Patient Safety Systems and Events

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Patient Safety Systems and Events

Today’s healthcare professional is highly trained in multiple facets of patient care. The increasing complexity of healthcare along with the expanding medical knowledge can be overwhelming and difficult to manage at times. Other factors can add to the stress and fatigue within the healthcare environment, such as turnover within the healthcare team, increased expectations to reduce costs, and changes in technology. A top priority of healthcare professionals and organizations is to “do no harm”, but human error, equipment failure, or a system breakdown can result in a patient safety event. Typically, however, the result is due to flaws or failures in the systems and processes.

As the importance for sustainable improvements in patient safety and the quality of patient care increases, the attention to patient safety has never been greater. Although much attention is paid to prevent patient harm, understanding the concepts and definitions related to patient safety events is a crucial step in taking a proactive approach to preventing potential harm.

1. Key Terms

**Patient Safety Event** is an event, incident, or condition that could have resulted or did result in harm to a patient.

**Adverse Event** is a patient safety event that resulted in harm to a patient. Adverse events should prompt notification of hospital leaders, investigation, and corrective actions. An adverse event may or may not result from an error.

**Sentinel Event** 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 reaches a patient and results in any of the following:

- Death
- Permanent harm
- Severe temporary harm
- Intervention is required to sustain life

**No-Harm Event** is a patient safety event that reaches the patient but does not cause harm.

**Close Call** (or “Near Miss” or “Good Catch”) is a patient safety event that did not reach the patient. Close calls should be tracked and used as opportunities to prevent harm.

**Hazardous (or “unsafe”) Conditions** 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.
2. Sentinel Events

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

- Unanticipated death or major permanent loss of function (not related to the natural course of the patient’s illness or underlying condition)
- 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

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, that is, 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 the patient’s body, on the wrong site of the patient’s body, or on 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
- A patient is abducted 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
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 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 sequela

### 3. Comprehensive Systematic Analysis

Organizations accredited by the Joint Commission are required to complete a comprehensive systematic analysis to identify the contributory factors of the sentinel event. A Root Cause Analysis (RCA) is one such method for completing this analysis. Key characteristics of a 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
- Identify 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.
4. 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 event occurring in the future. The action plan must address the following:

- Action to be taken
- Responsibility for implementation
- Time lines
- Strategies for measuring the effectiveness of the actions
- Strategies for sustaining the change

5. Patient Safety Systems

To help reduce variation, 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. This evaluates processes for potential failures, addresses the consequences of such failures, and identifies parts of the process that need improvement.

6. Conclusion

Throughout the organization, all parties of the healthcare team should participate in the prevention and preservation of patient safety through regular education and frequent reminders about potential high risk and hazard-prone processes. 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 remedying near-miss and actual adverse events. If a patient safety event occurs, a comprehensive systematic analysis should be performed with staff and leaders within the organization. Contributing factors should be identified and reviewed within the interprofessional team. Action plans will identify strategies to reduce the risk of reoccurrence and should not be directed at individual performance or behavior. Review and transparency of information regarding patient safety events is a critical component 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.
7. References

The Joint Commission, Comprehensive Accreditation Manual for Hospitals (CAMH): Sentinel Events (SE). Retrieved from:
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http://www.jointcommission.org/assets/1/6/PSC_for_Web.pdf

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