The Joint Commission

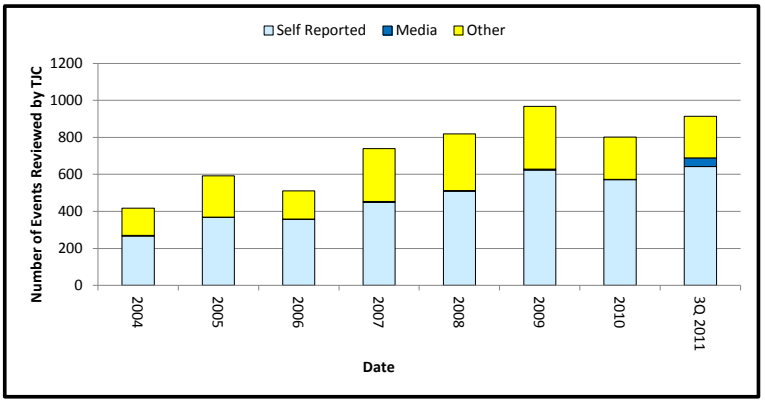
Summary Data of Sentinel Events Reviewed by The Joint Commission

Data Limitations: The reporting of most sentinel events to The Joint Commission is voluntary and represents only a small proportion of actual events. 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.

Total number of Sentinel Events reviewed by The Joint Commission 1995 through September 30, 2011	8305

Total Incidents Reviewed 1995 through 2003	
1995	1
1996	29
1997	119
1998	272
1999	421
2000	441
2001	398
2002	444
2003	416
1995 to 2003 Total	2541

Historical



Sources of Reviewable Sentinel Events 2004 through September 30, 2011	Total Incidents	Self-Reported	Non- Self Reported	% of Self Reported
2004	418	267	151	63.9%
2005	592	367	225	62.0%
2006	511	357	154	69.9%
2007	740	448	292	60.5%
2008	819	509	310	62.1%
2009	968	624	344	64.5%
2010	802	572	230	71.3%
January 1, 2011-September 30, 2011	914	643	271	70.4%
2004 through 3Q 2011 Total	5764	3787	1977	65.7%

Type of Sentinel Event	2004 -Sept. 30, 2011 Total	2009	2010	January-Sept.30, 2011
Abduction	22	1	1	0
Anesthesia-Related Event	82	15	6	11
Criminal Event	226	34	28	38
Delay In Treatment	646	123	95	101
Dialysis-Related Event	6	2	2	0
Elopement	65	8	14	4
Fall	439	81	56	73
Fire	81	15	8	13
Infant Discharge to Wrong Family	2	0	1	0
Infection-Related Event	135	28	14	14
Inpatient Drug Overdose	53	7	8	11
Maternal Death	93	13	16	12
Med Equipment-Related	164	24	25	27
Medication Error	319	43	44	28
Op/Post-op Complication	604	94	86	101
Other Unanticipated Event****	346	52	38	51
Perinatal Death/Injury	194	31	31	27
Radiation Overdose*	25	5	8	6
Restraint Related Event	108	11	5	13
Self-Inflicted Injury	40	6	7	5
Severe Neonatal Hyperbilirubinemia*	4	0	2	1
Suicide	568	87	67	99
Transfer-Related Event	18	2	3	4
Transfusion Error	92	12	5	14
Unintended Retention of a Foreign Body*	606	119	133	136
Utility System Failure	6	0	0	2
Ventilator Death	38	6	6	8
Wrong–patient, wrong-site, wrong-procedure	782	149	93	115
Total Incidents Reviewed	5764	968	802	914

Sentinel Event Settings 2004 through September 30, 2011	#	%
Hospital	3708	64.3%
Psychiatric hospital	663	11.5%
Ambulatory care	204	3.5%
Psych unit in general hospital	308	5.3%
Emergency department	394	6.8%
Behavioral health facility	215	3.7%
Home care	96	1.7%
Long term care facility	74	1.3%
Other**	66	1.1%
Office-based surgery	36	0.6%
Total	5764	100%

Sentinel Event Outcome 2004 through Sept. 30, 2011	#	%
Patient death	3576	61.3%
Loss of Function	532	9.1%
Other***	1727	29.6%
Total patients impacted*****	5835	100.0%

*Unintended retention of a foreign object , Severe Neonatal Hyperbilirubinemia & Radiation Overdose were added to the definition of reviewable events in 2005. This data represents events reviewed since that date, not 1995-2010.

**Other includes: Disease Specific Care, Diagnostic Imaging, Hospice Care

***Other includes: Unexpected Additional Care/Extended Care, and Psychological Impact

****Other include: Asphyxiation, Burn, Choked on food, Drowned, Found unresponsive

*****Multiple patients may be impacted by a single event.