Safety Action Series

Changes to the Joint Commission Sentinel Events Chapter

Focus on Severe Maternal Morbidity
Speaker Panel

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Disclosures

- Lisa Buczkowski, RN, MS has no real or perceived conflicts of interest to disclose.

- Gerry Castro, PhD, MPH has no real or perceived conflicts of interest to disclose.

- Erin Dupree, MD, FACOG has no real or perceived conflicts of interest to disclose.

- John Wachtel, MD, FACOG has no real or perceived conflicts of interest to disclose.

- Ron Wyatt, MD, MHA, DMS (HON) has no real or perceived conflicts of interest to disclose.
Objectives

 Provide a detailed overview of the changes to the Joint Commission Sentinel Events Chapter:
  • Review the revised sentinel event list with a focused discussion on the new definition of severe maternal morbidity
  • Explain the concepts of the comprehensive systematic analysis process

 Provide tips and suggestions for conducting effective root cause analyses following a severe maternal event
Severe Maternal Morbidity: Clarification of the 2015 Joint Commission Sentinel Event Policy
Definition of Sentinel Event

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*
*Severe temporary harm*

Critical, potentially life-threatening harm lasting for a limited time with no permanent residual, but requires transfer to a higher level of care/monitoring for a prolonged period of time, transfer to a higher level of care for a life-threatening condition, or additional major surgery, procedure, or treatment to resolve the condition.

An event is also considered sentinel if it is one of the following:

- Suicide of any patient receiving care, treatment, and services in a staffed around-the-clock care setting or within 72 hours of discharge, including from the hospital’s emergency department (ED)
- Unanticipated death of a full-term infant
- Discharge of an infant to the wrong family
- Abduction of any patient receiving care, treatment, and services
Cont’d

• Any elopement (that is, unauthorized departure) of a patient from a staffed around the-clock care setting (including the ED), leading to death, permanent harm, or severe temporary harm to the patient

• Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities (ABO, Rh, other blood groups)
• Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of any patient receiving care, treatment, and services while on site at the hospital

• Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of a staff member, licensed independent practitioner, visitor, or vendor while on site at the hospital
Cont’d

- Invasive procedure, including surgery, on the wrong patient, at the wrong site, or that is the wrong (unintended) procedure
- Unintended retention of a foreign object in a patient after an invasive procedure, including surgery
- Severe neonatal hyperbilirubinemia (bilirubin >30 milligrams/deciliter)
Cont’d

• Prolonged fluoroscopy with cumulative dose >1,500 rads to a single field or any delivery of radiotherapy to the wrong body region or >25% above the planned radiotherapy dose

• Fire, flame, or unanticipated smoke, heat, or flashes occurring during an episode of patient care

• Any intrapartum (related to the birth process) maternal death or severe maternal morbidity
Severe Maternal Morbidity

DEFINITION

A patient safety event that occurs intrapartum through the immediate postpartum period (24 hrs), that requires the transfusion of 4 or more units of blood products (fresh frozen plasma, packed red blood cells, whole blood, platelets) and/or admission to the intensive care unit (ICU). Admission to the ICU is defined as admission to a unit that provides 24-hour medical supervision and is able to provide mechanical ventilation or continuous vasoactive drug support.

- American College of Obstetrics and Gynecology, the US Centers for Disease Control and Prevention, and the Society of Maternal and Fetal Medicine

See [here](#) for a joint statement from ACOG, AWHONN, SMFM, TJC on definition and revised policy.
Case Example #1

A G4P3 woman with known placenta accreta underwent cesarean birth during which expected but profound bleeding requiring 4 units of packed red blood cells occurs. She was monitored in the ICU overnight with a subsequent unremarkable postpartum stay and was discharged.

Comment: Since this woman received four units of packed red blood cells and required ICU admission, this case meets the criteria for severe maternal morbidity and should undergo a multidisciplinary review. Although there may be identification of areas for improvement (eg, consultation in advance, interventional radiology), this does not meet the criteria for a Joint Commission sentinel event because the patient’s underlying condition (placenta accreta) would be expected to result in this type of blood loss. Nevertheless, there may be areas for improvement to be identified.
Case Example #2

A woman at 40 weeks 0 days presented with preeclampsia with severe features and developed very elevated blood pressures requiring multiple mediations and an ICU admission.

Comment: This case is similar to case #1 and does not meet the criteria for a Joint Commission sentinel event because the patient’s underlying condition (preeclampsia with severe features) would be expected to result in this type of treatment. Again this case would benefit from a multidisciplinary review for improvement opportunities. However, had she experienced a stroke, the case should be reviewed as a sentinel event given the severe temporary and potentially permanent harm related to the complication.
Case Example #3

A G1P0 woman with gestational diabetes and preeclampsia was admitted for a medically indicated induction of labor. Her cervix was long and closed, a long induction ensued, and after 36 hours of oxytocin induction with an epidural and two hours of pushing she delivered vaginally. After spontaneous delivery of an intact placenta, she hemorrhaged profusely. She required 6 units of packed red blood cells and was transferred to the ICU in unstable condition.

Comment: This case also meets the definition for severe maternal morbidity and should undergo multidisciplinary review. However, this outcome is not due to the patient’s underlying medical condition and therefore meets the criteria for a Joint Commission sentinel event.
Case Example #4

A woman at 39 weeks 2 days underwent a scheduled repeat cesarean birth and during the procedure is noted to have multiple premature ventricular contractions on the cardiac monitor. She was admitted to the ICU for cardiac monitoring for 24 hours and received no further treatment.

Comment: This case meets the criteria for severe maternal morbidity and should be subject to a multidisciplinary review. It may or may not rise to the level of a Joint Commission defined sentinel event depending on the findings during the review.
Comprehensive Systematic Analysis
Objectives of Root Cause Analysis/Comprehensive Systematic Analysis

1. Identify hazards and vulnerabilities that impact patient safety and then prioritize them.
2. To determine if action is required.
3. Ensure the timely execution of an RCA and formulation of effective sustainable improvements and corrective actions.
4. Ensure follow-through to implement recommendations.
5. Measure whether corrective actions were successful.
6. Ensure that leadership at all levels of the organization participate to make sure that RCAs are performed when appropriate, in a timely manner, and that corrective actions are implemented to improve patient safety.
Rules of Causation*

1. Clearly show the “cause and effect” relationship

2. Use specific and accurate descriptors for what occurred, rather than negative and vague words.

3. Human errors must have a preceding cause.

4. Violations of procedure are not root causes, but must have a preceding cause.

5. Failure to act is only causal when there is a pre-existing duty to act.

*Department of Veterans Affairs, Veterans Health Administration Patient Safety Handbook 1050.01, March 4, 2011

*Marx, David “Maintenance Error Causation” A technical report prepared for the Federal Aviation Administration; June 9, 1999
Review of Comprehensive Systematic Analyses and Action Plans

A comprehensive systematic analysis will be reviewed for thoroughness, credibility, and acceptability.

To be thorough, the comprehensive systematic analysis must include the following:

• The analysis repeatedly asks a series of “Why” questions, until it identifies the systemic causal factors associated with each step in the sequence that led to the sentinel event
• The analysis focuses on systems and processes, not solely on individual performance
• A determination of the human and other factors most directly associated with the sentinel event and the process(es) and systems related to its occurrence
• The analysis of the underlying systems and processes through the series of “Why” questions determines where redesign might reduce risk
• An inquiry into all areas appropriate to the specific type of event
• An identification of risk points and their potential contributions to this type of event
• A determination of potential improvement in processes or systems that would tend to decrease the likelihood of such events in the future, or a determination, after analysis, that no such improvement opportunities exist
To be **credible**, the comprehensive systematic analysis must do the following:

- Include participation by a process owner who is not a member of the response team; typically this is a senior leader of the hospital or a designee**
- Include individuals most closely involved in the processes and systems under review be internally consistent (that is, not contradict itself or leave obvious questions unanswered)
- Provide an explanation for all findings of “not applicable” or “no problem”
- Include a bibliography of any relevant literature

An action plan will be considered **acceptable** if it does the following:

- Identifies changes that can be implemented to reduce risk or formulates a rationale for not undertaking such changes
- Identifies, in situations where improvement actions are planned, who is responsible for implementation, when the action will be implemented, how the effectiveness of the actions will be evaluated, and how the actions will be sustained
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Tips for Performing a Root Cause Analysis
Root cause analysis (RCA) is a group of problem-solving methods aimed at identifying the underlying causes of problems or events. The practice of RCA is predicated on the belief that problems are best solved by attempting to correct or eliminate underlying causes, as opposed to merely addressing the immediately obvious symptoms.
RCA: General Principles

- RCA is more effective than treating only the symptoms of a problem.
- RCA must be performed systematically.
- Conclusions must be backed up by evidence.
- It is common to have more than one root cause for any given problem.
Use and Focus of RCA

• Used as a learning tool to:
  – Prevent similar errors in the future
  – Facilitate open communication
  – Promote teamwork
  – Enhance patient safety and quality of care

• Focuses on systems and processes rather than individual performance

http://www.va.gov/ncps/vision.html#RCA
1. Form a Root Cause Analysis Team

2. Identify Problem

3. Gather information/evidence

4. Determine the Root Causes and Contributing Factors

5. Explore risk reduction and quality improvement strategies

6. Implement redesigns

7. Monitor and evaluate new system
1. Forming RCA team

Potential Participants

- Physician
- Nurse
- Pharmacist
- Social Worker
- Administrator
- Risk manager
- Quality Improvement Analyst
- Patient (member of community)
- Information Systems
- Facilitator
2. Identify the Problem

- Define the adverse event/near miss that occurred
- Establish what area the Root Cause Analysis will investigate
- Keep it simple
- Brainstorm primary cause(s), e.g., patient death caused by medication overdose

ACOG Committee on Patient Safety and Quality Improvement
3. Gather information/evidence

Interview all those involved in the process leading up to the event

- Clinicians
- Administration
- Health Unit Coordinator
- Social Workers
- Patient, if possible
- Patient’s family, if applicable
Summary

• RCA is a retrospective learning tool
• Evaluates Sentinel Events, near misses
• Concentrates on system issues rather than individual blame
• Regulatory agency requirement
• RCA is part of a continuous quality improvement program
Q&A Session

Press *1 to ask a question

You will enter the question queue
Your line will be unmuted by the operator for your turn

A recording of this presentation will be made available on our website:
www.safehealthcareforeverywoman.org
Next Safety Action Series

Connected Regional Projects

Wednesday, February 18 | 11:00 a.m. ET

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