Sentinel Events and Sentinel Event Alerts
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

Are they reported?
- YES, to Risk Management

What happens next?
- 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’s Response to Sentinel Event Alerts

- 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>
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<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>
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<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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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

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

- 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

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

- **SERIOUS PREVENTABLE ADVERSE EVENT**
  - 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.