Joint Commission Online

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In this issue

Patient safety

Sentinel event statistics released for 2014

The Joint Commission updated its sentinel event statistics for 2014. Data from the 8,645 incidents reviewed from 2004 through 2014 show that a total of 8,876 patients have been affected by these events, with 5,177 (58.3 percent) resulting in the patient's death, 831 (9.4 percent) resulting in loss of function, and 2,868 (32.3 percent) resulting in unexpected additional care and/or psychological impact. The Joint Commission reviewed a total of 764 sentinel events during 2014. The 10 most frequently reported types of sentinel events and the 10 most frequently identified root causes (spanning several types of events) for 2014 are shown in the tables. The Joint Commission Office of Quality and Patient Safety (OQPS) collaborates with organizations on identifying a sentinel event's root causes and creating an action plan to reduce the risk that similar events might occur in the future.

Most frequently reported Sentinel Events January 1-December 31, 2014 (764 total)	
Unintended retention of a foreign object	112
Falls	91
Suicide	82
Delay in treatment	73
Other unanticipated events*	73
Wrong-patient, wrong-site or wrong-procedure	67
Operative/postoperative complication	52
Criminal event (assault/rape/homicide)	47
Perinatal death/injury	32
Medication error	18
* Includes asphyxiation, burns, choking, drowning and being found unresponsive	

Most frequently identified root causes for Sentinel Events January 1-December 31, 2014 (2,378 total)	
Human factors (ex: staff supervision issues)	547
Leadership (ex: organizational planning)	517
Communication (ex: with patients or administration)	489
Assessment (includes timing or scope of assessments)	392
Physical environment (ex: fire safety)	115
Information management (ex: medical records)	72
Care planning (planning and/or interdisciplinary collaboration)	72
Health information technology-related (ex: incompatibility between devices)	59
Operative care (ex: blood use or patient monitoring)	58
Continuum of care (includes transfer and/or discharge of patient)	57

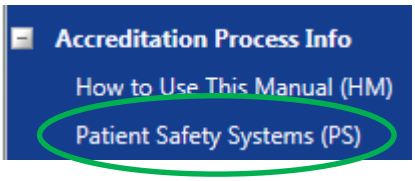
"In 2014 the leading root causes and contributory factors are examples of cognitive failures," says Ronald Wyatt, M.D., M.H.A., medical director, The Joint Commission. "Cognitive failure is preventable and safety-critical industries take a systems view. Health care organizations must focus on factors that influence errors and operationalize strong corrective actions aimed at improving working conditions and eliminating all preventable injury, harm and death."

The data reflects the Sentinel Event Policy in effect through the end of 2014 – that is, the OQPS and the organization traditionally discussed whether a reported sentinel event met reviewability criteria listed in the policy before collaborating on the root cause analysis and subsequent action plan. According to the redesigned Sentinel Event Policy effective January 1, 2015, **all sentinel events must be reviewed by the organization and are subject to review by The Joint Commission** (*see* November 2014 *Perspectives* and the "Sentinel Events" chapter in the accreditation and certification manuals). Another change is that root cause analyses have been recast as one form – albeit the most common one – of the comprehensive systematic analyses used to identify factors that contributed to a sentinel event. *Note: This data should not be used to draw conclusions about the actual relative frequency of events or trends in events over time.*

For more information, see the April 2015 issue of *Perspectives* or visit The Joint Commission's Sentinel Event webpages. (Contact: Gerry Castro, gcastro@jointcommission.org)

Clarification: No added standards in Patient Safety Systems chapter
In 2015, The Joint Commission included a new Patient Safety Systems chapter in the *Comprehensive Accreditation Manual for Hospitals (CAMH)*. The purpose of the chapter is to educate hospital leaders about the importance of an integrated patient-centered system that aims to improve quality of care and patient safety. The Joint Commission would like to clarify some misconceptions about the chapter:

- It contains no added standards. Instead, it describes how applying existing requirements can enhance patient safety.
- It is located immediately after the "How to Use This Manual" (HM) chapter in both the hard copy of the manual and in the *E-dition*.
- Any organization (not just hospitals) can view the Patient Safety Systems chapter on The Joint Commission website.



For more information, see the October 22, 2014 issue of *Joint Commission Online*. (Contact: Gerry Castro, gcastro@jointcommission.org)

Resources

Free course: Influenza Pandemic Preparedness and Response in Ambulatory Settings
The Joint Commission is offering a free online course to help clinicians prepare for an influenza pandemic. In the Influenza Pandemic Preparedness and Response in Ambulatory Settings course, participants will learn to:

- Effectively respond in the face of a pandemic
- Develop an influenza pandemic preparedness and response plan following a four-step guide
- Differentiate the virologic, epidemiologic and clinical features of pandemic influenza from seasonal influenza
- Understand how laboratory testing and diagnosis, patient management and treatment, and team training are essential components of the pandemic preparedness and response plan

The course offers continuing education credits, is available on iPads and tablets, and allows users to view and print transcripts anytime. Read the related blog post, Flu preparedness, no matter the season, by Beth Ann Longo, R.N., M.B.A., M.S.N., associate project director, Division of Healthcare Quality Evaluation. (Contact: PandemicPrep@jointcommission.org)

AAMI webinar presents strategies for ventilator alarm management
The Association for the Advancement of Medical Instrumentation (AAMI) Foundation is offering a free webinar, "Nurses and Respiratory Therapists: Working Together for Safe Alarm Systems Management," on Monday, May 11, from noon-1 p.m. ET. The webinar features a nurse and a respiratory therapist who have bridged the gap between the two disciplines and developed an alarms strategy at their respective facilities. Register. (Contact: Sarah Lombardi, slombardi@aami.org)

New on the Web

- **Updated Emergency Management Resources:** Violence/Security/Active Shooter; Vulnerable Populations
- **Quick Safety, Issue 12:** Transcription translates to patient risk

Learn more about Joint Commission Resources' offerings online or call 877-223-6866.