



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 ☐ Major Permanent Loss of Function in perinatal infant
☐ Unanticipated Perinatal Death ☐ Major Permanent Loss of Function present at discharge
☐ Suicide within 48 Hrs. of Discharge
-
6. Unanticipated Death or Major Permanent Loss of Function within 48 hours of treatment? ☐ Y ☐ N
-
7. Unanticipated patient transfer to another facility? ☐ Y ☐ N
-
8. Does this event meet NQF criteria? ☐ Y ☐ N (If Yes, continue on back – check all that apply)
-
9. Autopsy Requested ☐ Y ☐ N Autopsy Performed ☐ Y ☐ N
Medical Examiner Called ☐ Y ☐ N Medical Examiner Accepted Case ☐ Y ☐ N
-
10. Was equipment e.g., IV pump, medication vials, sequestered? ☐ N/A ☐ N ☐ Y Specify: _____
-
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