Learning from sentinel events in a large teaching hospital:
Incidence, patient and family participation, system failures and transparency

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CONCLUSION

- Analyzed sentinel events p/1000 admissions: 0.44 (0.04) compared to 0.73 in the NFU* benchmark
- The improvement theme's found were:
  - High risk medication & anticoagulation
  - Early detection and treatment of the deteriorating patient
  - Wrong site surgery
  - Fall incidents

* Dutch federation of university medical centers

BACKGROUND

A sentinel event is an unexpected and unintended occurrence related to the quality of care involving death or serious physical or psychological injury for the patient, or the risk thereof.

Healthcare organizations in the Netherlands are obliged by law to report sentinel events to the Healthcare Inspectorate within 3 days after determining the event.

Sentinel events are investigated by a multidisciplinary committee trained in Tripod beta analysis method.

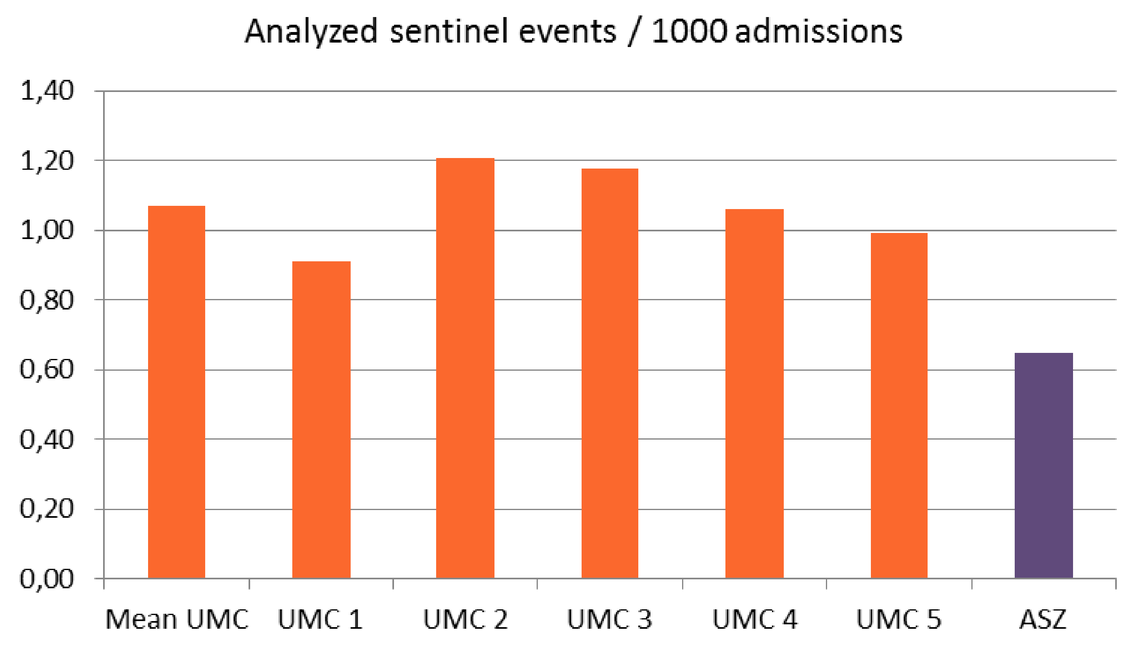
AIM

- Identification of the root causes of the sentinel events
- Describe the context of root causes to maximize organizational and system learning
- Suggest a format for transparency on sentinel events in order to support and improve the learning hospital wide and between hospitals

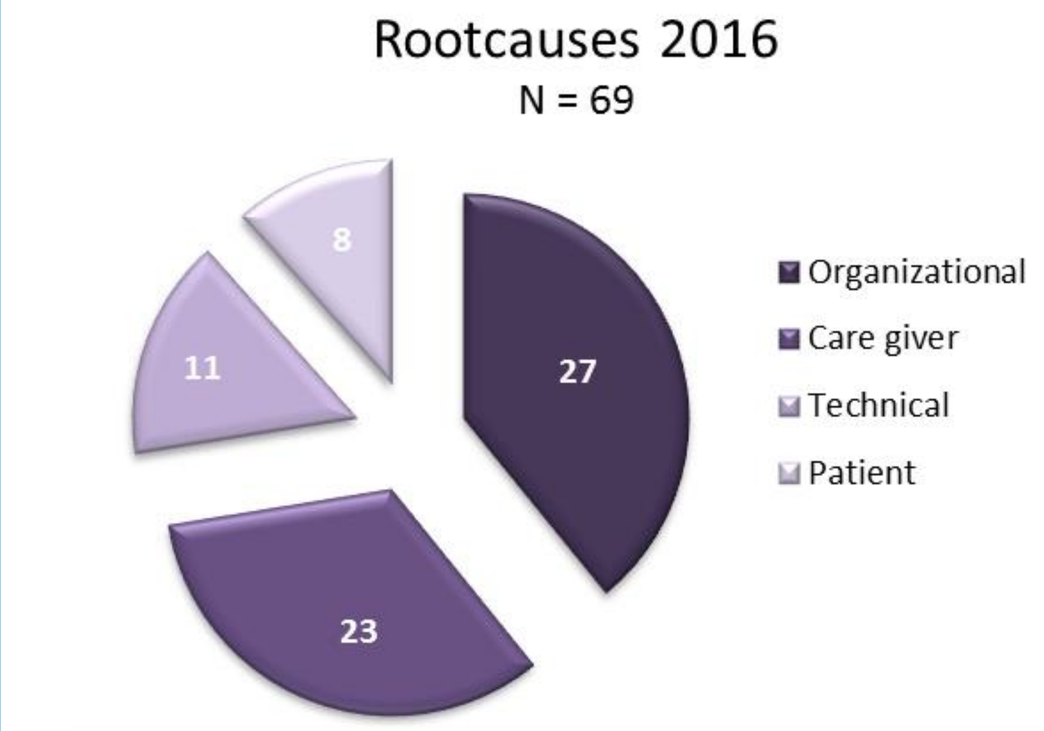
Method

- Determine number of possible SE's per 1000 admissions 2016
- Determine number of analyzed SE's per 1000 admissions 2016
- Analysis of sentinel event investigation reports 2016 to determine root causes using the categories of the Eindhoven Classification Model: PRISMA-medical Version
- Analysis of the event specific correspondence from the Healthcare Inspectorate

RESULTS 1



RESULTS 2



DISCUSSION

- Most improvement issues found were organization wide theme's
- In most themes there were multidisciplinary teams involved

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