Sentinel Event Statistics for 2014

From the January 1995 implementation of The Joint Commission's Sentinel Event Database through December 31, 2014, The Joint Commission has reviewed 11,186 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, root cause analyses, action plans, and follow-up activities, as tracking this aggregate 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 2014. Data from the 8,645 incidents reviewed from 2004 through 2014 show that a total of 8,876 patients have been affected by these events, with 5,177 (58.3%) resulting in the patient's death, 831 (9.4%) resulting in loss of function, and 2,868 (32.3%) resulting in unexpected additional care and/or psychological impact. The Joint Commission reviewed a total of 764 sentinel events during 2014; of these, 573 were voluntarily self-reported to The Joint Commission by an accredited organization and 191 were non–self-reported via the complaint process or the media. The 10 most frequently reported types of sentinel events are shown in the box at left below.

The Joint Commission Office of Quality and Patient Safety (OQPS) collaborates with organizations on identifying a sentinel event's root causes and creating an action plan to reduce the risk that similar events might occur in the future. Sentinel events are a result of multiple root causes; the 10 most frequently identified root causes (spanning several types of events) for 2014 are shown in the second box at right below.

Please note that the above data reflects the Sentinel Event Policy in effect through the end of 2014—that is, the OQPS and the organization traditionally discussed whether a self- or non–self-reported sentinel event met reviewability criteria listed in the policy before collaborating on the root cause analysis and subsequent action plan. According to the redesigned Sentinel Event Policy effective January 1, 2015, **all sentinel events must be reviewed by the organization and are subject to review by The Joint Commission** (*see* November 2014 *Perspectives*, page 3, and the "Sentinel Events" chapter in the accreditation and certification manuals). Another change going forward is that *root cause analyses* has been recast as one form—albeit the most common one—of the *comprehensive systematic analyses* used to identify factors that contributed to a sentinel event.

"In 2014 the leading root causes and contributory factors are examples of cognitive failures," says Ronald Wyatt, MD, MHA, medical director, The Joint Commission. "As Dietrich Dorner states in *The Logic of Failure* (1996):

> We find a tendency under time pressure to apply overdoses of established measures. We find an inability to think in terms of nonlinear networks of causation, an inability, that is, to properly assess the side effects and repercussions of one's behavior. We find an inadequate understanding of exponential development, an inability to see that a process that develops exponentially will, once it is begun, race to its conclusion with incredible speed. These are all failures of cognition.

"Cognitive failure is preventable," Wyatt adds, "and safety-critical industries take a systems view. Health care organizations must focus on factors that influence errors and operationalize strong corrective actions aimed at improving working conditions."

Please note that this data should not be used to draw conclusions about the actual relative frequency of events or trends in events over time. For more information visit http://www.jointcommission.org/sentinel_event.aspx.

Most Frequently Reported Sentinel Events, January 1–December 31, 2014

1. Unintended retention of a foreign object—112
2. Falls*—91
3. Suicide—82
4. Delay in treatment*—73
5. Other unanticipated events* †—73
6. Wrong-patient, wrong-site, or wrong-procedure—67
7. Operative/postoperative complication*—52
8. Criminal event (assault/rape/homicide)—47
9. Perinatal death/injury*—32
10. Medication error*—18

* Resulting in death or permanent loss of function

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

Most Frequently Identified Root Causes for Sentinel Events, January 1–December 31, 2014

1. Human factors (such as staff supervision issues)—547
2. Leadership (for example, organizational planning)—517
3. Communication (such as with patients or administration)—489
4. Assessment (includes timing or scope of assessments)—392
5. Physical environment (such as fire safety)—115
6. Information management (regarding, for example, medical records)—72
7. Care planning (planning and/or interdisciplinary collaboration)—72
8. Health information technology–related—59 (such as incompatibility between devices)
9. Operative care (such as blood use or patient monitoring)—58
10. Continuum of care (includes transfer and/or discharge of patient)—57