Sentinel Events

2025 Annual Report

1/1/2024 to 12/31/2024

Required by:

2 §8754 (4); PL 2009, c. 358

Submitted on June 5, 2026

Submitted by:
Maine Department of Health and Human Services
Maine Center for Disease Control and Prevention

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Executive Summary

When the Institute of Medicine published *To Err is Human* more than twenty-five years ago, the report drew national attention to the problem and prevalence of medical errors and underscored the importance of patient safety. In the years since its publication, patient safety research, reporting systems, and hospital programs focused on measurement and accreditation have evolved significantly.(1) Maine has taken an active role in advancing patient safety through its requirement for mandatory reporting of sentinel events (22 M.R.S.A. §§8751-8756) for hospitals, ambulatory surgical centers (ASCs), end stage renal disease facilities (ESRDs), and intermediate care facilities for individuals with intellectual disabilities (ICF/IID). Since 2004, these facilities have been required to report all sentinel events to the Sentinel Events Team (SET), with the goal of improving the quality of healthcare and increasing patient safety throughout the state. In 2025 a statutory change resulted in ICF/IIDs no longer being required to report sentinel events. The Sentinel Event Program provides a structured approach to understanding the underlying causes of sentinel events, which can lead to system and process changes that reduce the likelihood of future occurrences. The SET, part of the Division of Licensing and Certification (DLC), is responsible for overseeing the Sentinel Event Program.

The Sentinel Event Statute and Rules have several requirements, including the collection of data regarding sentinel events and sharing aggregated data with the Legislature and the public. This annual report provides information related to the number and types of sentinel events that were reported in 2025, as well as the actions taken by facilities to prevent future occurrences and to mitigate the harm caused by similar events. However, the work of the SET goes well beyond these data collection and reporting requirements. The SET provides extensive technical assistance to reporting facilities, providing guidance on understanding sentinel events and identifying their root causes. The SET has established relationships with reporting facilities, which promotes communication and interactions related to serious adverse events. A key feature of the Sentinel Events Program is the confidentiality outlined by statute, which protects sentinel event information from discovery, allowing reporting facilities to complete the system-wide investigations necessary to truly understand the causal factors of sentinel events.

The SET continues to publish a quarterly newsletter that focuses on key patient safety issues identified by reporting facilities in the state, as well as those issues that have been identified nationally. The newsletters include information and links to tools that are available to facilities as a means of assisting in the promotion of their patient safety programs.

[1] Two Decades Since To Err is Human: An Assessment of Progress and Emerging Priorities in Patient Safety, Bates and Singh, Health Affairs, November 2018

How to Use this Report

The Maine Sentinel Event Annual Report is one of many sources of information available to the public related to health care quality and patient safety. It is designed to provide an overview of the Sentinel Event Program, including background information regarding the program, review of SET activities, reporting of aggregated data and trends, and plans for the upcoming year.

The fact that health care providers are identifying and reporting potential adverse events to learn and to prevent harm to patients is a positive step in the work of improving patient safety. The sentinel event data listed in this report reflects organizational transparency in addressing patient safety issues. Consumers are discouraged from reaching conclusions about the safety of patient care in Maine healthcare facilities based only on the data included in this report. Consumers are encouraged to talk with their healthcare providers about questions or concerns related to patient safety, and to be active participants in their own health care.

The events listed in this report represent a very small fraction of all the health care services provided in Maine facilities. The number of reported events can fluctuate at a facility for a variety of reasons. The size of the facility, the volume of services, and the type and complexity of procedures will influence the number of events. The number of reported events will also be higher from facilities that are especially vigilant about identifying and reporting errors. This heightened vigilance helps foster an organizational culture wherein staff members feel comfortable reporting patient safety concerns without fear of reprisal. Health care facilities that embrace this safety-focused culture look at adverse events as opportunities to learn and improve.

Information regarding health care quality and safety is available from several organizations dedicated to promoting patient safety. A listing of some of these resources is provided in Appendix D of this report.

Background

Maine's Sentinel Event Program was established in 2002 with enactment of Public Law 2001, Chapter 678 to create a system for reporting all sentinel events, with the goal of improving the quality of health care and increasing patient safety throughout the state. Beginning in 2004, mandated reporting of sentinel events has been required of hospitals and ambulatory surgical centers (ASC), end stage renal disease facilities (ESRD), and intermediate care facilities for individuals with intellectual disabilities (ICF/IID facilities).

This report is submitted in accordance with Maine law (22 M.R.S.A. §§8751-8756) that requires that an annual report be provided to the Legislature, health care facilities, and the public on the aggregate number and type of sentinel events for the prior calendar year, rates of change, causative factors, and activities to strengthen patient safety in Maine.

This report is designed to:

- Build awareness of Maine's sentinel event reporting requirements and the follow-up process used by facilities and the SET when events occur;
- Provide aggregated data and information about the number and nature of sentinel events reported;
- Identify patterns and make recommendations to improve the quality and safety of patient care;
- Describe efforts to address underreporting;
- Review efforts to enhance the role of sentinel event reporting in improving patient safety; and
- Maintain best practice reporting by updating event criteria to current national standards.

Maine, along with all other New England states, is among the more than 30 states and the District of Columbia that have prioritized improvements in patient safety by implementing a sentinel event reporting program. Maine uses state-identified sentinel event criteria as well as the National Quality Forum's (NQF) list of serious reportable events. Appendix A contains the Maine-specific and NQF definitions of mandatory reportable sentinel events.

The Joint Commission, a health care accrediting agency for nearly 15,000 healthcare organizations, has been collecting sentinel event reports since 1995. This is a voluntary reporting program.

The Leapfrog Group, is a voluntary program, "aimed at mobilizing employer purchasing power to alert America's health industry that big leaps in health care safety, quality and customer value will be recognized and rewarded." The Leapfrog Hospital Survey compares hospitals' performance on the national standards of safety, quality, and efficiency that are deemed most relevant to consumers and purchasers of care. The survey is the only nationally standardized and endorsed set of measures that captures hospital performance in patient safety, quality and resource utilization. Leapfrog's Hospital Safety Score® assigns A, B, C, D and F grades to nearly 3,000 U.S. hospitals based on their ability to prevent errors, accidents, injuries, and infections. The Hospital Safety Score is calculated by top patient safety experts, peer reviewed, fully transparent, and free to the public. In 2025, Maine was ranked 18th in the Spring and 9th in the Fall among hospitals nationwide.

The Centers for Medicare and Medicaid Services (CMS) has a consumer-oriented website that helps individuals learn about hospital quality and safety measures. Quality measures are used to generate an overall score or "star rating" among various healthcare organizations including ASCs, ESRDs, and hospitals. In addition to patient satisfaction, these measures include information about patient safety, including complications and deaths and unplanned returns to the hospital.

Reporting Requirements

The Maine Sentinel Event Program receives the authority to carry out its activities from M.R.S.A. Title 22, Chapter 1684, §8754, Division Duties. This statute establishes a system for reporting sentinel events for the purpose of improving the quality of health care and increasing patient safety.

Notification: Facilities must notify the SET within three business days of discovering a possible sentinel event. The SET determines whether the incident conforms to the statutory definition of a sentinel event. Upon confirmation by the SET that the event meets the sentinel event criteria, the facility is required to submit a brief description of the incident to the SET. A copy of the notification form used by facilities can be found in Appendix A.

Root Cause Analysis: Facilities are required to conduct a root cause analysis after every sentinel event. A root cause analysis is a systematic approach to problem solving that identifies the causal factors related to an adverse event. The SET does not dictate how facilities conduct or record root cause analyses. The Joint Commission and the Veterans Administration have developed root cause analysis forms and processes that are available for healthcare facilities to use, without charge.

To be acceptable to the SET, root cause analyses must be both *thorough* and *credible*. For purposes of the Sentinel Event Program, these terms are defined as follows:

A *thorough* root cause analysis includes at least the following information:

- 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;
- 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 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.

A *credible* root cause analysis meets the following criteria:

- It includes participation by the leadership of the healthcare facility and by the individuals most closely involved in the processes and systems under review;
- It is internally consistent (that is, it does not contradict itself or leave obvious questions unanswered);
- It provides an explanation for all findings, including those identified as “not applicable” or “no problem;” and
- It includes the consideration of any relevant literature.

The root cause analysis report, including action plans, must be sent to the SET within 45 days of discovery of the sentinel event. The facility’s Chief Executive Officer (CEO) is required to sign this report to ensure their active engagement in understanding factors leading to the event and plans for mitigating its recurrence.

Once received, the SET reviews the report to determine that a thorough and credible evaluation was performed, and that appropriate action plans were developed with assigned responsibilities and timelines for their implementation. Reports that are incomplete are returned to the facility by the SET. The SET may provide technical assistance to facilities in discussing sentinel events, but it is the responsibility of the facility to conduct a thorough and credible root cause analysis. Once an acceptable report is received, the SET sends an acceptance letter to the facility's CEO. A flow chart diagramming the sentinel event case review process can be found in Appendix B.

A facility that knowingly violates any provision of the notification and/or the reporting requirements is subject to a financial penalty of up to $10,000.

The SET utilizes a confidential, secure database to gather and track information collected on reported events, their associated root causes, and applicable action plans. This database provides a management system for tracking events and incoming reports and is the primary source for the SET's data and reports. The sentinel event management system helps the SET identify patterns or trends in the frequency of sentinel events and common factors associated with events.

The SET provides facilities with facility-specific sentinel event data, which can be helpful in identifying ongoing issues. Aggregated data is made available in the Sentinel Event Annual Report. Deidentified root causes and action plans may be used by the SET for educational purposes.

Not all events reported to the SET meet the definition of a sentinel event. The SET will notify a facility if the reported event does not constitute a sentinel event. Facilities are encouraged, although not required, to report a "near miss." Conducting a root cause analysis of a "near miss" can help identify systems issues that, if not addressed, could result in a sentinel event in the future. The root cause and action plans from these near-miss reviews are entered into the database for educational purposes.

Annually, all covered facilities must provide the SET with a written attestation that contains an affirmative statement that it reported all sentinel events that occurred in the prior calendar year.

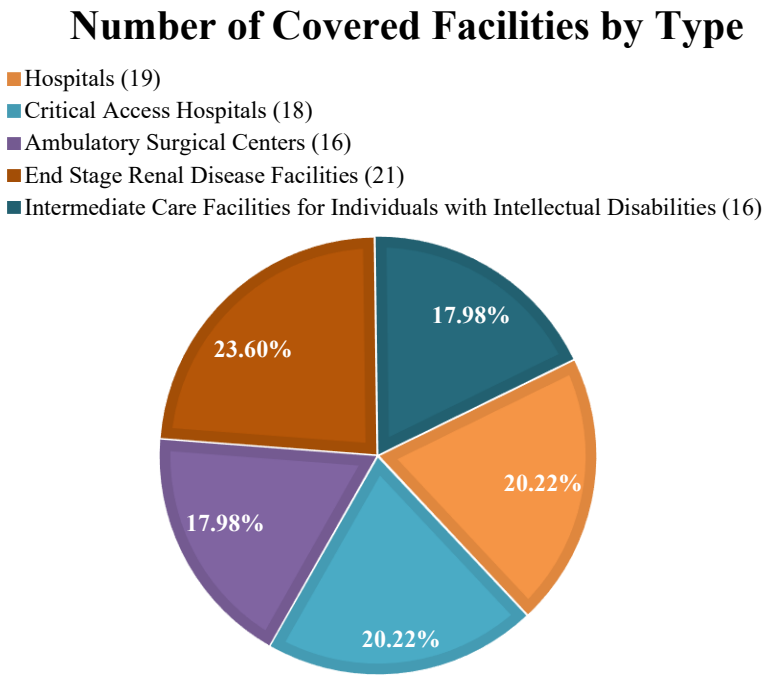
Confidentiality Provisions

By law, all sentinel event information submitted to the SET is considered privileged and confidential. No information about reporting facilities or providers is discoverable or made public. A firewall is maintained between the Sentinel Event Program and DLC licensing and certification programs. The only time that the SET is permitted to share information with DLC licensing and certification staff is when a reported sentinel event represents immediate jeopardy to the public. Immediate jeopardy is defined as a failure on the part of a healthcare facility and/or provider to comply with the Conditions of Participation for the Medicare and Medicaid certification program that has caused, or is likely to cause, serious injury, harm, impairment, or death to a patient.

Covered Facilities

In 2025, Maine initially had 90 health care facilities that were responsible for reporting sentinel events. Table 1 shows the distribution of covered facilities by type.

Table 1 Distribution of Covered Facilities in 2025



Reports by Facility Type

At the beginning of 2025, the Sentinel Event Program covered 90 facilities. By the end of 2025, 73 facilities were covered. One hospital closed, one ambulatory surgical centers (ASC) closed and one ASC opened, and statute changes included intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs) no longer reporting sentinel events. Of the 90 facilities initially covered, 40 (44 percent), reported sentinel events during 2025, which represents a 4 percent increase from 2024. Sentinel event reports were received from 33 (89 percent) Maine hospitals. An additional 3 hospitals that did not report sentinel events, reported "near miss" and/or non-reportable cases. Including these reports, 97 percent of hospitals reported a sentinel event, "near miss," or non-reportable event.

There were 262 sentinel events reported in 2025. Of the total, 250 were reported by hospitals, 10 were reported by ASCs, two were reported by end stage renal disease facilities (ESRD) facilities, and none were reported by an ICF/IID facility. 2 ICF/IIDs reported either a "near miss" or non-reportable case, 1 ASC that did not report a SE reported either a "near miss" or non-reportable case, 3 ESRDs that did not report a SE reported non-reportable cases. Forty-two (47 percent) facilities reported either a SE, "near miss," or non-reportable case to the SET in 2025. The SET encourages reporting if there is a question about whether an event meets criteria as a sentinel event; there is no penalty for reporting cases that are deemed to be non-reportable or a "near miss."

Table 2. Sentinel Events Reported by Facility Type 2025

Facility Type	Total Events Reported	Percent of All Events Reported
Hospitals	250	95.4%
Ambulatory Surgical Centers	10	3.8%
End Stage Renal Disease Facilities	2	0.7%
Intermediate Care Facilities for Individuals with Intellectual Disabilities	0	0%
Total	**262**	

Sentinel Events

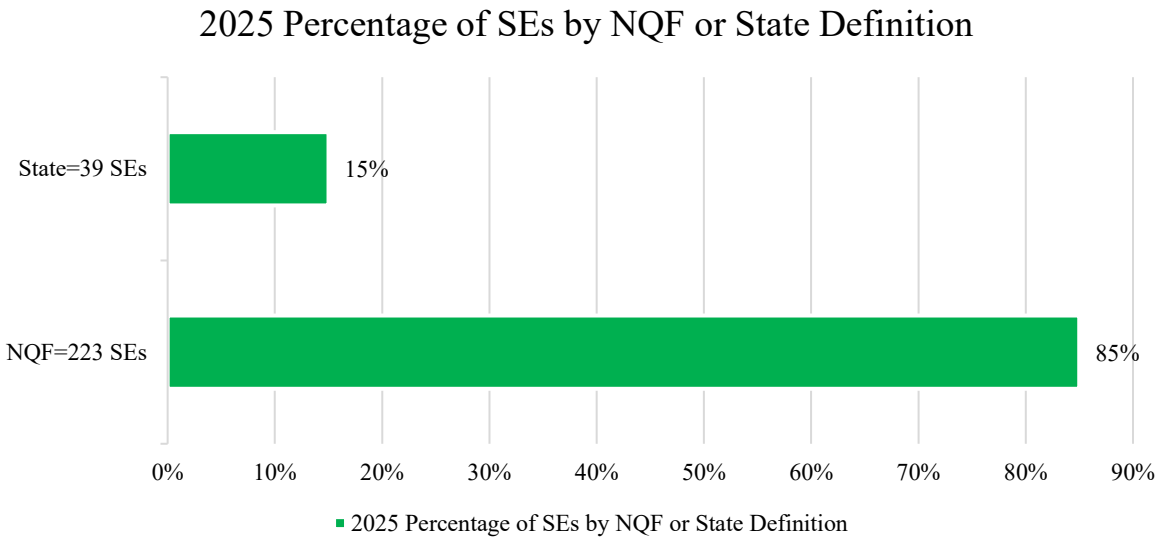
A total of 3,930 sentinel events have been reported to the SET since 2004, when the facilities covered began reporting. Few facilities reported sentinel events between 2004 and 2008. The SET engaged in outreach efforts to ensure that all facilities had a heightened awareness of the requirement to report, resulting in some increase in reporting, starting in 2008.

In 2010, the entire list of the National Quality Forum's (NQF) Serious Reportable Events was formally adopted as part of statutory changes. These events are sometimes referred to as "never events" because they represent situations that should never occur in healthcare facilities. The NQF Serious Reportable Events are structured around seven categories: Surgical, product or device, patient protection, care management, environmental, radiologic, and potentially criminal. This expansion of reporting requirements to include additional types of events resulted in a significant increase in the volume of reporting in 2010. The NQF Serious Reportable Events list underwent revision, and an updated list and guidance were published in January 2026. Sentinel Event rule revisions are underway as of the writing of this report and the updated NQF list will not be able to be implemented until those revisions are completed.

The inclusion of the NQF list was significant in that Maine providers were then required to utilize nationally recognized definitions for reportable events. The NQF is a consensus-driven, public-private partnership aimed at developing common approaches to identifying events that are serious in nature and have been determined to be largely preventable. The NQF list increasingly has become the basis for states' mandatory reporting systems. The list of NQF Serious Reportable Events is intended to capture events that are clearly identifiable, measurable, largely preventable, and of interest to the public and other stakeholders.

Comparability of definitions enhances clarity about what must be reported and provides benchmarks for comparing experiences across states. The primary goals are to prevent harm and enhance public trust. In 2025, 85 percent of the sentinel events reported conformed with the NQF definitions and 15 percent were based on State definitions.

Table 3. NQF or State Definition Distribution 2025

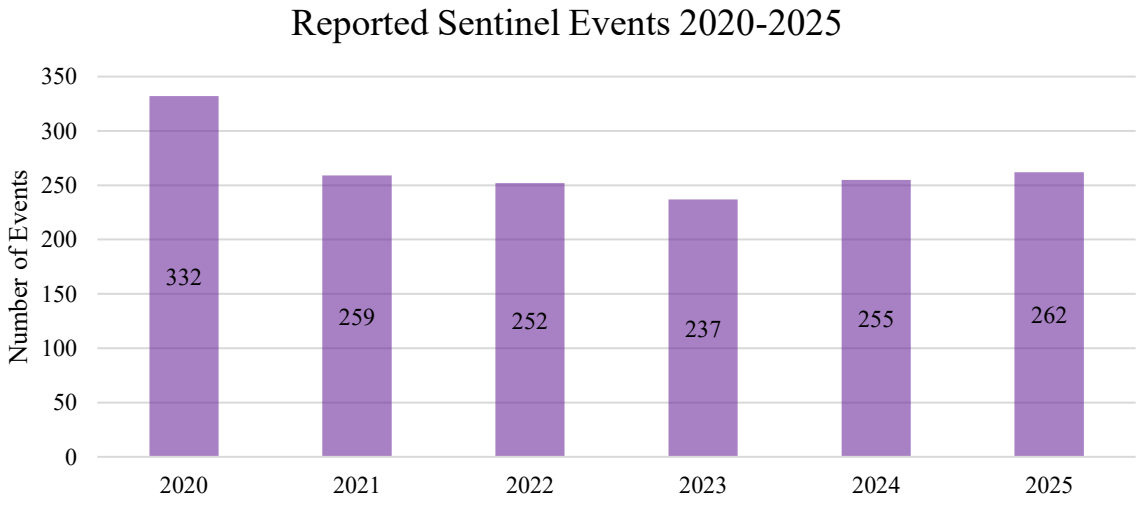


2025 Reported Events

There were 433 potential sentinel events reported in 2025. Of those, 123 events did not meet the criteria of a sentinel event, an additional 48 events were determined to be a "near miss," bringing the total number of actual sentinel events to 262.

Sixteen percent of sentinel events occurred either on a holiday (3) or a weekend (38). It should be noted that these numbers may not accurately represent when sentinel events occur since 37 percent of sentinel events were pressure injuries and they are typically identified Monday through Friday during daytime hours. The SET encourages facilities to identify the day of the week, time of day, and if the event occurred on a holiday for trending.

Table 4 Sentinel Events Reported by Year, 2020-2025

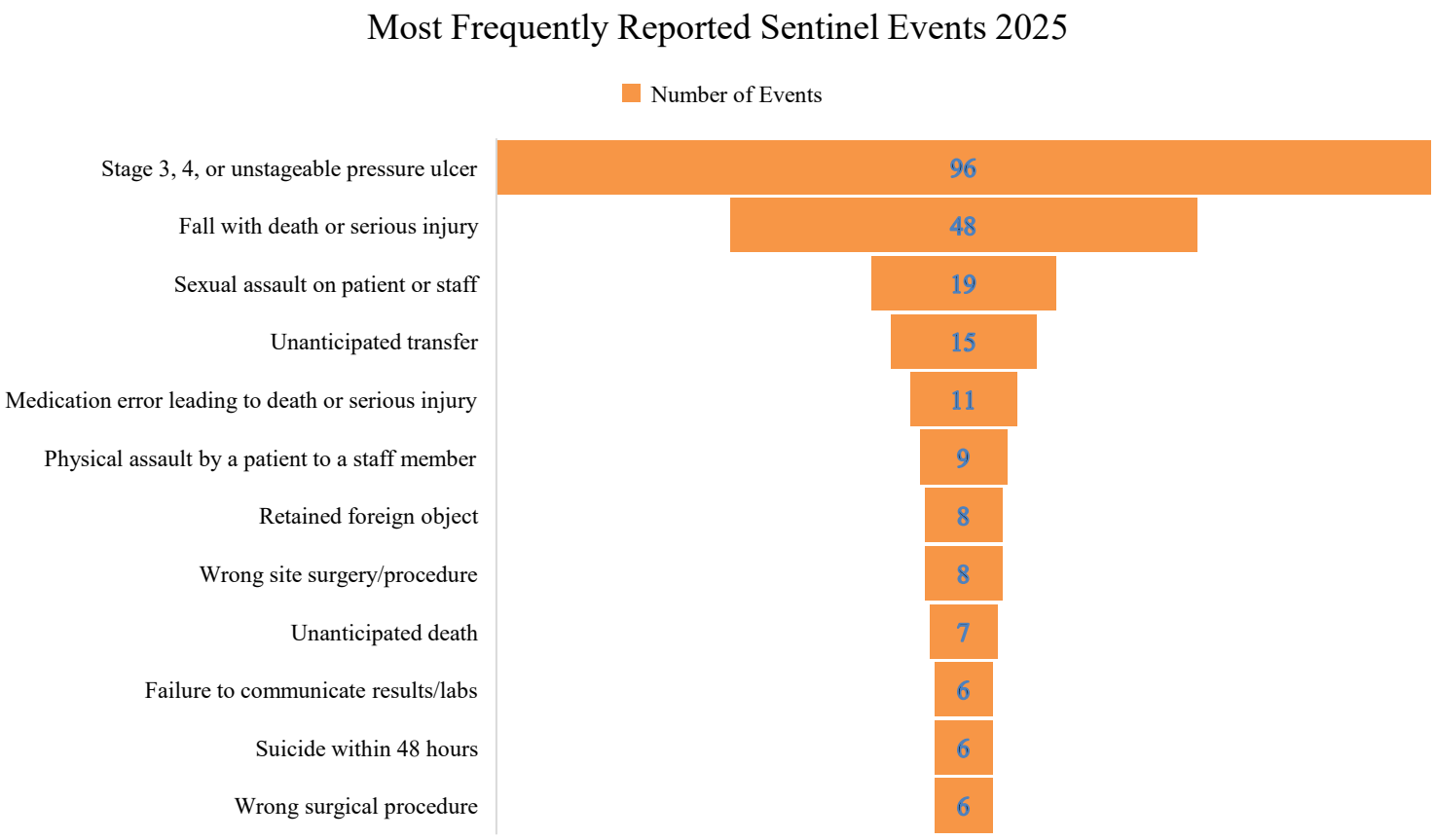


Types of Sentinel Events Reported

In 2025 there were 37 types of reportable sentinel events. A listing of all 2025 sentinel events can be found in Appendix C. Of the 37 event types, 25 event types were reported in 2025; 12 categories made up 91 percent of the total sentinel events reported, as listed below:

- Stage 3, 4, or unstageable pressure ulcer (facility acquired): 96 (37 percent)
- Patient death or serious injury associated with a fall: 48 (18 percent)
- Sexual assault on patient or staff: 19 (7 percent)
- Unanticipated Transfers: 15 (6 percent)
- Medication error with death or serious injury: 11 (4 percent)
- Physical assault by a patient to a staff member with serious injury/death: 9 (3 percent)
- Retained foreign object: 8 (3 percent)
- Wrong site surgery/procedure: 8 (3 percent)
- Unanticipated death: 7 (3 percent)
- Failure to communicate results/labs/ resulting in serious injury/death: 6 (2 percent)
- Suicide within 48 hours of treatment: 6 (2 percent)
- Wrong surgical procedure: 6 (2 percent)

Table 5 Most Frequently Reported Sentinel Events in 2025



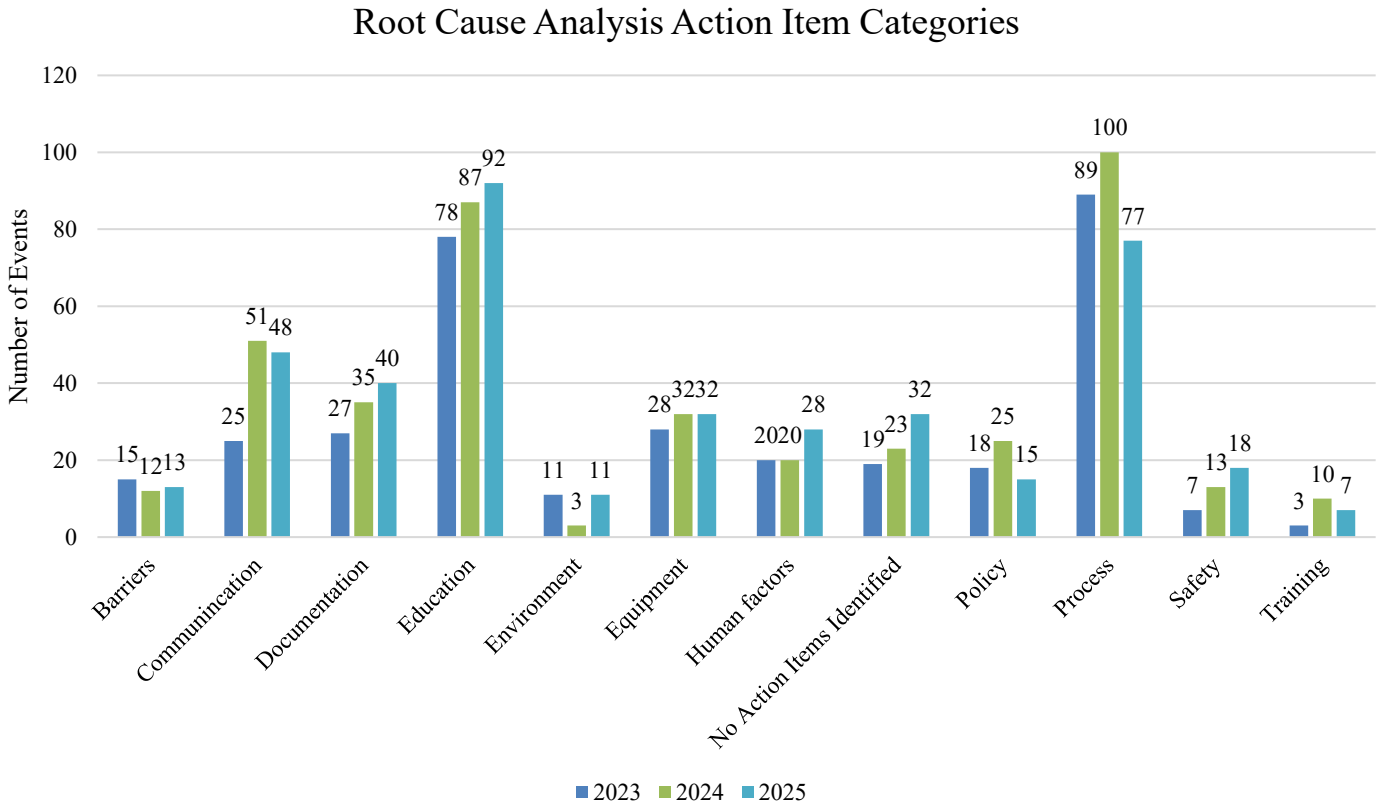
Key Findings from Reported Sentinel Events

- Pressure ulcers continue as the most frequently reported sentinel events over the past years.
- Pressure ulcer cases made up 96 of the 262 reported SEs in 2025 and this is slightly less than the 105 reported in 2024. There were 96 in 2023, 87 in 2022, and 90 in 2021.
- Falls with patient death or serious injury continue to remain the second most reported sentinel event.
- Falls increased slightly from 36 in 2023 to 44 in 2024 to 48 in 2025. There were 15 “near miss” falls reported in 2025.
- Retained foreign objects, wrong site surgeries, and wrong surgical procedures remain in the top ten reported events.
- Sexual assault reports have steadily increased with 11 in 2023, 16 in 2024, and 19 in 2025. We do not have the data to understand the cause of the increased reporting, but it is possibly due to a continued shift in facility culture (i.e. greater understanding of what are unaccepted behaviors) and ensuing increased identification and reporting of these types of events.
- The number of reported physical assaults are mostly consistent with 7 in 2022, 10 in 2023, 9 in 2024 and 9 in 2025. All 9 physical assaults reported in 2025 reflect staff being assaulted by patients.
- Failure to follow up on or communicate laboratory, pathology, or radiology test results remained the same with 6 in 2025 and 6 in 2024, yet showed an increase from 0 in 2023, 5 in 2022, and 3 in 2021.
- Unanticipated deaths continue to be a challenging category to interpret. Unless an autopsy is conducted, it is difficult to determine the true cause of death. When an autopsy is not conducted, the SET is left with using the death certificate that often lists the cause of death as being related to a person’s underlying medical condition. A record review may then be performed to determine if there is a concern about the quality of care provided.
- Unanticipated transfer cases can be challenging to determine as well and due to the nature of the category results in more ASC and critical access hospitals having these types of events. This is because they must transfer patients to hospitals providing additional services if needed, whereas a larger hospital with more services can transfer a patient within their hospital to a higher level of care unit or have ready access to specialty services not available at critical access hospitals and ASCs.

Root Cause Analysis: Action Items

When a sentinel event occurs, facilities are required to conduct a root cause analysis. Action items that were implemented because of root cause analysis findings are categorized by type. As can be seen in Table 6, the most common action item categories in 2025 were education, process, communication and documentation.

Table 6. Action Items Identified 2023-2025



Opportunities for Improvement

The process and education categories continue to have the most submitted action items to drive changes and increase patient safety. Necessary process changes are historically difficult to implement and sustain and making permanent changes takes commitment and follow-through across disciplines, units, and shifts, as well as support from leadership. Education of staff continues to be a frequently used action item and is used across a variety of event types. It may also indicate a need to further explore why there is an education deficit, the effectiveness of current education, or if there is another underlying reason processes are not being followed. Additionally, as previously mentioned in prior SE annual reports, following up on the effectiveness of the implemented action items can be challenging due to staff workload and competing priorities.

Reviews

The SET conducted thirteen on-site reviews in 2025. The SET successfully utilized a hybrid audit process to assess if facilities were meeting regulatory requirements. On-site reviews also allowed for collaboration among facilities and the SET for Q&A and clarification of the SE program requirements. On-site reviews enable the SET to review action item sustainability and identify trends around the state for improving patient safety. The SET also completed educational sessions with facilities about the SE program and reporting requirements.

Hospitals have the ongoing challenges of placing patients in skilled nursing, long term care, or mental health facilities to meet patient needs. There also continues to be financial and staffing challenges for a variety of reasons. In 2025, several closures occurred, including one hospital, (Northern Light Inland Hospital), and four labor and delivery units closed (Houlton Regional Hospital, Northern Light Inland Hospital, Mount Desert Island Hospital, and MaineHealth Waldo Hospital).

There are several sentinel event categories related to labor and delivery in low-risk pregnancies and unanticipated perinatal deaths. In 2025, there was one reported maternal death/serious injury case, one death or serious injury of a neonate, and two unanticipated perinatal deaths. The SET will continue to track these types of cases. It should be noted that the criteria for these types of events are rather narrow and may not represent issues that are occurring, yet do not rise to the level of serious injury or death needed to be a sentinel event. These types of lower injury cases and "near misses" should be reviewed to identify trends and make improvements to prevent additional and/or more serious events from occurring with this population.

Progress on Goals

During calendar year 2025, the SET continued to work with covered facilities and other agencies to enhance understanding of the Sentinel Event Program and the importance of patient safety. The following represents progress on the goals set for 2025:

1. *Goal*: Continue to provide technical assistance and consultations, as requested, to facilities covered under the sentinel event rules.
   Actions: The SET continues to provide technical assistance in understanding the requirements of the Sentinel Event Program. The SET also continues to receive phone calls and emails from facilities seeking clarification on topics such as whether a case meets criteria to be a SE, what the SE trends are around the state, or collaboration on action items. The SET strives to respond to facility correspondence within one business day.

2. *Goal*: Continue to assess facilities' compliance with M.R.S.A. Title 22, Chapter 1684, §8754, *Division Duties.* Continue with a hybrid process to perform reviews for covered facilities, which will consist of a remote and on-site process. Follow up criteria will include previously submitted RCA action items and their evaluation and sustainability reviews.

   Actions: The SET conducted thirteen on-site reviews in 2025. A hybrid review process was used that allowed for a more streamlined review process; much of the material is able to be reviewed off-site which uses less facility time. Review of previously submitted RCA action items was conducted, with findings that facilities are following through on submitted action items.

3. *Goal*: Continue the quarterly SE Newsletter to focus on trends noted in Maine, sentinel event data, and national patient safety issues.

Actions: The quarterly SE newsletter continued through 2025 with distribution in March, June, September, and December. Topics included: retained foreign objects, kindness in healthcare, RCA challenges, importance of quality improvement in healthcare, employee burnout, and identifying harm events. Newsletters are available on the Maine Sentinel Event website.

4. *Goal*: Amend sentinel event rules to clarify reporting criteria and better align with other recognized safety entities. Introduce the revised rules packet for review/approval when admissible.

   Actions: The SET began drafting SE rule revisions in 2025 in preparation for the expected update of the National Quality Forum list of Serious Reportable Events. This work will continue and should be completed in 2026, to allow rule to better reflect current patient safety trends and updated reportable sentinel event categories. As of the writing of this report, the proposed rule revision process is underway.

5. *Goal:* Coordinate patient safety related education to facilities in the SE program.

   Actions: The SET coordinated an education collaborative on October 2, 2025 in Augusta and by Zoom. Topics included presentations by Northern Maine Medical Center on fall prevention and sustaining change after sentinel events, MaineHealth on the RCA process and action plans, the Office of Chief Medical Examiner State of Maine on their processes, and the SET on trends and upcoming proposed changes to the program. The SET has a history of encouraging facilities to share what is working well for them and lessons learned to promote an informal means to share information around the state.

Program Goals 2026

In 2026, the SET will continue to enhance the Sentinel Event Program in the following areas:

1. Continue to provide technical assistance and consultations, as requested, to facilities covered under the sentinel event rules.
2. Continue to assess facilities' compliance with MRSA Title 22, Chapter 1684, §8754, *Division Duties.* Continue with a hybrid process to perform reviews for covered facilities, which will consist of a remote and on-site process. Follow up criteria will include previously submitted RCA action items and their evaluation and sustainability reviews.
3. Continue the quarterly SE Newsletter to focus on trends noted in Maine, sentinel event data, and national patient safety issues.
4. Complete sentinel event rule revision to update reporting criteria and incorporate revised National Quality Forum 2025 Serious Reportable Events list, and make other minor language changes.
5. Coordinate patient safety related education to facilities in the SE program.
6. Develop a system to track additional data points to enhance identifying what contributes to patient safety events.

Conclusion

The Sentinel Event program continues to provide oversight, technical support, and education to promote patient safety across Maine's healthcare system. The Sentinel Event Team conducts facility reviews to assess, evaluates root cause analyses and action plans, monitors trends statewide, and serves as a resource for sharing de-identified information and responding to facility inquiries. A quarterly newsletter and collaborative education sessions support the dissemination of patient safety practices and lessons learned across Maine facilities.

The Sentinel Event Program continues to promote a culture of collaboration, learning, and continuous improvement. While healthcare organizations nationwide face challenges in identifying, reporting, and responding to patient safety events, the Sentinel Event Program provides a framework that supports accountability and system-level improvement. In 2025, progress continued through statutory updates, ongoing facility engagement, and advancement toward rule revisions that will align with the updated National Quality Forum Serious Reportable Events list. Together, these efforts position the program to remain responsive to emerging patient safety issues and to support safer care for Maine people.

Appendix A – Reporting Form

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

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

1. What **is being reported?**
   - ☐ **Sentinel Event**
   - ☐ **Near Miss**
   - ☐ **Pending Review**

2. Today's **Date:** Click or tap here to enter text.
   Date of Discovery: Click or tap here to enter text.
   Date of Event: Click or tap here to enter text.
   Time of Event: Click or tap here to enter text.
   Date of Death (if applicable):

3. Facility Name: Click or tap here to enter text.
Reporter's Name: Click or tap here to enter text. **Reporter's Title:** Click or tap here to enter text.
Telephone Number: Click or tap here to enter text. **E-mail Address:** Click or tap here to enter text.
4. Briefly describe the event including location: Click or tap here to enter text.

5. Patient Age: Click or tap here to enter text. ☐ **M** ☐ **F**
Admitting Diagnosis: Click or tap here to enter text.
6. Does this event meet NQF criteria? ☒ **Y** ☐ **N**
(*If yes, continue on the next page and check appropriate box. If no, continue to question 7*)

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7. What type of event is being reported?

☐ **Unanticipated Death** unrelated to the natural course of the patient's illness or underlying condition, or proper treatment of that underlying condition.

☐ **Major permanent loss of function** present at discharge, unrelated to the natural course of the patient's illness.

☐ **Major Permanent loss of function**, within 48 Hrs., unrelated to the natural course of the patient's illness.

☐ **Unanticipated Death** within 48 Hrs. of Treatment

☐ **Suicide** within 48 hours of discharge

☐ **Major Permanent Loss of Function in perinatal infant** with a birth weight over 2,500 grams, unrelated to the natural course of the mother or patient's illness or underlying condition.

☐ **Unanticipated Perinatal Death** with a birth weight over 2,500 grams, unrelated to the natural course of the mother or patient's illness or underlying condition

☐ **Unanticipated Transfer** to another facility

Submission by secure email: Madeline.Orange@maine.gov
or Confidential Fax (207) 287-3251
Sentinel Event Hotline (207)287-5813
This information is protected from public disclosure

Revised July 1, 2024

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 or 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

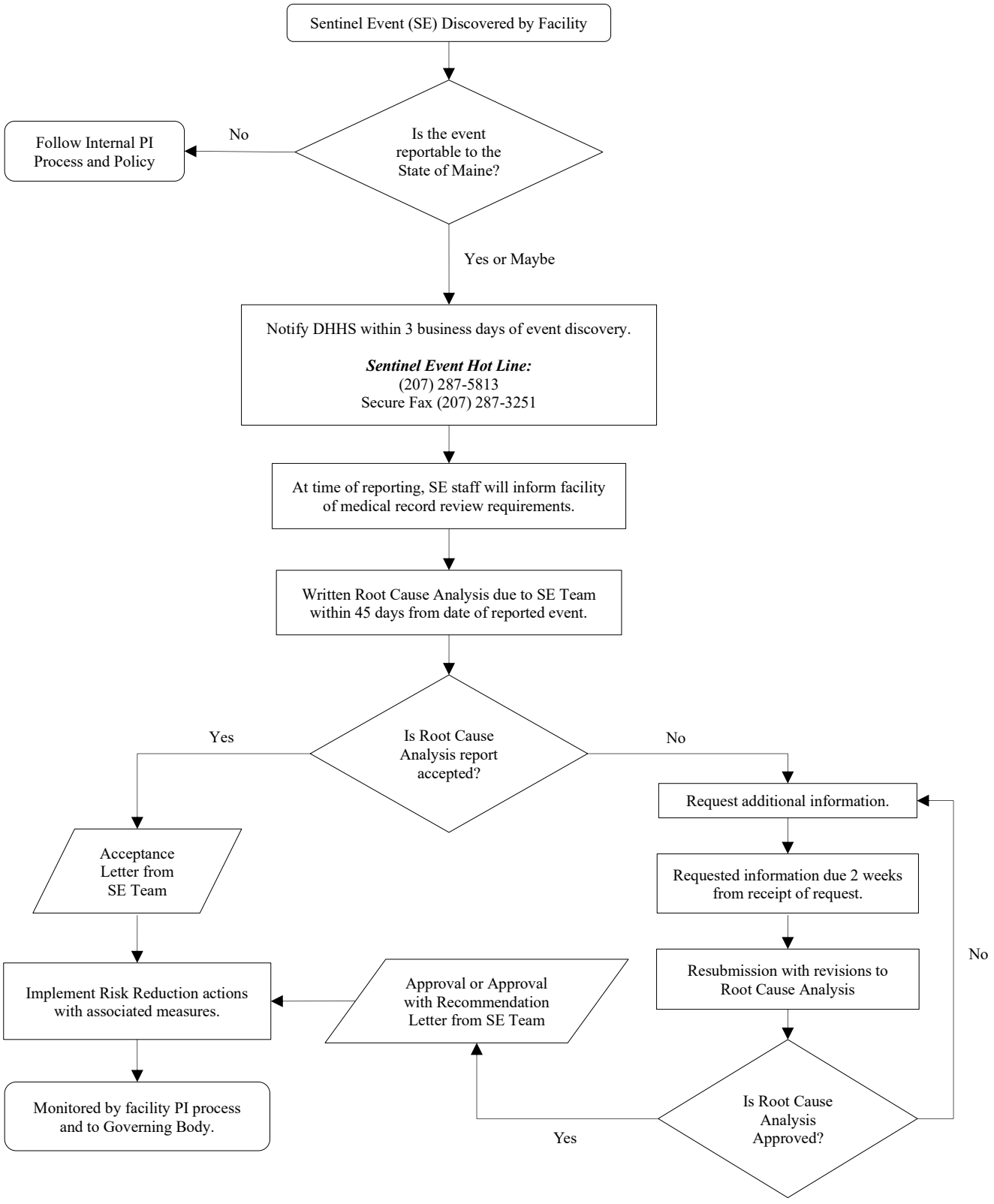
- ☐ Death or serious injury of a patient or staff associated with the introduction of a metal object into the MRI area

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

Appendix B – Sentinel Event Process Flow

State of Maine Department of Health and Human Services
Division of Licensing and Certification



Appendix C – 2025 Sentinel Events Reported by Type

Division of Licensing and Certification

Sentinel Events by Gender and Age

Between 01/01/2025 and 12/31/2025

			Gender		Age			
Scope	**Event Description**	**Total**	**Male**	**Female**	**Infant**	**<= 18**	**19-64**	**>=65**
NQF	Stage 3, 4, unstageable pressure ulcers acquired after admission to a health care setting	96	68	28	0	0	31	65
NQF	Patient death or serious injury associated with a fall while being cared for in a health care setting	48	24	24	0	2	10	36
NQF	Sexual abuse/assault: patient-staff	17	16	1	0	0	9	8
State	Unanticipated Patient Transfer to Another Facility	15	9	6	0	2	8	5
NQF	Patient death or serious injury associated with a medication error	11	2	9	2	0	3	6
NQF	Physical assault with serious injury: patient-staff	9	7	2	0	4	5	0
NQF	Unintended retention of a foreign object in a patient after surgery or other invasive procedure	8	2	6	0	0	4	4
NQF	Surgery or other invasive procedure performed on the wrong site	8	6	2	0	1	5	2
State	Unanticipated Death	7	3	4	0	1	3	3
NQF	Patient death or serious injury resulting from failure to follow up on or communicate laboratory, pathology or radiology test results.	6	2	4	0	0	2	4
State	Suicide Within 48 Hours of treatment	6	4	2	0	0	4	2
NQF	Wrong surgical or other invasive procedure performed on a patient	6	2	3	0	0	3	3
NQF	Patient suicide or attempted suicide resulting in serious disability while being cared for in a health care setting	4	2	2	0	1	3	0
State	Major Permanent Loss of Function present at discharge	4	1	3	1	0	2	1
State	Unanticipated Death within 48 hours of treatment	3	0	3	0	0	1	2
State	Unanticipated Perinatal Death	2	2	0	2	0	0	0
NQF	Discharge or release of a patient of any age, who is unable to make decisions, to other than an authorized person	2	2	0	0	0	2	0
NQF	Sexual abuse/assault: patient-patient	2	1	1	0	1	1	0
State	Permanent loss of function within 48 hours of treatment	2	0	2	0	0	2	0
NQF	Patient death or serious disability associated with patient elopement(disappearance)	1	0	1	0	0	0	1
NQF	Patient or staff death or serious injury associated with a burn incurred from any source while being cared for in a health care setting	1	0	1	0	0	1	0
NQF	Death or serious injury of a neonate associated with labor or delivery in a low risk pregnancy	1	0	1	1	0	0	0
NQF	Patient death or serious disability associated with the use or function of a device in patient care, in which the device is used for functions other than as intended	1	1	0	0	0	0	1
NQF	Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a health care setting	1	0	1	0	0	1	0
NQF	Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a health care setting	1	1	0	0	0	1	0
	Total:	*262*	*155*	*107*	*6*	*12*	*101*	*143*

Appendix D - Resources

The following represent some resources that support healthcare quality and safety:

Centers for Medicare & Medicaid Services | CMS: A consumer-oriented website that helps individuals learn about hospital quality and safety measures. CMS also offers a website to find and compare providers and facilities.

Hospital Safety Score: A public service provided by The Leapfrog Group, a nonprofit organization committed to driving quality, safety, and transparency in the U.S. health system.

Maine Hospital Association: The Maine Hospital Association represents 36 community-governed hospitals in Maine. Formed in 1937, the Augusta-based non-profit Association is the primary advocate for hospitals in the Maine State Legislature, the U.S. Congress and state and federal regulatory agencies. It also provides educational services and serves as a clearinghouse for comprehensive information for its hospital members, lawmakers and the public. MHA is a leader in developing health care policy and works to stimulate public debate on important health care issues that affect all of Maine's citizens.

Maine Health Data Organization: A State agency that collects health care data and makes those data available to researchers, policy makers, and the public while protecting individual privacy. The purpose of the organization is to create and maintain a useful, objective, reliable and comprehensive health information database that is used to improve the health of Maine citizens.

Maine Quality Forum: In 2003, the Maine Quality Forum was created as an independent division of Dirigo Health, to continue Maine's leadership in assuring high quality healthcare for its citizens. The Maine Quality Forum's mission is to advocate for high quality healthcare and help each Maine citizen make informed healthcare choices.

Maine DHHS Sentinel Event Resources

- Sentinel Event Annual Report
- Maine Sentinel Event Reporting Statute
- Rules Governing the Reporting of Sentinel Events

The Agency for Healthcare Research and Quality: AHRQ's mission is to produce evidence to make health care safer, higher quality, more accessible, equitable, and affordable, and to work within the U.S. Department of Health and Human Services and with other partners to make sure that the evidence is understood and used.

The Institute for Healthcare Improvement: The Institute for Healthcare Improvement (IHI) was officially founded in 1991, but our work began in the late 1980s as part of the National Demonstration Project on Quality Improvement in Health Care, led by Donald Berwick, MD, MPP, and a group of visionary individuals committed to redesigning health care into a system without errors, waste, delays, and unsustainable costs. Since then, we've grown from an initial collection of grant-supported programs to a self-sustaining organization with worldwide influence. While our

programs, projects, and priorities have changed with the times, we remain steadfastly committed to our mission to improve health and health care worldwide.

The National Academy for State Health Policy: A non-profit that helps "states achieve excellence in health policy and practice" by working with each other. The organization is based in Portland, ME and Washington, DC, and they provide a "forum for constructive work across branches and agencies of state government on critical health issues."

The Pennsylvania Patient Safety Authority: An independent state agency charged with taking steps to reduce and eliminate medical errors by identifying problems and recommending solutions that promote patient safety.

The National Quality Forum (NQF) is a not-for-profit organization that works to improve healthcare outcomes, safety, and affordability for all people by bringing all voices to the table for consensus on quality measurement and improvement standards.

The VA National Center for Patient Safety: Established in 1999 to develop and nurture a culture of safety throughout the Veterans Health Administration. Part of the VA Office of Quality, Safety and Value, their goal is the nationwide reduction and prevention of inadvertent harm to patients as a result of their care.

WhyNotTheBest.org: WhyNotTheBest.org was created by The Commonwealth Fund, and in January 2015, was transferred to IPRO, a national organization providing a full spectrum of healthcare assessment and improvement services. It is a free resource for health care professionals interested in tracking performance on various measures of health care quality. It enables organizations to compare their performance against that of peer organizations, against a range of benchmarks, and over time. Case studies and improvement tools spotlight successful improvement strategies of the nation's top performers. A regional map shows performance at the county, HRR, state, and national levels.

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