

## Facts about the Sentinel Event Policy

In support of its mission to continuously improve health care provided to the public, The Joint Commission reviews organizations' activities in response to sentinel events. A sentinel event is any unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injuries specifically include a 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.

Each accredited organization is required to define 'sentinel event' for its own purposes in establishing mechanisms to identify, report and manage these events. At a minimum, an organization's definition must include those events that are subject to review under the Sentinel Event Policy.

When a sentinel event occurs, the accredited organization is expected to conduct a timely, thorough and credible root cause analysis; develop an action plan designed to implement improvements to reduce risk; implement the improvements; and monitor the effectiveness of those improvements. Standards that create explicit expectations regarding the internal identification and management of sentinel events are found in the Performance Improvement (PI) and Leadership (LD) chapters of all accreditation manuals.

### Reviewable sentinel events

The definition of a reviewable sentinel event takes into account a wide array of occurrences applicable to a variety of health care organizations. Not all of the following occurrences may apply to a particular setting. The subset of sentinel events that is subject to review by The Joint Commission includes any occurrences that meet any of the following criteria:

- The event has resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition, or
- The event is one of the following (even if the outcome was not death or major permanent loss of function):
  - Suicide of any individual receiving care, treatment or 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 individual receiving care, treatment or services
  - Discharge of an infant to the wrong family
  - Rape
  - Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities
  - Surgery on the wrong individual or wrong body part
  - Unintended retention of a foreign object in an individual after surgery or other procedure
  - Severe neonatal hyperbilirubinemia (bilirubin >30 milligrams/deciliter)
  - Prolonged fluoroscopy with cumulative dose >1500 rads to a single field, or any delivery of radiotherapy to the wrong body region or 25 percent above the planned radiotherapy dose

Each accredited health care organization is encouraged, but not required, to report to The Joint Commission any sentinel event meeting these criteria. The Joint Commission may become aware of a reviewable sentinel event by some other means, such as from a patient, family member, or an employee of the organization, or through the media.

### Reasons for reporting a sentinel event to The Joint Commission

Self-reporting a sentinel event is not required, and there is no difference in the expected response, time frames or review procedures, whether the organization voluntarily reports the event or The Joint Commission becomes aware of the event by some other means. However, there are several advantages to the organization that self-reports a sentinel event:

- Reporting the event enables the addition of the “lessons learned” from the event to be added to The Joint Commission’s Sentinel Event Database, thereby contributing to the general knowledge about sentinel events and the reduction of risk for such events in other organizations.
- Early reporting provides an opportunity for consultation with Joint Commission staff during the development of the root cause analysis and action plan.
- The organization’s message to the public that it is doing everything possible to ensure that such an event will not happen again is strengthened by its acknowledged collaboration with The Joint Commission to understand how the event happened and what can be done to reduce the risk of such an event occurring in the future.

### **Required response to a reviewable sentinel event**

If The Joint Commission becomes aware (either through voluntary self-reporting or otherwise) of a sentinel event that meets the criteria for a reviewable sentinel event and the event has occurred in an accredited organization, the organization is expected to:

- Prepare a thorough and credible root cause analysis and action plan within 45 days of the event or of becoming aware of the event
- Submit to The Joint Commission its root cause analysis and action plan or otherwise provide for Joint Commission evaluation of its response to the sentinel event under an approved protocol, within 45 calendar days of the known occurrence of the event.

If the determination that an event is reviewable under the Sentinel Event Policy occurs more than 45 calendar days following the known occurrence of the event, the organization will be allowed 15 calendar days for its response.

### **The Sentinel Event Database**

In order to increase the general knowledge about sentinel events, their causes, and strategies for prevention, The Joint Commission collects and analyzes data from the review of sentinel events. These data and information form the content of The Joint Commission’s Sentinel Event Database. De-identified aggregate data relating to root causes and risk-reduction strategies form the basis for future error prevention advice to organizations through the newsletter *Sentinel Event Alert* and other media. Issues of *Sentinel Event Alert* are available on The Joint Commission’s Web site at [www.jointcommission.org/SentinelEvents](http://www.jointcommission.org/SentinelEvents).

### **Disclosable information**

If The Joint Commission receives an inquiry about the accreditation decision of an organization that has experienced a reviewable sentinel event, the organization’s accreditation decision will be reported in the usual manner without reference to the sentinel event. If an inquirer references the specific 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.

### **Submission of a Root Cause Analysis and Action Plan**

An organization that experiences a sentinel event subject to the Sentinel Event Policy is asked to submit the complete root cause analysis, including its findings; and the resulting action plan that describes the organization’s risk reduction strategies and measures for evaluating their effectiveness. The information is submitted to The Joint Commission using an online root cause analysis collection tool accessible from the secure extranet home page.

If the organization has concerns about waivers of confidentiality protections as a result of sending the root cause analysis documents to The Joint Commission, several alternative approaches to review of the organization’s response to the sentinel event are available, including having a sentinel event specialist or specially trained surveyor conduct an on-site visit to review the root cause analysis and action plan documents.

### **The Joint Commission’s Response**

After The Joint Commission staff has determined that an organization’s response to the reviewable sentinel event is acceptable, they will assign an appropriate follow-up activity, typically one or more sentinel event measures of success. If the response is unacceptable, staff will provide consultation to the organization on the criteria that have not yet been met and will allow an additional 15 calendar days beyond the original submission

period for the organization to resubmit its response. Subsequent submissions that do not meet established criteria can result in a change to an organization's accreditation decision.

**Handling sentinel event-related documents**

Handling of any root cause analysis and action plan is restricted to specially trained Joint Commission staff in accordance with procedures designed to protect the confidentiality of the documents. Upon completion of The Joint Commission review of any submitted root cause analysis and action plan and the abstraction of the required data elements for The Joint Commission's Sentinel Event Database, the information contained in the electronically submitted root cause analysis tool will be de-identified.

**For more information**

Call the sentinel event hotline at (630) 792-3700, or visit The Joint Commission's Web site, [www.jointcommission.org](http://www.jointcommission.org).