Sentinel Event Statistics for First Half of 2015

From the January 1995 implementation of The Joint Commission's Sentinel Event Database through June 30, 2015, The Joint Commission has reviewed 11,660 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 the first six months of 2015. Data from the 9,119 incidents reviewed from 2004 through the first half of 2015 show that these events have affected a total of 9,384 patients as follows:

- Death: 5,383 (57.4%) patients
- Unexpected additional care: 2,478 (26.4%) patients
- Permanent loss of function 847 (9.0%) patients
- Psychological impact: 300 (3.2%) patients
- Severe temporary harm: 77 (0.8%) patients
- Permanent harm: 30 (0.3%) patients

In addition, 200 (2.1%) patients were affected by other outcomes; for 69 (0.7%) 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 474 sentinel events during the first half of 2015; of these, 341 were voluntarily self-reported to The Joint Commission by an accredited or certified entity and 133 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 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. Root cause analyses are the most common form of the

Most Frequently Reported Sentinel Events, January 1–June 30, 2015

1. Wrong-patient, wrong-site, or wrong-procedure—58
2. Unintended retention of a foreign object—50
3. Suicide—48
4. Falls*—39
5. Delay in treatment*—37
6. Operative/postoperative complication*—36
7. Other unanticipated events†—34
8. Perinatal death/injury*—21
9. Medication error*—18
10. Fire-related events*—13

* Resulting in death or permanent loss of function

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

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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 the first half of 2015 are shown in the box at right.

"Patient safety matters. The aim is zero preventable injury, harm, and death," says Ronald Wyatt, MD, MHA, medical director, The Joint Commission. "Communication failures remain a top root cause of sentinel events in 2015. Team communication is mission critical to preventing harm.

"Teams must be trained to communicate more effectively through briefs, huddles, debriefs, and care transitions," Wyatt adds. "Improving team communication is a strong corrective action and will save lives."

It is estimated that fewer than 2% of all sentinel events are reported to The Joint Commission; of these, 67.9% (6,193 of 9,119 events) have been self reported since 2004. 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. For more information about sentinel events, visit The Joint Commission website at http://www.jointcommission.org/sentinel_event.aspx.

Most Frequently Identified Root Causes for Sentinel Events, January 1–June 30, 2015

1. Human factors (such as in-service education or credentialing/privileging)—464
2. Leadership (for example, organizational culture or complaint resolution issues)—382
3. Communication (whether it be oral, written, or electronic)—343
4. Assessment (includes patient observations and care decisions)—247
5. Physical environment (such as utilities and equipment management)—88
6. Health information technology–related (such as issues with automated dispensing systems)—74
7. Care planning (planning and/or collaboration issues)—64
8. Information management (having to do with, for example, patient identification)—29
9. Medication use (includes ordering and administering medications)—29
10. Performance improvement (such as data collection and analysis)—26