

The Joint Commission

Perspectives[®]

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Sentinel Event Statistics for 2012

From the January 1995 implementation of The Joint Commission's Sentinel Event Database through December 31, 2012, The Joint Commission has reviewed 9,535 reports of sentinel events and included information about them in the Sentinel Event Database. The Sentinel Event Database is designed "to increase the general knowledge about sentinel events, their contributing factors, and strategies for prevention"—a key goal of the enterprise's Sentinel Event Policy. Database content comprises data collected and analyzed from the review of sentinel events, root cause analyses (RCA), action plans, and follow-up activities, as tracking this aggregate information may help guide local efforts to prevent future occurrences.

The Joint Commission recently updated its summary data of sentinel event statistics for 2012. Sentinel event outcomes from 2004 through 2012 show that a total of 6,994 patients have been affected by these events, with 4,230 (59.9%) resulting in the patient's death, 654 (9.3%) resulting in loss of function, and 2,177 (30.8%) resulting in unexpected additional care and/or psychological impact. The Joint Commission reviewed a total of 901 sentinel events during 2012 alone; the 10 most frequently reported types are shown in the box on the left on page 3.

Sentinel events are reported to The Joint Commission voluntarily by an accredited organization or via the complaint process. When a reviewable sentinel event is voluntarily reported to The Joint Commission, or when The Joint Commission

becomes aware of the sentinel event through another means, a specially trained Joint Commission clinician collaborates with the organization to review its RCA and to create an action plan with strategies for reducing the risk that similar events might occur in the future. The majority of events have multiple root causes; the ten most frequently identified root causes (spanning several types of events) for 2012

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This column informs you of developments and potential revisions that can affect your accreditation and certification and tracks proposed changes before they are implemented. Items may drop off this list before the approval stage if they are rejected at some point in the process.

Executive Editor
Katie Byrne

Senior Project Manager
Cheryl Firestone

Manager, Accreditation Products
Helen M. Fry, MA

Executive Director, Publications
Catherine Chopp Hinckley, PhD

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CURRENTLY IN DEVELOPMENT

STANDARDS AND GOALS


- Proposed revisions to primary stroke center certification for the **disease-specific care** program
- Proposed new and revised requirements for the **ambulatory care** program
- Proposed new and revised requirements for emergency management oversight for the **critical access hospital** and **hospital** programs
- Proposed revisions to the primary care medical home certification option for the **ambulatory care** program
- Proposed requirements for a behavioral health home certification option for the **behavioral health care** program
- Proposed new National Patient Safety Goal on alarm management for the **critical access hospital** and **hospital** programs

POLICIES AND PROCEDURES

- Revisions to the Sentinel Event Policy for **all** programs

CORRECTION: Effective Date of California Law for CT Scans

There is an error in the article “ACCEPTED: Changes to Requirements for CA Organizations Performing CT Scans” in the October 2012 issue of *Perspectives* (pages 4–5). In announcing changes to requirements for organizations in California that perform computed tomography (CT) scans, the article stated that the section of the law that addresses the detailed reporting requirements becomes effective July 1, 2013. The article should have stated that this section of the law became effective July 1, 2012.


Please note, however, that the article *correctly* announces the effective date for the new Element of Performance (EP) The Joint Commission developed to address this section of the law. As announced, Information Management (IM) Standard IM.02.02.03, EP 13, becomes effective July 1, 2013. 

Sentinel Event Statistics for 2012

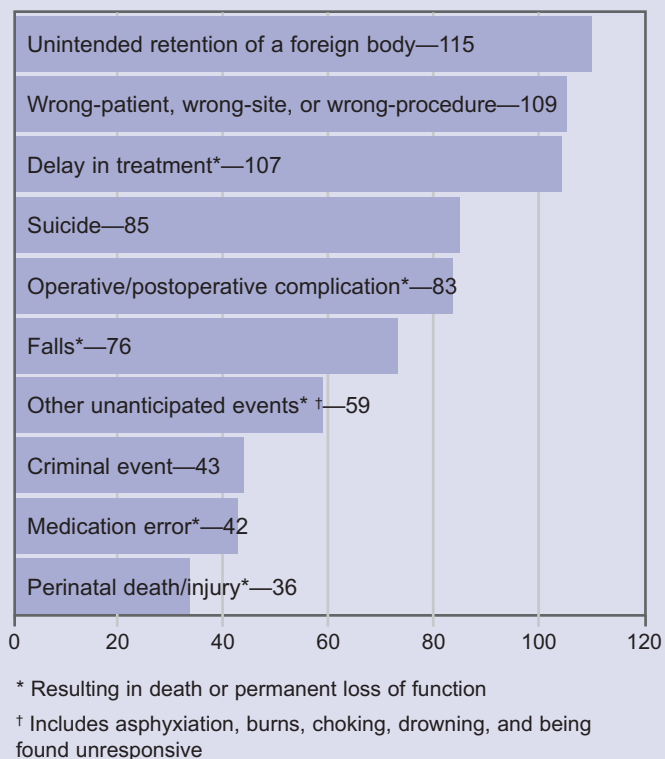
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are shown in the box below right. The same events appear (in a slightly different order) on both the 2011 (see May 2012 *Perspectives*, page 5) and 2012 lists.

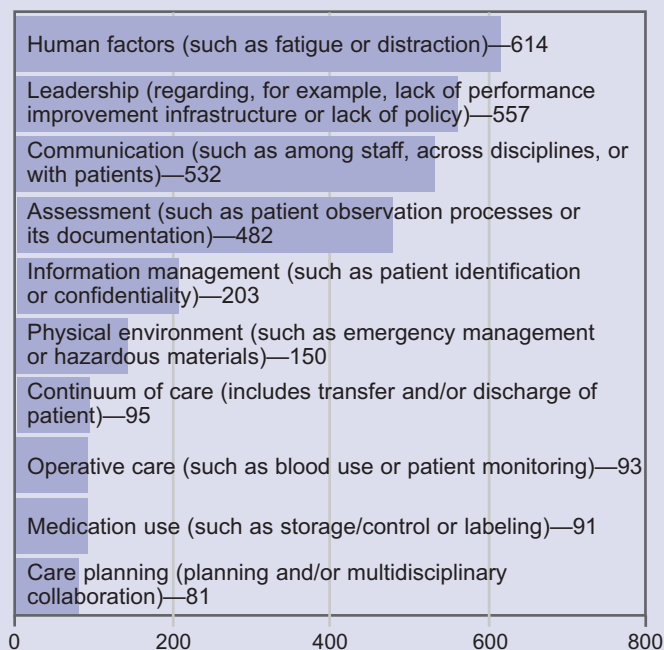
“Increasingly, organizations are identifying multiple causal and contributing factors for each event, indicating the complexities of the health care environment and the challenges within it,” says Anita Giuntoli, director, Office of Quality Monitoring, The Joint Commission.

It is estimated that fewer than 2% of all sentinel events are reported to The Joint Commission and that only about two-thirds of these are voluntarily reported. 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, visit The Joint Commission website at http://www.jointcommission.org/sentinel_event.aspx. 

Most Frequently Reported Sentinel Events, January 1–December 31, 2012



Most Frequently Identified Root Causes for Sentinel Events, January 1–December 31, 2012



New Speak Up Campaign for Palliative Care

The Joint Commission recently launched the newest in its series of Speak Up™ campaigns—“What You Need to Know About Your Serious Illness and Palliative Care”—to provide education about how palliative care can help patients and their families manage pain, symptoms, and stress during a serious or debilitating illness. Palliative care can relieve symptoms such as depression, appetite loss, pain, nausea, and sleeplessness as well as provide help with decision making, managing health care, and supporting family members.

The new campaign covers topics such as the following:

- How, when, and where to get palliative care
- Questions that palliative care providers may ask patients
- Questions that patients should ask palliative care providers
- How to pay for palliative care
- Where to find more information online

“Seriously ill patients have special physical, emotional, and spiritual needs,” says Ronald M. Wyatt, MD, MHA,

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Joint Commission Announces 1,000 Certified Primary Stroke Centers

On January 15, 2013, The Joint Commission and the American Heart/American Stroke Association announced Trinity Health in Minot, North Dakota, as the 1,000th organization to have currently achieved Joint Commission Primary Stroke Center Certification in the United States.

Developed in collaboration with the American Heart Association/American Stroke Association and launched in 2003, The Joint Commission's Primary Stroke Center Certification program is based on the Brain Attack Coalition's "Recommendations for the Establishment of Primary Stroke Centers." Certification is available only to stroke programs in Joint Commission–accredited acute care hospitals.

"We congratulate Trinity Health for their achievement as the 1000th Joint Commission–certified Primary Stroke Center in the country," says Jean Range, MS, RN, CPHQ, executive director, Disease-Specific Care Certification, The Joint Commission. "Trinity's Stroke Program will have an important impact on the quality of care for patients throughout their community. Today they join the ranks of Primary Stroke Centers throughout the United States with a strong commitment to saving patients from death or lifelong disability by meeting the highest standards for acute stroke care."


"We're very proud to have accomplished Joint Commission certification by providing this level of care for our stroke patients," says Maximo Kiok, MD, FAAN, neurologist and director of Trinity Health's stroke program. "At Trinity Health our practice is to pursue evidence-based medicine, which is proven to make a difference in the outcomes of

our patients." The 251-bed acute care, full-service hospital was reviewed in November 2012 by a Joint Commission stroke care expert for compliance with standards, clinical practice guidelines, and performance measurement activities.

Stroke programs that apply for advanced certification must meet the requirements for Joint Commission Disease-Specific Care Certification as well as additional clinically specific requirements and expectations. Primary Stroke Center Certification requirements include the following:

- Results of initial lab tests and diagnostic brain imaging within 45 minutes of order
- Capability to administer intravenous (IV) thrombolytic therapy within three hours of symptom onset
- A designated stroke unit
- A Primary Stroke Center medical director
- At least one public educational activity on stroke per year

Currently, 15 states require or recognize The Joint Commission and the American Heart Association/American Stroke Association's Primary Stroke Center Certification for designation as a Primary Stroke Center. These include Delaware, Florida, Georgia, Illinois, Maryland, Missouri, New Mexico, North Dakota, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Texas, Virginia, and Washington.

For more information about Advanced Certification for Primary Stroke Centers or core Disease-Specific Care Certification, please contact dscinfo@jointcommission.org or 630-792-5291. 


New Speak Up Campaign for Palliative Care

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medical director, Division of Healthcare Improvement, The Joint Commission. "By considering the option of palliative care, these patients and their families may find that palliative care is a way to prevent or relieve suffering."

Developed in collaboration with the American Academy of Hospice and Palliative Medicine, the Association of Professional Chaplains, the Center to Advance Palliative Care, the Hospice and Palliative Nurses Association, the Lance Armstrong Foundation, the National Association of Social Workers, and the National Hospice and Palliative Care

Organization, the new palliative care education campaign is part of The Joint Commission's award-winning Speak Up program. The program, which urges people to take an active role in their own health care, has grown to include seven animated videos and 13 posters since its launch in 2002.

Free downloadable files of all Speak Up media are available on The Joint Commission website at <http://www.jointcommission.org/speakup.aspx>. Select brochures and posters also are available for purchase through Joint Commission Resources at <http://store.jcrinc.com> or 877-223-6866. 

Clarifications and Expectations

Risk Assessment Process

A Seven-Step Approach

The Joint Commission has identified the need to increase the field's awareness and understanding of the Life Safety Code®. To address this need, The Joint Commission Perspectives® publishes the column Clarifications and Expectations, authored by George Mills, MBA, FASHE, CEM, CHFM, CHSP, director, Department of Engineering, The Joint Commission. This column clarifies standards expectations and provides strategies for challenging compliance issues, primarily in life safety and the environment of care, but also in the vital area of emergency management. You may wish to share the ideas and strategies in this column with your facility's leadership.*

The health care environment is fraught with risks. Specific actions, decisions, processes, projects, and hazards can all pose potential threats to staff, patient, and visitor safety. An organization should have a defined process for assessing environmental risks and deciding whether to accept, mitigate, or avoid them. This is particularly beneficial in situations in which there are “gray areas”—that is, no definitive right or wrong answers. For example, if your organization is trying to decide whether to store sharps containers next to the patient bedside in the intensive care unit, you should have a defined process for examining the risks involved with this activity, the potential consequences of those risks, whether there are any mitigating factors, and whether you need to put safeguards in place to prevent or lessen the effects of the identified risks.

A Sample Risk Assessment Process

Although The Joint Commission requires organizations to regularly assess and respond to risks throughout the environment, it is not prescriptive as to exactly what the risk assessment process must involve. Your organization will need to develop an approach that is appropriate for its size, scope, and patient population. To get started, consider the following seven-step approach:

* Life Safety Code® is a registered trademark of the National Fire Protection Association, Quincy, MA.

An organization should have a defined process for assessing environmental risks and deciding whether to accept, mitigate, or avoid them.

- **Step 1: Identify the issue(s).** This basically means that you need to clearly define the issue under study. Try to avoid combining several issues in a risk assessment, or the process could become complicated and confusing. Try to frame the issue as a yes/no question. For example, “Can we have exposed plumbing in a behavioral health unit?”
- **Step 2: Develop arguments that support the proposed process or issue.** When the issue is clearly defined, create a list of advantages or reasons that support the issue. Things to consider may include the impact on patient care delivery, staff, the work environment, visitors, public safety, finances, and so on.
- **Step 3: Develop arguments that disagree with the proposed process or issue.** These may be perceived concerns or situations that may pose a potential risk or that may impact a situation negatively. As part of this step, you should consider asking questions similar to those used in the previous step.
- **Step 4: Evaluate both arguments.** The evaluation should be impartial and should involve all the stakeholders affected by the decision.
- **Step 5: Reach a conclusion.** Make a decision to accept the risk or to take steps to mitigate or avoid the risk. After making a decision, you might want to submit a report of the risk assessment to the safety committee or performance improvement committee to ensure organizational consensus regarding the issue's resolution.

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Risk Assessment Process


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- **Step 6: Document the process.** The report mentioned in Step 5 (to the safety committee or a performance improvement committee) could serve as appropriate documentation, as could a discussion of the issue in the minutes of multidisciplinary committee meetings. Don't forget to update any relevant policies at this step!
- **Step 7: Monitor and reassess the conclusion.** Define a monitoring strategy up front. This should include a specific date or time frame in which to reassess the issue and resulting conclusion. If the reassessment determines that a different decision should have been made, submit the issue to the multidisciplinary committee for review. However, if

the evaluation confirms the conclusion, then document the confirmation and decide whether further monitoring is necessary.

A Few Examples

The following flowcharts map out the risk assessment process described here using real-world examples.

This month's column discusses an approach to risk assessment in the provision of safe health care. Next month's column will continue to focus on maintaining various life safety features by discussing the prevention of surgical fires. 

Example 1—Exposed Plumbing in a Behavioral Health Unit

Step 1: The issue: Can we have exposed plumbing in a behavioral health unit?



Step 2: Arguments supporting "yes"

- Maintains a standardized look for all patient rooms
- Have no history of adverse events associated with exposed plumbing
- Have clinical interventions in place to prevent patient self-harm even with pipes present
- Could have designated "high-risk" rooms that don't have exposed plumbing
- As treatment progresses, patients could move from a high-risk room to a low-risk room.



Step 3: Arguments supporting "no"

- Exposed plumbing presents opportunities for patient self-harm.
- What if a clinical intervention fails? How do we prevent patient harm then?

Step 4: Evaluation

- Include all stakeholders: unit physicians and nursing staff, risk management, facilities, and administration.



Step 5: Conclusion

- Decide whether to allow exposed pipes in behavioral health care unit.



Step 6: Documentation

- Update relevant policy with information based on the decision.
- Share the decision with the safety committee.



Step 7: Monitoring and reassessment

- Revisit the topic in three months.
- If decision is valid, revisit annually.

Example 2—Under-Sink Storage

Step 1: The issue: Can we store items under the sink in patient care areas?



Step 2: Arguments supporting “yes”

- Easy access to needed supplies
- Less crowding in other storage areas
- Glass, plastic, and non-patient care items would have minimal infection control (IC) risk.
- Could be appropriate for flower vases, watering cans, holiday decorations, and so on.



Step 3: Arguments supporting “no”

- Leaking faucets could damage items.
- Water presents IC risk, particularly for paper items.
- Conditions optimal for mold growth
- Contaminated patient care items could pose serious risk to patients.

Step 4: Evaluation

- Include all stakeholders: infection control, facilities, administration, and nursing.



Step 5: Conclusion

- Decide whether to allow storage under sinks in patient care areas.



Step 6: Documentation

- Update relevant policy.
- Share decision with safety committee.



Step 7: Monitoring and reassessment

- Revisit the topic in three months.
- If decision is valid, revisit annually.

Example 3—Cardboard Shipping Boxes in Central Supply

Step 1: The issue: Can we bring cardboard shipping boxes into central supply?



Step 2: Arguments supporting “yes”

- Unpacking external boxes in loading area minimizes risk.
- Internal storage boxes are designed for easy supply access.
- Avoid having to purchase separate supply containers
- Less labor involved in storing supplies



Step 3: Arguments supporting “no”

- Elements can damage external boxes.
- Wet boxes present IC risk.
- Bugs and other contamination sources represent risk.

Step 4: Evaluation

- Include all stakeholders: facilities, materials management, operating room manager, infection control, and administration.



Step 5: Conclusion

- Decide whether to allow cardboard shipping boxes in central supply.



Step 6: Documentation

- Update relevant policy.
- Share decision with safety committee.



Step 7: Monitoring and reassessment

- Revisit the topic in three months.
- If decision is valid, revisit annually.

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Superior Fulfillment
131 W. First St.
Duluth, MN 55802-2065
800-746-6578



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