

SENTINEL EVENT STATISTICS RELEASED FOR 2015



The Joint Commission Perspectives®

This article comes from the April 2016 issue of [Joint Commission Perspectives](#)®. Subscribe today for the latest updates from The Joint Commission, including information on Project REFRESH.

From the January 1995 implementation of The Joint Commission's Sentinel Event Database through December 31, 2015, The Joint Commission has reviewed 12,122 reports of sentinel events and included de-identified information about them in the Sentinel Event Database. Database content includes data collected and analyzed from the review of sentinel events and comprehensive systematic analyses, as tracking this information may help guide local efforts to enhance patient safety by mitigating future risk.

The Joint Commission recently updated its summary data of sentinel events statistics for 2015. Data from the 9,581 incidents reviewed from 2004 through 2015 show that these events have affected a total of 9,884 patients as follows:

- Death: 5,540 (56.1%) patients
- Unexpected additional care: 2,585 (26.2%) patients
- Permanent loss of function: 863 (8.7%) patients
- Psychological impact: 324 (3.3%) patients
- Severe temporary harm: 222 (2.2%) patients
- Permanent harm: 66 (0.7%) patients

In addition, 277 (2.8%) patients were affected by other outcomes; for 7 (0.1%) patients, the outcome was unknown.

All sentinel events must be reviewed by the organization and are subject to review by The Joint Commission. The Joint Commission reviewed a total of 936 sentinel events during 2015; of these, 698 were voluntarily self-reported by an accredited or certified entity, and 238 were non-self-reported via the complaint process or the media. The box below shows the 10 most frequently reported types of sentinel events.

The Joint Commission Office of Quality and Patient Safety (OQPS) collaborates with organizations on the completion of a comprehensive systematic analysis for identifying the causal and contributory factors to a sentinel event. Root cause analyses, which focus on systems and processes, are the most common form of the comprehensive systematic analyses used to identify factors that contributed to a sentinel event. The majority of sentinel events are a result of multiple root causes; the 10 most frequently identified root causes (spanning several types of events) for 2015 are shown in the box below.

"The contribution of human factors to safety must be viewed as an institutional emergent property—not an individual failure," says Ronald Wyatt, MD, MHA, patient safety officer (see the following page for the announcement of this new role) and medical director, The Joint Commission. "High-reliability organizations must consider cognitive ergonomics, which includes modifying equipment and continuously evaluating the workflow and task environments.

"Applying human factors engineering to improve a system helps establish and sustain a resilient health care organization that is sensitive to operations—one that can learn from, adapt to, and address active failures and latent conditions contributing to sentinel events," Wyatt adds. "The safety search requires a deep understanding of the impact of sociotechnical and cultural factors that can interfere with human awareness and the ability to respond to the unexpected."

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An estimated fewer than 2% of all sentinel events are reported to The Joint Commission; as this is not an epidemiologic data set, no conclusions should be drawn about the frequency of events. For more information, call the Office of Quality and Patient Safety at 630-792-3700 or visit http://www.jointcommission.org/sentinel_event.aspx.

MOST FREQUENTLY REPORTED SENTINEL EVENTS, JANUARY 1– DECEMBER 31, 2015

1. Unintended retention of a foreign object—116
2. Wrong patient, wrong site, or wrong procedure—111
3. Falls*—95
4. Suicide—95
5. Delay in treatment*—76
6. Operative/postoperative complication*—76
7. Other unanticipated events†—56
8. Criminal event—46
9. Perinatal death/injury*—42
10. Medication error*—41

*Resulting in death or permanent loss of function

†Includes asphyxiation, burns, choking on food, drowning, and being found unresponsive

MOST FREQUENTLY IDENTIFIED ROOT CAUSES FOR SENTINEL EVENTS, JANUARY 1–DECEMBER 31, 2015

1. Human factors (such as competency assessment and staff supervision)—999
2. Leadership (related to issues such as priority setting and complaint resolution)—849
3. Communication (among staff, administration, and/or patients and families)—744
4. Assessment (includes patient observations and care decisions)—545
5. Physical environment (such as emergency management and fire safety)—202
6. Health information technology-related—125 (refers to issues such as incompatibility between devices and hardware failure)
7. Care planning (planning and/or collaboration issues)—75
8. Operative care (includes blood use and/or patient monitoring)—62
9. Medication use (includes labeling and preparing medications)—60
10. Information management (having to do with, for example, the aggregation of data)—52