

**MEDDAC Regulation 40-30**

**Medical Services**

# **Sentinel Event Reporting**

**Headquarters  
U.S. Army Medical Department Activity  
Fort George G. Meade  
2480 Llewellyn Avenue  
Fort George G. Meade, MD 20755-5800  
19 April 2004**

**Unclassified**

# ***SUMMARY of CHANGE***

MEDDAC REG 40-30  
Sentinel Event Reporting

Specifically, this revision—

- o Changes the proponent of the regulation to the Patient Safety Manager.
- o Makes numerous changes throughout the regulation.

The revision of 23 January 2003—

- o Has been published in a new format that includes a cover and this “Summary of Change” page.
- o Reformats the title page. The Contents section now includes the page numbers that the various chapters and paragraphs begin on.
- o Changes “staff duty” and “SD” to read “administrative officer of the day” and “AOD”.

## Medical Services

### Sentinel Event Reporting

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**History.** This is the second revision of this publication, which was originally published on 5 September 2001.

**Summary.** This regulation establishes policy and procedures for reporting and reviewing sentinel events.

**Applicability.** This regulation applies to the Headquarters, U.S. Army Medical Department Activity, Fort George G. Meade (MEDDAC) and all outlying U.S. Army health clinics (USAHCs).

**Supplementation.** Supplementation of this regulation is prohibited.

**Proponent.** The proponent of this regulation is the Patient Safety Manager (PSM).

**Suggested improvements.** Users of this publication are invited to send comments and suggested improvements, by memorandum, directly to the Commander, U.S. Army Medical Department Activity, ATTN: MCXR-QM, Fort George G. Meade, MD 20755-5800, or to the MEDDAC's Command Editor by fax to (301) 677-8088 or e-mail to john.schneider@na.amedd.army.mil.

**Distribution.** Distribution of this publication is by electronic medium only.

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\* This publication supersedes MEDDAC Reg 40-30, dated 23 January 2003.

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## **Glossary**

## **Chapter 1 Introduction**

### **1-1. Purpose**

This regulation establishes responsibilities, policies and procedures for reporting and reviewing sentinel events occurring within the MEDDAC.

### **1-2. References**

Related publications and referenced forms are also listed in appendix A.

### **1-3. Explanation of abbreviations**

Abbreviations used in this memorandum are explained in the glossary.

### **1-4. Responsibilities**

a. *The MEDDAC Commander.* The MEDDAC Commander will—

- (1) Foster a cooperative atmosphere for the review of all sentinel events.
- (2) Be ultimately responsible for all medical care rendered within the MEDDAC.
- (3) With the assistance of the Deputy Commander for Clinical Services (DCCS), PSM, and Performance Improvement/Risk Manager (PI/RM), determine if occurrences meet the criteria of sentinel events.
- (4) Ensure all sentinel events are reported through Headquarters, North Atlantic Regional Medical Command, to Headquarters, U.S. Army Medical Command (MEDCOM), within 72 hours, and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) within five working days of the known occurrence of the sentinel event; submit a thorough and credible root cause analysis and action plan to JCAHO, via MEDCOM, within 45 days of reporting the sentinel event to MEDCOM. (The plan will identify opportunities for improvement or formulate a rationale for not undertaking such changes and monitoring the effectiveness, if warranted.)
- (5) Ensure that there are defined support systems in place for staff members who have who have been involved in sentinel events and that such involved staff are provided appropriate support.

b. *The DCCS.* The DCCS will—

- (1) Upon being notified of an occurrence, contact appropriate members of the clinical and administrative staffs whose expertise may be needed during initial investigation.
- (2) Assist the commander to determine whether an occurrence meets the criteria of a sentinel event.
- (3) Obtain a review of the incident within 30 days of the known occurrence of an event.
- (4) Oversee the implementation of corrective actions, if any.

c. *The PSM.* The PSM will—

- (1) Upon notification of a sentinel event, begin a case file and initiate actions to secure, preserve and protect evidence related to the sentinel event.
- (2) Notify the MEDDAC's legal representative at the Office of the Staff Judge Advocate, Fort George G. Meade, of the potential compensable sentinel event.
- (3) Under the direction of the DCCS, conduct a root cause analysis of the sentinel event and complete it within 30 days of the known occurrence of the sentinel event. (See chapter

2 for information specific to root cause analyses.)

(4) Present the completed root cause analysis and action plan to the commander and DCCS and place the case on the agenda of the Patient Safety Committee for review.

(5) Ensure the root cause analysis is reported through appropriate channels to MEDCOM and JCAHO.

(6) Ensure that the Patient Safety Program includes defined support systems for staff members who have been involved in sentinel events and that such involved staff are provided appropriate support. (Support systems provide individuals with additional help and support, such as access to trained facilitators, the chaplain, behavioral health, and the Ethics Committee. Support systems recognize that conscientious health care workers who are involved in sentinel events are themselves victims of the events and require support. Support systems also focus on the process rather than blaming the involved individuals.)

d. *The Administrative Officer of the Day (AOD), Kimbrough Ambulatory Care Center (KACC).* The KACC AOD will immediately notify the MEDDAC Commander and DCCS if there is an occurrence of a possible sentinel event, and make entries on DA Form 1594 (Daily or Duty Officer's Log) to document that each was contacted "regarding a patient issue."

e. *The responsible licensed independent practitioner (LIP) or his/her designee.* The responsible LIP or his/her designee will inform the patient (and, when appropriate, the patient's family) about unanticipated outcomes of care, treatment and/or services. These include—

(1) Outcomes of care, treatment and services that have been provided that the patient (or family) must be knowledgeable about to participate in current and future decisions affecting the patient's care, treatment and services.

(2) Unanticipated outcomes of care, treatment and services that relate to sentinel events considered reviewable by JCAHO.

f. *Staff members.* Staff members will—

(1) Know what constitutes a sentinel event.

(2) Report any occurrence of a suspected sentinel event immediately and properly; ensure the report, which is made on DA Form 4106 (Quality Improvement/Risk Management Document), contains a factual narrative of the event and a list of witnesses, and that no attempt is made to lay blame for the incident.

(3) Document in the patient's medical record the clinical care provided as a result of the sentinel event. Do not, however, state that an incident report was completed. Secure the record and notify the PSM so official copies can be requested.

(4) Ensure that any equipment suspected to have caused the incident is locked away in a secured area. Do not clean the equipment or alter it in any way. For example, do not change any dial settings or flip any switches.

## **Chapter 2**

### **Sentinel Events and Action Plans**

#### **2-1. 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 for serious adverse outcome. Such events are called sentinel because they signal the need for immediate impartial investigation and response.

## **2-2. Sentinel events subject to review by JCAHO**

a. The subset of sentinel events that is subject to review by JCAHO includes any occurrence that meets any of the criteria in paragraph (1) or (2) below:

(1) The event 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.

(2) The event was one of the following, even if the outcome was not death or major permanent loss of function:

(a) Infant abduction (from the premises of the medical treatment facility (MTF)).

(b) Rape (while being treated or on the premises of the MTF).

(c) Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities.

(d) Surgery on the wrong patient or on the wrong site.

b. For the minimum scope of root cause analysis for specific types of sentinel events, see table 2-1 (next page).

## **2-3. Acceptable root cause analyses**

A root cause analysis will be considered acceptable if it has the following characteristics:

a. It focuses primarily on systems and processes, not individual performance.

b. It progresses from special causes in clinical processes to common causes in organizational processes.

c. It repeatedly digs deeper by asking "Why?"; then, when answered, "Why?" again, and so on.

d. It identifies changes which could be made in systems and processes, either through re-design or development of new systems or processes, that would reduce the risk of such events occurring in the future.

e. It is thorough and credible, as described below in paragraphs 2-4 and 2-5, respectively.

## **2-4. Thorough root cause analyses**

To be thorough, a root cause analysis must include—

a. A determination of the human and other factors most directly associated with the sentinel event, and the process(es) and system(s) related to its occurrence.

b. Analysis of the underlying systems and processes through a series of "Why?" questions to determine where redesign might reduce risk.

c. Inquiry into all areas appropriate to the specific type of event as described in table 2-1, above.

d. Identification of risk points and their potential contributions to this type of event.

e. A determination of potential improvement in processes or systems that would tend to decrease the likelihood of such events in the future, or a determination, after analysis, that no such improvement opportunities exist.

**Table 2-1****Minimum scope of root cause analysis for specific types of sentinel events**

Detailed inquiry into these areas is expected when conducting a root cause analysis for the specified type of sentinel event. Inquiry into areas not checked (or listed) should be conducted as appropriate to the specific event under review.

	Suicide (24-hr care)	Medical error	Procedure complication	Wrong site surgery	Treatment delay	Restraint death	Elopement death	Assault, rape, or homicide	Transfusion death	Infant abduction
Behavioral assessment process <sup>1</sup>	X					X	X	X		
Physical assessment process <sup>2</sup>	X		X	X	X	X	X			
Patient identification process		X		X					X	
Patient observation procedures	X					X	X	X		
Care planning process	X		X			X	X			
Continuum of care	X				X	X				
Staffing levels	X	X	X	X	X	X	X	X	X	X
Orientation and training of staff	X	X	X	X	X	X	X	X	X	X
Competency assessment and credentialing	X	X	X		X		X	X		X
Supervision of staff <sup>3</sup>		X	X		X				X	
Communication with patient and family	X			X	X	X	X			
Communication among staff members		X	X	X	X	X			X	X
Availability of information		X	X	X	X				X	
Adequacy of technological support		X	X							
Equipment maintenance and management		X	X			X				
Physical environment <sup>4</sup>	X	X	X				X	X	X	X
Security systems and processes	X						X	X		X
Control of medications: storage and access		X								
Labeling of medications		X								

## Notes:

1. Includes the process for assessing patient's risk to self (and to others in cases of assault, rape or homicide where a patient is the assailant).
2. Includes search for contraband.
3. Includes supervision of physicians-in-training.
4. Includes furnishings, hardware (such as bars, hooks and rods), lighting and distractions.

## **2-5. Credible root cause analyses**

To be credible, a root cause analysis must—

- a. Include participation by the leadership of the organization and by the individuals most closely involved in the processes and systems under review.
- b. Be internally consistent (that is, not contradict itself or leave obvious questions unanswered).
- c. Provide an explanation for all findings of “not applicable” or “no problem”.
- d. Include consideration of any relevant literature.

## **2-6. Action plans**

An action plan will be considered acceptable if it—

- a. Identifies changes that can be implemented to reduce risk or formulates a rationale for not undertaking such changes.
- b. Where improvement actions are planned, identifies who is responsible for implementation, and when the action will be implemented, including any pilot testing and how the effectiveness of the actions will be evaluated.

## **2-7. Confidentiality of root cause analyses and action plans**

All root cause analyses and actions plans are treated as confidential by the MEDDAC and JCAHO.

# **Chapter 3**

## **Reporting Procedures**

### **3-1. Initial reporting**

Any incident that meets or is thought to meet the definition of a sentinel event will be reported immediately. (See the glossary for the definition of sentinel event.)

- a. During normal duty hours. The term “normal duty hours” is explained in the glossary.
  - (1) The staff member who witnesses or becomes knowledgeable of the incident will immediately notify the PSM by calling 301-677-8468 (or 7-8468 if calling from a military telephone on-post).
  - (2) The PSM will then immediately notify the MEDDAC Commander, DCCS, and PI/RM.
  - (3) The staff member having the most knowledge of the incident, which may not be the same staff member who reported the incident, will complete DA Form 4106, and turn it to the PI/RM within 24 hours of the incident. DA Form 4106 is available on FormFlow and can be completed electronically and hand delivered.
- b. After normal duty hours. The term “after normal duty hours” is explained in the glossary.
  - (1) The staff member who witnesses or becomes knowledgeable of the incident will immediately notify the AOD by calling 301-677-8741 (or 7-8741) if calling from a military telephone on post).
  - (2) The AOD will make an entry on DA Form 1594 regarding the report of the incident, then immediately notify the MEDDAC Commander and DCCS that a perceived sentinel event has occurred and provide them the details, as he or she knows them.
  - (3) The DCCS will then notify the PI/RM of the incident.

(4) The staff member having the most knowledge of the incident, which may not be the same staff member who reported the incident, will complete DA Form 4106, and turn it to the PI/RM within 24 hours of the incident. DA Form 4106 is available on FormFlow and can be completed electronically.

### **3-2. Facility reporting**

a. When there has been a sentinel event, the PSM will initiate an investigation of the incident and complete a root cause analysis 30 working days after the occurrence. The PSM will coordinate the investigation and, upon its completion, forward the results to the MEDDAC Commander and DCCS for comment and approval of recommended changes, if any.

b. The case will then be presented to the Patient Safety Committee. If the committee concludes that a specific provider(s) are directly involved in a breach of standard of care resulting in a sentinel event, information will be referred to the Risk Management Committee for action as appropriate.

## **Appendix A References**

### **Section I Required Publications**

#### **AR 40-68**

Clinical Quality Management. (Cited in para 1-4c(5).)

### **Section II Related publications**

A related publication is merely a source of additional information. The user does not have to read it to understand this publication.

#### **AR 310-25**

Dictionary of United States Army Terms

#### **AR 310-50**

Authorized Abbreviations, Brevity Codes, and Acronyms

Joint Commission on Accreditation of Health-care Organizations (JCAHO) Sentinel Event Policy, July 1998.1

The Comprehensive Accreditation Manual for Ambulatory Care (CAMAC) and Behavioral Healthcare (CAMBH), JCAHO

### **Section III Prescribed Forms**

This section contains no entries.

### **Section IV Referenced Forms**

#### **DA Form 1594**

Daily Staff Journal or Duty Officer's Log

#### **DA Form 4106**

Quality Improvement/Risk Management Document

**Glossary**  
**Section I**

**Section I**  
**Abbreviations**

**AOD**

administrative officer of the day

**DCCS**

Deputy Commander for Clinical Services

**JCAHO**

Joint Commission on Accreditation of Healthcare Organizations

**KACC**

Kimbrough Ambulatory Care Center

**MEDCOM**

U.S. Army Medical Command

**MEDDAC**

U.S. Army Medical Department Activity, Fort George G. Meade

**MTF**

medical treatment facility

**PI/RM**

Performance Improvement/Risk Manager

**PSM**

Patient Safety Manager

**Section II**  
**Terms**

**After normal duty hours**

Monday-Friday (1600-0730), Saturdays, Sundays, and all Federal holidays and training holidays falling on a weekday (Monday-Friday).

**Normal duty hours**

Monday through Friday, 0730-1600, except Federal holidays and training holidays.

**Root cause analysis**

A process for identifying the basic and casual factors that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event.