Maine Sentinel Event Notification and Near Miss Reporting Form

This form is required pursuant to 22 MRSA, Chapter 1684, and 10-44 CMR Chapter 114, Rules Governing the Reporting of Sentinel Events

Use this form to report a sentinel event or a near miss. Forward the completed form to the Sentinel Event Program confidential fax number (207) 287-3251.

1. What is being reported?

   ☐ Sentinel Event
   ☐ Near Miss

2. Today's Date: _____
   Date of Discovery: _____
   Date of Event: _____
   Time of Event: _____ AM/PM
   Date of Death (if applicable): _____

3. Patient Age: _____ ☐ M ☐ F Admitting Diagnosis: _____

4. Briefly describe the event including location: _____

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5. What type of event is being reported? Check all that apply

   ☐ Unanticipated Death
   ☐ Unanticipated Perinatal Death
   ☐ Suicide within 48 Hrs. of Discharge
   ☐ Major Permanent Loss of Function in perinatal infant
   ☐ Major Permanent Loss of Function present at discharge

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6. Unanticipated Death or Major Permanent Loss of Function within 48 hours of treatment? ☐ Y ☐ N

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7. Unanticipated patient transfer to another facility? ☐ Y ☐ N

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8. Does this event meet NQF criteria? ☐ Y ☐ N (*If yes, continue on back – check all that apply*)

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9. Autopsy Requested ☐Y ☐N Autopsy Performed ☐Y ☐N
   Medical Examiner Called ☐Y ☐N Medical Examiner Accepted Case ☐Y ☐N

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10. Was equipment e.g., IV pump, medication vials, sequestered? ☐ N/A ☐N ☐Y Specify: _____

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11. Reporter's Name: _____ Title: _____

    Telephone Number: _____ E-mail Address: _____

    Facility Name: _____

State notification of a Sentinel Event is required within one (1) business day of discovery.
Do not delay notification, for any reason, including pending autopsy or Medical Examiner results.

SENTINEL EVENT HOTLINE (207) 287-5813

This information is protected from public disclosure

NATIONAL CONSENSUS EVENTS
NATIONAL QUALITY FORUM SERIOUS REPORTABLE EVENTS

Surgical or Invasive Events
☐ Surgery or other invasive procedure performed on the wrong site
☐ Surgery or other invasive procedure performed on the wrong patient
☐ Wrong surgical or other invasive procedure performed on a patient
☐ Unintended retention of a foreign object in a patient after surgery or other invasive procedure
☐ Intraoperative or immediately postoperative/post-procedure death in an American Society of Anesthesiologists Class I patient
Product or device events
☐ Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting
☐ Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used for functions other than as intended
☐ Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting
Patient Protection Events
☐ Discharge or release of a patient of any age, who is unable to make decisions, to other than an authorized person
☐ Patient death or serious injury associated with patient elopement (disappearance)
☐ Patient suicide, attempted suicide or self-harm resulting in serious injury, while being cared for in a healthcare setting
Care management events
☐ Patient death or serious injury associated with a medication error (eg, errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)
☐ Patient death or serious injury associated with unsafe administration of blood products
☐ Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting
☐ Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy
☐ Patient death or serious injury associated with a fall while being cared for in a healthcare setting
☐ Stage 3 or 4 pressure and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting
☐ Artificial insemination with the wrong donor sperm or wrong egg
☐ Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen
☐ Patient death or serious injury resulting from failure to follow up on or communicate laboratory, pathology or radiology test results
Environmental Events
☐ Patient or staff death or serious injury with an electric shock in the course of a patient care process in a healthcare setting
☐ 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
☐ Patient or staff death or serious injury associated with a burn incurred from any source while being cared for in a healthcare setting
☐ Patient death or serious injury associated with the use physical restraints or bedrails while being cared for in a healthcare setting
Radiologic Events
☐ Death or serious injury of a patient or staff associated with the introduction of a metal object into the MRI area
Potential Criminal Events
☐ Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider
☐ Abduction of a patient/resident of any age
☐ Sexual abuse/assault on a patient or staff member within or on the grounds of the healthcare setting
☐ Death or serious injury of a patient or staff member resulting from a physical assault (ie, battery) that occurs within or on the grounds of the healthcare setting