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Top Sentinel Event Reports

Presenter: Anne Hulzing, MSLC, BSN, RN, CPPS, HACP
Patient Safety Specialist
Office of Quality and Patient Safety

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OBJECTIVES

-Define a Sentinel Event

-Share method of Data Collection

-Analyze the top Trends of Sentinel Events

Sentinel Event Definition

Sentinel Event Definition

- Sentinel events are a subcategory of adverse events.

- A sentinel event is a **patient safety event** (not primarily related to the natural course of a patient's illness or underlying condition) that reaches a patient and results in **death**, **severe harm** (regardless of duration of harm), or **permanent harm** (regardless of severity of harm).

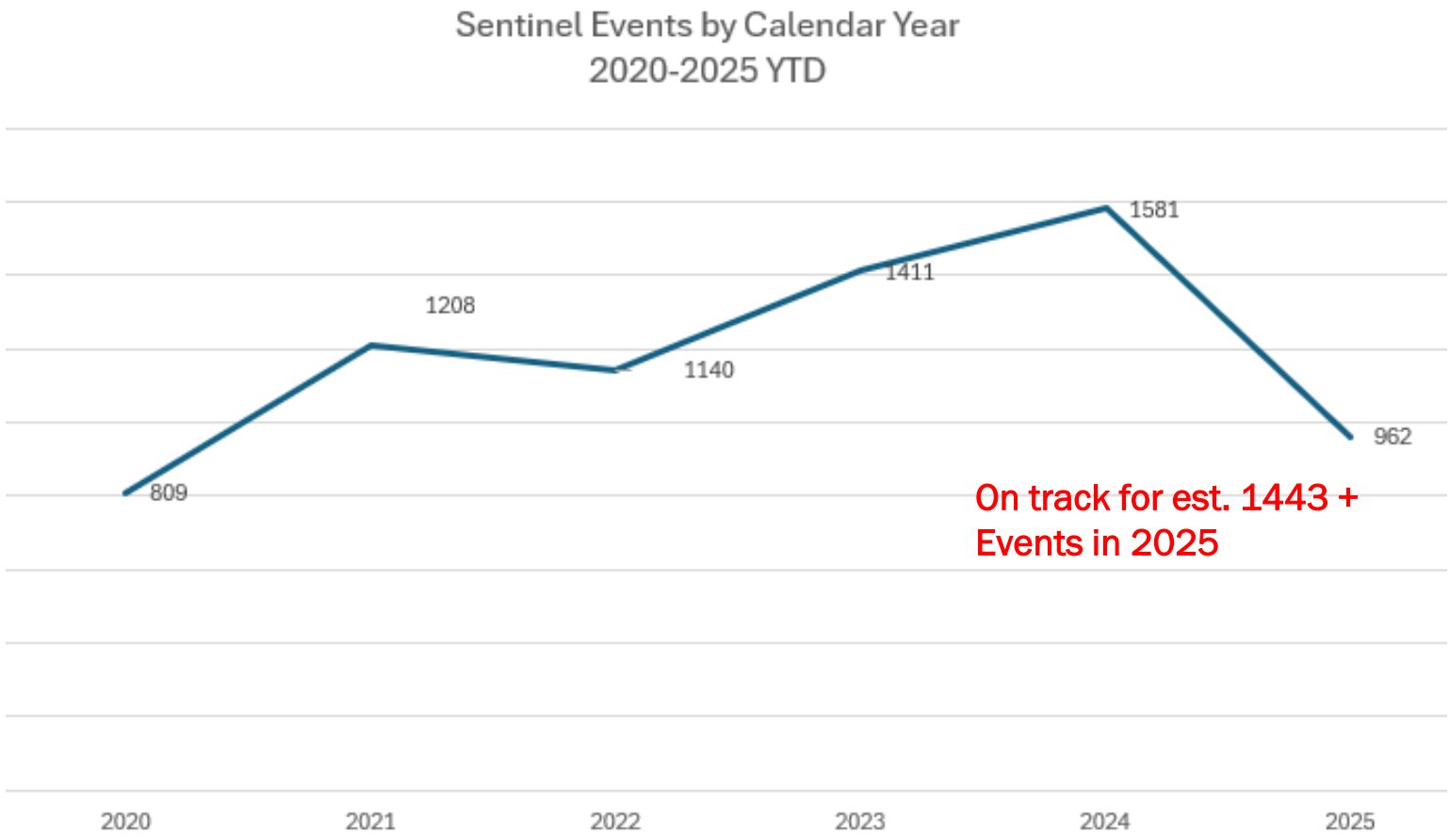
LINK: Sentinel Event Policy and Procedures | Joint Commission

Sentinel Event Reporting

- Each health care organization is **strongly encouraged**, but **not required**, **to report** to Joint Commission any patient safety event that meets Joint Commission definition of **sentinel event**
- **Sentinel events** reported to Joint Commission are **self-reported** by health care organizations that **recognize the value** of **working with the Office of Quality and Patient Safety** (OQPS) staff

LINK: Sentinel Event Policy and Procedures | Joint Commission

Sentinel Event Data Trends



Data date range 1/1/2020 through 8/8/2024

Sentinel Event Data Collection Methods

Sentinel Event Data Collection Methods

Event Details are collected by:

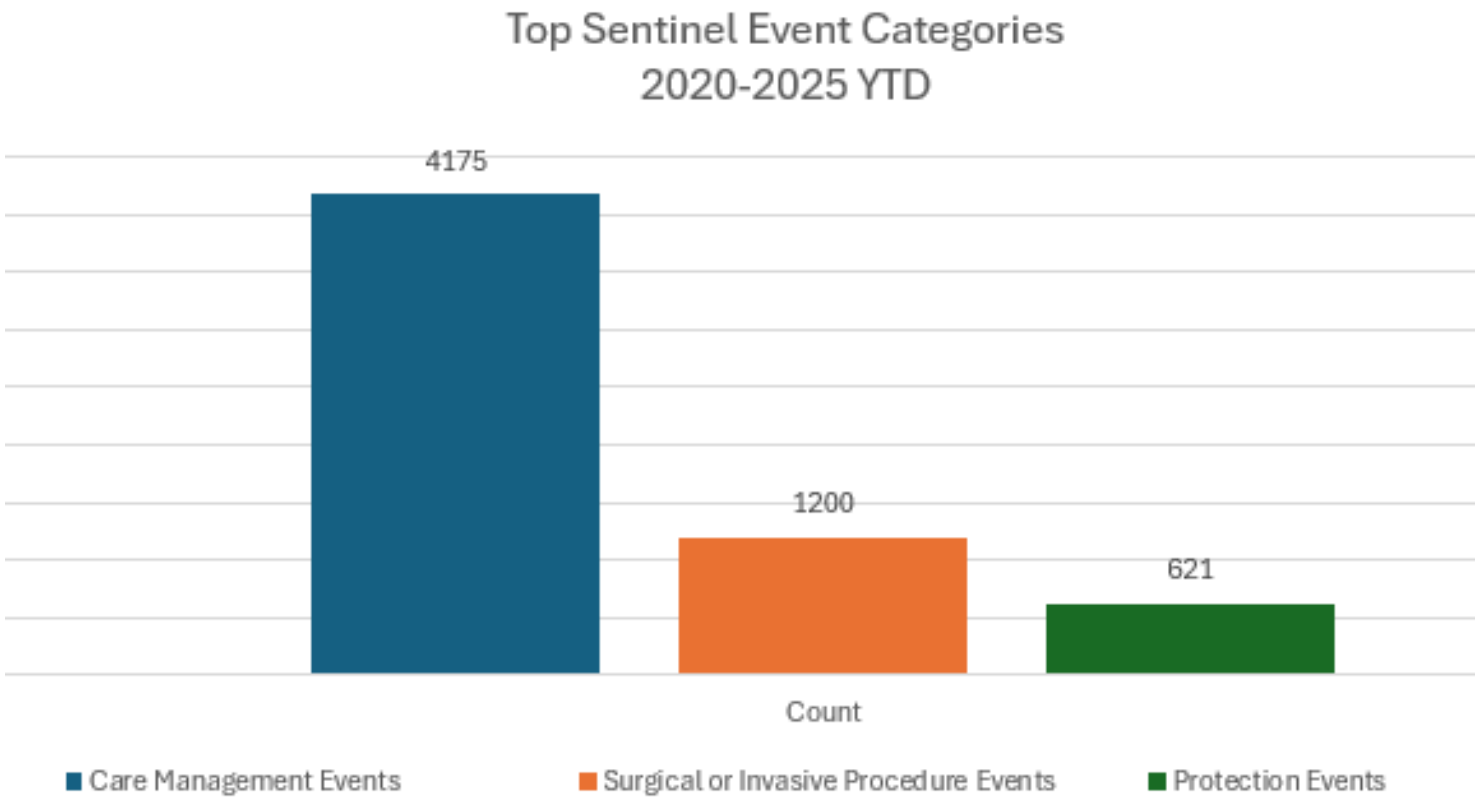
- Event Category
- Event Subcategory
- Event Additional Details (multiple per Event Subcategory)

Sentinel Event Data Collection Methods

Event Categories:

- Anesthesia-related event
- Care Management Events
- Environment Events
- Product or Device Events
- Protection Events
- Suicide - emergency dept
- Suicide — inpatient
- Suicide - offsite
- Surgical or Invasive Procedure Events

Top 3 Sentinel Event Categories

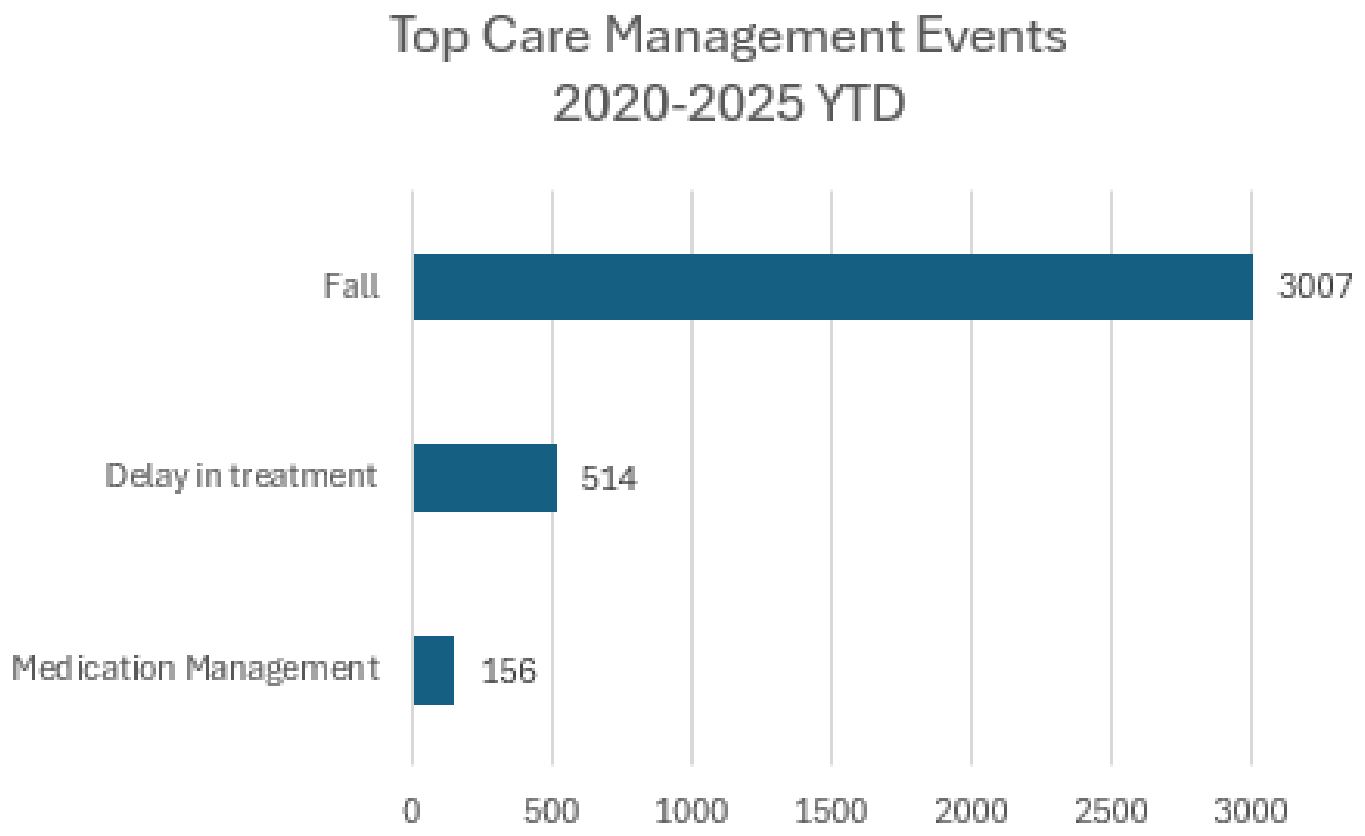


Sentinel Event Data Collection Methods

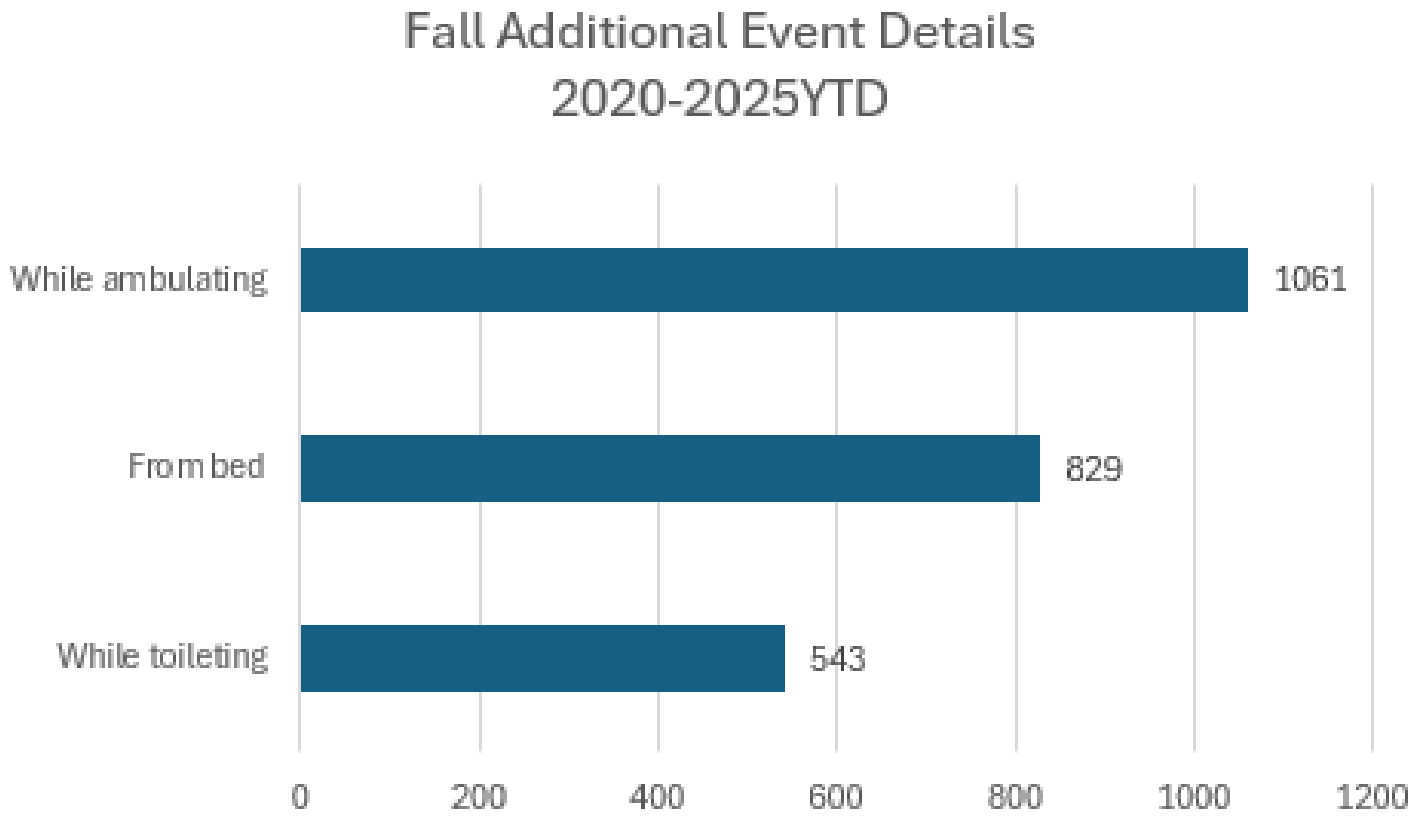
Care Management Event Subcategories:

- Clinical Alarm response
- Delay in treatment
- Fall
- Infection related
- Lab, Radiology, Pathology related
- Medication Management
- Perinatal Event
- Pressure Injuries
- Restraint Related Event
- Severe maternal morbidity Transition of Care
- VTE- Venous Thromboembolism

Top 3 Care Management Events



Top 3 Care Management Event: FALLS

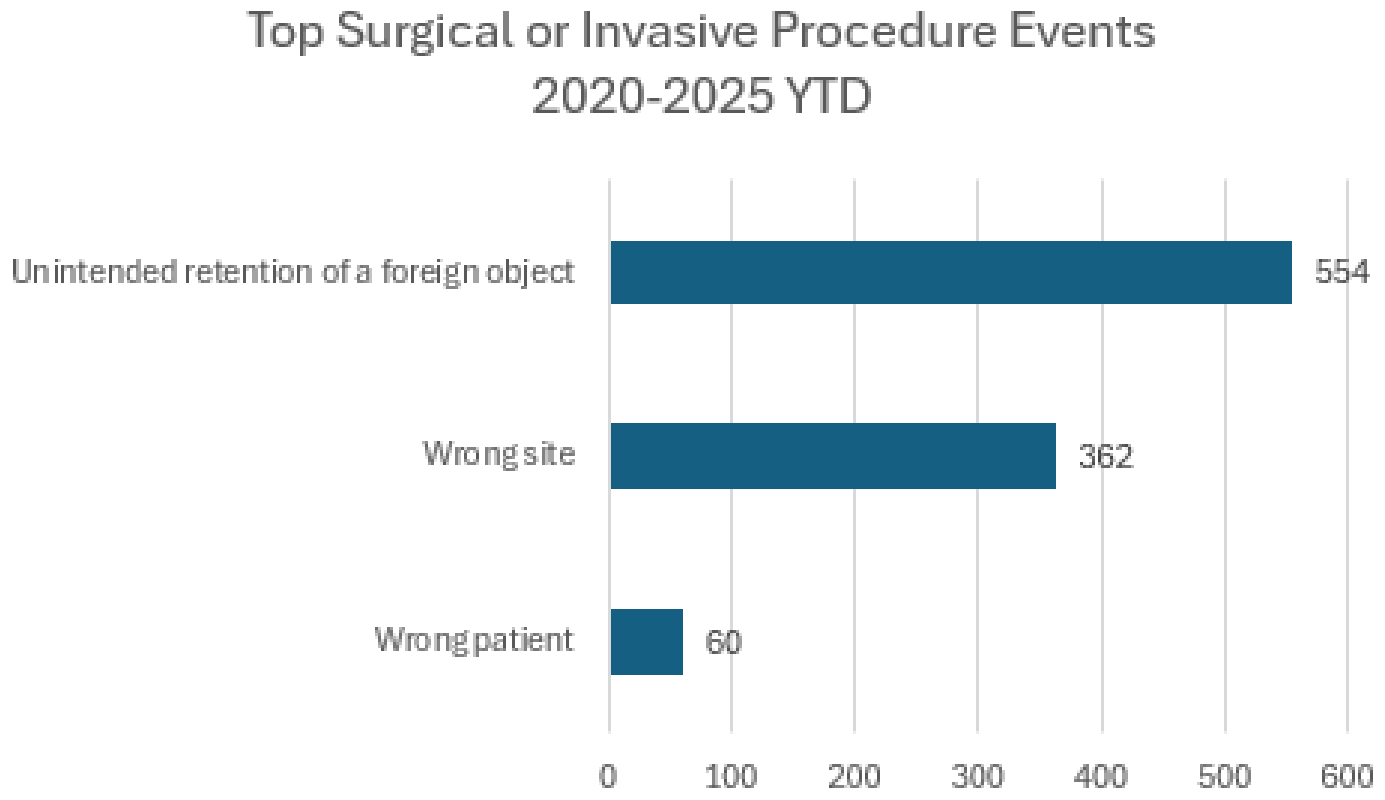


Sentinel Event Data Collection Methods

Surgical or Invasive Procedure Event Subcategories:

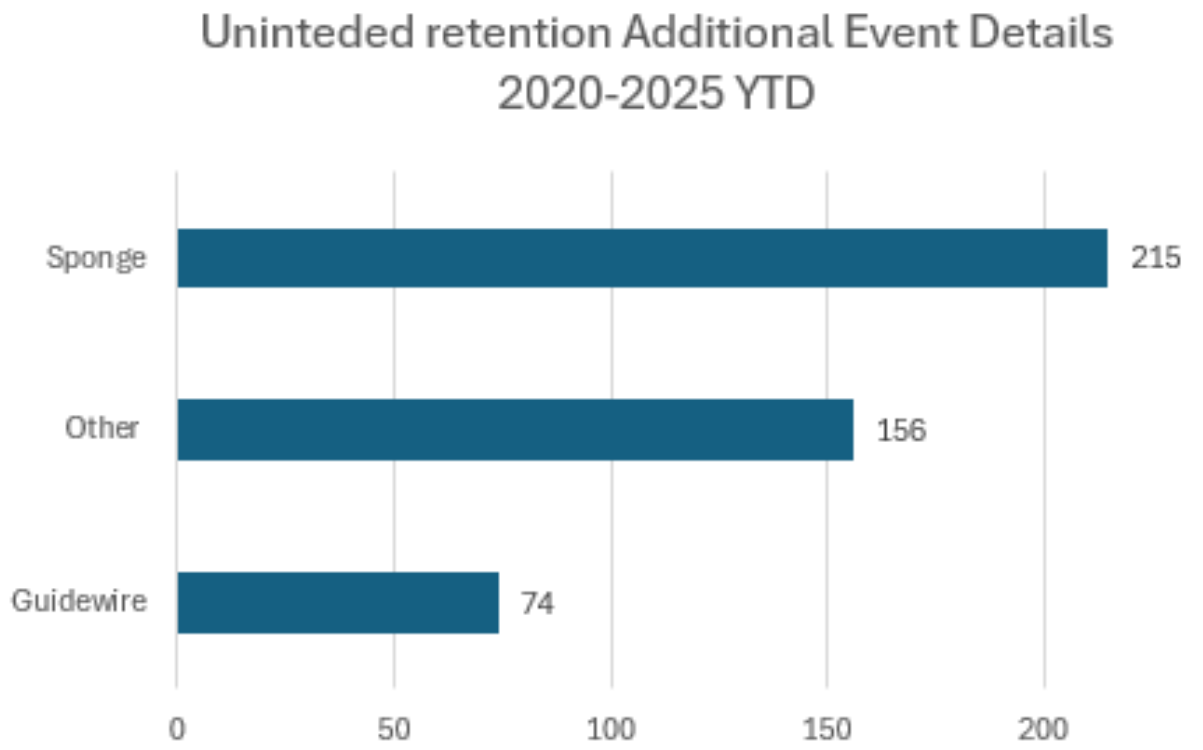
- Burns
- Op/ Post-op complications
- Unintended retention of a foreign object
- Wrong implant
- Wrong patient
- Wrong procedure
- Wrong site

Top 3 Surgical or Invasive Procedure Events



Top 3 Surgical or Invasive Procedure Event:

UNINTENDED RETENTION OF FOREIGN OBJECT (RFO)

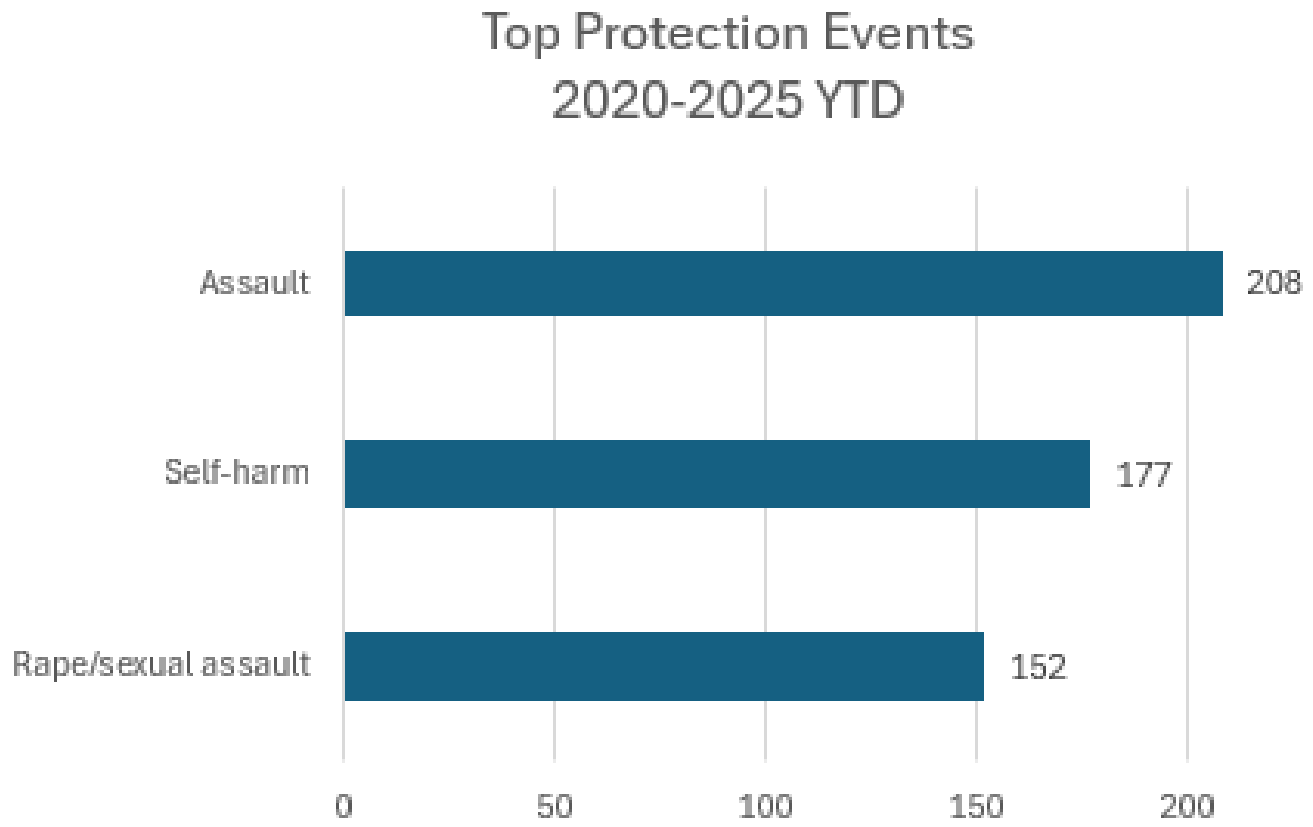


Sentinel Event Data Collection Methods

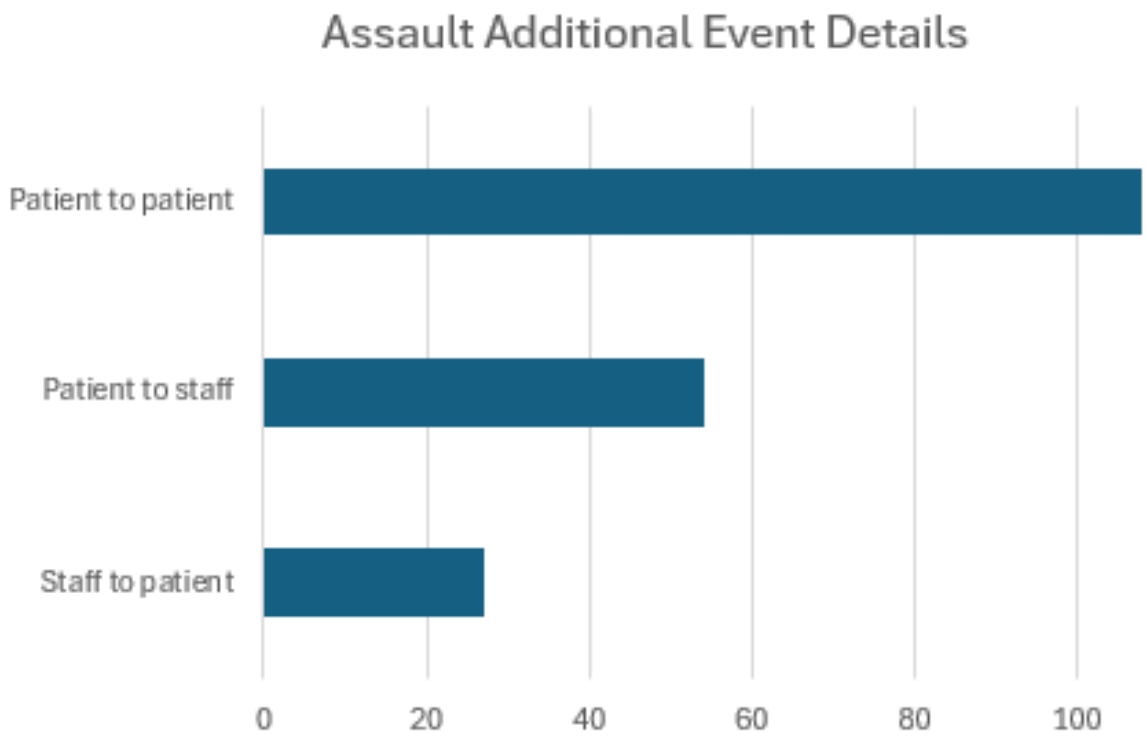
Protection Event Subcategories:

- Assault
- Elopement
- Homicide
- Infant abduction
- Infant discharge to wrong family
- Rape/ sexual assault
- Self-harm

Top 3 Protection Events



Top 3 Protection Event: ASSAULT



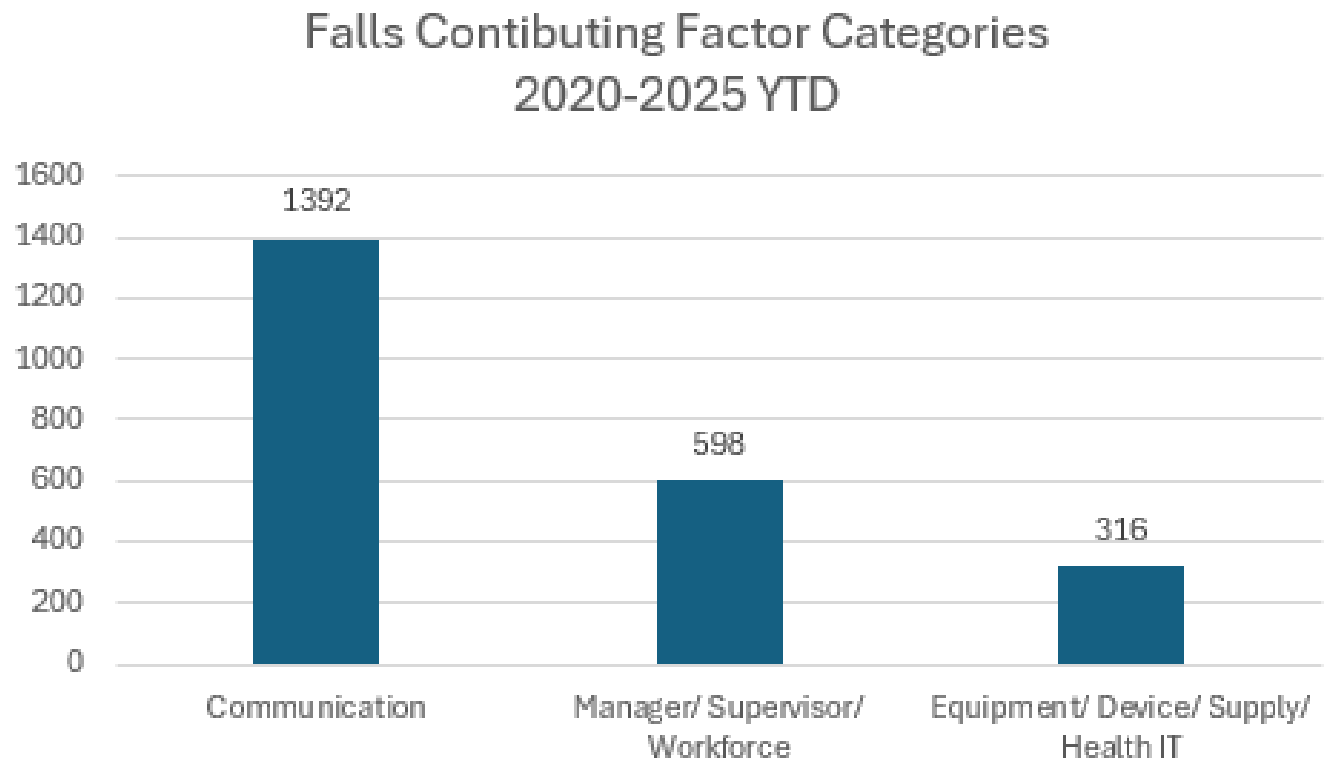
Sentinel Event Data Analysis

Comprehensive Systematic Analysis

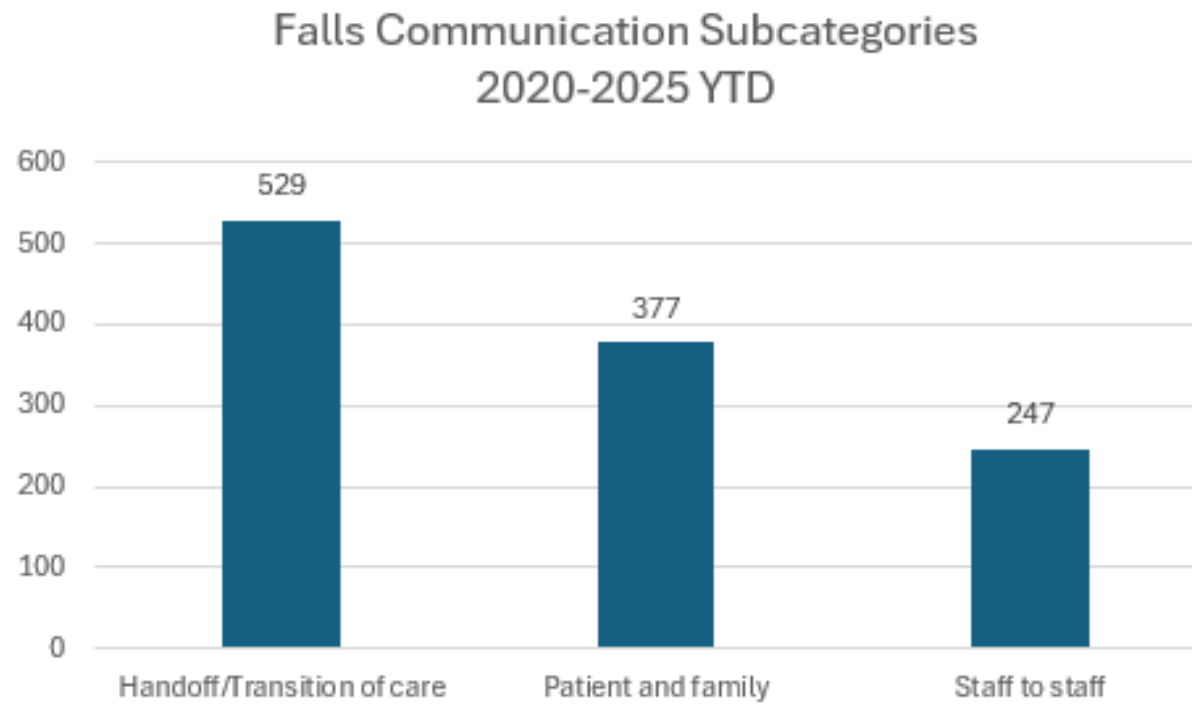
- Causal Factors
- Contributing Factors
  - Contributing Factor Categories
  - Contributing Factor Subcategories

JC's Root Cause Analysis Framework:
https://www.jointcommission.org/framework_for_conducting_a_root_cause_analysis_and_action_plan/

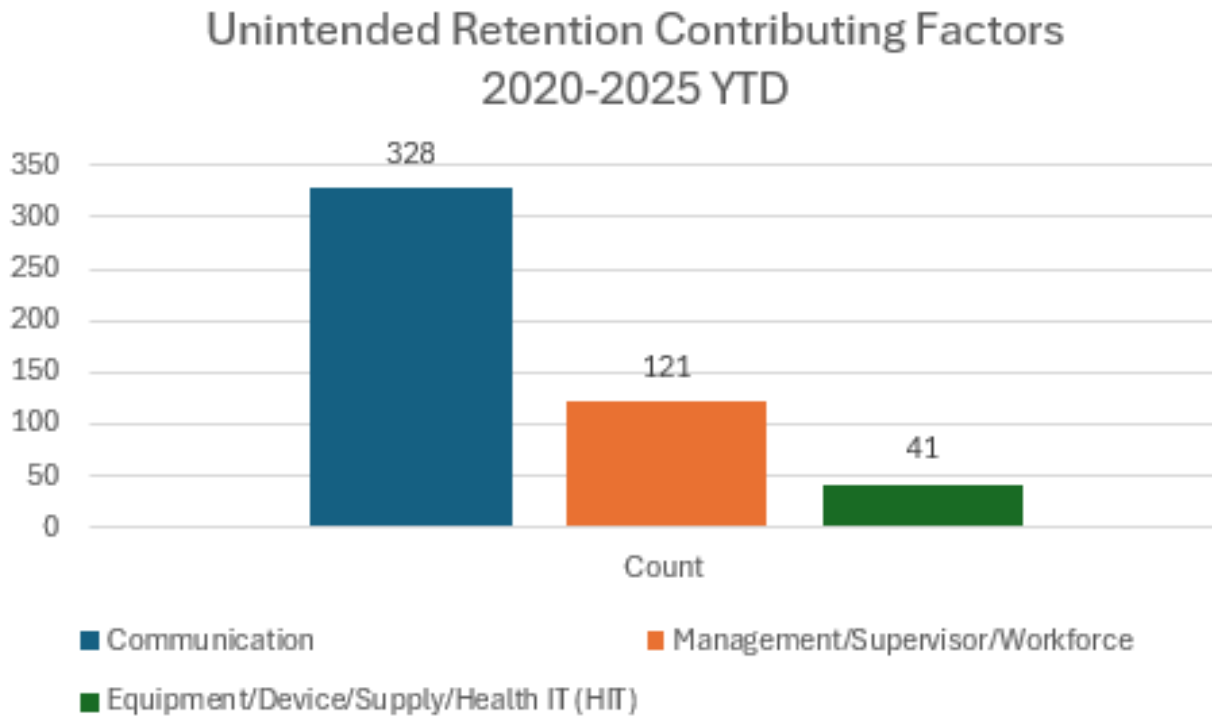
Top 3 FALLS
Contributing Factor Categories



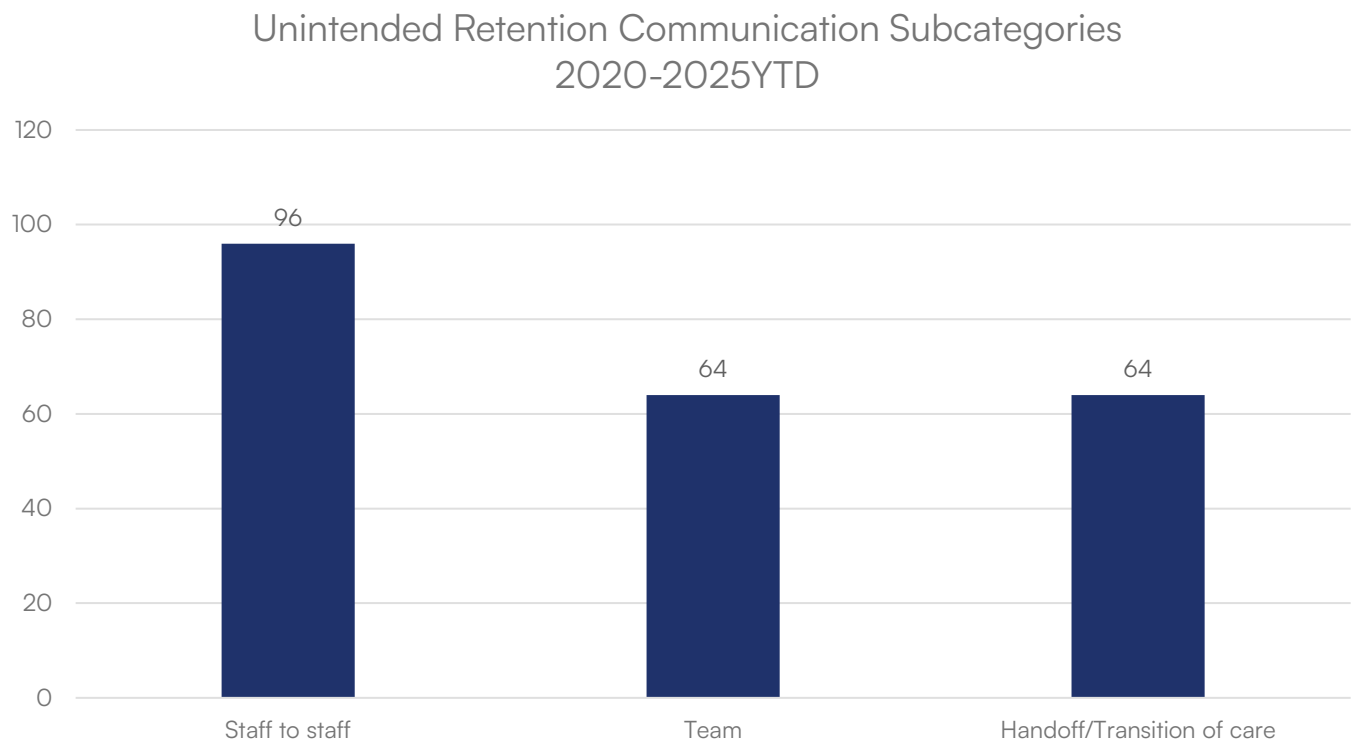
Top 3 FALLS Communication Contributing Factor Subcategories:



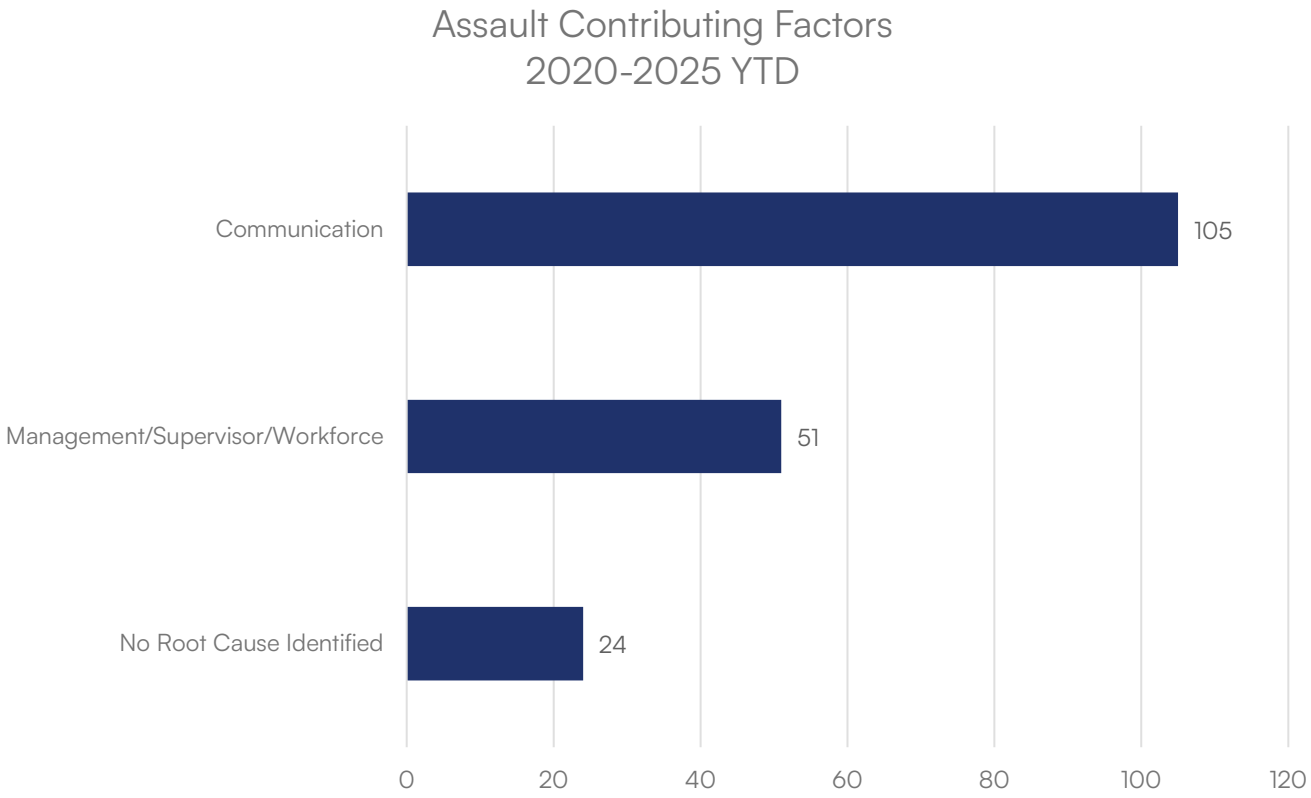
Top 3 UNINTENDED RFO Contributing Factor Categories



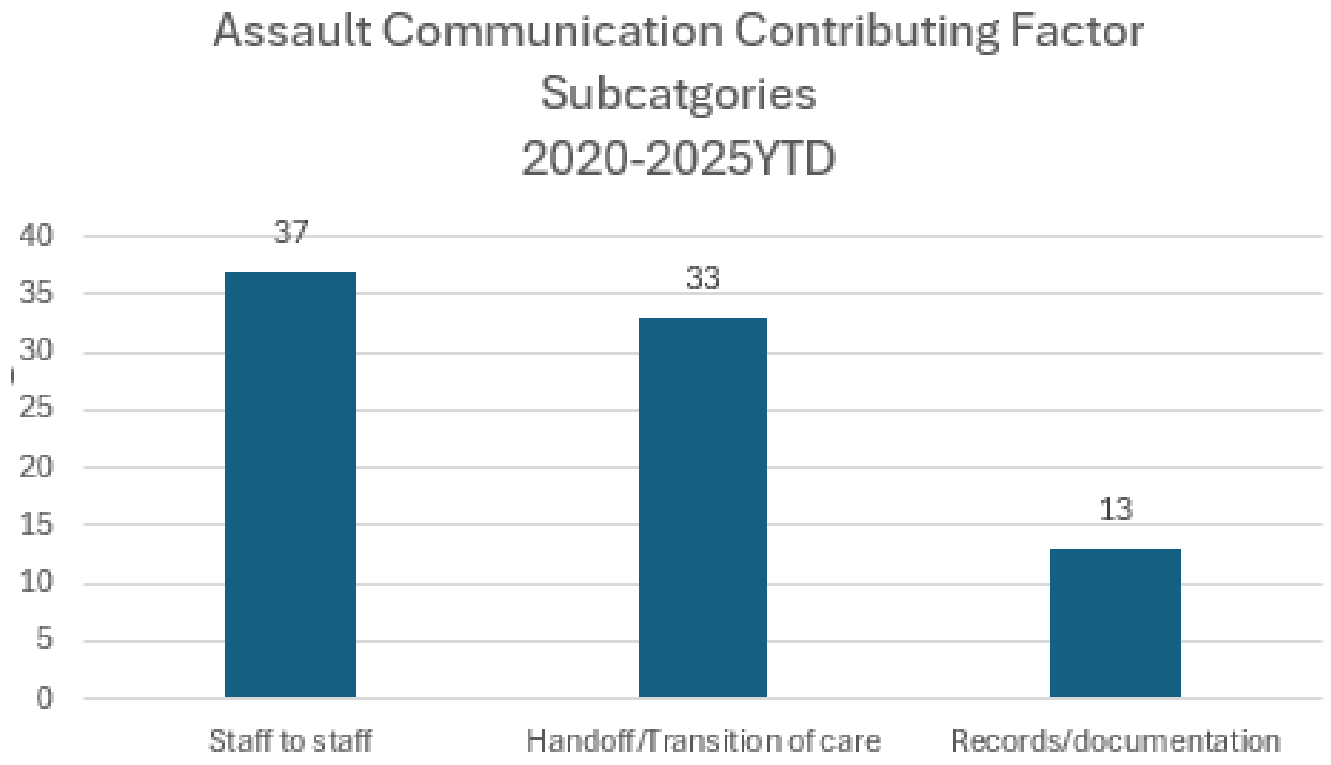
Top 3 UNINTENDED RFO Communication Contributing Factor Subcategories:



Top 3 ASSAULT Contributing Factor Categories:



Top 3 ASSAULT Communication Contributing Factor Subcategories:



Goals of a Sentinel Event Comprehensive Systematic Analysis

- Continuous learning
- Ongoing performance improvement
- Promote a Culture of Safety and a Just Culture
- Strive for High Reliability behaviors

It's a journey....not a destination!

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Benefits of self-reporting Sentinel Events (JC accredited organizations)

- Getting **support and expertise during the review** of a sentinel event
- Providing the health care organization an **opportunity to collaborate with a patient safety specialist** who maintains the following qualifications:
    - Masters-prepared clinician or human factors engineer
    - Certified Professional in Patient Safety (CPPS) from the Institute for Healthcare Improvement (IHI)
    - Experienced in reviewing similar events

Benefits of self-reporting Sentinel Events (JC accredited organizations)

- **Raising the level of transparency** in the health care organization, which **promotes a culture of safety**
- Conveying the message to the health care organization's public that it is **proactively working to prevent similar patient safety events** in the future

Acknowledgement

The Joint Commission appreciates the healthcare organizations that have voluntarily reported sentinel events. Your transparency allows for the analysis and identification of recurring systemic factors that contribute to avoidable harm, and the communication of these factors to advance patient safety.

Thank you for your commitment to safety and quality.

Resources

Sentinel Event Alert 55: Preventing falls and fall related injuries in health care facilities | Joint Commission

Sentinel Event Alert 58: Inadequate hand-off communication | Joint Commission

Quick Safety Issue 52: Advancing safety with closed-loop communication of test results | Joint Commission

Sentinel Event Alert 51: Preventing unintended retained foreign objects | Joint Commission

Sentinel Event Alert 45: Preventing violence in the health care setting | Joint Commission

Sentinel Event Alert 59: Physical and verbal violence against health care workers | Joint Commission