organization provides, whether or not the event is voluntarily self-reported to JCI. An appropriate response includes all 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 leaders
- 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
- Systemic improvement with measurable outcomes

Determining That a Sentinel Event Is Subject to Review

When a hospital is unsure whether an event is a sentinel event, voluntary self-reporting by submitting the event to JCI allows the OQPS to determine whether it is indeed a sentinel event (*see* the "Reporting a Sentinel Event to Joint Commission International" section). Based on available information received about the event, JCI 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 International leaders and the health care organization's leaders.

Relationship to the Survey Process

When conducting an accreditation survey, the surveyor(s) evaluates the health care organization's compliance with the applicable standards, International 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 whether there were any sentinel events reported to Joint Commission international.

During an accreditation survey, the surveyor(s) will assess the health care organization's compliance with the sentinel event–related standards (*see* **Standards GLD.04.00, QPS.03.04**, and **QPS.04.00**) in the following ways:

- Assess a health care organization's overall performance improvement practice, such as its processes for responding to safety events, adverse events, hazardous or unsafe conditions, close calls, and sentinel events *without inquiring about specific events* or asking for details of such events.
- Review the hospital's sentinel event policy and procedure for compliance with **GLD.04.00, ME 5** (patient safety events and sentinel events are defined).
- Review the health care organization's process and policy and procedure for responding to a sentinel event—a review of the process and relevant policy and procedure only, and *not a review of specific sentinel events* that may have occurred.
- Interview the health care 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 or a sentinel event is newly identified during normal survey activities, the surveyor will take the following steps:

- Inform the health care organization's chief executive(s) that the event has been identified during the course of normal survey activities.
- Inform the chief executive(s) that the event will be reported to Joint Commission International for further review by the Office of Quality and Patient Safety, with follow-up under the provisions of this Sentinel Event Policy (*see* the "Joint Commission International's Response" section)