

Editorial: Nursing's mandate to redefine the sentinel event

Historically, the role of a 'sentinel' was to stand atop the castle, watching and warning of threats to safety. In modern health care, a 'sentinel event' involves watching for, reporting on and learning about incidents such as medication errors or wrong-site surgery to improve patient safety. Sentinel events are defined as 'an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof' (Joint Commission on Accreditation of Healthcare Organizations 2012). However, the one-dimensionality of reporting clinical or procedural errors as 'sentinel events', while ignoring failures of fundamental care, is akin to guarding only one side of the castle.

Clinical errors are increasingly acknowledged in a blame-free environment for good reason (Black *et al.* 2011). To err is human, however, to be uncaring is unquestionably inhumane. Failing to provide fundamental care such as toileting patients rather than telling them to soil their bed can never be an 'unavoidable accident'. Whether this results from clinicians' actions or inactions, executive and managerial culpability, or system-wide failures matters little to the patient on the receiving end. Nurses, as professed patient advocates are optimally positioned to support the dignity of people in their care wherever possible. The indignity of illness, hospitalisation and reliance on health professionals for the most basic of needs is an arduous prospect for even the most resilient among us. Although the indignity of illness can be an unavoidable burden, its being compounded by fundamental failures in the provision of 'care' is entirely unacceptable. Until these failures of care are taken seriously enough to be classified as bona fide 'sentinel'

or 'never' events, they will be allowed to continue.

Relentless, harrowing reports of gross failures of 'care' suggest that some clinicians are merely occupying the position of 'nurse', not filling it. Interminable accounts from patients and their families (e.g. The Patients Association 2009, Francis 2013) have led to real concern about a perceived 'crisis in care' (Darbyshire & McKenna 2013). While some contend that these incidents are not widespread and factors contributing to their occurrence are complex, nurses cannot become blinkered bystanders, powerless victims or worse, wearily resigned perpetrators.

Indifference and indignity

Throughout the 'crisis reports', a recurring theme stands out; cold, casual indifference to patient dignity stemming from "poor" nursing care (Health Service Ombudsman 2011, Francis 2013). Wynne's (2010) experience highlighted this coldly apathetic approach to 'toileting' patients:

Rather than offering bedpans to those who were unable to get out of bed, patients were actually instructed to soil themselves and the nurses would change the bed afterwards.

Similarly, the Francis Report (Francis 2013, p. 13) amplified the possibility that such incidents were not as isolated as first imagined, finding that:

"Patients were left in excrement in soiled bed clothes for lengthy periods" and that "In spite of persistent requests for help, patients were not assisted in their toileting"

In isolation, such failures of humanity beggar belief, however, the plethora

of similar occurrences (Patient's Association Report 2009, Patient's Association Report 2011, Health Service Ombudsman 2011, Francis 2013, Tadd *et al.* 2011) suggested that heaping such indignity upon patients 'suited the staff's routines' (Health Service Ombudsman 2011, p. 36). Tadd's *et al.* (2011) review into failures of care found that inflicted indignity was endemic in the hospital experience of many older people. Some staff justified this 'just go in your bed' tactic as a sort of perverse risk management strategy, where it was 'safer' if the patient stayed in bed during their excretions.

Despite the onslaught of damning reports since late last decade, no clear evidence has emerged that this disturbing pattern is changing. Recent reports such as the Andrews Report (2014) and the CQC Assessment of Hinchingsbrooke Hospital (Care Quality Commission, 2015) in the UK exposed similar lapses in expected standards of humane care. 'Explanations' for such occurrences were unconscionable:

It was reported to us that unacceptable practice was used to cope with the consequences, such as immobilising patients requiring support and leaving them to soil themselves in their beds. (Andrews & Butler 2014, p. 21)

A disturbingly plausible possibility is that these examples are only snapshots of a broader problem. The indignity of 'iatrogenic encopresis and enuresis' being inflicted upon patients should act as a clarion call to the nursing profession. Without action, each subsequent report into these failures will offer more depressing reading while such constant criticism will erode patient confidence and the resilience of clinicians who do the right thing.

'Not on our watch'

One of the most curious and embarrassing elements in this is the fact that it took formal investigations and public reports to 'officially' expose this practice. We must surely ask 'why weren't these incidents reported as 'sentinel events', 'why did it take an external report for something to be done' and 'where were the voices of outraged nurses?' As a constant presence in the clinical environment and as self-proclaimed 'patient advocates', nurses must surely be sentinels where failures of humanity are evident. For staff to ignore patients' pleas to be helped to a toilet and leave them to wallow in a soiled or soaking bed for extended periods because they were 'too busy' must surely rank as a 'sentinel event'. Such events within an ostensibly caring environment demand investigation and subsequent explanation to identify how these occurrences were allowed to happen and what preventative actions will be initiated.

If nursing and health services are serious about protecting and promoting human dignity and rectifying this offence against everything that nursing should stand for, then it is time to demonstrate it rather than profess it. However, sentinel events continue to be myopically defined as 'medical' or procedural incidents without consideration of failures in upholding human dignity. Worryingly, a literature search revealed that no current system appears to monitor and respond to failures in the humanity and dignity of patient care as they would to physical safety risks. This is surely a 'line in the sand' issue for nursing. It is time that we took the lead here and instituted systems of monitoring, recording and most importantly, learning from 'near-miss' and other existential horror episodes. If nurses and nursing are 'for' anything, we are for the protection and enhancement of human dignity at times when people are at their most vulnerable.

To institute such a system where 'dignity emergencies' are classified as 'sentinel' or 'never', events would not require starting from scratch. There is an abundance of research, reporting matrices and tools (Ladner & Baker 2013, Speroni *et al.* 2013, Tunçalp & Souza 2014) devoted to sentinel events

that could be adapted and drawn upon to enable us to anticipate, prevent and respond to 'dignity emergencies'. The idea that these incidents are not isolated and infrequent should be a major concern for the profession of nursing. Nurses should adopt the role of the sentinels of yesteryear and systematically 'watch' for occurrences of sub-standard care. Nurses can be pivotal in redefining sentinel events and instituting a formal system of monitoring, reporting and preventing that will improve the quality of care. Such a system should embody the values of a 'patient-first' profession who believe in the preservation and support of human dignity during illness or incapacity.

This is elementally important to our profession. Nursing can and must embrace the role of the 'human dignity sentinel' and declare of 'just go in your bed/pad': 'not now, not ever, not on our watch'.

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