Sentinel Event Statistics for First Half of 2016

From the January 1995 implementation of The Joint Commission's Sentinel Event Database through June 30, 2016, The Joint Commission has reviewed 12,561 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 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 event statistics for the first six months of 2016. Data from the 9,632 incidents reviewed from 2005 through the first half of 2016 show that these events have affected a total of 9,922 patients as follows:

- Death: 5,394 (54.4%) patients
- Unexpected additional care: 2,624 (26.4%) patients
- Permanent loss of function 823 (8.3%) patients
- Psychological impact: 328 (3.3%) patients
- Severe temporary harm: 315 (3.2%) patients
- Permanent harm: 94 (0.9%) patients

In addition, 277 (2.8%) patients were affected by other outcomes; for 5 (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 439 sentinel events during the first six months of 2016; the majority of these—349—were voluntarily self-reported to The Joint Commission by an accredited or certified entity. Of the 90 non–self-reported sentinel events, 73 were reported via the complaint process, and 17 were reported via the media. The box below right shows the five most frequently reported types of sentinel events.

The Joint Commission Office of Quality and Patient Safety 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 root causes and contributing factors for the five most frequently reported types of sentinel events are described below.

Unintended Retention of a Foreign Object

Incidences of unintended retention of a foreign object were the most frequent sentinel event reported to The Joint Commission in 2014 and 2015 and remain a consistent challenge for organizations. One of the most commonly reported causative factors continues to be the absence of policies and procedures; moreover, in organizations where policies and procedures *are* in place, failure to comply with them can lead to sentinel events. Other causative factors include breakdowns in communication among physicians, patients, and/or staff; inadequate or incomplete education of staff; and problems with hierarchy and intimidation.

"One of W. Edwards Deming's key principles for effective leadership is 'Drive out fear, so that everyone may work effectively,'" says Ronald Wyatt, MD, MHA, patient safety officer and medical director, The Joint Commission. "It is not uncommon for care team members to share with The Joint Commission Office of Quality and Patient Safety that fear is the reason that an unsafe condition, a near miss, or even a harm is not reported to leadership. Fear of retaliation, fear of punishment, fear of job loss, fear of being labeled a troublemaker—any of these can result in a culture of silence that perpetuates harm."

The Joint Commission website provides the following resources on preventing the unintended retention of foreign objects:

- *Sentinel Event Alert* Issue 51: Preventing Unintended Retained Foreign Objects (https://www.jointcommission.org/sea_issue_51/)
- *Quick Safety* Issue 20: Strategies to Prevent URFOs (https://www.jointcommission.org/issues/detail.aspx?Issue=b2HmODYsxSnjoSk1%2biRMLvIMIrTTuGg%2b1ClLlv14%2b6I%3d)

Falls

Patient falls resulting in injury are a common occurrence in health care and are consistently among the sentinel events most frequently reviewed by The Joint Commission. The analysis of falls with injury reveals that the most common contributing factors pertain to the following:

- Inadequate assessment
- Communication failures
- Lack of adherence to protocols and safety practices

Five Most Frequently Reported Sentinel Events January 1–June 30, 2016

1. Unintended retention of a foreign object—52
2. Falls—52
3. Wrong patient, wrong site, or wrong procedure—47
4. Suicide—44
5. Delay in treatment—28

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

Falls account for a significant portion of the injuries sustained by hospitalized patients, patients and residents in nursing care centers, and recipients of home care. For more information, please review *Sentinel Event Alert* Issue 55: Preventing Falls and Fall-Related Injuries in Health Care Facilities on The Joint Commission website at https://www.jointcommission.org/assets/1/6/SEA_55_Falls_4_26_16.pdf.

Wrong Patient, Wrong Site, or Wrong Procedure

Wrong-patient, wrong-site, and/or wrong procedure events are preventable events that can lead to catastrophic harm to patients. These types of events stem from errors that occur during scheduling (such as those resulting from verbal instead of written requests for surgical bookings), during preoperative holding (such as inadequate patient identification), and in the operating room (such as lack of intraoperative site verification between multiple procedures).

Other causative factors for wrong-patient, wrong-site, and/or wrong procedure events may be related to flaws in the organizational culture; for example, policy changes may not be followed by adequate and consistent staff education, or staff are not empowered to speak up.

As Wyatt explains, "Leaders build resilient safety cultures by heeding the signals, not gaming the data, listening to care team voices, building trust, promoting reporting, and showing a commitment to organizational learning. Patient safety as the only core value should be everyone's responsibility."

The Joint Commission's Universal Protocol, which applies to all surgical and nonsurgical invasive procedures, includes established procedures and processes that are designed to prevent these types of events from occurring. Other helpful processes are available via the Targeted Solutions Tool® (TST®) for Safe Surgery on the Joint Commission Center for Transforming Healthcare website at http://www.centerfortransforminghealthcare.org/projects/detail.aspx?Project=2.

Patient Suicide

The 10th leading cause of death in the United States, suicide continues to be among the sentinel events most frequently reviewed by The Joint Commission. The most commonly identified causative factor for suicide was shortcomings in assessment—specifically, psychiatric assessment.

For more information, please review *Sentinel Event Alert* Issue 56: Detecting and Treating Suicide Ideation in All Settings on The Joint Commission website at https://www.jointcommission.org/sea_issue_56/.

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Delay in Treatment

A delay in treatment occurs when a patient does not receive an ordered treatment—whether it be a medication, a lab test, physical therapy, or other kind of treatment—during the time frame in which it was supposed to be delivered. Being unable to get an initial appointment or follow-up appointment in a timely manner may result in what is also considered a delay in treatment, as this can be a form of diagnostic error that may result in patient harm or death.

Quick Safety Issue 9: Preventing Delays in Treatment (https://www.jointcommission.org/issues/article.aspx?Article=qiDq9ABqL5P%2bJvIVVbvCetbRt4FiwbTAKELAcCSjJUs%3d) identified these causative factors:

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

"Leaders in high-reliability organizations practice and promote a collective mindfulness that requires reporting and responding to signals in the system of care, with urgency that is followed by visible improvement," Wyatt says. "In order to prevent harm, leaders should be able to respond mindfully, effectively—anything less defines a nominal leader. Excellence in leadership is a clear and explicit commitment to zero harm. Being free from harm *is* achievable."

An estimated fewer than 2% of all sentinel events are reported to The Joint Commission; of these, 69% (6,642 of 9,632 events) have been self reported since 2005. 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, please contact the Office of Quality and Patient Safety at patientsafetyreport@jointcommission.org or visit The Joint Commission website at http://www.jointcommission.org/sentinel_event.aspx.