



Sentinel Event Data

Event Type by Year

1995-2012

Sentinel Event

http://www.jointcommission.org/Sentinel_Event_Policy_and_Procedures/

- ▶ A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase “or risk thereof” includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.
- ▶ Such events are called “sentinel” because they signal the need for immediate investigation and response.
- ▶ The term “sentinel event” and “medical error” are not synonymous; not all sentinel events occur because of an error, and not all errors result in sentinel events.

Reviewable Sentinel Events

http://www.jointcommission.org/Sentinel_Event_Policy_and_Procedures/

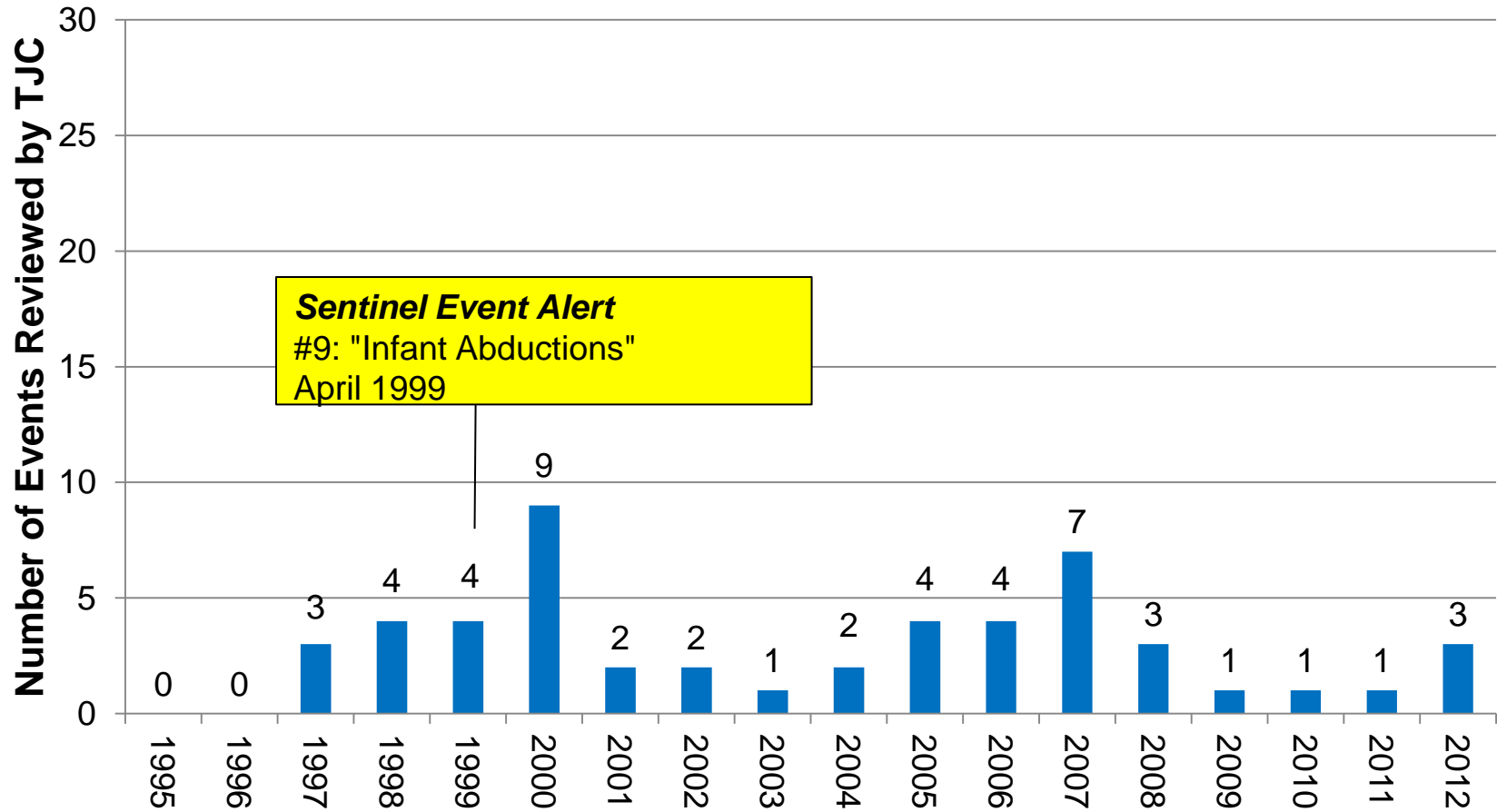
- ▶ The event has resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition.
- OR
- ▶ The event is one of the following *and does not require an outcome of death or major permanent loss of function*:
 - Suicide of any patient receiving care, treatment and services in a staffed around-the-clock care setting or within 72 hours of discharge.
 - Unanticipated death of a full-term infant
 - Abduction of any patient receiving care, treatment, and services
 - Discharge of an infant to the wrong family
 - Rape
 - Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities
 - Surgical and nonsurgical invasive procedures on the wrong patient, wrong site, or wrong procedure
 - Unintended retention of a foreign object in a patient after surgery or other procedure
 - Severe neonatal Hyperbilirubinemia (bilirubin >30 milligrams/deciliter)
 - Prolonged fluoroscopy with cumulative dose >1500 rads to a single field or any delivery of radiotherapy to the wrong body region or >25% above the planned radiotherapy dose

Data Limitations

- ▶ *The reporting of most sentinel events to The Joint Commission is voluntary and represents only a small proportion of actual events. Therefore, these data are not an epidemiologic data set and no conclusions should be drawn about the actual relative frequency of events or trends in events over time.*

Abduction Events Reviewed by The Joint Commission

(Of any individual receiving care, treatment or services)

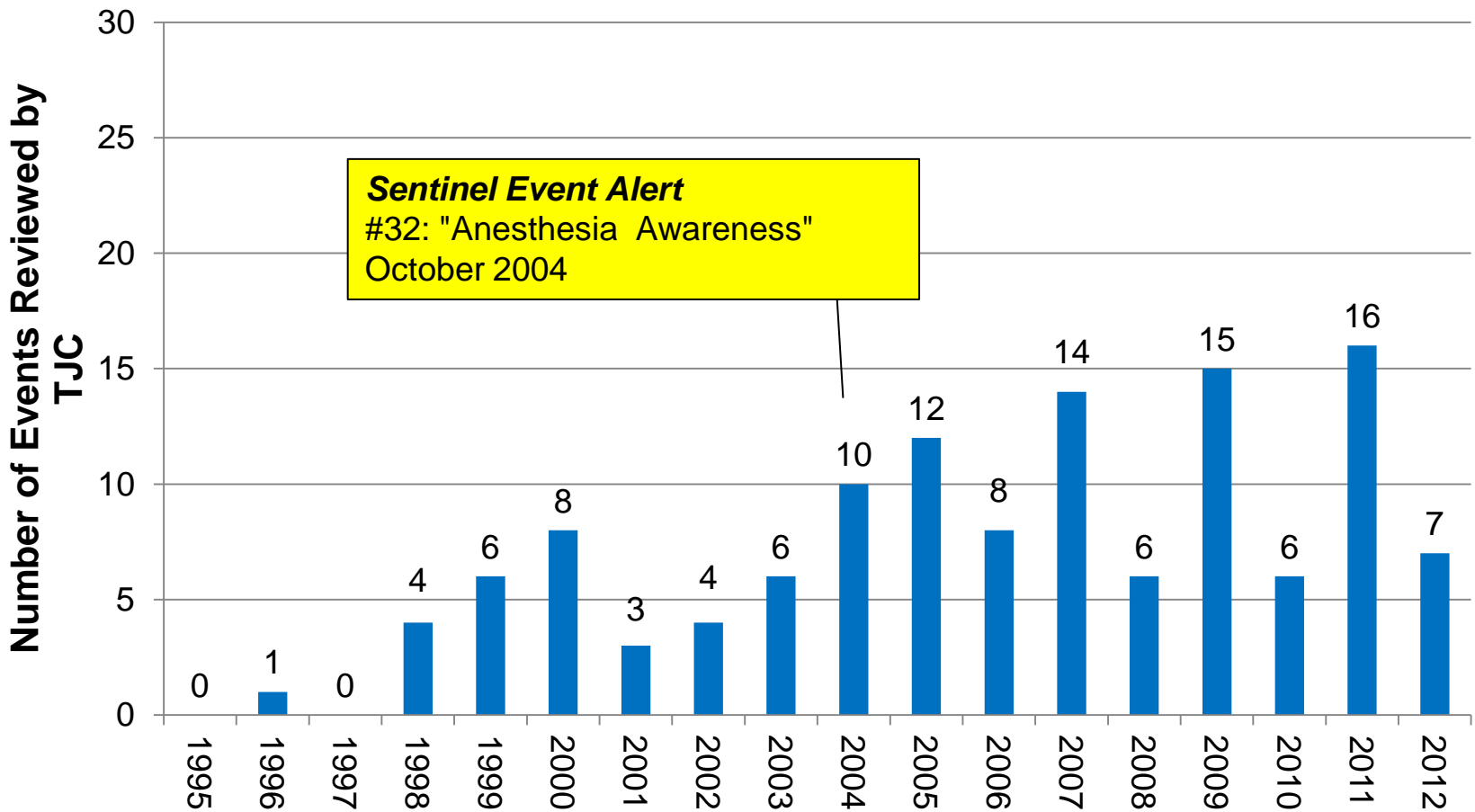


Sentinel Event Alert
#9: "Infant Abductions"
April 1999

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Anesthesia-related Events Reviewed by The Joint Commission

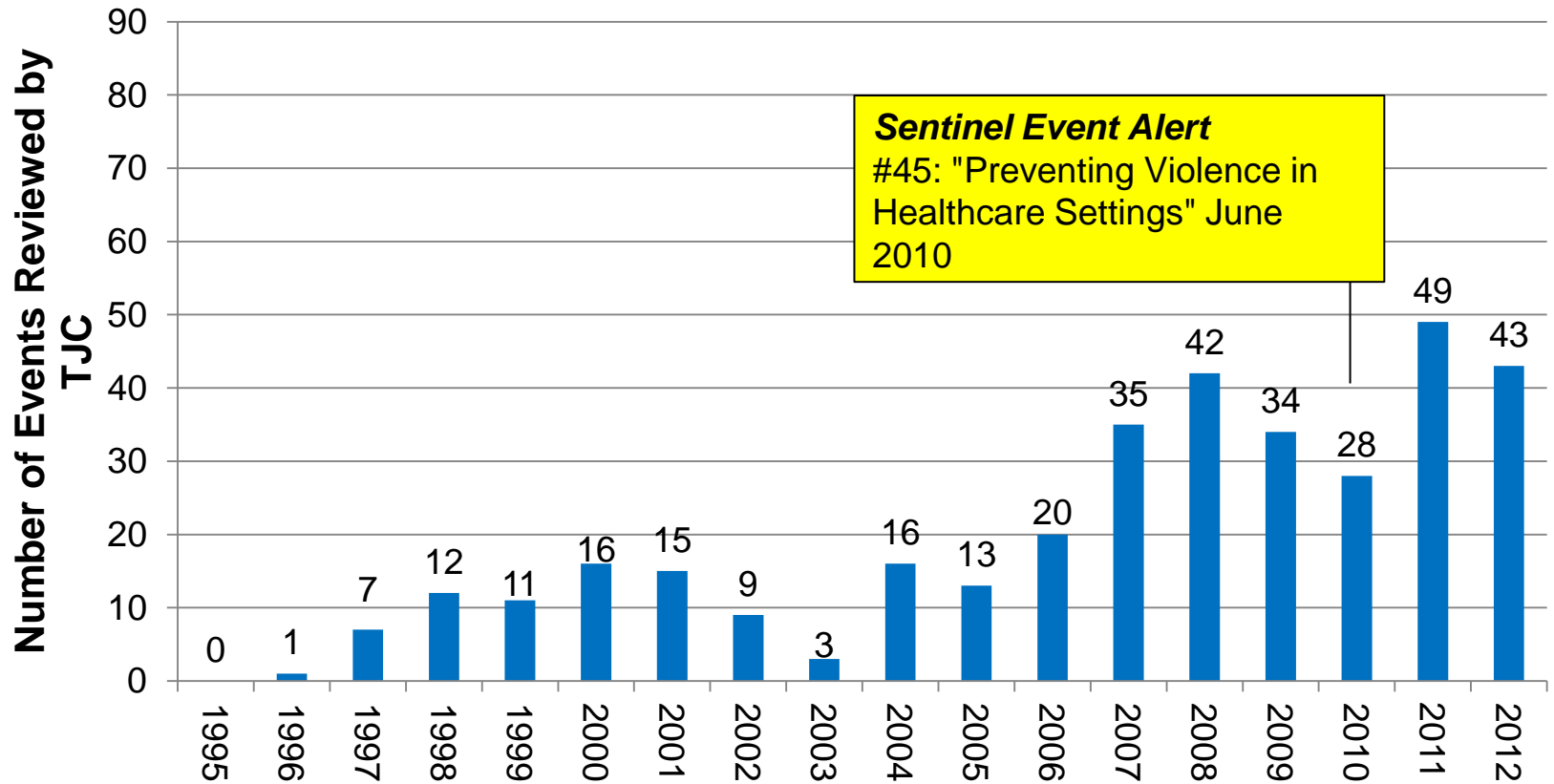
(Resulting in death or permanent loss of function)



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Criminal Events -- Assault/Rape/Homicide Reviewed by The Joint Commission

(Rape defined as un-consented sexual contact. One or more of the following must be present to determine reviewability: Any staff witnessed sexual contact; or sufficient clinical evidence or admission by the perpetrator)

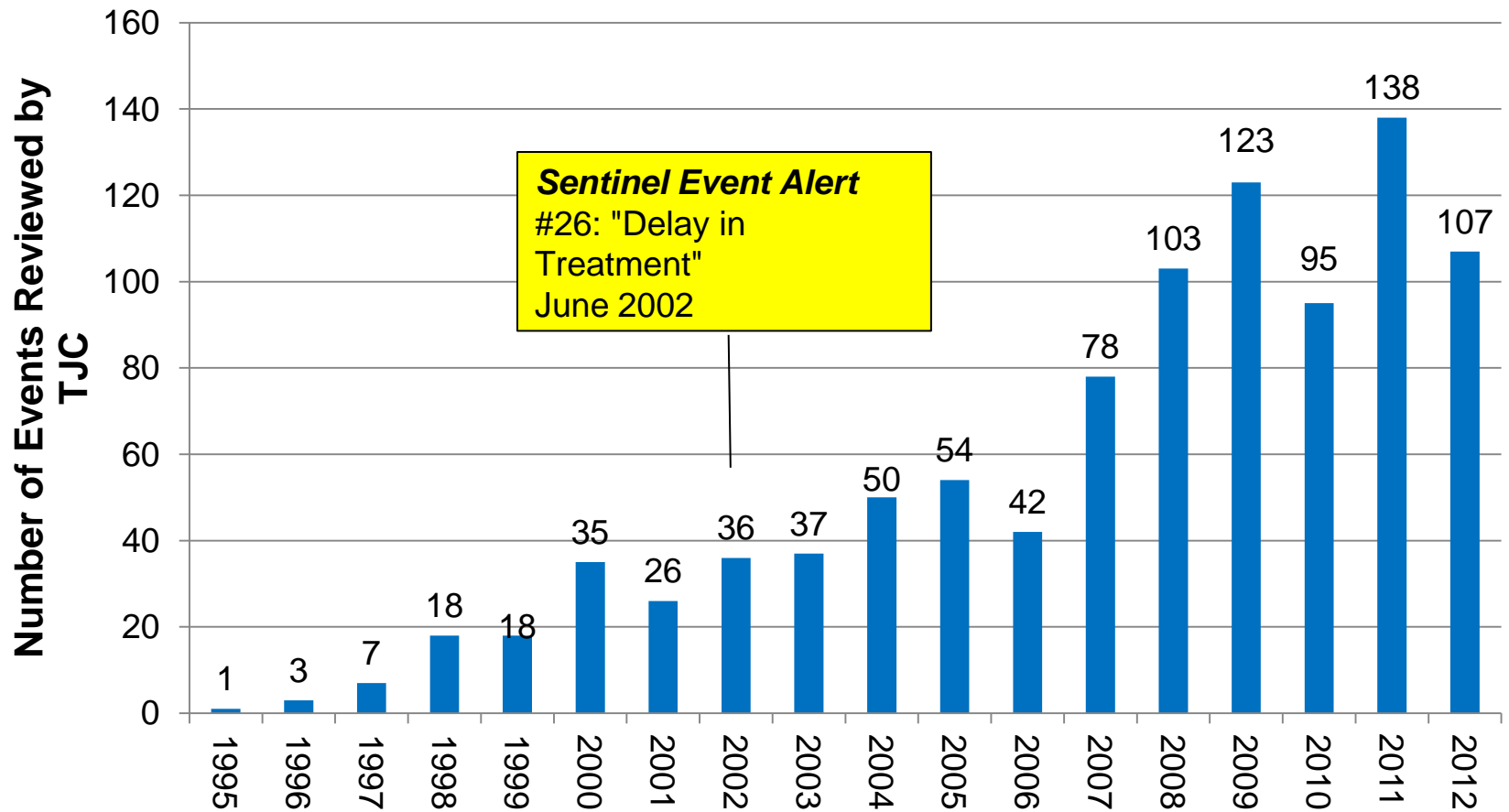


Sentinel Event Alert
 #45: "Preventing Violence in Healthcare Settings" June 2010

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Delay in Treatment Events Reviewed by The Joint Commission

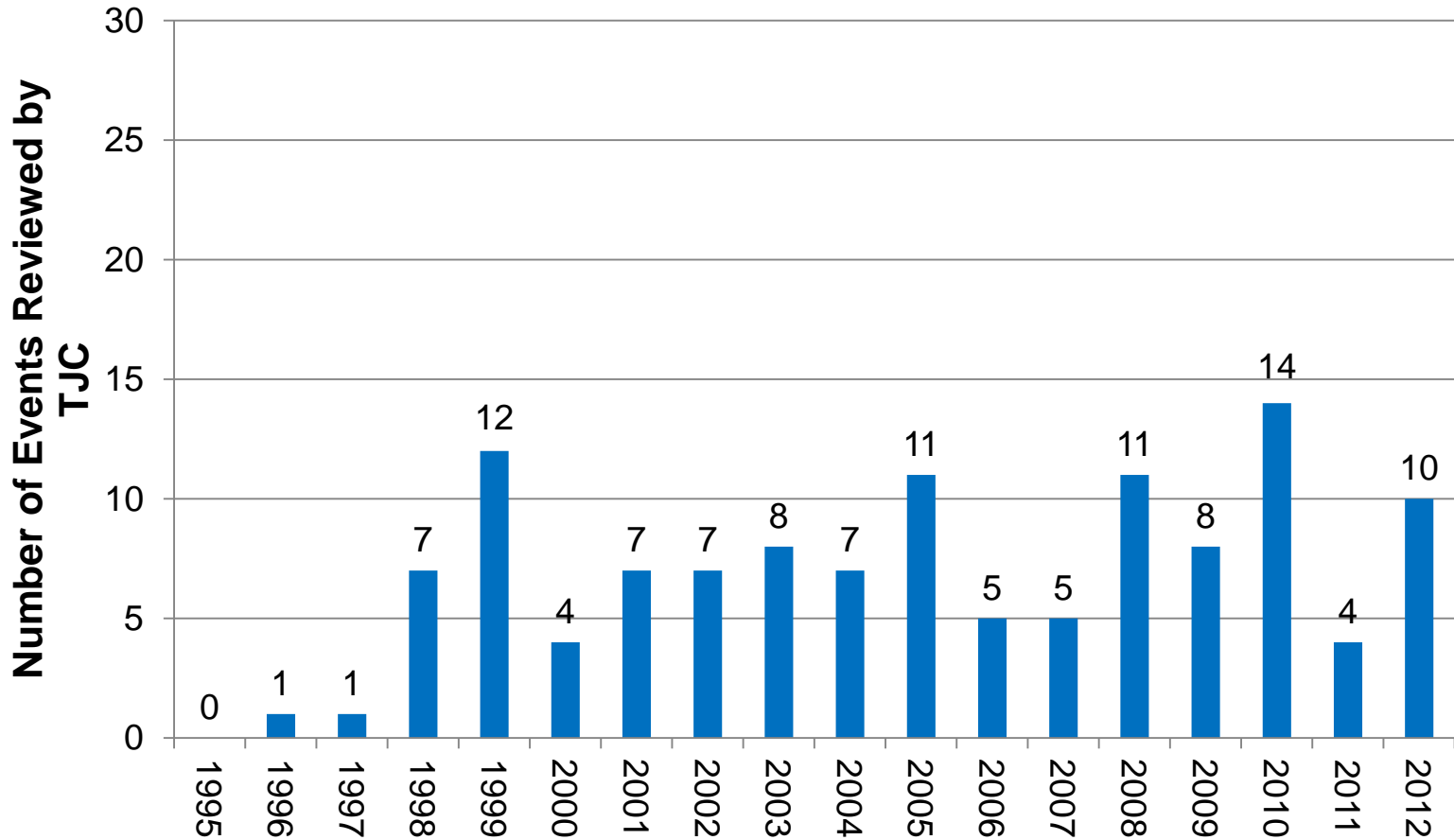
(Resulting in death or permanent loss of function)



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Elopement-related Events Reviewed by The Joint Commission

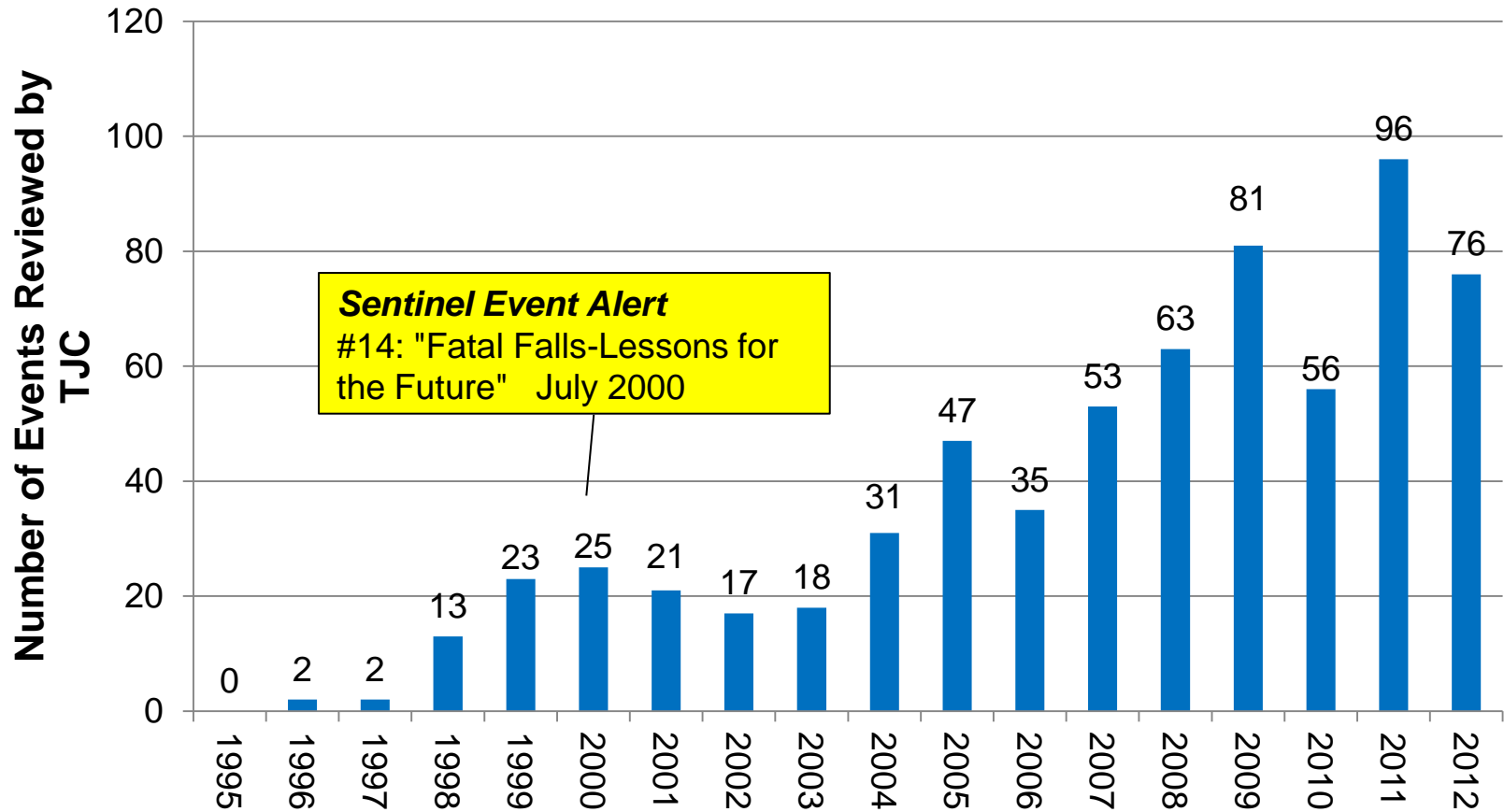
(Resulting in death or permanent loss of function)



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Fall-related Events Reviewed by The Joint Commission

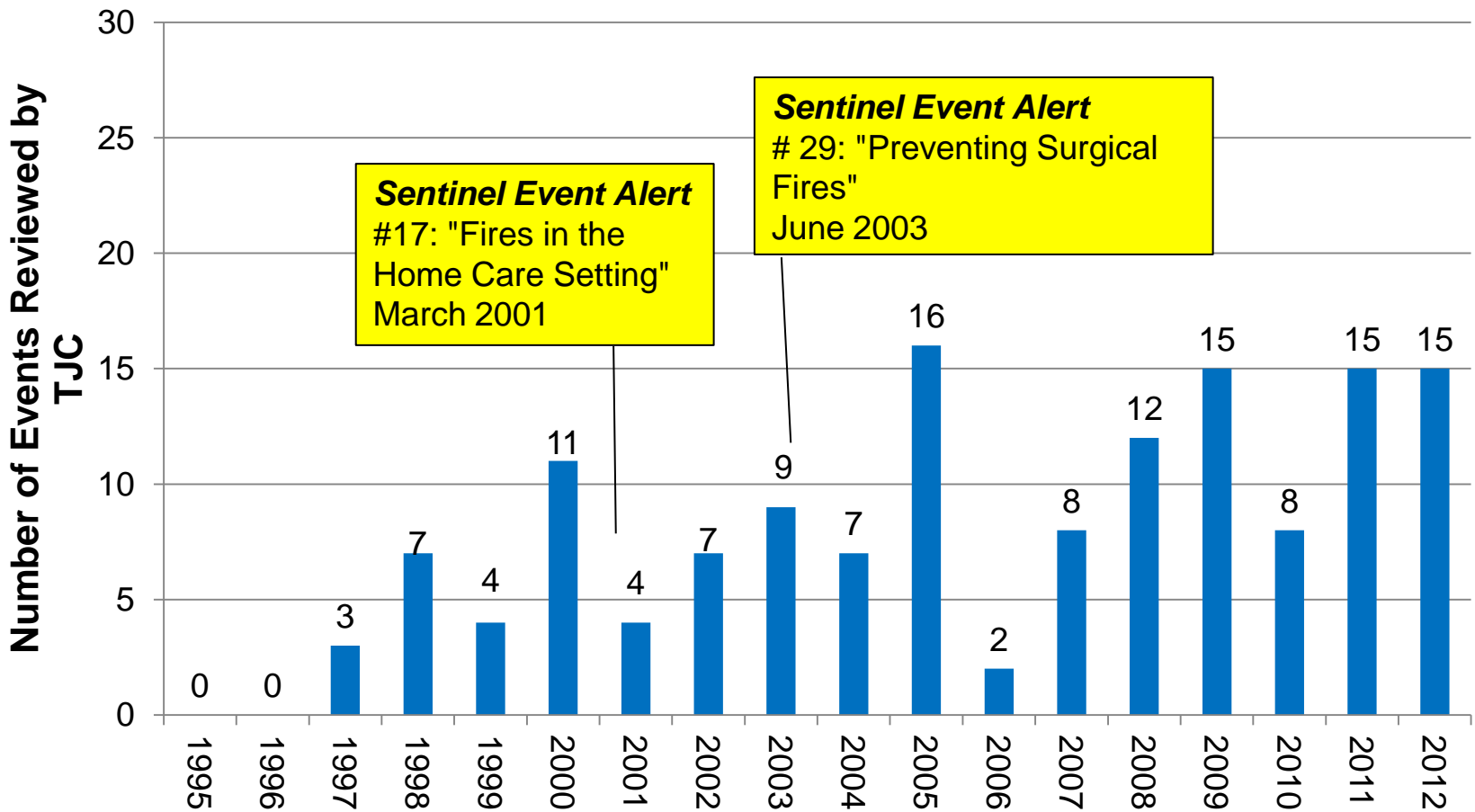
(Resulting in death or permanent loss of function)



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Fire-related Events Reviewed by The Joint Commission

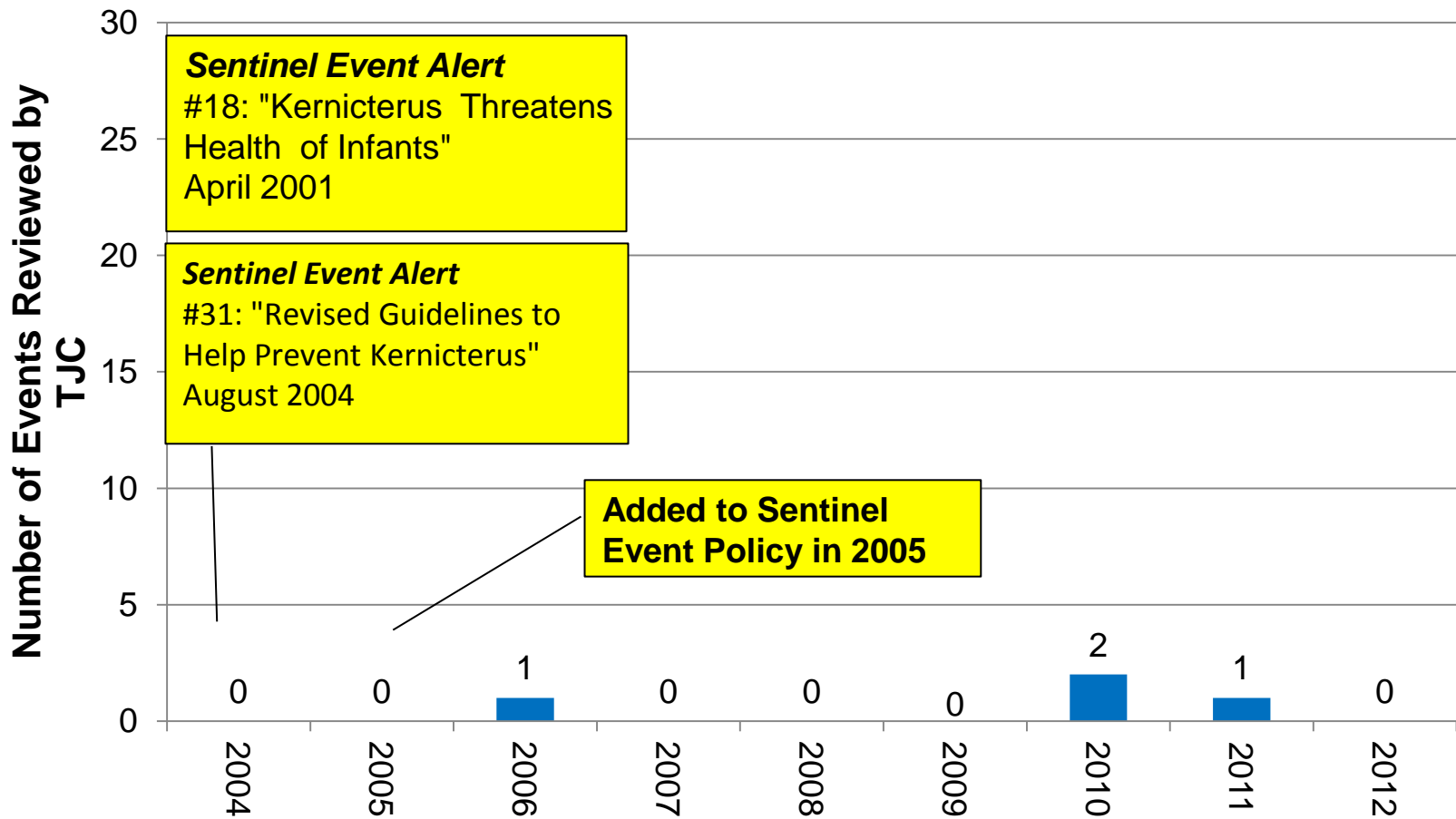
(Resulting in death or permanent loss of function)



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Hyperbilirubinemia Events Reviewed by The Joint Commission

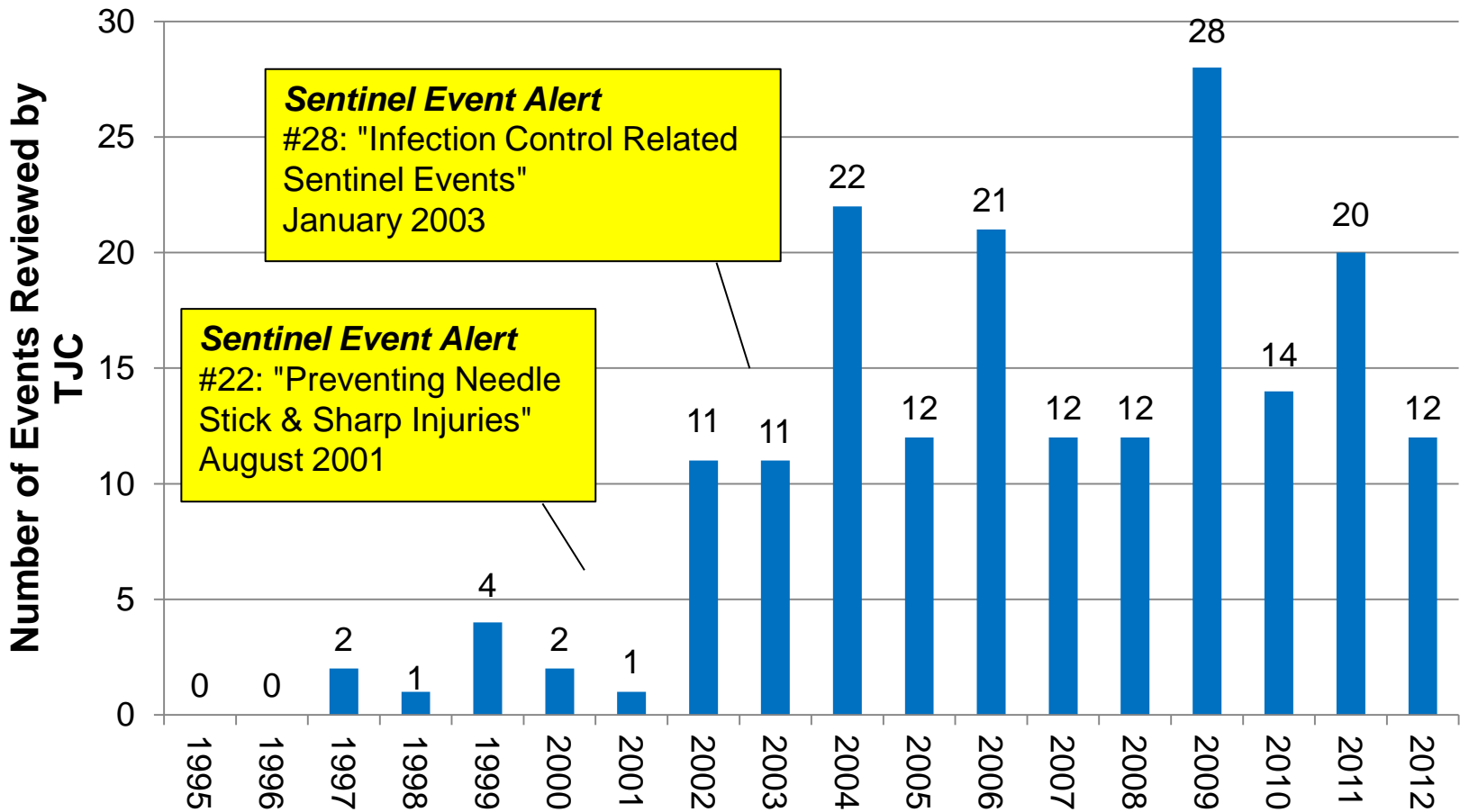
(Bilirubin > 30 milligrams/deciliter)



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Infection-related Events Reviewed by The Joint Commission

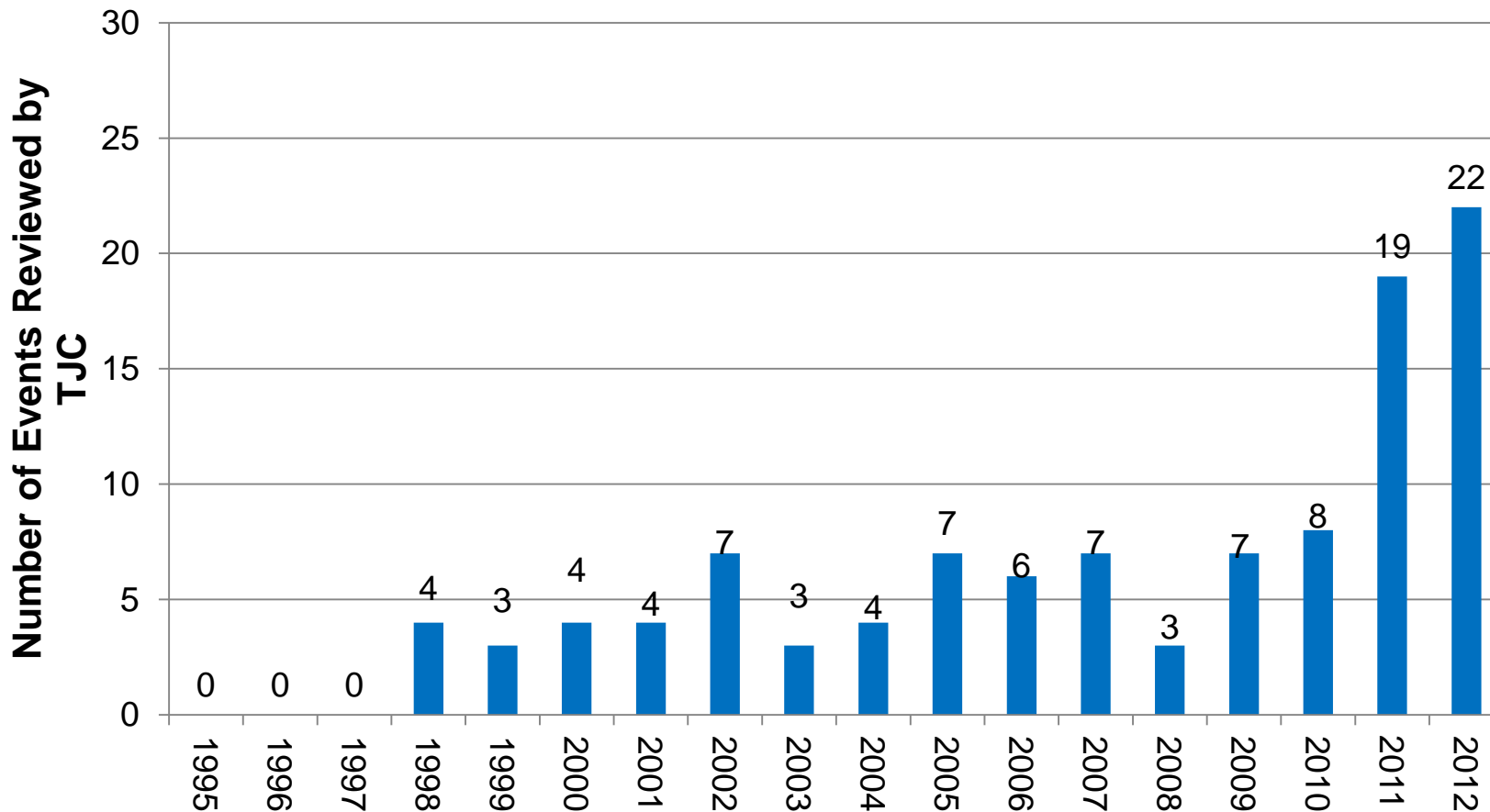
(Resulting in death or permanent loss of function)



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Inpatient Drug Overdose Events Reviewed by The Joint Commission

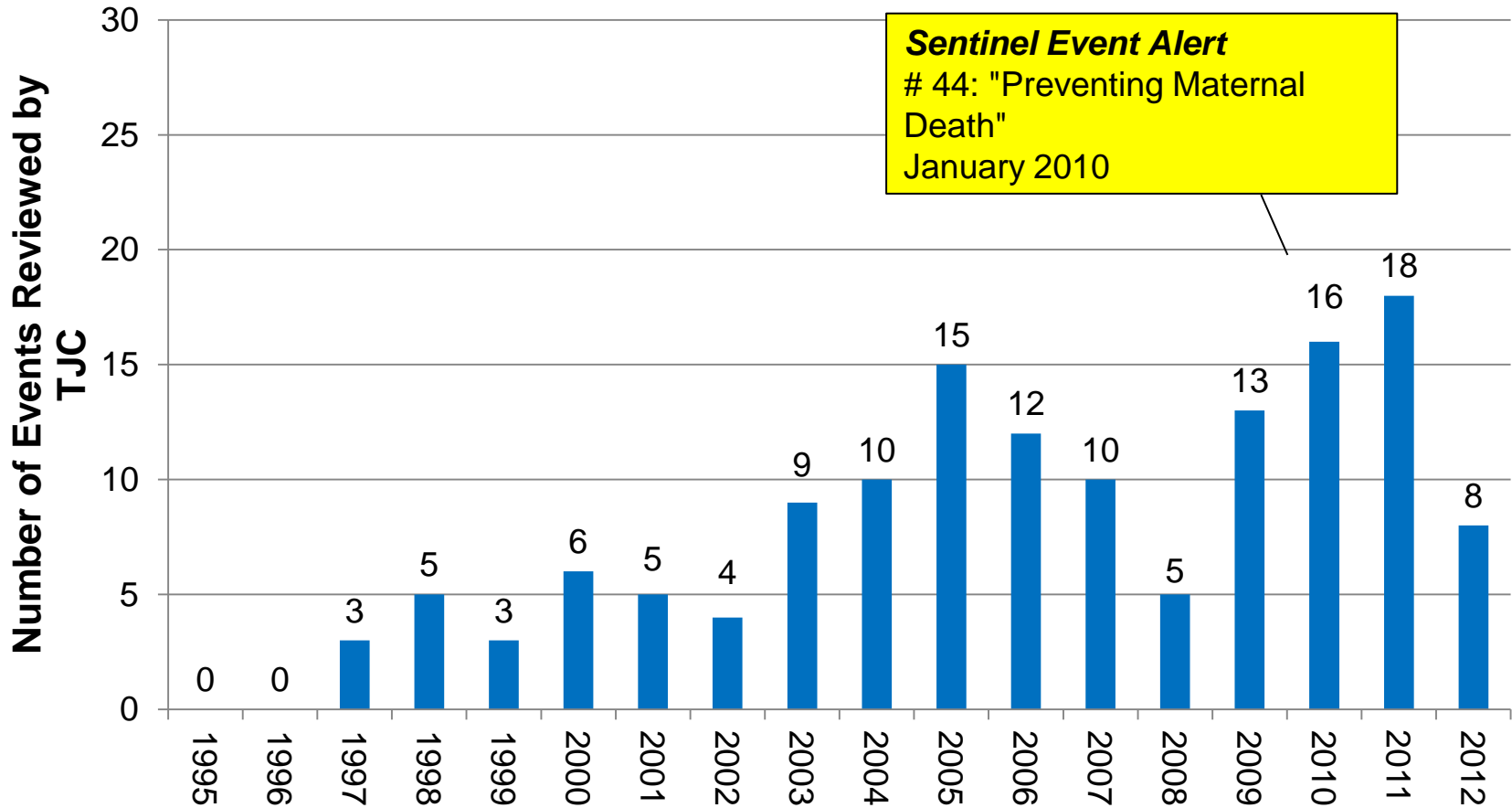
(Resulting in death or permanent loss of function)



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Maternal Events Reviewed by The Joint Commission

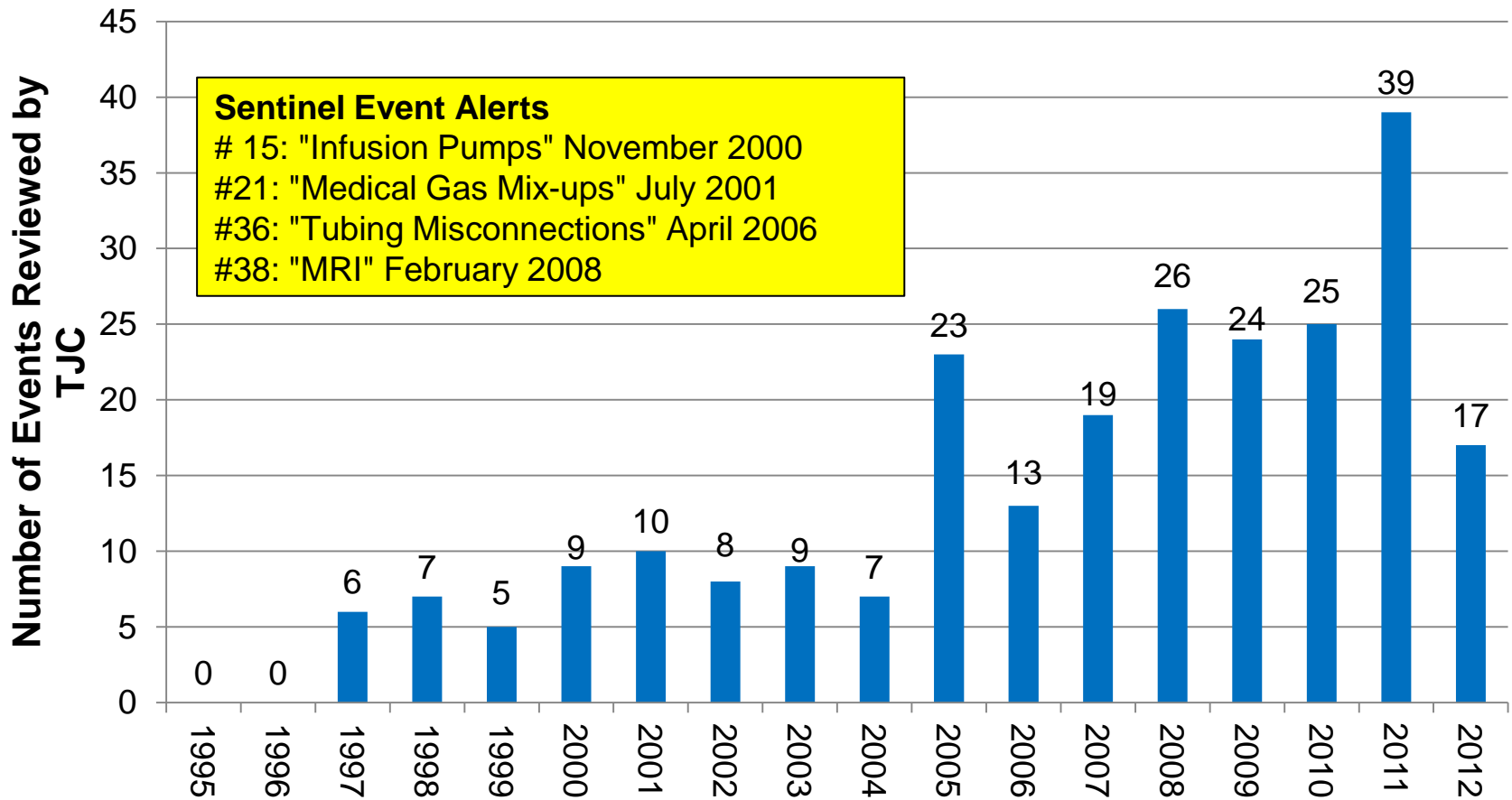
(Resulting in death or permanent loss of function)



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Medical Equipment-related Events Reviewed by The Joint Commission

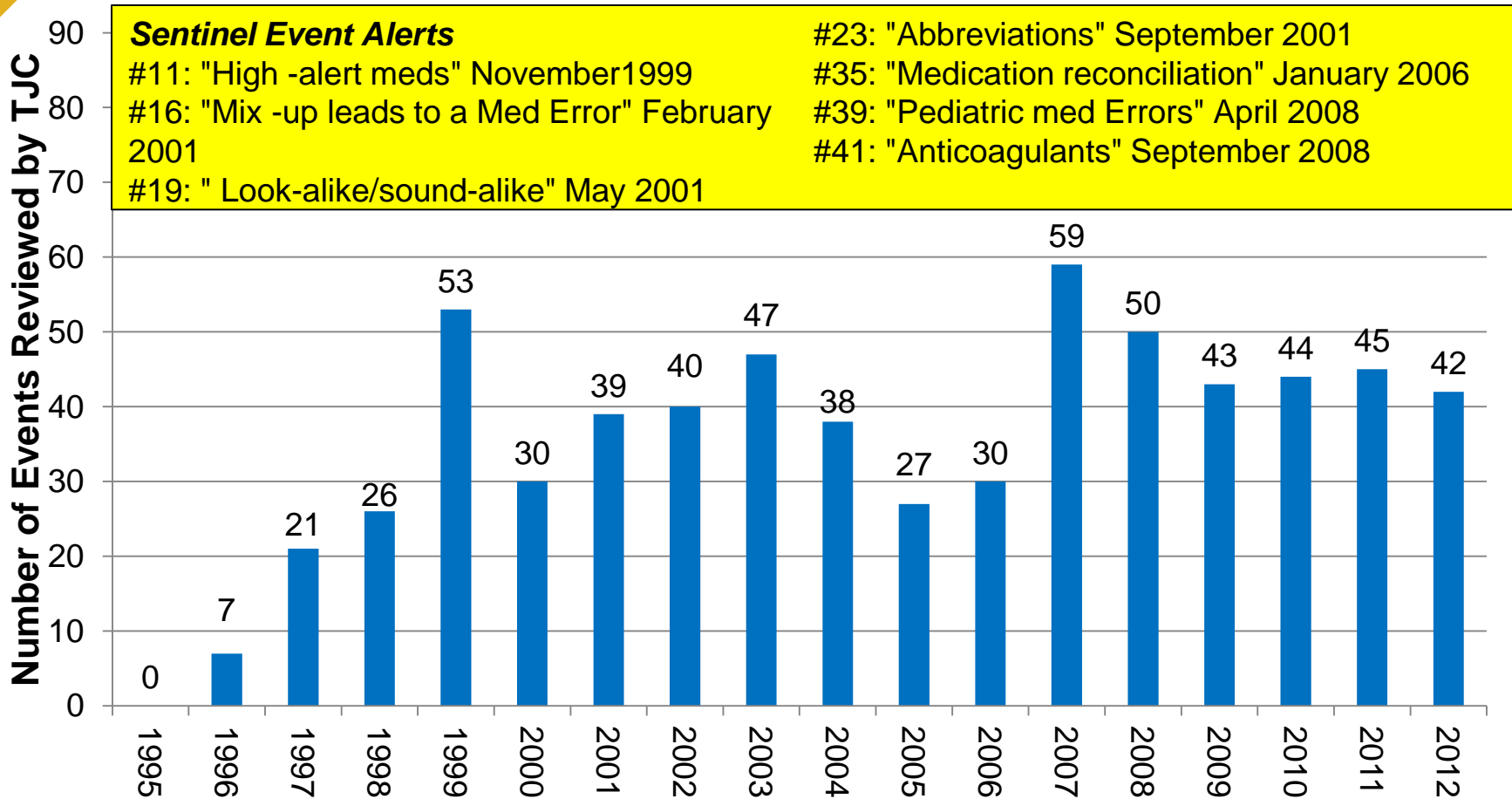
(Resulting in death or permanent loss of function)



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Medication Error Events Reviewed by The Joint Commission

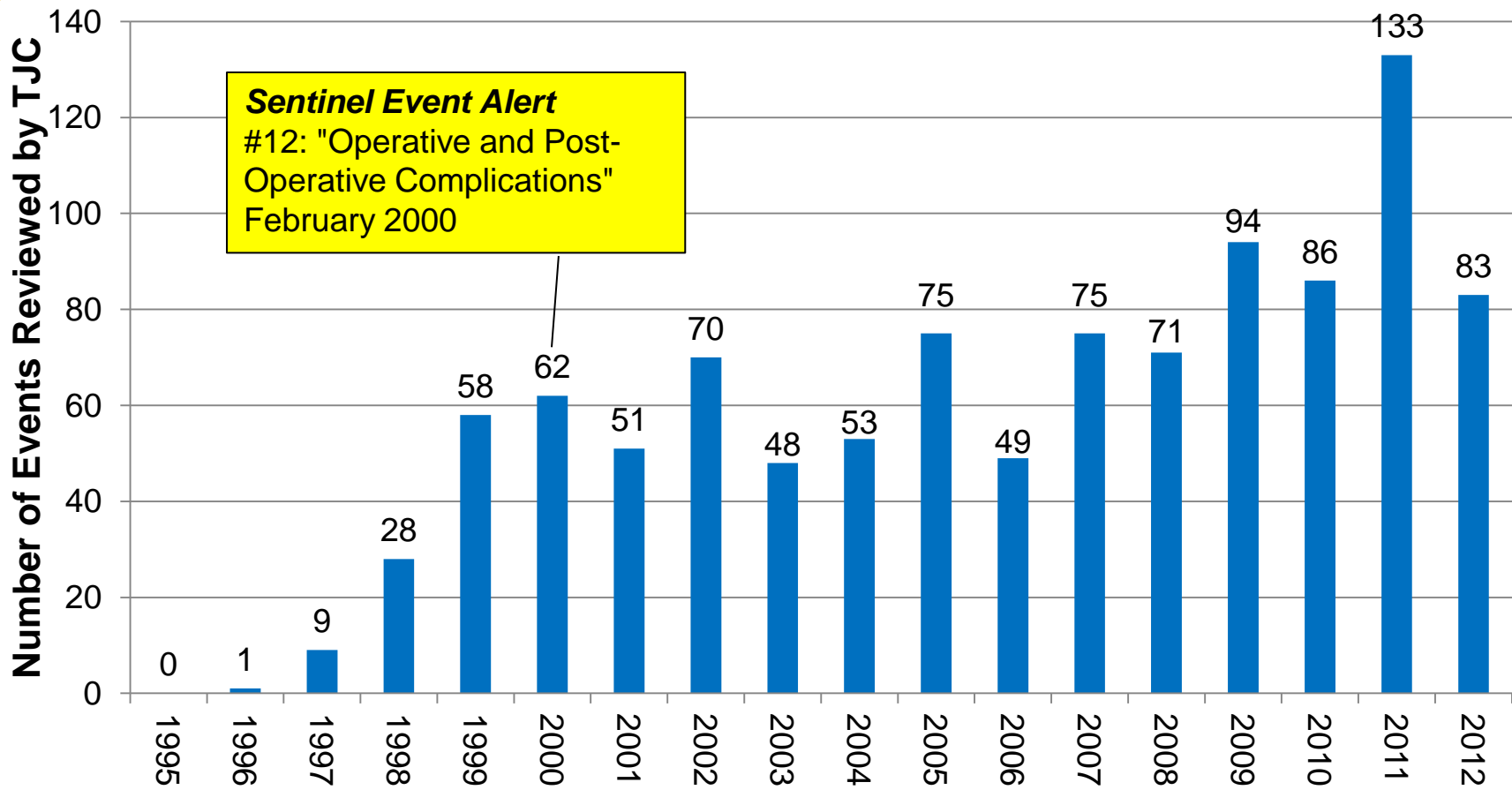
(Resulting in death or permanent loss of function)



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Op/Post-op Complication Events Reviewed by The Joint Commission

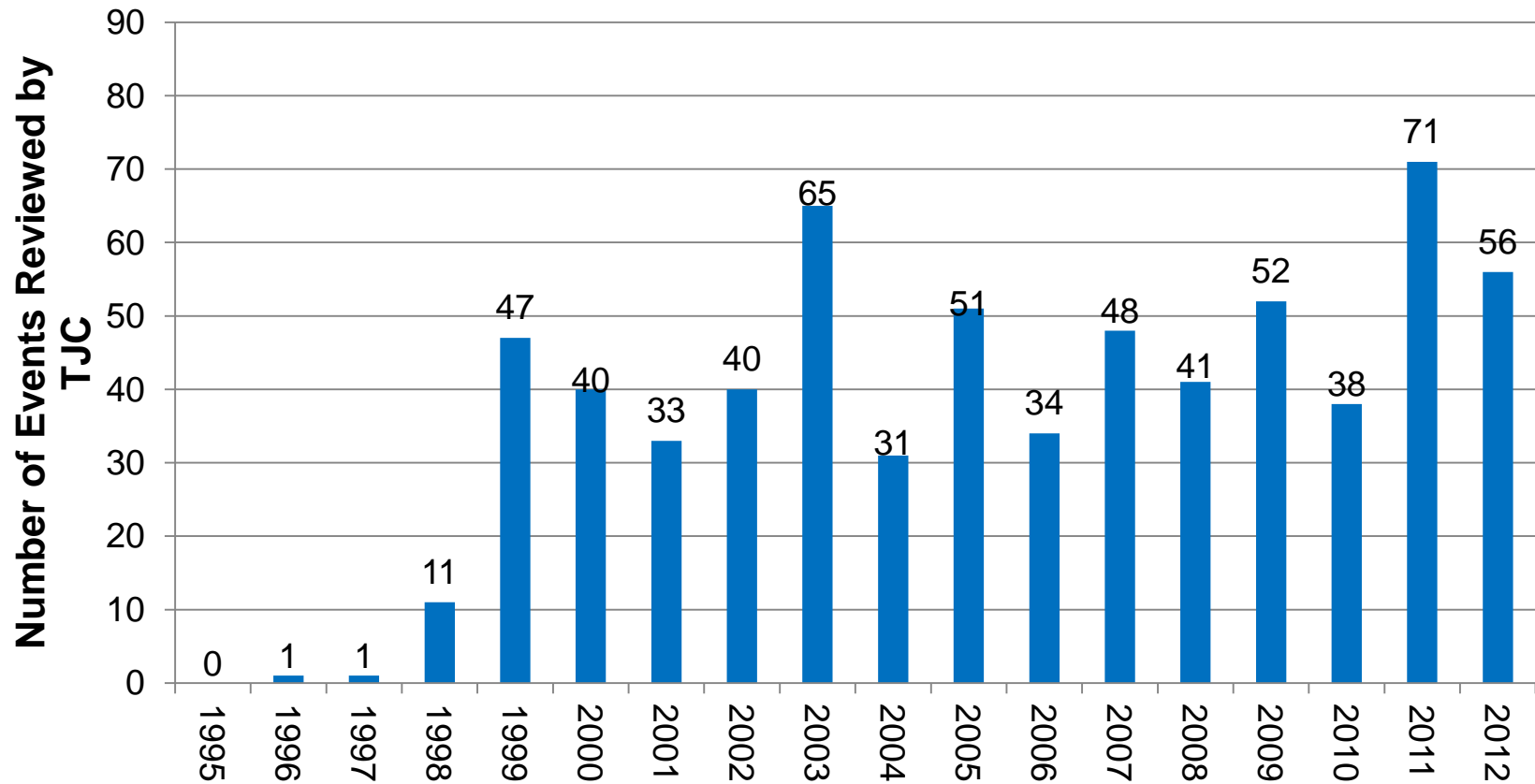
(Resulting in death or permanent loss of function)



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Other Unanticipated Events Reviewed by The Joint Commission

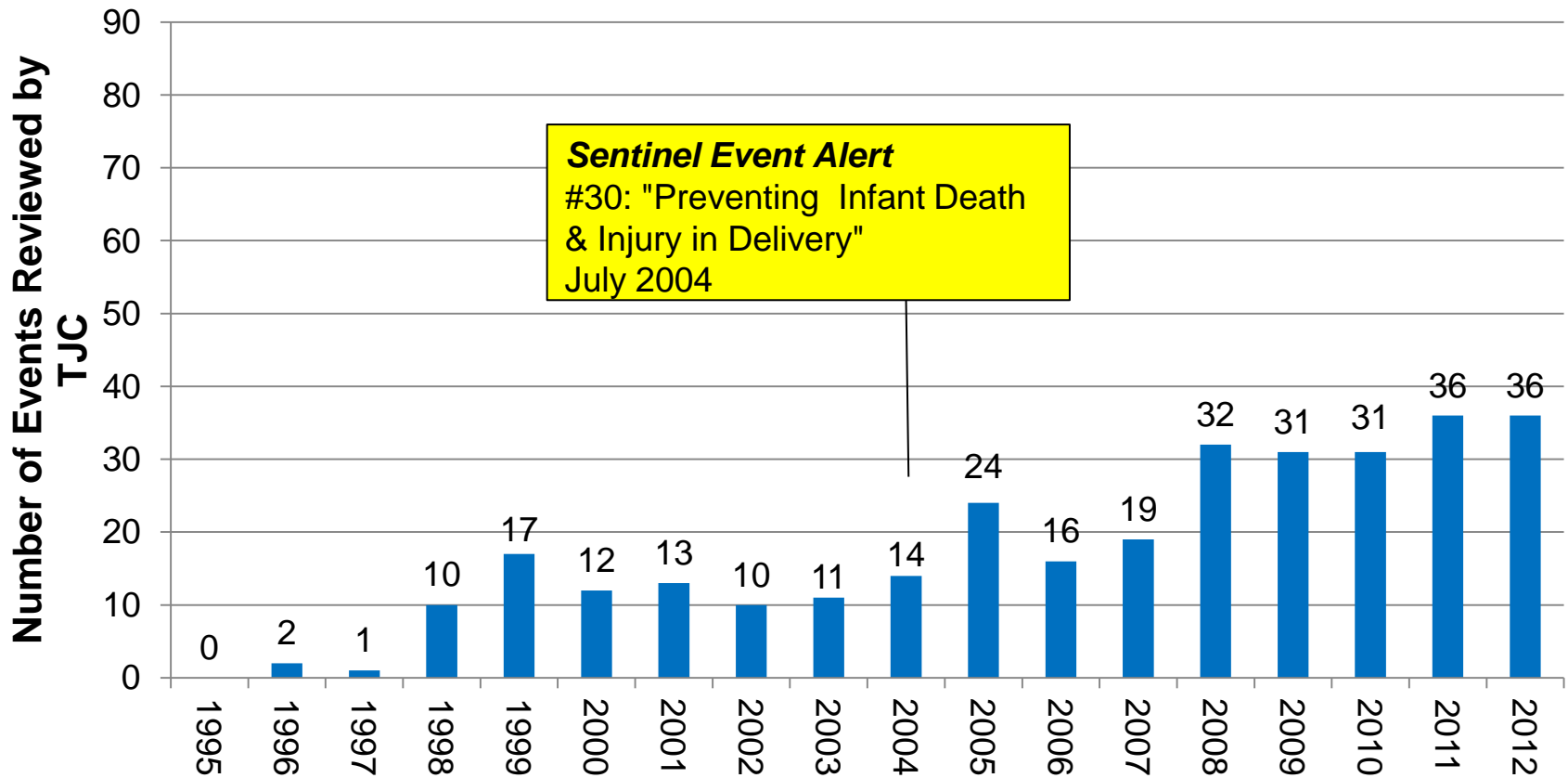
(Resulting in death or permanent loss of function--such as: asphyxiation, choking, drowning, found unresponsive)



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Perinatal Events Reviewed by The Joint Commission

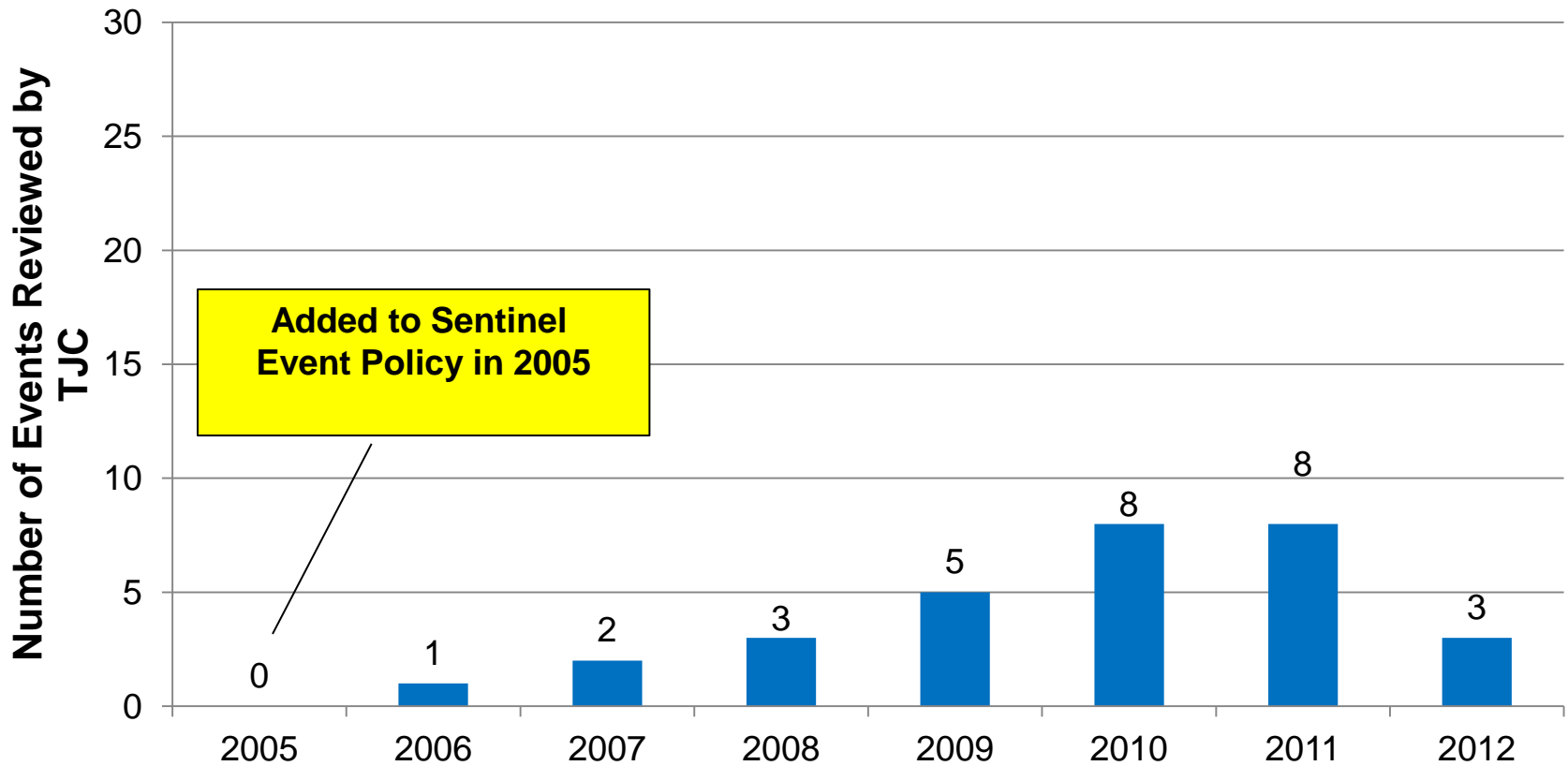
(Resulting in death or permanent loss of function--full-term infant 2500g or > and absence of obvious congenital abnormality)



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Radiation Overdose Events Reviewed by The Joint Commission

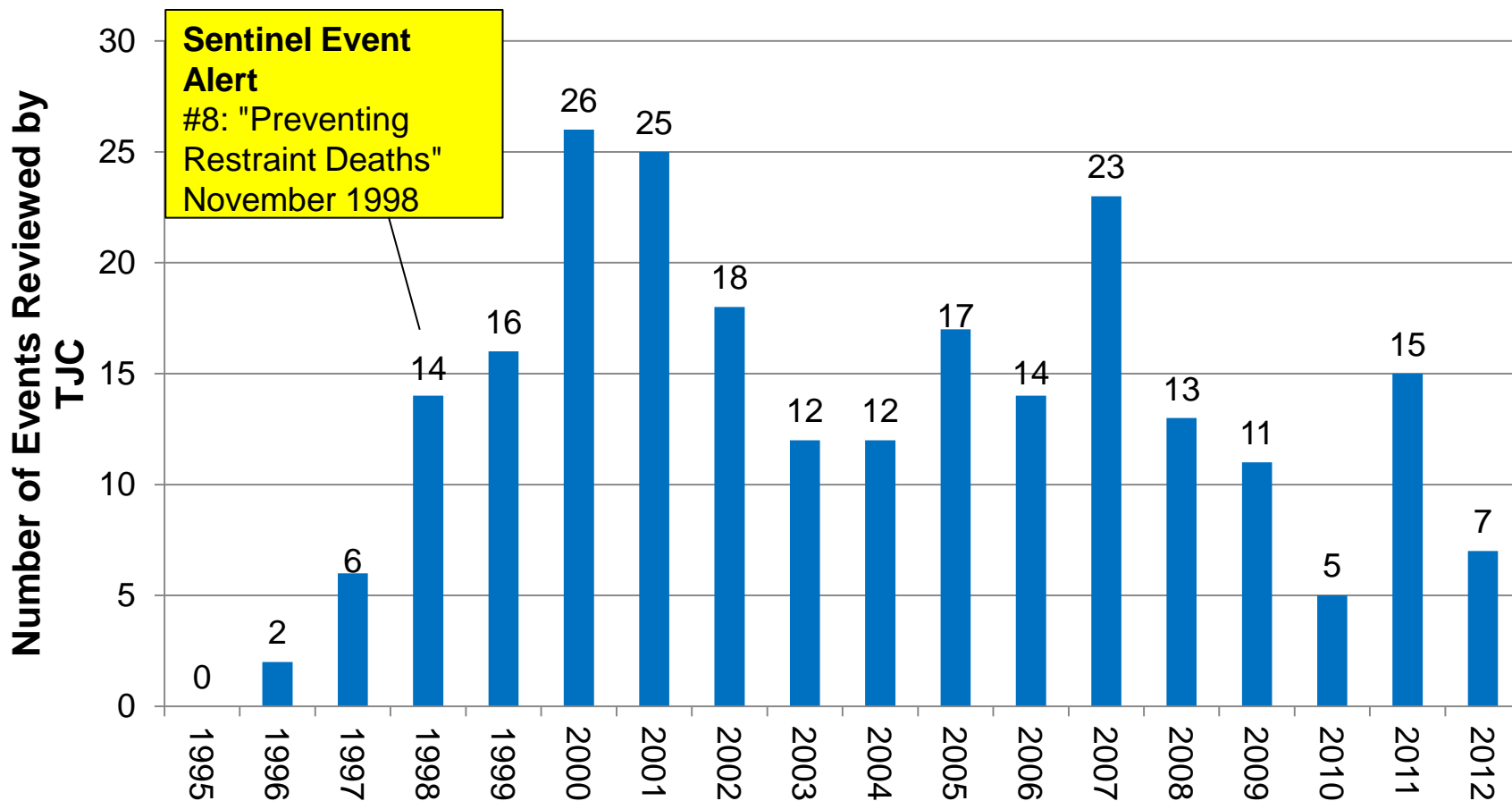
(Cumulative dose > 1500 rads to a single field, or any delivery of radiotherapy to the wrong body region or > 25% above the planned radiotherapy dose)



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Restraint-related Events Reviewed by The Joint Commission

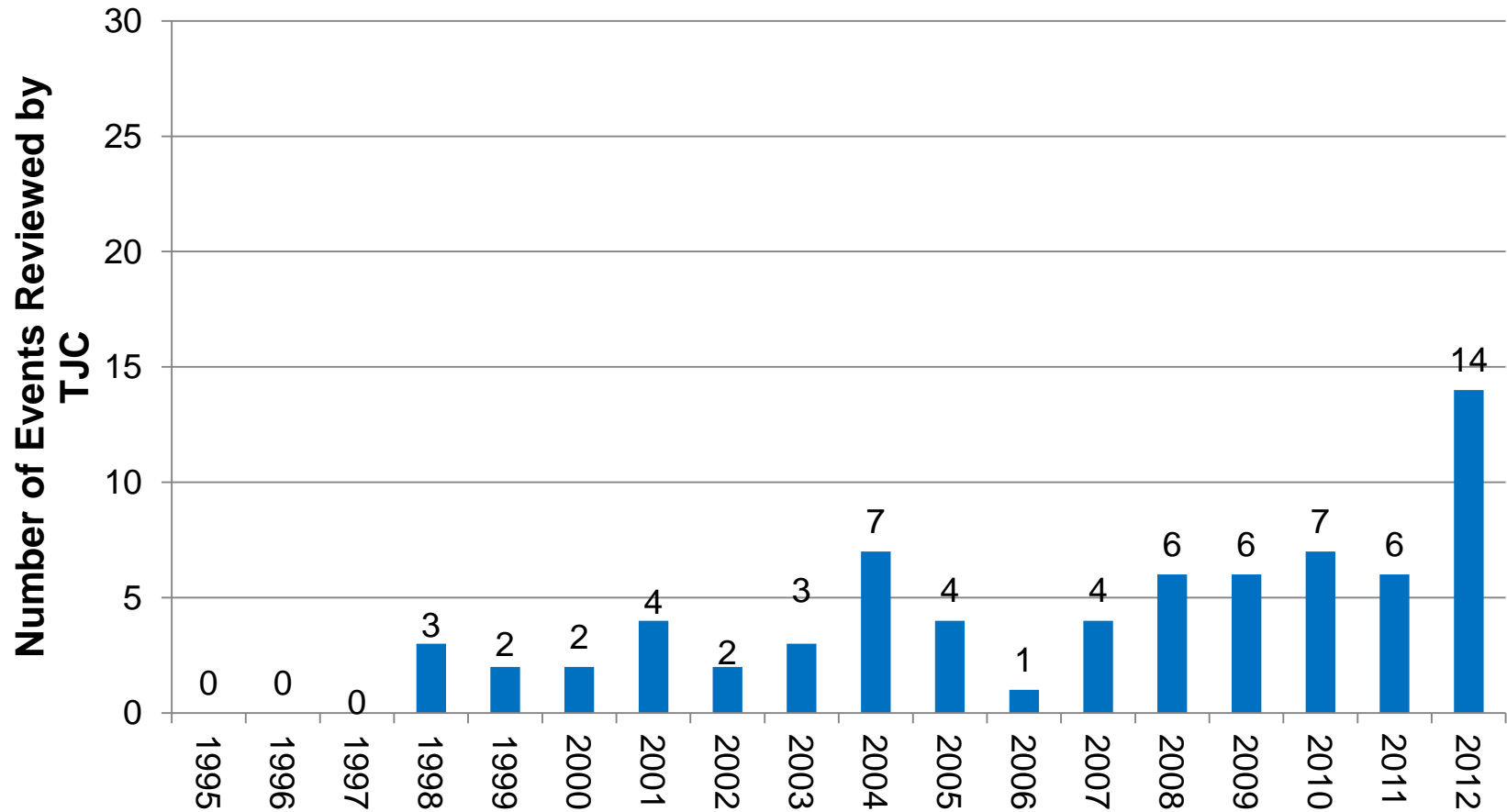
(Resulting in death or permanent loss of function)



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Self-inflicted Injury Events Reviewed by The Joint Commission

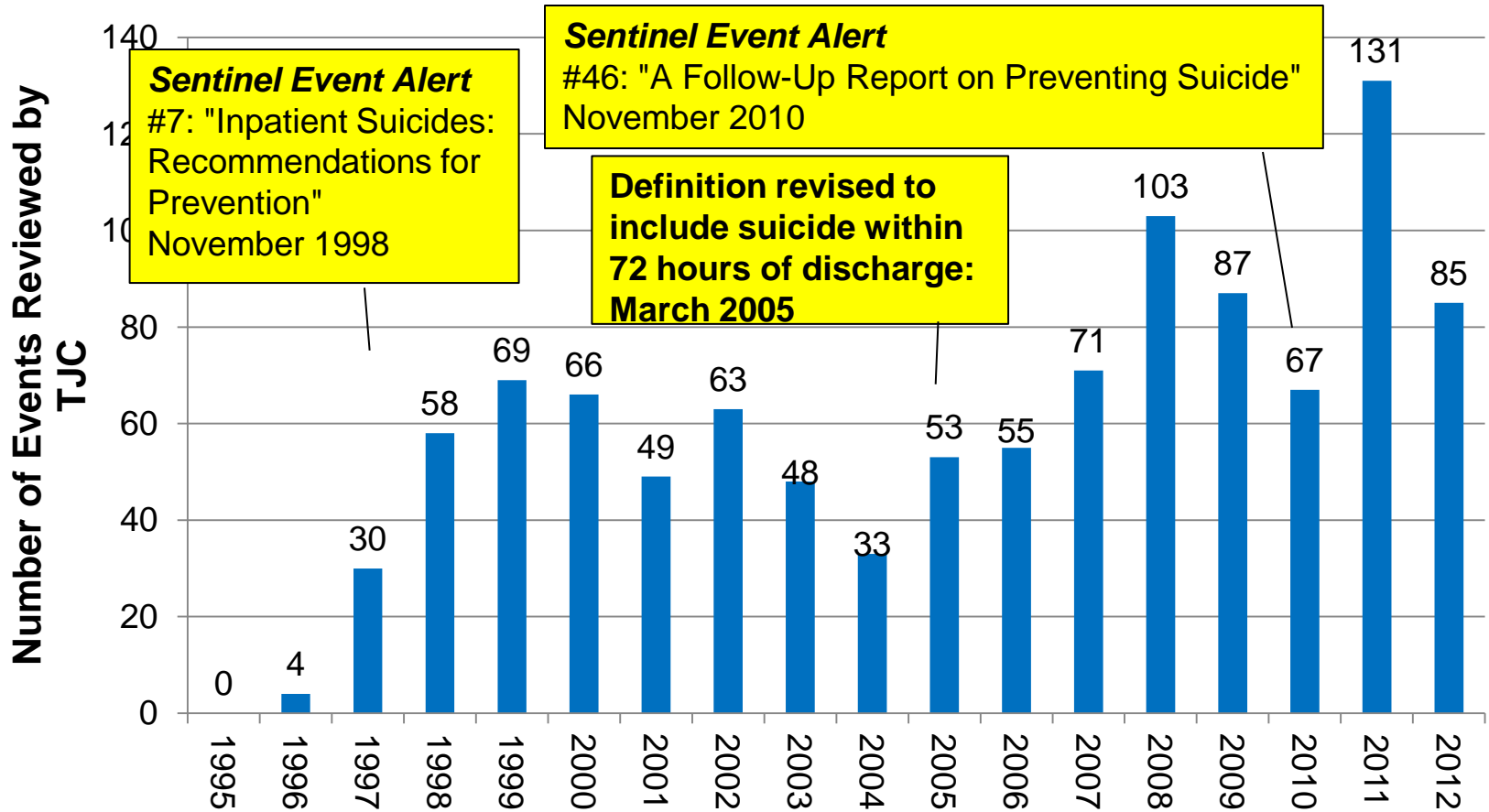
(Resulting in death or permanent loss of function--not related to suicide)



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Suicide Events Reviewed by The Joint Commission

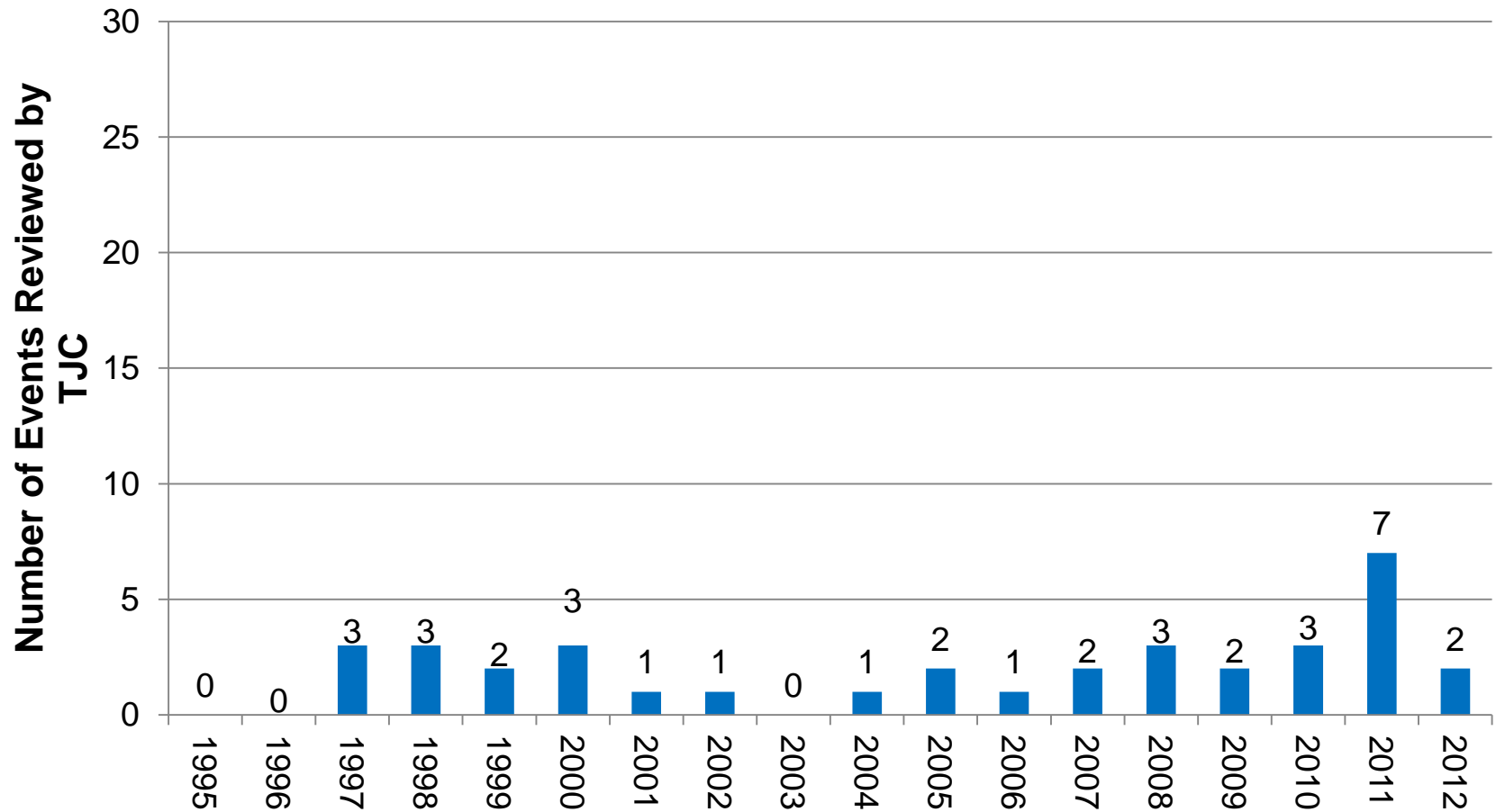
(Of any individual receiving care, treatment or services in a staffed around-the-clock care setting or within 72 hours of discharge)



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Transfer-related Events Reviewed by The Joint Commission

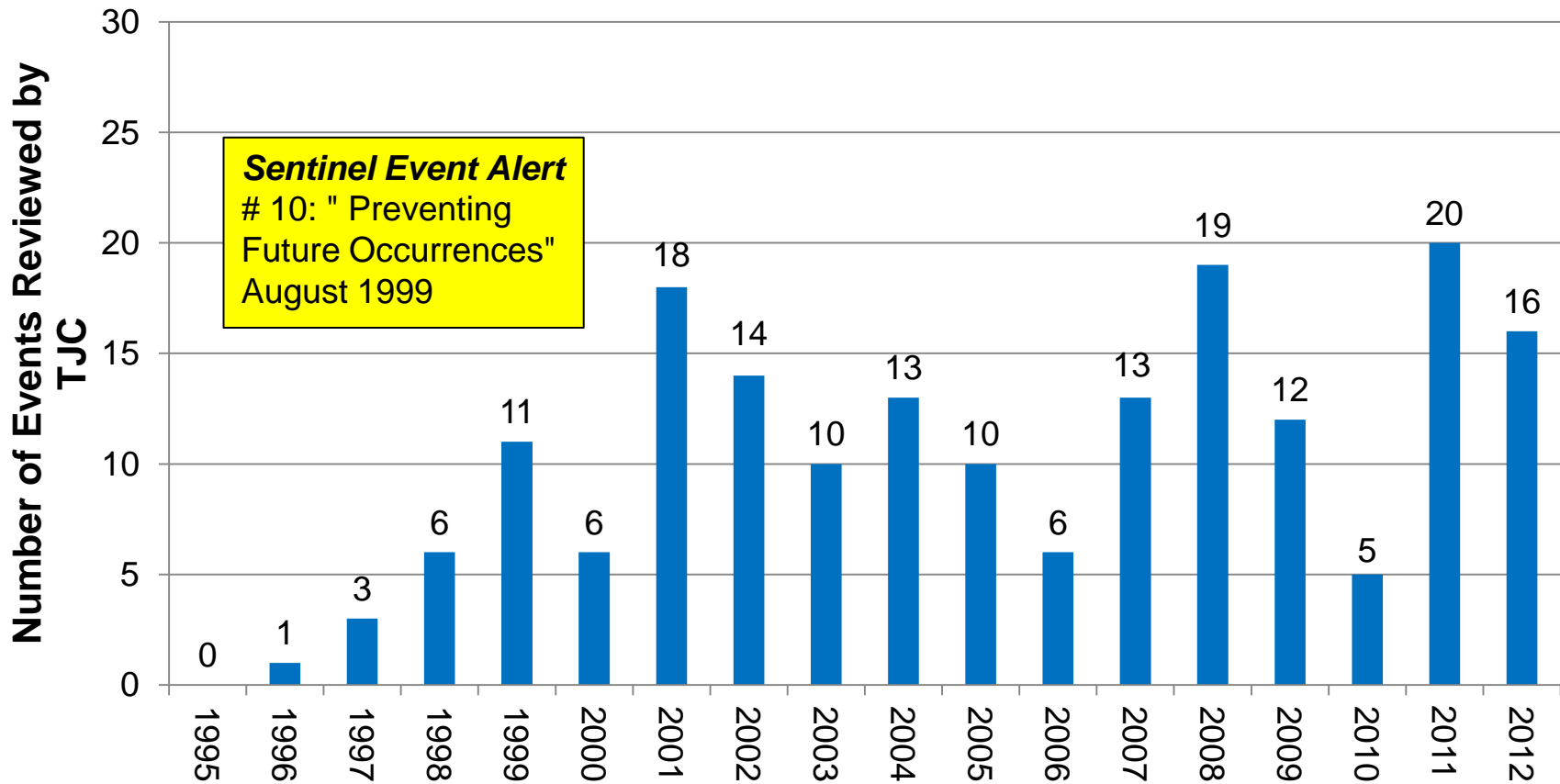
(Resulting in death or permanent loss of function)



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Transfusion-related Events Reviewed by The Joint Commission

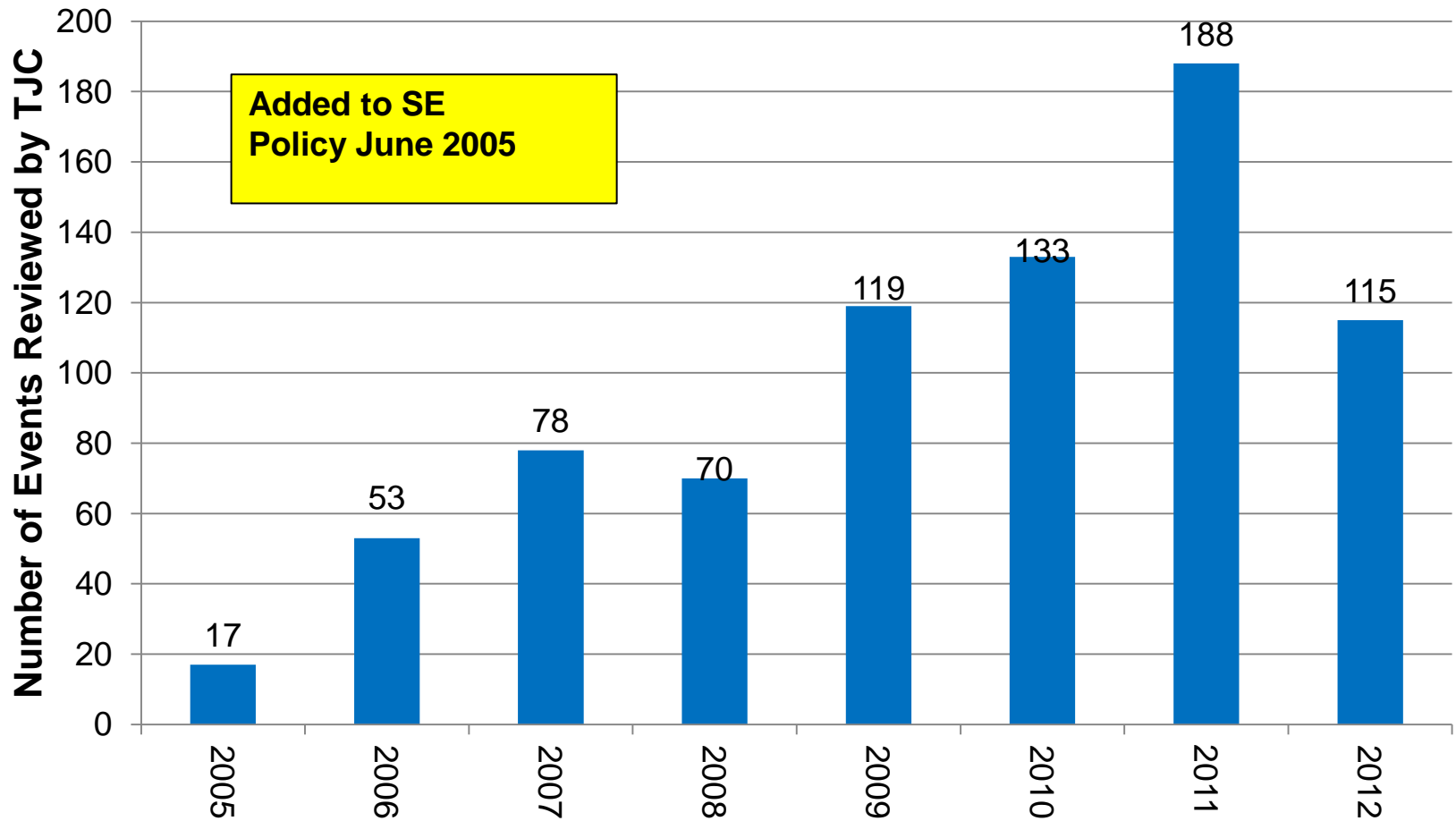
(Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities)



Sentinel Event Alert
10: " Preventing
Future Occurrences"
August 1999

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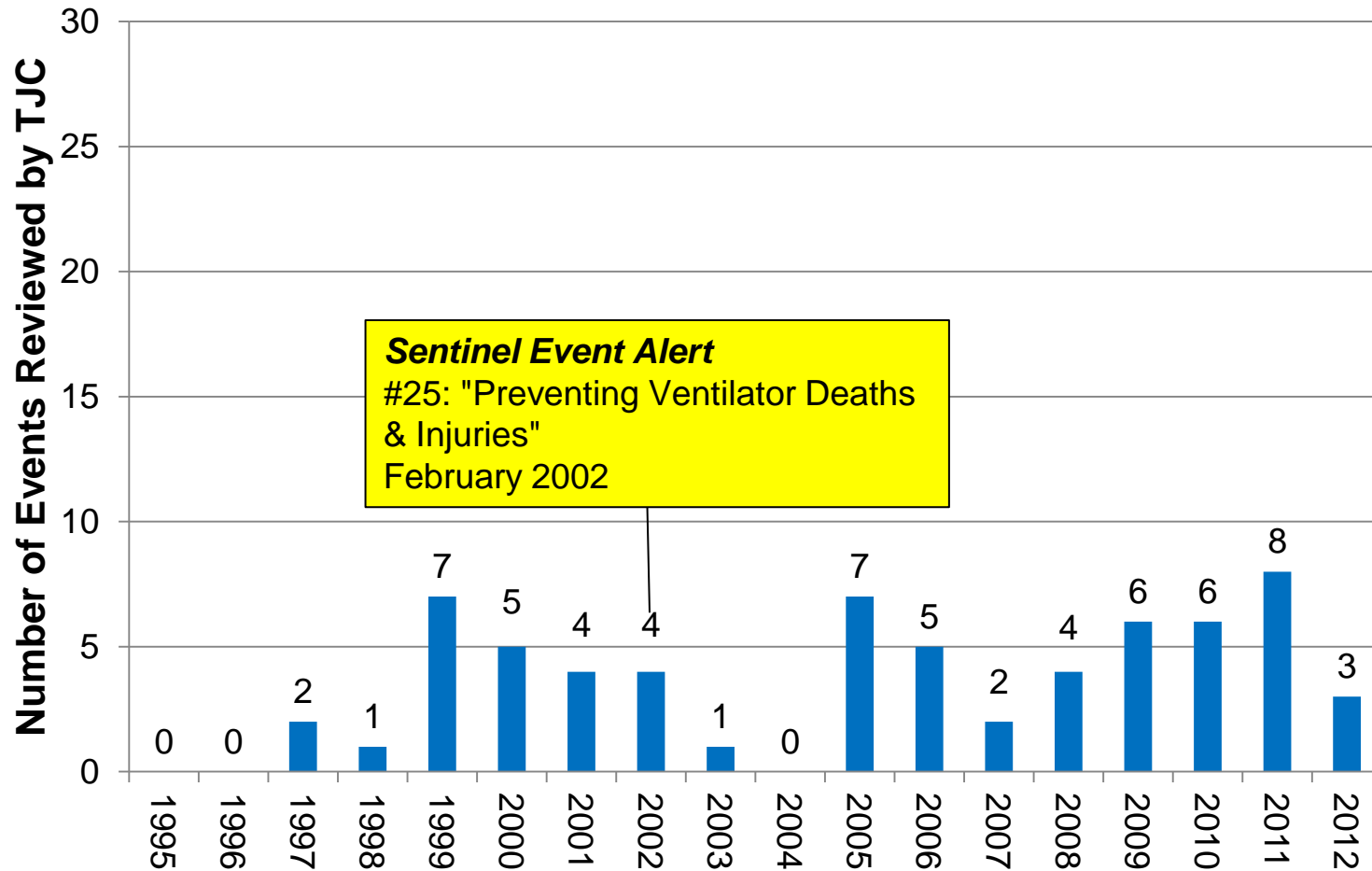
Unintended Retention of Foreign Object Events Reviewed by The Joint Commission



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Ventilator-related Events Reviewed by The Joint Commission

(Resulting in death or permanent loss of function)



Sentinel Event Alert

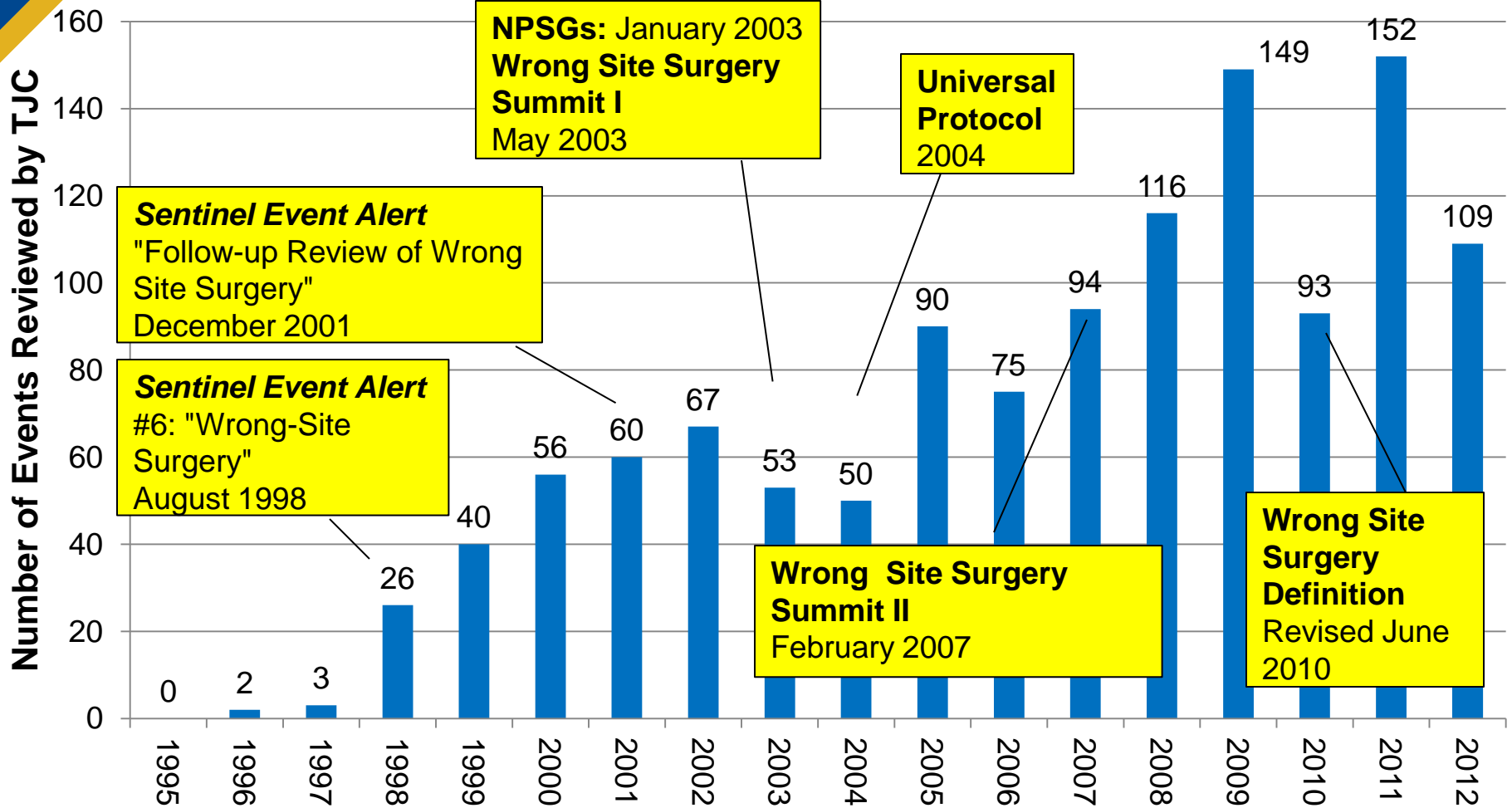
#25: "Preventing Ventilator Deaths & Injuries"

February 2002

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Wrong-patient, Wrong-site, Wrong-procedure Events Reviewed by The Joint Commission

(Regardless of the magnitude of the procedure)



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