Sentinel Event Data

General Information & 2022 Q1, Q2 Update

The current Sentinel Event Policy is available online at:
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:
  - Death
  - Permanent harm (regardless of severity of harm)
  - Severe harm (regardless of duration of harm)
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 health care organization’s emergency department (ED)
  - Unanticipated death of a full-term infant
  - Homicide of any patient receiving care, treatment, and services while on site at the organization or while under the care or supervision of the organization
  - Homicide of a staff member, licensed independent practitioner, visitor, or vendor while on site at the organization or while providing care or supervision to patients
  - Any intrapartum maternal death
  - Severe maternal morbidity (leading to permanent harm or severe harm)
Sentinel Event

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

  - Sexual abuse/assault of any patient receiving care, treatment, and services while on site at the organization or while under the care or supervision of the organization
  - Sexual abuse/assault of a staff member, licensed independent practitioner, visitor, or vendor while on site at the organization or while providing care or supervision to patients
  - Physical assault (leading to death, permanent harm, or severe harm) of any patient receiving care, treatment, and services while on site at the organization or while under the care or supervision of the organization
  - Physical assault (leading to death, permanent harm, or severe harm) of a staff member, licensed independent practitioner, visitor, or vendor while on site at the organization or while providing care or supervision to patients
Sentinel Event

- An event is also considered sentinel if it is one of the following:
  
  ▶ Surgery or other invasive procedure performed at the wrong site, on the wrong patient, or that is the wrong (unintended) procedure for a patient regardless of the type of procedure or the magnitude of the outcome
  
  ▶ 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 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 death, permanent harm, or severe harm
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)
  - Fluoroscopy resulting in permanent tissue injury when clinical and technical optimization were not implemented and/or recognized practice parameters were not followed
  - Any delivery of radiotherapy to the wrong patient, wrong body region, unintended procedure, or >25% above the planned radiotherapy dose
  - Fire, flame, or unanticipated smoke, heat, or flashes occurring during direct patient care caused by equipment operated and used by the organization. To be considered a sentinel event, equipment must be in use at the time of the event; staff do not need to be present.
Sentinel Event

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

  - Fall in a staffed-around-the-clock care setting or fall in a care setting not staffed around the clock during a time when staff are present resulting in any of the following:
    - Any fracture
    - Surgery, casting, or traction
    - Required consult/management or comfort care for a neurological (for example, skull fracture, subdural or intracranial hemorrhage) or internal (for example, rib fracture, small liver laceration) injury
    - A patient with coagulopathy who receives blood products as a result of the fall
    - 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 (January 2010 – June 2022)

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Top 10 Frequently Reviewed Sentinel Events (January 2021 – June 2022)

<table>
<thead>
<tr>
<th>Sentinel Event Type</th>
<th>CY 2021</th>
<th>Q1, Q2 2022</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fall</td>
<td>480</td>
<td>199</td>
</tr>
<tr>
<td>Wrong surgery*</td>
<td>116</td>
<td>19</td>
</tr>
<tr>
<td>Delay in treatment</td>
<td>105</td>
<td>25</td>
</tr>
<tr>
<td>Unintended retention of a foreign object</td>
<td>94</td>
<td>30</td>
</tr>
<tr>
<td>Suicide</td>
<td>70</td>
<td>26</td>
</tr>
<tr>
<td>Assault/Rape/Sexual Assault</td>
<td>59</td>
<td>16</td>
</tr>
<tr>
<td>Self-harm</td>
<td>47</td>
<td>11</td>
</tr>
<tr>
<td>Fire</td>
<td>42</td>
<td>10</td>
</tr>
<tr>
<td>Medication Management</td>
<td>31</td>
<td>12</td>
</tr>
<tr>
<td>Clinical alarm response</td>
<td>24</td>
<td>7</td>
</tr>
</tbody>
</table>

*Wrong surgery includes wrong site, wrong procedure, wrong patient and wrong implant.
Most Frequently Reviewed Sentinel Events
Last 5 Years

The most frequently reviewed sentinel events by The Joint Commission (CY2018 – June 2022):

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

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Patient Falls

The reporting of events to The Joint Commission is a voluntary process, and represents only a small proportion of actual events. Therefore, this information should not be viewed as reflecting an epidemiologic data set and no conclusions should be drawn about the actual relative frequency of events or trends in events over time.

### Patient Falls Last 5 Years

<table>
<thead>
<tr>
<th>Year</th>
<th>Falls</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018</td>
<td>134</td>
</tr>
<tr>
<td>2019</td>
<td>161</td>
</tr>
<tr>
<td>2020</td>
<td>171</td>
</tr>
<tr>
<td>2021</td>
<td>480</td>
</tr>
<tr>
<td>2022</td>
<td>199</td>
</tr>
</tbody>
</table>

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

### Most common activity leading to a fall

- Ambulating
- Falling from bed
- Toileting

### Most common injury

- Head injury/bleed
- Hip/leg facture

### Leading causes

- Inadequate staff-staff communication during handoffs, transition of care
- Policies not followed (e.g., fall risk assessment)
- Inadequate staff-staff communication of critical information
- Inadequate patient education
Unintended Retained Foreign Object

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Leading retained items

Unintended Retained Foreign Object
Last 5 Years

<table>
<thead>
<tr>
<th>Year</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
<th>2022</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>138</td>
<td>144</td>
<td>105</td>
<td>94</td>
<td>30</td>
</tr>
</tbody>
</table>

Leading outcomes

- Unexpected Additional Care/Extended Stay
- Severe Temporary Harm

Leading causes

- Inadequate staff-to-staff communication of critical information
- Inadequate team communication associated with a shared team task
- Inadequate staff-staff communication during handoffs, transition of care
- Policies not followed (e.g., count process)
Wrong Surgery (Wrong Site, Procedure, Patient, Implant)

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Wrong Surgery Last 5 Years

<table>
<thead>
<tr>
<th>Year</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018</td>
<td>101</td>
</tr>
<tr>
<td>2019</td>
<td>124</td>
</tr>
<tr>
<td>2020</td>
<td>93</td>
</tr>
<tr>
<td>2021</td>
<td>116</td>
</tr>
<tr>
<td>2022</td>
<td>19</td>
</tr>
</tbody>
</table>

Leading subcategory:
- Wrong site
- Wrong patient
- Wrong procedure
- Wrong implant

Leading outcomes:
- Unexpected Additional Care/Extended Stay
- Severe Temporary Harm
- Permanent Harm

Leading causes:
- Time-out not performed adequately
- Inadequate staff-staff communication during handoffs, transition of care
- Policies not followed adequately
- Inadequate communication of relevant patient information
Death by Suicide

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### Death by Suicide Last 5 Years

<table>
<thead>
<tr>
<th>Year</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018</td>
<td>84</td>
</tr>
<tr>
<td>2019</td>
<td>97</td>
</tr>
<tr>
<td>2020</td>
<td>81</td>
</tr>
<tr>
<td>2021</td>
<td>70</td>
</tr>
<tr>
<td>2022</td>
<td>26</td>
</tr>
</tbody>
</table>

### Leading method
- Hanging
- Gunshot
- Asphyxiation (not by hanging)
- Jumping from height

### Leading locations
- Offsite (within 72 hours of discharge)
- Inpatient setting
- Emergency department

### Leading causes
- Inadequate staff-staff communication during handoffs, transition of care
- Inadequate staff-to-staff communication of critical information
- Inadequate communication with outside provider, transition of care
- Policies not followed adequately
- Inadequate suicide risk assessment
Delay in Treatment

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Delay in Treatment Last 5 Years

<table>
<thead>
<tr>
<th>Year</th>
<th>Events</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018</td>
<td>64</td>
</tr>
<tr>
<td>2019</td>
<td>74</td>
</tr>
<tr>
<td>2020</td>
<td>71</td>
</tr>
<tr>
<td>2021</td>
<td>105</td>
</tr>
<tr>
<td>2022</td>
<td>25</td>
</tr>
</tbody>
</table>

Leading subcategory

- Delay in Treatment
- Last 5 Years

Leading outcomes

- Death
- Permanent harm
- Severe temporary harm
- Unexpected additional care
- Missed diagnosis
- Abnormal test result not addressed
- Misdiagnosis
- Abnormal test result not addressed

Leading causes

- Inadequate staff-staff communication during handoffs, transition of care
- Inadequate staff-staff communication of critical information
- Inadequate communication with outside provider, transition of care
- Policies not followed adequately