Sentinel Event Reporting

What We Know

› The Joint Commission (TJC) defines a sentinel event as “a patient safety event (not primarily related to the natural course of the patient’s illness or underlying condition) that reaches a patient and results in any of the following: death, permanent harm, severe temporary harm”\(^{(2)}\)
• These events are considered “sentinel” because they indicate a need for immediate investigation and response
› According to TJC Sentinel Event Policy established in 1996, healthcare organizations that are accredited by TJC are not required to report sentinel events; reporting is voluntary and involves a nonpunitive process. The Sentinel Event Policy contains information regarding the following requirements when an accredited healthcare organization submits a report to TJC of a sentinel event that has occurred:\(^{(2,3,5,9)}\)
  • A timely and complete root cause analysis within 45 days of the occurrence of the sentinel event or facility awareness of the event (for more information, see the Evidence-Based Care Sheet: Root Cause Analysis)
  • A corrective action plan to prevent further risk to patient safety; the corrective action plan should contain specific risk reduction strategies
  • Implementation procedures for the corrective action plan
  • The effectiveness of the corrective action plan; the corrective action plan should contain specific outcome measurements
› The Sentinel Event Policy requires each accredited healthcare organization to officially define the term “sentinel event” and develop protocols to identify, report, and manage such events that are specific to their organizational purpose. Each accredited healthcare organization’s definition of sentinel event is subject to review by TJC under the Sentinel Event Policy\(^{(5,7)}\)
› Sentinel event reporting to TJC is encouraged because it provides shared learning experiences and opportunities to develop corrective action plans to improve risk reduction strategies and patient safety. Sentinel event reporting assists in avoiding future sentinel events\(^{(2,3,5,9)}\)
  • TJC adds sentinel event reports to the Sentinel Event Database to create aggregate data, identify causal factors of the event, and develop prevention strategies\(^{(2,5)}\)
  • Sentinel Event Alerts and National Patient Safety Goals are created based on sentinel event reporting data. Sentinel Event Alerts have been released by TJC since 1998 with the goal of providing healthcare organizations with urgent information regarding specific sentinel events, causative factors, and precautionary strategies. National Patient Safety Goals are fundamental standards that are defined by TJC to focus on improved patient safety in the hospital setting. (For more information, see the series of Evidence-Based Care Sheets regarding National Patient Safety Goals)\(^{(2,5,2)}\)
› Healthcare organizations that are accredited by TJC report sentinel events to the TJC Office of Quality Monitoring Sentinel Event Unit, which has the following responsibilities:\(^{(2,5)}\)
• Review and determine whether the accredited healthcare organization’s root cause analysis and action plan that were formulated subsequent to a sentinel event are acceptable
  – As appropriate, TJC assigns follow-up activity in response to the healthcare organization’s report. TJC provides consultation to healthcare organizations that submit unacceptable root cause analyses and action plans, and offers an additional 15 days for submission of a revised report
• Conduct a root cause analysis and investigation and respond to complaints of a sentinel event that are filed by patients, patient’s families, employees of a healthcare organization, and/or the media. Sentinel events that are considered appropriate for review by TJC are events that meet the following criteria:(2)
  – Suicide of a patient receiving care in around-the-clock staffed setting or within 72 hours of discharge, including from the Emergency Department of a hospital
  – Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of a patient or staff member, licensed independent practitioner, visitor, or vendor while at the healthcare facility site
  – Unexpected death of a full-term infant
  – Discharge of an infant to the wrong family
  – Abduction of a patient who is receiving care, treatment, and services
  – Unauthorized departure of a patient from a staffed around-the-clock care setting that leads to death, permanent harm, or severe temporary harm to the patient
  – Wrong-site surgery or surgery on the wrong patient (for more information, see Evidence-Based Care Sheet: National Patient Safety Goals (The Joint Commission, 2015): Universal Protocol -- Time-Out before Procedures )
  – Unexpected death or major permanent loss of function that is unrelated to the course of the patient’s illness
  – Hemolytic transfusion reactions with major blood group incompatibility
  – Unintended retention of a foreign body in a patient after surgery or another invasive procedure
  – Severe neonatal hyperbilirubinemia > 30 mg/dL
  – Prolonged fluoroscopy with cumulative doses > 1,500 rads of radiation to a single body part or field
  – Delivery of radiotherapy to the wrong body region
  – Delivery of radiotherapy > 25% above the planned dose
  – Maternal death due to childbirth or delivery
  – Unanticipated smoke, flame, or fire during an episode of patient care
  – Maternal morbidity, not related to natural causes or an underlying condition, that may result in permanent or severe temporary harm to the patient

› Currently, 26 states and the District of Columbia have implemented mandatory sentinel event reporting requirements. The reporting process varies greatly from state to state. Sentinel events that are deemed reviewable by TJC may or may not be considered a mandatory reportable sentinel event under state law(2,3,8,9)
• The National Quality Forum (NQF) identifies 29 serious reportable events in seven categories in order to assist healthcare organizations and state sentinel event reporting systems in endorsing national standards for measuring and reporting performance in patient safety(8)
• Authors comparing the number of sentinel events reported to TJC for 24 patient care-related injuries (e.g., hemolytic transfusion errors, wrong-site surgery, falls) with the number reported in 15 states that had mandatory reporting found that the number of reports submitted was higher in states with mandatory reporting systems. The presence of a voluntary reporting system that involves threats of provider accountability results in a lower incidence of sentinel events being reported to TJC(9)
› Although sentinel event reporting is not actively enforced at the federal level, having a national mandatory reporting system for medical errors would create opportunities for a federal governing body to enforce evidence-based best practices to prevent future sentinel events(2)
› In 2015, TJC released an Event Alert on the safe use of health information technology (IT). Analyzing 3,375 sentinel events that resulted in permanent harm between January 2010 and June 2013, investigators identified 120 sentinel events - affecting 125 patients - as related to incorrect or miscommunicated health IT (e.g., ordering the incorrect medication, imaging ordered for the wrong patient, outpatient surgery issues due to system errors). TJC recommends careful assessment and ongoing optimization of the technology and maintaining a culture of safety within the clinical setting(1,4,6)
What We Can Do

› Learn about sentinel event reporting so you can improve patient safety and enhance quality of care in your facility; share this information with your colleagues
› Encourage colleagues to report sentinel events to TJC in order to promote shared learning experiences to avoid future sentinel events
  • Report sentinel events to TJC to improve risk reduction strategies and patient safety; contact TJC’s sentinel event hotline at (630) 792-3700
› Determine your state’s mandatory sentinel event reporting requirements
› In the event of a sentinel event in your facility, collaborate to conduct a timely and complete root cause analysis, develop and implement a corrective action plan to prevent further risk to patients, and monitor the effectiveness of the corrective action plan using measurable outcomes
  • Utilize TJC Framework for Conducting a Root Cause Analysis and Action Plan tool; for more information, see http://www.jointcommission.org/Framework_for_Conducting_a_Root_Cause_Analysis_and_Action_Plan/
› Refer to TJC Sentinel Event Alerts for current information regarding improving patient safety; for details, see https://www.jointcommission.org/sentinel_event.aspx
› Refer to the NQF Web site for a list of serious reportable events; for more information, see http://www.qualityforum.org/Topics/SREs/Serious_Reportable_Events.aspx

Coding Matrix

| M          | Published meta-analysis |
| SR         | Published systematic or integrative literature review |
| RCT        | Published research (randomized controlled trial) |
| R          | Published research (not randomized controlled trial) |
| C          | Case histories, case studies |
| G          | Published guidelines |
| RV         | Published review of the literature |
| RU         | Published research utilization report |
| QI         | Published quality improvement report |
| L          | Legislation |
| PGR        | Published government report |
| PFR        | Published funded report |
| PP         | Policies, procedures, protocols |
| X          | Practice exemplars, stories, opinions |
| GI         | General or background information/texts/reports |
| U          | Unpublished research, reviews, poster presentations or other such materials |
| CP         | Conference proceedings, abstracts, presentation |

References