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Understanding and Preventing Sentinel and Adverse Events

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Preventable medical errors threaten patient safety and are all too common in hospitals throughout the world. These errors—the most severe of which are called sentinel events, the less severe, adverse events—are not limited to lower quality organisations; excellent healthcare organisations can and do experience undesirable events. What separates excellent quality organisations from lesser ones is whether they respond to sentinel and adverse events in a way that significantly reduces the risk of the event occurring in the future. By conducting intensive system analysis, revising processes found to cause or contribute to these events, and monitoring the effectiveness of any changes, quality hospitals create a safer patient environment following an undesirable event.

With the release of the Joint Commission International Accreditation Standards for Hospitals, 3rd edition, US-based accreditation body Joint Commission International (JCI) introduced the international healthcare community to the term sentinel event, which when combined with the already familiar terms adverse event and near miss, describe the full range of undesirable events with varying degrees of serious outcomes. JCI also began requiring that all JCI-accredited hospitals heed JCI's Sentinel Event Policy (see Figure 1) as a baseline for compliance and develop a sentinel event policy of their own, as well as establishing a process to address a sentinel event when it occurs.

JCI defines a sentinel event as an unanticipated death or loss of function unrelated to the natural course of the patient's illness or underlying condition or wrong-site, wrong-procedure, wrong-patient surgery. Such an event is called sentinel because it signals a need for an immediate investigation and response. An adverse event is defined by JCI as an unanticipated, undesirable, or potentially dangerous occurrence in a healthcare organisation, and a near miss is any process variation that did not affect an outcome but for which a recurrence carries a significant chance of a serious adverse outcome; such a "near miss" falls within the scope of the definition of an adverse event.

Adhering to a sentinel event policy should not only reduce the occurrence of sentinel events, but should also help healthcare organisations create a culture committed to identifying errors before they occur as well as being comfortable reporting errors if and when they happen. A blame-free culture, recognising that sentinel and adverse events are often the result of total system failure rather than individual practitioners' failures, should be the basis of every sentinel event policy.

A blame-free culture is especially important in the intensive care unit (ICU). Because ICU work is intense, with many interactions occurring between patient and caregiver and as the nature of critical illness reduces both patients' natural resilience and their ability to defend themselves from the consequences of human error, patients in the ICU may be at a higher risk of experiencing a sentinel or adverse event. According to one study, 54.8% of patients who had been in an ICU during their stay had a serious adverse event as opposed to only 38.1% of those who never been in an ICU (The Joint Commission Guide to Priority Focus Areas, 2004). Researchers from the Harvard Medical Practice study also concluded that patients 65- years-old or older had twice the risk of experiencing an event due to negligence than did those between 16 and 45 (Brennan et al. 1991).

Although each event is unique, healthcare errors often have common root causes that can be prevented from happening in the future when all organisations are made aware of them. But, awareness of the most common sentinel events and root causes of them is only made possible when hospitals confidentially share their information with an organisation such as JCI. In the United States, voluntary sentinel event reporting has allowed the Joint Commission to create a database identifying risk factors and trends, and this information is available to healthcare organisations and others on the Joint Commission's website at [http://www.jointcommission.org/SentinelEvents/ Statistics/](http://www.jointcommission.org/SentinelEvents/Statistics/). Although JCI does not currently maintain such a database (it plans to establish such a resource in the near future) the US-based resource provides applicable data, trends, and guidance for organisations everywhere.

Conclusion

Because sentinel events have such a dramatic and devastating effect on patients, their families and also on the organisation and its staff, policies and procedures are necessary at such time of calamity. But ultimately, sentinel events are not about policies but all about people and learning and the resolve to not let such an event occur again. Ask any family of a patient who died from a sentinel event and they will relate that their one hope is that no other family will have to go through the same event.

Hospitals are learning environments that incorporate new knowledge and the latest scientific advances every day. The information and findings resulting from the root cause of a sentinel event needs to be elevated into that learning environment and the processes for improvement. To lock away the findings out of shame or fear of loss of prestige is a disservice to those affected by the event and leaves the same system vulnerabilities in place for another day and another event - eventually. Organisations also need to learn from the events that occurred in other organisations. This is facilitated by the JCI International Center for Patient Safety where organisations can access the best science and aggregate learning of the larger healthcare community. Patient safety solutions are available for immediate review and action by organisations ready to learn and incorporate new knowledge. This is a neverending cycle necessary for quality and safe patient care today and tomorrow.

Sentinel Events

In support of its mission to improve the safety and quality of healthcare provided to the international community, JCI reviews organisation activities in response to sentinel events in its accreditation process. The following apply:

- A sentinel event is an unanticipated occurrence involving death or major permanent loss of function unrelated to the natural course of the patient's illness or underlying condition.
- A sentinel event may occur due to wrong-site, wrong-procedure, wrong patient surgery.
- Such events are called "sentinel" because they signal a need for immediate investigation and response.
- The terms "sentinel event" and "medical error" are not synonymous; not all sentinel events occur because of an error and not all errors result in sentinel events. Goals of the Sentinel Event Policy

The policy has four goals:

1. To have a positive impact in improving patient care, treatment, and services and preventing sentinel events.
2. To focus the attention of an organisation that has experienced a sentinel event on understanding the causes that underlie the event, and on changing the organisation's systems and processes to reduce the probability of such an event in the future.
3. To increase general knowledge about sentinel events, their causes, and strategies for prevention.
4. To maintain the confidence of the public and internationally accredited organisations in the accreditation process.

Expectations for an Organisation's Response to a Sentinel Event

Accredited organisations are expected to identify and respond appropriately to all sentinel events occurring in the organisation or associated with services that the organisation provides, or provides for. Appropriate response includes conducting a timely, thorough, and credible root cause analysis; developing an action plan designed to implement improvements to reduce risk; implementing the improvements; and monitoring the effectiveness of those improvements. Reasons for Reporting a Sentinel Event to JCI Although self-reporting a sentinel event is not required and there is no difference in the expected response, time frames, or review procedures, whether the hospital voluntarily reports the event or JCI becomes aware of the event by some other means, there are two major advantages to the hospital that self-reports a sentinel event:

- Early reporting provides an opportunity for consultation with JCI central office staff during the development of the root cause analysis and action plan.
- The organisation's message to the public that it is doing everything possible to ensure that such an event will not happen again is strengthened by its acknowledgement and collaboration with JCI to understand how the event happened and what can be done to reduce the risk of such an event in the future.

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