Sentinel Event Policy and Procedures

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The Joint Commission adopted a formal Sentinel Event Policy in 1996 to help hospitals that experience serious adverse events improve safety and learn from those sentinel events. Careful investigation and analysis of Patient Safety Events (events not primarily related to the natural course of the patient's illness or underlying condition), as well as evaluation of corrective actions, is essential to reduce risk and prevent patient harm. The Sentinel Event Policy explains how The Joint Commission partners with health care organizations that have experienced a serious patient safety event to protect the patient, improve systems, and prevent further harm.

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

An event can also be considered sentinel event even if the outcome was not death, permanent harm, severe harm and intervention required to sustain life.

Such events are called "sentinel" because they signal the need for immediate investigation and response. Each accredited organization is strongly encouraged, but not required, to report sentinel events to The Joint Commission. Organizations benefit from self-reporting in the following ways:

- The Joint Commission can provide support and expertise during the review of a sentinel event.
- The opportunity to collaborate with a patient safety expert in The Joint Commission's Sentinel Event Unit of the Office of Quality and Patient Safety.
- Reporting raises the level of transparency in the organization and promotes a culture of safety.
- Reporting conveys the health care organization's message to the public that it is doing everything possible, proactively, to prevent similar patient safety events in the future.

Further, reporting the event enables "lessons learned" from the event to be added to The Joint Commission's Sentinel Event Database, thereby contributing to the general knowledge about sentinel events and to the reduction of risk for such events.

Sentinel Event Policy and Procedures by Accreditation and Certification Program Effective January 1, 2025

- Ambulatory Health Care
- Assisted Living Communities
- Behavioral Health Care and Human Services
- Critical Access Hospital
- Home Care
- Hospital
- Laboratory
- Nursing Care Center
- Office-Based Surgery
- Rural Health Clinics
- Telehealth

Alternatives for Sharing Sentinel Event-Related Information with The Joint Commission

The Sentinel Event Policy requires the organization to share its root cause analysis or comprehensive systematic analysis (RCA), plan of action (POA), and other sentinel event-related information with The Joint Commission. The organization is provided options for the method of sharing the information once the event is determined to be reviewable by the Office of Quality & Patient Safety (OQPS).

The methods of sharing the RCA are detailed below. The most frequently selected method is the Alternative 0, which has no fee.

Alternatively, if the organization has concerns about waivers of confidentiality protections as a result of sending the RCA documents to The Joint Commission, the following alternative approaches to a review of the organization's response to the sentinel event are acceptable. Any one of the four alternatives except the alternative 0 will result in a fee to the organization. Inquiries about the fee should be directed to The Joint Commission's Pricing Unit at 630.792.5115.

Regardless of the method of sharing selected by the organization, a bibliography should be completed as part of the RCA/POA process. The bibliography should contain evidence-based references pertinent to the sentinel event which the organization referred to during the completion of the RCA and POA. The organization will be required to provide a copy of that bibliography to the Patient Safety Specialist (PSS) reviewing the organization's RCA/POA.

Methods of sharing information include:

Alternative 0 (electronic submission of RCA and POA; Most frequently used method of sharing information with The OQPS Sentinel Event Unit - no fee.)

Once the event is determined sentinel, the PSS will place the RCA/POA tool on your secure extranet site. (The organization accesses the RCA tool from their secured extranet site.) This tool is completed online and includes the RCA, POA and bibliography. It is submitted to the Joint Commission within 45 business days of the date the organization became aware of the event. If the reporting occurs after day 45, the organization has 15 business days to complete the RCA/POA tool electronically and submit to The Joint Commission. A follow up conference call will be scheduled and conducted after the RCA/POA is received by The Joint Commission to discuss the information with the PSS. The Joint Commission will not release the information to any external entity and will vigorously defend the confidentiality of the information, if necessary, in the courts.

Have Questions?

Your account executive is here to help. Your dedicated account executive is your primary contact at The Joint Commission. They're here to help:

- Answer questions about your application and survey/review preparation.
- Support your post-survey/review activities.
- Connect you with other Joint Commission contacts when you need them.

Contact your Joint Commission account executive for assistance. If you do not know who your account executive is, simply call 1.888.527.9255.