

LifeSpan...A Community Service

Sentinel Event Policy and Procedures

In support of its mission to continuously improve the safety and quality of health care provided to the public, LifeSpan...A Community Service implements a process by which a sentinel event is studied, analyzed and a written to identify corrective actions to reduce or eliminate the re-occurrence of the event. This is a “root cause analysis”. A root cause analysis focuses primarily on systems and processes, not on individual performance. The analysis progresses from special causes* in clinical processes to common causes** in organizational processes and systems, and identifies potential improvements in these processes or systems that would tend to decrease the likelihood of such events in the future or determines, after analysis, that no such improvement opportunities exist.

WHAT IS A SENTINEL EVENT:

A sentinel event is an unexpected occurrence 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.

- Such events are called “sentinel” because they signal the need for immediate investigation and response.
- The terms “sentinel event” and “medical error” are not synonymous; not all sentinel events occur because of an error and not all errors result in sentinel events.

Action Plan

The product of the root cause analysis is an action plan that identifies the strategies that LifeSpan intends to implement in order to reduce the risk of similar events occurring in the future. The plan will address responsibility for implementation, oversight, pilot testing as appropriate, time lines, and strategies for measuring the effectiveness of the actions. The final report will then be submitted to the Board of Directors for review. The report will also be submitted to LifeWays CMH (if for a LifeWays consumer) and Adult Foster Care Licensing for an AFC Home resident and CARF in all cases.

The implementation of the self – root cause analysis will take place as soon after the event is discovered or reported.

*Special cause is a factor that intermittently and unpredictably induces variation over and above what is inherent in the system. It often appears as an extreme point (such as a point beyond the control limits on a control chart) or some specific, identifiable pattern in data.

**Common cause is a factor that results from variation inherent in the process or system. The risk of a common cause can be reduced by redesigning the process or system