On Demand Joint Commission Sentinel Event Transition Webinar Series: Alignment Overview

March 2026

00:00:01
Hello and welcome to our webinar, Joint Commission Sentinel Event Transition Webinar Series: Alignment Overview. I'm Jessica Woodruff, Project Manager for Engagement on Quality Improvement Programs here at Joint Commission, and today I'll be serving as this webinar's moderator. CE credit is available for this webinar for participants joining the live broadcast and the On Demand recording that will be published afterward.

00:00:31
Before we begin the webinar, we would like to offer just a few tips about webinar platform functionality. Audio is by Voice Over Internet Protocol only, so please use your computer speakers or headphones to listen in. There are no dial-in lines and participants are connected in listen-only mode. Feedback or dropped audio are common for live streaming events, so refresh your screen if this occurs. We will not be recognizing the Raise a Hand or Chat feature, but to ask a question, you can click the Question Mark icon in the audience toolbar. A panel will open for you to type your question and submit. And the slides are designed to follow Americans with Disability Act rules.

00:01:31
Speaking of the slides, they are now available. And while there are links provided throughout this webinar, they are not clickable on screen. By downloading the slides, you'll be able to access the links and also take notes. To access the slides now within the webinar platform on the left side of your navigation pane, you'll select the icon that represents a document. A new pop-up window will open and you can select the name of the file. A new browser window will open, and from it, you can download or print a PDF of the slides.

00:01:44
Today's handout will include, for this broadcast, the accessible slides, the Patient Safety Report, FAQ document, and CE handout. Slides will also be available within two weeks of this webinar on Joint Commission's website at the link provided at the bottom of this slide.

00:02:05
Many attending this webinar will wish to receive continuing education credit or Qualifying Education hours. All relevant information about continuing education credit is available within the handout we've included with this webinar, but have also been communicated within the webinar registration information. The attachment includes the list of the entities that will provide credit, the requirements for participants to earn credit, and information about how to complete the survey and obtain a certificate.

00:02:34
So, please be sure to download that attachment to learn more. Credit is available for the live webinar broadcast and the On Demand recording that will be published afterward. Please note, while the credit is being offered for the live broadcast and the On Demand webinar, you are only to obtain CE credit for one webinar, not both. For more information on Joint Commission's Continuing Education Policies, visit the link provided at the bottom of the slide.

00:03:04
The participant learning objectives for today are: Explain the changes for Joint Commission's accredited healthcare organizations can expect with the 2027 Sentinel Event transitions, apply NQF's SRE Inclusion Criteria and Clinical Application Guidance in event review, and outline the timeline of activities for this transition.

00:03:31
All staff and subject matter experts have disclosed they do not have any conflicts of interest. For example, financial arrangements, affiliations with, or ownership of organizations that provide grants, consultancies, honoraria, travel or other benefits that will impact the presentation of today's webinar content.

00:03:54
Today's Alignment Overview presentation will feature Doreen Donohue, Director of Quality and Patient Safety from Joint Commission, Ken Grubbs, Chief Nursing Executive and Executive Vice President from Joint Commission, and Kimberly Streett, director of performance improvement from National Quality Forum. Today's agenda will address Sentinel Event and Serious Reportable Events Alignment Overview, Key Changes for Healthcare Organizations in 2027, Event Review in Action: Understanding and Using SRE Technical Guidance, and a live Q&A.

I will stop here and turn things over to Ken Grubbs for our opening remarks. Ken, whenever you're ready, please take it away.

00:04:39
Well, thank you, Jessica. And let me start by saying, we appreciate the time you're spending with us today, and more importantly, the work you do every day to advance patient safety and workforce safety. The alignment of Joint Commission's Sentinel Event List with the National Quality Forum's Serious Reportable Events List represents an important step forward. One that brings greater clarity, consistency, and really shared understanding to how serious safety events are identified, reviewed, and learned from across healthcare.

Now while the Sentinel Event List is primarily focused on patient safety, we really want to stress the importance to us, and I know to you, the continued inclusion of workforce safety. Today, we will highlight the updated list that will also include three workforce safety Sentinel Events. We recognize the critical importance of a safe healthcare environment for patients and for our healthcare teams. So thank you for prioritizing workforce safety and along with patient safety.

And to be clear, while the list of events and the supporting guidance are evolving, our core focuses are not. Our focus on a culture of safety, a culture that supports reporting, psychological safety, and learning from patient and workforce safety events remains, ultimately allowing for meaningful improvements. This transition aims to streamline safety event reporting by consolidating historical, historically separate and parallel frameworks, reducing disparate reporting requirements, and enabling greater focus on meaningful improvements in patient safety.

So today's webinar is the first in a series designed to support you through this transition. Our objectives today are, as indicated, to outline the changes you can expect, share resources to help you navigate the update, and reinforce the importance of consistent and accurate reporting to support safety improvement efforts. We want to ensure you feel informed, supported, and confident well in advance of the January 2027 implementation. We are extremely mindful of how to advance safety while reducing burden. I encourage you to engage with our team, ask questions, assess your current systems, and actively participate in implementing these changes. And the best way for me to conclude my comments is to say thank you.

Thank you and your teams for all they do in service to patients and communities. Thank you for being a part of this important conversation and for your continued commitment to patient safety and workforce safety.

With that, I'll turn this over to Doreen Donohue, Director of the Office of Quality and Patient Safety, to walk us through today's agenda and to begin the discussion, Doreen?

00:08:00
Thank you, Ken. Good afternoon, everyone, and thank you for joining us today. As Jessica and Ken noted, today's meeting aims to provide foundational information that can help accredited organizations better prepare for the upcoming Sentinel Event Alignment Update in 2027. The concepts and updates I share today will be instrumental to the information we will share in future webinars. Our goal today is that you walk away feeling better equipped in how to approach the evaluation of a patient safety event and knowing the processes you need to take to decipher if it rises to the level of a Sentinel Event. We will start at a high level and get progressively into the weeds as we go further along, let's begin.

00:08:52
Joint Commission's Sentinel Event Policy reinforces what is expected of all accredited healthcare organizations. They are expected to identify Sentinel Events, examine root causes, and contributing factors, and implement improvements to reduce the risk of a recurrence. This core expectation is not changing with the transition.

Sentinel Event review is not just about compliance. It is a learning process that supports system improvement and prevention of future harm. Joint Commission works collaboratively with organizations when Sentinel Events occur, with the shared goal of strengthening safety systems and preventing similar events in the future.

00:09:37
With the policy in mind, let's turn to why reporting Sentinel Events matter, not just for individual organizations, but for learning across the healthcare field.

Since 1996, Joint Commission has maintained a Sentinel Event Database that contains de-identified aggregate data from reported events. Each year, this aggregate data is analyzed to better understand the conditions and contributing factors associated with Sentinel Events. Reporting supports the development of preventive strategies that healthcare organizations can use to strengthen safety systems and reduce future risk. These analysis also inform the establishment of national performance goals, helping translate lessons learned into system-level improvement.

Importantly, reporting is voluntary, but participation contributes to collective learning and advances patient safety beyond any single organization.

00:10:42
Beginning in 2027, the Sentinel Event List will adopt the updated events from the National Quality Forum Serious Reportable Event or SRE List, and retain three legacy workforce Sentinel Events.

What's important to emphasize upfront is that Joint Commission's core expectations are not changing. Accredited organizations are still expected to identify Sentinel Events, examine root causes and contributing factors, and implement improvements to reduce the risk of reoccurrence. Reporting Sentinel Events to Joint Commission will continue to be voluntary.

The updated Sentinel Event List will now include the 28 events from the NQF's SRE list, creating alignment between what were two parallel adverse event frameworks. The Joint Commission is not only aligning on the events, but also how the events are interpreted. Sentinel Event interpretation will align with the SRE Technical Guidance, meaning accredited organizations will use the SRE Inclusion Criteria and reference event-specific Clinical Application Guidance when reviewing events.

00:11:58
Released in January of this year, Joint Commission and NQF published the report, "Aligning Patient Safety Event Reporting: 2025 Updates to Sentinel Events and Serious Reportable Events," announcing the alignment of two parallel adverse event lists, Joint Commission Sentinel Events and NQF Serious Reportable Events, and support shared understanding across healthcare organizations when determining whether an event qualifies as a Sentinel Event.

The report has two parts. Part I provides an overview of the alignment, presents the 2025 SRE List, and summarizes the key updates made through NQF's consensus process. Part II contains the SRE Technical Guidance, which offers event-specific clinical guidance to support consistent interpretation and reporting.

Today's webinar focuses primarily on Part II, because this is where healthcare organizations will find the practical guidance needed to evaluate events using the updated SRE Inclusion Criteria.

The report is intended to be a practical operational resource, not only for Joint Commission-accredited organizations, but for anyone responsible for reviewing, implementing, or overseeing Sentinel Event or SRE reporting programs.

00:13:28
As we look ahead to the 2027 transition, Joint Commission has developed a roadmap to support organizations every step of the way. This includes a series of webinars that take a deeper dive into the updated Sentinel Event List, along with office hours for more interactive organization-specific questions. Joint Commission will also share an updated Sentinel Event chapter so organizations can review and prepare in advance of implementation.

And if questions come up as you are reviewing the report or thinking about how this applies to your organization, you can submit them at any time to SREInquiries@jointcommission.org. This inbox is specifically monitored to support questions related to SREs, Sentinel Events, alignment, and reporting.

00:14:21
Throughout this year, Joint Commission will host topic-specific webinars and office hours focused on each event category, Procedural, Product and Device, Patient Protection, Care Provision, and Workforce Safety to support deeper understanding and practical application.

Overall, this timeline is about giving you multiple touchpoints, education, dialogue, and written guidance, so you feel informed, supported, and confident well before the transition takes effect.

Dates may be subject to change and our team will continue to communicate upcoming events on our website and on social media. You can also stay informed by checking our Joint Commission webinar knowledge library for a list of these events and dates.

With this timeline in mind, let's turn to what these changes mean for healthcare organizations as we approach 2027.

00:15:28
As we move closer to implementation, it's important to understand what's changing and why it's changing, so accredited healthcare organizations are prepared for the transition in 2027.

00:15:43
These updates affect how Sentinel Events are defined, identified, and reviewed. There are three core areas healthcare organizations should focus on in preparation for the 2027 alignment. First, organizations should become familiar with the revised Sentinel Event definition, which will align with NQF's SRE inclusion criteria. Second, the Sentinel Event list itself is changing, reflecting alignment with the NQF SRE list. And third and most importantly, for day-to-day practice, organizations will use new Clinical Application Guidance to support consistent interpretation and event review.

While many organizations are already familiar with Sentinel Event and SRE review and reporting, the 2025 updates introduce significant changes. For more information on these, we encourage you to reference part one of the report.

For today, we are going to focus on what this means for the Sentinel Event Program, what will be different, the rationale behind the change, and how you can practically apply this guidance in your organization.

Let's start with the first of these changes, the revised Sentinel Event definition.

00:16:58
The first major change for organizations is the revised Sentinel Event definition, which will now align with NQF's SRE Inclusion Criteria.

Historically, Joint Commission's Sentinel Event definition and NQF's SRE Inclusion Criteria were developed separately, but they were already conceptually very similar, both focused on events that are serious and largely preventable, and tied to care delivery. With the 2027 update, these two definitions are now fully aligned, meaning organizations are no longer navigating parallel frameworks to determine whether an event qualifies as a Sentinel Event or an SRE. This alignment creates a single shared foundation for event identification and review, supporting more consistent interpretation across organizations and reducing confusion about reporting thresholds. Importantly, this is not a new standard. It is a formal alignment of existing expectations, bringing clarity and consistency to how serious patient safety events are evaluated.

Starting in January of 2027, to qualify as a Sentinel Event, the event must be clearly tied to a patient encounter with a healthcare delivery system, be serious and largely preventable.

Part two of the report provides additional detail and examples to help reviewers apply the inclusion criteria and practice, which we will be reviewing in the next section.

00:18:32
The second change is the Sentinel Event List, and is where organizations will likely notice the most visible change compared to the prior list. What's different is not just the number of events, but how the list is structured and interpreted. The Sentinel Event List will now include 31 events, 28 Serious Reportable Events, plus three retained workforce safety Sentinel Events. Many of these correlate with the current Sentinel Event and this is indicated by the symbol after the name.

In the previous Sentinel Event List, organizations relied heavily on event names and outcomes to determine whether an event qualified as a Sentinel Event. With this update, event identification is supported by Clinical Application Guidance to reduce interpretation variability across organizations. You'll also notice a grouping of events, Procedural, Product and Device, Patient Protection, Care Provision, and Workforce Safety, which mirrors the SRE structure.

Importantly, organizational responsibilities remain the same. Accredited healthcare organizations must identify these events, examine root causes and contributing factors, and implement improvements to reduce the risk of reoccurrence.

Overall, with the 2027 update, the Joint Commission Sentinel Event List and the NQF SRE List are now fully aligned, meaning organizations are no longer navigating parallel lists to determine whether an event qualifies as a Sentinel Event or an SRE.

00:20:14
While some of these events appear new, it's important to know that 13 of these events are established Sentinel Events. The remaining 15 events are not explicitly listed as Sentinel Events today, but they meet the current Sentinel Event definition. In other words, these are not new expectations. They are events that have historically qualified, but were not part of the list.

The report includes a crosswalk on pages 17 through 21 that shows exactly how Sentinel Events align with the updated SRE List, helping organizations understand where the overlap already exists.

00:20:55
In addition to adopting the SRE List, Joint Commission will continue to champion workforce safety as a vital priority throughout its accredited healthcare organizations by maintaining three legacy workforce safety events, homicide of a staff member, Sexual Abuse or Sexual Assault of a staff member, and physical assault of a staff member. These events are associated with a healthcare worker's inter or intrapersonal safety within or on the grounds of a healthcare setting. Clinical application guidance for these three workforce safety events will be available in July of 2026 and organizations will be notified when the guidance is released.

It's important to note that there are three Sentinel Events that can pose significant risk to all individuals, including healthcare workers, visitors, and vendors. These include Sentinel Event 5, an MRI event, Sentinel Event 11, the Fire, Flame, and Unanticipated Smoke Event, and Sentinel Event 16, the Sexual Abuse or Sexual Assault Event. Recognizing the parallel between Sentinel Event 16 and Sentinel Event 30, we ask that organizations track and report Sexual Abuse or Sexual Assault involving a staff member under the workforce safety event, Sentinel Event 30, while all other instances under the patient protection event, Sentinel Event 16.

The key takeaway is that workforce safety remains an explicit and intentional focus within the Sentinel Event Program, reinforcing that safety applies to patients, staff, and everyone in the healthcare environment.

00:22:46
The third change is the introduction of event-specific information that is designed to help reviewers identify and report events in a consistent manner. It is located in Part II of the report and is designed to operationalize the SRE Inclusion Criteria and help guide your decision on whether to report an event or not. The Clinical Application Guidance consists of the intent, Key Definitions, and reporting considerations.

The intent clarifies what the event is meant to capture and exclude. It identifies applicable settings and populations and serves as the starting point for review.

The Key Definitions define critical terms used in the event name, intent or reporting considerations, and it is sourced from nationally recognized organizations and subject matter experts.

The reporting considerations translates the inclusion criteria into three actionable prompts. Prompts are tailored to the event type, patient harm versus regardless of the

outcome, and it helps reviewers determine whether an event qualifies as a Sentinel Event by integrating intent, definitions, and clinical circumstances.

The bottom line is that these components provide a structured, practical approach to Sentinel Event review that reduces variation, supports consistent decision making, and strengthens reporting practices across healthcare settings.

00:24:24
Now that we have walked through the key changes organizations should understand for 2027, let's shift from overview to application and look at how these updates come together during event review. Please keep in mind any mention of Sentinel Events and Sentinel Event reporting in this section pertains to the post-alignment transition in January of 2027 and not the current Sentinel Event List.

00:24:53
The SRE Technical Guidance provides a structured, consistent approach for determining whether an event qualifies as a Sentinel Event. It helps reviewers move beyond event names and apply the inclusion criteria systematically. For event review, organizations should follow five key steps.

First, they should review the event name, then review the Intent, Exclusions, and Key Definitions, confirm the event is tied to a patient encounter, determine the level of harm, and assess whether the event was largely preventable.

These steps reinforce existing expectations and create a repeatable process that supports consistent interpretation.

Next, we'll walk through how these steps are applied, starting with the event name.

00:25:47
SRE and Sentinel Event names are intentional and signal reporting expectations at a high level. With this update, event names fall into two groups: patient harm and regardless of the outcome. 19 Sentinel Events names begin with patient harm. This naming convention signals to the reviewer that Sentinel Event reporting is heavily influenced by the level of harm experienced by the patient. A key example is Sentinel Event 19, Patient Harm Associated with a Medication Error. You would consider reporting a medication error that was tied to a patient encounter with a healthcare delivery system if it was associated with serious patient harm and was largely preventable.

Nine Sentinel Event names include regardless of the outcome. This naming convention signals to the reviewer that Sentinel Event reporting is not influenced by the level of harm experienced by the patient. Although all Sentinel Events are serious and should never occur, those denoted regardless of the outcome signal that there are no circumstances under which the occurrence of this event should go unreported, and its occurrence, including a near miss event, qualifies as a Sentinel Event. A key example is Sentinel Event 5, introduction of an unapproved, unscreened, or inappropriately approved device, implant or object into a MRI Zone 4 area, regardless of the outcome. You would consider reporting any instance of a metallic object entering an MRI Zone 4 area regardless of whether an individual experienced harm.

The naming convention provides an important starting point, but the name alone is not sufficient to determine whether an event qualifies. Reviewers must always use the full Clinical Application Guidance, including Intent, Definitions, and Reporting Considerations to decide.

00:27:59
The next step to emphasize is reviewing the event's Intent, Exclusions, and Key Definitions to establish a shared understanding of what the event is meant to capture and what it is not. Reviewers should use these sections as the foundation for event review rather than relying on the event name alone. The Intent clarifies scope and population, Exclusions provide illustrative examples of events that do not qualify, and Key Definitions clarify critical terminology.

Throughout the Clinical Application Guidance, clinical examples are added to bolster understanding. However, you may not recognize your exact event when referencing this guidance. That's okay, these circumstances do not capture every possible clinical scenario, nor do they provide exhaustive examples of events. Instead, this section provides reviewers salient examples to guide interpretation in a standardized way. If uncertainty arises, this is an appropriate point in the guidance to pause and confirm shared understanding before moving on to the next step.

00:29:17
Step three begins walking the reviewer through the updated Sentinel Event Definition's SRE Inclusion Criteria statement. To qualify as a Sentinel Event, an event that is clearly tied to a patient encounter with a healthcare delivery system must be serious and largely preventable. After reviewing the intent, Exclusion, and Key Definitions, this step focuses on determining whether the event occurred in the context of an interaction between an individual and a healthcare setting for the provision of healthcare services. The term

Encounter has multiple meanings across healthcare. It may reference the start of a medical record encounter when an individual checks in for an appointment or it may mean when a patient arrives on a unit where they have been admitted.

Understanding your own policies and practices alongside this definition is important when determining whether an event is clearly tied to a patient encounter with the healthcare delivery system.

If an event occurs prior to an interaction between an individual and a healthcare setting, it may not qualify as a Sentinel Event. A key example is Sentinel Event 17, patient harm associated with a fall. A fall event that occurs prior to an individual presenting for care would not qualify as a Sentinel Event.

Even when the connection seems obvious, this step reinforces the consideration of other clinical details and context to ensure the event meets this criterion before proceeding with further evaluation. These details help develop a robust clinical picture of the event and may include reminders an event may trigger another encounter with a different care setting or department, such as a transfer to a higher level of care or an admission from an outpatient setting to an emergency department.

00:31:13
Step four focuses on determining the level of harm associated with the event. We recognize that healthcare organizations track and trend all types of patient safety events using this or a similar classification system. This slide highlights the Joint Commission categories of harm and how they align with the updated Sentinel Events. It is important to note that not all harm categories are applicable to every Sentinel Event.

The Clinical Application Guidance provide specific clinical examples to guide reviewers in determining whether the event meets the serious criterion.

We mentioned already that naming convention signals to the reviewer that the Sentinel Event reporting is heavily influenced by the level of harm experienced by the patient.

So let's look at how the naming convention aligns with these harm levels. For Patient Harm Events: Death, severe harm, or permanent harm categories are the only harm categories that align with serious patient harm. For Regardless of Outcome events, all categories are considered serious, from near miss to death, and should trigger your internal processes for event analysis. So let's first walk through this for Patient Harm events.

00:32:34
So far, we've covered the first few steps for using the SRE Technical Guidance for event review. In the next few slides, we will discuss the final steps for Patient Harm events. Then we will compare that with the Regardless of Outcome Events.

00:32:52
These are the Sentinel Events that begin with patient harm. There are 19 events across four categories for which the scope of harm is limited to serious, meaning that the only circumstances that qualify as a Sentinel Event or an SRE are those that are clearly tied to a patient encounter with a healthcare delivery system and meet both the serious and largely preventable criteria.

So what does this mean?

Healthcare is complex, we know this, and there are circumstances that occur in which no matter if we do everything right, an event may occur. So these events focus only on those instances that result in serious patient harm and are likely avoidable when generally accepted performance standards of care are implemented.

00:33:44
Healthcare organizations should evaluate whether a patient harm Sentinel Event resulted in serious patient harm. To determine this, reviewers must assess whether the event meets one or more components of the serious criterion by considering if the event resulted in physical, emotional, or psychological harm, a major intervention or an impairment of an individual's ability to perform activities of daily living. As a reminder, the Clinical Application Guidance provides event-specific clinical examples for reference during this process.

If an event meets one or more of these components, the event meets the serious criterion.

So let's talk about each of these components.

00:34:34
First, Physical Harm.

As we mentioned earlier, the harm levels that are applicable to Patient Harm Sentinel Events are those that reach the patient and resulted in death, severe harm regardless of duration, or permanent harm regardless of severity. This slide also showcases commonly used harm classification systems to show which categories correspond to serious patient harm, and which emphasizes that organizations can align their own terminology to this to help ensure consistent determination across systems. All harm categories listed here align with the serious criterion.

So if an event results in any of the harm categories listed here, the physical harm component is met and the event meets the serious criterion.

00:35:28
Historically, the definition of harm has focused on physical harm to patients. However, errors that occur clearly have a broader and longer lasting effect on patients and families, including emotional or psychological harm.

So next, healthcare organizations will need to evaluate if the event resulted in emotional harm. The scale shown here is Press Ganey's Emotional Harm Classification & Severity scale. As with physical harm, if your organization uses different terminology, you will need to align your own terminology to this to help ensure consistent determination across systems. For an event to meet this component, it must result in Emotional Harm One, which is severe, long-term, or permanent impact.

A key reminder is that emotional harm is not what we think the impact is to the patient, but instead it must be assessed from the patient's perspective. An example can be an anesthesia awareness event, a rare occurrence when a patient becomes conscious during a procedure when they should be unconscious. Each person will perceive what they experience differently, so the event occurrence alone does not determine emotional harm occurred. Remember, we must talk to the patient, evaluate their perspective, and bring that back to the team for determination.

If the determination is that the patient experienced Emotional Harm One, the emotional or psychological harm component is met and the event meets the serious criterion.

00:37:08
The next component to consider is whether the event results in a major intervention. A Major Intervention is characterized by both its clinical significance and its impact on the patient's overall care trajectory, typically involving actions taken to prevent death, significant disability, or further clinical deterioration. Examples include medical, surgical, or diagnostic procedures that involve significant risk, general anesthesia, or substantial invasion of bodily integrity, and often require hospitalization, prolonged care, or result in significant pain, debilitation, or extended recovery.

While these are primarily focused on the physical impact of an event, you still want to consider how this impacts the patient emotionally or psychologically. A key example is Sentinel Event 22, Patient Harm Associated With the Irretrievable Loss of a Biological Specimen that is irreplaceable or is only replaceable through an invasive procedure. The loss of a specimen, whether replaceable or not, may affect the progression of an undiagnosed disease or threat of disease and impact the overall care trajectory.

If the determination is that the patient experienced a major intervention, this component is met and the event meets a serious criterion.

00:38:38
The last component to review is whether the event impacted the patient's ability to perform activities of daily living. Reviewers should assess the degree of assistance required for mobility and self-care tasks, taking into account the patient's pre-event functional status. An event that limits a patient's ability to perform ADLs can create unsafe conditions and significantly diminish quality of life, supporting a determination of serious harm.

If you determine the event altered a patient's ability to perform ADLs, this component is met and the event meets the serious criterion.

Reviewing these components have all been part of assessing the level of harm associated with an event. Step four in the process healthcare organizations should follow when determining if an event qualifies as a Sentinel Event. For Patient Harm Events, this includes evaluating if the event resulted in serious patient harm or met one of the four components of the serious criterion, including physical, emotional, or psychological harm that required major intervention or impaired a patient's ability to perform activities of daily living.

We want to compare this with the Regardless of Outcome Events, but first let's review the final step for event review.

00:40:06
Step five focuses on determining whether a Sentinel Event was largely preventable. Reviewers are prompted to assess whether the event was likely avoidable using generally accepted performance standards of care, including existing technologies, clinical methods, and widely recognized standards such as evidence-based practices, regulations, and clinical guidelines. In addition, reviewers should review relevant organizational or department-specific policies, procedures, and practices. Deviations from these standards of care are signals that an event was largely preventable.

The Clinical Application Guidance includes examples. However, it may not reflect the exact practice or policy that your organization follows. That's okay, these circumstances do not capture every possible set of standards for the event. Instead, this section provides reviewers with salient examples to guide interpretation in a standardized way. If uncertainty arises, this is an appropriate point to pause and confirm a shared understanding of the avoidable by any means currently available and generally accepted performance standards of care definitions, which are included in the how-to-use section of the technical guidance.

You do not need to overcomplicate this step. Ask your team, "Is what actually happened what should have happened?" "Is this the kind of care we would've wanted for ourselves or our loved ones?"

If your determination is that there was a variation or a deviation in standard of care, the event meets the Largely Preventable criterion.

Now let's shift and talk about the Regardless of Outcome Events.

00:42:01
These are the Sentinel Events that include regardless of outcome. There are nine events across three categories for which reporting is not influenced by the level of harm experienced by the patient. These events signal that there are no circumstances under which the occurrence of this event should go unreported, and its occurrence, including a near miss event, qualifies as a Sentinel Event.

Meaning that any occurrence of this event is considered serious and meet the qualifying statement, it is clearly tied to a patient encounter with a healthcare delivery system and meets both the serious and largely preventable criteria.

So what does this mean?

Earlier, we acknowledged that healthcare is complex, but contrary to Patient Harm events, any occurrence of these nine signal vulnerabilities in the processes that are in place to prevent an error. For example, timeouts before procedures to prevent delivery of care to the wrong site or wrong patient. Organizations also have processes in place to capture errors before they reach the patient or cause harm. These are often celebrated because they are caught. However, these also can signal significant system issues in our processes that must be addressed before serious patient harm occurs. So it's important to note that the Clinical Application Guidance for these events will help discern which of these may qualify as a Sentinel Event or an SRE versus not.

00:43:46
The expectation is the same for all events. Healthcare organizations need to examine causative factors of all instances and engage in process improvement activities to mitigate reoccurrence. However, for Regardless of the Outcome events, the review process is a bit different. Step one through three do not change. Reviewers still need to review the Event Name, Intent, Exclusions and Definitions, and that it is clearly tied to a patient encounter.

Steps four and five do change. Since any instance is considered serious, step four requires reviewers to determine whether the event reached the patient and if the event resulted in harm. Additionally, since any instance is considered largely preventable, reviewers will need to identify deviations from generally accepted performance standards of care.

To close, regardless of event type, patient harm, or regardless of the outcome, the expectation is the same. Healthcare organizations are responsible for identifying events, examining root causes and contributing factors, and implementing meaningful improvements to reduce the risk of reoccurrence.

The alignment of Sentinel Events and SREs does not change that responsibility. It clarifies and standardize how events are reviewed, helping organizations apply a consistent, practical approach grounded in the SRE inclusion criteria and Clinical Application Guidance.

With that foundation in mind, we will now move into our Q&A segment to address your questions.

00:45:19
I want to make sure that you're aware that you can submit your thoughts via the question panel. I'd like to welcome my colleague, Kim Streett, who has been tracking your comments and questions so far.

If we do not get a chance to answer your question, please know that all questions not answered during the live event will be reviewed by our team. And so I'll just welcome Kim to join us.

Live Q&A

00:45:45
Thank you, Doreen. It's nice to join you. I'll give you a moment to catch your breath there. You covered a lot of information. There've been a lot of great comments and questions in the chat, so we'll address as many as we can today. Some of them are very specific to the Joint Commission update with the Sentinel Event Policy or chapter.

So, Doreen, just ask hopefully some off-the-cuff simple ones to start with. One comment was asking about the Ambulatory chapter. It does not have a Sentinel Event chapter, so asking if there would be updates coming for the Ambulatory chapter as well?

Yes, there will.

00:46:22
Okay, second question specific to Joint Commission is when events are reported, "When Sentinel Events are reported to Joint Commission, does that trigger an onsite review or is that similar to a complaint coming into Joint Commission?"

No, so Sentinel Event reporting is completely separate from complaint reporting in my department. So if an organization self-reports a Sentinel Event, it is assigned to a Patient Safety Specialist who reaches out to the organization, sets up, generally, a phone call to discuss the situation and then determine what the next steps are. The Sentinel Event process is completely separate from the complaint process.

The only time we would go out for a for-cause survey for a Sentinel Event is if a complaint identifies a sentinel event in the complaint, and we have no record of that Sentinel Event from the organization, and it's serious enough for us to feel we need to go out and do a for-cause survey.

00:47:52
So the majority of the time, it's separate. And in what ways do you collaborate with the

organization when they report an event? What- Sure. Sort of, what's the added bonus of reporting? 'Cause I know that your team is very collaborative and it's a great resource.

Yes, it is. So a lot of times organizations report items that they believe are Sentinel Events, and then after discussion with the Patient Safety Specialist, it's determined it is not a Sentinel Event. And then on the flip side, events are reported that the organization is sort of questioning and not really sure, and the work with the Patient Safety Specialist determines that it is a Sentinel Event. What we ask organizations to do is to then, they submit their root cause analysis to us. That is analyzed by the patient safety specialist. At times, those root cause analysis are very thorough and have identified processes that have broken down and organizations have identified actions that they're going to be taking to make changes to their processes.

Some organizations are not as mature in that process, and so the Patient Safety Specialist will meet with the team from the organization, go through the root cause analysis, help and ask questions that the organization may not have asked and help to get them to the real root cause of the reason for the event and some action planning that the organization can do to address the process breakdowns.

00:49:14
And this is something that you guys do now, right? So it's available for all accredited organizations now.

It is.

And just as a reminder, it's a completely voluntary process.

Yes, it is.

00:49:26
But there are broader benefits of reporting, right? Is there any future hope of benchmarking across accredited organizations or what is it that you do with that data and how can it help drive patient safety improvements?

Sure, so now that data is aggregated and it is published yearly. In fact, the 2025 Sentinel Event Report for domestic organizations will be published in April of this year. But in 2025, I can tell you that across the over 20,000 organizations that we accredit, we receive 1,529 Sentinel Event Reports. That is just a fraction, and it's from about 5% of those organizations. So we have some organizations that are robust reporters, and we thank them and appreciate them very much. And then we have organizations who don't or are concerned.

And I understand that there are concerns with organizations who have patient safety organizations that don't want to report but until we get a more statistically significant number of organizations reporting, that data really is just informational. It can't be benchmarked and we can't really see where the true areas of issues are. The hope with the alignment of the Sentinel Events and the Serious Reportable Events is that now that we will have one list, we can combine databases, hopefully, and maybe have more meaningful data for organizations to use.

00:51:20
All right. Thank you so very much. Another question came in about the RCA paperwork that Joint Commission has, and will that also be updated to reflect the changes?

Yes, it will. Okay. Excellent.

00:51:34
And all of that goes into effect, as a reminder, January 1, 2027. All of the updates will be visible in June or July, I believe, right, Doreen?

Correct, so the new Sentinel Event chapter will come out in July of 2026 in advance of the January 1st, 2027 release. The Clinical Application Guidance for the three Workforce Safety Events will also be released in July of 2026 and then all of our paperwork will be updated to be reflective as of 1/1/2027.

00:52:13
Great, you addressed another question, 'cause there's only 28 events in the report, right? So where are the other three? 29, 30 and 31 is definitely in the works. That Clinical Application Guidance is being drafted and so thank you for already answering that.

SRE30 is one of those Workforce Safety Events, so is that, those... One question came in that said, are those mandatory or are those organization-specific?

I think there is a little confusion 'cause the report doesn't have them, but just for clarity, if you want to share what the expectation is around those three.

Sure, so the three Workforce Safety Events have been Sentinel Events and we're just carrying them over to the new expanded list. And we felt that it was extremely important to keep those workforce safety events as part of the Sentinel Event List. Reporting of Sentinel Events is completely voluntary, so organizations do not have to report anything to us.

However, the standards, both in the leadership standards, require organizations that have Sentinel Events, that they must internally do comprehensive analysis of those Sentinel Events and analyze those over time. So that is a standard requirement, not a Sentinel Event Policy requirement, if that makes sense.

It does to me, but I also have been in this space more than our audience, so please share if that's still confusing. But we want to definitely support and be a catalyst for working through events, talking through events, understanding the real-world examples that help make this, help make the application guidance, I guess, easier to understand.

Right, and just going back to the Workforce Safety piece, there are three Sentinel Events, SRE/Sentinel Events that do incorporate the workforce, and those are the MRI Sentinel Event, the Fire, Flame, and Unanticipated Smoke Event, and then there is a Sexual Assault Event that includes visitors, vendors, and workforce.

As I said in the presentation, if you experience a sexual assault of a member of your workforce, we would ask, if you are going to self-report, you would self-report that as Sentinel Event number 30.

If it is the sexual assault of a patient or a visitor or a vendor, that you report it under Sentinel Event 15. Is it 15? Correct.

00:55:03
All right. Thank you for that. And just as an added note, the Sentinel Event name is staying. It's adopting aligning with the Serious Reportable Events, but everything is going to shift to Sentinel Events and remain Sentinel Events.

Correct, so for the Joint Commission, so if you look at the report, you'll see those 28 Serious Reportable Events and they're numbered 1 through 28. We are adopting the same numerology, but we will be calling them Sentinel Event 1, Sentinel Event 2, whereas it would be SRE1 or SRE2 if you were using the SRE List. So they'll just align, but they will still be called Sentinel Events.

00:55:58
All right. We did not get to every question. There are a ton in here. A lot of questions are very event-specific. And I just want to put a plug in there that we are doing these webinars as a series, and the next webinar is going to focus on Procedural Events. They're going to be by category, so if you have specific questions related to one of those events, we're going to pull those out specifically from today and make sure that we're

answering those in the coordinating future webinars, 'cause that's where we're going to dive into the specific event and the details of those events.

There have been a lot of questions around Patient Encounter, the Serious Harm Definition and other definitions like Grounds of a Healthcare Setting, Presentation for Care. Those are very specific. There are definitions in the report. Some of the circumstances are very specific to the events. So I think if, to summarize this update and to summarize kind of what do we do with all of this information is look at and make sure you're reviewing, just as Doreen had shared, the application guidance from start to finish. So look at the name, look at the intent, really understand what's excluded, what's intended to be captured, what's not intended to be captured, review the definitions, and then look at your circumstances. The clinical circumstances are just examples. Your event may look completely different, but if it still falls in line with the scope of the event, the intent, you should consider it a candidate as a Sentinel Event and just walk through that criteria every single time.

We're here to answer questions all the time, and I know Jessica will share that in the closing remarks, but, Doreen, are there any key takeaways or any advice that you would like to share before we pass it to Jess?

00:57:41
The only thing I'd like to say to the organizations, first off, thank you for joining us today, and we appreciate the time that you took to hear what we're doing. We know that anytime we make a change, it can be difficult for healthcare organizations. And so our hope is is that over the next six months, as we move toward the transition, the webinars that we have set up and the office hours that we have set up will help you through this transition.

Please know if you have any questions at all, we will be answering those, as Kim said, in the subsequent webinars, that will be focused on each set of Sentinel Events. And just know that we appreciate all that you do, as Ken said when he started this webinar this morning, that we really do appreciate all that you do to keep our patients and our workforce safe. So thank you for taking the time, and I will hand it over to Jess now.

00:58:36
Thank you, Kim and Doreen, for moderating, facilitating our Q&A segment. I will now take us into the closeout of this webinar. If you haven't already, you can download the full report in the FAQ document using the links listed at the bottom of this slide.

April 29th, we will launch the On Demand Joint Commission Sentinel Event Transition Webinar Series, starting with the Procedural Events, as Kim mentioned earlier. On the next slide, you can view the schedule for all of the upcoming webinars that will be released.

In July, the Sentinel Events Chapter Update will be published to Joint Commission's webinar website.

00:59:16
You can refer to this slide to see upcoming On Demand events and Office Hours. Please note, dates may be subject to change, but also as mentioned, our team will continue to communicate with upcoming events on our website and social media.

You can also stay informed by checking our Joint Commission Webinar Knowledge Library for the list of the events and the dates.

00:59:43
Approximately two weeks after this live broadcast, you'll be able to access the recording, the slides, and the transcript on Joint Commission's webpage via the link provided at the bottom of the slide.

00:59:57
After reviewing this webinar and the resources, you may still have some questions remaining, and that's okay. If you have any questions associated with the webinar content, please submit your inquiries to SREinquiries@jointcommission.org.

If you have any questions about webinar operations or obtaining continuing education credits, please submit them to tjcwebinarnotifications@jointcommission.org.

01:00:23
Before we close out this webinar, here is some additional information about our survey. We use your feedback to inform future content, determining education gaps, and assess the quality of our educational programs. A QR code will appear on the next slide. You can use your mobile device to scan and access the survey, but if you prefer to take it later, an automated email will also deliver the link to the survey. The survey is only open for two weeks following this live broadcast, so please be sure to complete it promptly.

After you complete and submit your survey responses, you'll be redirected to a page from which you can print or download a blank certificate that you will complete by adding your name and credentials. In case you miss that opportunity to download, an automated email will also be sent to that ... Sorry, will also be sent to you that includes the link to the certificate.

01:01:19
So we'll leave this slide up for a few moments so participants can scan the QR code. Thank you to Doreen and Ken and Kim for developing and delivering today's webinar content. Thank you to Kim for facilitating our Q&A segment, and thank you to all of you.

Thanks to our staff in the background for responding to audience questions and offering operational support. This will conclude our webinar, and have a great day.