Sentinel Event Policy (SE)

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

Although organizations are not required to report sentinel events to Joint Commission, accredited organizations must have a policy detailing how the organization addresses sentinel events. The specific requirements of that policy are included in the "Leadership" (LD) and "Performance Improvement" (PI) chapters on E-dition®. The organization must complete a thorough comprehensive systematic analysis (most commonly a root cause analysis) to determine why the event occurred. The organization must then create a corrective action plan to prevent similar events from happening again, implement the plan, and monitor its effectiveness.

All accredited organizations are encouraged to self-report potential sentinel events to Joint Commission to allow collaboration with the Office of Quality and Patient Safety (OQPS). Timely reporting will promote early engagement with a patient safety specialist assigned to work with your organization.

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 identify not only the relative frequency of different categories of sentinel events reported each year, they 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 four goals:

1. To positively impact care, treatment, or services by helping health care organizations identify opportunities to change their culture, systems, and processes to prevent unintended harm
2. To help health care organizations that have experienced a sentinel event determine and understand contributing factors (including underlying causes, latent conditions, and active failures) and develop strategies to prevent or reduce such events in the future
3. To increase the health care organization's resilience by becoming a learning organization
4. To maintain the confidence of the public, clinical staff, and health care organizations in the priority of patient and individual safety in Joint Commission–accredited health care organizations

Identifying Sentinel Events

Sentinel events are a subcategory of adverse events. A *sentinel event* is a safety event (not primarily related to the natural course of a patient's or individual's illness or underlying condition) that reaches a patient or individual and results in death, severe harm (regardless of duration of harm), or permanent harm (regardless of severity of harm).

Sentinel events are not only events that occur during the care and treatment of individuals. Physical and verbal violence, abductions, and power failures are all potential sentinel events that can affect the health care organization and its patients or individuals served. **Joint Commission considers the following list of events, though not comprehensive, to be sentinel events if they occur under any Joint Commission–accredited health care organization, although some of these events are unlikely to occur in certain health care settings:**[*]

- Death caused by self-inflicted injurious behavior if any of the following apply:
  - While in a health care setting
  - Within 7 days of discharge from inpatient services
  - Within 7 days of discharge from an emergency department (ED)

[*] Throughout this section, terms that are shown in ***boldface and italics*** are defined in the "Key Terms" sidebar.

  - ❑ While receiving or within 7 days of discharge from the following behavioral health care services: Day Treatment/Partial Hospitalization Program (PHP)/ Intensive Outpatient Program (IOP), Residential, Group Home, and Transitional Supportive Living
- Unanticipated death of a full-term infant
- Homicide of any patient or individual receiving care, treatment, and services while on site at the organization or while under the care or supervision of the organization
- Homicide of a staff member, visitor, or vendor while on site at the organization or while providing care or supervision to patients or individuals
- Any intrapartum maternal death
- ***Severe maternal morbidity*** (leading to ***permanent harm*** or ***severe harm***)[†]
- ***Sexual abuse/assault*** of any patient or individual receiving care, treatment, and services while on site at the organization or while under the care or supervision of the organization
- Sexual abuse/assault of a staff member, visitor, or vendor while on site at the organization or while providing care or supervision to patients or individuals
- Physical assault (leading to death, permanent harm, or severe harm) of any patient receiving care, treatment, and services while on site at the organization or while under the care or supervision of the organization
- Physical assault (leading to death, permanent harm, or severe harm) of a staff member, visitor, or vendor while on site at the organization or while providing care or supervision to patients
- Surgery or other ***invasive procedure*** performed at the wrong site, on the wrong patient, or that is the wrong (unintended) procedure for a patient regardless of the type of procedure or the magnitude of the outcome
- 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 harm to the patient

[†] Ongoing vigilance to better identify patients at risk for severe maternal morbidity—and timely implementation of clinical interventions consistent with evidence-based guidelines—are important steps in the ongoing provision of safe and reliable care. Appropriate systems improvements can be informed by identifying occurrences of maternal morbidity, reviewing the cases, and analyzing the findings.

- Administration of blood or blood products having unintended ABO and non-ABO (Rh, Duffy, Kell, Lewis, and other clinically important blood groups) incompatibilities (with or without clinical sequelae),[‡] hemolytic transfusion reactions, or transfusions resulting in death, permanent harm, or severe harm[§]
- Unintended retention of a foreign object in a patient after an invasive procedure, including surgery[||]
- Severe neonatal hyperbilirubinemia (bilirubin >30 milligrams/deciliter)
- Fluoroscopy resulting in permanent tissue injury when clinical and technical optimization were not implemented and/or recognized practice parameters were not followed[#]
- Any delivery of radiotherapy to the wrong patient, wrong body region, unintended procedure, or >25% above the planned radiotherapy dose
- ***Fire***, flame, or unanticipated smoke, heat, or flashes occurring during direct patient care caused by equipment operated and used by the organization. To be considered a sentinel event, equipment must be in use at the time of the event; staff do not need to be present.
- Fall in a staffed-around-the-clock care setting or fall in a care setting not staffed around the clock during a time when staff are present resulting in any of the following:

[‡] If a clinical determination warrants the use of Rho(D) positive blood to a Rho(D) negative recipient or uncrossmatched blood for emergent or lifesaving interventions, it would not be considered a reviewable sentinel event.

[§] Administration of blood or blood products where safety, potency, or purity has been compromised while the blood product in question was in the laboratory's control would be considered a sentinel event. *Source*: Food and Drug Administration, Center for Biologics Evaluation and Research. 21 CFR 606.171.

[||] The time period after an invasive procedure encompasses any time after the completion of final skin closure, even if the patient is still in the procedural area or in the operating room under anesthesia. A failure to identify and correct an unintended retention of a foreign object prior to that point in the procedure represents a system failure, which requires analysis and redesign. It also places the patient at additional risk by extending the surgical procedure and time under anesthesia. If a foreign object (for example, a needle tip or screw) is left in the patient because of a clinical determination that the relative risk to the patient of searching for and removing the object exceeds the benefit of removal, this would not be considered a reviewable sentinel event. However, in such cases, the organization shall (1) disclose to the patient the unintended retention and (2) keep a record of the retentions to identify trends and patterns (for example, by type of procedure, by type of retained item, by manufacturer, by practitioner) that may identify opportunities for improvement.

[#] *Source*: Adapted from National Council on Radiation Protection and Measurements (NCRP): Outline of Administrative Policies for Quality Assurance and Peer Review of Tissue Reactions Associated with Fluoroscopically-Guided Interventions (https://ncrponline.org/wp-content/themes/ncrp/PDFs/Statement_11.pdf) and the US Food and Drug Administration (FDA). Accessed Jan 26, 2026.

- ❑ Any fracture
- ❑ Surgery, casting, or traction
- ❑ Required consult/management or comfort care for a neurological (for example, skull fracture, subdural or intracranial hemorrhage) or internal (for example, rib fracture, small liver laceration) injury
- ❑ A patient with coagulopathy who receives blood products because of the fall
- ❑ Death or permanent harm because of injuries sustained from the fall (not from physiologic events causing the fall)

Sidebar 1 provides definitions to help health care organizations navigate the requirements of this policy.

Sidebar 1. Key Terms

fire A rapid oxidation process, which is a chemical reaction resulting in the evolution of light and heat in varying intensities. **Source:** National Fire Protection Association. NFPA 901: Standard Classifications for Incident Reporting and Fire Protection Data. Quincy, MA: NFPA, 2016.

invasive procedure A procedure in which skin or mucous membranes and/or connective tissue are incised or punctured, an instrument is introduced through a natural body orifice, or foreign material is inserted into the body for diagnostic or treatment-related purposes. Examples of invasive procedures include central line and chest tube insertions, biopsies and excisions, and all percutaneous procedures (for example, cardiac, electrophysiology, interventional radiology). Exclusions include venipuncture, which is defined as a collection of blood from a vein.

Note: *This exclusion is still considered a patient safety event and should be reviewed by the appropriate local quality and safety teams.*

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

severe harm An event or condition that reaches the individual, resulting in life-threatening bodily injury (including pain or disfigurement) that interferes with or results in loss of functional ability or quality of life that requires continuous physiological monitoring and/or surgery, invasive procedure, or treatment to resolve the condition.

severe maternal morbidity A patient safety event that occurs from the intrapartum through the immediate postpartum period (24 hours), requiring the transfusion of 4 or more units of packed red blood cells (PRBC) and/or admission to the intensive care

continued on next page

Sidebar 1. *(continued)*

unit (ICU). *Admission to the ICU* is defined as admission to a unit that provides 24-hour medical supervision and can provide mechanical ventilation or continuous vasoactive drug support. **Sources:** American College of Obstetrics and Gynecology, the US Centers for Disease Control and Prevention, and the Society of Maternal-Fetal Medicine.

sexual abuse/assault Nonconsensual sexual contact of any type with an individual. Sexual abuse includes, but is not limited to, the following:

- Unwanted intimate touching of any kind, especially of the breasts, buttocks, or perineal area
- All types of sexual assault or battery, such as rape, sodomy, and coerced nudity (partial or complete)
- Forced observation of masturbation and/or sexually explicit images, including pornography, texts, or social media
- Taking sexually explicit photographs and/or audio/video recordings of an individual and maintaining and/or distributing them (for example, posting on social media); this would include, but is not limited to, nudity, fondling, and/or intercourse involving an individual

Generally, sexual contact is nonconsensual in the following situations:

- When the individual lacks the cognitive or legal ability to consent even though appearing to want the contact to occur
- When the individual does not want the contact to occur

Other examples of nonconsensual sexual contact may include but are not limited to situations where an individual is sedated, is temporarily unconscious, or is in a coma. An individual's apparent consent to engage in sexual activity is not valid if it is obtained from the individual lacking the capacity to consent, or consent is obtained through intimidation, coercion, or fear, whether it is expressed by the individual or suspected by staff. Any forced, coerced, or extorted sexual activity with an individual, regardless of the existence of a preexisting or current sexual relationship, is considered to be sexual abuse.

Organizations are required to investigate and protect an individual(s) from nonconsensual sexual relations anytime the organization has reason to suspect that the individual(s) does not wish to engage in sexual activity or may not have the cognitive or legal ability to consent.

Note 1: *Reference for the above is the CMS State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities.*

continued on next page

Sidebar 1. *(continued)*

Note 2: *The first appearance of the terms in this sidebar are shown in **boldface and italics** in the Identifying Sentinel Events section.*

References

1. CMS *State Operations Manual* Appendix PP - Guidance to Surveyors for Long Term Care Facilities. https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/downloads/appendix-pp-state-operations-manual.pdf
2. Title 42 Chapter IV Subchapter G Part 483 Subpart B - Requirements for Long Term Care Facilities. https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-B

In cases in which the health care organization is uncertain an event meets Joint Commission's definition of a sentinel event, the event will be presumed to be a safety event, requiring comprehensive analysis. In the spirit of collaboration and shared learning, it is requested that this analysis be shared with OQPS.

All sentinel events must be reviewed by the health care organization and are subject to review by Joint Commission. Accredited health care organizations are expected to identify and respond appropriately to all sentinel events (as defined by Joint Commission) occurring in the health care organization or associated with services that the organization provides. An appropriate response includes all of the following:

- A formalized team response that stabilizes the patient or individual, discloses the event to the patient or individual and family, and provides support for the family as well as staff involved in the event
- Notification of organization leaders
- Immediate investigation
- Completion of a comprehensive systematic analysis for identifying the causal and contributory factors
- 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

Determining That a Sentinel Event Is Subject to Review

To determine if an event is sentinel, the organization must electronically submit a self-report (*see* the Reporting a Sentinel Event to Joint Commission section). Based on available information received about the event, a patient safety specialist from OQPS will determine whether an event meets the definition of *sentinel event* (as described in the Identifying Sentinel Events section). Any discrepancy in this determination will be resolved through discussions between Joint Commission leaders and the organization's leaders.

Relationship to the Survey Process

When conducting an unannounced accreditation survey, the surveyor(s) evaluates the health care organization's compliance with the applicable standards, National Patient Safety Goals, and Accreditation Participation Requirements. Surveyors are instructed not to search for or investigate sentinel events during an accreditation survey or to inquire about sentinel events that have been reported to Joint Commission.

During the survey, the surveyor(s) will assess the organization's compliance with sentinel event–related standards and performance improvement standards in the following ways:

- Assess an organization's performance improvement practices, such as its processes for responding to safety events, adverse events, hazardous unsafe conditions, close calls, and sentinel events
- Review the health care organization's process for responding to a sentinel event
- Interview the organization's leaders and staff about their expectations and responsibilities for identifying, reporting on, and responding to sentinel events

The surveyor makes no determination of whether the event is a sentinel event and does not review comprehensive systematic analysis documents and determine credibility, thoroughness, or acceptability. However, the surveyor may identify a Recommendation for Improvement if the organization has not completed a comprehensive systematic analysis of the event (including a corrective action plan) within 45 days of the event.

Required Organization Response to a Sentinel Event

All sentinel events must undergo a comprehensive systematic analysis by the health care organization, regardless of whether the events are reported to Joint Commission. If a reported sentinel event is determined to meet the criteria of this policy in a Joint Commission–accredited organization, the health care organization is expected to do the following:

- Prepare a thorough and credible comprehensive systematic analysis and corrective action plan within 45 business days of the event or of becoming aware of the event.
- Submit its comprehensive systematic analysis and corrective action plan electronically to Joint Commission, or otherwise provide its response to the sentinel event using an approved methodology within 45 business days of the known occurrence of the event for Joint Commission evaluation. Joint Commission OQPS staff will conduct a collaborative review with the organization's leaders or designee to determine whether the analysis and action plan are acceptable. The approaches to this review appear in the Submitting the Comprehensive Systematic Analysis and Corrective Action Plan section.

The fact that a health care organization has experienced a sentinel event will not impact its accreditation decision. However, willful failure to respond appropriately to the sentinel event could have such an impact. For instance, if the health care organization fails to submit a comprehensive systematic analysis within an additional 45 days following its due date, its accreditation decision may be impacted. In these instances, patient safety specialists in OQPS, along with OQPS leaders, would recommend to the executive leaders of Joint Commission and the Accreditation Council to revise the health care organization's accreditation status.

Figure 1 provides a general timeline for the overall process.

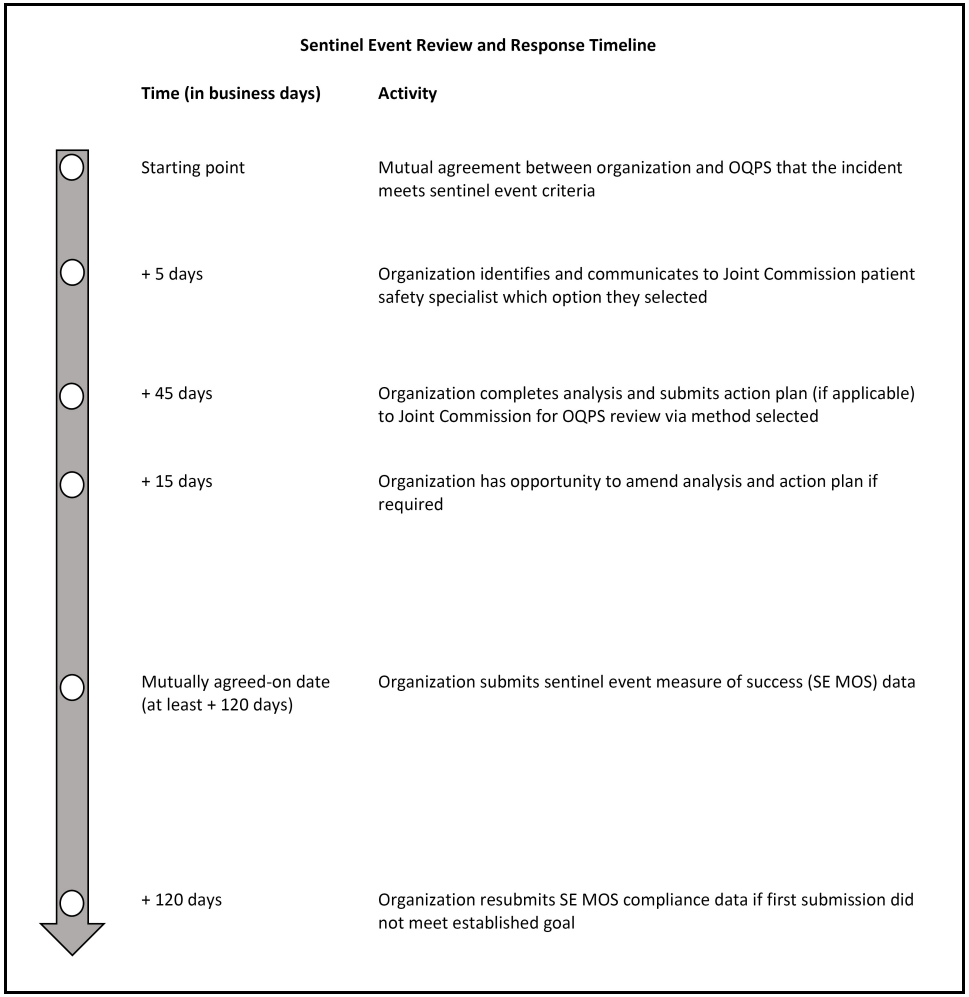

Figure 1. *This general timeline provides an overview of the sentinel event response process.*

Reporting a Sentinel Event to Joint Commission

Each health care organization is strongly encouraged, but not required, to report to Joint Commission any safety event that meets Joint Commission's definition of *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. Place the cursor over "Continuous Compliance Tools" and select "Self-Report Sentinel Event" from the drop-down list. Follow the directions on screen 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.

Conducting a Comprehensive Systematic Analysis

The health care organization must complete a comprehensive systematic analysis to identify the causal and contributory factors to any known sentinel event. A *comprehensive systematic analysis* is defined simply 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 (addressed in the next section) with the use of evidence-based practices or tools.

Joint Commission staff use the analysis, which focuses on systems and processes, to review the organization's analysis and verify it is thorough and credible (*see* the Review of Comprehensive Systematic Analyses and Corrective Action Plans section). The organization's selected comprehensive systematic analysis method should address the

questions from Joint Commission's Framework for Root Cause Analysis and Corrective Actions.[**] There are several mandatory fields within the form which 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 the Review of Comprehensive Systematic Analyses and Corrective Action Plans section 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

[**] Joint Commission: Framework for Root Cause Analysis and Corrective Actions. https://digitalassets.jointcommission.org/api/public/content/3559a1e9d41842348122ca1f2c627e96?v=291853c9. Accessed Jan 26, 2026.

[††] 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.

proposed solutions. An evidence-based tool, such as the VA's National Center for Patient Safety's action hierarchy,[§§] can help the team identify strong actions that provide effective and sustained system improvement.

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 (NPSF), 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 the Review of Comprehensive Systematic Analyses and Corrective Action Plans section 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 reports a sentinel event must 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

[§§] 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.

[||||] 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.

health care organization staff. These documents should not include the names of organization staff, patients, or individuals served involved in the sentinel event or other protected personal health information (PHI).

Joint Commission must receive a request for review of an organization's response to a sentinel event within five (5) business days of the self-report of a sentinel event.

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 consultation to the health care organization if the response is unacceptable 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. If the response is still unacceptable, the health care organization's accreditation decision may be impacted.

Review of Comprehensive Systematic Analyses and Corrective Action Plans

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 systems 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)
- 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/individual or family member when appropriate, and individuals close to the process under review)[##]

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* the Handling Sentinel Event–Related Documents section).

[##] Joint 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.

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 or follow-up activities.

Follow-up Activities

After Joint Commission has determined 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 agreed-upon documentation of sustained improvement and reduction of risk, which may include one or more measures of success (MOS) or a review of the sentinel event at the health care organization.

Sentinel Event Measures of Success

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 measures (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 pre-established 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 pre-established 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. An *Immediate Threat to Health or Safety* is a threat that represents immediate risk and has or may potentially have serious adverse effects on the health or

safety of the patient. All potential Immediate Threats to Health or Safety are referred to Joint Commission executive leaders for authorization to conduct an unannounced for-cause survey. If an on-site survey is conducted, the health care organization will be billed a sufficient charge, based on an established fee schedule, to cover the costs of conducting such a survey. (*See* the For-Cause Surveys section in "The Accreditation Process" [ACC] chapter of E-dition or the *Comprehensive Accreditation Manual* for more information.)

Handling Sentinel Event–Related Documents

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.

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.

The 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 or individual 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 Alert*s, National Patient Safety Goals®, and other methods of information sharing. The information disseminated from Joint Commission's Sentinel Event Database can help an organization identify a problem or area for analysis. For example, organizations can learn about sentinel events that occur with significant frequency, their root causes, and possible risk reduction strategies through Joint Commission's *Sentinel Event Alert*s.

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/en-us/knowledge-library/support-center/standards-interpretation/sentinel-event-policy-and-procedures.