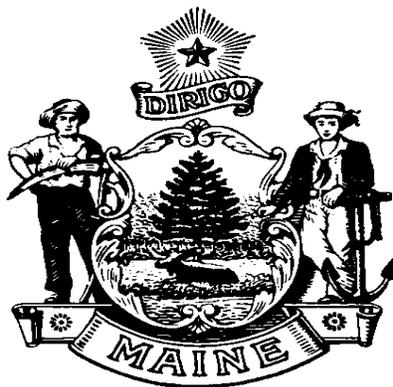


# Rules Governing the Reporting of Sentinel Events

10-144 CMR Chapter 114  
Effective Date: February 1, 2013



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National Quality Forum (NQF), Serious Reportable Events in Healthcare 2011, Washington, DC: NQF, 2011. Reproduced with permission.		

**Purpose.** The Regulations Governing the Reporting of Sentinel Events create a system for reporting all sentinel events to improve the quality of healthcare and increase patient safety. The reporting system focuses the attention of a healthcare facility on understanding the causes that underlie the event and on changing systems and processes to reduce the probability of future events.

**Section 1. Definitions.** As used in these rules, unless the context otherwise indicates, the following terms have the following meanings.

- 1.1 Adverse.** For the purposes of these rules, “adverse” means a negative consequence of care that results in unintended injury or illness, which may or may not have been preventable.
- 1.2 Associated with.** For the purposes of these rules, “associated with” means that it is reasonable to initially assume that the adverse event was due to the referenced course of care; further investigation or root cause analysis of the unplanned event may be needed to confirm or refute the presumed relationship.
- 1.3 Disability.** “Disability” means a physical or mental impairment that substantially limits one or more of the major life activities of an individual. (see Americans with Disabilities Act).
- 1.4 Discovered.** For the purposes of these rules, “discovered” means the point at which one becomes aware of a sentinel event.
- 1.5 Division.** “Division” means the Department of Health and Human Services (DHHS), Division of Licensing and Regulatory Services (DLRS).
- 1.6 Event.** “Event” means a discrete, auditable, and clearly defined occurrence.
- 1.7 Final Agency Action.** “Final Agency Action” means a decision by DHHS which affects the legal rights, duties or privileges of specific persons, which is dispositive of all issues, legal and factual, and for which no further recourse, appeal or review is provided within DHHS, 5 M.R.S.A. §8002.
- 1.8 Healthcare Facility.** “Healthcare facility” or “facility” means a state institution as defined by 34-B M.R.S.A. Chapter 1 or a healthcare facility licensed by the division, excluding a facility licensed as a nursing facility by 22 M.R.S.A. Chapter 405 or licensed as an assisted housing program by 22 M.R.S.A. Chapter 1664. “Healthcare facility” includes:
- 1.8.1** A general and specialty hospital licensed pursuant to 22 M.R.S.A. Chapter 405.

- 1.8.2** An ambulatory surgical facility licensed pursuant to 22 M.R.S.A. § 1812-E.
- 1.8.3** An end-stage renal disease (ESRD) facility licensed pursuant to 22 M.R.S.A. Chapter 412. These rules do not apply to home dialysis. Home dialysis means dialysis performed at home by an ESRD patient or caregiver who has completed an appropriate course of training.
- 1.8.4** An intermediate care facility for individuals who are intellectually disabled (ICF/IID) licensed pursuant to 22 M.R.S.A. Chapter-405.
- 1.9** **Hyperbilirubinemia.** “Hyperbilirubinemia” means bilirubin levels greater than 30 mg/dl.
- 1.10** **Hypoglycemia.** “Hypoglycemia” means blood glucose levels less than 60 mg/dl.
- 1.11** **Immediate jeopardy.** "Immediate jeopardy" means a situation in which the provider's noncompliance with one or more conditions of participation in the federal Medicare program has caused, or is likely to cause, serious injury, harm or impairment to or death of a patient.
- 1.12** **Inter-facility transfer.** “Inter-facility transfer” means any transfer, after initial assessment and stabilization of the patient, from, and to, a healthcare facility, or within the same health system, including but not limited to:
- 1.12.1** Hospital to hospital.
- 1.12.2** Clinic to hospital.
- 1.12.3** Hospital to rehabilitation facility.
- 1.12.4** Ambulatory surgical facility to hospital.
- 1.12.5** Hospital to long term care.
- 1.12.6** ESRD to hospital.
- 1.13** **Major Life Activities.** For the purposes of these rules, “major life activities” means functions, including but not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, working and the operation of a major bodily function. Major bodily functions include but are not limited to functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain,

respiratory, circulatory, endocrine, and reproductive functions. (see the federal Americans with Disabilities Act).

- 1.14 Major Permanent Loss of Function.** “Major permanent loss of function” means sensory, motor, physiological or intellectual impairment that was not present at the time of admission and
- 1.4.1** requires continued treatment or
  - 1.4.2** imposes persistent major restrictions in activities of daily living; and
  - 1.14.3** is unrelated to the natural course of the patient's illness or underlying condition or proper treatment of that illness or underlying condition in a health care facility.
- 1.15 Near Miss Event.** “Near miss” means an event or situation that did not produce patient injury, but only because of chance, which may include, but is not limited to, robustness of the patient or a fortuitous, timely intervention.
- 1.16 Neonate.** “Neonate” means the first 28 days of life.
- 1.17 Perinatal Period.** “Perinatal period” means the 28<sup>th</sup> week of gestation to the 28<sup>th</sup> day of life.
- 1.18 Pregnancy, High Risk.** “High risk pregnancy” means a pregnancy in which the mother or the developing fetus has a condition that places one or both of them at a higher-than-normal-risk for complications, either during the pregnancy (antepartum), during delivery (intrapartum), or following the birth (postpartum).
- 1.19 Pregnancy, Low Risk.** “Low risk pregnancy” means a pregnancy occurring in a woman aged 18-39 who has no previous diagnosis of essential hypertension, renal disease, collagen vascular disease, liver disease, cardiovascular disease, placenta previa, multiple gestation, intrauterine growth retardation, smoking, pregnancy-induced hypertension, premature rupture of membranes, or other previously documented condition that poses a high risk of poor pregnancy outcome.
- 1.20 Preventable.** For the purposes of these rules “preventable” means an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure.
- 1.21 Root Cause Analysis (RCA).** “Root cause analysis” means a structured process for identifying the causal or contributing factors underlying adverse events. The RCA follows a predefined protocol for identifying the specific factors in causal categories.

**1.22 Sentinel Event.** A “sentinel event” means:

- 1.22.1** An unanticipated death, or patient transfer to another health care facility, unrelated to the natural course of the patient's illness or underlying condition or proper treatment of that illness or underlying condition in a health care facility;
- 1.22.2** A major permanent loss of function unrelated to the natural course of the patient's illness or underlying condition or proper treatment of that illness or underlying condition in a health care facility that is present at the time of the discharge of the patient.
  - 1.22.2.1** For the purposes of ESRDs, the term “discharge” means within 48 hours of a treatment.
  - 1.22.2.2** If within 14 days of discharge from the facility, evidence is discovered that the major loss of function was not permanent, the health care facility is not required to submit a report pursuant to 22 M.R.S.A. § 8753 (2);
- 1.22.3** An unanticipated perinatal death or major permanent loss of function in an infant, with a birth weight over 2,500 grams that is unrelated to the natural course of the infant's or mother's illness or underlying condition or unrelated to the proper treatment of the infant's or mother's illness or underlying condition in a healthcare facility; and
- 1.22.4** Other serious and preventable events described in this section or Appendix A of these rules pursuant to 22 M.R.S.A. §8752 (4-A) (D).

**Incorporation By Reference.** Appendix A incorporates by reference “Specifications of the Serious Reportable Events in Healthcare – 2011 Update” of the National Quality Forum (NQF). See 5 M.R.S.A. §8056(1)(B)(1).

**Copies of Incorporated Matter Available.** In addition to its availability in Appendix A of these rules, copies of “Specifications of the Serious Reportable Events in Healthcare – 2011 Update” may be found at [http://www.qualityforum.org/projects/hacs\\_and\\_sres.aspx](http://www.qualityforum.org/projects/hacs_and_sres.aspx) or may be obtained at cost from the Maine DHHS, Division of Licensing and Regulatory Services, 11 State House Station, Augusta, Maine 04333.

**Failure to Comply is Violation of Rules.** Failure to comply with the provisions of Appendix A “Specifications of the Serious Reportable Events in Healthcare – 2011 Update” constitutes a violation of these rules.

**1.22.4.1** Surgical Events

- 1.22.4.1.1.** Surgery performed on the wrong body part.
- 1.22.4.1.2** Surgery performed on the wrong patient.
- 1.22.4.1.3** Wrong surgical procedure performed on a patient.
- 1.22.4.1.4** Unintended retention of a foreign object in a patient after surgery or other procedure.
- 1.22.4.1.5** Intraoperative or immediately postoperative death in an ASA Class 1 patient. ASA Class 1 patient is an acronym for “American Society of Anesthesiologists Classification 1 (Normal Healthy Patient)”.

**1.22.4.2** Product or Device Events

- 1.22.4.2.1** Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the healthcare facility.
- 1.22.4.2.2** Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended.
- 1.22.4.2.3** Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility.

**1.22.4.3** Patient Protection Events

- 1.22.4.3.1** Infant discharged to the wrong person.
- 1.22.4.3.2** Patient death or serious disability associated with patient elopement (disappearance).
- 1.22.4.3.3** Patient suicide, or attempted suicide, resulting in serious disability while being cared for in a healthcare facility.

**1.22.4.4** Patient Treatment Events

- 1.22.4.4.1** Patient death or serious disability associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration).
- 1.22.4.4.2** Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA-incompatible blood or blood products.
- 1.22.4.4.3** Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare facility.
- 1.22.4.4.4** Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a healthcare facility.
- 1. 2.4.4.5** Death or serious disability (kernicterus) associated with failure to identify and treat hyperbilirubinemia in neonates.
- 1.22.4.4.6** Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility.
- 1.22.4.4.7** Patient death or serious disability due to spinal manipulative therapy.
- 1.22.4.4.8** Artificial insemination with the wrong donor sperm or wrong egg.
- 1.22.4.5** Environmental Events
  - 1.22.4.5.1** Patient death or serious disability associated with an electric shock while being cared for in a healthcare facility.
  - 1.22.4.5.2** Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances.

**1.22.4.5.3** Patient death or serious disability associated with a burn incurred from any source while being cared for in a healthcare facility.

**1.22.4.5.4** Patient death or serious disability associated with a fall while being cared for in a healthcare facility.

**1.22.4.5.5** Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a healthcare facility.

**1.22.4.6** Criminal Events

**1.22.4.6.1** Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider.

**1.22.4.6.2** Abduction of a patient of any age.

**1.22.4.6.3** Sexual assault on a patient within or on the grounds of a healthcare facility.

**1.22.4.6.3.1** If *one or more* of the following criteria is met, the facility is required to submit notification regarding a sexual assault:

**1.22.4.6.3.2** Any staff-witnessed sexual assault.

**1.22.4.6.3.3** Sufficient clinical evidence obtained by the healthcare facility to support allegations of sexual assault.

**1.22.4.6.3.4** Admission by the perpetrator of a sexual assault that occurred on the premises.

**1.22.4.6.4** Death or a significant injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare facility.

**1.23 Sentinel Events Team.** The Sentinel Events Team (SET), a unit of the Division of Licensing and Regulatory Services (DLRS), is assigned the responsibility to implement these rules.

- 1.24 Serious.** For the purposes of these rules, “serious” means an event that results in death or loss of a body part, disability or loss of bodily function lasting more than seven days or still present at the time of discharge from a facility or requires major intervention for correction including but not limited to higher level of care or surgery.
- 1.25 Sexual Assault.** “Sexual assault” as a reportable event means nonconsensual sexual contact that is not part of medically necessary health care involving a patient and another patient, staff member, or other perpetrator while being treated or on the premises of the healthcare facility, including oral, vaginal or anal penetration or fondling of the patient’s sex organ(s) by another individual’s hand, sex organ or object.
- 1.26 Spinal Manipulative Therapy.** “Spinal manipulative therapy” means all types of manual techniques, including spinal mobilization (movement of a joint within its physiologic range of motion) and manipulation (movement beyond its physiologic range of motion), regardless of their precise anatomic and physiologic focus or their discipline of origin.
- 1.27 Surgery.** “Surgery” means an invasive operative procedure, including a minimally invasive procedure, in which skin or mucous membranes and connective tissue is incised or an instrument is introduced through a natural body orifice.

**Section 2. Facility Responsibilities.**

**2.1 Notification and Reporting System.** A health care facility must have a Sentinel Event Notification and Reporting System as part of its hospital-wide, integrated patient safety program for all departments, programs, and services within the facility that includes but is not limited to:

**2.1.1 Discovery System.** Each health care facility shall have policies and procedures for identifying a sentinel event (Section 1.22). The written policies and procedures must include but not limited to the following:

**2.1.1.1** Copy of the current Sentinel Events Reporting law, 22 M.R.S.A. Chapter 1684.

**2.1.1.2** Copy of the current Rules Governing the Reporting of Sentinel Events, 10-144 C.M.R. Ch. 114.

**2.1.1.3** Procedures for preservation of evidence, including but not limited to the following:

**2.1.1.3.1** Procedure for sequestering equipment involved in the event.

**2.1.1.3.2** Procedure for sequestering other evidence including but not limited to medication vials and intravenous (IV) administration bags.

**2.1.1.3.3** Procedure for identifying clinical indications for requesting an autopsy.

**2.1.1.4** Procedure for periodically reviewing a sample of death logs, transfer logs, patient complaints, patient records submitted for case review, resuscitation reviews and other records as a quality assurance mechanism to assure that cases are being identified and reported.

**2.1.1.5** Procedure for communicating the definition of a sentinel event throughout the organization.

**2.1.2 Notification Policy.** Facility sentinel event notification policies and procedures shall include but are not limited to the following:

**2.1.2.1** Facility procedure for notifying the SET.



**Section 3. Standardized Procedures.**

**3.1 Notification by next business day.** The healthcare facility must notify the SET of a sentinel event (Section 1.22) by the next business day after the event occurred or the next business day after the facility discovers that the event occurred. The notification must include but is not limited to the date and time of notification, the name of the health care facility, the type of sentinel event, and the date and time the sentinel event occurred.

**3.2 Notification Procedure.** Immediately upon discovery of a sentinel event, the facility must act in accordance with its notification procedures as required by Section 2.1 of these rules.

**3.2.1** Notification of the discovery of a sentinel event must not be delayed secondary to internal deliberations or pending autopsy or medical examiner results.

**3.2.2** Within 1 business day of the discovery of a sentinel event, the healthcare facility must send the department-approved sentinel event notification form to the SET by facsimile or encrypted e-mail.

**3.3 Situational Notification Considerations.**

**3.3.1 Inter-facility Transfer Notification.** A sending facility is required to submit to the SET notification regarding a sentinel event when the transfer to another facility is unrelated to the natural course of the patient's illness or underlying condition; or unrelated to the proper treatment of that illness or underlying condition in its healthcare facility.

**3.3.2 Discharge Follow-up Notification.**

**3.3.2.1** A facility is required to submit to the SET notification by the next business day after the event occurred or the next business day after the facility discovers that the event occurred regarding a sentinel event involving a patient with a major permanent loss of function that is present at the time of discharge that is unrelated to the natural course of the patient's illness or underlying condition or proper treatment of that illness or underlying condition in a health care facility.

**3.3.2.1.1** If within 14 days of discharge from a health care facility, evidence is discovered that the major loss of function was not permanent, the facility must submit the department-approved Functional Evidence form with supporting documentation to the SET, and the

health care facility is not required to submit a report pursuant to 22 M.R.S.A. § 8753 (2).

**3.3.2.2** A facility is required to submit to the SET notification by the next business day after the event occurred or the next business day after the facility discovers that the event occurred when a sentinel event involving a death or major permanent loss of function occurs within 48 hours of treatment or procedure in an emergency department, ambulatory surgical facility, or end stage renal disease facility that is unrelated to the natural course of the patient's illness or underlying condition; or unrelated to the proper treatment of that illness or underlying condition in a healthcare facility.

**3.3.2.3** A facility is required to submit to the SET notification by the next business day after the event occurred or the next business day after the facility discovers that the event occurred when the suicide of a patient occurs within 48 hours of discharge from a healthcare facility.

**3.4 SET Case Review.** Upon receipt of a notification or report of a sentinel event, the SET completes an initial review and may take other action that it determines to be appropriate pursuant to these rules. The facility must comply with the following requirements for the SET case review:

**3.4.1** Provide a copy of the patient's medical record.

**3.4.2** Provide a timeline of the event.

**3.4.3** Present details of the event.

**3.4.4** Schedule SET conference with the CEO or Administrator.

**3.4.5** Schedule SET de-briefing regarding the findings with the facility.

**3.5 Immediate Jeopardy.** The division personnel responsible for sentinel event oversight shall report to the division's licensing section only incidences of immediate jeopardy and each condition of participation in the federal Medicare program related to the immediate jeopardy for which the provider is out of compliance.

**Section 4. Root Cause Analysis (RCA).**

- 4.1 RCA Required.** The healthcare facility is required to submit to the SET a thorough and credible root cause analysis no later than 45 days after notification of the sentinel event. The RCA may exclude protected professional competence review information pursuant to the Maine Health Security Act.
- 4.2 RCA Report.** The RCA must be submitted in an envelope labeled ‘confidential’ and the written report must contain at least the following:
- 4.2.1** Facility-specific unique identifier provided by the SET.
  - 4.2.2** The root cause analysis.
  - 4.2.3** Signature of the chief executive officer (CEO) of the facility.
  - 4.2.4** Other information significant to the identification of systems improvements with the goal being prevention of the recurrence of a similar sentinel event, including but not limited to the following:
    - 4.2.4.1** The final timeline of events.
    - 4.2.4.2** Identification of the occurrence of a similar event or events.
    - 4.2.4.3** Evidence of evaluation of the corrective actions implemented as a result of the similar event or events,
    - 4.2.4.4** Evidence of communication with the receiving facility in the event of an inter-facility transfer.
    - 4.2.4.5** An action plan that includes at least the following:
      - 4.2.4.5.1** Where improvement actions are planned, identification of who is responsible for implementation, when the action will be implemented (including any pilot testing), and how the effectiveness of the action will be evaluated.
      - 4.2.4.5.2** Identification of actions and rationale that clearly and specifically address each proximal cause and contributing factor of the sentinel event.
- 4.3 Thorough and Credible RCA.** An acceptable RCA must comply with the following:

- 4.3.1** A *thorough* root cause analysis includes at least the following information:
- 4.3.1.1** A determination of the human and other factors most directly associated with the sentinel event and the processes and systems related to its occurrence;
  - 4.3.1.2** An analysis of the underlying systems and processes to determine where redesign might reduce risk;
  - 4.3.1.3** An inquiry into all areas appropriate to the specific type of event;
  - 4.3.1.4** An identification of risk points and their potential contributions to the event;
  - 4.3.1.5** A determination of potential improvement in processes or systems that would tend to decrease the likelihood of such an event in the future or a determination, after analysis, that no such improvement opportunities exist;
  - 4.3.1.6** An action plan that identifies changes that can be implemented to reduce risks or formulates a rationale for not undertaking such changes; and,
  - 4.3.1.7** Where improvement actions are planned, an identification of who is responsible for implementation, when the action will be implemented and how the effectiveness of the action will be evaluated.
- 4.3.2** A *credible* root cause analysis meets the following criteria:
- 4.3.2.1** It includes participation by the leadership of the healthcare facility and by the individuals most closely involved in the processes and systems under review;
  - 4.3.2.2** It is internally consistent (that is, not contradict itself or leave obvious questions unanswered);
  - 4.3.2.3** It provides an explanation for all findings, including those identified as “not applicable” or “no problem,” and
  - 4.3.2.4** It includes the consideration of any relevant literature.

**4.4 Additional Information.** The SET may request additional information regarding the RCA and action plan, and the facility must comply as follows:

**4.4.1** The facility must submit its written response to the SET written request for additional information within 14 days of receipt of the request, and the response must be signed by the Chief Executive Officer.

**Section 5. Near Miss Events.**

- 5.1 Voluntary Self-Reporting.** A healthcare facility may notify the SET of the occurrence of a near miss event (Section 1.15). Reports shall be made on department-approved forms and include requested documentation. 22 M.R.S.A. Sec. 8753 (5).
- 5.2 Report.** The Sentinel Events Annual Report shall include near miss aggregate data analysis for near miss detection methodologies, causative factors and safety improvements.

**Section 6. Consumer Complaints: SET Compliance Review.**

- 6.1 Complaints.** Any person with a licensing complaint may contact the division's Intake and Complaints Unit at 1-800-383-2441. If, upon review, the division determines that the reported event constitutes a sentinel event, it is referred to the SET.
- 6.2 SET On-site review.** The SET may conduct an announced and unannounced visit to any facility to achieve the following:
- 6.2.1** Determine compliance with these rules.
  - 6.2.2** Perform reviews based on complaints received by the division.
  - 6.2.3** Perform reviews based on third-party case identification.
  - 6.2.4** Review documents including but not limited to medical records, RCA reports, and committee meeting minutes. Professional competence review information protected pursuant to the Maine Health Security Act is excluded.

**Section 7. Confidential and Privileged Information.**

**7.1 Confidential and privileged information.** Communication with the division is privileged and confidential.

**7.1.1** The division shall take appropriate measures to protect the security of any information to which these rules apply.

**7.1.1.1 Consultants.** When consultants are retained by the SET they shall be held to the same standards regarding confidentiality and privileged information.

**7.1.2** Notifications and reports concerning sentinel events, near miss events, and suspected sentinel events filed pursuant to these rules and all information collected or developed as a result of the filing and proceedings pertaining to the filing, regardless of format, are confidential and privileged information.

**7.1.3** Pursuant to these rules, privileged and confidential information is not:

**7.1.3.1** Subject to public access under Title 1 M.R.S.A. Chapter 13, except for data developed from the reports that do not identify or permit identification of the healthcare facility;

**7.1.3.2** Subject to discovery, subpoena or other means of legal compulsion for its release to any person or entity; or

**7.1.3.3** Admissible as evidence in any civil, criminal, judicial or administrative proceeding.

**7.1.4** Pursuant to these rules, the transfer of any information by a healthcare facility to the division or to a national organization that accredits healthcare facilities may not be treated as a waiver of any privilege or protection established by applicable Maine laws.

**7.1.5** These rules may not be construed to limit other privileges that are available under federal or other laws of this State that provide for greater peer review or confidentiality protections than the peer review and confidentiality protections provided by these rules.

**7.1.6** For the purposes of these rules, “privileged and confidential information” does not include:

**7.1.6.1** Any final administrative action;

**7.1.6.2** Information independently received pursuant to a third party complaint investigation conducted pursuant to department rules; or

**7.1.6.3** Information designated as confidential under the rules and laws of this State.

**7.2 Federal law.** These rules do not affect the obligations of the department relating to federal law.

**Section 8. Enforcement.**

- 8.1 Immunity.** A person who in good faith reports a near miss event, a suspected sentinel event or a sentinel event or provides a RCA pursuant to these rules is immune from any civil or criminal liability for the act of reporting or participating in the review conducted by the SET.
- 8.1.1** “Good faith” does not include instances when a false report is made and the person reporting knows the report is false. These rules may not be construed to bar civil or criminal action regarding perjury or regarding the sentinel event that led to the report.
- 8.2 Financial Penalty.** When the division determines that a healthcare facility failed to report a sentinel event as required by these rules, the healthcare facility is subject to a financial penalty, payable to the State of Maine, of not more than \$10,000 per violation.
- 8.2.1** Each failure to report is a separate violation.
- 8.2.2** If a facility in good faith notified the division of a suspected sentinel event and the division later determines it is a sentinel event, the facility is not subject to a penalty for that event.
- 8.2.3** Funds collected pursuant to these rules must be deposited in a dedicated special revenue account to be used to support sentinel event reporting and education.
- 8.3 Notice of Imposition of Penalty.** The SET shall send written notice to the healthcare facility stating the amount of the financial penalty imposed for failure to report a sentinel event. The notice shall include but is not limited to the date of the event and the deadline for filing an appeal of the penalty.
- 8.3.1** Payment of the penalty is due within 10 days of receipt of the written notice of imposition of a penalty or the date of final agency action, whichever is later.
- 8.4 Administrative Hearing.** To contest the imposition of a penalty, a healthcare facility must submit to the division a written request for an administrative hearing within 10 days of receipt of the notice of imposition of a penalty.
- 8.5 Judicial Review.** Judicial appeal must be in accordance with 5 M.R.S.A. chapter 375, subchapter 7.
- 8.6 Injunction to require compliance.** Notwithstanding any other remedies provided by law, the Office of the Attorney General may seek an injunction to require compliance with the provisions of these rules.

**8.7 District Court Complaint for violations.** The Office of the Attorney General may file a complaint with the District Court seeking injunctive relief for violations of these rules.

**Statutory Authority**

22 M.R.S.A. Chapter 1684

22 M.R.S.A. §42

22-A M.R.S.A. §205

**Regulatory History**

Public Law 2001, chapter 678, established laws governing the reporting sentinel events and instructed the department to adopt rules to implement chapter 678.

**ADOPTED**

Deleted sentinel events reporting provisions in the following:

- 10-144 C.M.R. Ch. 112 Regulations for the Licensure of General and Specialty Hospitals in the State of Maine.
- 10-144 C.M.R. Ch. 118 Regulations Governing the Licensing and Functioning of Intermediate Care Facilities for Persons with Mental Retardation.
- 10-144 C.M.R. Ch. 125 Regulations Governing the Licensing of Ambulatory Surgical Facilities.
- 10-144 C.M.R. Ch. 126 Regulations Governing the Licensing and Functioning of End Stage Renal Disease Units/Facilities.

**ADOPTED**

[New] 10-144 C.M.R. Chapter 114, Rules Governing the Reporting of Sentinel Events, replaces the sentinel events reporting provisions in 10-144 C.M.R. Chapters 112, 118, 125, and 126.

**EFFECTIVE DATE:**

January 1, 2009 – filing 2008-579

**AMENDED**

April 17, 2010 – filing 2010-141

**AMENDED**

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## APPENDIX A EVENT SPECIFICATIONS AND IMPLEMENTATION GUIDANCE

The following table presents the specifications for the proposed consensus standards. The information presented represents an update of the 2006 report with revision and additions made by the Serious Reportable Events Steering Committee utilizing NQF Member and public submissions and consultation with experts in the various fields. These proposed voluntary consensus standards are the intellectual property of the National Quality Forum and as such they are open source, fully accessible, and disclosed.

Definitions of key terms are included in the Glossary (Appendix B) and, where the terms are used in the event description or additional specifications, are considered part of the specifications of the events.

Implementation Guidance is not proposed for endorsement. It amplifies statements in the Event and Additional Specifications, which are proposed for endorsement, with examples and explanations based on experience of those organizations/entities that have implemented event reporting as well as recommendations of the NQF Serious Reportable Events Steering Committee. It does not purport to be either comprehensive or even across the events and is *not* a requirement of either.

1. SURGICAL OR INVASIVE PROCEDURE EVENTS		
EVENT	ADDITIONAL SPECIFICATIONS	IMPLEMENTATION GUIDANCE
<p>A. Surgery or other invasive procedure performed on the wrong site</p> <p>Applicable settings:</p> <ul style="list-style-type: none"> <li>• Hospitals</li> <li>• Outpatient/Office-based Surgery Centers</li> <li>• Ambulatory Practice Settings/Office-based Practices</li> <li>• Long-term Care/Skilled Nursing Facilities</li> </ul>	<p>Defined as any surgery or other invasive procedure performed on a body part or site that is not consistent with the correctly documented informed consent for that patient.</p> <p>Surgery or other invasive procedure includes, but is not limited to, endoscopies, lens implants, lesion removal, injection into joints.</p> <p>Excludes emergent situations that occur in the course of surgery or other invasive procedure and/or whose exigency precludes obtaining informed consent.</p>	<p>It should be noted that a correctly documented informed consent for patients whose procedures will not be carried out in an operating room may not involve a “surgical consent form”; however, it does require informed consent be documented in the patient record.</p> <p>Although an incorrectly placed surgical mark could result in surgery being performed on the wrong body part, surgery does not begin at time the surgical mark is made on the patient. Placing a mark on the wrong body part or site does not in itself constitute wrong site surgery.</p> <p>Wrong site surgery or invasive procedure, corrected during the procedure, is still a wrong site procedure if the surgery/ procedure had begun, based on the definition in glossary.</p>

1. SURGICAL OR INVASIVE PROCEDURE EVENTS		
EVENT	ADDITIONAL SPECIFICATIONS	IMPLEMENTATION GUIDANCE
		<p>This event is intended to capture instances of:</p> <ul style="list-style-type: none"> <li>• surgery or other invasive procedure on the right body part but on the wrong location/site on the body; e.g. left/right (appendages/organs), wrong digit, level (spine), stent placed in wrong iliac artery, steroid injection into wrong knee, biopsy of wrong mole, burr hole on wrong side of skull;</li> <li>• delivery of fluoroscopy or radiotherapy to the wrong region of the body;</li> <li>• use of incorrectly placed vascular catheters;</li> <li>• use of incorrectly placed tubes (for example, feeding tubes placed in the lung or ventilation tubes passed into the esophagus).</li> </ul> <p>This event is not intended to capture:</p> <ul style="list-style-type: none"> <li>• changes in plan upon entry into the patient with discovery of pathology in close proximity to the intended place where risk of a second surgery or procedure outweighs benefit of patient consultation, or unusual physical configuration (for example adhesions, spine level/extra vertebrae).</li> </ul>
<p>B. Surgery or other invasive procedure performed on the wrong patient</p> <p>Applicable settings:</p> <ul style="list-style-type: none"> <li>• Hospitals</li> <li>• Outpatient/Office-based Surgery Centers</li> <li>• Ambulatory Practice Settings/ Office-based</li> </ul>	<p>Defined as any surgery or invasive procedure on a patient that is not consistent with the correctly documented informed consent for that patient.</p> <p>Surgery or other invasive procedure includes, but is not limited to, endoscopies, lens implants, lesion removal, injection into joints.</p>	<p>It should be noted that a correctly documented informed consent for patients whose procedures will not be carried out in an operating room may not involve a “surgical consent form”; however, it does require informed consent be documented in the patient record.</p> <p>This event is intended to capture:</p> <ul style="list-style-type: none"> <li>• surgical procedures (whether or not completed) initiated on one patient</li> </ul>

<b>1. SURGICAL OR INVASIVE PROCEDURE EVENTS</b>		
<b>EVENT</b>	<b>ADDITIONAL SPECIFICATIONS</b>	<b>IMPLEMENTATION GUIDANCE</b>
Practices <ul style="list-style-type: none"> <li>• Long-term Care/Skilled Nursing Facilities</li> </ul>		intended for a different patient.  Use of accepted patient identification procedures is key to avoiding such events.
C. Wrong surgical or other invasive procedure performed on a patient  Applicable settings: <ul style="list-style-type: none"> <li>• Hospitals</li> <li>• Outpatient/Office-based Surgery Centers</li> <li>• Ambulatory Practice Settings/ Office-based Practices</li> <li>• Long-term Care/Skilled Nursing Facilities</li> </ul>	Defined as any surgical or other invasive procedure performed on a patient that is not consistent with the correctly documented informed consent for that patient.  Surgery or other invasive procedure includes, but is not limited to, endoscopies, lens implants, lesion removal, injection into joints.  Excludes emergent situations that occur in the course of surgery or other invasive procedures and/or whose exigency precludes obtaining informed consent.	It should be noted that a correctly documented informed consent for patients whose procedures will not be carried out in an operating room may not involve a “surgical consent form”; however, it does require informed consent be documented in the patient record.  This event is intended to capture: <ul style="list-style-type: none"> <li>• insertion of the wrong medical implant into the correct surgical site.</li> </ul> This event is not intended to capture: <ul style="list-style-type: none"> <li>• changes in plan upon entry into the patient with discovery of pathology in close proximity to the intended place where risk of a second surgery/ procedure outweighs benefit of patient consultation, or unusual physical configuration (for example adhesions, spine level/extra vertebrae).</li> </ul>
D. Unintended retention of a foreign object in a patient after surgery or other invasive procedure  Applicable settings: <ul style="list-style-type: none"> <li>• Hospitals</li> <li>• Outpatient/Office-based Surgery Centers</li> <li>• Ambulatory Practice</li> </ul>	Includes medical or surgical items intentionally placed by provider(s) that are unintentionally left in place.  Excludes a) objects present prior to surgery or other invasive procedure that are intentionally left in place; b) objects intentionally implanted as part of a planned intervention; and c) objects not present prior to	This event is intended to capture: <ul style="list-style-type: none"> <li>• occurrences of unintended retention of objects at any point after the surgery/procedure ends regardless of setting (post anesthesia recovery unit, surgical suite, emergency department, patient bedside) and regardless of whether the object is to be removed after discovery;</li> <li>• unintentionally retained objects (including such things as wound</li> </ul>

<b>1. SURGICAL OR INVASIVE PROCEDURE EVENTS</b>		
<b>EVENT</b>	<b>ADDITIONAL SPECIFICATIONS</b>	<b>IMPLEMENTATION GUIDANCE</b>
Settings/ Office-based Practices • Long-term Care/Skilled Nursing Facilities	surgery/procedure that are intentionally left in when the risk of removal exceeds the risk of retention (such as microneedles, broken screws).	packing material, sponges, catheter tips, trocars, guide wires) in all applicable settings.
E. Intraoperative or immediately postoperative/ postprocedure death in an ASA Class I patient  Applicable settings: • Hospitals • Outpatient/Office-based Surgery Centers • Ambulatory Practice Settings/ Office-based Practices	Includes all ASA Class I patient deaths in situations where anesthesia was administered; the planned surgical procedure may or may not have been carried out.  Immediately post-operative means within 24 hours after surgery or other invasive procedure was completed or after administration of anesthesia (if surgery/procedure not completed).	This event is intended to capture: • ASA Class I patient death associated with the administration of anesthesia whether or not the planned surgical procedure was carried out.

<b>2. PRODUCT OR DEVICE EVENTS</b>		
<b>EVENT</b>	<b>ADDITIONAL SPECIFICATIONS</b>	<b>IMPLEMENTATION GUIDANCE</b>
<p>A. Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting</p> <p>Applicable settings:</p> <ul style="list-style-type: none"> <li>• Hospitals</li> <li>• Outpatient/Office-based Surgery Centers</li> <li>• Ambulatory Practice Settings/ Office-based Practices</li> <li>• Long-term Care/Skilled Nursing Facilities</li> </ul>	<p>Includes contaminants in drugs, devices, or biologics regardless of the source of contamination and/or product.</p> <p>Includes threat of disease that changes patient's risk status for life requiring medical monitoring not needed before the event</p>	<p>This event is intended to capture:</p> <ul style="list-style-type: none"> <li>• contaminations that can be seen with the naked eye or with use of detection mechanisms in general use. These contaminations are to be reported at such time as they become known to the provider or healthcare organization. Contaminants may be physical, chemical, or biological in nature. Not all contaminations can be seen with the naked eye (e.g., hepatitis and HIV) or readily detected using generally available or more specialized testing mechanisms (e.g., cultures, nucleic acid testing, mass spectrometry, and tests that signal changes in pH or glucose levels). Contamination that is inferred and changes risk status for life (e.g., consider a syringe or needle contaminated once it has been used to administer medication to a patient by injection or via connection to a patient's intravenous infusion bag or administration set).</li> </ul> <p>This event is intended to capture:</p> <ul style="list-style-type: none"> <li>• administration of contaminated vaccine or medication (e.g., intramuscular antibiotic);</li> <li>• serious infection from contaminated drug or device used in surgery or an invasive procedure (e.g., a scalpel);</li> <li>• occurrences related to use of improperly cleaned or maintained device.</li> </ul>

<b>2. PRODUCT OR DEVICE EVENTS</b>		
<b>EVENT</b>	<b>ADDITIONAL SPECIFICATIONS</b>	<b>IMPLEMENTATION GUIDANCE</b>
<p>B. Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended</p> <p>Applicable settings:</p> <ul style="list-style-type: none"> <li>• Hospitals</li> <li>• Outpatient/Office-based Surgery Centers</li> <li>• Ambulatory Practice Settings/ Office-based Practices</li> <li>• Long-term Care/Skilled Nursing Facilities</li> </ul>	<p>Includes, but is not limited to, catheters, drains and other specialized tubes, infusion pumps, ventilators, and procedural and monitoring equipment.</p>	<p>This event is intended to capture:</p> <ul style="list-style-type: none"> <li>• occurrences whether or not the use is intended or described by the device manufacturers' literature.</li> </ul>
<p>C. Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting</p> <p>Applicable settings:</p> <ul style="list-style-type: none"> <li>• Hospitals</li> <li>• Outpatient/Office-based Surgery Centers,</li> <li>• Long-term Care/Skilled</li> <li>• Nursing Facilities</li> </ul>	<p>Excludes death or serious injury associated with neurosurgical procedures known to present a high risk of intravascular air embolism.</p>	<p>This event is intended to capture:</p> <ul style="list-style-type: none"> <li>• high-risk procedures, other than neurosurgical procedures, that include, but are not limited to, procedures involving the head and neck, vaginal delivery and caesarean section, spinal instrumentation procedures and liver transplantation;</li> <li>• low-risk procedures including those related to lines placed for infusion of fluids in vascular space.</li> </ul>

<b>3. PATIENT PROTECTION EVENTS</b>		
<b>EVENT</b>	<b>ADDITIONAL SPECIFICATIONS</b>	<b>IMPLEMENTATION GUIDANCE</b>
<p>A. Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person.</p> <p>Applicable settings:</p> <ul style="list-style-type: none"> <li>• Hospitals</li> <li>• Outpatient/Office-based Surgery Centers</li> <li>• Ambulatory Practice Settings/ Office-based Practices</li> <li>• Long-term Care/Skilled Nursing Facilities</li> </ul>		<p>The terms "authorized" and "decision-making capacity" are defined in the glossary. Release to "other than an authorized person" includes removing the patient/resident without specific notification and approval by staff even when the person is otherwise authorized.</p> <p>Examples of individuals who do not have decision-making capacity include: newborns, minors, adults with Alzheimer's.</p> <p>Individual healthcare organizations or other relevant jurisdictional authorities may have specific requirements for assessing decision-making capacity.</p>
<p>B. Patient death or serious injury associated with patient elopement (disappearance).</p> <p>Applicable settings:</p> <ul style="list-style-type: none"> <li>• Hospitals</li> <li>• Outpatient/Office-based Surgery Centers</li> <li>• Ambulatory Practice Settings/ Office-based Practices</li> <li>• Long-term Care/Skilled Nursing Facilities</li> </ul>	<p>Includes events that occur after the individual presents him/herself for care in a healthcare setting.</p> <p>Excludes events involving competent adults with decision-making capacity who leave against medical advice or voluntarily leave without being seen.</p>	<p>The term "elopement" and "competent" adult should be interpreted in accordance with prevailing legal standards in applicable jurisdictions.</p> <p>Of note, an assessment that identifies patients at 'risk' of elopement or a chief complaint and findings of risk accompanied by organizationally defined measures to be taken when risk is identified could be useful in both prevention and event analysis.</p> <p>This is not intended to capture:</p> <ul style="list-style-type: none"> <li>• death or serious injury that occurs (after the patient is located) due to circumstances unrelated to the elopement.</li> </ul>

<p>C. Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting</p> <p>Applicable settings:</p> <ul style="list-style-type: none"> <li>• Hospitals</li> <li>• Outpatient/Office-based Surgery Centers</li> <li>• Ambulatory Practice Settings/ Office-based Practices</li> <li>• Long-term Care/Skilled Nursing Facilities</li> </ul>	<p>Includes events that result from patient actions after they present themselves for care in a healthcare setting.</p> <p>Excludes deaths resulting from self-inflicted injuries that were the reason for admission/presentation to the healthcare facility.</p>	<p>This event is not intended to capture patient suicide or attempted suicide when the patient is not physically present in the “healthcare setting “as defined in the glossary.</p>
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<b>4. CARE MANAGEMENT EVENTS</b>		
<b>EVENT</b>	<b>ADDITIONAL SPECIFICATIONS</b>	<b>IMPLEMENTATION GUIDANCE</b>
<p>A. Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)</p> <p>Applicable settings:</p> <ul style="list-style-type: none"> <li>• Hospitals</li> <li>• Outpatient/Office-based Surgery Centers</li> <li>• Ambulatory Practice Settings/ Office-based Practices</li> <li>• Long-term Care/Skilled Nursing Facilities</li> </ul>	<p>Excludes reasonable differences in clinical judgment on drug selection and dose.</p> <p>Includes, but is not limited to, death or serious injury associated with a) over- or under-dosing; b) administration of a medication to which a patient has a known allergy or serious contraindication, c) drug-drug interactions for which there is known potential for death or serious injury, d) improper use of single-dose/single-use and multi-dose medication vials and containers leading to death or serious injury as a result of dose adjustment problems.</p>	<p>This event is intended to capture:</p> <ul style="list-style-type: none"> <li>• the most serious medication errors including occurrences in which a patient receives a medication for which there is a contraindication or a patient, known to have serious allergies to specific medications/ agents, receives those medications/ agents, resulting in serious injury or death. These events may occur as a result of failure to collect information about contraindications or allergies, failure to review such information available in information systems, failure of the organization to assure availability of such information and prominently display such information within information systems, or other system failures that are determined through investigation to be cause of the adverse event.</li> <li>• occurrences in which a patient dies or suffers serious injury as a result of failure to administer a prescribed medication;</li> <li>• occurrences in which a patient is administered an over- or under-dose of a medication including insulin, heparin, and any other high alert medication including but not limited to medications listed on the Institute for Safe Medication Practices “High Alert Medication List”;</li> <li>• occurrences in which a patient dies or suffers serious injury as a result of wrong administration technique.</li> </ul> <p>This event is not intended to capture:</p> <ul style="list-style-type: none"> <li>• patient death or serious injury associated with allergies that could not reasonably have been known or discerned in advance of the event.</li> </ul>

4. CARE MANAGEMENT EVENTS		
EVENT	ADDITIONAL SPECIFICATIONS	IMPLEMENTATION GUIDANCE
<p>B. Patient death or serious injury associated with unsafe administration of blood products</p> <p>Applicable settings:</p> <ul style="list-style-type: none"> <li>• Hospitals</li> <li>• Outpatient/Office-based Surgery Centers</li> <li>• Ambulatory Practice Settings/ Office-based Practices</li> <li>• Long-term Care/Skilled Nursing Facility</li> </ul>		<p>Unsafe administration includes, but is not limited to, hemolytic reactions and administering a) blood or blood products to the wrong patient; b) the wrong type; or c) blood or blood products that have been improperly stored or handled.</p> <p>This event is not intended to capture :</p> <ul style="list-style-type: none"> <li>• patient death or serious injury associated with organ rejection other than those attributable to a hyperacute hemolytic reaction</li> <li>• patient death or injury when cause is not detectable by ABO/HLA matching.</li> </ul>
<p>C. Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting</p> <p>Applicable settings:</p> <ul style="list-style-type: none"> <li>• Hospitals</li> <li>• Outpatient/Office-based Surgery Centers</li> </ul>	<p>Includes events that occur within 42 days post-delivery.</p> <p>Excludes deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy, or cardiomyopathy.</p>	<p>This event is not intended to create a new obligation. The organization's obligation is to report the event when made aware of the maternal death or serious injury either by readmittance or by the patient's family.</p>
<p>D. Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy</p> <p>Applicable settings:</p> <ul style="list-style-type: none"> <li>• Hospitals</li> <li>• Outpatient/Office-based Surgery Centers</li> </ul>	<p>Includes, for the office-based surgery, birthing center or "home" setting, unplanned admission to an inpatient setting within 24 hours of delivery</p>	<p>Unplanned admission to other than the birth setting should be verified with the identified birth setting.</p>

<b>4. CARE MANAGEMENT EVENTS</b>		
<b>EVENT</b>	<b>ADDITIONAL SPECIFICATIONS</b>	<b>IMPLEMENTATION GUIDANCE</b>
<p>E. Patient death or serious injury associated with a fall while being cared for in a healthcare setting</p> <p>Applicable settings:</p> <ul style="list-style-type: none"> <li>• Hospitals</li> <li>• Outpatient/Office-based Surgery Centers</li> <li>• Ambulatory Practice Settings/ Office-based Practices</li> <li>• Long-term Care/Skilled Nursing Facilities</li> </ul>	<p>Includes but is not limited to fractures, head injuries, and intracranial hemorrhage</p>	<p>Of note, an assessment that identifies patients at 'risk' of fall, findings of risk accompanied by organizationally defined measures to be taken when risk is identified could be useful in both prevention and event analysis.</p>
<p>F. Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting</p> <p>Applicable settings:</p> <ul style="list-style-type: none"> <li>• Hospitals</li> <li>• Outpatient/Office-based Surgery Centers</li> <li>• Long-term Care/ Skilled Nursing Facilities</li> </ul>	<p>Excludes progression from Stage 2 to Stage 3 if Stage 2 was recognized upon admission and excludes pressure ulcers that develop in areas where deep tissue injury is documented as present on admission/presentation.</p>	<p>Although this event could occur in the ambulatory surgery environment based on patient condition and surgery time, it will be difficult to discern. Pre- and post- skin assessment will be key.</p>

<b>4. CARE MANAGEMENT EVENTS</b>		
<b>EVENT</b>	<b>ADDITIONAL SPECIFICATIONS</b>	<b>IMPLEMENTATION GUIDANCE</b>
<p>G. Artificial insemination with the wrong donor sperm or wrong egg</p> <p>Applicable settings:</p> <ul style="list-style-type: none"> <li>• Hospitals</li> <li>• Outpatient/Office-based Surgery Centers</li> <li>• Ambulatory Practice Settings/ Office-based Practices</li> </ul>		<p>The organization's obligation is to report the event when made aware of the occurrence.</p>
<p>H. Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen.</p> <p>Applicable settings:</p> <ul style="list-style-type: none"> <li>• Hospitals</li> <li>• Outpatient/Office-based Surgery Centers</li> <li>• Ambulatory Practice Settings/ Office-based Practices</li> <li>• Long-term Care/Skilled Nursing Facilities</li> </ul>	<p>Includes events where specimens are misidentified, where another procedure cannot be done to produce a specimen</p> <p>Includes progression of an undiagnosed disease or threat of disease that changes the patient's risk status for life, requiring monitoring not needed before the event</p>	<p>This event is not intended to capture:</p> <ul style="list-style-type: none"> <li>• procedures where the specimen was properly handled, but the specimen proved to be nondiagnostic.</li> </ul> <p>Inability to secure a replacement for a lost specimen can occur with excisional biopsy as well as in organ removal.</p>

<b>4. CARE MANAGEMENT EVENTS</b>		
<b>EVENT</b>	<b>ADDITIONAL SPECIFICATIONS</b>	<b>IMPLEMENTATION GUIDANCE</b>
<p>I. Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results.</p> <p>Applicable settings:</p> <ul style="list-style-type: none"> <li>• Hospitals</li> <li>• Outpatient/Office-based Surgery Centers</li> <li>• Ambulatory Practice Settings/ Office-based Practices</li> <li>• Long-term Care/Skilled Nursing Facilities</li> </ul>	<p>Includes events where failure to report increased neonatal bilirubin levels result in kernicterus.</p>	<p>Examples of serious injury are a new diagnosis, or an advancing stage of an existing diagnosis (e.g., cancer).</p> <p>Failure to follow up or communicate can be limited to healthcare staff or can involve communication to the patient.</p>

<b>5. ENVIRONMENTAL EVENTS</b>		
<b>EVENT</b>	<b>ADDITIONAL SPECIFICATIONS</b>	<b>IMPLEMENTATION GUIDANCE</b>
<p>A. Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting</p> <p>Applicable settings:</p> <ul style="list-style-type: none"> <li>• Hospitals</li> <li>• Outpatient/Office-based Surgery Centers</li> <li>• Ambulatory Practice Settings/ Office-based Practices</li> <li>• Long-term Care/Skilled Nursing Facilities</li> </ul>	<p>Excludes events involving patients during planned treatments such as electric countershock /elective cardioversion.</p>	<p>This event is intended to capture:</p> <ul style="list-style-type: none"> <li>• patient death or injury associated with unintended electric shock during the course of care or treatment;</li> <li>• staff death or injury associated with unintended electric shock while carrying out duties directly associated with a patient care process, including preparing for care delivery.</li> </ul> <p>This event is not intended to capture:</p> <ul style="list-style-type: none"> <li>• patient death or injury associated with emergency defibrillation in ventricular fibrillation or with electroconvulsive therapies;</li> <li>• injury to staff who are not involved in patient care.</li> </ul>
<p>B. Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or is contaminated by toxic substances</p> <p>Applicable settings:</p> <ul style="list-style-type: none"> <li>• Hospitals</li> <li>• Outpatient/Office-based Surgery Centers</li> <li>• Ambulatory Practice Settings/ Office-based Practices</li> <li>• Long-term Care/Skilled Nursing Facilities</li> </ul>		<p>This event is intended to capture:</p> <ul style="list-style-type: none"> <li>• events in which the line is attached to a reservoir distant from the patient care unit or in a tank near the patient such as E-cylinders, anesthesia machines.</li> </ul>

<b>5. ENVIRONMENTAL EVENTS</b>		
<b>EVENT</b>	<b>ADDITIONAL SPECIFICATIONS</b>	<b>IMPLEMENTATION GUIDANCE</b>
<p>C. Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting</p> <p>Applicable settings:</p> <ul style="list-style-type: none"> <li>• Hospitals</li> <li>• Outpatient/Office-based Surgery Centers</li> <li>• Ambulatory Practice Settings/ Office-based Practices</li> <li>• Long-term Care/Skilled Nursing Facilities</li> </ul>		<p>This event is intended to capture burns that result from:</p> <ul style="list-style-type: none"> <li>• operating room flash fires, including second degree burn in these cases;</li> <li>• hot water;</li> <li>• sunburn in the patient with decreased ability to sense pain;</li> <li>• smoking in the patient care environment.</li> </ul>
<p>D. Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting</p> <p>Applicable settings:</p> <ul style="list-style-type: none"> <li>• Hospitals</li> <li>• Outpatient/Office-based Surgery Centers</li> <li>• Ambulatory Practice Settings/ Office-based Practices</li> <li>• Long-term Care/Skilled Nursing Facilities</li> </ul>		<p>The event is intended to capture:</p> <ul style="list-style-type: none"> <li>• instances where physical restraints are implicated in the death; e.g., lead to strangulation/entrapment, etc.</li> </ul>

<b>6. RADIOLOGIC EVENTS</b>		
<b>EVENT</b>	<b>ADDITIONAL SPECIFICATIONS</b>	<b>IMPLEMENTATION GUIDANCE</b>
<p>A. Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area</p> <p>Applicable settings:</p> <ul style="list-style-type: none"> <li>• Hospitals</li> <li>• Outpatient/Office-based Surgery Centers</li> <li>• Ambulatory Practice Settings/ Office-based Practices</li> </ul>	<p>Includes events related to material inside the patient's body or projectiles outside the patient's body.</p>	<p>This event is intended to capture injury or death as a result of projectiles including:</p> <ul style="list-style-type: none"> <li>• retained foreign object</li> <li>• external projectiles</li> <li>• pacemakers</li> </ul>

<b>7. POTENTIAL CRIMINAL EVENTS</b>		
<b>EVENT</b>	<b>ADDITIONAL SPECIFICATIONS</b>	<b>IMPLEMENTATION GUIDANCE</b>
<p>A. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider</p> <p>Applicable settings:</p> <ul style="list-style-type: none"> <li>• Hospitals</li> <li>• Outpatient/Office-based Surgery Centers</li> <li>• Ambulatory Practice Settings/ Office-based Practices</li> <li>• Long-term Care/Skilled Nursing Facilities</li> </ul>		<p>This event is intended to capture:</p> <ul style="list-style-type: none"> <li>• those without licensure to provide the care given;</li> <li>• those with licensure who represent themselves and act beyond the scope of their licensure.</li> </ul> <p>It is not intended to capture individuals who are practicing within the scope of their license whom patients or others mistakenly bestow titles beyond that scope when such is not encouraged by the provider.</p>

<b>7. POTENTIAL CRIMINAL EVENTS</b>		
<b>EVENT</b>	<b>ADDITIONAL SPECIFICATIONS</b>	<b>IMPLEMENTATION GUIDANCE</b>
<p>B. Abduction of a patient/resident of any age</p> <p>Applicable settings:</p> <ul style="list-style-type: none"> <li>• Hospitals</li> <li>• Outpatient/Office-based Surgery Centers</li> <li>• Ambulatory Practice Settings/ Office-based Practices</li> <li>• Long-term Care/Skilled Nursing Facilities</li> </ul>		<p>This event is intended to capture:</p> <ul style="list-style-type: none"> <li>• removal of a patient/resident, who does not have decisionmaking capacity, without specific notification and approval by staff even when the person is otherwise authorized to be away from the setting.</li> </ul> <p>Examples of individuals who do not have decisionmaking capacity include: newborns, minors, adults with Alzheimer's.</p>
<p>C. Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting</p> <p>Applicable settings:</p> <ul style="list-style-type: none"> <li>• Hospitals</li> <li>• Outpatient/Office-based Surgery Centers</li> <li>• Ambulatory Practice Settings/ Office-based Practices</li> <li>• Long-term Care/Skilled Nursing Facilities</li> </ul>		<p>Language and definitions may vary based on state statute; however, the principle and intent remain regardless of language required based on jurisdiction.</p>

<b>7. POTENTIAL CRIMINAL EVENTS</b>		
<b>EVENT</b>	<b>ADDITIONAL SPECIFICATIONS</b>	<b>IMPLEMENTATION GUIDANCE</b>
<p>D. Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting.</p> <p>Applicable settings:</p> <ul style="list-style-type: none"> <li>• Hospitals</li> <li>• Outpatient/Office-based Surgery Centers</li> <li>• Ambulatory Practice Settings/ Office-based Practices</li> <li>• Long-term Care/Skilled Nursing Facilities</li> </ul>		<p>Language and definitions may vary based on state statute (e.g., many states have existing statutes that use the terms “first degree assault” or “second degree assault” or “battery”).</p>

## Notice of Agency Rule-making Adoption

**AGENCY:**

Division of Licensing and Regulatory Services, Department of Health and Human Services

**CHAPTER NUMBER AND TITLE:** 10-144 C.M.R. Ch 114, Rules Governing the Reporting of Sentinel Events

**ADOPTED RULE NUMBER:**

(LEAVE BLANK - ASSIGNED BY SECRETARY OF STATE)

**CONCISE SUMMARY**

The rules replace the outdated 2007 NQF list of serious reportable events with the 2011 updated list published by the National Quality Forum (NQF). (See Appendix A of the rules.) The Maine rules governing the reporting of sentinel events incorporate by reference the National Quality Forum (NQF) list of serious reportable events. The 2011 NQF list includes the following changes:

1. A NEW category is added to the NQF list: “Radiologic Events” is now Category 6;
  2. A NEW event is added at Category 1E: patient death associated with the administration of anesthesia;
  3. The event in Category 3A is expanded to include the discharge or release (to other than an authorized person) of a person “of any age who is unable to make decisions” (the word “infant” is deleted);
  4. The event in Category 3C is expanded to include “self-harm” (Patient suicide, attempted suicide or self-harm);
  5. A number of changes are made to Category 4 including the following: three events in the 2007 list are not in the 2011 list (deletes hypoglycemia, hyperbilirubinemia, and spinal manipulative therapy); there are three NEW events (4D: death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy; 4H: death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen; and 4I: death or serious injury resulting from failure to follow up or communicate laboratory pathology or radiology test results);
  6. An event was moved out of Category 5 and into Category 4E (death or serious injury associated with a fall); and
  7. An event in Category 7C is expanded to include the underlined words: (Sexual abuse/assault on a patient or staff member).
- The definitions of “Serious” and “Surgery” have been updated for consistency with the 2011 NQF events. See Sections 1.24 and 1.27.
  - The department also made non-substantive changes to this rule including: [1] implementing the federal change of the term ICF/MR (Intermediate Care Facilities for Persons with Mental Retardation) to ICF/IID (Intermediate Care Facility for Individuals who are Intellectually Disabled); and [2] updated reference to the 2011 NQF list of serious reportable events. See Sections 1.8.4 and 1.22.4.

**EFFECTIVE DATE:** February 1, 2013

**AGENCY CONTACT PERSON: AGENCY NAME: ADDRESS TELEPHONE:**

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DATE: January 24, 2013

TO: Interested Parties

FROM: Kenneth Albert, RN, Esq., Director, Division of Licensing and Regulatory Services

SUBJECT: Adopted Rules Governing the Reporting of Sentinel Events, 10-144 C.M.R. Ch 114.  
**Effective Date: February 1, 2013**

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The adopted amendments replace the outdated 2007 NQF list of serious reportable events with the 2011 updated list published by the National Quality Forum (NQF). (See Appendix A of the rules).

- The 2011 NQF list includes the following changes:
  - [1] A NEW category is added to the NQF list: “Radiologic Events” is now Category 6;
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  - [3] The event in Category 3A is expanded to include the discharge or release (to other than an authorized person) of a person “of any age who is unable to make decisions” (the word “infant” is deleted);
  - [4] The event in Category 3C is expanded to include “self-harm” (Patient suicide, attempted suicide or self-harm);
  - [5] A number of changes are made to Category 4 including the following: three events in the 2007 list are not in the 2011 list (deletes hypoglycemia, hyperbilirubinemia, and spinal manipulative therapy); there are three NEW events (4D: death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy; 4H: death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen; and 4I: death or serious injury resulting from failure to follow up or communicate laboratory pathology or radiology test results);
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- The definitions of “Serious” and “Surgery” have been updated for consistency with the 2011 NQF events. See Sections 1.24 and 1.27.
- The department also made non-substantive changes to this rule including: [1] implementing the federal change of the term ICF/MR (Intermediate Care Facilities for Persons with Mental Retardation) to ICF/IID (Intermediate Care Facility for Individuals who are Intellectually Disabled); and [2] updated reference to the 2011 NQF list of serious reportable events. See Sections 1.8.4 and 1.22.4.

The adopted rule is posted at <http://www.maine.gov/dhhs/dlrs/rulemaking/adopted.shtml> Call (207) 287-9300 to have a paper copy of the rule mailed to you.