are to:

A. Seek to improve patient care by reviewing and responding to Sentinel Events as set forth by the Joint Commission (JC) Sentinel Event policy and procedures¹;

B. Support the improvement of patient safety and quality improvement initiatives by complying with the state-mandated reporting requirements identified in Attachment A, Composite of State Reporting Requirements (“Attachment A”);

C. Support patient safety improvement by reviewing any event which meets the description of any one of the National Quality Forum (NQF) Safe Practices²;

D. Comply with the requirements contained within the [Corporate Integrity Agreement](#) (CIA) September 27, 2006 between Tenet Healthcare Corporation and the Office of Inspector General (OIG) of the Department of Health and Human Services and the [Regulatory Compliance Policy COMP-RCC 4.21, Internal Reporting of Potential Compliance Issues](#) by internally reporting any potential Sentinel Event to the Hospital Compliance Officer and Corporate Risk Management.

E. Evaluate all JC-reviewable Sentinel Events with Corporate Quality Management and Corporate Regulatory Counsel to determine if a voluntary report should be made to JC; and

F. Assist in differentiating among the varying reporting requirements. Attachment A includes a reference tool listing the requirements for JC, NQF and state reporting requirements.

¹ The JC Sentinel Event Policies and Procedures are set forth in the Comprehensive Accreditation Manual for Hospitals, Sentinel Events Chapter.

² National Quality Forum Safe Practices are available through the NQF website <http://www.qualityforum.org/> and are summarized on Attachment A.

[Facility Logo]	[Facility Name] Patient Safety Policy	No.	CQ-2.010
	Title: SENTINEL EVENT RESPONSE AND REPORTING POLICY	Page:	2 of 8
		Origination Date:	10-01-96
		Previous Policy Dated:	07-22-05 8-15-02; 8-28-00
		Effective Date:	06-01-08
		Hospital Governing Board Approval Date:	

III. DEFINITIONS:

A. **Sentinel Event** – an unexpected event 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. Attachment A includes a list of JC-reviewable Sentinel Events.

B. **Reviewable Sentinel Events** – that subset of Sentinel Events that the JC, NQF or Department of Health Services (DHS)³ will review if it becomes aware of the Sentinel Event, either through the Facility’s voluntary self-report or otherwise. See Attachment A.

C. **Adverse Event** – an untoward incident, therapeutic misadventure, iatrogenic injury or other unexpected event with the potential for harm but which does not meet the definition of a Sentinel Event and is directly associated with the care or services provided within the Facility.

D. **Intense Assessment** – any form of review of an Adverse Event. It may but is not required to be on the JC framework. Intense assessments shall be conducted in accordance with state peer review, quality assurance, performance improvement or other state statute.

E. **Unanticipated Outcome** – an outcome that is not anticipated in the normal course of the patient’s care.

F. **Root Cause Analysis** – a process for identifying the base or contributing causal factors that underlie variations in performance associated with Adverse Events, Sentinel Events or near misses. (See [JC Framework for Root Cause Analysis](#)).

IV. POLICY

A. The Facility shall utilize an internal reporting system, specifically eSRM, to identify, address, document and report to the appropriate local administrators, Corporate Clinical Loss Prevention designee and Corporate Regulatory Counsel all potential Sentinel Events. In response to each Sentinel Event, the Facility shall:

³ state Department of Health or other state facility licensing body

[Facility Logo]	[Facility Name] Patient Safety Policy	No.	CQ-2.010
	Title: SENTINEL EVENT RESPONSE AND REPORTING POLICY	Page:	3 of 8
		Origination Date:	10-01-96
		Previous Policy Dated:	07-22-05 8-15-02; 8-28-00
		Effective Date:	06-01-08
		Hospital Governing Board Approval Date:	

1. conduct a timely, thorough and credible root cause analysis via Root Cause Meetings where attendees of multidisciplinary groups are both constant and variable based on the event. Participants shall include staff involved in the event when appropriate;

2. develop an action plan with measurable action items designed to implement improvements to reduce risk;

3. implement those improvements; and

4. monitor the effectiveness of those improvements.

B. Reporting of Sentinel Events to JC is voluntary, and the Facility shall only report Reviewable Sentinel Events to JC after consultation with Corporate Quality Management and Corporate Regulatory Counsel. The Facility may, but is not required to, conduct an intense assessment of any Adverse Event.

C. Tenet’s Chief Compliance Officer shall determine which Sentinel Events are required to be reported to the OIG pursuant to the CIA after consultation with the Hospital Compliance Officer, Regional Compliance Director, Corporate Quality Management and Corporate Regulatory Counsel.

V. PROCEDURE:

A. Facility Implementation

The Facility’s Risk Manager, Event Manager, or other appropriate person with responsibility for these functions (the “Risk Manager”) shall ensure that the following steps are followed to comply with this policy.

1. Complete an Occurrence Report

a. All Facility staff⁴ are required to report unanticipated outcomes pursuant to the Facility’s Patient Safety Event Reporting and Accountability Policy.

b. The Risk Manager or designee shall review all event reports each day to determine whether they meet the definition of a potential Sentinel Event.

⁴ “Facility staff” means the Facility’s employees, agency staff, contractors and volunteers.

[Facility Logo]	[Facility Name] Patient Safety Policy	No. CQ-2.010
	Title: SENTINEL EVENT RESPONSE AND REPORTING POLICY	Page: 4 of 8
		Origination Date: 10-01-96
		Previous Policy Dated: 07-22-05 8-15-02; 8-28-00
		Effective Date: 06-01-08
		Hospital Governing Board Approval Date:

c. The Risk Manager or designee shall identify all potential Sentinel Events in the occurrence reporting system by signaling the appropriate button which will notify Corporate Risk Management.

d. For all potential Sentinel Events and Adverse Events, the Risk Manager or designee shall ensure that the occurrence reporting system contains a description of the unexpected occurrence as well as the date of occurrence and medical record number(s).

2. Report to the Appropriate Person

a. The Risk Manager shall report all potential Sentinel Events to Facility Administration, Corporate Clinical Loss Prevention designee and the Hospital Compliance Officer. The report shall include the following information:

- (1) Patient name and date of occurrence;
- (2) Description of the occurrence;
- (3) Current status of the patient and discharge date;
- (4) If the patient expired, whether the death was related to the natural course of the patient's underlying condition;
- (5) If the patient expired, whether the case will be referred to the medical examiner;
- (6) Patient's type of insurance (this information is required solely for the purposes of determining CIA reporting obligations and does not impact whether any steps outlined in this policy need to be taken);
- (7) Whether notification of the event has been made to the patient and/or family; and
- (8) Whether the Risk Manager believes that any state or Federal reporting obligations are triggered (i.e., reporting to DHS; reporting restraint deaths to the Centers for Medicare and Medicaid Services (CMS); reporting pursuant to the Safe Medical Devices Act, etc.).

[Facility Logo]	[Facility Name] Patient Safety Policy	No.	CQ-2.010
	Title: SENTINEL EVENT RESPONSE AND REPORTING POLICY	Page:	5 of 8
		Origination Date:	10-01-96
		Previous Policy Dated:	07-22-05 8-15-02; 8-28-00
		Effective Date:	06-01-08
		Hospital Governing Board Approval Date:	

b. The Risk Manager shall also notify:

- (1) Patient Financial Services (PFS) Director of Patient Financial Services (DPS) or designee, to place the bill on hold while the potential Sentinel Event is being investigated as described below;
- (2) The Litigation Manager or defense counsel as appropriate; and
- (3) The Facility’s Regional Counsel as appropriate and described below in Section V.A.6.

3. Billing Procedures for Reviewable Sentinel Events

a. Upon identification of a Reviewable Sentinel Event, regardless of payor, the Risk Manager shall notify the DPS or designee to place the bill on hold while the Risk Manager completes an investigation of the facts. If services were rendered to the patient prior to the occurrence of the potential Sentinel Event, the Risk Manager may authorize the DPS or designee to release the portion of the claim that pre-dates the potential Sentinel Event.

b. The DPS or designee shall place the bill on hold using the manual hold process and identifying the reason for the hold as “per Risk Management request.”

c. While the bill remains on hold, the Risk Manager and Litigation Manager shall determine what services related to the Reviewable Sentinel Event will not be submitted for reimbursement. The Risk Manager shall document the rationale for the decision in the occurrence reporting system.

d. Upon the Risk Manager’s closure of the investigation, the Risk Manager shall notify the DPS or designee, in writing, of what charges shall not be billed to the patient or payor. The DPS or designee shall document the adjustments in the patient accounting system, identifying such charges as “non-covered services” and using the [appropriate risk management adjustment codes](#) (see [Payments and Adjustments section, PFS Standard Tables and Request Forms SharePoint site](#)).

[Facility Logo]	[Facility Name] Patient Safety Policy	No.	CQ-2.010
	Title: SENTINEL EVENT RESPONSE AND REPORTING POLICY	Page:	6 of 8
		Origination Date:	10-01-96
		Previous Policy Dated:	07-22-05 8-15-02; 8-28-00
		Effective Date:	06-01-08
		Hospital Governing Board Approval Date:	

4. Disclose to the Patient/Family

All unanticipated outcomes shall be disclosed to the patient and/or family within 24 hours of the anticipated outcome in a team-like fashion and shall follow the [Tenet Model Patient/Family Notification Procedure](#). Once the disclosure has been completed, it shall be appropriately documented in the medical record. Items to be documented include, but are not limited to:

- Physician and Facility representatives present
- Family members present
- Summary of conversation
- Patient/family response
- Documentation of patient/family understanding of the discussion
- Follow-up communication intervals

5. Immediately Review Restraint Deaths with Regulatory Counsel

If the potential Sentinel Event involves:

- death: in or resulting from restraints;
- death within 24 hours of removal of restraints (whether used for acute care purposes or behavioral purposes); or
- death within one week where the restraint is considered to be contributory to the patient's death,

the Facility's Risk Manager shall immediately consult with Regulatory Counsel to determine whether the restraint death requires a report to CMS in accordance with [42 C.F.R. 482.13](#).

For additional information, refer to:

- [Tenet Model Policy CQ 4.004, Restraint & Seclusion Policy for Facilities with Behavioral Health Units,](#)
- [Tenet Model Policy CQ 4.005, Restraint & Seclusion Policy for Facilities without Behavioral Health Units, and](#)
- [CMS website](#)

[Facility Logo]	[Facility Name] Patient Safety Policy	No. CQ-2.010
	Title: SENTINEL EVENT RESPONSE AND REPORTING POLICY	Page: 7 of 8
		Origination Date: 10-01-96
		Previous Policy Dated: 07-22-05 8-15-02; 8-28-00
		Effective Date: 06-01-08
		Hospital Governing Board Approval Date:

6. Review Potential Sentinel Events with Regional Counsel to Determine State Reporting Obligations

The Risk Manager or designee shall immediately consult with Regional Counsel when the Risk Manager believes that state law requires a report of an Adverse Event or Sentinel Event pursuant to state law as identified in Attachment A.

7. Refer the Occurrence Report to the Appropriate Medical Staff Committee

If the Occurrence Report requires physician or nursing peer review, the Risk Manager shall forward the Event Report to the appropriate medical staff committee for follow-up.

8. Determine Whether to Voluntarily Report the Sentinel Event to the JC

Reporting of Sentinel Events to the JC will be determined on a case-by-case basis following discussions with the Facility CEO, Tenet's Clinical Quality/Quality Management Department and Tenet Regulatory Counsel. If the Facility desires to voluntarily report the Sentinel Event to JC, the Risk Manager shall make the appropriate selection in the risk management reporting system, which will notify Corporate Risk Management.

9. Complete the Root Cause Analysis and Action Plan

Within fourteen (14) calendar days of the date of occurrence, the Risk Manager shall complete the [Root Cause Analysis and Action Plan](#) and submit it to the Corporate Clinical Loss Prevention designee. Consult with Hospital Compliance Officer on CIA Reporting Obligations

10. No later than fourteen (14) calendar days after the date of occurrence (i.e., the date that the Root Cause Analysis is due), the Hospital Compliance Officer and Risk Manager shall jointly prepare a draft reportable event letter to the OIG and submit it for review by Corporate Clinical Loss Prevention designee, Corporate Regulatory Counsel, the Regional Compliance Director and Tenet Chief Compliance Officer. The Tenet Chief Compliance Officer or designee shall determine whether the Sentinel Event is required to be reported to the OIG and shall timely submit the reportable event letter to the OIG.

[Facility Logo]	[Facility Name] Patient Safety Policy	No. CQ-2.010
	Title: SENTINEL EVENT RESPONSE AND REPORTING POLICY	Page: 8 of 8
		Origination Date: 10-01-96
		Previous Policy Dated: 07-22-05 8-15-02; 8-28-00
		Effective Date: 06-01-08
		Hospital Governing Board Approval Date:

B. Enforcement

All employees whose responsibilities are affected by this Policy are expected to be familiar with the basic procedures and responsibilities created by this Policy. Failure to comply with this Policy will be subject to appropriate disciplinary action pursuant to all applicable policies and procedures, up to and including termination. Such disciplinary action may also include modification of compensation, including any merit or discretionary compensation awards.

VI. REFERENCES:

- [Joint Commission](#)
- [National Quality Forum Safe Practices](#)
- [Corporate Integrity Agreement September 27, 2006 between Tenet Healthcare Corporation and the Office of Inspector General of the Department of Health and Human Services](#)
- [Regulatory Compliance Policy COMP-RCC 4.21, Internal Reporting of Potential Compliance Issues](#)
- [Payments and Adjustments section, PFS Standard Tables and Request Forms SharePoint site](#)
- [Medicare Conditions of Participation, Patient Rights 42 C.F.R. 482.13](#)
- [Tenet Model Policy CQ 4.004, Restraint & Seclusion Policy for Facilities with Behavioral Health Units](#)
- [Tenet Model Policy CQ 4.005, Restraint & Seclusion Policy for Facilities without Behavioral Health Units](#)
- [CMS website](#)

VII. ATTACHMENT

- Attachment A, Composite of JC, NQF and State Reporting Requirements (revised 3/25/09)