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)

The surveyor(s) is not authorized to make a determination of whether the event is a sentinel event, or focus on or investigate the event further, nor is the surveyor(s) authorized to review comprehensive systematic analysis documents and determine the credibility, thoroughness, or acceptability of that analysis. Only the Office of Quality and Patient Safety may do this. However, the surveyor(s) is authorized to score a finding of noncompliance if the health care organization has not completed a comprehensive systematic analysis of the event (including a corrective action plan) within 45 days of the event. The surveyor(s) may score only to the time frame for completion of the comprehensive systematic analysis and not to the content of that analysis or the event itself. It is important to note that the hospital must also comply with all applicable laws and regulations regarding these time frames if these differ from the JCI requirements, but this is separate from the JCI process.

In this case, *after* the completion of the current on-site accreditation survey activities, OQPS will contact the health care organization to inquire about the event and determine whether submission of a comprehensive systematic analysis to JCI is required. If so, the health care organization will follow the steps described in the "Required Health Care Organization Response to a Sentinel Event" section of this policy.

Required Health Care Organization Response to a Sentinel Event

The health care organization must perform a comprehensive systematic analysis for all sentinel events, regardless of whether the events are voluntarily self-reported to JCI (*see* "Conducting a Comprehensive Systematic Analysis" for examples and resources). When a voluntarily self-reported sentinel event is determined to meet the criteria of this policy in a JCI–accredited organization, the health care organization is expected to do the following:

- Prepare a thorough and credible comprehensive systematic analysis and corrective action plan within 30 business days of the event or of becoming aware of the event.
- Submit its comprehensive systematic analysis and corrective action plan to Joint Commission International, or otherwise provide its response to the sentinel event using an approved methodology within 45 business days of the known occurrence of the event for Joint Commission International evaluation.

JCI will conduct a collaborative review with the health care organization's leaders or designee to determine whether the analysis and action plan are acceptable. JCI intends for the process to be collaborative and helpful rather than punitive, and the fact that a health care organization has experienced a sentinel event will not impact its accreditation decision. However, *purposeful* failure to respond appropriately to a sentinel event could have such an impact. In these instances, OQPS would recommend to the executive leaders of JCI and the JCI Accreditation Council to review the health care organization's accreditation status.

Reporting a Sentinel Event to Joint Commission International

Each health care organization is strongly encouraged, but not required, to voluntarily self-report to JCI any patient safety event that meets the definition of *sentinel event*. In fact, most sentinel events reported to JCI are self-reported by health care organizations. Health care organizations benefit from self-reporting in the following ways:

- Getting support and expertise during the review of a sentinel event
- An opportunity to collaborate directly with JCI
- Raising the level of transparency in the health care organization, which promotes a culture of safety
- Conveying the message to the health care organization's public that it is proactively working to prevent similar patient safety events in the future

A health care organization can report a sentinel event or ask to clarify whether an event meets the sentinel event definition at JCIQuality@jcrinc.com.