# Why Organizations Self Report Sentinel Events to The Joint Commission

Joint Commission–accredited organizations are encouraged—but not mandated—to self report sentinel events. In fact, about 70% of the reviewable sentinel events received by The Joint Commission Office of Quality and Patient Safety (OQPS) are self reported by organizations.

## Joint Commission Objectives for Self Reporting

Many accredited organizations regularly self report events and work through the root cause analysis (RCA) process with an OQPS Patient Safety Specialist. The Joint Commission's aim in learning about these events is its overall interest in promoting patient safety. However, the process is also designed to support more specific objectives.

One specific objective of The Joint Commission is to feed its de-identified Sentinel Event Database, which provides organizations with information about event types, frequencies, and root causes. Event reporting also enables The Joint Commission to validate that the organization has completed a thorough and credible RCA and that the implementation and monitoring of action items will enhance patient safety by mitigating future risk.

Still another objective is to create shared learning. During the interaction between the organization and The Joint Commission Patient Safety Specialist, there are often opportunities to share lessons learned from past events in a de-identified fashion. For example, if the sentinel event involves wrong-site surgery, the Patient Safety Specialist may share actions that have been effective for other organizations in redesigning a process surrounding laterality for surgical cases. The Patient Safety Specialist may also share opportunities for improving other areas based on knowledge of past events. The discussion between the Patient Safety Specialist and the organization—meant to maximize the sharing of information—is also designed to help the organization maximize patient safety.

## Industry Importance of Self Reporting

An accredited organization's comfort with the self-reporting process speaks to the transparency the organization is striving for. Transparency is viewed as a critical component in the organization's development of a culture of safety. Often defined as "the free uninhibited sharing of information," transparency is considered the most important single attribute of a culture of safety.[1]

Transparency in self reporting events allows for shared learning among organizations. Reporting is essential to facilitate widespread sharing of lessons learned from incidents among many organizations.[2] The sharing of information gained from analysis of incidents assists organizations to be safer places for patients. However, because reporting events to The Joint Commission is voluntary—and because there is no single comprehensive nationwide reporting system—it is believed that The Joint Commission is aware of less than 5% of the sentinel events that occur in accredited organizations.

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## Organization Benefits of Self Reporting

Upon completing a Sentinel Event Measure of Success, organizations that have worked with Joint Commission OQPS Patient Safety Specialists are offered a survey to provide feedback about the experience. Recently, OQPS circled back to a few responding organizations and asked some critical questions regarding the self-report process: Why do organizations self report, and what are the perceived benefits of the process?

Marla Daniels, chief nursing officer at Grace Health System in Lubbock, TX, believes working with The Joint Commission through the RCA process allows the organization to gain knowledge from a different perspective on how to improve. Her organization engages frontline staff and sees self reporting as a shared learning process without any punitive intent. Melissa Kempken, manager of quality assurance and corporate compliance at Home Care Medical in New Berlin, WI, said, "We believe that if all accredited organizations are reporting . . . we can learn from each other to improve patient safety." Both Daniels and Kempken stated that self reporting is part of their organizational culture.

Sandi Paige, director of quality support services and risk management at Nash Health Care Systems in Rocky Mount, NC, believes self reporting is part of the organization's transparent culture, which includes reporting as "the right thing to do." As Paige said, "It shows you hold yourselves and the organization . . . accountable for actions that contribute to maintaining and improving safety." Paige believes her organization benefits from working with the OQPS as it helps with gaining better processes and proactive approaches.

All survey responders said they believe that self reporting to The Joint Commission felt constructive and nonpunitive. The self-reporting process was seen as a way to emphasize to staff the importance of identifying and communicating risks

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and actual events. Cindi Richardson, QAPI coordinator at Hospice of North Idaho in Hayden, ID, shared the importance of including staff in the process; her staff are very aware that the organization works with The Joint Commission and involves staff in the communication with the OQPS. Staff view working with the OQPS as a positive experience. As Paige said, "After years of doing RCAs with groups of staff involved, (we) most always come away with a feeling of relief and belief that the reporting was the right thing to do, and we are a better facility for doing it."

## Positive Step on the Patient Safety Journey

While responding positively about the self reporting experience, several survey responders did mention the investment of time and people in doing the RCA, implementing the plan of action, and monitoring processes. However, the process was viewed as a necessary cost in the organization's journey toward promoting patient safety. The time required for interacting with OQPS for review of the RCA and plan of action was not seen as a burden. Several responders believed the added benefit in working with OQPS was the Patient Safety Specialist's ability to share information from prior events, which may assist the organization in proactively mitigating risk in a variety of areas. The electronic method for sharing the RCA and plan of action with The Joint Commission incurs no cost to the organization, and it was felt that the knowledge gained through the experience could be priceless in enhancing safety for organizations.

To learn more about partnering with the OQPS on reviewable sentinel events, please call 630-792-3700 or e-mail seu@jointcommission.org.

## References

1. Leape L, et al. Transforming healthcare: A safety imperative. *Qual Saf Health Care*. 2009;18(6):424–428.
2. Massachusetts Coalition for the Prevention of Medical Errors. When Things Go Wrong: Responding to Adverse Events. A Consensus Statement of the Harvard Hospitals. Mar 2006. Accessed Aug 11, 2014. http://www.macoalition.org/documents/respondingToAdverseEvents.pdf


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