The Joint Commission
Sentinel Events

Attachment II

The Joint Commission adopted a formal Sentinel Event Policy in 1996 to help hospitals that experience serious adverse events improve safety and learn from those sentinel events. Careful investigation and analysis of patient safety events, as well as evaluation of corrective actions, is essential to reduce risk and prevent patient harm. The Sentinel Event Policy explains how The Joint Commission partners with hospitals that have experienced a serious patient safety event to protect the patient, improve systems, and prevent further harm.

Definition of Sentinel Event

A sentinel event is a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in any of the following:

- Death
- Permanent harm
- Severe temporary harm

An event is also considered sentinel if it is one of the following:

- Suicide of any patient receiving care, treatment, and services in a staffed around-the-clock care setting or within 72 hours of discharge, including from the hospital's emergency department (ED)
- Unanticipated death of a full-term infant
- 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 temporary harm to the patient
- Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities (ABO, Rh, other blood groups)
- Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of any patient receiving care, treatment, and services while on site at the hospital
- Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of a staff member, licensed independent practitioner, visitor, or vendor while on site at the hospital
- Invasive procedure, including surgery, on the wrong patient, at the wrong site, or that is the wrong (unintended) procedure
- Unintended retention of a foreign object in a patient after an invasive procedure, including surgery
- Severe neonatal hyper-bilirubinemia (bilirubin >30 milligrams/deciliter)
- Prolonged fluoroscopy with cumulative dose >1,500 rads to a single field or any delivery of radiotherapy to the wrong body region or >25% above the planned radiotherapy dose
- Fire, flame, or unanticipated smoke, heat, or flashes occurring during an episode of patient care
- Any intrapartum (related to the birth process) maternal death
- Severe maternal morbidity when it (not primarily related to the natural course of the patient's illness or underlying condition) reaches a patient and results in any of the following: Permanent harm or severe temporary harm

The above list is consistent across all Joint Commission accreditation programs, though some of these events may be unlikely to occur in certain settings. In cases in which the hospital is uncertain that a patient safety event is a sentinel event as defined by The Joint Commission, the event will be presumed to be a sentinel

event and the hospital's response will be reviewed under the Sentinel Event Policy according to the prescribed procedures and time frames.

Such events are considered "sentinel" because they signal a need for immediate investigation and response. Accredited hospitals are expected to identify and respond appropriately to all sentinel events (as defined by The Joint Commission) occurring in the hospital or associated with services that the hospital provides. An appropriate response includes all of 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 hospital leadership
- Immediate investigation
- Completion of a comprehensive systematic analysis for identifying the causal and contributory factors
- Corrective actions
- Time line for implementation of corrective actions
- Systemic improvement