**Discuss a sentinel event that occurred in your facility or unit and what was the outcome? Please provide details of the event**.

I was working in a surgery unit where I was assigned to a patient who was scheduled to do right modified radical mastoidectomy for right chronic suppurative otitis media. Usually the patient only shaves around the right or left ear depending on the ear that needs to be operated. My patient shaved the entire head because he said he don’t like the way he look when only one part of the head in shaved. Hospital escort came and patient was transported to the operating room for right modified radical mastoidetomy. Patient came back to the unit following surgery with dressings on the left side of the ear. I was shocked to see that because I knew that patient right ear needs to be operated, not the left one. I immediately called the operating room and spoke to one of the nurses and to find out, they operate the wrong ear by mistake. One of the family member was in a medical field and he contacted the Joint commission about the sentinel event that occurred in our hospital and hospital had to prepare a thorough and credible root cause analysis and action plan within 45 days of the event.

**Did any policy/procedure, guideline, change, or develop in response to the event? If so what was it and did it help?**

Following the root cause analysis they found that there was no intraoperative site verification because it was a busy day where multiple procedure was performed by the same provider, and he and his team did two modified radical mastoidectomy(right ear) prior to this case. There was also no effective hand-off communication or briefing process. After doing the root cause analysis they made an action plan where they made a mandatory pre-operating briefing in the operating room with the patient involvement to verify patient identity, procedure site and side, along with other critical elements that need to be verified and addressed but are a part of the Time Out process.

**Do you feel the event could have been avoided? Why or why no**

I feel the event could have been avoided because after doing the root cause analysis they found the cause of the event was lack of intraoperative site verification by the provider and lack of effective hand-off communication or briefing process. If the provider had done intraoperative site verification and also if there was proper communication between the health care team then this event could have been avoided.

**Was staffing an issue that impacted on the event?**

No staffing was not an issue that impacted on the event, the issue was improper communication and lack of intraoperative site verification.

**The Joint Commission established the 2018 National Patient Safety Goals (NPSG) with the overall goal to improve patient safety, was the sentinel event related to any of their 2018 goals?**

Yes, the sentinel event was related to 2018 goals.

Under UP.01.01.01: Conduct a preprocedure verification process

Under UP.01.02.01: Mark the procedure site

Under UP.01.03.01: A time-out is performed before the procedure.

**Reference:**

1: National Patient Safety Goals Effective January 2018. (n.d.). Retrieved April 20, 2018, from https://www.jointcommission.org/assets/1/6/NPSG\_Chapter\_HAP\_Jan2018.pdf

2: D. (2010, November 04). Sentinel Events. Retrieved from http://www.youtube.com/watch?v=4HwTBXFkW2U