Sentinel Event Procedures Undergo Scrutiny

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Substantial changes were made to the Joint Commission on Accreditation of Healthcare Organizations' Sentinel Event Procedures at the November 1997 Board of Commissioners meeting. With an implementation date scheduled for April 1, 1998, all Joint Commission accredited healthcare organizations should review and update their sentinel event policies.

The Joint Commission first developed this system of self-reporting and self-analysis of healthcare "accidents" in 1996, in response to increasing public concern over headlines announcing unbelievable errors in the delivery of healthcare. But beyond the headlines there was good reason to increase efforts to reduce adverse events. A Harvard Medical Practice study done in the early 1990s reported a 3.7 percent rate of adverse events in hospital stays, with 4.3 percent of these resulting in death or total permanent disability. These percentages translate into 180,000 deaths annually.

The Joint Commission defines a sentinel event as "an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase, 'or risk thereof' includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome."

Of the first 135 sentinel events reviewed, the Joint Commission's Accreditation Committee found:

- Thirty events relating to medication errors
- Twenty-six inpatient suicides
- Eight events of surgery on the wrong side
- Eight deaths related to delays in treatment
- Five deaths of patients in restraints
- Four transfusion-related deaths
- Two events involving medical gas systems
- Two infant abductions

Goals of the Sentinel Event Policy

In other disciplines, like engineering, it is known that error-prone processes have certain characteristics, several of which can be applied to healthcare. In researching errors in healthcare the Joint Commission developed a prevention, education, and research agenda. This agenda recognized some systemic causes for the current state.

Specifically they found:

- A standard taxonomy is needed for errors
- The epidemiology of error in healthcare is unknown
- Reliance on self-reporting in a punitive environment is not practical
- The healthcare industry has failed to make error prevention a primary goal
- Engineering models are applicable to error reduction in healthcare

In response to the public demand and in keeping with its emphasis on continuous improvement, the Joint Commission developed the Sentinel Event Policy. The goals of the policy are:

- To have a positive impact in improving care
- To focus attention on underlying causes and risk reduction
- To increase the general knowledge about sentinel events, their causes, and prevention
- To maintain public confidence in the accreditation process

Sentinel Event Process

Striking a balance between encouraging organizations to analyze, report, and address sentinel events and fairly translating these events into accreditation outcomes continues to challenge the Joint Commission. The latest changes attempt to clarify the definition, process, and outcomes of the Joint Commission's policy.

First, they have expanded the definition (as shown above) and required reporting of a sentinel event if it has resulted in an unanticipated death or major permanent loss of function, or is one of the following types of events:

- Infant abduction
- Infant discharged to the wrong family
- Rape (by another patient or staff)
- Hemolytic transfusion reaction
- Surgery on the wrong patient or wrong body part

An organization should report sentinel events to the Joint Commission within five days of its knowledge of the event and complete a root cause analysis within 30 days of the report. If these requirements are met, the organization will not be placed on accreditation watch. Organizations that comply will not have any information about the event made public by the Joint Commission, unless the inquirer specifically references the event; then the Joint Commission will confirm that they are aware of the event and that the organization is working through the sentinel event review process.

Accreditation watch will be initiated if the Joint Commission learns of a sentinel event that was not reported, confirms that event with the CEO, and determines that there is a reasonable potential for reducing future occurrences. An on-site evaluation may be scheduled to evaluate the occurrence. Accreditation watch will also be applied if the organization reports a sentinel event, but does not follow up with an appropriate root cause analysis within the 30-day timeline. Once placed on accreditation watch, the organization has 15 days to submit a root cause analysis report. Accreditation watch status is publicly disclosed.

Root Cause Analysis

When an organization has identified a sentinel event, the Joint Commission requires a root cause analysis. Rather than assigning blame, a root cause analysis focuses primarily on systems and processes. The analysis is a process for identifying the most basic factor or factors that cause variation in performance--including a sentinel event. Its purpose is to identify change that could be made in systems and processes through redesign, in an effort to improve the overall level of performance and reduce the risk of an adverse event.

Here are some steps for conducting a root cause analysis after a sentinel event:

- Assign a team to assess the sentinel event. The team should include staff at all levels closest to the issue and include those with decision-making authority
- Establish a way of communicating progress to senior leadership
- Create a high-level work plan that includes dates and specific objectives
- Clearly define the issue regarding the sentinel event and be sure that the team shares a common understanding of the issue
- Brainstorm all possible or potential contributing causes. Continue to ask why, until you have exhausted all logical possibilities
- Sort and analyze your cause list
- Begin determining which processes each cause is a part of and whether it is a special or a common cause of that process or system
- For a special cause in a process, search for the common cause in the systems of which the process is a part
- Begin designing and implementing changes as soon as possible, don't wait until you are finished with the analysis to reduce immediate risk
- Periodically assess your progress
- Be thorough
- Focus improvement efforts on the larger systems
- Redesign to eliminate the root cause

- Measure and assess to evaluate whether the redesign produced the expected results

Joint Commission's Response

Once the organization has submitted its root cause analysis, the Joint Commission has 30 days to review and accept the organization's report. If it is not acceptable, the organization has 15 days to resubmit a new analysis. The Joint Commission may decide that problems with the initial analysis may require an on-site evaluation to assist the organization in performing the root cause analysis. If the second root cause analysis is still inadequate, Joint Commission staff recommends to the Accreditation Committee that the organization be placed in preliminary nonaccreditation.

If the initial analysis if acceptable, the Accreditation Committee will review the analysis and the results of any on-site evaluation and the Joint Commission will issue an Official Accreditation Decision Report which:

- Reflects the Accreditation Committee's recommendation to make any changes to the organization's previous accreditation status and terminate any accreditation watch
- Includes any Type I recommendations related to standard compliance issues that have not been corrected
- Assigns an appropriate follow-up activity—typically a written report or a site visit—within six months to verify that corrective actions were put in place and were effective

Finally, any sentinel event evaluated under this policy will be reviewed at the organization's next full accreditation survey to ensure risk reduction strategies have been effective.

References

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