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Investigating Sentinel Events: How to Find and Resolve Root Causes

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Investigating Sentinel Events: How to Find and Resolve Root Causes

by Patrice L. Spath

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Patrice Spath's spiral-bound 142-page book provides administrators of health care facilities with a consultant's prescription for responding to adverse patient outcomes. All organizations should use "principles and techniques of total quality management" to establish a "systematic process that uses information gathered during an investigation of an undesirable event to determine the underlying reasons for deficiencies or failures," Spath writes, referring to this process as "root cause analysis." In the opening chapter of her book, Spath argues that these tools of analysis, used in a variety of industries, can and should also be used by health care organizations to develop an appropriate systemic response to adverse or unexpected health outcomes.

In Chapter 2, entitled "What is a Sentinel Event?," Spath draws on malpractice studies, Joint Commission on Accreditation of Healthcare Organization standards of incident reporting, risk management criteria for job-related injury, and other professional screening criteria to conclude that there is no "right" definition for an "important single event." Each organization should develop its own definition of a sentinel event, as well as procedures and methods for investigating the causes of those adverse outcomes, she suggests.

Next, in Chapter 3, "Accreditation Issues," Spath informs managers that the changing requirements of regulatory bodies and accrediting agencies about notification of incidents may require more sophisticated tools of analysis. (Indeed, this reviewer suspects that the Joint Commission's implementation of its Accreditation Watch process may well have been the catalyst behind publication of this manual.) In this chapter, Spath provides insights into and practical tips on how an organization might respond to a Joint Commission request for a report on an unexpected patient outcome. Her major recommendation, however, is that organizations should move beyond Joint Commission requirements for establishing the causes of adverse outcomes and establish more sophisticated "root cause" methodologies.

In Chapter 4, "Sentinel Event Investigation," Spath offers readers specific tools for accomplishing that objective, listing 11 types of analysis that organizations can use to identify an event's causal factors. These range from an Events and Causal Factors Chart developed by the National Safety Board for use in reporting accidents, to the Failure Mode and Effect Analysis now required by the Federal Drug Administration in the event of adverse patient outcomes related to drug and medical device use. In addition to describing these various tools and how one identifies a root cause, Spath provides information on how to develop action and follow-up plans and how to report investigation results.

So far, so good. Yet despite the title of this work—*Investigating Sentinel Events: How to Find and Resolve Root Causes*—it is surprising that Spath focuses solely on analysis of causes of adverse patient outcomes, rather than on issues related to their resolution. Perhaps she assumes that the tools of root cause analysis are similar to those used in ongoing improvement programs and that the systemic solutions she envisions are to be built on preexisting techniques of total quality management.

Implicit in Spath's conceptual analysis is confidence that tools of analysis that have been used successfully in other industries will lead to successful systemic resolutions in health care. Regrettably, this reviewer lacks the confidence that Spath's version of root cause analysis will, in fact, produce systemic solutions to patient injury in health care. That is because although Spath speaks of removing "blame" from the process of investigation, she fails to deal with one of the most important factors in the existing paradigm for resolution of bad patient outcomes: the fear of litigation.

Indeed, Spath makes only passing reference to the role of law in determining how patient injuries should be investigated and, implicitly, resolved. She even goes so far as to recommend against including the organization's lawyer as a member of the investigating team because the only role she anticipates for a lawyer is to "protect the organization from liability and discover a defendable cause for the event" of a bad patient outcome. It is only at the very end of her book that she encourages someone in the organization to ask, "What is the role of the hospital's legal counsel in a root cause analysis?"

Furthermore, she asserts that it is important to ensure that information collected is protected from "legal discovery and other unauthorized disclosure." Spath's advice seems realistic, given the attitudes of health care professionals toward the present system of medical liability. But, for better or for worse, that system is part of the existing method of responding to adverse patient outcomes. Her advice, and the conventional advice of defense counsel, encourages health care organizations to keep the patient or the patient's family members in the dark during and

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after an investigation into cause. This approach may be seen as a necessity from the point of view of lawyers who want to win cases for their hospital clients. But, one may ask, what does it contribute to building patient trust and confidence that the health care system is committed to the highest standards of patient care and safety?

A resolution of the causes of patient injury or death that ignores the importance of providing patient or patient's family members with an understanding of the causes of the event contributes little to encouraging us to think about health care as a system. Perhaps there is a better way. Take, for example, the experience that has come to be known as the Martin Memorial Hospital case, which involved the death of a young child during a routine surgical procedure.

In this case, Martin Memorial shared its findings about the causes of the accident both with the child's parents and with their lawyer. At the recent annual forum of the National Health Council, the hospital's risk manager, insurance representative, and lawyer, as well as the parents' lawyer, spoke openly as participants in a panel discussion on how the case was quickly settled after it was determined that the hospital's drug handling system had been implicated in the tragic accident. The collaborative process described by the panel members clearly focused on the health and safety of the patient involved, as well as on the health and safety of future patients. Most of those in the audience—which included physicians, nurses, pharmacists, and insurers, as well as lawyers—seemed inspired by this candid and refreshing approach.

Making this kind of patient-centered process a model for investigating and resolving adverse patient outcomes requires a major rethinking of our present responses to risks and patient injuries. Hospitals would have to develop policies and procedures regarding which cases to settle, while acknowledging that the legal system's definition of cause might differ radically from its own standards for determining causes of patient injuries. Insurers would have to form partnerships with hospital managers to develop optimal systems for detecting and correcting the systemic causes of patient injury. Health care professionals and facilities would have to accept the fact that the existence of some system of accountability for patient injury—even a highly imperfect system of medical liability — is a condition of patient trust. Finally, but perhaps most importantly, lawyers who represent patients and hospitals would have to learn to judge their professional effectiveness not by whether or not their clients win a judgment, but by what happens to patients who are involved in sentinel events or to surviving family members.

Spath provides us with a method of detecting and correcting medical errors within health care organizations. But her vision of resolving patient injury excludes the human face of the sentinel event: the patient and the family members. As a result, she offers readers no insight into how society's existing system of accountability for medical errors could be improved upon if there were better understanding not only of the causes of patient injury, but also of the systems that promote patient health and safety. Until health care professionals start to develop analyses that demonstrate how the medical liability system affects the internal medical error detection and reporting systems of health care organizations, the public is unlikely to modify the medical liability system.

In one sense, Spath's book is practical: it costs $40 and even provides a template for writing an incident report required by an accrediting or state agency. It also identifies software that can be used in developing charts and reports on the causes of patient injury for use in the course of investigations. But let the buyer beware. If you are a manager of a health care organization who is concerned only with minimizing costs and organizational disruption, Spath's recommendations are likely to seem relatively easy and inexpensive to implement. If, however, you are a health care manager or member of a board of directors of a health care organization who is concerned with trying to inspire a whole new organizational culture of improved patient safety, perhaps you should read a different book.

Larry I. Palmer is professor of law at Cornell University and a member of the National Patient Safety Foundation's Board of Directors. He has written extensively on issues related to law and medicine. From 1987 to 1994, he served as a vice president of Cornell University and was a member of Cornell's Quality Council, the Total Quality Improvement effort of the university.

Read more about it!

These resources may be available through your local library for further exploration into root cause analysis:

- *Conducting a Root Cause Analysis in Response to a Sentinal Event.* Oakbrook, IL: Joint Commission on Accreditation of Healthcare Organizations. 1996.
- Deming WE. *Out of the Crisis.* Cambridge MA: Massachusetts Institute of Technology, Center for Advanced Engineering Studies. 1982.
- Dew JR. In search of the root cause. *Quality Progress.* 24(3): 97-102, March 1991.
- Wilson PF, Dell LD, Anderson GF. *Root Cause Analysis.* Milwaukee, WI: American Society for Quality Control Press. 1993.