Sentinel Events
Medical Errors

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Medical Errors

• Medical errors can occur at any health care facility.

• The majority of these mistakes are due to simple human error.
To Err Is Human: Building a Safer Health System
Institute of Medicine Report, November 1999

• 44,000 – 98,000 patient deaths annually due to error
• Studies conducted by Harvard researchers in 1991 indicated 3.7% of hospitalized patients suffer significant iatrogenic injuries, typically from errors or negligence
• Average of 1.7 mistakes per patient per day in ICU (out of 200 patient-care activities)
Prevalence

- 1% failure rate is too high to be tolerated
- At 99.9%, there would be two unsafe plane landings at O’Hare airport each day, U.S. post-office would lose 16,000 pieces of mail, and 32,000 bank checks would be deducted from wrong accounts every hour
- Goal: 50% reduction in errors over the next 5 years (IOM Report)
IOM recommendations on error reduction

- Establish National Center for Patient Safety within DHHS
- Mandatory reporting of sentinel events to state agencies
- Engage consumers, purchasers, accreditors, regulators
- Effect a culture shift to make safety a top priority
Medical Errors

• An error is defined as the failure of a planned action to be completed as intended (i.e., error of execution) or the use of a wrong plan to achieve an aim (i.e., error of planning) IOM Report)
Adverse Event

• An unintentional injury or complication which results in disability, death, or prolonged hospital stay and is caused by medical management rather than the underlying condition of the patient. An adverse event attributable to error is a “preventable adverse event.”

• Negligent adverse events represent a subset of preventable adverse events that satisfy legal criteria used in determining negligence.

IOM REPORT
Sentinel Events

- The Joint Commission on Accreditation of Health care Organizations (JCAHO) reviews facility responses to certain adverse events, called *sentinel events*, as a part of the facility's accreditation process.
- These events are called sentinel events because they signal the need for an immediate response.
Sentinel Event

Incidents that involve unexpected death or serious injury or the risk of death and serious physical or psychological injury or risk thereof that is not related to the natural course of the patient's condition

*Serious injury specifically includes the loss of limb or function.*

*The phrase, "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.*
Type Sentinel Events
listed in order of frequency

1. inpatient suicides
2. events of surgery at the wrong site
3. operative/post op complications
4. events relating to medication errors
5. deaths related to delay in treatment
6. patient falls (13 multi-story)
7. deaths of patients in restraints
8. assault/rape/homicide
9. transfusion-related events
10. perinatal death/injury
11. deaths following elopement
12. fires
13. anesthesia related events
14. infection related events

Of 2840 sentinel events reviewed by the Joint Commission, January 1995 through September 2004:
Purpose for Identifying and Reporting Potential Sentinel Events

• To reduce the probability of such an event in the future
• To have a positive impact in improving patient care
• To identify processes and systems that can be strengthened
What to do?

When you become aware of a sentinel event

1. Report to your supervising physician at the time of the discovery
2. Supervising physician notifies the attending physician and risk management team
3. Physician or his/her designee informs patient and family
4. Risk Management initiates investigation of event
Risk Management

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Conclusions

• To err is human
• Being smart and careful may not be enough
• Medical errors needlessly kill many of our patients
• Medical errors are preventable
• Let us move from a culture of blame to a culture of safety

http://www.sma.org.sg/whatsnew/ethics/ethicsNov02/1minicourse/
The end

• Proceed to post test
• Print post test
• Complete post test
• Return post test to Dr. Sandra Oliver
• TAMUII 407i
Case Study

- 27 year-old patient with leukemia died after erroneous intrathecal administration of vincristine
- Drug should have been given IV
- Error was made by a junior house-officer only recently graduated from medical school
- Coroner found doctor criminally negligent in causing death of patient
Case Study (cont’d)

• Physician had to endure adverse publicity and faced possible criminal prosecution
• Later, BME found unfortunate event occurred because of lack of supervision of a junior doctor in training
• Wisely ruled not guilty of gross negligence
Post test question

• Identify processes and systems that can be strengthened to prevent recurrence of such an event in the future.