SE Statistics as of: 10/26/2015

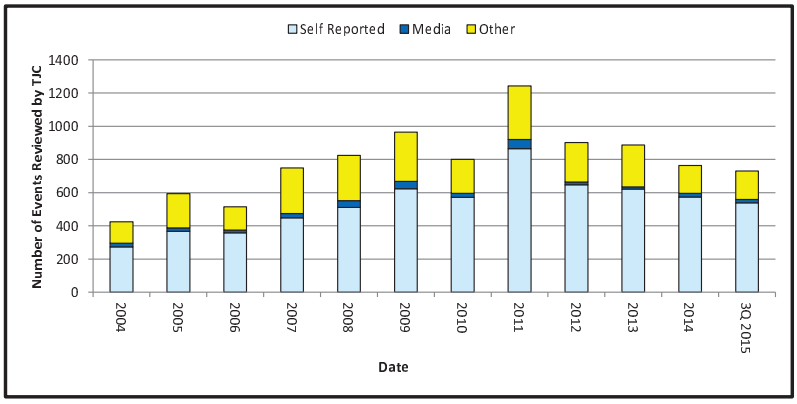
Summary Data of Sentinel Events Reviewed by The Joint Commission

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 3Q 2015	11917

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 3Q 2015	Non-self reported	Self Reported	Total	%Self Reported
2004	151	267	418	63.9%
2005	225	367	592	62.0%
2006	154	357	511	69.9%
2007	292	448	740	60.5%
2008	310	509	819	62.1%
2009	344	624	968	64.5%
2010	230	572	802	71.3%
2011	378	865	1243	69.6%
2012	253	648	901	71.9%
2013	265	622	887	70.1%
2014	191	573	764	75.0%
3Q 2015	193	538	731	73.6%
2004 through 3Q 2015 Total	2986	6390	9376	68.2%

Sentinel Event Settings 2004 through 3Q 2015	#	%
Hospital	6248	66.7%
Psychiatric hospital	942	10.1%
Ambulatory care	351	3.7%
Psych unit in general hospital	484	5.2%
Emergency department	503	5.4%
Behavioral health facility	350	3.7%
Home care	181	1.9%
Long term care facility	106	1.1%
Other***	117	1.2%
Office-based surgery	89	0.9%

Type of Sentinel Event	2004 - 3Q 2015 Total	2013	2014	3Q 2015
Anesthesia-Related Event	110	8	6	2
Criminal Event	409	52	47	30
Delay In Treatment	1035	113	73	59
Dialysis-Related Event	12	1	2	0
Elopement	98	9	6	4
Fall	777	82	91	66
Fire	136	9	10	19
Infant Abduction	29	2	0	1
Infant Discharge to Wrong Family	3	0	0	0
Infection-Related Event	185	13	12	7
Inpatient Drug Overdose	108	8	8	9
Maternal Death	129	7	11	4
Med Equipment-Related	229	20	9	7
Medication Error	462	38	18	28
Op/Post-op Complication	904	77	52	56
Other Unanticipated Event***	628	81	73	49
Perinatal Death/Injury	335	35	32	29
Radiation Overdose*	41	4	4	3
Restraint Related Event	129	4	2	6
Self-Inflicted Injury	85	9	5	16
Severe Neonatal Hyperbilirubinemia*	8	0	0	2
Suicide	932	90	82	75
Transfer-Related Event	28	2	1	1
Transfusion Error	136	7	7	8
Unassigned	102	0	31	71
Unintended Retention of a Foreign Body*	1072	102	112	85
Utility System Failure	7	0	0	0
Ventilator Death	51	5	3	2
Wrong–patient, wrong-site, wrong-procedure	1196	109	67	92
Total Incidents Reviewed	9376	887	764	731

Sentinel Event Outcome 2004 through 3Q 2015	#	%
Patient death	5469	57.0%
Permanent harm	49	0.5%
Permanent loss of function	857	8.9%
Severe temporary harm	152	1.6%
Psychological impact	313	3.3%
Unexpected additional care	2540	26.5%
Unknown	11	0.1%
Other	203	2.1%
Total patients impacted****	9594	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 include: Asphyxiation, Burn, Choked on food, Drowned, Found unresponsive

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