SENTINEL EVENTS
GROUP 6

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Introduction

- An unexpected incident, related to system or process deficiencies, which leads to death or major and enduring loss of function for a recipient of healthcare services.
- Loss of function refers to sensory, motor, physiological, or psychological impairment not present at the time services were sought or begun

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- A sentinel event is a Patient Safety Event that reaches a patient and results in any of the following:
- Death
- Permanent harm
- Severe temporary harm and intervention required to sustain life

TYPES OF SENTINEL EVENTS

- Surgical Events - wrong body part/ patient/ procedure, retained instrument, death during the procedure, anesthesia related events
- Device or Product events - contaminated drugs and device, breakdown or failure
- Patient protection events - attempted suicide, intentional injury, nosocomial infection
- Environmental events - burn, slip, fall, electric shock
- Care management events - hemolytic reaction, medication errors
- Criminal events - abduction, sexual assault, physical assault on the grounds of healthcare facility

ROOT-CAUSE ANALYSIS AND ACTION PLAN

- Organization should conduct a root-cause analysis to identify contributing factors within 45 days of a sentinel event or becoming aware of the event.
- This analysis focuses on systems and processes, not individual performance.
- All persons involved with the event in any way should participate in the analysis, as each may have important insights and observations.
- The sooner root-cause analysis takes place, the better—while the circumstances are fresh in participants' minds.

Why do Sentinel event occur

- Systemic problems rather than the mistake of an individual
- Inadequate communication between healthcare provider and patient
- Incorrect assessment of Patients condition
- Inadequate training and orientation

Expectations from Organization

- Root cause analysis
- Process to identify basic or causal factors of Sentinel event in future
- Action plan
- Plan to identify strategies to implement reduce risk of Sentinel event
- Survey process
- Evaluate the facilities compliances with applicable standards

Training frequency

- To be incorporated in Induction module of all new joiners in HCO.
- To be incorporated in the routine training schedule
- Pre and post training evaluation to assess the knowledge level of trainees.

Targeted audience

- Nursing staff
- Consultants/RMO/Paramedical workers
- Security/Cafeteria personals
- House keeping staff
- Maintenance department personals

Suggestions

- Proper and timely reporting of Sentinel event in HCO is to be encouraged
- CAPA should be implemented as an priority to prevent future risks
- Proper implementation of different checklists.
- Involvement of multi disciplinary team for RCA and CAPA

Thank You