

Sentinel Event Policy (SE)

Careful identification, investigation, and analysis of patient safety events, as well as 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 partners with health care organizations that have experienced a serious patient safety event to protect future patients, improve systems, and prevent further harm.

Although reporting sentinel events to Joint Commission is voluntary, accredited organizations are required to have a policy detailing how the organization addresses sentinel events. The specific requirements of that policy are included in the “Leadership” (LD), “Medical Staff” (MS), and “National Performance Goals” (NPG) chapters in Edition® or in the *Comprehensive Accreditation Manual*.

Contacting Joint Commission following a sentinel event allows the health care organization to avail itself of the wealth of expertise and experience of its staff. Joint Commission patient safety specialists can help analyze root causes, redesign processes, and monitor performance improvement practices and other aspects of the sentinel event process.

Self-reporting reinforces the 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 enhances Joint Commission’s Sentinel Event Database, which may help other organizations prevent similar events. The more organizations report their own sentinel events, the better and more meaningful sentinel event statistics become. Joint Commission sentinel event data not only identify the relative frequency of different categories of sentinel events but also provide information on trends in the occurrence of the most reported sentinel event categories.

Goals of the Sentinel Event Policy

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. Joint Commission’s Sentinel Event Policy has the following five 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 support 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 a 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 Joint Commission–accredited health care organizations
5. To maintain confidentiality

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 is clearly tied to a patient encounter, serious, and largely preventable. Any event that meets this definition is considered a sentinel event.** Sidebar 1 defines these and other key terms.

Although sentinel events are patient safety events, Joint Commission will continue to champion workforce safety as a vital priority throughout its accredited health care organizations by maintaining three workforce sentinel events. These are focused solely on violence toward staff members.

These three events do not need to be clearly tied to a patient encounter, but they need to have occurred within or on the grounds of a health care setting of which the staff member is employed or has a contract/affiliation with (for example, licensed practitioners). The events must be serious and largely preventable.

Using the National Quality Forum's 2025 Serious Reportable Event (SRE) List and three legacy workforce sentinel events, Joint Commission has developed a **Sentinel Event List consisting of 31 events** across five categories: Procedural Events, Product or Device Events, Patient Protection Events, Care Provision Events, and Workforce Safety Events.

The Sentinel Event List includes the following two classifications—“patient harm” and “regardless of the outcome” (*see* Figure 1)—to guide organizations on the process for reporting expectations.

1. **Patient harm** indicates that the event in review must be clearly tied to a *patient encounter* with a health care delivery system and meet both the *serious* and *largely preventable* criteria to qualify as a sentinel event. These events require organizations to assess for serious patient harm (that is, death, severe harm, or permanent harm).
2. **Regardless of the outcome** indicates that all instances of the event qualify as a sentinel event. Any instance of this event signals a vulnerability in a safety system that can lead to serious harm and is deemed likely avoidable with the implementation of generally accepted performance standards (GAPS) of care. These events require organizations to assess all levels of harm (that is, death, severe harm, permanent harm, moderate harm, minimal harm, and no harm). For the majority of “regardless of the outcome” events, near misses (defined as an event that is caught before reaching the patient) should also be reported.

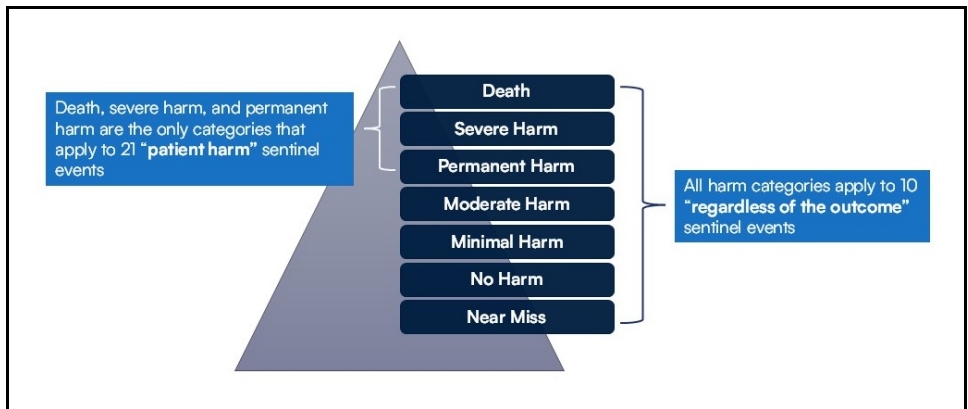


Figure 1. *How the sentinel event classification aligns with Joint Commission’s harm categories.*

Joint Commission considers the following list of events to be sentinel events if they are tied to a patient encounter, serious, largely preventable, and occur at any Joint Commission–accredited organization. However, some of these events are unlikely to occur in certain health care settings.

Procedural Events

SE 1. Surgery or other invasive procedure performed at the wrong site, on the wrong patient, or that is the wrong procedure, *regardless of the type of procedure or the outcome*

SE 2. Unintended retention of a medical or surgical item in a patient after surgery or other invasive procedure, *regardless of the type of procedure or the outcome*

SE 3. Patient harm associated with perioperative or periprocedural anesthesia or sedation of an ASA Class I or ASA Class II patient

SE 4. Medically assisted reproduction with the wrong donor sperm or egg, *regardless of the outcome*

SE 5. Introduction of an unapproved, unscreened, or inappropriately approved device, implant, or object into an MR Zone IV area, *regardless of the outcome*

SE 6. Patient harm associated with an MRI-related thermal injury

SE 7. Administration of radiotherapy to the wrong patient, to the wrong body region, by an unintended procedure, or that is the wrong dose, *regardless of the outcome*

Product or Device Events

SE 8. Patient harm associated with the use of contaminated drugs, devices, or biologics

SE 9. Patient harm associated with the use or function of a medical device in patient care, in which the device is used or functions other than as intended

SE 10. Patient harm occurring when systems designated for oxygen or other gas to be delivered to a patient contain no gas, the wrong gas, or are contaminated by toxic substances

SE 11. Fire, flame, or unanticipated smoke, heat, or flashes occurring during direct patient care caused by equipment operated and used by the healthcare setting, *regardless of the outcome*

Patient Protection Events

SE 12. Discharge or release of a patient who does not have decision-making capacity to other than an authorized person or entity, *regardless of the outcome*

SE 13. Patient harm associated with the disappearance or unauthorized departure of a patient who does not have decision-making capacity

SE 14. Patient suicide or suicide attempt that occurs after presentation for care or within seven days of discharge or release, *regardless of the outcome*

SE 15. Patient harm associated with the use of chemical restraints, physical restraints, or seclusion

SE 16. Sexual abuse or sexual assault within or on the grounds of a healthcare setting, *regardless of the outcome*

Care Provision Events

SE 17. Patient harm associated with a fall

SE 18. Patient harm associated with an unintended burn from any source

SE 19. Patient harm associated with a medication error

SE 20. Patient harm associated with unsafe processing or administration of blood products

SE 21. Patient harm associated with a Stage 3 pressure injury, Stage 4 pressure injury, unstageable pressure injury, or deep tissue pressure injury acquired after admission

SE 22. Patient harm associated with the irretrievable loss of a biological specimen that is irreplaceable or is only replaceable by an invasive procedure

SE 23. Patient harm resulting from failure to act on clinically significant laboratory, pathology, or radiology test results

SE 24. Patient harm associated with an intravascular air embolism

SE 25. Maternal patient harm associated with labor or delivery in a low-risk pregnancy

SE 26. Neonatal patient harm associated with labor or delivery in a low-risk pregnancy

SE 27. Patient harm associated with the care of a neonate

SE 28. Patient harm associated with unrecognized clinical deterioration

Workforce Safety Events

SE 29. Physical assault of a staff member within or on the grounds of a healthcare setting, *regardless of the outcome*

SE 30. Sexual abuse or sexual assault of a staff member within or on the grounds of a healthcare setting, *regardless of the outcome*

SE 31. Homicide of a staff member within or on the grounds of a healthcare setting

Sidebar 1. Critical Information for Sentinel Event Review

Health care organizations should reference Part II of *Aligning Patient Safety Event Reporting: 2025 Updates to Sentinel Events and Serious Reportable Events*, available at <https://digitalassets.jointcommission.org/api/public/content/b4e8988066e74717ae9801edb2bfb9de?v=071ea64a> (henceforth referred to as “Alignment Report”) for guidance on determining if an event meets Joint Commission’s definition of a sentinel event. Additional key terms to support event review are provided below.

Note: *While the guidance in the Alignment Report references Serious Reportable Events (SREs), all of the information, including categorization, event numbering, and clinical application guidance is applicable and should be used for Sentinel Event Review.*

sentinel event: An event that is clearly tied to a *patient encounter* with a health care delivery system must be *serious* and *largely preventable*.

patient encounter: An interaction between an individual and a health care setting for the purpose of providing health care services or assessing the health status of the individual. Encounters can be billable events but are not limited to billable interactions. The patient encounter has an associated location or modality (for example, office, home, electronic health record [EHR], phone, e-mail, other telemedicine methods) within which the interaction occurred, including synchronous and asynchronous communication.

serious: An event resulting in death or contributing to patient harm that includes physical, emotional, or psychological harm(s) that requires major intervention (for example, surgery, higher level of care, treatment post discharge) or impairs a patient’s ability to perform activities of daily living (ADLs). (See pages 26–29 of the Alignment Report for supporting guidance and definitions for assessing the serious criterion.)

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Sidebar 1. (continued)

largely preventable: An event that is likely avoidable by any means currently available within the generally accepted performance standards (GAPS) of care and triggers further investigation into causative factors. (See page 29 of the Alignment Report for supporting guidance and definitions for assessing the largely preventable criterion.)

clinical application guidance: Event-specific guidance for evaluating whether an event aligns with the sentinel event definition. The clinical application guidance provides detailed information for each sentinel event, organized by category. Sentinel event–specific guidance comprises four key components: event name, intent, key definitions, and reporting considerations. (See Part II of the Alignment Report.)

permanent harm: An event or condition that reaches the patient resulting in any level of harm that permanently alters and/or affects an individual's baseline health.

severe harm: An event or condition that reaches the patient, resulting in life-threatening bodily injury (including pain or disfigurement) that interferes with and/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.

moderate harm: An event or condition that reaches the patient and may require an intervention or extended length of stay; however, it does not permanently alter and/or affect an individual's baseline health.

minimal harm: An event or condition that reaches the patient, resulting in no intervention or extended length of stay.

near miss: An event that is caught before reaching the patient.

Accredited health care organizations are expected to have a defined process to identify and respond appropriately to all sentinel events occurring in the health care organization or associated with services that the organization provides. An appropriate response includes 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.
- Investigation within 48 hours of the event to determine if it is clearly tied to a *patient encounter* with a health care delivery system, serious, and largely preventable.

- Completion of a comprehensive systematic analysis for “patient harm” events in which the serious criterion is met or for “regardless of the outcome” events in which death, severe harm, or permanent harm has occurred. For “regardless of the outcome” events in which death, severe harm, or permanent harm did not occur, a review for potential safety system issues should occur. These should be completed within 45 business days.
- 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.

Some events may qualify for multiple sentinel events. Health care organizations are encouraged to select the sentinel event that is most directly associated with the event’s causative factors

Determining When an Event Is a Sentinel Event

Accredited health care organizations are encouraged to use a structured, consistent approach to determine if an event qualifies as a sentinel event. Health care organizations should go beyond the event name and apply the updated sentinel event definition systematically. **Referring to the Clinical Application Guidance in the Alignment Report, or in collaboration with a Joint Commission Office of Quality and Patient Safety (OQPS) specialist, health care organizations should follow five steps for Sentinel Event Review, which are depicted in Table 1.** The steps will differ based on the naming classification the sentinel event follows.

Table 1. Five Steps Process for Sentinel Event Review	
“Patient Harm” Events	“Regardless of the Outcome” Events
Step 1: Review event name	No change—complete step 1

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Table 1. (continued)

Step 2: Review event intent, exclusions, and key definitions in the Alignment Report Health care organizations should always review these sections as it provides foundational details about what is meant to be captured, exclusions, and relevant terms	No change—complete step 2
Step 3: Assess if the event is clearly tied to a patient encounter with a health care delivery system The Clinical Application Guidance provides key details related to the event intent (including pertinent clinical details that may be in the medical record or reminders that an event can trigger another encounter with a different care setting or department)	No change—complete step 3
Step 4: Determine the level of harm associated with the event Assess whether the event resulted in any of the four components of the serious criterion (physical harm, emotional or psychological harm, major intervention, impairment of a patient's ability to perform ADLs). Only events that result in death, severe harm, or permanent harm will meet the serious criterion. See pages 26–29 of the Alignment Report for guidance on how to evaluate serious harm for each of these components. Note: The Clinical Application Guidance contains event-specific considerations and clinical circumstances to aid reviewers in determining if an event resulted in serious harm.	Step 4: Any instance is considered serious. Health care organizations should assess if the event was caught prior to reaching the patient (that is, a near miss or reached the patient, regardless of the outcome) - All harm categories apply to these events (death, severe harm, permanent harm, moderate harm, minimal harm, no harm, near miss) - Only those events that result in death, serious harm, or permanent harm require a comprehensive analysis. All others require a review for potential safety system issues.
Step 5: Assess if the event was largely preventable	Step 5: Any instance is considered largely preventable. Health care organizations should identify which deviations in GAPS of care or setting-specific standards occurred.

Reporting a Sentinel Event to Joint Commission

Each health care organization is strongly encouraged, but not required, to report to Joint Commission any patient safety event that meets the Joint Commission definition of a sentinel event. In fact, a vast majority of sentinel events reported to Joint Commission

are self-reported by health care organizations that recognize the value of working with OQPS staff. A health care organization benefits from self-reporting in the following ways:

- Getting support and expertise during the review of a sentinel event
- Providing the health care organization an opportunity to collaborate with a patient safety specialist who maintains the following qualifications:
 - Masters-prepared clinician
 - Certified Professional in Patient Safety (CPPS) from the Institute for Healthcare Improvement (IHI)
 - Experienced in reviewing similar events
- 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 through its *Joint Commission Connect*® extranet site. Under "Continuous Compliance Tools," select "Self-Report Sentinel Event" from the drop-down list. Follow the directions to submit the report.

When a sentinel event is reported to Joint Commission, OQPS will assign a patient safety specialist. This is the organization's main contact if there are questions about completing the process.

Self-Reporting a Sentinel Event to Joint Commission

If a Joint Commission–accredited organization elects to self-report a sentinel event to Joint Commission and it meets the criteria of this policy, the health care organization is expected to do the following:

- Prepare a thorough and credible comprehensive systematic analysis and corrective action plan for all "patient harm" sentinel events that meet the serious criterion and "regardless of the outcome" sentinel events that result in death, severe harm, or permanent harm within 45 business days of the event or of becoming aware of the event. For "regardless of the outcome" events in which death, severe harm, or permanent harm did not occur, a review for potential safety system issues should occur within 45 business days of the event.

- For all “patient harm” sentinel events that meet the serious criterion and “regardless of the outcome” sentinel events that result in death, severe harm, or permanent harm, organizations should submit their comprehensive systematic analysis and corrective action plan electronically to Joint Commission for evaluation. Joint Commission OQPS staff will conduct a collaborative review with organization leaders or a designee to determine whether the analysis and action plan are acceptable. (*See Comprehensive Systematic Analysis and Corrective Action Plan.*)
- For “regardless of the outcome” events in which death, severe harm, or permanent harm did not occur, organizations may be asked to share their review and any identified safety system issues with OQPS staff.

Conducting a Comprehensive Systematic Analysis

Whether or not the health care organization reports a sentinel event to Joint Commission, it is expected to complete a comprehensive systematic analysis for all **“patient harm” sentinel events that meet the serious criterion or “regardless of the outcome” sentinel events that result in death, severe harm, or permanent harm** to identify the causal and contributory factors. A comprehensive systematic analysis is defined as a process for identifying basic or causal factors underlying variation in performance, including the occurrence or possible occurrence of a sentinel event. A root cause analysis, for example, is one common type of comprehensive systematic analysis. The organization can determine its internal process, tools, and methodologies to conduct such an analysis. Any comprehensive systematic analysis should include a bibliography of recent evidence-based literature to guide the organization in developing a strong corrective action plan (*see Developing a Corrective Action Plan*) with the use of evidence-based practices or tools.

Note: *Regardless of the outcome, sentinel events that do not result in death, severe harm, or permanent harm require a review for potential safety system issues. The 5 Whys, for example, is one type of review that can be done.*

For organizations that self-report, a Joint Commission patient safety specialist conducts a review of the analysis to verify it is thorough and credible (*see Review of Comprehensive Systematic Analyses and Corrective Action Plans*). The organization’s selected comprehensive systematic analysis method should address the questions from Joint Commission’s Framework for Root Cause Analysis and Corrective Actions (available at <https://digitalassets.jointcommission.org/api/public/content/>)

3559a1e9d41842348122ca1f2c627e96?v=291853c9). There are several mandatory fields within the form that must be completed by the organization. If the organization chooses to do so, it can upload supporting documents with its submission.

A health care organization's comprehensive systematic analysis should identify system vulnerabilities so that they can be eliminated or mitigated. It should not focus on individual health care worker performance but should seek out underlying systems-level causations that manifested in personnel-related performance issues.* To help adhere to these characteristics, it is recommended but not required that organizations consider the following guidelines when developing causative factor statements:†

- Clearly show the cause-and-effect relationship.
- Use specific and accurate descriptors for what occurred rather than negative and vague words.
- Include a preceding cause for any human errors or violations of procedure (that is, do not consider them root causes or causal factors).
- Classify a failure to act as a causal factor only when there is a preexisting duty to act.

See Review of Comprehensive Systematic Analyses and Corrective Action Plans for more detail on what is considered a thorough and credible analysis.

Developing a Corrective Action Plan

An end product of the comprehensive systematic analysis is a corrective action plan. The corrective action plan identifies the strategies that the health care organization intends to implement to reduce the risk of similar events occurring in the future. When formulating a corrective action plan, the review team should analyze the strength of its proposed solutions. An evidence-based tool, such as the action hierarchy from the Veterans Administration's National Center for Patient Safety‡ can help the team identify strong actions that provide effective and sustained system improvement.

*National Patient Safety Foundation. *RCA²: Improving Root Cause Analyses and Actions to Prevent Harm*. Boston: National Patient Safety Foundation, 2015. Available at <https://www.ihi.org/library/tools/rca2-improving-root-cause-analyses-and-actions-prevent-harm> or at <https://www.ashp.org/-/media/assets/policy-guidelines/docs/endorsed-documents/endorsed-documents-improving-root-cause-analyses-actions-prevent-harm.ashx>. Accessed Jan 26, 2026.

†Department of Veterans Affairs, Veterans Health Administration. VHA Patient Safety Improvement Handbook 1050.01. Mar 4, 2011. Amended Mar 5, 2024. https://www.va.gov/VHApublications/ViewPublication.asp?pub_ID=10209. Accessed Jan 26, 2026.

‡US Department of Veterans Affairs National Center for Patient Safety. 2021 *Guide to Performing a Root Cause Analysis*. Figure 7. Action Hierarchy, pages 22–23. https://www.patientsafety.va.gov/docs/RCA-Guidebook_02052021.pdf. Accessed Jan 26, 2026.

The organization should identify at least one intermediate or stronger action (as defined in the action hierarchy) to eliminate or mitigate system hazards or vulnerabilities identified in the comprehensive systematic analysis. The corrective action plan must address the following:

- Identifying corrective actions to eliminate or reduce system hazards or vulnerabilities directly related to causal and contributory factors
- Identifying who is responsible for implementing corrective actions
- Determining timelines to complete corrective actions
- Developing strategies to evaluate the effectiveness of the corrective actions
- Developing strategies to sustain the change

The National Patient Safety Foundation, now merged with IHI, provides detailed guidance on developing effective corrective action plans in its report, *RCA²: Improving Root Cause Analyses and Actions to Prevent Harm*.[§]

See Review of Comprehensive Systematic Analyses and Corrective Action Plans for more detail on what is considered an acceptable corrective action plan.

Submitting the Comprehensive Systematic Analysis and Corrective Action Plan

A health care organization that self-reports a “patient harm” sentinel event that meets the serious criterion or a “regardless of the outcome” sentinel event that results in death, severe harm, or permanent harm is expected to submit a comprehensive systematic analysis, including the resulting corrective action plan that describes the health care organization’s risk reduction strategies as well as how the strategies will be evaluated and measured to determine effectiveness. This information is submitted electronically and will be reviewed collaboratively with Joint Commission staff and health care organization staff. These documents should not include the names of organization staff or patients involved in the sentinel event or other protected personal health information.

[§]National Patient Safety Foundation. *RCA²: Improving Root Cause Analyses and Actions to Prevent Harm*. Boston: National Patient Safety Foundation, 2015. Available at <https://www.ihi.org/library/tools/rca2-improving-root-cause-analyses-and-actions-prevent-harm> or at <https://www.ashp.org/-/media/assets/policy-guidelines/docs/endorsed-documents/endorsed-documents-improving-root-cause-analyses-actions-prevent-harm.ashx>. Accessed Jan 26, 2026.

Joint Commission's Response

Patient safety specialists from Joint Commission assess the health care organization's response to the sentinel event against three criteria:

1. Thoroughness of the comprehensive systematic analysis
2. Credibility of the comprehensive systematic analysis
3. Acceptability of the organization's corrective action plan

A Joint Commission patient safety specialist will provide feedback to the health care organization if the response is not adequate and will allow an additional 15 business days beyond the original submission period for the organization to resubmit its response, including revised corrective actions if necessary.

Review of Comprehensive Systematic Analyses and Corrective Action Plans

For organizations that self-report, Joint Commission patient safety specialists review the comprehensive systematic analysis and corrective action plans for thoroughness, credibility, and acceptability.

To be thorough, the analysis must do the following:

- Repeatedly ask "Why?" until the analysis identifies the systemic causal factors associated with each step in the sequence that led to the sentinel event
- Focus on systems and processes, not solely on individual performance
- Determine the human and other factors most directly associated with the sentinel event and the process(es) and system(s) related to its occurrence
- Use the analysis to help determine where redesign might reduce risk
- Inquire into all areas appropriate to the specific type of event
- Identify risk points and their potential contributions to this type of event
- Determine potential improvement in processes or systems that would tend to decrease the likelihood of such events in the future or determine, after analysis, that no such improvement opportunities exist

To be credible, the analysis must do the following:

- Be clear (understandable information)
- Be accurate (validated information and data)
- Be precise (objective information and data without internal inconsistencies)
- Be relevant (focus on issues related or potentially related to the sentinel event)
- Be complete (cover all causes and potential causes)

Shading indicates a change effective January 1, 2027, unless otherwise noted in the What's New.

- Be systematic (methodically conducted)
- Possess depth (ask and answer all of the relevant “Why” questions and explain any “not applicable” finding)
- Possess breadth of scope (cover all possible systemic factors wherever they occur)
- Reflect diverse perspectives (include a process owner or designee, a patient or family member when appropriate, and individuals close to the process under review)¹¹

To be considered acceptable, the corrective action plan must do the following:

- Identify changes that can be implemented to reduce risk, or formulate a rationale for not undertaking such changes
- Identify, in situations in which improvement actions are planned, the following:
 - Who (by title) is responsible for implementation
 - When the action will be implemented (including any pilot testing)
 - How the effectiveness of the actions will be evaluated
 - How the actions will be sustained
 - The point at which alternative actions will be considered if improvement targets are not met
 - At least one stronger or intermediate-strength action

All comprehensive systematic analysis and corrective action plans will be considered and treated as confidential by Joint Commission (*see* Handling Sentinel Event–Related Documents).

If Joint Commission finds the analysis and action plan thorough, credible, and acceptable, a patient safety specialist from Joint Commission will notify the organization and assign one or more follow-up activities.

Follow-up Activities

For organizations that self-report, after Joint Commission determines that a health care organization has conducted a thorough comprehensive systematic analysis (for example, root cause analysis) and developed a comprehensive corrective action plan, Joint Commission will notify the organization whether the analysis and action plan are acceptable and will assign an appropriate follow-up activity. This will be a mutually

¹¹Joint Commission does not require the active involvement of a senior leader in the day-to-day work of the comprehensive systematic analysis team. However, the team should report to the senior leader or designee, and the individual should be involved in deciding or approving the actions the organization will take as a result of the comprehensive systematic analysis.

agreed-upon documentation of sustained improvement and reduction of risk, which may include one or more measures of success or a review of the sentinel event at the health care organization.

Sentinel Event Measures of Success

For organizations that self-report, the health care organization's follow-up activity may be conducted through the sentinel event measure of success (SE MOS) process. The organization will identify one or more SE MOS—that is, one or more numerical or quantifiable measure (ideally with a numerator and denominator), usually related to an audit, which determines if the organization effectively sustained the planned corrective action(s). The organization will track the measure for at least 120 days (or four months) and report its compliance to Joint Commission. The organization's report, due on a mutually agreed-upon date, should demonstrate whether the organization reached its identified SE MOS and is sustaining compliance.

The health care organization's accreditation decision may be impacted under the following circumstances:

- An SE MOS submitted on time does not meet preestablished levels of compliance, and a Joint Commission patient safety specialist requests an additional 120 days (or four months) of data that still does not meet preestablished levels of compliance.
- Submission of an SE MOS more than 90 days (or three months) after the mutually agreed upon date.

Optional On-Site Review of a Sentinel Event

Joint Commission will generally not conduct an on-site review of a self-reported sentinel event unless it determines that a potential ongoing Immediate Threat to Health or Safety exists. If an on-site survey is conducted, the health care organization will be billed based on an established fee schedule to cover the costs of conducting such a survey. (*See For-Cause Surveys in "The Accreditation Process" [ACC] chapter of E-dition or the Comprehensive Accreditation Manual for more information.*)

Handling Sentinel Event–Related Documents

For organizations that self-report, Joint Commission restricts access to any submitted comprehensive systematic analysis and corrective action plan to specially trained staff in accordance with procedures designed to protect the confidentiality of the documents. All documents associated with sentinel event submission are protected and confidential.

Joint Commission will retain any corrective action plan(s) resulting from the analysis of the sentinel event long enough to serve as the basis for appropriate follow-up activities, such as the SE MOS or other mutually agreed-upon documentation of sustained improvement. After the organization implements the corrective action plan and Joint Commission verifies it meets the established levels of compliance, the information contained in any electronically submitted analysis will be de-identified after OQPS completes its review.

Sentinel Event Database

Joint Commission collects and analyzes aggregate data from the comprehensive systematic analyses, corrective action plans, and follow-up activities in its Sentinel Event Database. Joint Commission develops and maintains the database in a manner that excludes organization, caregiver, and patient identifiers. Aggregate data relating to root causes and risk reduction strategies for sentinel events that occur with significant frequency form the basis for future error-prevention advice to health care organizations through *Sentinel Event Alerts*, National Performance Goals™, and other methods of information sharing.

Overseeing the Sentinel Event Policy

The executive leaders of Joint Commission are responsible for approval of this policy and overseeing its implementation.

For more information about Joint Commission's Sentinel Event Policy, visit Joint Commission's website at <https://www.jointcommission.org/resources/sentinel-event/>.

