Safety Solutions Monitoring

Clinical nurses' experiences with sentinel events

By Misty Stone, MSN, RN

Little is known about nurses' perceptions of sentinel events (SEs) and/or the changes needed in the work environment to best support nurses following such events. The Joint Commission defines an SE as an unexpected occurrence involving death and/or serious physical and/or psychological injury to a patient.[1] Although data about SE numbers are accessible, there's little information about nurses' perceptions of these events.

For the years 2005 to 2017, The Joint Commission reported that 67% of all SEs occurred in a hospital setting.[1] SEs for the years 2005 to 2017 claimed the lives of 5,826 patients, with an overall total of 11,189 patients impacted in some way.[1] Although patients and families are dramatically affected after an SE, so is the nurse who was involved in the event. In the days following such an event, the needs of the nurse are overlooked during this very difficult and traumatic time, leaving them to suffer in silence.[2]

The purpose of this study was to describe nurses' experiences with SEs in hospital settings, including intensive care, medical-surgical, long-term care, psychiatric, and Alzheimer units. (See *Research box.*)

Study design and demographics

For this pilot study, a qualitative descriptive phenomenologic approach was used for data collection and analysis to capture the lived human experience of RNs who experienced an SE. Hospital clinical nurses were recruited for this pilot study because, according to The Joint Commission's statistics, many SEs occur in the hospital setting.[1] Participants were recruited using purposive sampling through social media (such as Facebook). Participation was voluntary, with consent obtained from each participant. Institutional Review Board approval for the study was obtained before recruitment.

One-on-one semistructured interviews were conducted in a private place of the participant's choosing. After obtaining basic demographic information (age, gender, years of nursing experience), open-ended questions were asked to gather information regarding the SE that occurred, the nurse's feelings about the SE, the work environment before and after the SE, and the type(s) of support provided to the nurse following the SE. Probing questions focused on what happened before, during, and after the SE, the nurse's perceptions of why the SE occurred, and if the SE could have been prevented. *(See Participant SE experiences.)*

Five RNs, each from different hospitals, shared their SE experiences with the researcher. One participant had an associate degree in nursing and four participants had a master's degree in nursing education. Of the five participants, four held leadership positions (charge nurse and/or nurse supervisor) when the SE occurred, so they gave their experience from that perspective. One participant worked on the ICU, one on a psychiatry unit, one on an Alzheimer unit, and two on medical-surgical units. Years of nursing experience for the participants at the time of the SEs ranged from 1 to 30 years.

Inclusion criteria included being a nurse who was involved (directly or indirectly) with an SE in a hospital setting in the US and being able to read and write English. Exclusion criteria included being unable to read or write English and never being involved in an SE in a hospital setting in the US.

Data collection and analysis

Interviews were audio recorded and transcribed verbatim by the researcher. Names of the participants were changed to pseudonyms. The researcher used bracketing to put aside the information previously learned about

Participant SE experiences

The eight SEs described by the participants were:

- a young patient who became paralyzed
- a patient who jumped from the second story window of the psychiatry unit
- a patient who escaped a psychiatry unit and was found on a postpartum unit
- a patient who was found with her head and neck trapped in a hospital bed's side rails
- a patient on an Alzheimer unit who escaped the unit and was lost in the woods
- a patient who was misdiagnosed and subsequently died
- a renal patient who received four times the dose of a prescribed medication
- a nonverbal patient whose care was being overseen by hospital residents.

Research box

- The purpose of this pilot study was to develop an understanding of nurse perceptions of SEs.
- Five RNs were interviewed; one from the ICU, two from the medical-surgical unit, one from the psychiatric unit, and one from the Alzheimer unit.
- All participants were RNs; one had an associate degree in nursing and four had a master's degree in nursing education.
- Each participant was from a different hospital located in the US.
- The participants' years of nursing experience at the time of the SE ranged from 1 to 30 years.
- One-on-one semistructured interviews with open-ended questions were conducted in a private place of the participant's choosing from May 2018 through June 2018.
- Two main themes were identified from the participants' experiences of being involved in an SE: failures of the work environment and when emotions, feelings, and behaviors affect practice and personal life.

the phenomenon to examine the data collected. The researcher recorded field notes to document participant emotions, responses, and the environmental context to get a thick description of the participant's story. For an audit trail, the researcher kept a personal journal, which ensured rigor. Interviews were conducted in a private setting of the participant's choosing that was free of distractions and ensured confidentiality.

Data analysis followed Munhall's conceptual model of phenomenology that explored the uniqueness and the human experience of each participant.[3] The researcher spent significant time dwelling with the data until the essence and themes of the participants' experiences were identified. Dwelling with the data included listening to the audio-recorded interviews numerous times and comparing field notes with the audio recordings, which allowed the researcher to become fully immersed in the data to acquire an understanding of the participants' experiences while making sense of these accounts. Through extraction of each participant's significant statements that pertained directly to the phenomenon of interest, the researcher was able to formulate meanings. The researcher then categorized the formulated meanings into common themes.

Although the researcher conducted the coding of data independently, it was reviewed for accuracy by another researcher to ensure that the themes and relationships were presented accurately. This process continued until a consensus was reached, which established credibility and dependability of the data analysis process.[4]

Results

Two main themes were identified from the participants' experiences of being involved in an SE: failures of the work environment, and when emotions, feelings, and behaviors affect practice and personal life.

Failures of the work environment

For the theme "failures of the work environment," the participants noted that the work environment wasn't welcoming, and the nurse's problems were the nurse's problems to be dealt with. One participant stated, "We were always busy … We were actually licensed for 20 patients and often ran a census of 22 to 25." Another shared, "We were all new nurses… We were short-staffed that day… My problems were my problems." Another added, "Sometimes the elevator door would just open. We'd been telling people that the elevator door wasn't doing what it was supposed to, and they argued with us… Our nurse manager and even the head leadership people wouldn't listen, they just didn't believe us."

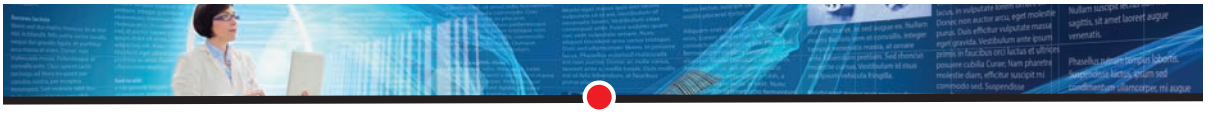
During the interview, participants shared their perceptions as to why the SEs occurred. "Honestly, I think [the nurse] probably wasn't mentored good enough because this wasn't the first time a mistake had happened, but this was the first time a mistake of this caliber had happened," stated one participant. Another said, "I don't think the resident listened to his nurse [me]… The doctor was leaving the floor while we were rounding with the residents… I went running after him and I said my patient, he's going to die. He said trust me they [the residents] got this, and I believed him… As far as they [the residents and provider] knew, they were going to let my patient die but they hadn't told me." She continued, "I felt like I wasn't being listened to by the provider or my nurse manager… I stayed after work that night… I charted a whole note about every time I had talked to the resident and what I had said. The next day a coworker called me to tell me that he [the patient] had died during the night."

When emotions, feelings, and behaviors affect practice and personal life

Participants described how they continue to relive the SE, even years later. For the theme "when emotions, feelings, and behaviors affect practice and personal life," several of the participants noted that they were afraid another mistake was going to occur again. Due to such fears, one participant considered changing hospital units, with another participant stating, "She [the clinical nurse] was visibly distraught [so much so] she couldn't even participate in the code… She actually ended up transferring out of the ICU within 3 months." Another voluntarily stepped down as the unit's charge nurse. One participant shared how one nurse who was directly involved in an SE left nursing after 20 years in the profession, stating, "She [the clinical nurse] called out sick several days after all that

happened. She never returned to the unit and she ended up leaving nursing altogether. She wasn't even old enough to retire."

One participant said, "After a sentinel event experience, you're constantly holding yourself accountable." Another shared, "I actually went and shadowed in another department at the hospital." And another participant stated, "Every day when I would clock in, I would ask myself when is it going to happen again? Did I do the right thing? Every day!"



"After a sentinel event experience, you're constantly holding yourself accountable."

Discussion

Each participant described how the SE experience caused significant distress, comparing it with posttraumatic stress. Two participants described that they felt as though they were reliving the event due to the lengthy investigation process that was conducted by risk management and nursing leadership in the weeks and months following the SE. One participant stated, "I understand they [risk management and nurse managers] needed to do their investigation, but I needed help too. I needed help in understanding what happened, and I needed someone to listen to me and to hear what I was feeling. But that never happened." All participants noted how they would have liked support from their nurse managers following the SE.

The participants' recollections of the events were precise and vivid, recalling the smallest details, such as the time of day the event occurred and the nurse-to-patient staffing ratio; some could recall the patient's room number. The participants experienced feelings such as guilt, anger, and embarrassment following the SEs. One participant noted that after the SE, her confidence was shattered because of how she was treated in the days following the SE. She stated, "Not only did I lose my confidence, but I lost my identity as a nurse."

Being involved in an SE can be stressful and traumatic, causing substantial distress. Although research studies show that peer and organizational support are needed following an SE,[5] surprisingly all five participants talked about how this wasn't provided or ever offered to them or their colleagues. When organizational support is lacking following traumatic events such as SEs, the literature suggests that nurses can experience emotions similar to those seen in posttraumatic stress disorder.[6] This reinforces the importance of ensuring that nurses receive emotional support from nurse managers, their peers, and the overall organization to move past the event and thrive in the nursing profession.[7] The literature suggests that this support should come in the form of peer support programs, but the debate about whether emotional support should be a one-size-fits-all approach is ongoing.[1] Studies have made various suggestions for emotional and peer support strategies that can be used in organizations, such as using trained peer-to-peer supporters.[1,5,8,9]

Limitations and recommendations

This pilot study included a small number of participants. The small sample size could be due to the psychological trauma that's often associated with being involved in an SE. The sample size may limit the transferability of the study's findings. In addition, for recruitment and sampling, there's potential for self-selection bias due to the strategies that were used to reach this specific population of individuals. Regarding potential recall bias, it was noted that due to the profound effects of the SEs, participants were able to vividly discuss their experiences. More research is needed to explore organizational barriers and facilitators for developing and sustaining support programs for nurses following an SE.

Nursing management implications

Nurse managers need to have an active role in supporting clinical nurses after an SE and in the weeks and months to follow; caring for the caregiver should be the nurse manager's priority. In a healthcare environment that currently faces a nursing shortage, nurse managers and organizational leaders must develop and sustain support programs for nurses following an SE so they don't leave the organization. NM

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