

University of Michigan Hospitals & Health Centers

Orientation to the Sentinel Event Process

Definition of a Sentinel Event:

An unexpected occurrence involving death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition. The following are also considered Sentinel Events:

- Infant abductions
- Infants discharged to the wrong family
- Rape by either another patient or staff
- Hemolytic transfusion reaction
- Surgery on the wrong patient or body part
- Suicide of a hospitalized patient

Definition of a Root Cause Analysis (RCA):

A systematic process to determine the underlying reasons for a sentinel event. The analysis focuses on systems and processes rather than individuals. The analysis repeatedly digs deeper by asking "Why?"; then, when answered, "Why?" again. The RCA assists in the identification of changes that should be made in systems and processes through redesign or new development and that reduce the risk of reoccurrence of the event. Root Cause Analyses must be completed within 45 calendar days for all sentinel events.

* Definitions from UMHHC Policy #30-07-004, Sentinel Event Review

JCAHO description of thorough and credible Root Cause Analysis (paraphrased)

Thorough:

- Determine human and other factors associated with the event and the processes and systems related to its occurrence
- Analyze the underlying systems and processes through a series of "why?" questions
- Inquiry into all areas appropriate as defined by the "Minimum Scope of Root Cause Analysis"
- Identify risk points and their potential contributions to this type of event
- Determine the potential improvement in processes or determine, after analysis, that no such improvement opportunities exist

Credible:

- Include participation by hospital leadership and individuals most closely involved with the process
- Is internally consistent (doesn't contradict itself or leave unanswered questions)
- Provides an explanation for all findings of "not applicable"
- Include consideration of any relevant literature

Attachments:

Exhibit A of the UMHHC Sentinel Event Policy - Flowchart for Sentinel Events
Minimum Scope of Root Cause Analysis document (JCAHO)
Sample Action Plan Form

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