PRESENTATION ON SENTINEL EVENT (CQI 9)




CAHO ADVANCED GROUP 4

Dr. Hemanta Kumar,

Dr. Mukul Lal

Mr. Souvik Das,

Mr. Vinod Kumar

Reviewed by:
Dr.Lallu Joseph
Secretary General
CAHO

Faculty:
Dr. Vijay Agarwal
Dr. Suneel C Mundkur
Mr. Vinod Kumar
Ms. Niyati Maun
Dr. Jeet Patwari
Dr. Joseph Fidelis

DEFINITIONS OF SENTINEL EVENT: Sentinel Event is an unexpected Event happening at the hospital which involving death or serious physical damage (loss of limb or function) or psychological injury, or "the risk there of".

"Risk there of" is defined as any variation in a process for which a recurrence carries a significant chance of an adverse outcome

NABH 4th Edition (Standard & Objective Element)

Standard

CQI.9.	Sentinel events are intensively analysed.

Objective Elements

a. The organisation has defined sentinel events. *

Interpretation: The sentinel events relating to system or process deficiencies that are relevant and important to the organisation must be clearly defined.

The list of the identified and relevant sentinel events shall be documented.

Refer to glossary for definition of "sentinel events".

b. The organisation has established processes for intense analysis of such events.

Interpretation: The established processes should include reporting the occurrence of such events on standardised incident report forms.

c. Sentinel events are intensively analysed when they occur.

Interpretation: Root-cause analysis of all such events should be carried out by a multi-disciplinary committee taking inputs from the units/ discipline/departments concerned. All sentinel events shall be analysed within 24-working hours of occurrence.

d. Corrective and preventive actions are taken based on the findings of such analysis.

Interpretation: The findings and recommendations arrived at after the analysis should be communicated to all personnel concerned to correct the systems and processes to prevent recurrences. Any change in the policy or procedure is reflected as an amendment in the organisation's documentation.

LIST OF SENTINAL EVENTS :-

SURGICAL EVENTS:-

- Surgery performed on the wrong body part
- Surgery performed on the wrong patient.
- Wrong surgical procedure performed on the wrong patient.
- Patient death during or immediately post surgical procedure.
- Retained swab or instruments in the patient discovered immediately post surgical procedure
- Damage to structure (eg. Ureter, bowel, vessel).
- Delayed or missed diagnosis (eg. ectopic pregnancy).
- Failed procedures (eg. abortion, sterilization)
- Unplanned return to theater.

DEVICE OR PRODUCT EVENTS:

Patient death or serious disability associated with the –

- The use of contaminated drug, devices or products.
- The use or function of a device in a manner other than the devices intended use.
- The failure or breakdown of a device or medical equipment.

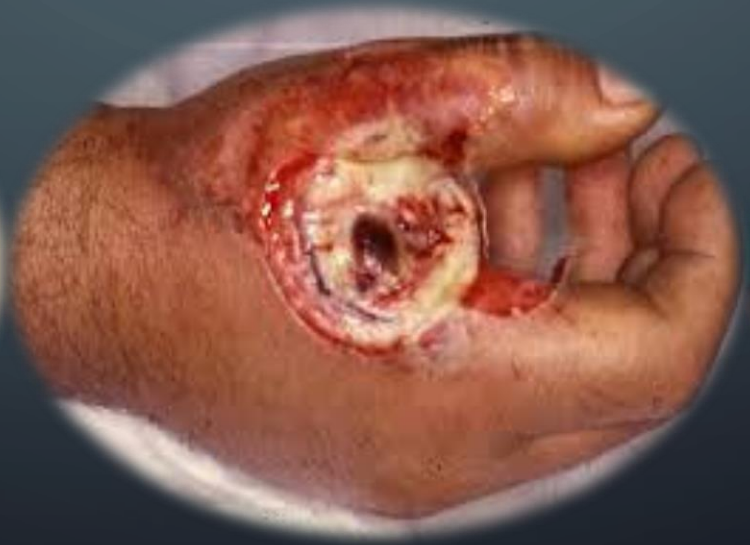
PATIENT PROTECTION EVENTS:

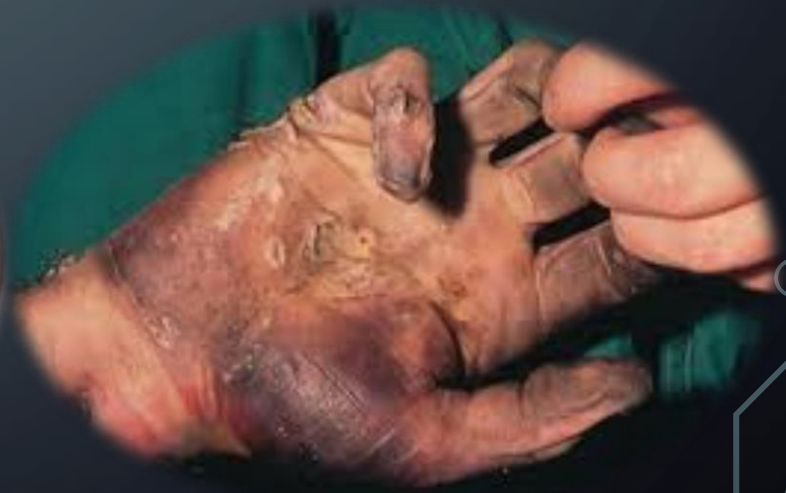
- Discharge of an infant to the wrong person.
- Patient death or serious disability associated or elopement from the heath care facility.
- Patient suicide, attempted suicide or deliberate self harm resulting in serious disability.
- Intentional injury to a patient by a staff member, another patient, visitors or others.
- Any incident in which a line designated for oxygen or other care to be delivered to a patient contains wrong gas or is contaminated by toxic substances.
- Nosocomial infection or disease causing patient death or serious disability.

ENVIRONMENTAL EVENTS:

Patient death or serious disability while in HCO associated with-

- Burn from any source.
- A slip, trip or fall.
- An electrical shock.
- Restraint.





CARE MANAGEMENT EVENTS :

- Patient death or serious disability associated with hemolytic reaction due to administration of ABO- Incompatible blood or blood products.
- Maternal death or serious disability associated with labour delivery or delivery in low risk pregnancy.
- Medication error leading to the death or any serious disability of patient due to incorrect administration of drugs.
  - ---Omission.
  - ---Wrong Dosage.
  - ---Wrong Dose preparation
  - ---Wrong time.
  - ---Wrong rate of administration.
  - ---Wrong administration technique.
  - ---Wrong patient
- Patient death or serious disability associated with avoidable delay.
  - --- in treatment.
  - --- in response to abnormal test results.

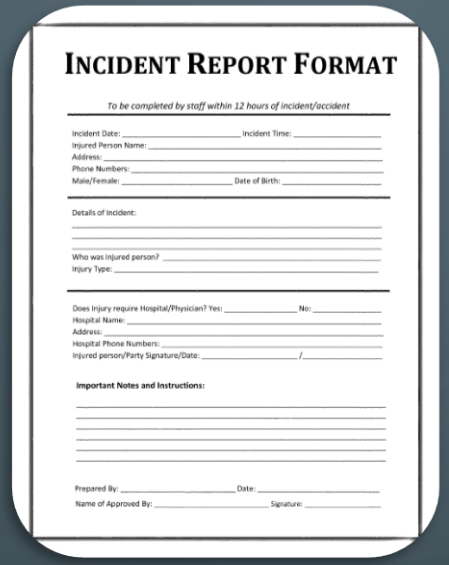
CRIMINAL EVENTS:

- Any criminal instance of care by or provided by an individual impersonating a clinical member of staff (Doctor /Nurse).
- Abduction of patient.
- Sexual assault on a patient within or on grounds of the health care.
- Death or significant injury of a patient or staff member resulting from a physical assault or other crime that occurs within the grounds of the heath care organization.

OTHER EVENTS :

- Maternal death (due to any cause)/ Death on the OT table.
- Blood loss > 1500 ml
- Caesarian section followed by hysterectomy.
- Anaesthesia related complication.
- Pulmonary embolism
- Neonatal death.

Incident Reporting Form



INCIDENT REPORT FORMAT

To be completed by staff within 12 hours of incident/accident

Incident Date: _____ Incident Time: _____
Injured Person Name: _____
Address: _____
Phone Numbers: _____
Male/Female: _____ Date of Birth: _____

Details of Incident:
_____
_____
_____
Who was injured person? _____
Injury Type: _____

Does Injury require Hospital/Physician? Yes: _____ No: _____
Hospital Name: _____
Address: _____
Hospital Phone Numbers: _____
Injured person/Party Signature/Date: _____/_____

Important Notes and Instructions:
_____
_____
_____
_____
_____
_____

Prepared By: _____ Date: _____
Name of Approved By: _____ Signature: _____

Root Cause Analysis: A "Root Cause Analysis" is a process for identifying the basic or causal factor(s) that underlie variation in performance including the occurrence or possible occurrence of a Sentinel Event.

PROCEDURE FOR IDENTIFYING AND RESPONDING TO SENTINEL EVENTS

- **Reporting Mechanism:** If any individual in the Hospital (including, but not limited to, any individual employed by the Hospital, any individual who independently contracts with the Hospital to provide health care services to patients at the Hospital, any member of the Hospital's Medical Staff, and any allied health care professional) discovers, witnesses, has knowledge of or otherwise becomes aware of any unexpected occurrence that is a possible Sentinel event must report to safety committee or any senior official of the hospital

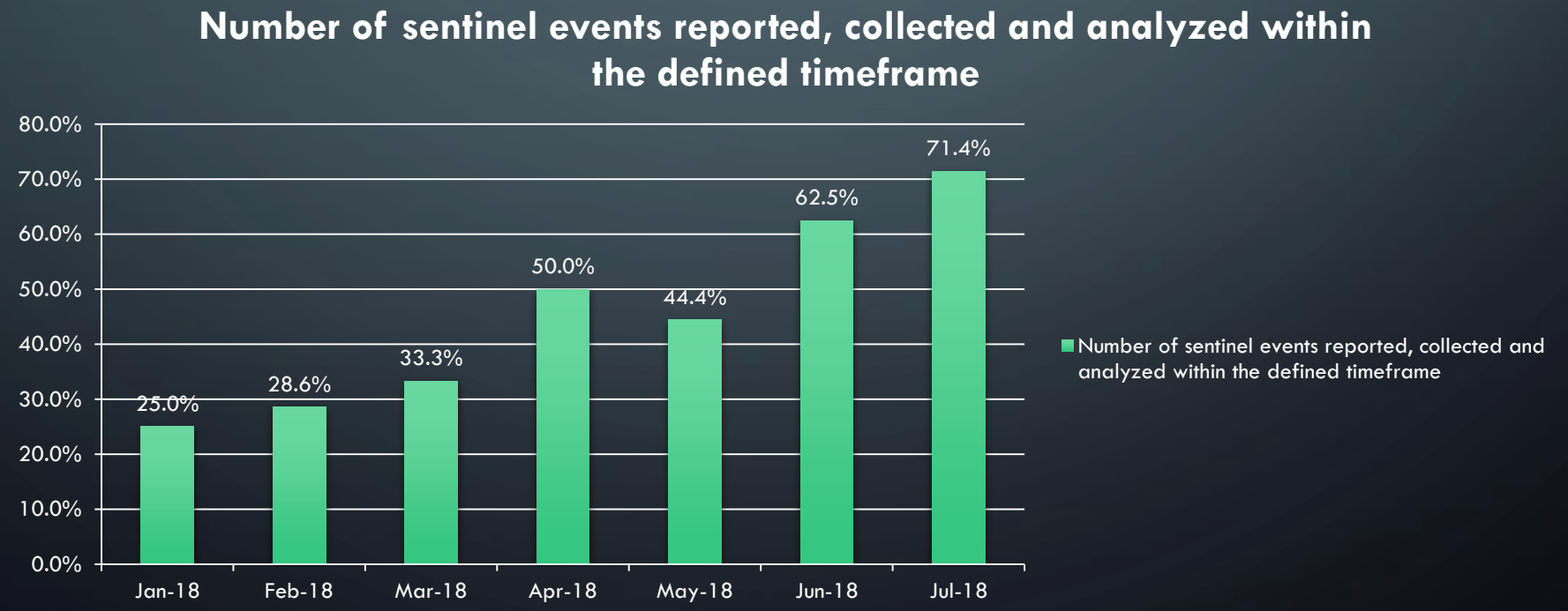
Completion of Root Cause Analysis and Action Plan: The committee shall investigate and understand the causes that underlie the event within seventy-two (72) hours and complete a thorough and credible Root cause analysis and resulting Action Plan describing the Hospital's risk reduction strategies, within 15 days of the known occurrence of the Sentinel Event.

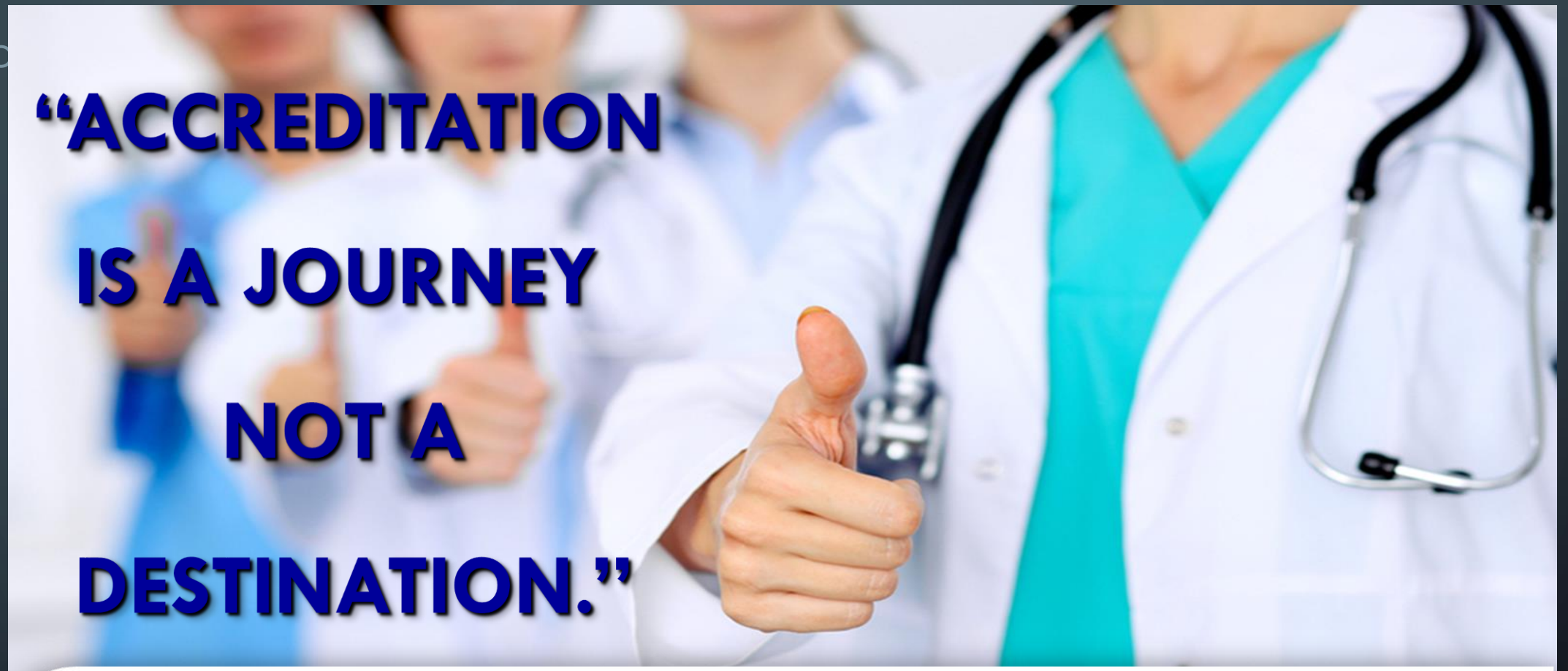
Report: The committee shall after completing the Root Cause Analysis and Action Plan, produce full documentation of the Root Cause Analysis and Action Plan to head of the Hospital. The head of the hospital shall subsequently direct the Root Cause Analysis and Action Plan to be reported to and thoroughly reviewed by the Hospital's other relevant committees if deems appropriate

Sentinel Events reported, collected and analyzed within the defined timeframe

Number of sentinel events reported, collected and analyzed within the defined timeframe

$$= \frac{\text{Number of sentinel events reported ,collected and analyzed within the defined timeframe}}{\text{Number of sentinel events reported, collected and analyzed}} \times 100$$





CAHO Advanced Group 4

Thank you