Sentinel Event Alert

Issue 1 - February 28, 1998
New Publication

We are pleased to introduce the first issue of Sentinel Event Alert, a periodic publication dedicated to providing important information relating to the occurrence and management of sentinel events in Joint Commission-accredited health care organizations. Sentinel Event Alert, to be published when appropriate as suggested by trend data, will provide ongoing communication regarding the Joint Commission’s Sentinel Event Policy and Procedures, and most importantly, information about sentinel event prevention. It is our expectation and belief that in sharing information regarding the occurrence of sentinel events, we can ultimately reduce the frequency of medical errors and other adverse events.

Initially, Sentinel Event Alert will be mailed to the organization chief executive officers and Joint Commission survey coordinators; however, it is expected that eventually Sentinel Event Alert will be sent via broadcast fax. In the future, staff from the Joint Commission will be contacting your organization to collect appropriate fax and e-mail addresses.

While the topic of this first issue is particularly relevant to acute care facilities, we will share information of relevance to all accredited organizations in future issues.

"The way to prevent tragic deaths from accidental intravenous injection of concentrated KCl is excruciatingly simple -- organizations must take it off the floor stock of all units. It is one of the best examples I know of a 'forcing function' -- a procedure that makes a certain type of error impossible."

Lucian L. Leape, M.D.
Harvard School of Public Health

Medication Error Prevention -- Potassium Chloride

In the two years since the Joint Commission enacted its Sentinel Event Policy, the Accreditation Committee of the Board of Commissioners has reviewed more than 200 sentinel events. The most common category of sentinel events was medication errors, and of those, the most frequently implicated drug was potassium chloride (KCl). The Joint Commission has reviewed 10 incidents of patient death resulting from misadministration of KCl, eight of which were the result of direct infusion of concentrated KCl. In all cases, a contributing factor identified was the availability of concentrated KCl on the nursing unit.

In six of the eight cases, the KCl was mistaken for some other medication, primarily due to similarities in packaging and labeling. Most often, KCl was mistaken for sodium chloride, heparin or furosemide (Lasix).

Issue For Consideration

In light of this experience, the Joint Commission suggests that health care organizations NOT make concentrated KCl available outside of the pharmacy unless appropriate specific safeguards are in place.

"Unfortunately, there are too many in health care who feel that if it hasn't happened to them, the adverse experiences of others do not apply. That is why potassium chloride concentrate vials can still be found in patient care areas."

Michael Cohen, MS, FASHP, President, Institute for Safe Medication Practices