Patient Safety Systems and Events

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INTRODUCTION

Today’s healthcare professionals are highly trained in many aspects of patient care. But the increasing complexity of healthcare, coupled with expanding medical knowledge, can be overwhelming and difficult to manage at times.

Adding to stress and fatigue within the healthcare environment are other factors such as:

- Turnover within the healthcare team
- Increased expectations to reduce costs
- Changes in technology

A top priority for healthcare professionals and organizations is to “do no harm.” Human error, equipment failure, or a system breakdown can result in an adverse patient safety event. Typically, however, the result is due to flaws or failures in the systems and processes.

Today, the attention to patient safety has never been greater. Understanding the concepts and definitions related to patient safety events is a crucial step in taking a proactive approach to preventing potential harm.

PURPOSE/OVERALL GOAL

This module outlines the key terms regarding patient safety events, The Joint Commission’s policies for when safety events occur, and the steps that organizations must take to ensure that a similar event does not occur in the future.

The goal of this module is to help you, as a healthcare worker, understand the types of patient safety events that occur in the healthcare setting and the processes in place to address and help prevent them.

COURSE OBJECTIVES

After completing this module, the learner should be able to:

1. Define key terms related to patient safety
2. Describe the types of patient safety events that are reviewable by The Joint Commission
3. Describe ways in which organizations analyze and address patient safety events
4. Explain the benefits of patient safety systems
KEY TERMS

Patient Safety Event – This is a broad category that includes any event, incident, or condition that could have resulted or did result in harm to a patient.

Adverse Event – This is patient safety event that resulted in harm to a patient.
  • If an adverse event occurs, hospital leaders should be promptly notified, and an investigation and corrective actions should take place.
  • An adverse event may or may not result from an error.

Sentinel Event – This is a subcategory of adverse events. A sentinel event is a patient safety event (not primarily related to the natural course of the patient’s illness or underlying condition) that affects a patient and results in any of the following:
  • Death
  • Permanent harm
  • Severe temporary harm
  • Intervention required to sustain life

No-Harm Event – This is a patient safety event that affects a patient but does not cause harm.

Close Call – Also called a “near miss” or “good catch,” this is a patient safety event that did not affect a patient. Close calls should be tracked and used as opportunities to prevent harm.

Hazardous (or Unsafe) Condition – This is a circumstance (other than a patient’s own disease process or condition) that increases the probability of an adverse event. Hazardous Conditions should be tracked and used as opportunities to prevent harm.
SENTINEL EVENTS

The Joint Commission partners with healthcare organizations that have experienced certain patient safety events to improve systems and prevent any further harm. But while hospitals should address all patient safety events, not all of them must be reviewed by the Commission.

The Joint Commission has defined the following criteria for sentinel events that are subject to review:

1. Unanticipated death or major permanent loss of function (not related to the natural course of the patient’s illness or underlying condition)
2. One of the following (even if the outcome was not death or major permanent loss of function not related to the natural course of the patient’s illness or underlying condition):
   - Suicide
   - Unanticipated death of a full-term infant
   - Abduction of any patient
   - Discharge of an infant to the wrong family
   - Rape, assault (leading to death or permanent loss of function), or homicide of any patient, staff member, licensed independent practitioner, visitor, or vendor while on site at the healthcare organization

Reviewable Sentinel Events

The following are examples of sentinel events that are reviewable under The Joint Commission’s Sentinel Event Policy:

- Any patient death, paralysis, coma, or other major permanent loss of function associated with a medication error
- A patient commits suicide within 72 hours of being discharged from a hospital setting that provides staffed around-the-clock care
- Any elopement (unauthorized departure) of a patient from an around-the-clock care setting resulting in a temporally related death (suicide, accidental death, or homicide) or major permanent loss of function
- A hospital performing the wrong invasive procedure or operating on:
  - the wrong side of a patient’s body
  - the wrong site on a patient’s body
  - the wrong patient
- Any intrapartum (related to the birth process) maternal death
- Any perinatal death unrelated to a congenital condition in an infant having a birth weight greater than 2,500 grams
- Abduction of a patient from the hospital where he or she receives care, treatment, or services
- Assault, homicide, or other crime resulting in death or major permanent loss of function of a staff member, licensed independent practitioner, visitor, or vendor
- A patient fall that results in death or major permanent loss of function as a direct result of the injuries sustained in the fall
- Hemolytic transfusion reaction involving major blood group incompatibilities
- A foreign body, such as a sponge or forceps, that was left in a patient after surgery
Non-Reviewable Patient Safety Events
Patient safety events that are NOT reviewable under The Joint Commission’s Sentinel Event Policy include:

- Any close call ("near miss")
- Full or expected return of limb or bodily function to the same level as prior to the adverse event by discharge or within two weeks of the initial loss of said function, whichever is the longer period
- Any sentinel event that has not affected a recipient of care (patient, individual, resident)
- Medication errors that do not result in death or major permanent loss of function
- Suicide other than in an around-the-clock care setting or following elopement (unauthorized departure) from such a setting
- A death or loss of function following a discharge against medical advice (AMA)
- Unsuccessful suicide attempts unless resulting in a major permanent loss of function
- Minor degrees of hemolysis not caused by a major blood group incompatibility and with no clinical consequences
COMPREHENSIVE SYSTEMATIC ANALYSIS

Organizations accredited by The Joint Commission are required to complete a comprehensive systematic analysis to identify the causes of a sentinel event.

A Root Cause Analysis (RCA) is one such method for completing this analysis. Key characteristics of RCA are:

- Analysis is thorough and credible
- Focus is on the system and processes, not on individual performance
- Progresses from special causes in clinical processes to common causes in organizational processes
- Analysis repeatedly digs deeper by asking “Why?” – then, when answered, asks “Why?” again, and so on
- Identification of risk points and their potential contributions to this type of event
- Identification of changes that could be made in systems and processes that would reduce the risk of such events occurring in the future
- Includes participation by the leadership of the hospital and by individuals most closely involved in the processes and systems under review

RCA is just one example of an approach for conducting a comprehensive systematic analysis. Other tools and methodologies may be used by the organization to achieve that same result.
**ACTION PLANS**

An Action Plan is the product of the Comprehensive Systematic Analysis that identifies the strategies the organization intends to implement to reduce the risk of a similar patient safety event occurring in the future.

The action plan must address the following:
- Action to be taken
- Responsibility for implementation
- Timelines
- Strategies for measuring the effectiveness of the actions
- Strategies for sustaining the change

One such action plan is the Failure Modes and Effects Analysis (FMEA), which is used to identify how processes or systems may fail. Using FMEA allows hospitals to:
- Identify the process or system at high risk for failure
- Determine why it might fail
- Examine the effects of failure
- Create new ideas on how to make the process safer

The goal in FMEA is to fix the potential failure before an adverse event can actually occurs.

The FMEA technique was initially developed for use by the U.S. military. It was then expanded to the aerospace industry, nuclear power, aviation, and other fields. FMEA was introduced in healthcare in 2002 in response to The Joint Commission’s requirement that hospitals perform a proactive risk assessment on all high-risk processes at least once each year.
PATIENT SAFETY SYSTEMS

To help reduce risk and improve quality, organizations should have an integrated Patient Safety System that includes the following:

- Safety culture, which is the product of individual and group beliefs, values, attitudes, perceptions, competencies, and patterns of behavior that determine the organization’s commitment to quality and patient safety
- Validated methods to improve processes and systems
- Standardized ways for interdisciplinary teams to communicate and collaborate
- Safely integrated technologies

A key factor in preventing patient harm is conducting a proactive risk assessment, which:

- Evaluates processes for potential failures
- Addresses the consequences of such failures
- Identifies parts of the process that need improvement
CONCLUSION

Patient safety is the responsibility of all members of the healthcare team. Regular education and frequent reminders about potential high-risk and hazard-prone processes can go a long way toward preserving patient safety.

Organizations that employ a blame-free culture – one in which no one is ridiculed or reprimanded for errors – are the most successful in gaining employee cooperation with reporting as well as remediying near-miss and actual adverse events.

Review and transparency of information regarding patient safety events is critical in an organization’s ongoing development of a culture of safety. Lessons learned from these analyses should be openly shared throughout the organization as a means of preventing future errors and system breakdown.

REFERENCES: