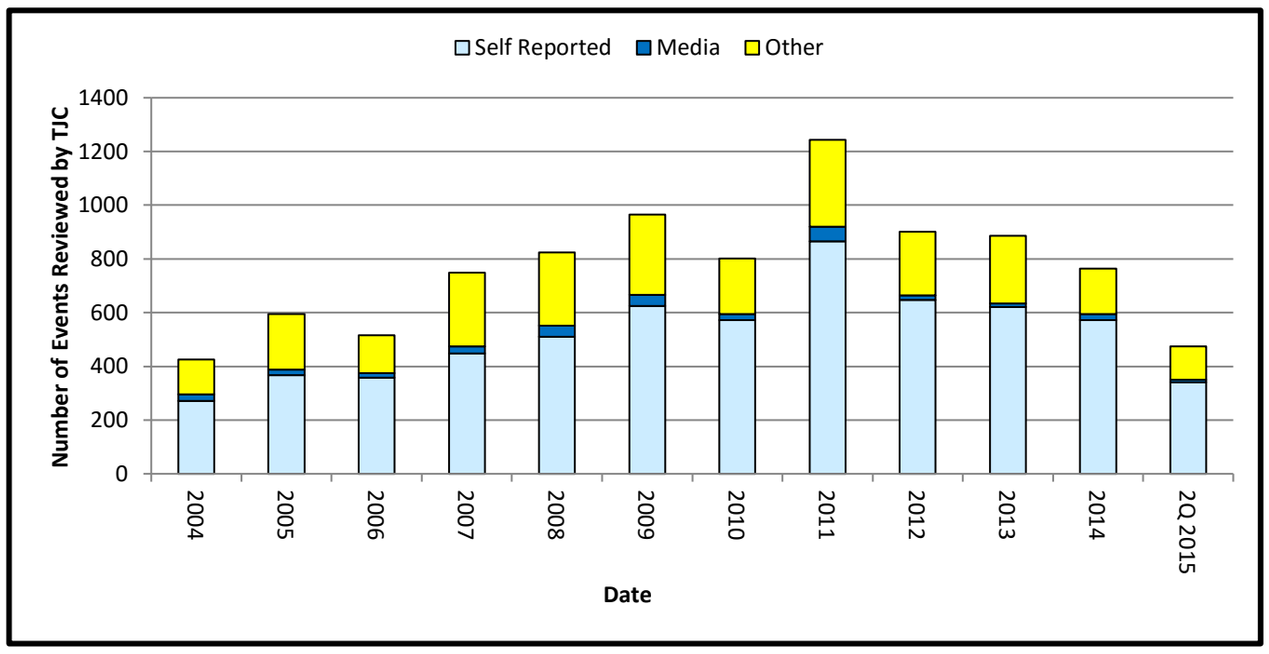
SE Statistics as of: 7/9/2015

Summary Data of Sentinel Events Reviewed by The Joint Commission

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.

Total number of Sentinel Events reviewed by The Joint Commission 1995 through 2Q 2015	11660

Total Incidents Reviewed 1995 through 2003	
1995	1
1996	29
1997	119
1998	272
1999	421
2000	441
2001	398
2002	444
2003	416
1995 to 2003 Total	2541



Sources of Reviewable Sentinel Events 2004 through 2Q 2015	Non-self reported	Self Reported	Total	%Self Reported
2004	151	267	418	63.9%
2005	225	367	592	62.0%
2006	154	357	511	69.9%
2007	292	448	740	60.5%
2008	310	509	819	62.1%
2009	344	624	968	64.5%
2010	230	572	802	71.3%
2011	378	865	1243	69.6%
2012	253	648	901	71.9%
2013	265	622	887	70.1%
2014	191	573	764	75.0%
2Q 2015	133	341	474	71.9%
2004 through 2Q 2015 Total	2926	6193	9119	67.9%

Sentinel Event Settings 2004 through 2Q 2015	#	%
Hospital	6066	66.6%
Psychiatric hospital	910	10.0%
Ambulatory care	340	3.7%
Psych unit in general hospital	484	5.3%
Emergency department	503	5.5%
Behavioral health facility	336	3.7%
Home care	176	1.9%
Long term care facility	103	1.1%
Other***	117	1.3%
Office-based surgery	79	0.9%

Type of Sentinel Event	2004 - 2Q 2015 Total	2013	2014	2Q 2015
Anesthesia-Related Event	109	8	6	1
Criminal Event	391	52	47	12
Delay In Treatment	1013	113	73	37
Dialysis-Related Event	12	1	2	0
Elopement	95	9	6	1
Fall	750	82	91	39
Fire	130	9	10	13
Infant Abduction	29	2	0	1
Infant Discharge to Wrong Family	3	0	0	0
Infection-Related Event	182	13	12	4
Inpatient Drug Overdose	102	8	8	3
Maternal Death	127	7	11	2
Med Equipment-Related	228	20	9	6
Medication Error	452	38	18	18
Op/Post-op Complication	884	77	52	36
Other Unanticipated Event***	613	81	73	34
Perinatal Death/Injury	327	35	32	21
Radiation Overdose*	39	4	4	1
Restraint Related Event	128	4	2	5
Self-Inflicted Injury	77	9	5	8
Severe Neonatal Hyperbilirubinemia*	7	0	0	1
Suicide	905	90	82	48
Transfer-Related Event	28	2	1	1
Transfusion Error	134	7	7	6
Unassigned	97	0	31	66
Unintended Retention of a Foreign Body*	1037	102	112	50
Utility System Failure	7	0	0	0
Ventilator Death	51	5	3	2
Wrong–patient, wrong-site, wrong-procedure	1162	109	67	58
Total Incidents Reviewed	9119	887	764	474

Sentinel Event Outcome 2004 through 2Q 2015	#	%
Patient death	5383	57.4%
Permanent harm	30	0.3%
Permanent loss of function	847	9.0%
Severe temporary harm	77	0.8%
Psychological impact	300	3.2%
Unexpected additional care	2478	26.4%
Unknown	69	0.7%
Other	200	2.1%
Total patients impacted****	9384	100.0%

*Unintended retention of a foreign object , Severe Neonatal Hyperbilirubinemia & Radiation Overdose were added to the definition of reviewable events in 2005. This data represents events reviewed since that date, not 1995-2010.

**Other includes: Disease Specific Care, Diagnostic Imaging, Hospice Care

***Other include: Asphyxiation, Burn, Choked on food, Drowned, Found unresponsive

****Multiple patients may be impacted by a single event.