Ann Ist Super Sanità 2024 | Vol. 60, No. 4: 303-310
DOI: 10.4415/ANN_24_04_09

Recommendations for preventing sentinel events: results of a national cross-sectional survey in Italy

Emanuele Sebastiani[1,2], Massimo Maurici[1], Michele Tancredi Loiudice[2] and Domenico Mantoan[3]

[1]*Dipartimento di Biomedicina e Prevenzione, Università degli Studi di Roma Tor Vergata, Rome, Italy*
[2]*Unità Operativa Complessa Ricerca, Agenzia Nazionale per i Servizi Sanitari Regionali, Rome, Italy*
[3]*Agenzia Nazionale per i Servizi Sanitari Regionali, Rome, Italy*

Abstract

Introduction. In 2005, the Italian Ministry of Health entrusted the National Agency for Regional Healthcare Services (Agenzia Nazionale per i Servizi Sanitari Regionali, AGENAS) with the task of monitoring the implementation of recommendations to prevent sentinel events, which are serious adverse events that can compromise patient safety. The aim is to provide Regions and healthcare facilities with a standardised method for managing these events. Currently, there are nineteen recommendations developed with the support of regional experts and other stakeholders.

Objective. This study assessed the applicability and implementation of these recommendations in Italy, also comparing data on the most frequently reported sentinel events.

Materials and Methods. The study, conducted from March to October 2023, involved all acute care, rehabilitation, and post-acute long-term care facilities, both public and private. A questionnaire was used to gather information on the applicability and implementation of the recommendations as of December 31, 2022. The data were analysed using the statistical software Jamovi.

Results. 34.7% of the facilities found no recommendations applicable, while 18.4% considered all 19 recommendations. Regarding implementation, 35.5% did not implement any recommendations, while 11.3% implemented all 19. In particular, Recommendation 4 ("Prevention of patient suicide in hospital") was not implemented by 16% of the facilities.

Conclusions. The applicability of the recommendations varies depending on the type of facility. The implementation rate is influenced by the diversity of participating facilities. The low implementation of Recommendation 4 suggests a need for further investigation to understand the challenges faced.

Key words

- recommendations
- sentinel events
- adverse events
- clinical risk
- risk management

INTRODUCTION

In 2005, the Italian Ministry of Health asked the National Agency for Regional Healthcare Services (Agenzia Nazionale per i Servizi Sanitari Regionali, AGENAS) to activate the monitoring of the implementation at the company level of the recommendations on the prevention of sentinel events to share with the Regions and Autonomous Provinces (PA) and the Health Authorities a univocal method of surveillance and management of the prevention of these events on the national territory, to guarantee the essential levels of care (*livelli essenziali di assistenza*, LEA).

The sentinel event was defined [1] in the 2009 Monitoring Protocol as an "adverse event of particular gravity, potentially avoidable, which may result in death or serious harm to the patient, and which causes a loss of public confidence in the health service. The occurrence of a single case is sufficient to trigger a fact-finding investigation to ascertain whether eliminable or reducible factors contributed to it and to implement appropriate corrective measures by the organisation".

The Joint Commission International [2] has defined a sentinel event as an event that causes death, permanent harm or serious temporary harm to a patient. For this body, sentinel events result in a loss of public confidence in the health service and major repercussions for health organisations, professionals, and local and regional administrations. The term sentinel refers to a system problem that could lead to similar events in the future. As defined by the Joint Commission Interna-

Address for correspondence: Emanuele Sebastiani, Unità Operativa Complessa Ricerca, Agenzia Nazionale per i Servizi Sanitari Regionali, Via Puglie 23, 00187 Rome, Italy. E-mail: sebastiani@agenas.it.

tional, sentinel events initially included only situational events occurring in patients; since 2013, the concept has been expanded to include "harmful events" for staff, visitors, and the organisation.

To raise awareness of the potential danger of certain circumstances, to indicate the actions to be taken to prevent adverse events and to promote the assumption of responsibility by health professionals, the Ministry of Health, in collaboration with experts from the Regions and Autonomous Provinces, has been drafting and disseminating "Recommendations for the prevention of sentinel events" since 2005, and to date nineteen have been published.

Recommendations for the prevention of sentinel events (*Multimedia Appendix A available online as Supplementary Materials*) are defined [3] as: "Clinical and organisational care recommendations on conditions/situations that may cause serious and/or fatal consequences for patients. They aim to: raise awareness of the potential danger of certain circumstances; provide tools to manage clinical risk and prevent adverse events; promote the assumption of responsibility by operators and policy makers; and constitute reference documents for the evaluation of sentinel events". This study arises from multiple impulses. First, there have been significant regulatory updates. The Law of 8 March 2017, n. 24 [4], introduced provisions regarding the safety of care and the professional liability of healthcare providers. This law also established the Regional Centres for the management of healthcare risks.

Subsequently, the Decree of 29 September 2017 [5] established the National Observatory of Good Practices (Osservatorio Nazionale delle Buone Pratiche sulla Sicurezza nella Sanità). This decree defines its composition and functions, which include the collection of data on risks, adverse events, sentinel events, and those without harm [6].

Finally, the Ministerial Decree of 19 December 2022 [7] addresses the evaluation of quality, safety, and appropriateness of activities for accreditation and contractual agreements with healthcare facilities. Among the verification requirements, it mandates the application and dissemination of clinical risk recommendations.

In addition, the applicability and implementation of the recommendations on clinical risk are included in the LEA questionnaire, which contains the information necessary to verify the fulfilment of the obligations to which the regions are bound according to the regulations in force, as indicated in the State-Regions Agreement of 23 March 2005.

AGENAS, at the request of the Ministry of Health, has developed a dynamic system for monitoring the applicability and implementation of these recommendations to provide a single national platform to support the Regions and Autonomous Provinces [8] .The computerised system allows the Regions and Autonomous Provinces to start monitoring one or more times a year with the support of AGENAS and to be able to constantly observe the status of applicability and implementation of the recommendations by the public and private health and hospital companies in their respective territories. By analogy with other institutional monitoring tools, the general architecture of the system envisages an articulation on three levels: central (AGENAS and Ministry of Health), regional, and corporate. The tool on which the monitoring system is based is a questionnaire on the applicability and implementation of each recommendation.

Aim of the study

Based on the stated objective and activities, the aim of the study is to analyse in detail how the 19 recommendations for the prevention of sentinel events are applicable and implementable across all acute healthcare facilities. This includes evaluating their implementation in different healthcare contexts and comparing data related to the most frequently reported sentinel events in 2022. In summary, the goal is to enhance patient safety through the proper application of the recommendations and to identify potential areas for improvement.

MATERIALS AND METHODS

The descriptive observational study was conducted in Italy, collaborating with risk managers at both the regional level and within individual healthcare facilities. The facility risk managers participated by responding to a questionnaire between March and October 2023, using a secure online platform. To facilitate completion, the platform provided a manual, FAQs, and training modules.

Once the questionnaire was completed by the facility risk managers, the regional risk managers performed a formal review of the content and submitted the final version to AGENAS. The questionnaire, designed specifically for this study, consisted of nine questions. These questions aimed to explore how the individual recommendations were applicable and implemented within the healthcare facilities. The questions were as follows (attached image of the platform):

1. Is the individual recommendation considered applicable in the facility?
2. Has the individual recommendation been implemented, meaning there is a plan or program for its execution?
3. Has the individual recommendation been implemented? (Details per company and facility).
4. What is the total coverage and ongoing implementation for each recommendation? (Provide details per company and facility).
5. What difficulties were encountered during implementation?
6. How is the implementation of the individual recommendation monitored? (Specify the method and frequency).
7. Were one or more stakeholders involved in the implementation process of the individual recommendation?
8. What communication initiatives have been promoted by the facility? (Information, training courses, conferences, etc.).
9. Is there a PDF document referring to the individual recommendation (company procedure)?

This cross-sectional study included all healthcare facilities providing acute care, rehabilitation, and post-acute long-term care, both public and private, accred-

ited according to the Ministry of Health's dataset. The responses collected pertain to the applicability and implementation of the recommendations for preventing sentinel events, updated as of December 31, 2022.

Quality control

To reduce the risk of data entry errors, a check was carried out by the regional contact person (regional risk managers) after completion by the company contact persons. The regional contact persons conducted a formal logical check of what was declared by the company contact persons and verified the relevance of the document attached to the specific Recommendation and the content declared in the individual questions.

Population and sample

For our analysis, we determined the sample size using the dataset from the Ministry of Health, which includes the HSP (Health Service Provider) 11 and HSP 11 bis registries. A total of 1,323 healthcare facilities were anticipated, of which 865 actively participated by completing all the questionnaires for each recommendation. HSP 11 provides a list of accredited healthcare facilities, offering essential information such as type (hospitals, clinics, etc.), location, and services provided. In contrast, HSP 11 bis is an updated version that enriches this data with more specific details regarding facility management, access methods, and the professionals involved. These tools are crucial for managing and monitoring the healthcare system in Italy, as they facilitate data collection and the assessment of service quality, making them an essential reference sample for our research.

Cut-off and limitations

Currently, the implementation of the recommendations is outlined in the document "Notes for completing the documentation for 2019" from the Ministry of Health. Regions must submit information regarding the questionnaire to verify the delivery of essential levels of care (LEA), ensuring that the conditions of appropriateness are met and that the necessary resources for the National Health Service (Servizio Sanitario Nazionale, SSN) are available. To evaluate the results, Regions must complete a table (point AS 1.1. Clinical risk and patient safety) indicating how many recommendations have been implemented in their facilities. A Region is considered compliant if it has implemented at least 14 out of 18 recommendations and if at least 80% of the healthcare organisations in the Region have applied each recommendation. Unfortunately, the missing data from one Region is due to the absence of a regional clinical risk manager during the monitoring; this lack of a regional manager was a limitation of the study, as it hindered the completion of the questionnaires by the risk managers of the healthcare facilities. Another limitation to consider is the low applicability value for some recommendations, as certain recommendations, as mentioned earlier, are tied to the type of services they provide.

Statistical analysis

The data were entered and organised in a Microsoft Excel file, to allow the data of the participating structures to be entered (Structure Code; Region Code; Name of Region or Autonomous Province; Province; Province Code; Name of Health Authority; Municipality; Structure Name; Type; Applicability, Implementation) and analysed with the statistical calculation software Jamovi version 2.3.28.

RESULTS

The following cross-sectional observational study investigated how healthcare facilities reacted in terms of applicability and implementation to the recommendations for the prevention of sentinel events proposed by the Italian Ministry of Health.

There were 1,323 facilities involved in Italy, of which 865 responded, broken down by individual Region or Autonomous Province. The percentage of facilities for each Region and Autonomous Province is shown in *Table 1*.

Table 2 shows the total expected facilities and the responding facilities by type and level of care complexity. The typologies with the highest representation in the sample are: Private nursing homes – Accredited constituting 37.80% of the sample; and Directly operated hospitals constituting 45.27% of the sample, while the lowest percentage is represented by Research Institutions 0.23% of the sample and Private University Polyclinics 0.15% of the sample. The remaining types accounted for less than 16.55% of the sample.

Out of the total of 1,323 facilities involved, of which 865 responded, the percentage of recommendations that were considered applicable and/or responded to the questionnaire was analysed: 458 facilities were not considered applicable and/or responded for any Recommendation, representing 34.62% of the sample, while 18.37% of the facilities considered applicable and/or responded for all nineteen recommendations. 0.08% of the facilities considered four to six recommendations as applicable and/or responded, 0.23% considered one to three recommendations as applicable and/or responded, 0.30% considered seven to eight recommendations as applicable and/or responded, 0.53% considered ten recommendations as applicable and/or responded, 1.44% of the facilities considered nine recommendations as applicable and/or responded, and a percentage ranging from 2.95% to 4.38% considered eleven to eighteen recommendations as applicable and/or responded.

The percentage of applicability per recommendation of each facility involved was analyses, as shown in *Table 3*.

The lowest percentages of applicability of the recommendations in all the typologies in the sample are: Recommendation 6 "Recommendation for the prevention of maternal death related to labour and/or delivery" and Recommendation 16 "Recommendation for the prevention of death or permanent disability in healthy newborns weighing >2,500 grams not related to congenital disease", being recommendations that preclude types of facilities with the presence of a delivery room, while some recommendations that are applicable in any context have a high percentage of applicability.

The percentage of implementation of the recommendations out of the total number of facilities was then analysed: 470 facilities did not implement and/or

Table 1
Data on the expected and responding Italian Regions and Autonomous Provinces in monitoring recommendations for the prevention of sentinel events

Regions	Expected	Percentage of total	Respondents	Percentage respondents
Abruzzo	27	2.04	27	100.00
Basilicata	15	1.13	2	13.33
Calabria	57	4.31	37	63.16
Campania	128	9.67	91	71.09
Emilia-Romagna	102	7.71	95	92.16
Friuli Venezia Giulia	21	1.59	19	90.48
Lazio	126	9.52	88	69.05
Liguria	36	2.72	25	69.44
Lombardia	190	14.36	166	86.84
Marche	39	2.95	15	38.46
Molise	9	0.68	3	33.33
Piemonte	99	7.48	67	67.68
Provincia Autonoma di Bolzano	18	1.36	18	100.00
Provincia Autonoma di Trento	15	1.13	5	33.33
Puglia	82	6.20	38	46.34
Sardegna	40	3.02	4	10.00
Sicilia	138	10.43	0	0.00
Toscana	76	5.74	65	80.26
Umbria	24	1.81	24	100.00
Valle d'Aosta	2	0.15	1	0.00
Veneto	79	5.97	75	94.94
Total	**1323**	**100.00**	**865**	**65.38**

Table 2
Types of responding facilities by level of complexity in monitoring recommendations for the prevention of sentinel events

Types of structures	Expected	Percentage of the total	Respondents	Percentage respondents
AO integrated with the National Health Service	16	1.21	9	56.25
AO integrated with the university	27	2.04	26	96.29
Hospital	49	3.70	29	59.18
Private nursing home – Accredited	500	37.80	283	56.60
Research organisation	3	0.23	2	66.66
Institutes for hospitalization and care with a scientific character – Foundation	11	0.83	10	90.90
Scientific institute for hospitalization and treatment – Private	42	3.17	33	78.57
Institutes for hospitalization and care with a scientific character – Public	32	2.42	20	62.50
Qualified institute presidium of the USL	14	1.06	10	71.42
Directly operated hospital	599	45.27	418	69.72
Classified or assimilated hospital within the meaning of article 1 last paragraph of Law 132/1968	28	2.12	23	82.14
Private university hospital	2	0.15	2	100.00
Total	**1323**	**100.00**	**865**	**100.00**

AO: Hospital trust integrated into the National Health Service (NHS), meaning it is part of the publicly funded healthcare system, providing comprehensive healthcare services to the population; USL: Local Health Units.

Table 3
Percentage of applicability per Recommendation of each facility

N	Recommendations	Yes	No	Not filled in
1	Correct use of concentrated solutions of potassium chloride (KCL) and other concentrated solutions containing potassium	822/865 (95.03%)	34/865 (3.93%)	9 (1.04%)
2	Recommendation to prevent retention of gauze, instruments, or other material within the surgical site	658 (76.07%)	152 (17.57%)	55 (6.36%)
3	Recommendation for proper identification of patients, surgical site, and procedure	706 (81.62%)	112 (12.95%)	47 (5.43%)
4	Recommendation for the prevention of patient suicide in hospital	830 (95.95%)	25 (2.89%)	10 (1.16%)
5	Recommendation for the prevention of transfusion reaction due to AB0 incompatibility	808 (93.41%)	49 (5.66%)	8 (0.92%)
6	Recommendation for the prevention of maternal death related to labor and/or delivery	337 (38.96%)	369 (42.66%)	159 (18.38%)
7	Recommendation for the prevention of death, coma or serious harm resulting from errors in drug therapy	848 (98.03%)	5 (0.58%)	12 (1.39%)
8	Recommendation to prevent acts of violence against health workers	851 (98.38%)	12 (1.39%)	2 (0.23%)
9	Recommendation for the prevention of adverse events resulting from malfunction of medical devices/medical electrical equipment	845 (97.69%)	11 (1.27%)	9 (1.04%)
10	Recommendation for the prevention of bisphosphonate osteonecrosis of the maxilla/mandible	518 (59.88%)	245 (28.32%)	102 (11.80%)
11	Death or serious injury resulting from a malfunction of the transport system (in-hospital, out-of-hospital)	732 (84.62%)	103 (11.91%)	30 (3.47%)
12	Prevention of errors in therapy with "Look-alike/sound-alike" drugs	855 (98.84%)	5 (0.58%)	5 (0.58%)
13	Recommendation for the prevention and management of patient falls in healthcare facilities	859 (99.30%)	3 (0,35%) (0.35%)	3 (0.35%)
14	Recommendation for the prevention of errors in therapy with antineoplastic drugs	486 (56.18%)	275 (31,79%) (31.80%)	104 (12,02%) (12.02%)
15	Death or serious injury resulting from incorrect assignment of the triage code in the 118 operations center and/or within the emergency department	466 (53.87%)	324 (37.46%)	75 (8.67%)
16	Recommendation for the prevention of death or permanent disability in a healthy newborn weighing >2,500 grams unrelated to congenital disease	338 (39.07%)	362 (41.85%)	165 (19.08%)
17	Recommendation for reconciliation of drug therapy	850 (98.26%)	3 (0.35%)	12 (1.39%)
18	Recommendation for the prevention of errors in therapy resulting from the use of abbreviations, acronyms, acronyms and symbols	839 (97.00%)	15 (1.73%)	11 (1.27%)
19	Recommendation for handling solid oral dosage forms	812 (93.87%)	36 (4.16%)	17 (1.97%)

AB0: AB0 reaction refers to an immune response that occurs when there is an incompatibility between the donor's and recipient's AB0 blood groups, leading to the destruction of transfused red blood cells; N: number.

respond to any recommendations, representing 54.33%. For each recommendation, the implementation related to applicability was analysed. The recommendations that show the lowest values in terms of implementation, despite low percentages of non-applicability are: Recommendation 4 "Recommendation for the prevention of patient suicide in hospital"; Recommendation 17 "Recommendation for the reconciliation of drug therapy"; Recommendation 18 "Recommendation for the prevention of errors in therapy resulting from the use of abbreviations, acronyms, acronyms, and symbols" and Recommendation 19 "Recommendation for the handling of solid oral pharmaceutical forms".

The percentages of facilities that implemented between one and eleven recommendations were analysed, those that, by type of participating facilities, could be applicable in all the facilities involved in the study. Among the Hospital authorities integrated with the University those with <eleven recommendations implemented are 223 and 177 Directly managed hospitals. We have the lowest figure among Research Institutions and Private University Polyclinics with several implemented recommendations <11 equal to 1.

Comparing the data on the three most reported sentinel events in 2023 and 2022 [9] with the most frequently reported events in the report published by the Ministry of Health (January 2005 - December 2020) [10], the following sentinel events highlighted:

- Sentinel event number 9: "Death or serious harm due to a patient falling"
- Sentinel event number 10: "Suicide or attempted suicide of a patient in hospital"
- Sentinel event number 12: "Death or serious harm due to violence against a healthcare worker"

For each of these events, the percentage of facilities, by type, that have not implemented the related recom-

mendations for the prevention of sentinel events was analyzed. The recommendations in question are:

- Recommendation 4: "Prevention of patient suicide in hospital"
- Recommendation 8: "Prevention of violence against healthcare workers"
- Recommendation 13: "Prevention and management of patient falls in healthcare facilities".

As shown in *Table 4*, for Recommendation number 4 "Recommendation for the prevention of patient suicide in hospital", out of 855 responding facilities 720 stated that they implemented it and 135 did not (15.79%). The largest percentage of non-implementation is represented by the Institutes for hospitalisation and care with a scientific character – Public (35.00%), the Hospital companies integrated with the National Health Service (22.22%) and the Private nursing home accredited (19.93%). For Recommendation number 8 "Recommendation to prevent acts of violence against health workers", out of 852 responding facilities 794 declared to implement it and 68 did not (7.89%). The highest percentage of non-implementation is represented by the Institutes for hospitalisation and care with a scientific character – Public (30.00%), by the Hospital companies integrated with the National Health Service (22.22%) and by the Private nursing home – Accredited (13.17%).

For Recommendation number 13 "Recommendation for the prevention and management of patient falls in health care facilities", out of 862 responding to facilities 831 declared to implement it and 31 did not (3.60%). The highest percentage of non-implementation is represented by the Institutes for hospitalisation and care with a scientific character – Public for 20.00% and by the Hospital companies integrated with the National Health Service for 11.11%.

DISCUSSION

The analysis conducted showed that, out of a total of 1,323 facilities, 865 responded to the administered questionnaire. The percentage of non-respondents is prevalent in some regions and evenly distributed across the country, and it is evident in certain types of facilities without a clear distinction among different levels of complexity. This situation raises questions about the potential to optimise communication and awareness regarding the importance of participation in the questionnaire, suggesting that health authorities should intensify informational efforts in areas with lower response rates. The number of recommendations deemed applicable varies according to the different types of facilities and the services provided. However, the number of those actually implemented is influenced not only by their applicability but also by the variety of facility types. This

Table 4
Implementation of Recommendations 4, 8, 13 by type of facility

	Recommendation 4 "Recommendation for the prevention of patient suicide in hospital"				Recommendation 8 "Recommendation to prevent acts of violence against health workers"				Recommendation 13 "Recommendation for the prevention and management of patient falls in healthcare facilities"			
	A	**NI**	**I**	**%NI**	**A**	**NI**	**I**	**%NI**	**A**	**NI**	**I**	**%NI**
Hospital companies integrated with the National Health Service	9	1	8	11.11	9	2	7	22.22	9	2	7	22.22
Hospital company integrated with the University	26	0	26	0.00	26	0	26	0.00	26	1	25	3.85
Hospital company	29	1	28	3.45	29	1	28	3.45	29	2	27	6.90
Private nursing home – Accredited	280	9	271	3.21	281	56	225	19.93	281	37	244	13.17
Research organisation	2	0	2	0.00	2	0	2	0.00	2	0	2	0.00
Institutes for hospitalisation and care with a scientific character – Foundation	10	0	10	0.00	10	0	10	0.00	10	0	10	0.00
Institutes for hospitalisation and care with a scientific character – Private	33	0	33	0.00	33	4	29	12.12	33	1	32	3.03
Institutes for hospitalisation and care with a scientific character – Public	20	4	16	20.00	20	7	13	35.00	20	6	14	30.00
Qualified institute presidium of the local health unit	10	0	10	0.00	10	1	9	10.00	10	1	9	10.00
Directly operated hospital	418	16	402	3.83	410	63	347	15.37	417	17	400	4.08
Classified or assimilated hospital within the meaning of article 1 last paragraph of Law 132/1968	23	0	23	0.00	23	1	22	4.35	23	1	22	4.35
Private university hospital	2	0	2	0.00	2	0	2	0.00	2	0	2	0.00
Total	**862**	**31**	**831**	**3.60**	**855**	**135**	**720**	**15.79**	**862**	**68**	**794**	**7.89**

A: applicable; NI: not implemented; I: implemented.

indicates a need for in-depth qualitative analysis to better understand the reasons behind low implementation rates and the specific barriers faced by some facilities.

Among the recommendations that exhibit critical issues in their implementation are Recommendation n. 4 "Recommendation for the prevention of patient suicide in hospital" (13.25%) and Recommendation n. 6 "Recommendation for the prevention of maternal death related to labor" (11.57%). These data highlight the need to develop targeted training and awareness programs for healthcare personnel to improve understanding and skills in managing these critical issues.

In contrast, the remaining recommendations show an implementation rate exceeding 90%, suggesting that some practices are already well integrated into facility routines. It may be beneficial to analyse the success factors of these recommendations and consider adopting similar strategies for those that are less implemented.

Further critical issues emerge from a cross-analysis of sentinel event data and the corresponding recommendations. For instance, sentinel event number nine "Death or serious injury due to patient fall" is directly linked to Recommendation n. 13 on fall prevention. This suggests that the lack of effective implementation of such recommendations could be correlated with an increase in sentinel events. Therefore, it is essential to implement ongoing monitoring and specific intervention strategies to reduce these incidents.

Finally, the data present some limitations, as this is the first time data collection has been conducted, providing a general overview of situations that require more detailed analysis. It is suggested to establish a regular cycle of data collection and analysis to monitor progress over time and make necessary adjustments. It is crucial to conduct comparisons between facilities while considering their organisational aspects, fostering a collective reflection on the necessary changes in risk management practices in Italy.

CONCLUSIONS

There is a significant percentage of non-respondents, evenly distributed across different regions and types of facilities. This raises concerns about the effectiveness of communication and awareness regarding the importance of participation in the questionnaire, suggesting that health authorities should intensify informational efforts, especially in areas with lower response rates.

The recommendations considered applicable vary according to the different types of facilities and services, highlighting the need for in-depth qualitative analyses to understand the reasons behind the low implementation rates and the specific barriers faced by some facilities. Recommendations that present critical issues, such as those related to the prevention of suicide and maternal death, require the urgent development of targeted training and awareness programs for healthcare personnel to improve skills in managing these critical issues.

In contrast, recommendations with implementation rates exceeding 90% suggest that some practices are already well integrated into facility routines. It is essential to analyse the success factors of these recommendations and consider adopting similar strategies for those that are less implemented.

Moreover, the cross-analysis of sentinel event data and the corresponding recommendations highlights the correlation between the lack of effective implementation of recommendations and the increase in sentinel events, such as patient falls. Therefore, it is essential to implement ongoing monitoring and specific intervention strategies to reduce such incidents.

Finally, since this is the first data collection conducted, it is important to recognize certain limitations. It is advisable to establish a regular cycle of data collection and analysis to monitor progress over time and make necessary adjustments. Additionally, it is crucial to conduct comparisons between facilities while considering their organisational aspects, fostering a collective reflection on the necessary changes in risk management practices in Italy. Only through a collaborative and systematic approach will it be possible to improve the quality of care and ensure greater patient safety.

Author contributions

Conceptualization: ES; methodology: ES; software: ES, MM; validation: ES, MTL, DM; formal analysis: ES, MTL; investigation: ES, MTL; resources: ES; data curation: ES, MM, MTL; writing – original draft preparation: ES, MC, MTL; writing – review and editing: ES, MM, MTL, DM; visualization: ES; supervision: MTL; project administration: MTL, DM. All Authors have read and approved the published version of the manuscript.

Conflict of interest statement

The Authors declare no conflicts of interest.

Funding

There is no funding to report for this publication.

Received on 8 August 2024.
Accepted on 5 November 2024.

REFERENCES

1. Ministero della Salute. Protocollo per il monitoraggio degli eventi sentinella. 2024. Available from: https://www.salute.gov.it/imgs/C_17_pubblicazioni_3462_allegato.pdf.
2. Patra KP, De Jesus O. Sentinel Event. In: StatPearls. Treasure Island (FL): StatPearls Publishing; 2023. Available from: http://europepmc.org/books/NBK564388.
3. Ministero della Salute. Governo clinico e sicurezza delle cure – Linee guida e raccomandazioni. Available from: https://www.salute.gov.it/portale/sicurezzaCure/dettaglioContenutiSicurezzaCure.jsp?id=250&area=qualita&menu=lineeguida.
4. Italia. Legge 8 marzo, n. 24. Disposizioni in materia di sicurezza delle cure e delle persone assistite, nonché sulla responsabilità professionale degli operatori sanitari. Gazzetta Ufficiale – Serie Generale n. 64, 17 marzo 2017.

5. Italia. Decreto del Ministero della Salute 29 settembre 2017. Istituzione dell'Osservatorio Nazionale sulle Buone Pratiche per la Sicurezza in Sanità. Gazzetta Ufficiale – Serie Generale n. 248, 23 ottobre 2017.
6. Osservatorio Nazionale delle Buone Pratiche sulla Sicurezza nella Sanità. Glossario 2024. Available from: https://www.buonepratichesicurezzasanita.it/index.php/attivita/glossario.
7. Italia. Decreto del Ministero della Salute 19 dicembre 2022. Valutazione in termini di qualità, sicurezza e appropriatezza dei servizi erogati per l'accreditamento e gli accordi contrattuali con le strutture sanitarie. Gazzetta Ufficiale – Serie Generale n.305, 31 dicembre 2022.
8. AGENAS. Monitoraggio delle raccomandazioni per la prevenzione degli eventi sentinella 2024. Available from: https://raccomandazioni.agenas.it/.
9. Ministero della Salute. Governo clinico e sicurezza delle cure. Report protocollo monitoraggio degli eventi sentinella 2023-2022. Available from: https://www.salute.gov.it/imgs/C_17_pubblicazioni_3474_allegato.pdf.
10. Ministero della Salute. Governo clinico e sicurezza delle cure. 6th Report: Sentinel event monitoring protocol (January 2005 - December 2020). Available from: https://www.salute.gov.it/portale/sicurezzaCure/.