What is a Sentinel Event?

- A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically include loss of limb or function.

- Such events are referred to as “sentinel” because they signal the need for immediate investigation and response.
Sentinel Events

0 Are they reported?
   0 YES, to Risk Management

0 What happens next?
   0 The event is investigated by Risk Management in conjunction with the Vice President of Quality Management within 24 hours of the event, and a multi-disciplinary team as needed
Examples

- Suicide
  - Of a patient in a setting where a patient receives round-the-clock care
- Infant or child abduction
- Blood transfusion errors
- Wrong side/site surgery
- Deaths involving restraints
- Fatal falls
What Is a Sentinel Event Alert?

- A publication distributed by the Joint Commission to all Joint Commission-accredited health care organizations
  - Identifies “root causes” and “risk reduction strategies based upon best practices” throughout the healthcare industry
- Director of Risk Management provides units with a “Sentinel Event Alerts Grid” that identifies:
  - Sentinel Event Alert focus
  - Root Causes
  - Recommendations
  - Analysis/Actions taken
Trinitas Regional Medical Center monitors the Joint Commission “Sentinel Event Alert” newsletters

- Performs a self-assessment of current practice and implements risk reduction strategies that are suitable for the institution. (See examples below)

<table>
<thead>
<tr>
<th>Sentinel Event Alert</th>
<th>Trinitas Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fatal Falls</td>
<td>Fall protocol revised; risk of fall assessed on admission</td>
</tr>
<tr>
<td>Med errors relating to potentially dangerous abbreviations</td>
<td>List of unacceptable abbreviations put into place. Staff education.</td>
</tr>
<tr>
<td>Infection Control related deaths</td>
<td>CDC hand washing guidelines instituted, Indicator for unexpected death related to nosocomial infection added to mortality review. (NPSG #7).</td>
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</table>
N.J. Law Requires Mandatory Reporting of Serious Preventable Adverse Events!

- The Patient Safety Act (effective Oct. 2004) requires mandatory reporting of certain preventable adverse events that occur in any licensed health care facility.
The Patient Safety Act

0 The Patient Safety Act defines the serious preventable adverse events (SPAE) as:

0 An adverse event that is a preventable event and results in death or loss of a body part of disability or loss of bodily function lasting more than seven days or still present at time of discharge.
Categories of SPAEs

0 Care Management-Related Events
   0 Transfusion of incompatible blood

0 Environmental Events
   0 Death due to use of restraints or bedrails

0 Product or Device-Related Events
   0 Use of contaminated drugs or devices

0 Surgical Events
   0 Coma or death occurring during or after surgery

0 Patient Protection Events
   0 Discharge of infant to wrong person
How to Report a SPAE

- If you are involved in a SPAE occurrence:
  - Complete an incident report
  - Report the event to your Manager/Supervisor who will notify the Director of Risk Management
  - The Director of Risk Management will report the incident to the State Department of Health within the 5 day timeframe.
  - Follow-up by TRMC will consist of submission within 45 days of a Root Cause Analysis of the reported event.
Patient Safety Act
Key Definitions

0 ADVERSE EVENT:
   0 An event that is a negative consequence of care that results in
   unintended injury or illness, which may or may not have been
   preventable.

0 EVENT:
   0 A discrete, auditable and clearly defined occurrence.

0 NEAR MISS:
   0 An occurrence that could have resulted in an adverse event but
     was prevented.
Patient Safety Act
More Key Definitions

0 PREVENTABLE EVENT
  0 An event that could have been anticipated and prepared against but occurs because of an error or other system failure.

0 SERIOUS PREVENTABLE ADVERSE EVENT
  0 An adverse event that is a preventable event and results in death or loss of a body part, or disability or loss of bodily function lasting more than seven days or still present at time of discharge from a healthcare facility.