

Ambulatory Clinic Policy and Procedure

Title: MANAGEMENT OF SENTINEL EVENTS AND ROOT CAUSE ANALYSIS	Policy Number: EP 8.2
Regulation: Joint Commission Reference:	Effective Date: 7/2022

Policy Statement:

It is the policy of the Texas Tech Physicians of El Paso (TTP-EP) to identify and manage patient safety events, in order to measure, assess, and improve the organization's performance.

Scope and Distribution:

This policy applies to activities performed at and will be distributed to all TTP-EP 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 affects a patient and results in any of the following: death, permanent or severe temporary harm/loss of function. 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:
 - 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.
 - vii. Fall event – Fall resulting in any of the following: any fracture; surgery, casting, or traction; required consult/management or comfort care for a neurological (for example, skull fracture, subdural or intracranial hemorrhage) or internal (for example, rib fracture, small liver laceration) injury; or a patient with coagulopathy who receives blood products as a result of the fall; death or permanent harm as a result of injuries sustained from the fall (not from physiologic events causing the fall).

2. **Reporting Procedure:** 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 and directly or indirectly to the Office of Quality Improvement or Risk Management.

3. **Root Cause Analysis:** A root cause analysis and action plan will be performed within 45 business days of receiving a sentinel event report 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



Ambulatory Clinic Policy and Procedure

the Quality Improvement Director, Risk Management, and clinical leadership as appropriate. An action plan will be developed as warranted. Improvement actions will be monitored for effectiveness by the Quality Improvement Office and the Root Cause Analysis Team.

- 4. As “**Sentinel Event Alerts**” become available from The Joint Commission, they will be reviewed and distributed to the appropriate committees and clinical staff for awareness and implementation.

Policy Number: EP 8.2	Original Approval Date: 01/2015
Version Number: 3	Revision Date: 07/2022
Signatory approval on file by: Juan Figueroa, M.D. Director of Clinical Operations Clinic Medical Directors Committee, Chair Texas Tech Physicians of El Paso	
	