Most Commonly Reviewed Sentinel Event Types

The Joint Commission

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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

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

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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

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Sentinel Event

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

- Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities (ABO, Rh, other blood groups)
- 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
- Severe maternal morbidity

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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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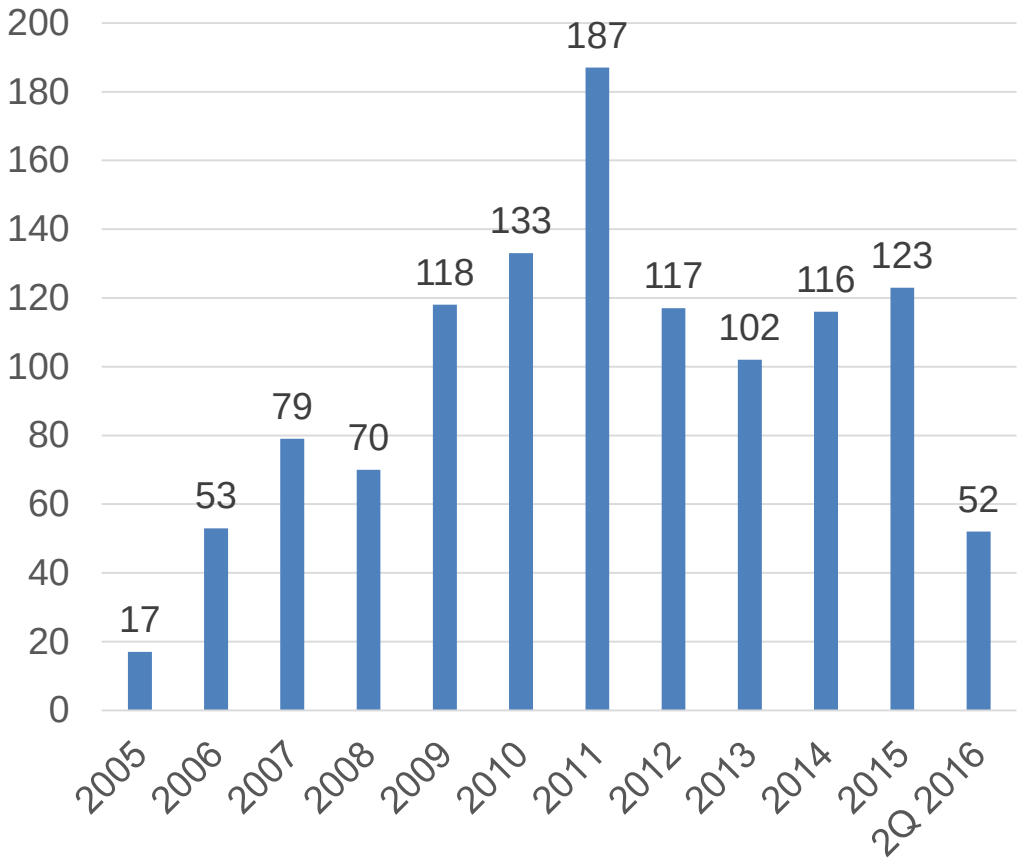
Unintended Retention of Foreign Object

Unintended retained foreign objects (URFOs) were the most frequent sentinel event reported to The Joint Commission in 2015 (116 reported) and 2014 (112 reported) indicating that preventing URFOs continues to be a challenge for organizations.



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Unintended Retention of Foreign Object

Object	Incidents
Sponge	58
Other	31
Catheter guidewire	14
Needle	7
Catheter sheath	< 5
Retractor	< 5
Raney clip	< 5
Acorn head	< 5

In 2015, the most frequently reported retained foreign object were sponges. A broad variety of "other" medical device related objects was the second largest category followed by catheter guidewires and needles.

In October 2013 issued a *Sentinel Event Alert* on Preventing unintended retained foreign objects. The most commonly reported causative factors continue to be:

- The absence of policies and procedures
- Failure to comply with existing policies and procedures
- Problems with hierarchy and intimidation
- Failure in communication with physicians
- Failure of staff to communicate relevant patient information
- Inadequate or incomplete education of staff

For safety actions to consider see the January 2016 *Quick Safety* Strategies to prevent URFOs.

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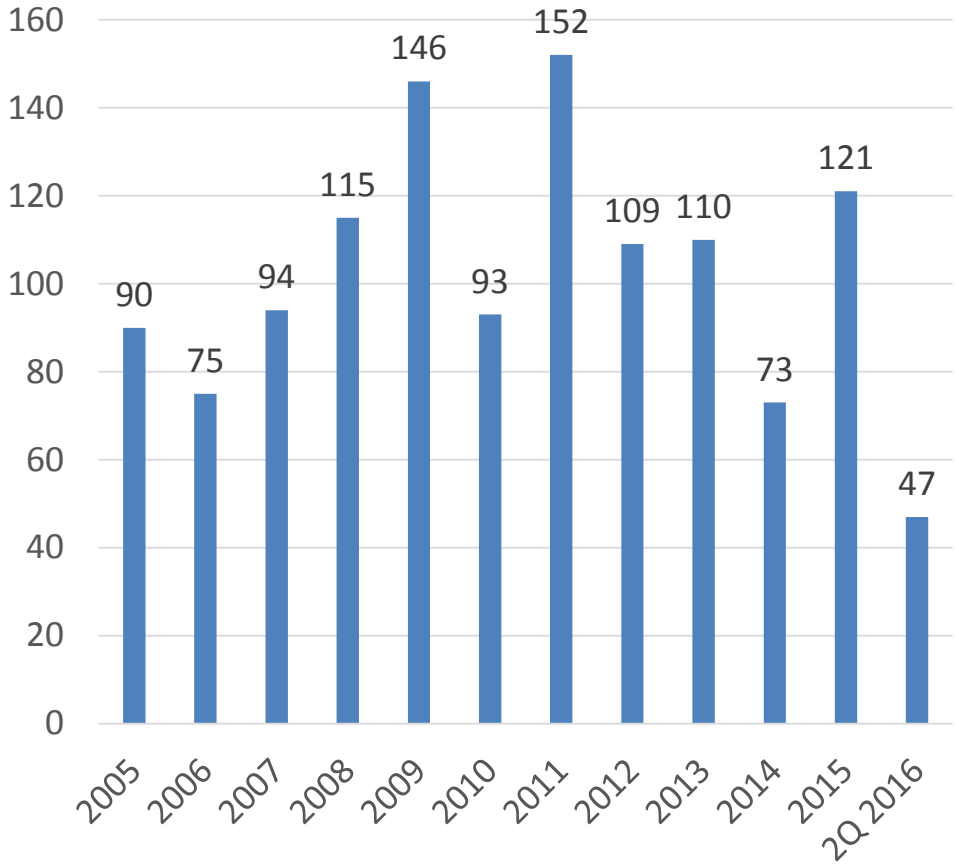
Wrong-patient, wrong-site, wrong-procedure

Wrong-patient, wrong-site, wrong procedure events are relatively rare, 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.



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Wrong-patient, wrong-site, wrong-procedure

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

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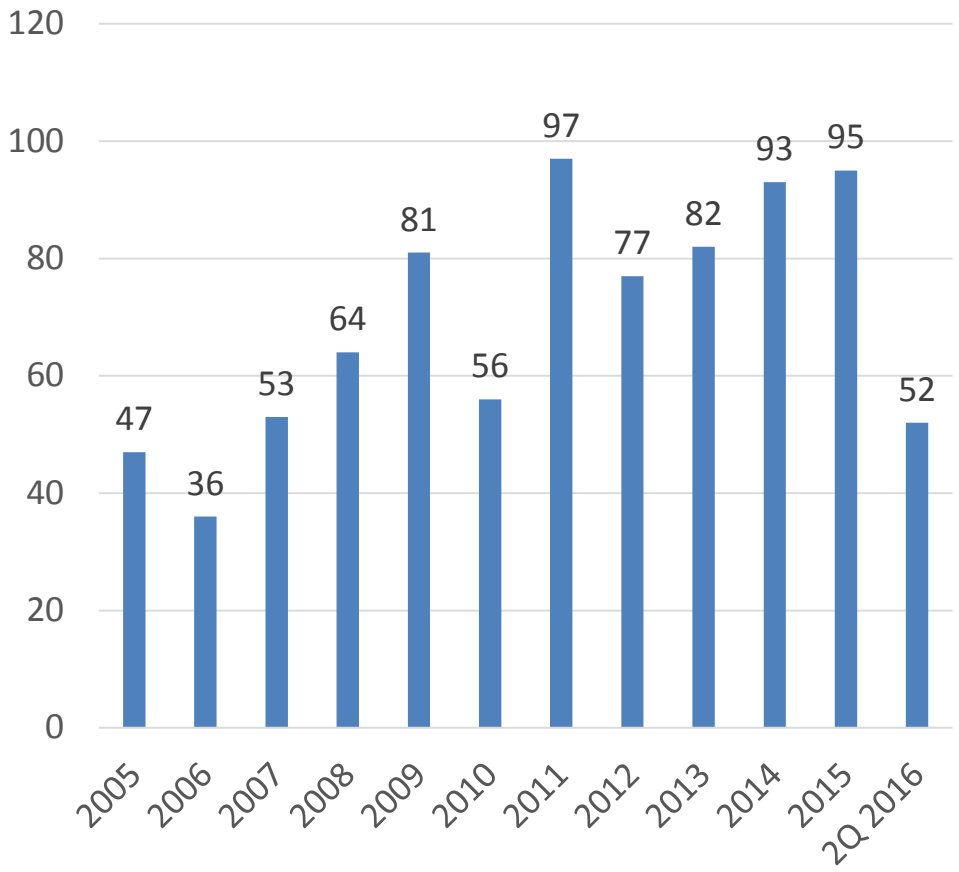
Patient Fall

Patient falls resulting in injury are a common occurrence in healthcare and are consistently among the most frequently reviewed Sentinel Events by The Joint Commission.



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Patient Fall

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 practices
- Inadequate staff orientation, supervision, staffing levels or skill mix
- Deficiencies in the physical environment
- Lack of leadership

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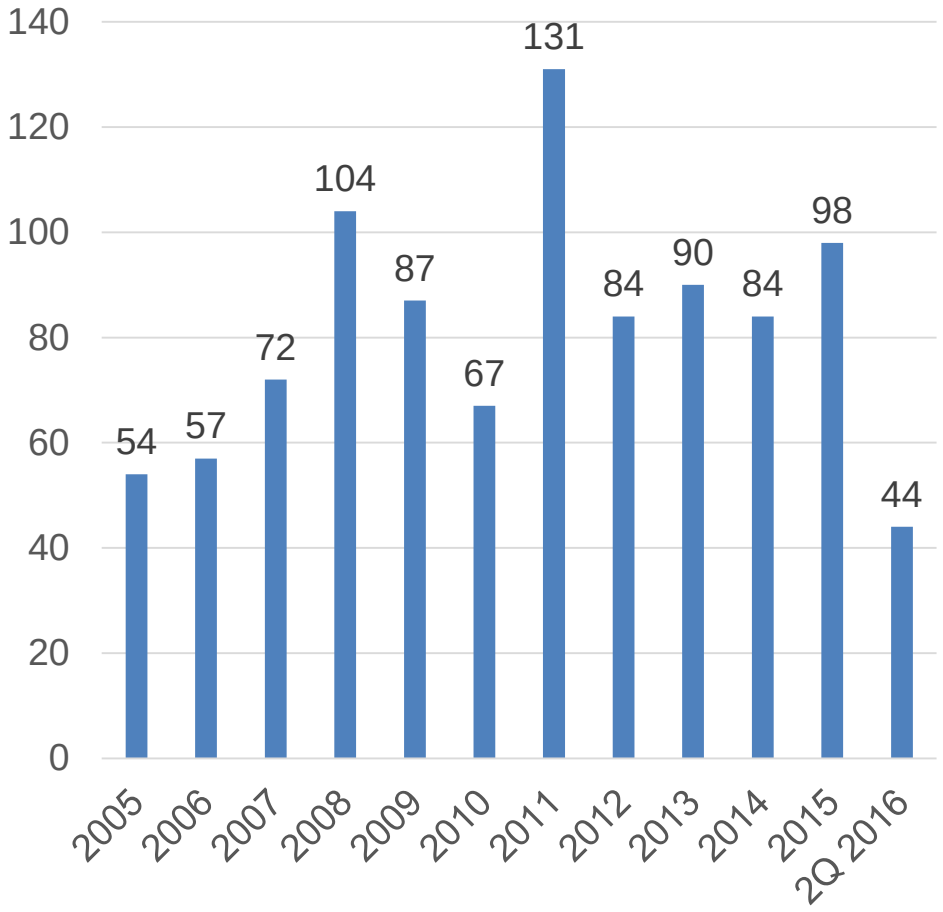
Patient Suicide

Suicide is the 10th leading cause of death in the United States and continues to be consistently among the most frequently reviewed Sentinel Events reviewed by The Joint Commission.



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Patient Suicide

The Joint Commission issued a *Sentinel Event Alert* on Detecting and treating suicide ideation in all settings on February 2016.

- The most commonly identified causative factor was shortcomings in assessment, specifically psychiatric assessment.
- The suggested actions in the alert include suicide ideation detection, as well as the screening, risk assessment, safety, treatment, discharge, and follow-up care of at-risk individuals.

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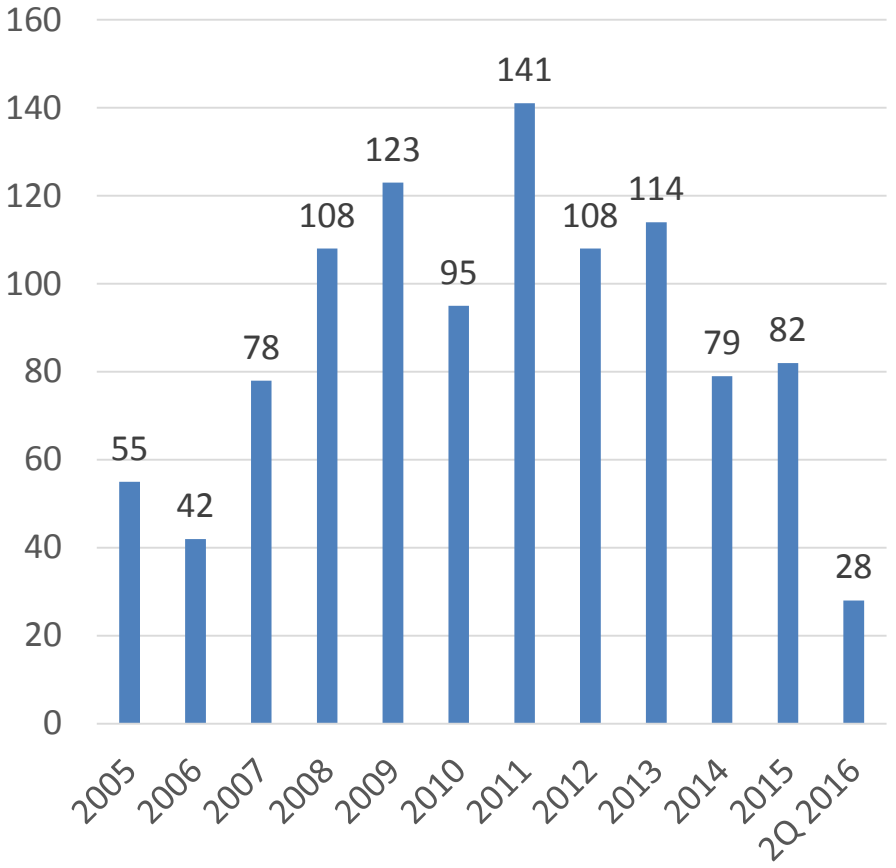
Delay in Treatment

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. This would also apply to not being able to get an initial appointment or follow-up appointment in a timely manner. It can be a form of diagnostic error that may result in patient harm or death.



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Delay in Treatment

On January 2015 a *Quick Safety* on Preventing delays in treatment was issued. Identified causative factors included:

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

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