

Poor communication and system errors are major causes of preventable medical error.



Most Frequently Identified Root Causes of Sentinel Events Reviewed by The Joint Commission by Year

The majority of events have multiple root causes (Please refer to subcategories listed on slides 5-7)

2011 (N=1243)		2012 (N=901)		2013 (N=887)	
Human Factors	899	Human Factors	614	Human Factors	635
Leadership	815	Leadership	557	Communication	563
Communication	760	Communication	532	Leadership	547
Assessment	689	Assessment	482	Assessment	505
Physical Environment	309	Information Management	203	Information Management	155
Information Management	233	Physical Environment	150	Physical Environment	138
Operative Care	207	Continuum of Care	95	Care Planning	103
Care Planning	144	Operative Care	93	Continuum of Care	97
Continuum of Care	137	Medication Use	91	Medication Use	77
Medication Use	97	Care Planning	81	Operative Care	76

67% of adverse events



The reporting of most sentinel events to The Joint Commission is voluntary and represents only a small proportion of actual events. Therefore, these root cause data are not an epidemiologic data set and no conclusions should be drawn about the actual relative frequency of root causes or trends in root causes over time.

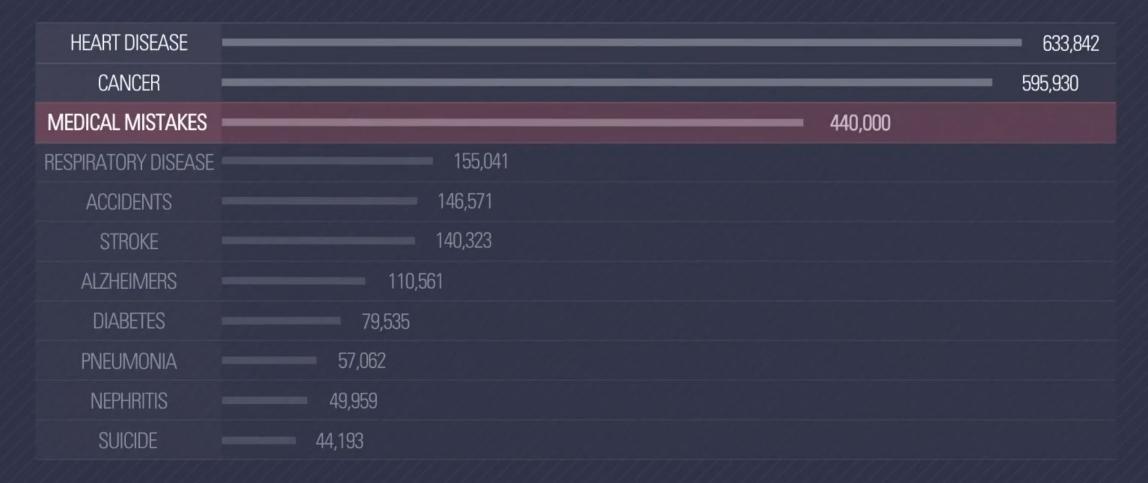
Office of Quality Monitoring - 8







LEADING CAUSES OF DEATH





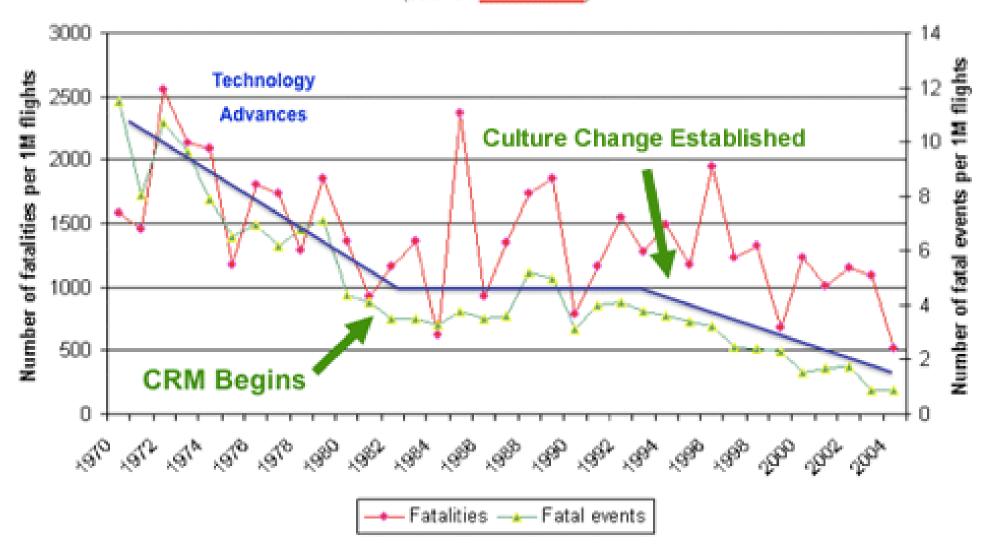




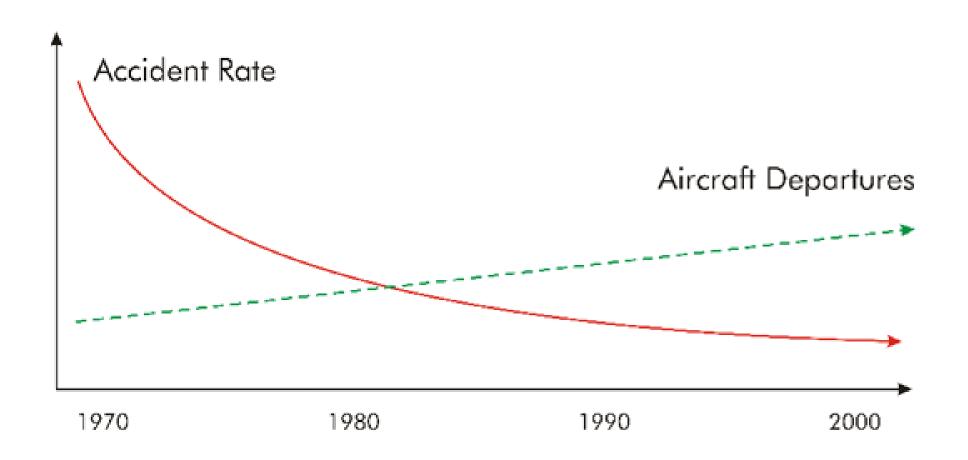


Results of CRM in Aviation

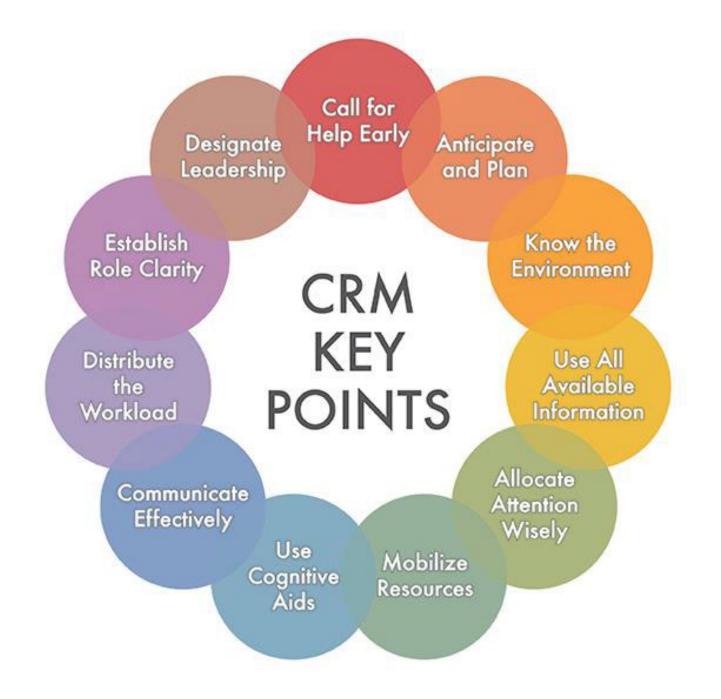
(Data from airdisaster.com)







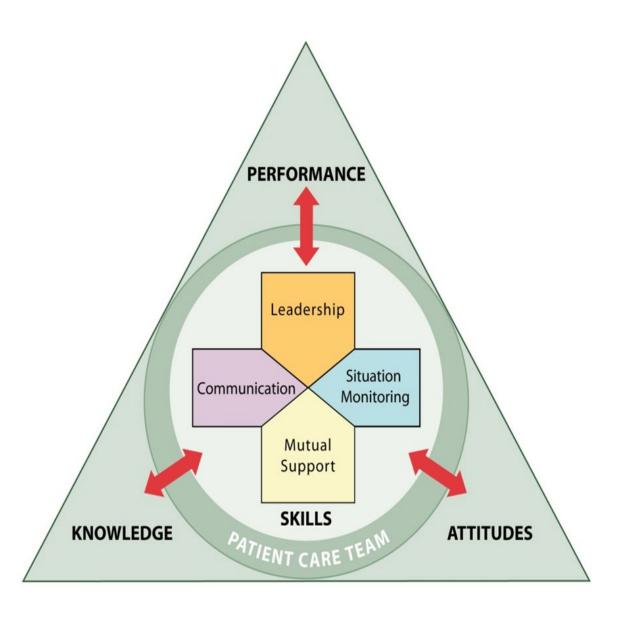






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