Sentinel Event Policy (SE)

Careful identification, investigation, and analysis of patient safety events*, as well as strong corrective actions that provide effective and sustained system improvement, is essential to reduce risk and prevent patient or resident harm. The Sentinel Event Policy explains how The Joint Commission partners with health care organizations that have experienced a serious patient safety event to protect future patients, improve systems, and prevent further harm.

Although organizations are not required to report sentinel events to The Joint Commission, accredited organizations must have a policy detailing how the organization addresses sentinel events. The specific requirements of that policy are included in the "Leadership" (LD) and "Performance Improvement" (PI) chapters on E-dition® or in the hard-copy Comprehensive Accreditation Manual. The organization must complete a thorough, comprehensive, systematic analysis (most commonly a root cause analysis) to determine why the event occurred. The organization must then create a corrective action plan to prevent similar events from happening again, implement the plan, and monitor its effectiveness.

All accredited organizations are encouraged to self-report potential sentinel events to The Joint Commission to allow collaboration with the Office of Quality and Patient Safety (OQPS). Timely reporting will promote early engagement with a patient safety specialist assigned to work with your organization.

Contacting The Joint Commission following a sentinel event allows the health care organization to avail itself of the wealth of expertise and experience of its staff. Joint Commission patient safety specialists can help analyze root causes, redesign processes, and monitor performance improvement practices and other aspects of the

*In the term patient safety event, the word "patient" corresponds to "patient or resident" in the Nursing Care Center setting.

event statistics become. The Joint Commission's sentinel event data identify not only the relative frequency of different categories of sentinel events reported each year, they also provide information on trends in the occurrence of the most reported sentinel event categories.

Goals of the Sentinel Event Policy

The Joint Commission adopted a formal Sentinel Event Policy in 1996 to help hospitals that experience serious adverse events improve safety and learn from those sentinel events. The Joint Commission's Sentinel Event Policy has the following four goals:

1. To positively impact care, treatment, and services by helping health care organizations identify opportunities to change their culture, systems, and processes to prevent unintended harm
2. To help health care organizations that have experienced a sentinel event determine and understand contributing factors (including underlying causes, latent conditions, and active failures) and develop strategies to prevent or reduce such events in the future
3. To increase the health care organization's resilience by becoming a learning organization
4. To maintain the confidence of the public, clinicians, and health care organizations in the priority of patient and resident safety in Joint Commission–accredited health care organizations

Identifying Sentinel Events

Sentinel events are a subcategory of adverse events. A sentinel event is a patient safety event (not primarily related to the natural course of a patient's or resident's illness or underlying condition) that reaches a patient or resident and results in death, severe harm (regardless of duration of harm), or permanent harm (regardless of severity of harm).

Sentinel events are not only events that occur during the care and treatment of individuals. Physical and verbal violence, abductions, and power failures are all potential sentinel events that can affect the health care organization and its patients or residents. The Joint Commission considers the following list of events, though not comprehen-

sive, to be sentinel events if they occur under any Joint Commission–accredited health care organization, although some of these events are unlikely to occur in certain health care settings:[†]

- Death caused by self-inflicted injurious behavior if any of the following apply:
  - While in a health care setting
  - Within 7 days of discharge from inpatient services
  - Within 7 days of discharge from emergency department (ED)
  - While receiving or within 7 days of discharge from the following behavioral health care services: Day Treatment/Partial Hospitalization Program (PHP)/Intensive Outpatient Program (IOP), Residential, Group Home, and Transitional Supportive Living
- Unanticipated death of a full-term infant
- Homicide of any patient or resident receiving care, treatment, and services while on site at the organization or while under the care or supervision of the organization
- Homicide of a staff member, visitor, or vendor while on site at the organization or while providing care or supervision to patients or residents
- Any intrapartum maternal death
- *Severe maternal morbidity* (leading to *permanent harm* or *severe harm*)[‡]
- *Sexual abuse/assault* of any patient or resident receiving care, treatment, and services while on site at the organization or while under the care or supervision of the organization
- Sexual abuse/assault of a staff member, visitor, or vendor while on site at the organization or while providing care or supervision to patients or residents
- Physical assault (leading to death, permanent harm, or severe harm) of any patient or resident receiving care, treatment, and services while on site at the organization or while under the care or supervision of the organization
- Physical assault (leading to death, permanent harm, or severe harm) of a staff member, visitor, or vendor while on site at the organization or while providing care or supervision to patients or residents

[†] Throughout this section, terms that are shown in *boldface and italics* are defined in the "Key Terms" sidebar.

[‡] Ongoing vigilance to better identify patients at risk for severe maternal morbidity—and timely implementation of clinical interventions consistent with evidence-based guidelines—are important steps in the ongoing provision of safe and reliable care. Appropriate system improvements can be informed by identifying occurrences of maternal morbidity, reviewing the cases, and analyzing the findings.

Surgery or other *invasive procedure* performed at the wrong site, on the wrong patient, or that is the wrong (unintended) procedure for a patient regardless of the type of procedure or the magnitude of the outcome

Discharge of an infant to the wrong family

Abduction of any patient or resident receiving care, treatment, and services

Any elopement (that is, unauthorized departure) of a patient or resident from a staffed around-the-clock care setting (including the ED), leading to death, permanent harm, or severe harm to the patient or resident

Administration of blood or blood products having unintended ABO and non-ABO (Rh, Duffy, Kell, Lewis, and other clinically important blood groups) incompatibilities,[§] hemolytic transfusion reactions, or transfusions resulting in death, permanent harm, or severe harm[‖]

Unintended retention of a foreign object in a patient after an invasive procedure, including surgery[#]

Severe neonatal hyperbilirubinemia (bilirubin >30 milligrams/deciliter)

Fluoroscopy resulting in permanent tissue injury when clinical and technical optimization were not implemented and/or recognized practice parameters were not followed[**]

[§] If a clinical determination warrants the use of Rho(D) positive blood to a Rho(D) negative recipient or uncrossmatched blood for emergent or life-saving interventions, it would not be considered a reviewable sentinel event.

[‖] Administration of blood or blood products where safety, potency, or purity has been compromised while the blood product in question was in the laboratory's control would be considered a sentinel event. Source: Food and Drug Administration, Center for Biologics Evaluation and Research. 21 CFR 606.171.

[#] The time period after an invasive procedure encompasses any time after the completion of final skin closure, even if the patient is still in the procedural area or in the operating room under anesthesia. A failure to identify and correct an unintended retention of a foreign object prior to that point in the procedure represents a system failure, which requires analysis and redesign. It also places the patient at additional risk by extending the surgical procedure and time under anesthesia. If a foreign object (for example, needle tip or screw) is left in the patient because of a clinical determination that the relative risk to the patient of searching for and removing the object exceeds the benefit of removal, this would not be considered a reviewable sentinel event. However, in such cases, the organization shall (1) disclose to the patient the unintended retention and (2) keep a record of the retentions to identify trends and patterns (for example, by type of procedure, by type of retained item, by manufacturer, by practitioner) that may identify opportunities for improvement.

[**] Source: Adapted from National Council on Radiation Protection and Measurements (NCRP): Outline of Administrative Policies for Quality Assurance and Peer Review of Tissue Reactions Associated with Fluoroscopically-Guided Interventions (https://ncrponline.org/wp-content/themes/ncrp/PDFs/Statement_11.pdf) and the US Food and Drug Administration (FDA). Accessed Jan 11, 2024

Any delivery of radiotherapy to the wrong patient or resident, wrong body region, unintended procedure, or >25% above the planned radiotherapy dose

Fire, flame, or unanticipated smoke, heat, or flashes occurring during direct patient or resident care caused by equipment operated and used by the organization. To be considered a sentinel event, equipment must be in use at the time of the event; staff do not need to be present.

Fall in a staffed-around-the-clock care setting or fall in a care setting not staffed around the clock during a time when staff are present resulting in any of the following:

- Any fracture
- Surgery, casting, or traction
- Required consult/management out of comfort care for a neurological (for example, skull fracture, subdural or intracranial hemorrhage) or internal (for example, rib fracture, small liver laceration) injury
- A patient or resident with coagulopathy who receives blood products as a result of the fall
- Death or permanent harm as a result of injuries sustained from the fall (not from physiologic events causing the fall)

The sidebar "Key Terms" provides definitions to help health care organizations navigate the requirements of this policy.

Sidebar 1. Key Terms

fire A rapid oxidation process, which is a chemical reaction resulting in the evolution of light and heat in varying intensities. *Source*: National Fire Protection Association. NFPA 901: Standard Classifications for Incident Reporting and Fire Protection Data. Quincy, MA: NFPA, 2016.

invasive procedure A procedure in which skin or mucous membranes and/or connective tissue are incised or punctured, an instrument is introduced through a natural body orifice, or foreign material is inserted into the body for diagnostic or treatment-related purposes. Examples of invasive procedures include central line and chest tube insertions, biopsies and excisions, and all percutaneous procedures (for example, cardiac, electrophysiology, interventional radiology). Exclusions include venipuncture, which is defined as a collection of blood from a vein. Note: *This*

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Sidebar 1. *(continued)*

permanent harm An event or condition that reaches the individual, resulting in any level of harm that permanently alters and/or affects an individual's baseline health.

severe harm An event or condition that reaches the individual, resulting in life-threatening bodily injury (including pain or disfigurement) that interferes with or results in loss of functional ability or quality of life that requires continuous physiological monitoring and/or surgery, invasive procedure, or treatment to resolve the condition.

severe maternal morbidity A patient safety event that occurs from the intrapartum through the immediate postpartum period (24 hours), requiring the transfusion of 4 or more units of packed red blood cells (PRBC) and/or admission to the intensive care unit (ICU). *Admission to the ICU* is defined as admission to a unit that provides 24-hour medical supervision and can provide mechanical ventilation or continuous vasoactive drug support. *Sources*: American College of Obstetrics and Gynecology, the US Centers for Disease Control and Prevention, and the Society of Maternal-Fetal Medicine.

sexual abuse/assault Nonconsensual sexual 27.30Td0.5f100Tz2

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Sidebar 1. ***(continued)***

suspected by staff. Any forced, coerced, or extorted sexual activity with an individual, regardless of the existence of a preexisting or current sexual relationship, is considered to be sexual abuse.

Organizations are required to conduct an investigation and protect an individual(s) from nonconsensual sexual relations anytime the organization has reason to suspect that the individual(s) does not wish to engage in sexual activity or may not have the

that

- Completion of a comprehensive, systematic analysis for identifying the causal and contributory factors
- Strong, corrective actions derived from the identified causal and contributing factors that eliminate or control system hazards or vulnerabilities and result in sustainable improvement over time
- Timeline for implementation of corrective actions
- Systemic improvement with measurable outcomes

Determining That a Sentinel Event Is Subject to Review

To determine if an event is sentinel, the organization must electronically submit a self-report (see the "Reporting a Sentinel Event to The Joint Commission" section). Based on available information received about the event, a patient safety specialist from OQPS will determine whether an event meets the definition of sentinel event (as described in the "Identifying Sentinel Events" section). Any discrepancy in this determination will be resolved through discussions between Joint Commission leadership and the organization's leadership.

Relationship to the Survey Process

When conducting an unannounced accreditation survey, the surveyor(s) evaluates the health care organization's compliance with the applicable standards, National Patient Safety Goals, and Accreditation Participation Requirements. Surveyors are instructed not to search for or investigate sentinel events during an accreditation survey, or to inquire about sentinel events that have been reported to The Joint Commission.

During the survey, the surveyor(s) will assess the organization's compliance with sentinel event–related standards (see Standard LD.03.09.01) and performance improvement standards in the following ways:

- Assess an organization's performance improvement practices, such as its processes for responding to safety events, adverse events, hazardous unsafe conditions, close calls, and sentinel events
- Review the health care organization's process for responding to a sentinel event
- Interview the organization's leaders and staff about their expectations and responsibilities for identifying, reporting on, and responding to sentinel events

If a potential serious patient safety event is newly identified during survey activities, the surveyor will take the following steps:

- Inform the organization's CEO that the event has been identified
- Inform the CEO the event will be reported to The Joint Commission for further review and follow-up under the provisions of the Sentinel Event Policy

The surveyor makes no determination of whether the event is a sentinel event and does not focus on or investigate the event further, nor are they authorized to review comprehensive systematic analysis documents and determine credibility, thoroughness, or acceptability. However, the surveyor may identify a Recommendation for Improvement if the organization has not completed a comprehensive systematic analysis of the event (including a corrective action plan) within 45 days of the event.

After the completion of on-site survey activities, once received by OQPS, a patient safety specialist will contact the organization to explore the event and determine whether The Joint Commission requires submission of a comprehensive systematic analysis. If so, the organization will follow the steps described in the "Required Organization Response to a Sentinel Event" section.

Required Organization Response to a Sentinel Event

All sentinel events must undergo a comprehensive systematic analysis by the health care organization, regardless of whether the events are reported to The Joint Commission. If a reported sentinel event is determined to meet the criteria of this policy in a Joint Commission–accredited organization, the health care organization is expected to do the following:

- Prepare a thorough and credible comprehensive systematic analysis and corrective action plan within 45 business days of the event or of becoming aware of the event.
- Submit its comprehensive systematic analysis and corrective action plan to The Joint Commission, or otherwise provide its response to the sentinel event using an approved methodology within 45 business days of the known occurrence of the event for Joint Commission evaluation. Joint Commission OQPS staff will conduct a collaborative review with the organization's leadership or designee to determine whether the analysis and action plan are acceptable. The alternative approaches to this review appear in the "Submitting the Comprehensive Systematic Analysis and Corrective Action Plan" section.

The fact that a health care organization has experienced a sentinel event will not impact its accreditation decision. However, willful failure to respond appropriately to the sentinel event could have such an impact. For instance, if the health care organization fails to submit a comprehensive systematic analysis within an additional 45 days following its due date, its accreditation decision may be impacted. In these instances, patient safety specialists in OQPS, along with OQPS leadership, would recommend to the executive leadership of The Joint Commission and the accreditation council to revise the health care organization's accreditation status.

Figure 1 provides a general timeline for the overall process.

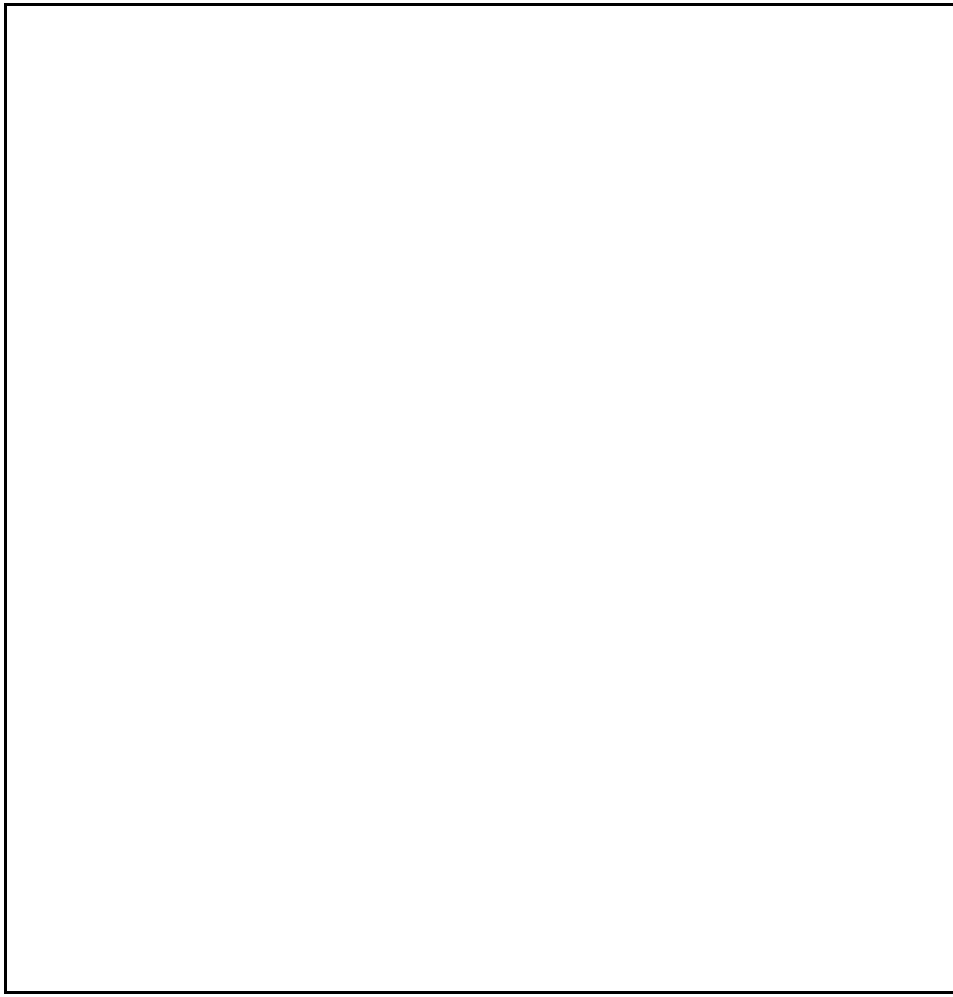

Figure 1. This general timeline provides an overview of the sentinel event response process.

Reporting a Sentinel Event to The Joint Commission

Each health care organization is strongly encouraged, but not required, to report to The Joint Commission any patient,

any

formulating a corrective action plan, the review team should analyze the strength of its proposed solutions. An evidence-based tool, such as the VA's National Center for Patient Safety's action hierarchy,[lll] can help the team identify strong actions that provide effective and sustained system improvement.

The organization should identify at least one intermediate or stronger action (as defined in the action hierarchy) to eliminate or mitigate system hazards or vulnerabilities identified in the comprehensive systematic analysis. The corrective action plan must address the following:

The plan

[lll] US Department of Veterans Affairs National Center for Patient Safety 2021 Guide to Performing a Root Cause Analysis Figure 7. Action Hierarchy, pages 22–23. https://www.patientsafety.va.gov/docs/RCA-Guidebook_02052021.pdf Accessed Jan 11, 2024

[mm] National Patient Safety Foundation RCA2: Improving Root Cause Analyses and Actions to Prevent Harm. Boston: National Patient Safety Foundation; 2015. Available with a membership at https://ihi.org or at https://www.ashp.org/-/media/assets/policy-guidelines/docs/endorsed-documents/endorsed-documents-improving-root-cause-analyses-actions-prevent-harm.ashx Accessed Jan 11, 2024

and health care organization staff. These documents should not include the names of organization staff, patients, or residents involved in the sentinel event or other protected personal health information (PHI).

If the health care organization has concerns about sending the comprehensive systematic analysis and supporting documents to The Joint Commission, it has several options for a Joint Commission review of its response to the sentinel event. The Joint Commission has four alternative approaches to a review of the organization's response to the sentinel event, as shown in Table 1.

Table 1. Options for a Joint Commission Review of an Organization's Response to a Sentinel Event

OPTION	DESCRIPTION	LOCATION OF REVIEW
Alternative 0	The organization submits its comprehensive systematic analysis and corrective action plan documents through the organization's secure *Joint Commission Connect* extranet site.	Scheduled conference call
Alternative 1	A review of the comprehensive systematic analysis and corrective action plan documents brought by the health care organization's staff to Joint Commission headquarters, which are then returned to the health care organization on the same day.	The Joint Commission headquarters or web conference alternative
Alternative 2	A review of the comprehensive systematic analysis and corrective action plan documents by a Joint Commission patient safety specialist at the health care organization.	Health care organization or web conference alternative
Alternative 3	A review of the organization's sentinel event response process and corrective action plan by a Joint Commission patient safety specialist at the health care organization. The patient safety specialist may ask questions regarding the comprehensive systematic analysis but will not review the document itself. The patient safety specialist will,	

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The Joint Commission's Response

Patient safety specialists from The Joint Commission assess the health care organization's response to the sentinel event against three criteria:

1. Thoroughness of the comprehensive systematic analysis
2. Credibility of the comprehensive systematic analysis
3. Acceptability of the organization's corrective action plan

A Joint Commission patient safety specialist will provide consultation to the health care organization if the response is unacceptable and will allow an additional 15 business days beyond the original submission period for the organization to resubmit its response, including revised corrective actions if necessary. If the response is still unacceptable, the health care organization's accreditation decision may be impacted.

Review of Comprehensive Systematic Analyses and Corrective Action Plans

Joint Commission patient safety specialists review the comprehensive systematic analysis and corrective action plans for thoroughness, credibility, and acceptability.

To be thorough, the analysis must do the following:

Repeatedly ask "Why?" i 10.5 0 rg 1cd.is

assign an appropriate follow-up activity. This will be a mutually agreed-upon documentation of sustained improvement and reduction of risk, which may include one or more measures of success (MOS) or a review

Disclosable Information

If The Joint Commission receives an inquiry about the accreditation decision of a health care organization that has experienced a sentinel event, the organization's current accreditation status will be reported in the usual manner, without making reference to the sentinel event. If the inquirer specifically references the particular

Overseeing the Sentinel Event Policy

The executive leadership of The Joint Commission is responsible for approval of this policy and overseeing its implementation.

For more information about the Joint Commission's Sentinel Event Policy, visit the Joint Commission's website at https://www.jointcommission.org/resources/patient-safety-topics/sentinel-event/sentinel-event-policy-and-procedures/.