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/

The Joint Commission

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:

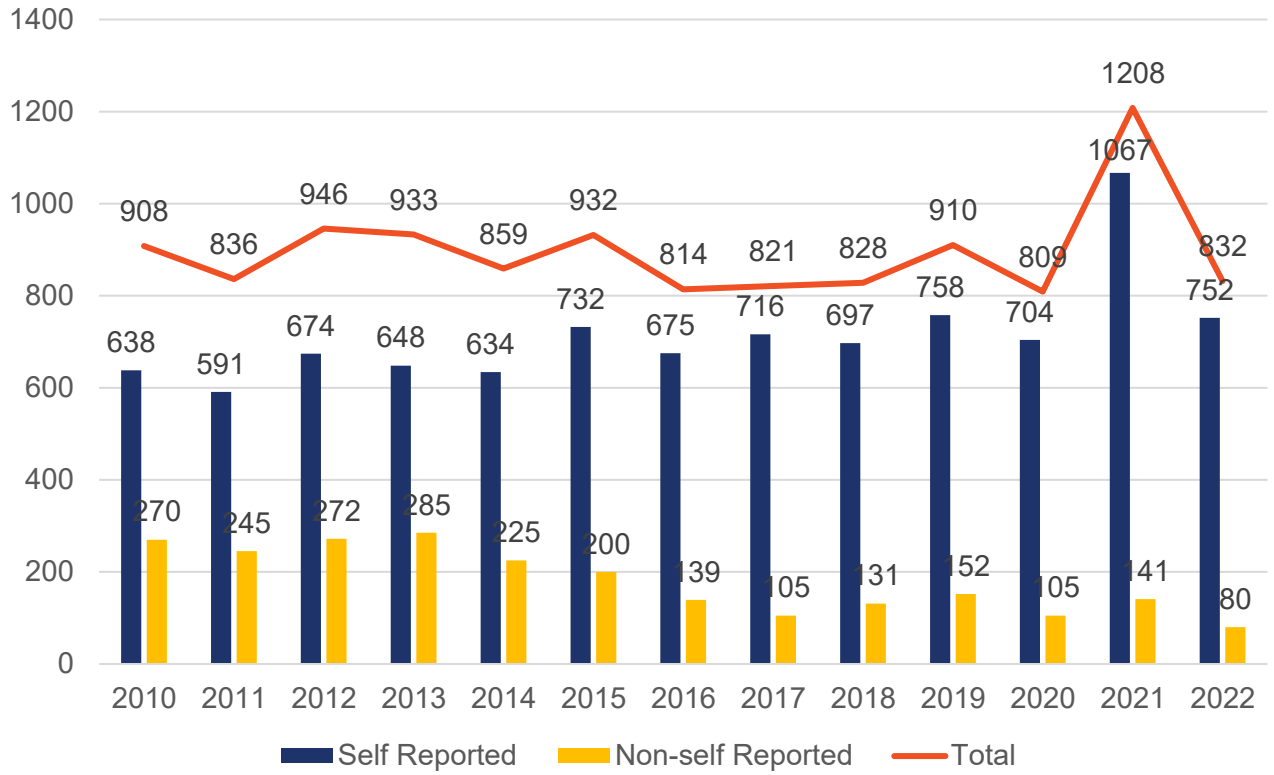
- Unintended retention of a foreign object in a patient after an invasive procedure, including surgery
- Severe neonatal hyperbilirubinemia (bilirubin >30 milligrams/deciliter)
- Fluoroscopy resulting in permanent tissue injury when clinical and technical optimization were not implemented and/or recognized 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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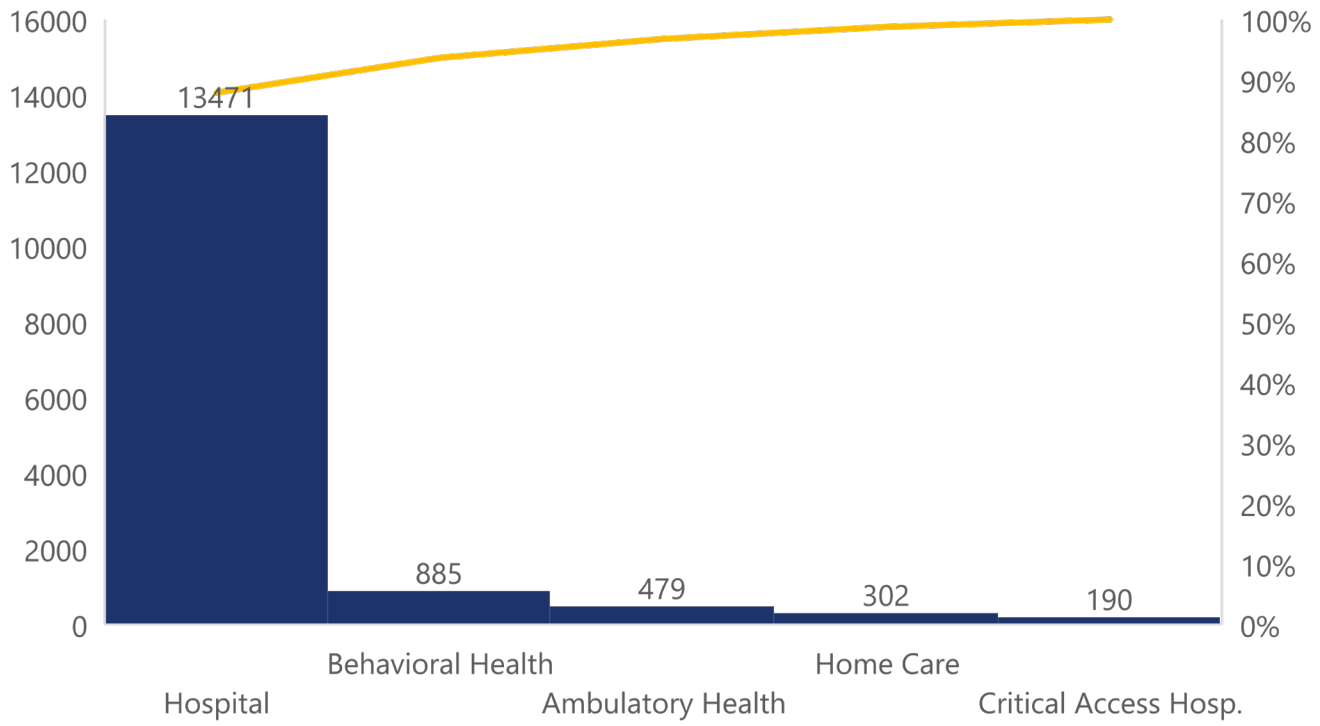
Sentinel Event by Settings (January 2010 – June 2022)



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

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

*Wrong surgery includes wrong site, wrong procedure, wrong patient and wrong implant.

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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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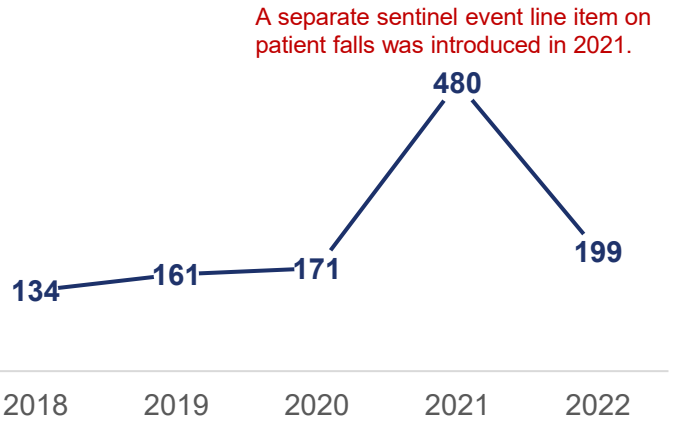
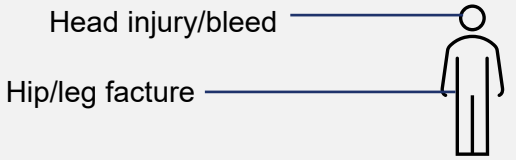
Patient Falls

Patient Falls Last 5 Years



Most common activity leading to a fall

Most common injury



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

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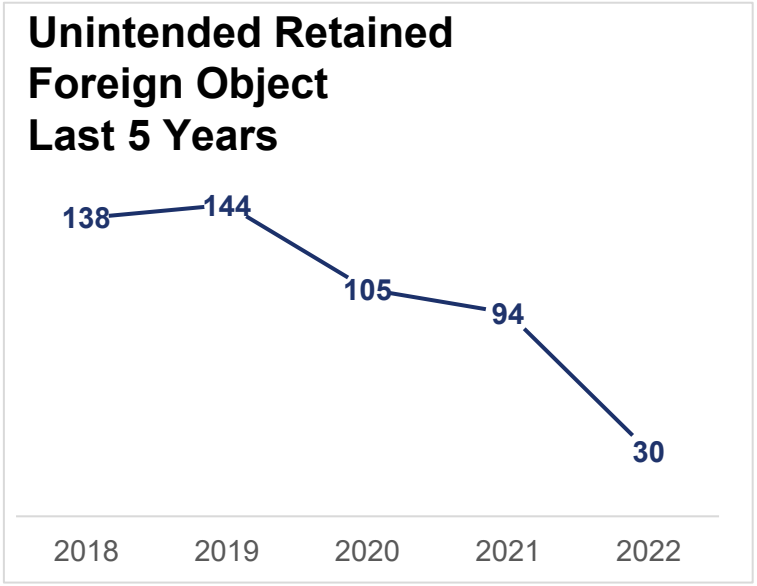
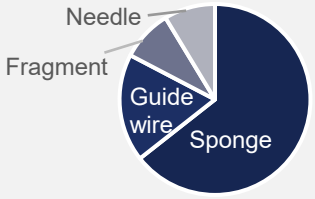
Unintended Retained Foreign Object



Leading retained items



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)

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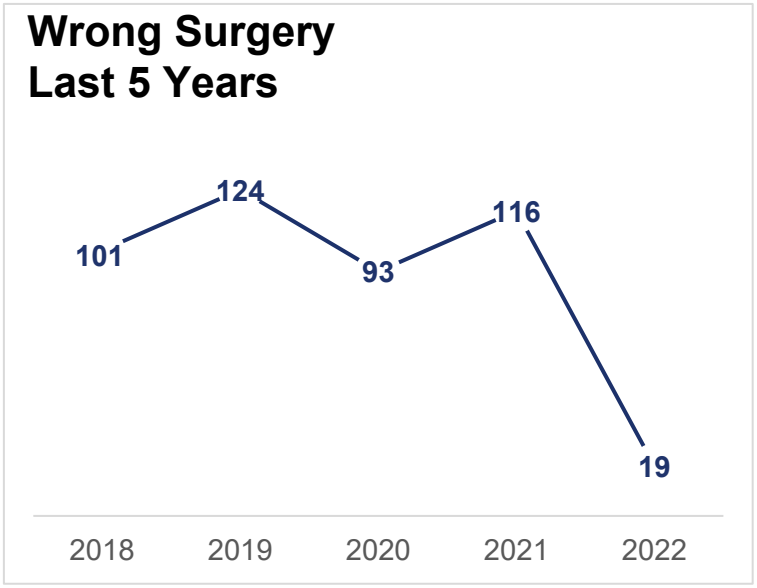
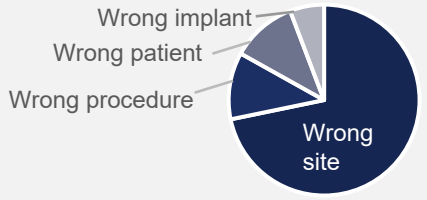
Wrong Surgery (Wrong Site, Procedure, Patient, Implant)



Leading subcategory



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

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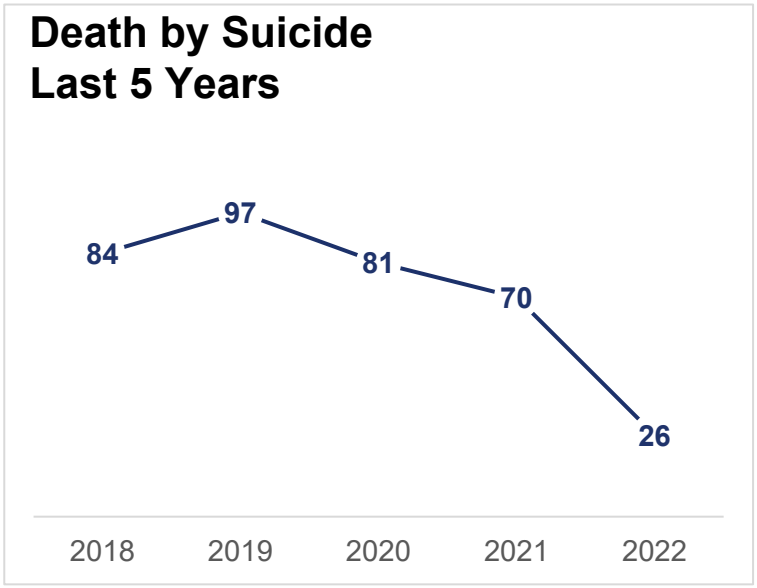
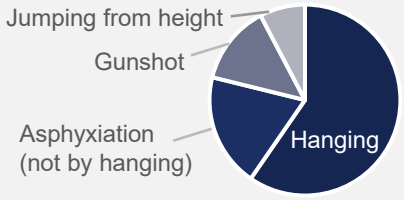
Death by Suicide



Leading method



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

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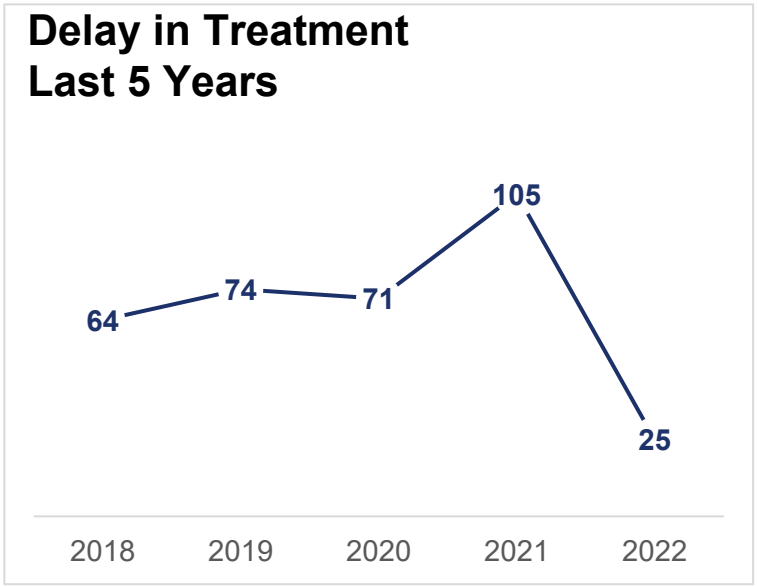
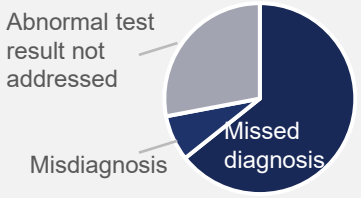
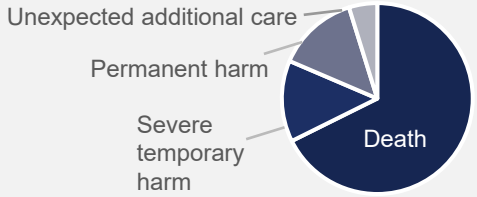
Delay in Treatment



Leading subcategory



Leading outcomes



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

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