Sentinel Event Alert Analysis

PLAN												DO		CHECK	ACT
		Potential Problem Area													
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#17 Fires in the Home Care Setting March 20, 2001 Home Health care patients who were either injured or killed as a result of a fire in the home. These home care patients were receiving supplemental oxygen service and in each case, the patient was over the age of 65. Root															
#16 – Identifying and Prioritizing the High Risk Processes February 27, 2001 JCAHO alert contains information regarding conducting a proactive risk assessment. The new patient safety standard in the Leadership chapter of the hospital accreditation manual (LD5.2) requires hospital leaders to implement a program to reduce the risk of sentinel events and medical/health care errors by conducting pro-active risk assessment.	N/A														
#15 – Infusion Pumps 15a)Free flow of IV fluid into a patient when a caregiver temporarily removes an administration set from the pump 15b)Wrong drug concentration Wrong rate is set error and high risk meds	N Y	✍	✍	✍	✍	✍	✍	✍							
#14 – Fatal Falls Common causes of falls identified include:	Y	✍	✍	✍	✍	✍	✍	✍	??	✍					

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?? Altered mental status ?? History of previous falls ?? Use of sedation ?? Anticoagulation therapy ?? Urinary urgency Identified root causes of falls included: ?? Communication among caregivers during shift change reports ?? Caregivers not documenting changes in conditions ?? Inadequate communication from families regarding patient conditions and history of falling ?? Environmental design (open windows, unsecured areas)														
#13-Summary of Reductions **No action required**														
#12-Operations & post-op complications Feb 4, 2000 ?? Feeding tube insertion into bronchus ?? Massive fluid overload from absorption of irrigation fluids during GU procedures ?? Open orthopedic procedures associated with acute resp. failure including cardiac arrest in the OR ?? Endoscopy procedures with perforation of adjacent organs (liver lacerations most frequent) ?? Central venous catheter insertion into an artery ?? Imaging-directed percutaneous biopsy or tube placement resulting in liver laceration, peritonitis, or resp. arrest while temporarily off prescribed oxygen ?? Complications associated with		✍	✍			✍	✍	✍						

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misplaced tubes or catheters due to failure to confirm the position of the tube or catheter (usually by x-ray), misinterpretation of the radiographic image by a non-radiologist, or failure to communicate the results of the confirmation procedure **Summary of Root Causes noted in the above incidents:** ?? Necessary personnel not being available when needed ?? Pre-operative assessment incomplete ?? Deficiencies in credentialing and privileging ?? Inadequate supervision of house staff ?? Inconsistent post-operative monitoring procedures ?? Failure to question inappropriate orders														
#11-High Alert Meds & Patient Safety (Nov. 11, 1999) The top five high-alert medications identified by the Institute for Safe Medication Practices (ISMP) are: ?? Insulin ?? Opiates and narcotics ?? Injectable potassium chloride (or phosphate) concentrate ?? Intravenous anticoagulants (heparin) ?? Sodium Chloride solutions above 0.9 percent Common risk factors in causing the above events: **Insulin** ?? Lack of dose check systems ?? Insulin and Heparin vials kept in close proximity to each other on a nursing unit leading to mix-ups ?? Use of "U" as and abbreviation for "units" in medication orders (which	Y	✍	✍	✍	✍	✍	✍	✍						

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"units" in medication orders (which can be confused with "O" resulting in a ten-fold overdose) ?? Incorrect rates being programmed into an infusion pump **Opiates and Narcotics** ?? Parental narcotics stored in nursing areas as floor stock ?? Confusion between hydromorphone and morphine ?? Patient-Controlled ?? analgesia (PCA) errors regarding concentration and rate **Injectable Potassium Chloride or Phosphate Concentrate** ?? Storage of concentrated potassium chloride/phosphate outside the pharmacy ?? Mixing of potassium chloride/phosphate extemporaneously ?? Request for unusual concentrations **Intravenous Anticoagulants (Heparin)** ?? Unclear labeling regarding concentration and total volume ?? Multi-dose containers ?? Confusion between heparin and insulin due to similar measurement units and proximity of storage **Sodium Chloride solutions above 0.9 percent** ?? Storing sodium chloride solutions (above 0.9 percent) on nursing units ?? Large numbers of concentration/formulation available ?? No double check system in place														
#10 Blood Transfusion Errors (Aug. 30, 1999)		✍	✍			✍								

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The risk factors identified in blood transfusion errors involve the following root causes: ?? Patient assessment such as incomplete patient/blood verification ?? Patient assessment such as the signs and symptoms of a transfusion reaction is not recognized ?? Care planning such as no informed consent ?? Lab procedures such as multiple samples crossmatched at the same time or a crossmatch being started before the order was received ?? Staff-related factors such as blood for multiple operating room patients being stored together in the same refrigerator ?? Equipment related factors such as incomplete communication among caregivers or patient identification band, specimen label or blood label errors.		? ?												
#9 Infant Abductions (Apr. 9, 1999) Facts: ?? All the abductions took place in hospitals with more than 400 beds ?? Five of the events occurred in the mother's room ?? Two of the events in the nursery ?? One in the neonatal ICU ?? All abductors were female In all the cases the abductor impersonated a nurse, volunteer physician, or the infant's mother. ?? Abductions took place when the infants were taken for testing, left unattended in the nursery, or when mother was napping or showering		✍												

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Root cause analysis of incidents found the following six general categories: ?? Security equipment factors such as not being available, operational, or used as intended ?? Physical environmental factors such as no one line of sight to entry points as well as unmonitored elevator or stairwell access ?? Inadequate patient education ?? Staff-related factors such as insufficient staffing lev els ?? Information related factors such as birth information published in local newspapers, delay in notifying security when an abduction was suspected, improper communication of relevant information among caregivers and improper communication between hospital units. ?? Organizational cultural factors such as reluctance to confront unidentified visitors/providers Suggested interventions to reduce risk of infant abduction: ?? Develop and implement proactive infant abduction program ?? Include information on infant abduction in orientation ?? Enhance patient education concerning abduction precautions ?? Attach secure identically numbered band to baby (wrist and ankle bands), mother, father, or significant other immediately after birth ?? Footprint the baby, take a color photo and record the baby's physical examination within two hours of birth ?? Require staff to wear up-to-date, conspicuous, color photograph identification badges ?? Discontinue publication of birth notices in local newspapers														

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?? Consider options for controlling access to nursery post/part unit ?? Consider implementing an infant security tag or abduction alarm system.														
#8 Preventing Restraint Deaths (Nov 18, 1998) The following risk factors may contribute to the risk of restraint deaths: ?? Restraining of people who smoke ?? Restraining of patients with deformities that preclude proper application of restraining device (especially vest restraints) ?? Restraining a patient in the supine position (increases the risk of aspiration) ?? Restraining a patient in the prone position (predisposes risk of suffocation) ?? Restraining patient in room that's not under continuous observation by Staff The following root causes were identified in the majority of cases: ?? Patient assessment, such as incomplete medical assessment or incomplete examination of the patient (for example, failure to identify contraband, such as matches, weapons) ?? Inadequate care planning, such as alternatives not fully considered, restraints used as punishment, and inappropriate room or unit assignment. ?? Lack of patient observation procedures or practices ?? Staff-related factors, such as use of split side rail protectors; use of two point restraints; use of high neck vest; incorrect application of a restraining device; or a monitor or alarm not working or not being used when appropriate.		✍	✍	✍		✍		✍						

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#7 Inpatient Suicides (Nov. 6, 1998) 75% of cases reported the method of suicide was a hanging in the bathroom, bedroom, or closet. 20% were the result of patients jumping from a roof or window. Root cause analysis identified the following causes: ?? The environment of care, such as the presence of non-breakaway bars, rods or safety rails; lack of testing of breakaway hardware; and inadequate security ?? Patient assessment methods, such as incomplete suicide risk assessment at intake, absent ?? Incomplete reassessment, and incomplete examination of the patient (example to identify contraband) ?? Staff related factors such as insufficient orientation and training, incomplete competency review or credentialing, and inadequate staffing levels Incomplete or infrequent patient observations ?? Information related factors such as incomplete communication among caregivers and information being unavailable when needed ?? Improper assignment of patient to an inappropriate unit or location Suggested risk reduction strategies: ?? Standardized suicide risk assessment/reassessment procedures ?? Updating staffing model ?? Enhancing staff orientation/education regarding suicide risk factors ?? Updating policies and procedures for patient observation ?? Consistency of observation monitoring procedures		✍		✍										

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?? Sound procedures for contraband detection and engagement of family and friends in the process ?? Identifying and removing or replacing non breakaway hardware. ?? Weight testing all breakaway hardware ?? Sound security measures (locking mechanisms, patient monitors and alarms) ?? Education for family/friends regarding suicide risk factors														
#6 Wrong Site Surgery (Aug. 28, 1998) Identified factors that may contribute to risk of wrong surgery site: ?? More than one surgeon involved in the case, either because multiple procedures were contemplated or because the care of the patient was transferred to another surgeon ?? Multiple procedures were conducted on the same patient during a single trip to the OR, especially if the procedures were on different sides of the patient ?? Unusual time pressures, related to unusual start time or pressure to speed up the preoperative procedures ?? Unusual patient characteristics such a physical deformity or massive obesity that might alter the usual process for equipment set up or positioning of the patient Root cause analysis of the cases most often related to communication, preoperative assessment of the patient, and the procedures used to verify the operative site. Communication issues fell into two categories ?? Failure to engage the patient (or family when appropriate) in the process of identifying the correct			✍					✍						

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process of identifying the correct surgical site, either during the informed consent process or by the physical act of making the intended surgical site. ?? Incomplete or inaccurate communication among members of the surgical team, often through exclusion of certain members of the tea, (i.e.: surg techs) from the participation of site verification process or through the reliance solely on the surgeon for determining the correct operative site. Suggested strategies for reducing the risk of wrong-sit surgeries: ?? Clearly mark the operative site and involve the patient in the marking process. ?? Require an oral verification of the correct site in the OR by each member of the surgical team ?? Develop a verification checklist that includes all documents referencing the intended operative site, including the medical record, X-rays and other imaging studies, the OR record, the anesthesia record and direct observation of the marked operative site of the patient														
#1,2,3,4 & 5 alerts are not related to any patient care activities														