Medical Center Policy 300 - Attachment C

Page

1

1

Of

Critical Clinical Event

An unexpected occurrence that in the judgment of the Chief Executive Officer or designee, Chief Medical Officer, Chief Nursing Officer, Chief Quality Officer, Patient Safety Officer, or Director of Risk Management requires immediate investigation. A list of Critical Clinical Events, although not comprehensive is included below.

- An unanticipated death*, including but not limited to:
 - Any patient death, including those associated with adverse medication reaction or error, fall, heath care-acquired infection, and/or procedures.
 - Unanticipated perinatal death unrelated to a congenital condition in an infant weighing greater than 2500 grams
 - Intrapartum maternal death related to the birth process
- A major permanent loss of function*, including but not limited to:
 - o Development of a neurologic deficit not present on admission, including coma, paralysis, nerve damage, blindness, related or unrelated to medical or surgical procedures
 - Adverse medication reaction resulting in permanent disability
 - Heath care-acquired infection resulting in permanent disability
 - Birth trauma (e.g., Erb's palsy)
 - Unanticipated medical and/or surgical complications causing disability
 - Birth/ brain injuries unrelated to a congenital condition
- Medical/ Surgical intervention on the wrong patient, wrong body side, or wrong organ*
- Unplanned removal of an organ during surgery
- Pathology/Tissue mismatch resulting in undiagnosed cancer or delay in diagnosis of cancer
- Unplanned foreign bodies left in patients
- Procedures performed by unlicensed staff
- Accidental burns
- Hemolytic transfusion reactions involving major blood group incompatibility*
- Admission as a result of an adverse occurrence in the outpatient setting
- Significant equipment related injury
- Infant abduction or discharge to the wrong family*
- A patient suicide* in a setting where the patient is housed around the clock
- A patient elopement* from an around the clock setting, resulting in a temporally related death (suicide or homicide), or major permanent loss of function
- Rape by another patient or staff*
- Staff sexual misconduct with a patient
- Jail/custody cases (e.g., alleged civil rights violations, alleged discrimination)
- Intrafacility/interfacility transfers resulting in disability or death
- Significant patient dissatisfaction
- Major disease outbreaks
- Other significant clinical events that may subject the DHS to adverse publicity or liability
 - *May be a sentinel event and must be evaluated by the Chief Executive Officer or designee.

REVISED

February 27, 2023; April 8, 2024