Sentinel Event Policy (SE)

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essentialto reduceriskandpreventpatientharm.TheSentinelEventPolicyexplains howTheJointCommissionpartnerswithhealthcareorganizationsthathave experiencedaseriouspatientsafetyeventto protectfuturepatients,improvesystems, andpreventfurtherharm.

Although organizationsarenot required to reportsentinelevents to The Joint Commission,accreditedorganizationsmusthaveapolicydetailinghowtheorganization addressessentinelevents.Thespecificrequirementsof that policyareincludedin the "Leadership(LD) and"PerformanceImprovement"(PI) chapterson E-dition® Critical AccessHospital.Theorganizationmustcompleteathoroughcomprehensivesystematic analysis(mostcommonlyarootcauseanalysis)to determinewhy the eventoccurred. The organizationmustthencreateacorrectiveactionplantopreventsimilarevents from happeningagain,implementtheplan,andmonitoritseffectiveness.

All accreditedorganizationsareencouragedto self-reportpotentialsentinelevents to The Joint Commissionto allowcollaborationwith the Office of Quality and Patient Safety(OQPS).Timelyreportingwill promoteearlyengagementwith a patientsafety specialistassignedto workwith your organization.

ContactingTheJointCommissionfollowingasentinelevent allowsthehealthcare organizationto availitselfof the wealthof expertiseandexperienceof its staff.Joint Commissionpatientsafetyspecialistscanhelpanalyzerootcauses,redesignprocesses, andmonitorperformanceimprovementpracticesandotheraspectsof the sentinelevent process.

Self-reportingreinforcestheorganization'smessageto the publicthatit is doing everythingit canto preventa recurrence.Sharinginformation,particularlylessons learnedwith TheJointCommissionenhancesTheJointCommission'sSentinelEvent Database,whichmayhelpotherorganizationspreventsimilarevents.Themore organizationsreporttheirown sentinelevents,thebetterandmoremeaningfulsentinel eventstatisticsbecome.TheJointCommissionsentinelevent dataidentifynot only the

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

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§ 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, a 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)

Shading indicates a change effective July 1, 2024, unless otherwise noted in the What's New.

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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 or 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 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 co

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

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 contact of any type with an individual. Sexual abuse includes, but is not limited to, the following:

- Unwanted intimate touching of any kind, especially of the breasts, buttocks, or perineal area
- All types of sexual assault or battery, such as rape, sodomy, and coerced nudity (partial or complete)
- Forced observation of masturbation and/or sexually explicit images, including pornography, texts, or social media
- Taking sexually explicit photographs and/or audio/video recordings of an individual and maintaining and/or distributing them (for examplecbpt1.6r (examplecTj 45.45.4 40.36

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

Note 1: Reference for the above is the CMS State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities.

Note 2: The first appearance of the terms in this sidebar are shown in ***boldface and italics*** in the "Identifying Sentinel Events" section.

References

1. CMS State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf
2. Title 42 Chapter IV Subchapter G Part 483 Subpart B - Requirements for Long Term Care Facilities. https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-B

In cases in which the health care organization is uncertain an event meets The Joint Commission's definition of a sentinel event, the event will be presumed to be a patient safety event, requiring comprehensive analysis. In the spirit of collaboration and shared learning, it is requested that this analysis be shared with OQPS.

All sentinel events must be reviewed by the health care organization and are subject to review by The Joint Commission. Accredited health care organizations are expected to identify and respond appropriately to all sentinel events (as defined by The Joint Commission) occurring in the health care organization or associated with services that the organization provides. An appropriate response includes all of the following:

- A formalized team response that stabilizes the patient, discloses the event to the patient and family, and provides support for the family as well as staff involved in the event
- Notification of organization leadership
- Immediate investigation
- 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
- System improvement with measurable outcomes

Figure 1 provides a general timeline for the overall process.

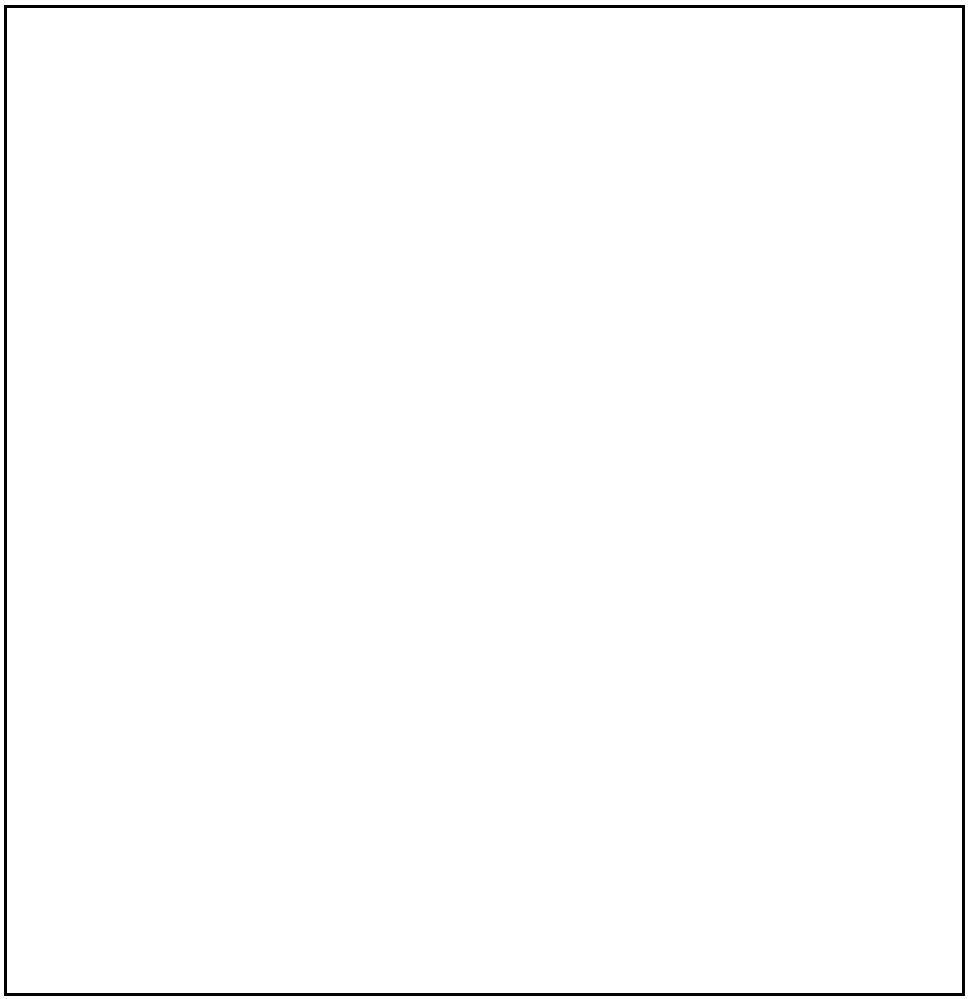

Figure 1. *This general timeline provides an overview of the sentinel event response process.*

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 safety event that meets the Joint Commission definition of *sentinel event*. In fact, a vast majority of sentinel events reported to The Joint

Commissionare self-reportedby healthcareorganizationsthat recognizethe valueof workingwith OQPSstaff.A healthcareorganizationbenefitsfrom self-reportingin the followingways:

- Gettingsupportandexpertiseduringthereviewof a sentinelevent
- Providingthehealthcareorganizationan opportunityto collaboratewith a patient safetyspecialistwho maintainsthefollowingqualifications:
  - Masters-preparedclinicianor human

Joint Commission staff use the analysis, which focuses on systems and processes, to review the organization's analysis and verify it is thorough and credible (*see* the "Review of Comprehensive Systematic Analyses and Corrective Action Plans" section). The organization's selected comprehensive systematic analysis method should address the questions from The Joint Commission's Framework for Root Cause Analysis and Corrective Actions.

[**] The Joint Commission Framework for Root Cause Analysis and Corrective Actions. https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/sentinel-event/rca_framework_101017.pdf Accessed Jan 11, 2024

[††] 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

[‡‡] Department of Veterans Affairs, Veterans Health Administration. VHA Patient Safety Improvement Handbook 1050.01 Mar 4, 2011. https://www.va.gov/VHApublications/ViewPublication.asp?pub_ID=10209 Accessed Jan 11, 2024

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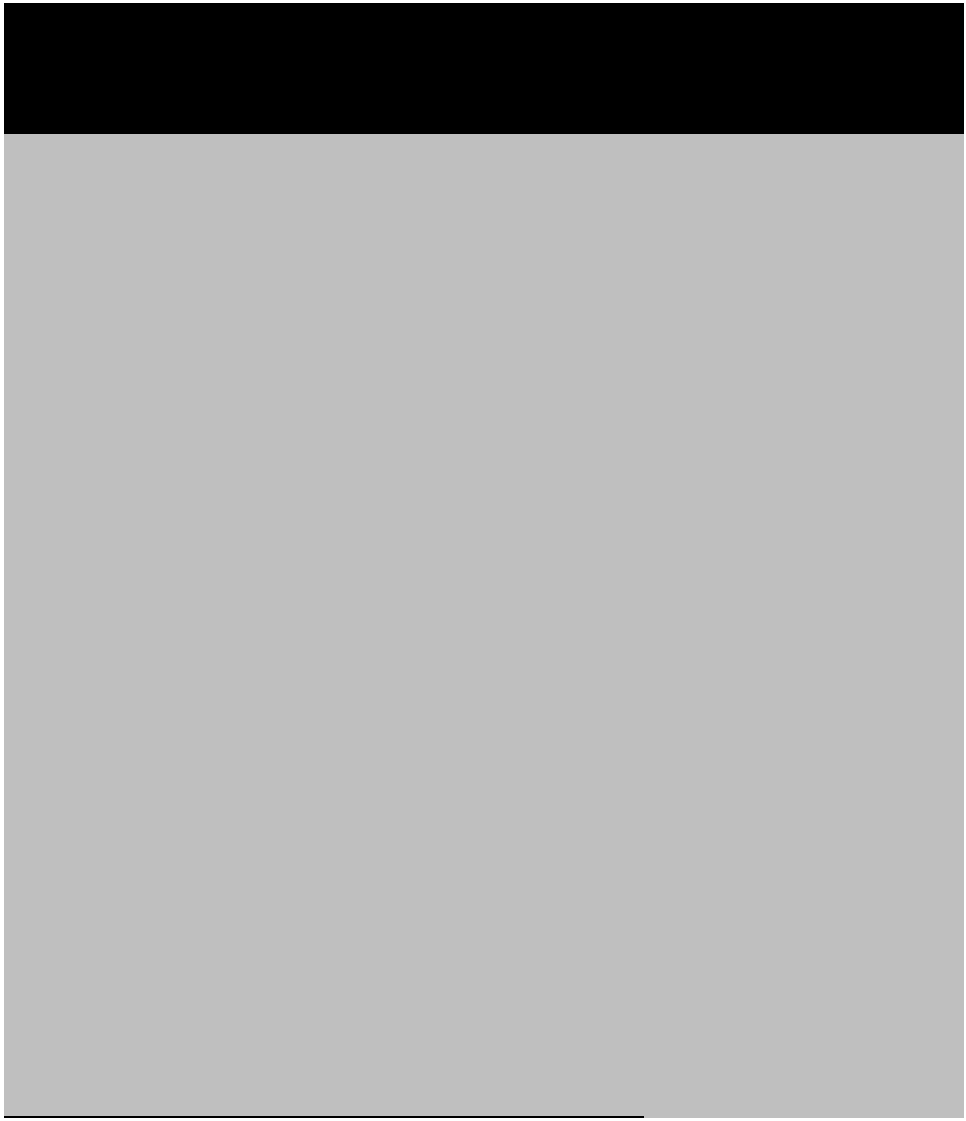

Table 1. ***(continued)***

OPTION	DESCRIPTION	LOCATION OF REVIEW
Alternative 4	A survey of the health care organization by a specially trained Joint Commission surveyor limited to the following activities: a. Interviews and relevant documentation review (including, if applicable, the patient's medical record) to evaluate the following: • The process the organization uses to respond to sentinel events • The relevant policies and procedures preceding and following the health care organization's review of the specific event, sufficient to allow the surveyor to consider the adequacy of the health care organization's response to the sentinel event and its ability to provide safe care, treatment, or services b. Tracer activity on the health care organization's management functions relevant to the sentinel event and the care, treatment, or services under review	Health care organization

Alternatives 1, 2, and 3 can be performed via web-based video conferencing with a patient safety specialist who is located at The Joint Commission while the organization's participants remain at the organization's location (Web-Alternative). Or, the organization can choose to have a patient safety specialist visit the facility or send a representative to The Joint Commission. Alternative 4 is an on-site survey.

The Joint Commission must receive a request for review of an organization's response to a sentinel event using any of the alternative options within five business days of the self-report of a sentinel event.

Alternatives 1 to 4 will result in a fee to the health care organization to cover the average direct costs of the option. Fees can be located on the pricing page accessible from the organization's *Joint Commission Connect* extranet site.

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

Be complete (cover all causes and potential causes)
Be systematic (methodically conducted)
Possess depth (ask and answer all of the relevant "Why" questions and explain any "not applicable" finding)
Possess breadth of scope (cover all possible systemic factors wherever they occur)
Reflect diverse perspectives (include a process owner or designee, patient or family member when appropriate, and individuals close to the process under review)[##]

To be considered *acceptable*, the corrective action plan must do the following:

Identify changes that can be implemented to reduce risk, or formulate a rationale for not undertaking such changes
Identify, in situations in which improvement actions are planned, the following:
- Who (by title) is responsible for implementation
- When the action will be implemented (including any pilot testing)
- How the effectiveness of the actions will be evaluated
- How the actions will be sustained
- The point at which alternative actions will be considered if improvement targets are not met
- At least one stronger or intermediate-strength action

All comprehensive systematic analyses and corrective action plans will be considered and treated as confidential by The Joint Commission (*see* the "Handling Sentinel Event–Related Documents" section below).

If The Joint Commission finds the analysis and action plan thorough, credible, and acceptable, a patient safety specialist from The Joint Commission will notify the organization and assign one or more follow-up activities.

Follow-up Activities

After The Joint Commission has determined that a health care organization has conducted a thorough comprehensive systematic analysis (for example, root cause analysis) and developed a comprehensive corrective action plan, The Joint Commission will notify the organization whether the analysis and action plan are acceptable and will

[##] The Joint Commission does not require the active involvement of a senior leader in the day-to-day work of the comprehensive systematic analysis team. However, the team should report to the senior leader or designee, and the individual should be involved in deciding or approving the actions the organization will take as a result of the comprehensive systematic analysis.

assign an appropriate follow-up activity. This will be a mutually agreed-upon documentation of sustained improvement and reduction of wil4hy

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 sentinel event, The Joint Commission will acknowledge that it is aware of the event and currently is working or has worked with the organization through the sentinel event review process.

Handling Sentinel Event–Related Documents

The Joint Commission restricts access to any submitted comprehensive systematic analysis and corrective action plan to specially trained staff in accordance with procedures designed to protect the confidentiality of the documents.

The Joint Commission will retain any corrective action plan(s) resulting from the analysis of the sentinel event long enough to serve as the basis for appropriate follow-up activities, such as the SEMOS or other mutually agreed-upon documentation of sustained improvement. After the organization implements the corrective action plan and The Joint Commission verifies it meets the established levels of compliance, the information contained in any electronically submitted analysis will be de-identified after OQPS completes its review.

The Sentinel Event Database

The Joint Commission collects and analyzes aggregate data from the comprehensive systematic analyses, corrective action plans, and follow-up activities in its Sentinel Event Database. The Joint Commission develops and maintains the database in a manner that excludes organization, caregiver, and patient identifiers.

Aggregate data relating to root causes and risk reduction strategies for sentinel events that occur with significant frequency form the basis for future error-prevention advice to health care organizations through *Sentinel Event Alerts*, National Patient Safety Goals®, and other methods of information sharing. The information disseminated from the Sentinel Event Database of The Joint Commission can help an organization identify a problem or area for analysis. For example, organizations can learn about sentinel events that occur with significant frequency, their root causes, and possible risk reduction strategies through The Joint Commission's *Sentinel Event Alerts*.

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/.