Sentinel Event Policy
Expanded Beyond Patients

The Joint Commission defines sentinel event as “an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase ‘or the risk thereof’ includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.”

Since its inception in 1996, The Joint Commission’s Sentinel Event Policy has focused on unexpected death or injury only when a patient, resident, or individual receiving care, treatment, or services is the victim. However, The Joint Commission recently expanded its policy to include certain harm events to staff, visitors, or vendors that occur while they are on the premises of the health care organization. The expansion is effective July 1, 2013.

The subset of reviewable sentinel events includes any occurrence that has resulted in an unanticipated death or major permanent loss of function not related to the natural course of the individual’s illness or underlying condition. Examples of these events include a fall resulting in major permanent loss of function or a medication error that results in death.

Events reviewable under the Sentinel Event Policy also include the defined subset of occurrences (even when they do not result in serious injury or death) in the box on page 3. The additional, recently approved language is underlined.

Maintaining Security and Safety

Because an incident that occurs to a staff member, visitor, or vendor on the premises of a health care organization presents security and safety concerns for everyone (including patients/residents/individuals served), broadening the list of reviewable sentinel events promotes improved

Continued on page 3
security and safety throughout the overall environment. In addition, identifying such incidents as reviewable sentinel events requires an organization to conduct a root cause analysis and implement mitigating actions based upon the findings. Should The Joint Commission become aware of the occurrence, the health care organization must share the analysis, actions, and associated measurement activities with the Office of Quality Monitoring.

The principles of high reliability hold leadership accountable to be uncompromising in its commitment to a culture of safety within the organization. An organizational culture of safety would encompass all people within an organization and not just one group (that is, patients, residents, or individuals served). The revision to the Sentinel Event Policy supports this principle by not differentiating in its processes and by ensuring a robust review, regardless of who the victim is, of any sentinel event. As with all activity involved in root cause analyses, the aim is to learn as well as to improve.

For more information, please contact Anita Giuntoli, RN, BSN, MJ, director, Office of Quality Monitoring, The Joint Commission, at agiuntoli@jointcommission.org or 630-792-5867. 

---

**Reviewable Sentinel Events**

- Suicide of any patient/resident/individual served receiving care, treatment, and services in a staffed around-the-clock care setting or within 72 hours of discharge
- Unanticipated death of a full-term infant
- Abduction of any patient/resident/individual served receiving care, treatment, and services
- Discharge of an infant to the wrong family
- Sexual abuse/assault (including rape) [of any patient/resident/individual served receiving care, treatment, and services]
- Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities (ABO, Rh, other blood groups)
- Invasive procedure, including surgery, on the wrong patient, wrong site, or wrong procedure
- Unintended retention of a foreign object in a patient after surgery or other invasive procedures
- Severe neonatal hyperbilirubinemia (bilirubin >30 milligrams/deciliter)
- Prolonged fluoroscopy with cumulative dose >1,500 rads to a single field or any delivery of radiotherapy to the wrong body region or >25% above the planned radiotherapy dose
- Rape, assault (leading to death or permanent loss of function), or homicide of a staff member, licensed independent practitioner, visitor, or vendor while on site at the health care organization