I. Title

Sentinel Events

II. Policy

UTMB is committed to patient safety. Any employee who has knowledge of a sentinel event, or a near miss that could lead to a sentinel event, involving a UTMB patient, must notify his/her supervisor or administrator as soon as possible. The supervisor or the administrator must notify Patient Safety or Risk Management immediately. All unusual events should be reported by using the designated event reporting system.

Pursuant to Texas Health and Safety Code Chapter 161, and Texas Occupations Code Chapter 160, all findings from an investigation is confidential and privileged and shall be maintained by Patient Safety for the use of UTMB Health’s patient safety and risk management committee reporting structure and process(es).

In addition, for patients who are also subjects in a research protocol, other reporting may be required per Institutional Review Board (IRB) policy.

A formal root cause analysis (RCA) will be conducted under the auspices of the UTMB Quality & Healthcare Safety Department for events that meet the definition of sentinel event including:

A. Events that 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 following events (even if the outcome was not death or major permanent loss of function):
   1. Suicide of any patient receiving care, treatment, and services in a staffed, around-the-clock care setting or within 72 hours of discharge, including from the hospital’s emergency department (ED);
   2. Unanticipated death of a full-term infant;
   3. Abduction of any patient receiving care, treatment, or services;
   4. Discharge of an infant to the wrong family;
   5. Rape, assault (leading to death or permanent loss of function), or homicide of any patient receiving care, treatment or services while on site at the hospital;
   6. Rape, assault (leading to death or permanent loss of function), or homicide of a staff member, licensed independent practitioner, visitor, or vendor while on site;
   7. Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities (ABO, Rh, or other blood groups);
   8. Invasive procedure, including surgery, on the wrong patient, at the wrong site, or that is the wrong (unintended) procedure;
   9. Unintended retention of a foreign object in an individual after surgery or other invasive procedure;
10. Severe neonatal hyperbilirubinemia (bilirubin more than 30 milligrams/deciliter);
11. 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 percent above the planned radiotherapy dose; or
12. Any elopement (that is, unauthorized departure) of a patient from a staffed, around-the-clock care setting (including the ED), leading to death, permanent harm, or severe temporary harm to the patient.
13. Fire, flame, or unanticipated smoke, heat, or flashes occurring during an episode of patient care.
14. Any intrapartum (related to the birth process) maternal death
15. Severe maternal morbidity (not primarily related to the natural course of the patient’s illness or underlying condition) when it reaches a patient and results in permanent harm or severe temporary harm.

III. Procedures
Patient Safety, Risk Management, and/or another appropriately designated UTMB department, will initiate an investigation of a reported sentinel event, adverse event, or near miss, if applicable, immediately after notification and will work with Health System leadership to determine if an RCA should be conducted. A formal RCA may be conducted for adverse events or near misses at the discretion of Health System leadership.

All RCAs will involve UTMB staff whose departments are associated with the event. The Quality & Healthcare Safety department will work with the applicable departments to determine participants in the RCA meeting.

Refer to the UTMB Health System RCA Process.

IV. Relevant Federal and State Statutes
45-CFR-46.103
Joint Commission Sentinel Events (SE) Accreditation Process information found within the Comprehensive Accreditation Manual (CAMH) for hospitals

V. Related UTMB Policies and Procedures
IHOP – 03.02.04 – Sexual Harassment and Sexual Misconduct
IHOP - 06.01.04 - Significant Events Reporting
IHOP - 09.13.13 - Unusual Event Reporting
IHOP - 09.13.14 - Adverse Drug Events
IHOP - 09.13.18 - Disclosure of Unanticipated Outcomes

VI. Additional References
UTMB Health System RCA Process
The Joint Commission
VII. Dates Approved or Amended

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VIII. Contact Information

Health System Administration
(409) 266-9915