§8753. Mandatory reporting of sentinel events

A health care facility shall notify the division whenever a sentinel event has occurred, as provided in this chapter. [PL 2009, c. 358, §2 (AMD).]

1. Notification. A health care facility shall notify the division of a sentinel event 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 the date and time of notification, the name of the health care facility and the type of sentinel event pursuant to section 8752, subsection 4-A.
[PL 2009, c. 358, §2 (AMD).]

2. Reporting. The health care facility shall file a written report no later than 45 days following the notification of the occurrence of a sentinel event pursuant to subsection 1. The written report must be signed by the chief executive officer of the facility and must contain the following information:

A. Facility name and address; [PL 2001, c. 678, §1 (NEW); PL 2001, c. 678, §3 (AFF).]

B. Name, title and phone number of the contact person for the facility; [PL 2001, c. 678, §1 (NEW); PL 2001, c. 678, §3 (AFF).]

C. The date and time of the sentinel event; [PL 2001, c. 678, §1 (NEW); PL 2001, c. 678, §3 (AFF).]

D. The type of sentinel event and a brief description of the sentinel event; and [PL 2009, c. 358, §2 (AMD).]

E. [PL 2009, c. 358, §2 (RP).]

F. [PL 2009, c. 358, §2 (RP).]

G. [PL 2009, c. 358, §2 (RP).]

H. A thorough and credible root cause analysis. A root cause analysis is thorough and credible only in accordance with the following.

(1) A thorough root cause analysis must include: a determination of the human and other factors most directly associated with the sentinel event and the processes and systems related to its occurrence; an analysis of the underlying systems and processes to determine where redesign might reduce risk; an inquiry into all areas appropriate to the specific type of event; an identification of risk points and their potential contributions to the event; 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; an action plan that identifies changes that can be implemented to reduce risks or formulates a rationale for not undertaking such changes; and, 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.

(2) A credible root cause analysis must include participation by the leadership of the health care facility and by the individuals most closely involved in the processes and systems under review, is internally consistent without contradictions or unanswered questions, provides an explanation for all findings, including those identified as "not applicable" or "no problem," and includes the consideration of any relevant literature.

(3) The root cause analysis submitted to the division may exclude protected professional competence review information pursuant to the Maine Health Security Act. [PL 2009, c. 358, §2 (NEW).]

[PL 2009, c. 358, §2 (AMD).]

3. Cooperation. A health care facility that has filed a notification or a report of the occurrence of a sentinel event under this section shall cooperate with the division as necessary for the division to fulfill its duties under section 8754.
[PL 2001, c. 678, §1 (NEW); PL 2001, c. 678, §3 (AFF).]

4. Immunity. A person who in good faith reports a near miss, a suspected sentinel event or a sentinel event or provides a root cause analysis pursuant to this chapter is immune from any civil or criminal liability for the act of reporting or participating in the review by the division. "Good faith" does not include instances when a false report is made and the person reporting knows the report is false. This subsection may not be construed to bar civil or criminal action regarding perjury or regarding the sentinel event that led to the report.
[PL 2009, c. 358, §2 (AMD).]

5. Near miss notification. A health care facility may notify the division of the occurrence of a near miss. Should a facility report a near miss, the notification must include the date and time of notification, the name of the health care facility and the type of event or situation pursuant to section 8752, subsection 4-A that is related to the near miss.
[PL 2009, c. 358, §2 (NEW).]

SECTION HISTORY

PL 2001, c. 678, §1 (NEW). PL 2001, c. 678, §3 (AFF). PL 2009, c. 358, §2 (AMD).