Sentinel Event Policy (SE)

Careful identification, investigation, and analysis of serious patient safety events, and strong corrective actions that provide effective and sustained system improvement, are essential to reduce risk and prevent patient harm. The Sentinel Event Policy explains how Joint Commission International (JCI) partners with health care organizations that have experienced a serious patient safety event to protect future patients, improve systems, and prevent further harm.

Although health care organizations are not required to report sentinel events to JCI, accredited health care organizations must have a policy detailing how the organization addresses sentinel events. The specific requirements for that policy's content are included in the "Governance, Leadership, and Direction" (GLD) chapter (*see* **Standard GLD.04.00**) of the *Joint Commission International Accreditation Standards for Hospitals*, 8th Edition. The health care organization must complete a thorough comprehensive systematic analysis (most commonly a root cause analysis) to determine why the event occurred. The health care organization must then create a corrective action plan to prevent similar events from happening again, implement the plan, and monitor its effectiveness.

All accredited health care organizations are encouraged to voluntarily self-report potential sentinel events to Joint Commission International to allow collaboration with the Office of Quality and Patient Safety (OQPS). Timely reporting will promote early engagement with JCI to work with your organization. However, reporting a sentinel event to JCI does not take the place of reporting such events to other entities such as Ministries of Health when required by laws and regulations.

Contacting Joint Commission International after a sentinel event allows the health care organization to use the OQPS patient safety staff's expertise and experience. JCI can help analyze root causes, redesign processes, and monitor performance improvement practices and other aspects of the sentinel event process.

Voluntarily self-reporting sentinel events reinforces the health care organization's message to the public that it is doing everything it can to prevent a recurrence. Sharing information, particularly lessons learned, with Joint Commission International enhances Joint Commission International's Sentinel Event Database, which may help other organizations learn from them to prevent similar events. The more health care organizations report their own sentinel events, the better and more meaningful sentinel event statistics become. Joint Commission International sentinel event data identify not only the relative frequency of different categories of sentinel events reported each year, but they also provide information on trends in the occurrence of the most reported sentinel event categories.

Goals of the Sentinel Event Policy

The purpose of the JCI Sentinel Event Policy is to help hospitals that experience serious adverse events improve safety and learn from those sentinel events. JCI's Sentinel Event Policy has the following four goals:

1. To positively impact care, treatment, and services by helping health care organizations identify opportunities to change their culture, systems, and processes to prevent unintended harm.