CONCEPT

Clinical Incident Management: Sentinel Event Review and Global Trigger Tool

19 – 23 July 2027
Barcelona - Eixample district four-star



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Introduction:

Clinical incident management breaks down in many hospitals before any analysis starts: staff stop filing reports because nothing comes back, harm is graded differently on each ward, sentinel events are escalated late and review actions stop at reminders and retraining. Voluntary reports also miss much of the harm that record review finds. This Core Concept course gives patient safety officers, clinical risk managers and department heads a working method for incident intake, harm grading, sentinel event review, trigger-tool record review and closing the loop. Participants produce a Clinical Incident Management Procedure and a Sentinel Event Review File for a case.

Course Objectives:

- Design a clinical incident reporting pathway with a taxonomy, mandatory data fields and defined reporter, handler and reviewer roles
- Triage incoming reports, grade actual and potential harm consistently and route each event to a proportionate learning response
- Recognise sentinel and serious events against agreed definitions and run the escalation, notification and review team set-up
- Run a trigger-tool record review on a random sample of discharged patients and calculate adverse event rates
- Convert review findings into stronger actions from the action hierarchy, with owners, measures and verified closure
- Report incident themes on dashboards, feed learning back to reporters and link findings to open disclosure and claims handling

Target Audience:

- Patient safety officers who run the incident reporting system, screen reports and coordinate event reviews
- Clinical risk managers who hold the risk register, handle serious event escalation and liaise with claims and legal teams
- Department and unit heads who receive incident reports for their area and must close actions within set timescales
- Quality managers responsible for adverse event measurement, incident dashboards and committee reporting
- Patient relations and complaints managers who coordinate open disclosure conversations after harm

Course Outline:

Day 1: Clinical Incident Landscape, Taxonomy and Reporting Culture

- Patient Safety Incident Terminology: Near Miss, No-Harm Incident, Adverse Event and Sentinel Event
- Passive Versus Active Detection: Voluntary Reports, Trigger-Tool Review and Direct Observation
- Incident Taxonomy Design: Event Categories, Contributing Factors and Mandatory Data Fields
- Reporting Culture Barriers: Fear of Blame, Missing Feedback and Physician Under-Reporting
- Incident Management Current-State Audit Using a Reporting Pathway Map

Day 2: Triage, Harm Grading and Sentinel Event Escalation

- Daily Incident Safety Huddle and Report Screening Workflow
- NCC MERP Harm Categories and Severity Assessment Matrix for Actual and Potential Harm
- Sentinel and Serious Event Definitions: Wrong-Site Surgery, Retained Objects, Inpatient Suicide and Transfusion Errors
- Escalation Protocol: Immediate Safety Actions, Executive Notification and External Reporting Timelines
- Proportionate Learning Response Selection: After Action Review, Swarm Huddle, Thematic Review and Full Review

Day 3: Global Trigger Tool Record Review Methodology

- IHI Global Trigger Tool Structure: Care, Medication, Surgical, Intensive Care, Perinatal and Emergency Modules
- Random Record Sampling, Inclusion Rules and Time-Limited Primary Review
- Two-Stage Review: Primary Reviewer Screening and Physician Authentication of Adverse Events
- Adverse Events per 1,000 Patient Days, per 100 Admissions and Percent of Admissions Harmed
- Trigger Review Worksheet Practice on Anonymised Discharge Records

Day 4: Sentinel Event Review Team, Action Hierarchy and Closing the Loop

- Sentinel Event Review Charter: Team Composition, Independence, Terms of Reference and Timescales
- Brief Analysis Toolkit for Clinical Events: Chronology, Cause-and-Effect Diagram and Five Whys
- RCA2 Action Hierarchy: Stronger, Intermediate and Weaker Actions with Outcome Measures
- Feedback to Reporters and Affected Staff: Closure Letters, Learning Summaries and Second-Victim Support
- Links to Open Disclosure, Patient and Family Engagement and Medico-Legal Claims Files

Day 5: Case Work: Incident Management Procedure and Sentinel Event Review File

- Case File: Delayed Recognition of a Deteriorating Patient Leading to Unplanned Intensive Care Transfer
- Case Triage, Harm Grading and Escalation Decision Log
- Incident Dashboard Build: Reporting Rate, Harm Mix, Open Actions and Recurring Themes
- Clinical Incident Management Procedure and Sentinel Event Review File Drafting
- Review File Defence Before a Mock Patient Safety Committee

Skills You Will Gain:

- Incident Taxonomy Design
- Harm Severity Grading
- Sentinel Event Escalation
- Trigger-Tool Record Review
- Adverse Event Rate Calculation
- Review Team Facilitation
- Corrective Action Strength Rating
- Incident Trend Reporting

Why Attend This Course:

- Leave with a Clinical Incident Management Procedure and a Sentinel Event Review File built on a realistic case
- Find the harm that voluntary reports miss by running trigger-tool record review alongside the reporting system
- Replace reminder-and-retrain actions with stronger system fixes that a patient safety committee can verify
- Compare incident handling with patient safety and risk peers from public, private, teaching and specialist hospitals and clinics

Conclusion:

A reporting system earns trust only when every report is graded consistently, serious harm is escalated at once and staff see what changed. The course moves from incident terminology, taxonomy and reporting culture, through triage, harm grading and sentinel event escalation, to Global Trigger Tool record review, then to the review team, brief analysis, the action hierarchy, feedback and links to disclosure and claims. The final day produces a Clinical Incident Management Procedure and a Sentinel Event Review File ready for committee review.