1. **Policy Purpose**

1.1. To have a positive impact in improving patient care, treatment, and services and preventing sentinel events.

1.2. To focus the attention of an organization that has experienced a sentinel event on understanding the causes that underlie the event, and on changing the organization’s systems and processes to reduce the probability of such an event in the future.

1.3. To increase the general knowledge about sentinel events, their causes, and strategies for prevention.

1.4. To maintain the confidence of the public and accredited organizations in the accreditation process.

2. **Policy Statement**

2.1. It is mandatory of all healthcare facilities (governmental and private) to report sentinel events to National Health Regulatory Authority (NHRA) based on circular (1) issued by the Supreme Council of Health.

2.2. This policy and procedure guidelines define the process for identification, reporting for sentinel events to the National Health Regulatory Authority in Kingdom of Bahrain.

3. **Definitions**

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tr>
<td>Sentinel events</td>
<td>Any unanticipated occurrence involving death, serious physical or psychological injury or risk thereof to a patient not arising from the natural course of the patient’s illness.</td>
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<td>Risk thereof</td>
<td>Includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.</td>
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<td>Adverse Event</td>
<td>Serious incidents, therapeutic misadventures, iatrogenic injuries, or other adverse occurrences directly associated with care or services provided.</td>
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4. **Areas of responsibility**
   4.1. All healthcare facilities (governmental and private).

5. **Sentinel events include:**
   5.1. Unexplained or unexpected death.
   5.2. Major permanent loss of function not related to the natural course of the patient's illness or underlying condition.
   5.3. Confirmation of transfusion reaction
   5.4. Significant medication error
   5.5. Significant adverse anesthesia event
   5.6. Suicide of a patient receiving care, treatment, or services in a staffed around-the-clock care setting or within 72 hours of discharge
   5.7. Unanticipated death of a full-term infant.
   5.8. Surgery on the wrong side of the patient’s body
   5.9. Surgery on the wrong patient
   5.10. Retention of a foreign object in a patient’s body after an intervention.
   5.11. Suspected criminal acts

6. **Procedures**
   6.1. When a sentinel event occurs at the health care facility, the director of the facility or designee should notify the NHRA within 24 hours from the date of the event using the Sentinel Event Reporting Form through email (incidents@nhrs.bh).
   6.2. The notification should be supported with the following documents which should be forwarded to NHRA within five working days:
       6.2.1. Copy of the medical record
       6.2.2. Copy of radiological images
       6.2.3. Statements from the concerned professionals’ involved/in charge of the patient.
       6.2.4. Copy of investigation report(s) from the facility/related policy(s).

7. **Role of NHRA after receiving the notification**
   7.1. NHRA will investigate the case and notify the healthcare facility accordingly.
   7.2. In cases where misconduct is suspected, further proceedings may be initiated by NHRA against the concerned professionals.
7.3. Should there be comments of recommendations for improvement of the condition leading the sentinel event, these will be communicated to the concerned healthcare facility directly.

7.4. NHRA will keep a record of all sentinel events received, investigation reports, and any other documents related to the reported incidents.