Sentinel event

A1. Sentinel Event Review of the medical record for the specified patient (SP) was completed 09/16/12. The medical record revealed that the SP was a minor child with a diagnosis of history of frequent and recurrent tonsillitis and was scheduled to have the tonsils and adenoids removed 09/14/12 at 10: 30 AM as an outpatient procedure. Review of the medical record for the day of 09/14/12 revealed that the SP was admitted to the pre-admission testing area at 9: 00 AM. At 10: 00 AM the SP was in the pre-operative area with the peripheral intravenous line in place and the pre-operative medications were being administered.

At 10: 30 AM the SP was in the operating room (OR) and the procedure was performed as scheduled. At 11: 15 AM, the SP was moved from the OR to the post anesthesia care unit (PACU). At 12: 15 PM, the SP was successfully recovered from the procedure and both the surgeon and the anesthesiologist cleared the SP to go home. The medical record revealed a nurse’s note by the pre-operative nurse on 09/14/12 at 10: 30 AM that documented a conversation between the pre-operative nurse and the SP’s mother where the mother stated she was leaving to run an errand involving an older sibling and left a cellular telephone number.

The only documented instruction from the mother was for the nurse to call if the SP got out of surgery sooner than expected. In aninterviewwith the PACU nurse conducted on 09/15/12 at 10: 00 AM, the PACU nurse stated that on 09/14/12 at approximately 12: 30 PM, the patient was released for home to her father, who was identified by his driver’s license; the PACU nurse stated that she provided written instructions for the patient’s post-operative care and follow up appointment to the father.

The PACU nurse stated that the patient’s father verbalized understanding of the discharge instructions and left with the patient. The medical record lacked documentation of this encounter. The medical record also lacked documentation of any restrictions as to which parent was permitted to take the patient home. The patient’s mother arrived at the hospital on 09/14/12 at approximately 1: 00 PM to take the patient home and was extremely distraught when she discovered her daughter was not in the PACU as she expected.

There was a shift change at 1: 00 PM and the oncoming nurses did not know that the patient was released to her father. As a result, security was called and a hospital-wide child abduction alert (code pink) was activated. In addition to hospital security, local law enforcement was also notified of the missing child. The SP’s mother told the hospital security officer that she and the SP’s father were divorced and she had full custody of the SP and the SP’s siblings. On 09/14/12 at approximately 1: 30 PM, the SP was located at the father’s residence, in the care of the father.

The SP’s father stated that he took the SP to his residence to wait for the SP’s mother to arrive. No charges were filed against the SP’s father. The hospital management and security personnel assured the SP’s mother that this incident would be investigated and processes would be put in place to prevent it from happening in the future. A2. Personnel There were several employees who had interactions with the SP and her mother during the outpatient hospital procedure. The first person was the hospital registrar who took the SP’s demographic information from the SP’s mother.

The next person was the pre-operative nurse who took obtained the SP's clinical information and medical history from the SP's mother, performed the initial physical assessment (height, weight, vital signs, cardio-pulmonary, and head to toe), and obtained peripheral intravenous access. The people who then interacted with the SP were the surgeon, the anesthesiologist, and the operating room nurses. The surgeon also had an office visit with the SP and her mother in the days leading up to the surgery. The OR nurse took over care when the SP was moved from the pre-operative area to the OR.

The OR nurse made the SP comfortable until she was under the anesthesia and began the recovery process after the surgery was completed. The next person who interacted with the SP was the post anesthesia care unit (PACU) nurse. The PACU nurse was responsible for monitoring the SP during the recovery phase when she was coming out from under the anesthesia. During the post anesthesia phase, the surgeon and the SP assessed and evaluated the SP. Both the surgeon and the anesthesiologist had to sign the papers to release the patient to the discharge nurse. Finally, the patient was transferred to the care of the discharge nurse.

The discharge nurse released the SP to her father. After the SP's mother came back to the hospital and reported the SP was missing, the ChiefNursingOfficer (CNO) was immediately involved. The CNO met with the SP's mother and alerted the security team and local police to the disappearance of the child. The local police were able to locate the SP at her father's house approximately 30 minutes after she was reported missing. The CNO had theresponsibilityto the SP's mother to launch the investigation

into the cause of her disappearance and to implement a plan of correction so the incident could be prevented in the future. A3.

Personnel Issues Several factors negatively affected the coordination of patient care by the employees on 09/14/12. First, thecommunicationbetween the admission personnel and the SP’s mother was ineffective when the registrar failed to obtain privacy information and/or ask about any custody situation. Second, the pre-operative nurse did obtain the custody information and the mother’s cellular telephone number and documented these on her clip board. However, the pre-operative nurse failed to report this as important information to the operating room nurse upon transfer of the SP from the pre-operative area to the operating room.

As a result, the operating room nurse did not alert the PACU nurse to this important information upon transfer of the SP from the OR to the PACU area. The hospital failed to have hand off policies and procedures in place when a patient was moved from one area of surgery to another. They depended solely on their electronic record and did not have any reporting requirements in place when a patient was moved from the admission to pre-operative to operative to post-operative areas. There was a cultural/language barrier between the PACU nurse and the Hipic discharge nurse making verbal communication very difficult.

Other factors of poor communication were staffing ratios and the perspectives and attitudes of the staff. In interviews conducted with the registrar, the pre-operative nurse, the PACU nurse, and the discharge nurse after the sentinel event, they all had a negative, finger pointing attitude of doing the minimum to get by and not taking responsibility for the sentinel

event. There was also a cumulative feeling among the staff of fear of reprimand or of being ignored in expressing thoughts about the security of pediatric patients in the surgery area, “ Organizational structure has a direct impact n the communication within an organization. The way the hierarchy of an organization is designed either invites feedback, open-mindedness and effective communication or stifles, controls and restricts the ability of subordinates to freely express thoughts, feelings and ideas (Papa 2012). ” In the post sentinel event interview, the pre-operative nurse expressed an idea about matching hospital wrist bands for both the child and the parent. This was a good idea, but no system for matching wrist bands was in place.

The pre-operative and post-operative areas were understaffed that day making communication among the nurses hurried and ineffective, ultimately creating gaps in communication and contributing to the sentinel event. The fact that the surgical area was so short staffed left very little time for the nurses to give hand off reports. As a result, many important details were overlooked. The CNO failed to ensure that the required monthly staffing meetings were held among the surgical team members.

Finally, the security personnel were not even called for several minutes after the SP was reported as missing and the security manager failed to perform the “ code pink” child abduction drills on a quarterly basis as required by the hospital’s policy. A3a. Improve Interactions The initiative to improve interactions among the personnel working on 09/14/12 included a new policy implemented on 10/01/12 regarding obtaining custody information and privacy information at the point of registration for any minor child whether it is in the emergency room, inpatient, or outpatient areas of the hospital.

This policy included a stipulation that three things are established: a list of people who are permitted private information, a list of people who are permitted to take the patient out of the hospital, and a four digit pin number established by the parent. Information and/or the patient themselves will only be released strictly to a person who is both on the privacy list and who have the pin number. A policy and procedure was also implemented on 10/01/12 in the outpatient surgery area which included detailed procedures for patient hand off when the patient was moved from one area to the next.

A new patient hand off form was created which included basic demographic data, medical history, allergies, medication profile, the privacy list, pin number, and any other pertinent custody information for minor children. The registrar must document that both a verbal report and the written report were given to the pre-operative nurse. The pre-operative nurse must then document this same information was relayed both verbally and in writing to the OR nurse and the OR nurse is also required to document this same information was relayed both verbally and in writing to the PACU nurse.

The hand off forms must be signed by both the person reporting off and the person receiving the report and filed in the patient's paper chart or scanned into the patient's electronic medical record. A mandatory in-service meeting for all staff was held on 09/28/12 to teach the staff the new policy and procedures. Also, the required monthly staff meetings for the entire surgical team (including physicians) will be implemented to serve as a town hall approach discussion to get any complaints or suggestions by the staff out in the open.

In addition to the monthly staff meeting, there will be required in-serviceeducationfor the staff for the next twelve months including patient safety, child abduction prevention, improvisational workshops to prompt discussion among staff, patient hand-off, time out before discharge, patient rights, diversity training, verbal communication, nonverbal communication, shift change reporting, patient satisfaction, and patient education. A4. Quality Improvement The identification and data gathering quality improvement method was used in the root cause analysis of the sentinel event.

First the problem was identified; the processes needing improvement were pediatric safety and staff communication. These processes were identified through the post sentinel event interviews of the staff, administrative staff post sentinel event huddles, and surgery staff post sentinel event huddle (including security staff). The data was gathered from the SP’s medical records and a timeline was created starting when the SP entered the hospital and ending when the SP left the hospital with her father. This timeline included an analysis of what was actually done by each employee and also what should have been done to prevent the sentinel event.

The question of why was asked when inactions were determined to be what resulted in the sentinel event. Along with the SP’s medical record, all other medical records for minor children who received outpatient surgery at the hospital during the first two weeks in September were also analyzed to determine that the inactions on the part of the outpatient surgery staff were a systemic problem and that this was not an isolated case. Staffing ratio

policies were reviewed and security policies on “ code pink” drills were also reviewed.

Staff meetings were held weekly where feedback was provided to staff during the root cause analysis process regarding performance indicators and benchmarking against other hospitals of similar size in the areas of patient hand offs, staff to patient ratios and performance of security drills including child abduction drills. After the data was gathered, all involved in the sentinel event were gathered and a list of causes of the sentinel event was created. This list was used in creating the recommendations to improve staff communication and creating the process change to ensure that the sentinel even does not recur.

B1. Risk Management Program The process of obtaining custody information and privacy information at the point of registration for any minor child, in all areas of the hospital, will be managed and directed by the head Quality Improvement Officer of the hospital. The new policy also has a requirement to prevent the sentinel event from happening again; at the point of registration any minor child under the age of 18 will have a bar-coded band put on their wrist or if they are less than four years old, on their ankle.

The parent(s) or legal guardian(s) will be required to wear a wrist band with a matching bar code. Before the child is discharged home, both wrist bands will be scanned with the computer bar code scanner to ensure the wrist bands match. Only the parent(s) or guardian(s) with proof of legal custody will have the wrist band. Additionally, at the point of registration, the parent(s) or guardian(s) will be asked to choose a four digit pin number which will be noted in the electronic medical record under the security tab.

At the point of discharge, the parent(s) or guardian(s) will be required to give the four digit pin number before the child is released to them for discharge. These measures are to be implemented by 10/05/12 with 100% compliance expected by 10/12/12. Starting on 10/05/12, the Quality Improvement Officer will audit 25% of all admission paperwork on a weekly basis to ensure compliance with the new policy. The Quality Improvement Officer will keep a log of this audit process and the outcomes of the audits. If a registrar is found to be out of compliance with the requirement, disciplinary action will occur.

Starting 10/05/12, the Nurse Manager of the outpatient surgery area is required to audit 25% of the outpatient medical records on a weekly basis for compliance with the new patient hand off policy and procedure which applies to adult and minor child patients. She will also keep a log of this audit process and the outcomes of the audits. The Quality Improvement Officer and the Nurse Manager of the outpatient surgery area will hold bi-weekly meetings with the heads of each department in the hospital to review the audit results and to obtain feedback from each department regarding the new policies and procedures.

The Nurse Manager of the outpatient surgery area will hold bi-weekly meetings with the outpatient surgery staff to review the audit results and to obtain feedback on the new admission process for minor children and the new patient hand off process for all patients. Starting 10/01/12, the Nurse Manager of the outpatient surgery area will also be responsible for closely monitoring the daily staffing ratios and ensuring that adequate staff is working during each shift.

Also starting 10/01/12, the head of the security department will be responsible for performing the “ code pink” drills monthly and documenting these in the security log book. New security cameras will also be installed in the outpatient surgery area, at all exit doors, by 10/12/12. B1a. Resources The resources needed to support the changes to prevent the sentinel event from recurring are the medical staff, corporate compliance staff, administrative staff, human resources, and outside compliance consultants.

The legal team was immediately involved in the sentinel event to minimize the risk involved in an event such as child abduction. Thefinancedepartment will provide the financial resources to purchase the new bar coded band system and the new security cameras. The staff will need to be trained on the new policies and procedures by the education department. Also, it is essential that each shift and each department have an adequate staffing ratio which is the responsibility of the hospital administration and the CNO.

Human resources, administration, and the CNO were involved in interviewing and counseling the staff involved in the sentinel event. They will have an ongoing responsibility to follow up with the staff to ensure compliance with the new policies and procedures. Outside compliance consultants were also utilized in completing the root cause analysis, creation of the plan of correction, and implementing the plan of correction. C. Sources Papa, J. (2012, May 9). General format. Retrieved from http://www. ehow. com/about_6071356_communication-organizational-structure. html