Most Commonly Reviewed Sentinel Event Types

Updated 02/01/21

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.

Sentinel Event

A sentinel event is a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in any of the following:

- Death
- Permanent harm
- Severe temporary harm and intervention required to sustain life

The Sentinel Event Policy is available online at:
http://www.jointcommission.org/Sentinel_Event_Policy_and_Procedures/

The Joint Commission

Sentinel Event

An event is also considered sentinel if it is one of the following:

- Suicide of any patient receiving care, treatment, and services in a staffed around-the clock care setting or within 72 hours of discharge, including from the hospital's emergency department (ED)
- Unanticipated death of a full-term infant
- Discharge of an infant to the wrong family
- Abduction of any patient receiving care, treatment, and services
- Any elopement (that is, unauthorized departure) of a patient from a staffed around the-clock care setting (including the ED), leading to death, permanent harm, or severe temporary harm to the patient

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Sentinel Event

An event is also considered sentinel if it is one of the following:

- Administration of blood or blood products having unintended ABO and non-ABO (Rh, Duffy, Kell, Lewis, and other clinically important blood groups) incompatibilities,† hemolytic transfusion reactions, or transfusions resulting in severe temporary harm, permanent harm, or death
- Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of any patient receiving care, treatment, and services while on site at the hospital
- Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of a staff member, licensed independent practitioner, visitor, or vendor while on site at the hospital
- Invasive procedure, including surgery, on the wrong patient, at the wrong site, or that is the wrong (unintended) procedure

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Sentinel Event

An event is also considered sentinel if it is one of the following:

- Unintended retention of a foreign object in a patient after an invasive procedure, including surgery
- Severe neonatal hyperbilirubinemia (bilirubin >30 milligrams/deciliter)
- Prolonged fluoroscopy with cumulative dose >1,500 rads to a single field or any delivery of radiotherapy to the wrong body region or >25% above the planned radiotherapy dose
- Fire, flame, or unanticipated smoke, heat, or flashes occurring during an episode of patient care
- Any intrapartum (related to the birth process) maternal death

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Sentinel Event

An event is also considered sentinel if it is one of the following:

- Severe maternal morbidity (not primarily related to the natural course of the patient's illness or underlying condition) when it reaches a patient and results in permanent harm or severe temporary harm
- Fall resulting in any of the following: any fracture; surgery, casting, or traction; required consult/management or comfort care for a neurological (e.g., skull fracture, subdural or intracranial hemorrhage) or internal (e.g., rib fracture, small liver laceration) injury; a patient with coagulopathy who receives blood products as a result of the fall; or death or permanent harm as a result of injuries sustained from the fall (not from physiologic events causing the fall)

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Top Five Sentinel Events Reviewed by The Joint Commission

The most frequently reviewed sentinel events by The Joint Commission are:

1) Falls
2) Unintended Retention of a Foreign Object (URFO)
3) Suicide
4) Wrong Surgery
5) Delay in Treatment

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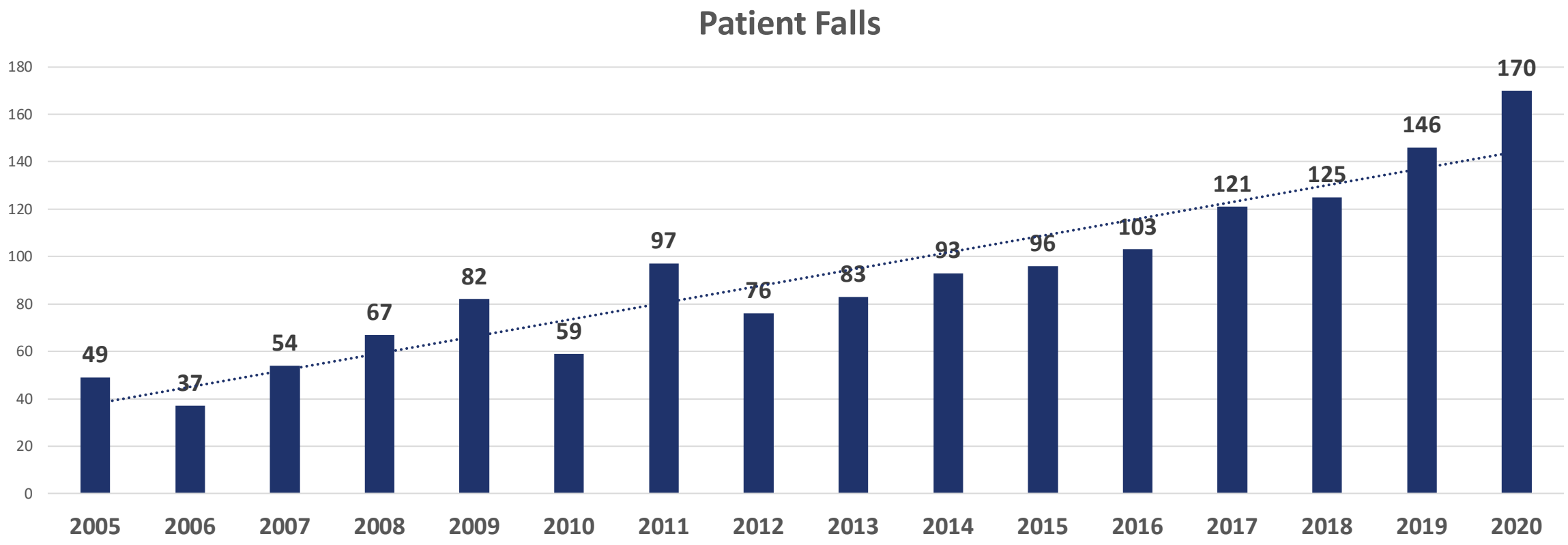
Patient Falls

Patient falls resulting in injury are consistently among the most frequently reviewed Sentinel Events by The Joint Commission. Patient falls remained the most frequently reported sentinel event for 2020.



The Joint Commission

Patient Falls

In September 2015, The Joint Commission issued a *Sentinel Event Alert* on Preventing falls and fall-related injuries in health care facilities.

Analysis of falls with injury reveals the most common contributing factors pertain to:

- Inadequate assessment
- Communication failures
- Lack of adherence to protocols and safety practice
- Inadequate staff orientation, supervision, staffing levels or skill mix
- Deficiencies in the physical environment
- Lack of leadership

Patient Falls

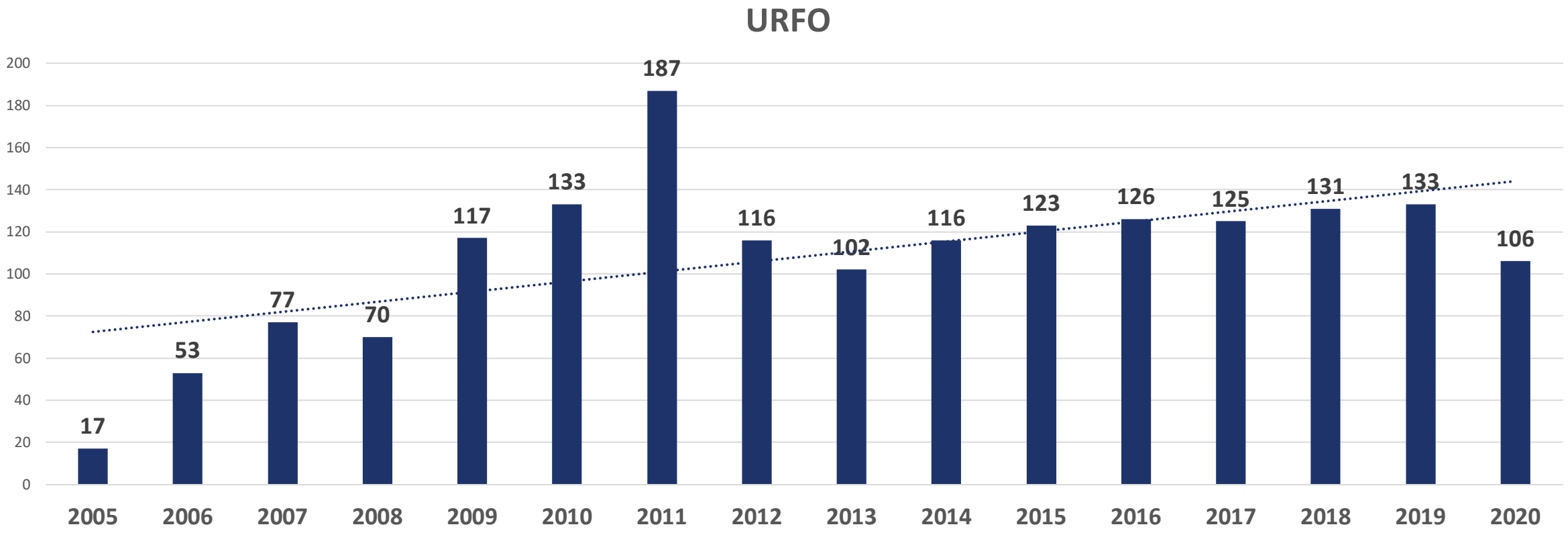
Quick Safety 40 calls for increased attention to the underrecognized issue of **infant falls.**

Literature suggests that the most prevalent maternal risk factors associated with newborn falls and drops include:

- Cesarean birth
- Use of pain medication within four hours
- Second or third postpartum night, specifically around midnight to early morning hours
- Drowsiness associated with breastfeeding

Unintentionally Retained Foreign Object (URFO)

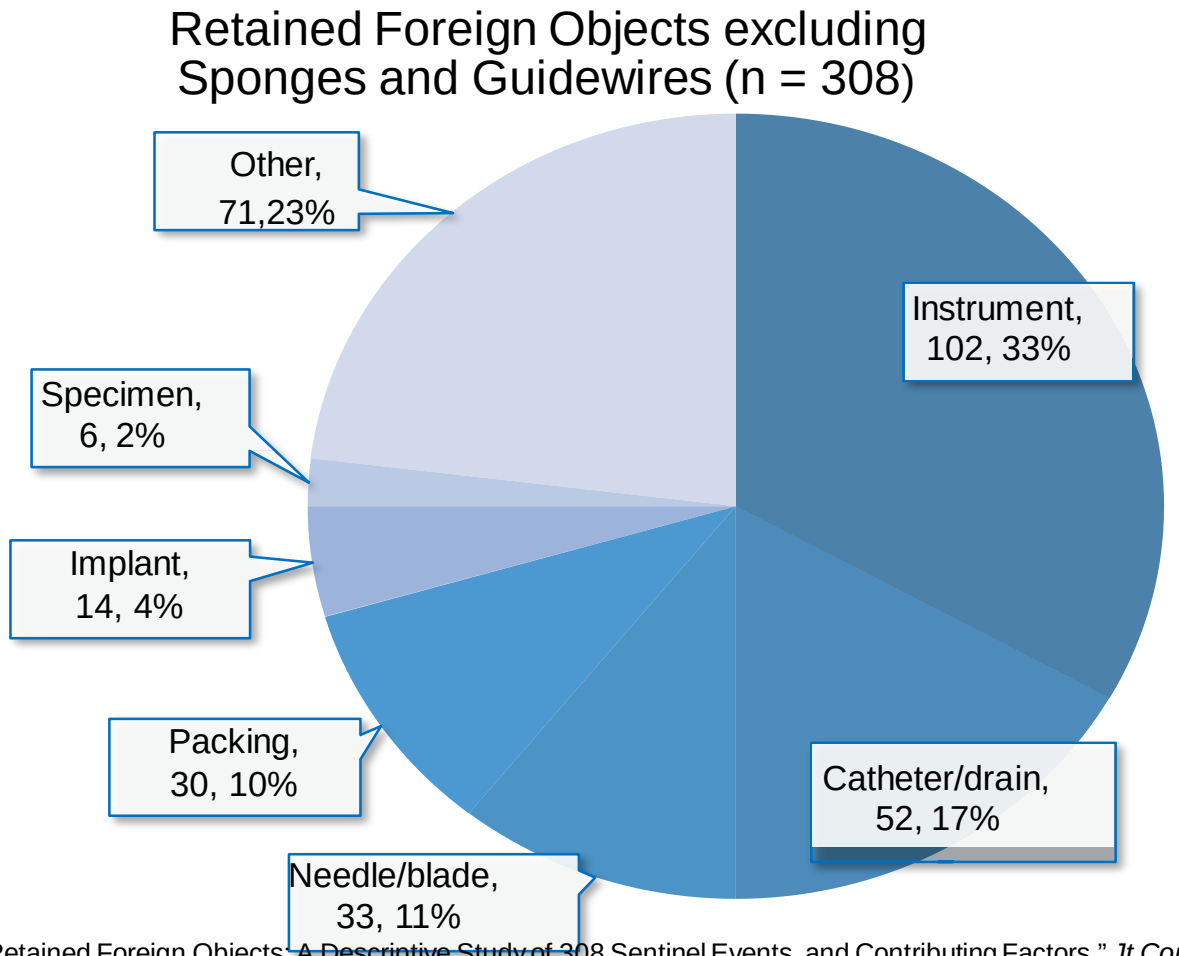
Unintentionally Retained Foreign Object (URFO) was the most frequently reported sentinel event to The Joint Commission in 2017 and 2018. URFOs dropped to second most frequent in 2019 and 2020.



The Joint Commission

Unintended Retention of Foreign Object

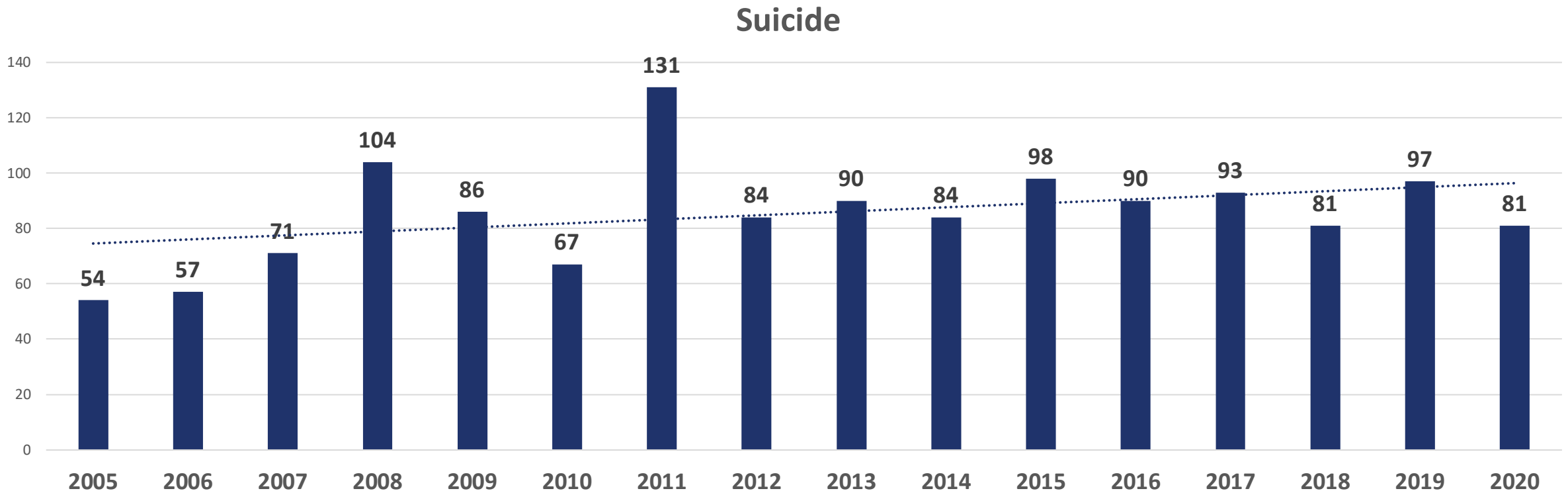
Steelman and colleagues[1,2,3] analyzed URFO sentinel events reported to The Joint Commission between 2012 and 2018. Their reviews describe the types of objects retained (n = 308), analyzing sponges (n = 319) and guidewires (n =73) separately. Anatomical regions, settings, contributing factors, and recommendations for prevention based on their findings are also described.



1. Steelman VM, Shaw C, Shine L, Hardy-Fairbanks AJ. "Unintentionally Retained Foreign Objects: A Descriptive Study of 308 Sentinel Events and Contributing Factors." *Jt Comm J Qual Patient Saf*. 2018 Oct 16.
2. Steelman VM, Thenuwara K, Shaw C, Shine L. "Unintentionally Retained Guidewires: A Descriptive Study of 73 Sentinel Events." *Jt Comm J Qual Patient Saf*. 2018 Sep 24.
3. Steelman VM, Shaw C, Shine L, Hardy-Fairbanks AJ. "Retained surgical sponges: a descriptive study of 319 occurrences and contributing factors from 2012 to 2017." *Patient Saf Surg*. 2018 Jun 29;12:20.

Suicide

Suicide continues to be consistently among the most frequently reviewed Sentinel Events reviewed by The Joint Commission. Suicide of any patient receiving care, treatment, and services in a staffed around-the clock care setting or within 72 hours of discharge, including from the hospital's emergency department (ED) is considered a Sentinel Event.



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Patient Suicide

National Patient Safety Goal 15.01.01 has been revised to take a high-level approach to suicide prevention, focused on helping organizations improve processes and environments for individuals at risk for suicide. https://www.jointcommission.org/resources/patient-safety-topics/patient-safety/
Specific areas addressed include:

- Environmental risk assessments
- Minimizing environmental risks
- Screening for suicide risk using a validated tool
- Developing plans to mitigate suicide based on individual's overall level of risk
- Following policies and procedures for counseling and follow-up care for individuals identified at risk for suicide

Also see Suicide portal https://www.jointcommission.org/resources/patient-safety-topics/suicide-prevention/ on The Joint Commission website, for the Suicide Risk Recommendations from Suicide Risk Reduction Expert Panel (see "Compliance with Suicide Recommendations" section).

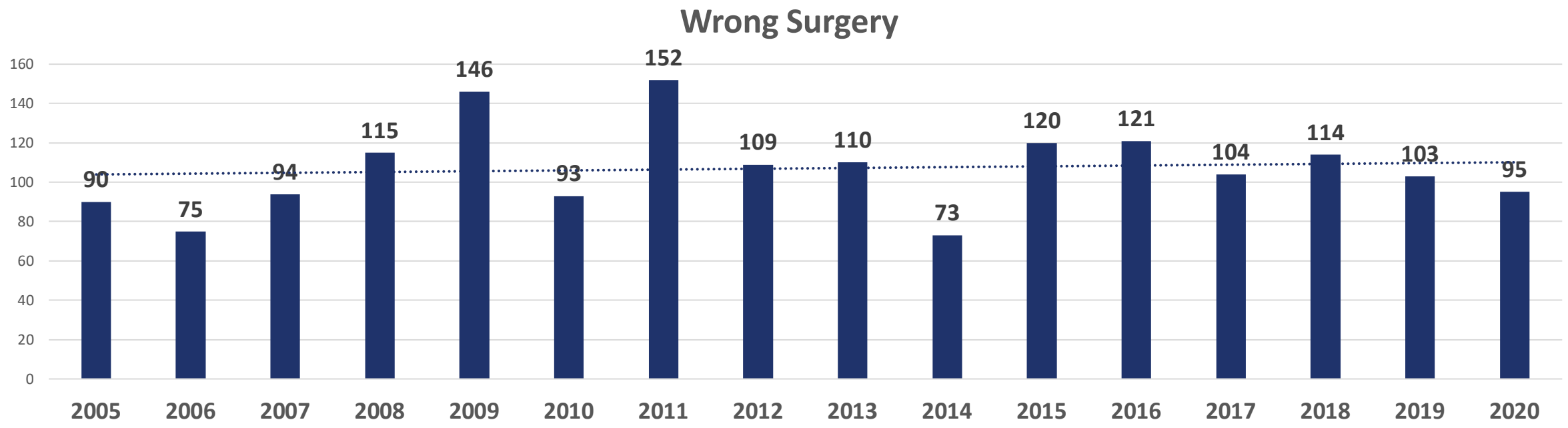
The Joint Commission

Wrong Surgery:

Wrong patient, Wrong site, Wrong procedure, Wrong implant

Wrong-patient, wrong-site, wrong procedure events are preventable events that can lead to catastrophic harm to patients. In late 2018 the categorization was expanded to include delineation for wrong-implant.

The Joint Commission's Universal Protocol, the Center for Transforming Healthcare's Targeted Solution Tool for Safe Surgery, and the World Health Organization Surgical Safety Checklist are well established procedures and processes that can help prevent these types of events from occurring.



The Joint Commission

Wrong Surgery

Organizations that participated in the Center for Transforming Healthcare's project to develop the Targeted Solution Tool for Safe Surgery identified 29 main causes of wrong site surgeries that occurred during scheduling, in pre-op holding, in the operating room, or which stemmed from the organizational culture as well as potential solutions for these causes.

Scheduling

- Office schedulers do not verify presence and accuracy of booking documents.
- Schedulers accept verbal requests for surgical bookings instead of written documents.
- Unapproved abbreviations, cross- outs and illegible handwriting.

Pre-op holding/holding

- Primary documents – such as consent, history and physical, orders, operating room schedule – are missing, inconsistent or incorrect.
- Inconsistent use of site-marking.
- Time-out process for regional blocks is inconsistent or absent.
- Inadequate patient verification by the team because of rushing or other distractions.

Operating room

- When the same provider performs multiple procedures, there is no intraoperative site verification.
- Hand-off communication or briefing process is ineffective.
- Primary documentation is not used to verify patient, procedure, site, and side immediately prior to incision.
- Site marks are removed during prep.
- Distractions and rushing occur during time-out, or the time- out occurs before all staff members are ready or before prep and drape.
- Time-out is performed without full participation.

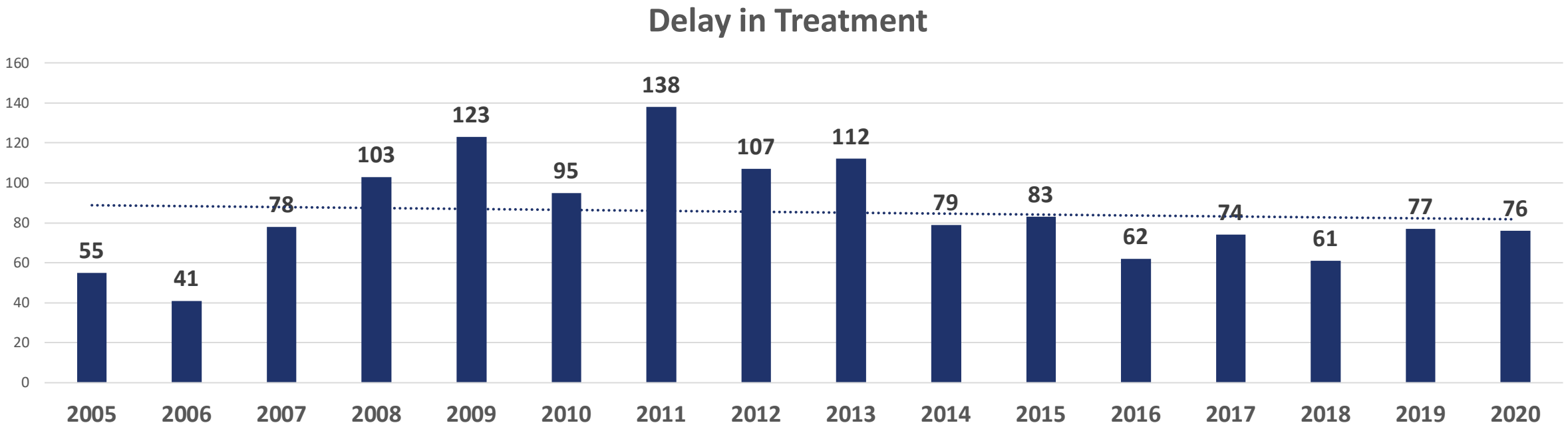
Organizational culture

- Organizational focus on patient safety is inconsistent.
- Staff is passive or not empowered to speak up.
- Policy changes are not followed by adequate and consistent staff education.

The Joint Commission

Delay in Treatment

A delay in treatment is when a patient does not get a treatment – whether it be a medication, lab test, physical therapy treatment, or any kind of treatment – that had been ordered for them in the time frame in which it was supposed to be delivered. Other examples include not being able to get an initial appointment or follow-up appointment in a timely manner or a diagnostic error that may result in patient harm or death.



The Joint Commission

Delay in Treatment

A Quick Safety issued in January 2015 on Preventing Delays in Treatment identified several causative factors including:

- Inadequate assessments
- Poor planning
- Communication failures
- Human factors such as lapses and cognitive bias
- Poor scheduling systems
- Understaffing
- Misdiagnosis