	INODAYA Hospitals - Kakinada		Documentation code: INH/PSQ.Doc.No:8
	Policy On Sentinel Event		**Prepared date:** 05/09/2023
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1. **POLICY:**

   This Policy establishes a process for identifying and responding appropriately to all Sentinel Events and occurring within the Hospital.

2. **PURPOSE**

   The purpose of the policy is to reduce the probability of occurrence of sentinel events in the future.

3. **DEFINITIONS:**

   A. **Sentinel Event:** Sentinel Event is an unexpected happening at the hospital involving death or serious physical (loss of limb or function) or psychological injury, or "the risk thereof", "Risk there of" is defined as any variation in a process for which a recurrence carries a significant chance of an adverse outcome

   B. **Root Cause Analysis:** A "Root Cause Analysis" is a process for identifying the basic or causal factor(s) that underlie variation in performance including the occurrence or possible occurrence of a Sentinel Event.

4. **ABBREVIATIONS (IF ANY):**

   HA- Hospital Management

   QO – Quality Office

5. **SCOPE:**

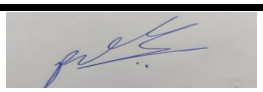
   It includes patients, hospital employees, and visitors.

6. **RESPONSIBILITY:**

   Hospital safety committee and Quality assurance Committee coordinated by the Quality Office

7. **DISTRIBUTION:**

   All patient care areas

Prepared by: 	**Verified by:** 	**Approved by:** 
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Medical Director	Chief Executive Officer	Managing Director

8. PROCESS DETAILS:

8.1 DESCRIPTION OF THE PROCESS

Following events are included under sentinel events:

I Surgical events

a. Surgery performed on wrong body part
b. Surgery performed on wrong patient
c. Wrong surgical procedure performed on patient
d. Retained instrument or object in patient discovered after surgery/procedure
e. Patient death during or immediately after surgical procedure
f. Patient death due to adverse anesthesia event

II. Device or product event

Patient death or severe disability associated with

a. the use of contaminated drugs, devices or any other product supplied by the hospital
b. Use and function of a device in a manner other than the device's intended use
c. Failure or breakdown of device or medical equipment
d. Intravascular air embolism

III. Patient protection event

a. Discharge of an infant to wrong person
b. Patient death or sever disability due to elopement from the hospital
c. Patient suicide, attempted suicide or deliberate self-harm resulting into serious disability

d. Any incidence in which a line designated for oxygen or other came to be delivered to a patient and contains wrong gas or is contaminated by toxic substances
e. Nosocomial infection or disease causing serious disability

IV. Environmental events

Patient death or serious disability while being cared for in the hospital associated with:

i. A burn incurred from any source
ii. A slip, trip or fall
iii. An electric shock
iv. Use of restraint or bedrail

V. Care management event

a. Patient death or serious disability associated with a hemolytic reaction due to administration of ABO-incompatible blood or blood products
b. Maternal death or serious disability associated with labour or delivery in a low-risk pregnancy
c. Medication error leading to the serious disability of patient due to incorrect administration of drugs, for example
   i. Omission error
   ii. Dosage error
   iii. Wrong time error
   iv. Wrong rate of administration error
   v. Wrong patient error
d. Patient death or serious disability associated with an avoidable delay in treatment or response to abnormal test results

VI. Criminal events

a. Any instance of care by or provided by an individual impersonating a clinical member of the staff
b. Abduction of a patient
c. Sexual assault on a patient within or on grounds of the hospital
d. Death or significant injury of a patient or staff member resulting from a sexual assault or other crime that occurs within or on grounds of the hospital

8.2 ACTIVITY

ACTION:

Any incidence of above nature if came in to notice of any member of the hospital shall be reported to top management. A record of this event shall be made with all details.

Occurrence of these event signals the need for immediate action and investigation.

Following system shall be followed to handle these events

1. **Creation of Committee:** The Hospital head shall form a temporary team for in-depth investigation and analysis of the event. The team shall be organized and conduct its proceedings and investigate and analyze the event.
2. **Composition of the Sentinel event investigation Committee:** The team shall be composed of the following:

- Medical director & Hospital administrator
- Nursing superintendent
- Head of department for Clinical Services
- Primary consultant of the patient
- Designated staff persons
- Quality Office representatives

3. **Duties of the Committee:** The Committee shall:

- Investigate an occurrence or process variation
- Determine whether such occurrence or process variation meets the definition of a Sentinel event
    - Ensure completion of a thorough and credible Root Cause Analysis and resulting Action Plan describing the Hospital's risk reduction strategies when a Sentinel Event occurs in the hospital or is associated with services that the hospital provides, or provides for.

4. **Procedure for identifying and responding to sentinel events**

4.1 **Application of policy:** If any individual in the Hospital (including, but not limited to, any individual employed by the Hospital, any individual who independently contracts with the Hospital to provide health care services to patients at the Hospital, any member of the Hospital's Medical Staff, and any allied health care professional) discovers, witnesses, has knowledge of or otherwise becomes aware of any unexpected occurrence that is a possible Sentinel event must report to safety committee or any senior official of the hospital

4.2 **Completion of Root Cause Analysis and Action Plan:** The committee shall investigate and understand the causes that underlie the event within seventy-two (72) hours and complete a thorough and credible Root cause analysis and resulting Action Plan describing the Hospital's risk reduction strategies, within 15 days of the known occurrence of the Sentinel Event.

4.3 **Report:** The committee shall after completing the Root Cause Analysis and Action Plan, produce full documentation of the Root Cause Analysis and Action Plan to HA. The HA shall subsequently direct the Root Cause Analysis and Action Plan to be reported to and thoroughly reviewed by the Hospital's other relevant committees if deems appropriate

5. **Root cause analysis**

5.1 Purpose of Root Cause Analysis The purpose of the Root Cause Analysis is to understand how and why a Sentinel or High Risk Event occurred and to prevent the same or similar Event from occurring in the future. The Root Cause Analysis is expected to uncover any underlying hospital's systems and processes that can be changed to reduce the likelihood of human fallibility in the future.

5.2 **Action Plan:** The committee shall create a work plan that identifies changes to be implemented with target dates for accomplishing specific objectives.

5.3 **Focus on Systems and Processes :** The Root Cause Analysis must focus primarily on systems and processes, not individual performance; it shall identify changes and improvements that could be made in system and processes, either through correction of existing systems or processes or development of new systems or processes, that would reduce the risk of such events occurring in the future

6 **Documents related to sentinel events are confidential**

6.1 The Root Cause Analysis, Action Plan, and other related documents produced by the committee are confidential Root Cause Analysis and the Action Plan are documents prepared by the committee and constitute final product containing recommendations

identifying strategies that the Hospital intends to implement to reduce the risk of Sentinel Events occurring in the future.

6.2 Disclose of unanticipated outcomes of care that relate to sentinel events. The hospital has designated the HA or his designee's responsible to inform the patient and when appropriate, the patients' family about these outcomes of care.

6.3 Legal implication of release of above information**:** Once the event is identified as sentinel event, no employee of the hospital or committee members are allowed to release any kind of information related to it to any external individual or agency. All the matters related to release of any information of occurrence of sentinel event, processes followed and action taken, either to patient, family, police, media, social organizations etc. are taken by director on discretion of legal advisor.

09. RECORDS AND FORMATS:

- Incident reporting data base
- Root cause analysis form

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