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.

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.