

Sentinel Event Data

General Information & 2021 Update

The current Sentinel Event Policy is available online at:
[http://www.jointcommission.org/Sentinel Event Policy and Procedures/](http://www.jointcommission.org/Sentinel_Event_Policy_and_Procedures/)

Sentinel Event 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.

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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

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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
- ▶ 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
- ▶ Fire, flame, or unanticipated smoke, heat, or flashes occurring during an episode of patient care

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

- ▶ 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
- ▶ 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

Sentinel Event

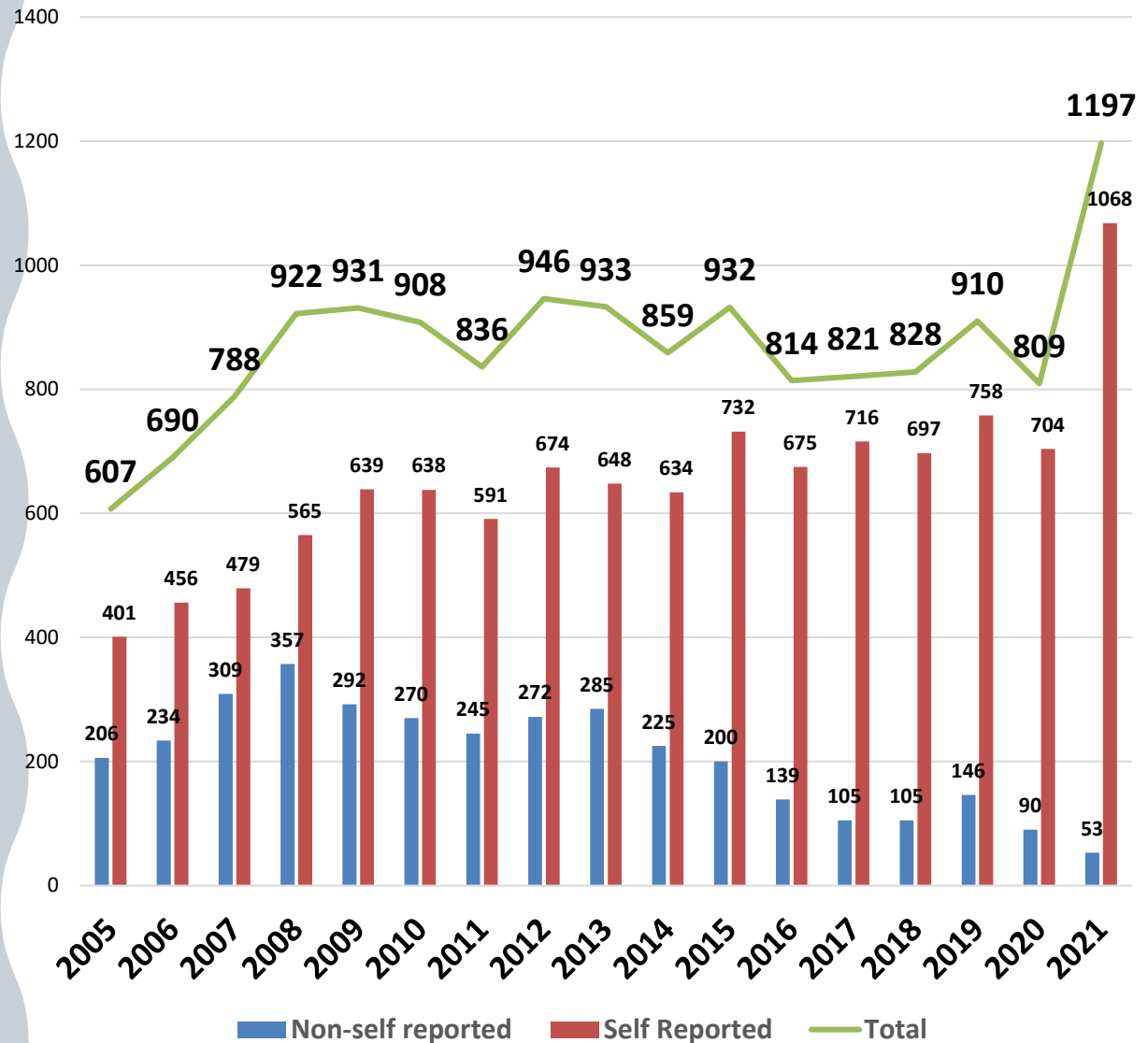
The current Sentinel Event Policy is available online at: [http://www.jointcommission.org/Sentinel Event Policy and Procedures/](http://www.jointcommission.org/Sentinel_Event_Policy_and_Procedures/)

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

- ▶ Any intrapartum (related to the birth process) maternal death
- ▶ 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)

Sentinel Events Reviewed by Year, by Source

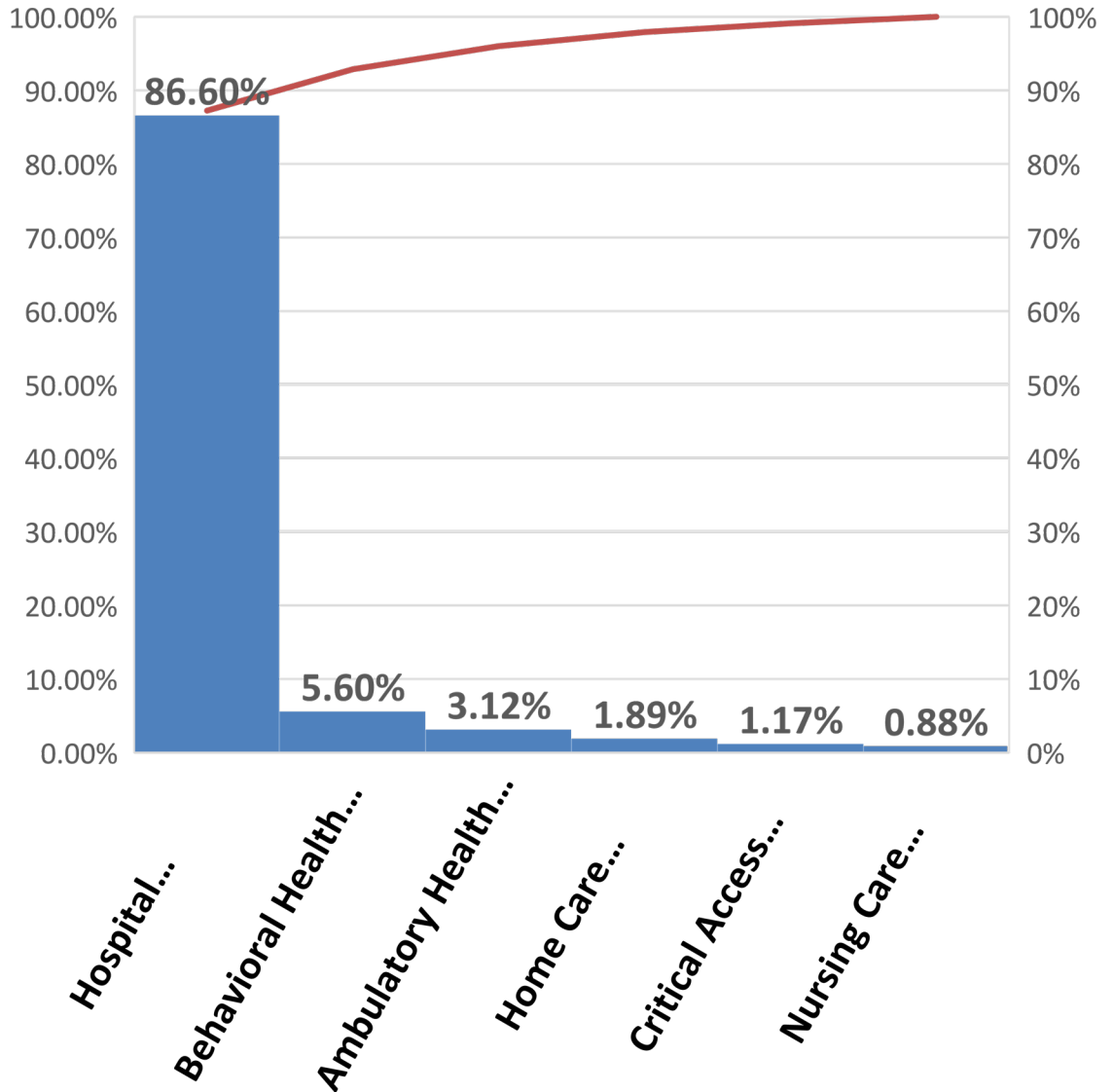
Jan 2005 – Dec
2021



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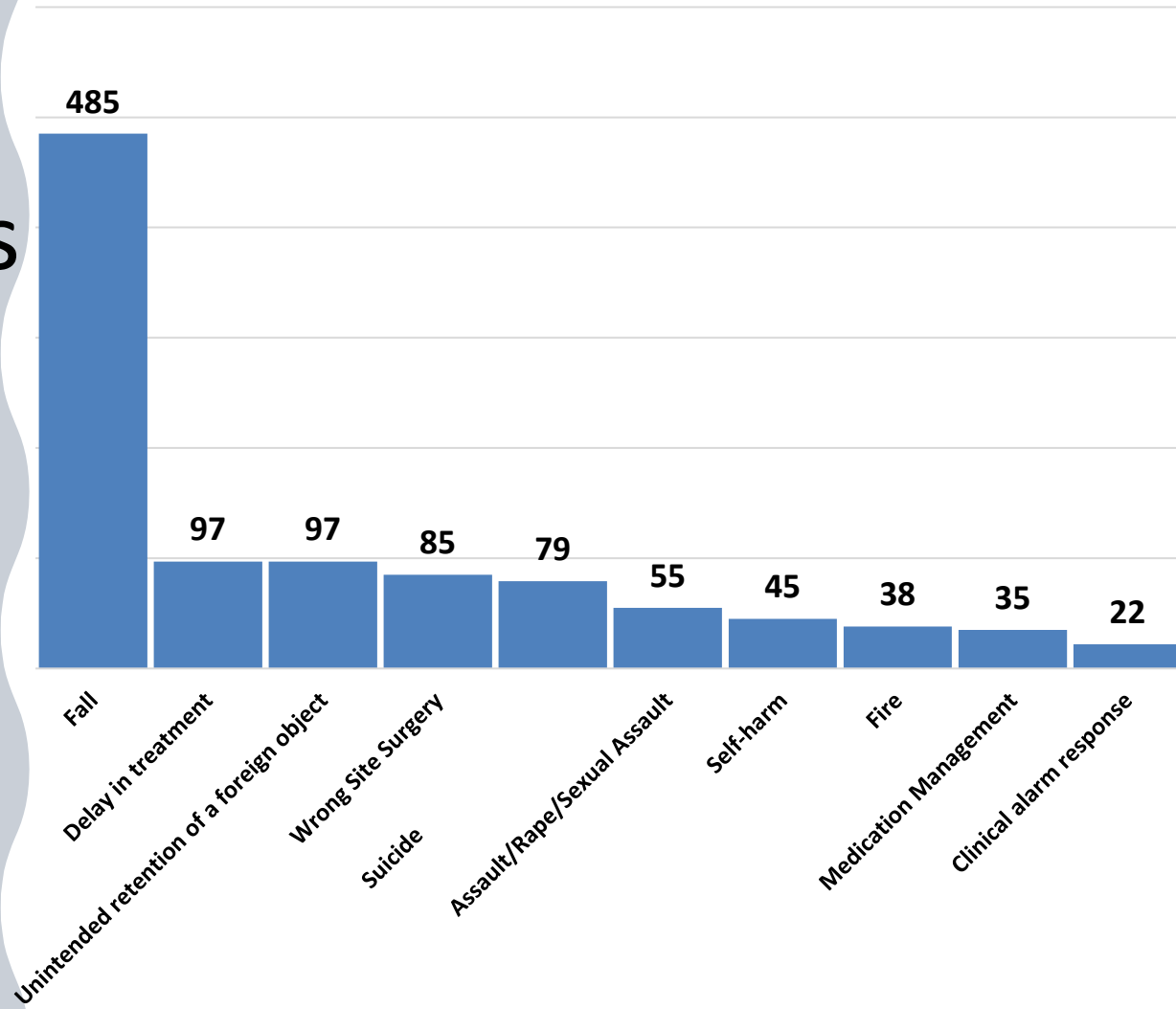
Sentinel Event Settings

Jan 2005 –
Dec 2021



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Top 10 Frequently Reviewed Sentinel Events in 2021



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Most Frequently Reviewed Sentinel Events

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

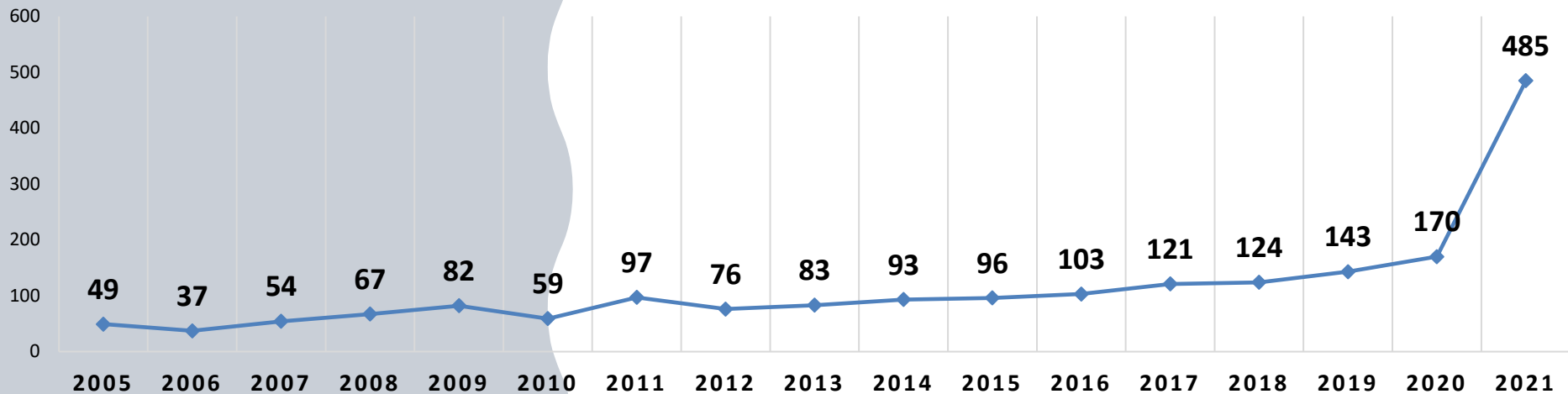
- ▶ Falls
- ▶ Unintended Retention of a Foreign Object (URFO)
- ▶ Wrong Surgery (Wrong patient, Wrong site, Wrong procedure, Wrong implant)
- ▶ Suicide
- ▶ Delay in Treatment

Patient Falls

Patient falls resulting in injury are consistently among the most frequently reviewed Sentinel Events by The Joint Commission.

A separate sentinel event line item on patient falls was introduced in 2021.

SENTINEL EVENT VOLUME RELATED TO PATIENT FALLS



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Patient Fall

[Sentinel Event Alert 55](#) on Preventing falls and fall-related injuries in health care facilities provides an analysis of most common contributing factors as:

- ▶ 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

[Quick Safety 40](#) calls for increased attention to the underrecognized issue of infant falls and include most prevalent maternal risk factors associated with newborn falls and drops as:

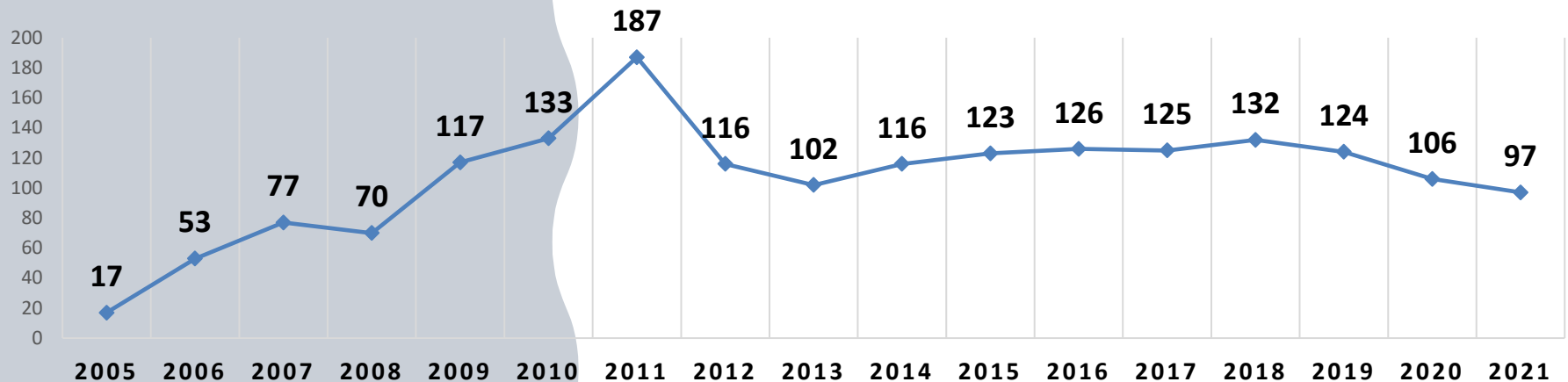
- ▶ Cesarean birth
- ▶ Use of pain medication within four hours
- ▶ Second or third postpartum night, specifically around midnight to early morning hours
- ▶ Drowsiness associated with breastfeeding

Unintended Retention of a Foreign Object

Unintended Retention of Foreign Object (URFO) is one of the most frequently reported sentinel events to The Joint Commission.

[Sentinel Event Alert 51](#) provides recommendations and strategies to reduce the risk of unintentionally retained foreign objects.

SENTINEL EVENT VOLUME RELATED TO UNINTENTIONALLY RETAINED FOREIGN OBJECTS

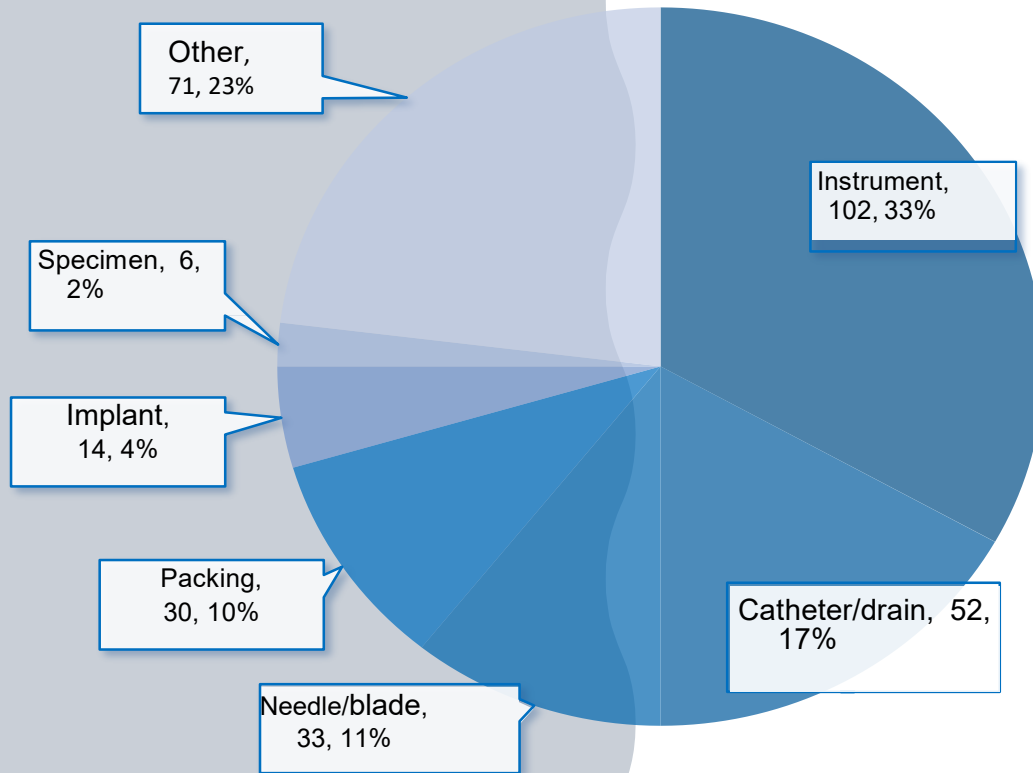


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Unintended Retention of a Foreign Object

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.

Retained Foreign Objects excluding Sponges and Guidewires (n=308)



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.

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Wrong-patient, wrong site, wrong procedure, wrong implant events are preventable events that can lead to catastrophic harm to patients.

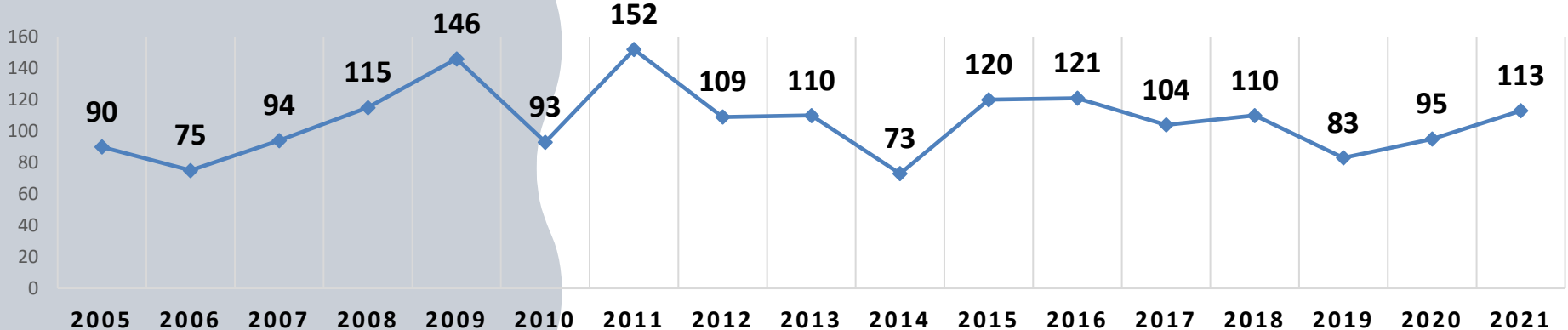
The Joint Commission's [Universal Protocol](#), the Center for Transforming Healthcare's [Targeted Solution Tool for Safe Surgery](#), and the [World Health Organization Surgical Safety Checklist](#) are well established procedures and processes that can help prevent these types of events from occurring.

The Joint Commissions' [Speak Up for Safe Surgery](#) webpage provides great resources for patients to be informed and involved member of the care team during a surgery.

Wrong Surgery-

Wrong-patient,
Wrong-site,
Wrong procedure,
Wrong implant events

SENTINEL EVENT VOLUME RELATED TO WRONG SURGERY



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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.

Wrong Surgery- Wrong-patient, Wrong-site, Wrong procedure, Wrong implant events



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.

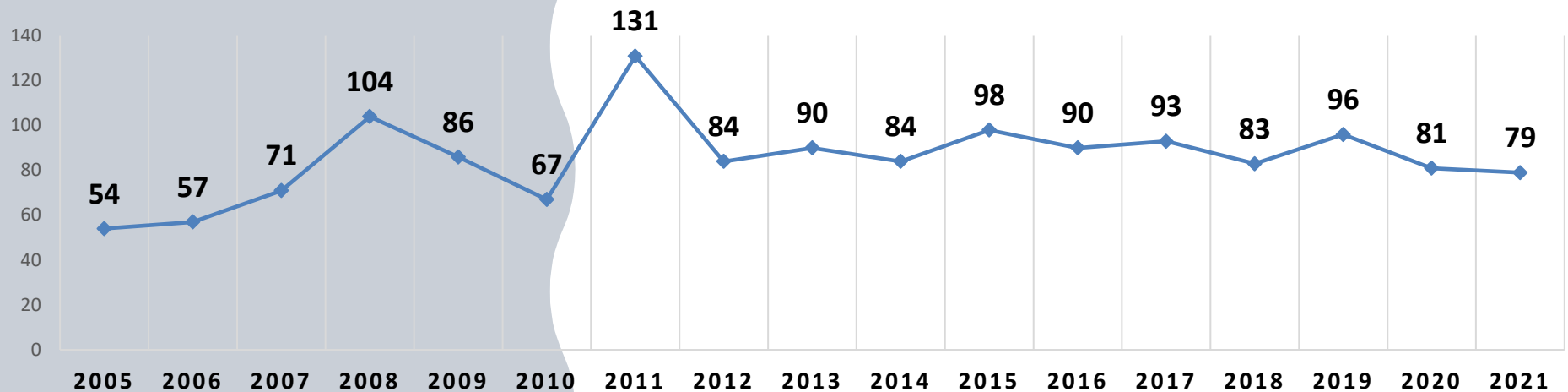
Suicide

Suicide in a staffed around-the clock care setting or within 72 hours of discharge, including from the hospital's emergency department (ED).

World Health Organization estimates that more than 700,000 people die by suicide every year. For each suicide, there are more than 20 suicide attempts.

Patient suicides continue to be consistently among the most frequently reviewed Sentinel Events reviewed by The Joint Commission.

SENTINEL EVENT VOLUME RELATED TO SUICIDES



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Suicide

Suicide in a staffed around-the clock care setting or within 72 hours of discharge, including from the hospital's emergency department (ED).

[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.

The Joint Commission [Suicide Prevention](#) website include Recommendations from Suicide Risk Reduction Expert Panel. Specific areas addressed include:

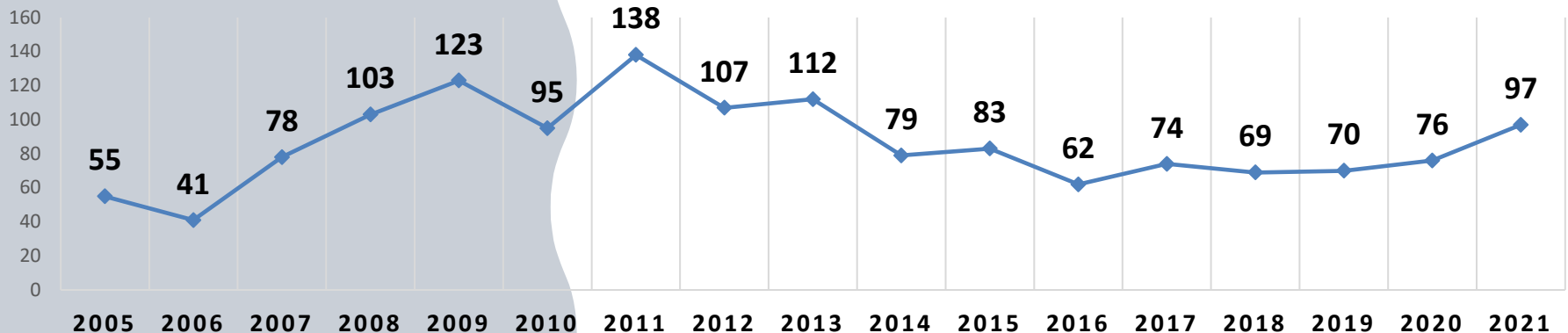
- ▶ Environmental risk assessments
- ▶ Minimizing environmental risks
- ▶ Screening for suicide risk using a validated tool
- ▶ Developing plans to mitigate suicide based on individual's overall level of risk
- ▶ Following policies and procedures for counseling and follow-up care for individuals identified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

Delay in Treatment

A delay in treatment is when a patient does not get a treatment that had been ordered for them in the time frame in which it was supposed to be delivered.

E.g., Delays with medication, lab test, physical therapy treatment, or any kind of treatment, delays with getting an initial appointment or follow-up appointment in a timely manner or, a diagnostic error that may result in patient harm or death.

SENTINEL EVENT VOLUME RELATED TO DELAY IN TREATMENT



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Delay in Treatment

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