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, clinical staff, and health care organizations in the priority of patient safety in JCI–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 illness or underlying condition) that reaches a patient and:

- results in death
  or
- severe harm (regardless of duration of harm)
  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.
  or
- permanent harm (regardless of severity of harm)
  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.

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. Joint Commission International considers the following list of events, though not comprehensive, to be sentinel events if they occur in any Joint Commission International–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 following behavioral health care
- Unanticipated death of a full-term infant
- Homicide of any patient receiving care, treatment, and services while on site at the health care organization or while under the care or supervision of the organization
- Homicide of a staff member, visitor, or vendor while on site at the health care organization or while providing care or supervision to patients
- Any intrapartum maternal death
- Severe maternal morbidity (leading to *permanent harm* or *severe harm*)
  - *Severe maternal morbidity* is defined as 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.
  - 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 systems improvements can be informed by identifying occurrences of maternal morbidity, reviewing the cases, and analyzing the findings.
- Sexual abuse/assault of any patient receiving care, treatment, and services while on site at the health care 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 health care organization or while providing care or supervision to patients
  - *Sexual abuse/assault* is defined as 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 example, posting on social media); this would include but is not limited to nudity, fondling, and/or intercourse involving an individual.
  - Generally, sexual contact is nonconsensual in the following situations:
    - When the individual lacks the cognitive or legal ability to consent even though appearing to want the contact to occur
    - When the individual does not want the contact to occur
    - Other examples of nonconsensual sexual contact may include but are not limited to situations in which an individual is sedated, is temporarily unconscious, or is in a coma. An individual's apparent consent to engage in sexual activity is not valid if it is obtained from the individual lacking the capacity to consent, or consent is obtained through intimidation, coercion, or fear, whether it is expressed by the individual or suspected by staff. Any forced, coerced, or extorted sexual activity with an individual, regardless of a preexisting or current sexual relationship, is considered sexual abuse.
    - Health care organizations are required to investigate 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 cognitive or legal ability to consent.
- Physical assault (leading to death, permanent harm, or severe harm) of any patient receiving care, treatment, and services while on site at the health care 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 health care organization or while providing care or supervision to patients
- 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
  - *invasive procedure* is defined as 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, defined as a collection of blood from a vein. **Note:** *This exclusion is still considered a patient safety event and should be reviewed by the appropriate local quality and safety teams.*
- Discharge of an infant to the wrong family
- Abduction of any patient receiving care, treatment, and services

- Any elopement (that is, unauthorized departure) of a patient from a staffed around-the-clock care setting (including the ED), leading to death, permanent harm, or severe harm to the patient
- 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
  - 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.
  - 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.
- Unintended retention of a foreign object in a patient after an invasive procedure, including surgery
  - 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 health care 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.
- 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
- Any delivery of radiotherapy to the wrong patient, wrong body region, unintended procedure, or > 25% above the planned radiotherapy dose
- Fire, flame, or unanticipated smoke, heat, or flashes occurring during direct patient care caused by equipment operated and used by the health care 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 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)

In cases in which the health care organization is uncertain if an event meets Joint Commission International's definition of a sentinel event, the event will be presumed to be a patient safety event, which still requires a comprehensive analysis (*see also* **Standard QPS.03.04**). In the spirit of collaboration and shared learning, it is requested that this analysis be shared with the Office of Quality and Patient Safety.

Accredited health care organizations are expected to identify and respond appropriately to all sentinel events (as defined by JCI) occurring in the health care organization or associated with services that the health care

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)