

Sentinel Events

I. Sentinel Events

In support of its mission to continuously improve the safety and quality of health care provided to the public, the Joint Commission reviews organizations' activities in response to sentinel events in its accreditation process, including all full accreditation surveys and random unannounced surveys and, as appropriate, for-cause surveys.

- A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.
- Such events are called "sentinel" because they signal the need for immediate investigation and response.
- The terms "sentinel event" and "medical error" are not synonymous; not all sentinel events occur because of an error and not all errors result in sentinel events.

II. Goals of the Sentinel Event Policy

The policy has four goals:

1. To have a positive impact in improving patient care, treatment, and services and preventing sentinel events
2. To focus the attention of an organization that has experienced a sentinel event on understanding the causes that underlie the event, and on changing the organization's systems and processes to reduce the probability of such an event in the future
3. To increase the general knowledge about sentinel events, their causes, and strategies for prevention
4. To maintain the confidence of the public and accredited organizations in the accreditation process

III. Standards Relating to Sentinel Events

Standards

Each Joint Commission accreditation manual contains standards in the "Improving Organization Performance" (PI) chapter that relate specifically to the management of sentinel events. These standards are PI.1.10, PI.2.20, PI.2.30, and PI.3.10.

Organization-Specific Definition of Sentinel Event

The Improving Organization Performance standard, PI.2.30, requires each accredited organization to define "sentinel event" for its own purposes in establishing mechanisms to identify, report, and manage these events. While this definition must be consistent with the general definition of sentinel event as published by the Joint Commission, accredited organizations have some latitude in setting more specific parameters to define "unexpected," "serious," and "the risk thereof." At a minimum, an organization's definition must include those events that are subject to review under the Sentinel Event Policy as defined in Section IV of this chapter.

Expectations Under the Standards for an Organization's Response to a Sentinel Event

Accredited organizations are expected to identify and respond appropriately to all sentinel events (as defined by the organization in accordance with the preceding paragraph) occurring in the organization or associated with services that the organization

provides, or provides for. Appropriate response includes conducting a timely, thorough, and credible root cause analysis; developing an action plan designed to implement improvements to reduce risk; implementing the improvements; and monitoring the effectiveness of those improvements.

Root Cause Analysis

Root cause analysis is a process for identifying the basic or causal factors that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event. A root cause analysis focuses primarily on systems and processes, not on individual performance. It progresses from special causes* in clinical processes to common causes† in organizational processes and systems and identifies potential improvements in processes or systems that would tend to decrease the likelihood of such events in the future or determines, after analysis, that no such improvement opportunities exist.

Action Plan

The product of the root cause analysis is an action plan that identifies the strategies that the organization intends to implement in order to reduce the risk of similar events occurring in the future. The plan should address responsibility for implementation, oversight, pilot testing as appropriate, time lines, and strategies for measuring the effectiveness of the actions.

Survey Process

When conducting an accreditation survey, the Joint Commission seeks to evaluate the organization's compliance with the applicable standards and to score those standards based on performance throughout the organization over time (for example, the preceding 12 months for a full accreditation survey or the preceding 4 months for an initial survey). Surveyors are instructed not to seek out specific sentinel events beyond those already known to the Joint Commission.

If, in the course of conducting the usual survey activities, a sentinel event is identified, the surveyor will take the following steps:

- Inform the CEO that the event has been identified
- Inform the CEO the event will be reported to the Joint Commission for further review and follow-up under the provisions of the Sentinel Event Policy

During the on-site survey, the surveyor(s) will assess the organization's compliance with sentinel event-related standards in the following ways:

- Review the organization's process for responding to a sentinel event
- Interview the organization's leaders and staff about their expectations and responsibilities for identifying, reporting, and responding to sentinel events
- Ask for an example of a root cause analysis that has been conducted in the past year to assess the adequacy of the organization's process for responding to a sentinel event. Additional examples may be reviewed if needed to more fully assess the organization's understanding of, and ability to conduct, root cause

* **Special cause** is a factor that intermittently and unpredictably induces variation over and above what is inherent in the system. It often appears as an extreme point (such as a point beyond the control limits on a control chart) or some specific, identifiable pattern in data.

† **Common cause** is a factor that results from variation inherent in the process or system. The risk of a common cause can be reduced by redesigning the process or system.

analyses. In selecting an example, the organization may choose a “closed case” or a “near miss”[‡] to demonstrate its process for responding to a sentinel event.

IV. Reviewable Sentinel Events

Definition of Occurrences That Are Subject to Review by the Joint Commission Under the Sentinel Event Policy

The definition of a reviewable sentinel event takes into account a wide array of occurrences applicable to a wide variety of health care organizations. Any or all occurrences may apply to a particular type of organization. Thus, not all of the following occurrences may apply to your particular organization. The subset of sentinel events that is subject to review by the Joint Commission includes any occurrence that meets any of the following criteria:

- The event has resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient’s illness or underlying condition^{§**}
or
- The event is one of the following (even if the outcome was not death or major permanent loss of function unrelated to the natural course of the patient’s illness or underlying condition):
 - Suicide of any patient receiving care, treatment and services in a staffed around-the-clock care setting or within 72 hours of discharge
 - Unanticipated death of a full-term infant
 - Abduction of any patient receiving care, treatment, and services
 - Discharge of an infant to the wrong family
 - Rape^{††}
 - Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities

[‡] **Near miss** Used to describe any process variation that did not affect an outcome but for which a recurrence carries a significant chance of a serious adverse outcome. Such a “near miss” falls within the scope of the definition of a sentinel event but outside the scope of those sentinel events that are subject to review by the Joint Commission under its Sentinel Event Policy.

[§] A distinction is made between an adverse outcome that is primarily related to the natural course of the patient’s illness or underlying condition (not reviewed under the Sentinel Event Policy) and a death or major permanent loss of function that is associated with the treatment (including “recognized complications”) or lack of treatment of that condition, or otherwise not clearly and primarily related to the natural course of the patient’s illness or underlying condition (reviewable). In indeterminate cases, the event will be presumed reviewable and the organization’s response will be reviewed under the Sentinel Event Policy according to the prescribed procedures and time frames without delay for additional information such as autopsy results.

^{**} “Major permanent loss of function” means sensory, motor, physiologic, or intellectual impairment not present on admission requiring continued treatment or lifestyle change. When “major permanent loss of function” cannot be immediately determined, applicability of the policy is not established until either the patient is discharged with continued major loss of function, or two weeks have elapsed with persistent major loss of function, whichever occurs first.

^{††} *Rape* as a reviewable sentinel event is defined as unconsented sexual contact involving a patient and another patient, staff member, or other perpetrator while being treated or on the premises of the organization, including oral, vaginal, or anal penetration or fondling of the patient’s sex organ(s) by another individual’s hand, sex organ, or object. One or more of the following must be present to determine reviewability:

- Any staff-witnessed sexual contact as described above
- Sufficient clinical evidence obtained by the organization to support allegations of unconsented sexual contact
- Admission by the perpetrator that sexual contact, as described above, occurred on the premises

- Surgery on the wrong patient or wrong body part^{††}
- Unintended retention of a foreign object in a patient after surgery or other procedure
- Severe neonatal hyperbilirubinemia (bilirubin >30 milligrams/deciliter)
- Prolonged fluoroscopy with cumulative dose >1500 rads to a single field or any delivery of radiotherapy to the wrong body region or >25% above the planned radiotherapy dose

Examples of reviewable sentinel events and nonreviewable events are provided in Table 1.

How the Joint Commission Becomes Aware of a Sentinel Event

Each organization is encouraged, but not required, to report to the Joint Commission any sentinel event meeting the above criteria for reviewable sentinel events. Alternatively, the Joint Commission may become aware of a sentinel event by some other means such as communication from a patient, a family member, an employee of the organization, a surveyor, or through the media.

Reasons for Reporting a Sentinel Event to the Joint Commission

Although self-reporting a sentinel event is not required and there is no difference in the expected response, time frames, or review procedures, whether the organization voluntarily reports the event or the Joint Commission becomes aware of the event by some other means, there are several advantages to the organization that self-reports a sentinel event:

- Reporting the event enables the addition of the “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 in many other organizations
- Early reporting provides an opportunity for consultation with Joint Commission staff during the development of the root cause analysis and action plan
- The organization’s message to the public that it is doing everything possible to ensure that such an event will not happen again is strengthened by its acknowledged collaboration with the Joint Commission to understand how the event happened and what can be done to reduce the risk of such an event in the future

Required Response to a Reviewable Sentinel Event

If the Joint Commission becomes aware (either through voluntary self-reporting or otherwise) of a sentinel event that meets the above criteria and the event has occurred in an accredited organization, the organization is expected to do the following:

- Prepare a thorough and credible root cause analysis and action plan within 45 calendar days of the event or of becoming aware of the event
- Submit to the Joint Commission its root cause analysis and action plan, or otherwise provide for Joint Commission evaluation of its response to the sentinel event under an approved protocol (*see* Section VI), within 45 calendar days of the known occurrence of the event

The Joint Commission will then determine whether the root cause analysis and action plan are acceptable. If the determination that an event is reviewable under the Sentinel Event Policy occurs more than 45 calendar days following the known occurrence of the event, the organization will be allowed 15 calendar days for its response. If the organization fails to submit an acceptable root cause analysis within the 45 calendar days

^{††} All events of surgery on the wrong patient or wrong body part are reviewable under the policy regardless of the magnitude of the procedure or the outcome.

(or within 15 calendar days, if the 45 calendar days have already elapsed), the following consequences will result (depending on the length of time the organization fails to submit a root cause analysis):

- If the organization has failed to submit a root cause analysis within an additional 30 days following its due date, its accreditation decision will automatically be changed to Provisional Accreditation, and both the organization and the Accreditation Committee will be notified.
- If the organization has failed to submit a root cause analysis within 60 days following its due date, its accreditation decision will automatically be changed to Conditional Accreditation, and both the organization and the Accreditation Committee will be notified.
- If the organization then continues to fail to submit a root cause analysis for 90 days following its due date, a recommendation for Denial of Accreditation will be presented to the Accreditation Committee. The organization would then be given the opportunity to submit a response to the Accreditation Committee. However, if the Committee were to reach a Denial of Accreditation Decision because the organization has failed to submit any root cause analysis, the organization would not have access to the appeals process.

Please note that an organization that experiences a sentinel event as defined by the organization, but that does not meet the criteria for review under the Sentinel Event Policy is still expected to complete a root cause analysis (as required by standard PI.2.30) but does not need to submit it to the Joint Commission.

Review of Root Cause Analyses and Action Plans

A root cause analysis will be considered acceptable if it has the following characteristics:

- The analysis focuses primarily on systems and processes, not on individual performance
- The analysis progresses from special causes in clinical processes to common causes in organizational processes
- The analysis repeatedly digs deeper by asking “Why?”; then, when answered, “Why?” again, and so on
- The analysis identifies changes that could be made in systems and processes (either through redesign or development of new systems or processes) which would reduce the risk of such events occurring in the future
- The analysis is thorough and credible

To be thorough, the root cause analysis must include the following:

- A determination of the human and other factors most directly associated with the sentinel event and the process(es) and systems related to its occurrence
- An analysis of the underlying systems and processes through a series of “Why?” questions to determine where redesign might reduce risk
- An inquiry into all areas appropriate to the specific type of event as described in Table 2
- An identification of risk points and their potential contributions to this type of event
- A determination of potential improvement in processes or systems that would tend to decrease the likelihood of such events in the future, or a determination, after analysis, that no such improvement opportunities exist

To be credible, the root cause analysis must do the following:

- Include participation by the leadership of the organization and by individuals most closely involved in the processes and systems under review
- Be internally consistent (that is, not contradict itself or leave obvious questions unanswered)
- Provide an explanation for all findings of “not applicable” or “no problem”

- Include consideration of any relevant literature

An action plan will be considered acceptable if it does the following:

- Identifies changes that can be implemented to reduce risk or formulates a rationale for not undertaking such changes
- Identifies, in situations where improvement actions are planned, who is responsible for implementation, when the action will be implemented (including any pilot testing), and how the effectiveness of the actions will be evaluated

All root cause analyses and action plans will be considered and treated as confidential by the Joint Commission. A detailed listing of the minimum scope of root cause analysis for specific types of sentinel events is included in Table 2.

Follow-up Activities

After the Joint Commission has determined that an organization has conducted an acceptable root cause analysis and developed an acceptable action plan, the Joint Commission will notify it that the root cause analysis and action plan are acceptable and will assign an appropriate follow-up activity, typically one or more sentinel event measures of success (SE MOS) due in four months (*see* Sentinel Events Measures of Success).

V. The Sentinel Event Database

To achieve the third goal of the Sentinel Event Policy, “to increase the general knowledge about sentinel events, their causes, and strategies for prevention,” the Joint Commission collects and analyzes data from the review of sentinel events, root cause analyses, action plans, and follow-up activities. These data and information form the content of the Joint Commission’s Sentinel Event Database.

The Joint Commission is committed to developing and maintaining this Sentinel Event Database in a fashion that will protect the confidentiality of the organization, the caregiver, and the patient. Included in this database are three major categories of data elements:

1. Sentinel event data
2. Root cause data
3. Risk reduction data

Deidentified aggregate data relating to root causes and risk-reduction strategies for sentinel events that occur with significant frequency will form the basis for future error-prevention advice to organizations through *Sentinel Event Alert* and other media. The Sentinel Event Database is also a major component of the evidence base for the National Patient Safety Goals.

VI. Procedures for Implementing the Sentinel Event Policy

Voluntary Reporting of Reviewable Sentinel Events to the Joint Commission

If an organization wishes to report an occurrence in the subset of sentinel events that are subject to review by the Joint Commission, the organization will be asked to complete a form accessible through their extranet home page. From the home page, select “Self Report Sentinel Event” from the “Continuous Compliance Tools” section.

Reviewable Sentinel Events That Are Not Reported by the Organization

If the Joint Commission becomes aware of a sentinel event subject to review under the Sentinel Event Policy which was not reported to the Joint Commission by the organization, the CEO of the organization is contacted, and a preliminary assessment of the sentinel event is made. An event that occurred more than one year before the date the Joint Commission became aware of the event will not, in most cases, be reviewed under the Sentinel Event Policy. In such a case, a written response will be requested from the organization, including a summary of processes in place to prevent similar occurrences.

Determination That a Sentinel Event Is Reviewable Under the Sentinel Event Policy

Based on available factual information received about the event, Joint Commission staff will apply the above definition to determine whether the event is reviewable under the Sentinel Event Policy. Challenges to a determination that an event is reviewable will be resolved through consultation with senior staff in the Division of Accreditation and Certification Operations.

Initial On-Site Review of a Sentinel Event

An initial on-site review of a sentinel event will usually not be conducted unless it is determined that there is a potential ongoing immediate threat to patient health or safety or potentially significant noncompliance with Joint Commission standards. Immediate Threat to Life incidents include situations in which the organization's noncompliance with one or more standards has caused, or is likely to cause, serious injury, harm, impairment, or death to a patient and is likely to continue. Complaints are assigned this priority if the information indicates immediate corrective action is necessary. All are immediately referred to Joint Commission Executive Leadership for authorization to conduct an unannounced for-cause survey. If an on-site ("for-cause") review is conducted, the organization will be billed an appropriate amount based on the established fee schedule to cover the costs of conducting such a survey.

Disclosable Information

If the Joint Commission receives an inquiry about the accreditation decision of an organization that has experienced a reviewable sentinel event, the organization's accreditation decision will be reported in the usual manner without making reference to the sentinel event. If the inquirer specifically references the specific sentinel event, the Joint Commission will acknowledge that it is aware of the event and currently is working or has worked with the organization through the sentinel event review process.

Submission of Root Cause Analysis and Action Plan

The organization that experiences a sentinel event subject to the Sentinel Event Policy is asked to submit two documents: (1) the complete root cause analysis, including its findings; and (2) the resulting action plan that describes the organization's risk reduction strategies and measures for evaluating their effectiveness. This information will be submitted to the Joint Commission Central Office using an online RCA collection tool, also accessible from the "Continuous Compliance Tools" section of the extranet home page, under the "Sentinel Event Activities" link.

The root cause analysis and action plan are not to include the name(s) of caregivers and patients involved in the sentinel event.

Alternatively, if the organization has concerns about waivers of confidentiality protections as a result of sending the root cause analysis documents to the Joint

Commission, the following alternative approaches to a review of the organization's response to the sentinel event are acceptable:

1. A review of the root cause analysis and action plan documents brought to Joint Commission headquarters by organization staff then taken back to the organization on the same day
2. An on-site visit by a specially trained surveyor to review the root cause analysis and action plan
3. An on-site visit by a specially trained surveyor to review the root cause analysis and findings without directly viewing the root cause analysis documents through a series of interviews and a review of relevant documentation. For purposes of this review activity, "relevant documentation" includes, at a minimum, any documentation relevant to the organization's process for responding to sentinel events, the patient's medical record, and the action plan resulting from the analysis of the subject sentinel event. The latter serves as the basis for appropriate follow-up activity.
4. When the organization affirms that it meets specified criteria respecting the risk of waiving confidentiality protections for root cause analysis information shared with the Joint Commission, an on-site visit by a specially trained surveyor to conduct the following:
 - a. Interviews and review relevant documentation, including the patient's medical record, to obtain information about the following:
 - The process the organization uses in responding to sentinel events
 - The relevant policies and procedures preceding and following the organization's review of the specific event, and the implementation thereof, sufficient to permit inferences about the adequacy of the organization's response to the sentinel event
 - b. A standards-based survey that traces a patient's care, treatment, and services and the organization management functions relevant to the sentinel event under review.^{§§}

Any one of the four alternatives will result in a sufficient charge to the organization to cover the average direct costs of the visit. Inquiries about the fee should be directed to the Joint Commission's Pricing Unit at 630/792-5115.

The Joint Commission must receive a request for review of an organization's response to a sentinel event using any of these alternative approaches within at least five business days of the self-report of a reviewable event or of the initial communication by the Joint Commission to the organization that it has become aware of a reviewable sentinel event.

The Joint Commission's Response

Staff assesses the acceptability of the organization's response to the reviewable sentinel event, including the thoroughness and credibility of any root cause analysis information reviewed and the organization's action plan. If the root cause analysis and action plan are found to be thorough and credible, the response will be accepted and one or more SE MOS will be assigned.

If the response is unacceptable, staff will provide consultation to the organization on the criteria that have not yet been met and will allow an additional 15 calendar days beyond the original submission period for the organization to resubmit its response.

If the response does not meet established criteria, the organization's accreditation decision automatically will be changed to Provisional Accreditation, and both the organization and the Accreditation Committee will be notified. The Joint Commission

^{§§} For more information about the tracer methodology, see "The Accreditation Process" chapter in each program manual.

staff will provide additional consultative support to the organization and allow an additional 10 business days to submit an acceptable root cause analysis and action plan. The organization's accreditation decision reverts to Accredited when the root cause analysis and action plan are determined to be acceptable.

If the third submission continues to not meet established criteria, the Joint Commission staff will recommend that the organization's accreditation decision be changed to Conditional Accreditation, and both the organization and the Accreditation Committee will be notified. The organization will have one final 45-day period in which to submit an acceptable root cause analysis and action plan. If the submitted root cause analysis and action plan still do not meet established criteria, the Accreditation Committee of the Joint Commission will be requested to change the organization's accreditation decision to Preliminary Denial of Accreditation.

When the organization's response (initial or revised) is found to be acceptable, the Joint Commission issues a letter that does the following:

- Reflects the Joint Commission's determination to continue or modify the organization's current accreditation decision
- Assigns an appropriate follow-up activity, typically one or more sentinel event measures of success due in four months

Sentinel Events Measures of Success

The organization's follow-up activity will be conducted through the measure of success (MOS) process. An MOS is a numerical or quantifiable measure usually related to an audit that determines if a planned action was effective and sustained. The SE MOS are due four months after the root cause analysis and action plan are determined acceptable. If the planned action can be associated with a standard or National Patient Safety Goal requirement, it will have a level of compliance expectation based on the type of element of performance (EP) for the associated standard or National Patient Safety Goal requirement. That is, if the action is equivalent to an EP that is identified as an "A" EP, the level of compliance expectation for the SE MOS for that action will be 100%. If the action is equivalent to an EP that is identified as a "C" EP, the minimum required level of compliance for the SE MOS for that action will be 90%. If the action cannot be associated with an existing standard or National Patient Safety Goal requirement, the organization will identify the level of compliance expectation, which must be at least 85%, subject to approval by the Joint Commission. The following information further outlines the SE MOS requirement:

- If an SE MOS is 30 or more days late, the organization's accreditation status will automatically be changed to Provisional Accreditation, and both the organization and the Accreditation Committee will be notified.
- If an SE MOS is 60 or more days late, the Joint Commission staff will recommend that the organization's accreditation decision be changed to Conditional Accreditation, and both the organization and the Accreditation Committee will be notified.
- If an SE MOS is submitted on time but does not meet established levels of compliance, the Joint Commission staff will request an additional four months of data. The organization's accreditation decision will be changed to Provisional Accreditation, and both the organization and the Accreditation Committee will be notified.
- If the second set of data meets established levels of compliance, the organization will be restored to Accredited.
- If the second set of data does not meet established levels of compliance, the Joint Commission staff will recommend that the organization's accreditation decision will be changed to Conditional Accreditation, and both the organization and the

Accreditation Committee will be notified. Any further actions will be based on the standards-based MOS decision rules.

A decision to maintain or change the organization's accreditation decision as a result of the follow-up activity or to assign additional follow-up requirements will be based on existing decision rules unless otherwise determined by the Accreditation Committee.

Handling Sentinel Event–Related Documents

Handling of any submitted root cause analysis and action plan is restricted to specially trained staff in accordance with procedures designed to protect the confidentiality of the documents.

Upon completion of the Joint Commission review of any submitted root cause analysis and action plan and the abstraction of the required data elements for the Joint Commission's Sentinel Event Database, the original root cause analysis documents and any copies will be destroyed. Upon request, the original documents will be returned to the organization. With the new electronic process the information contained in the electronically submitted RCA tool will be deidentified once the review is completed.

The action plan resulting from the analysis of the sentinel event will initially be retained to serve as the basis for the SE MOS. Once the action plan has been implemented and meets the established levels of compliance as determined through the SE MOS, the Joint Commission will destroy the action plan. If the SE MOS was submitted electronically the information will likewise be deidentified upon completion of the review.

Oversight of the Sentinel Event Policy

The Accreditation Committee of the Joint Commission's Board of Commissioners is responsible for overseeing the implementation of this policy and procedure. In addition to reviewing and deciding individual cases involving changes in an organization's accreditation decision, the senior staff in Accreditation and Certification Operations will periodically audit the root cause analyses and SE MOS and report these findings to the Accreditation Committee. For the purposes of these audits, the Joint Commission temporarily retains random samples of these documents. Upon completion of the audit, these documents are also destroyed. For more information about the Joint Commission's Sentinel Event Policy and Procedures, visit the Joint Commission's Web site at <http://www.jointcommission.org> or call the Sentinel Event Hotline at 630/792-3700.

Table 1. Examples of Reviewable and Nonreviewable Sentinel Events*

Examples of Sentinel Events That are Reviewable Under the Joint Commission's Sentinel Event Policy

Any patient death, paralysis, coma, or other major permanent loss of function associated with a medication error.

A patient commits suicide within 72 hours of being discharged from a hospital setting that provides staffed around-the-clock care.

Any elopement, that is unauthorized departure, of a patient from an around-the-clock care setting resulting in a temporally related death (suicide, accidental death, or homicide) or major permanent loss of function.

A hospital operates on the wrong side of the patient's body.

Any intrapartum (related to the birth process) maternal death.

Any perinatal death unrelated to a congenital condition in an infant having a birth weight greater than 2,500 grams.

A patient is abducted from the hospital where he or she receives care, treatment, or services.

Assault, homicide, or other crime resulting in patient death or major permanent loss of function.

A patient fall that results in death or major permanent loss of function as a direct result of the injuries sustained in the fall.

Hemolytic transfusion reaction involving major blood group incompatibilities.

A foreign body, such as a sponge or forceps, that was left in a patient after surgery.

Note: An adverse outcome that is *directly related* to the natural course of the patient's illness or underlying condition, for example, terminal illness present at the time of presentation, is **not** reportable except for suicide in, or following elopement from, a 24-hour care setting (see above).

Examples of Sentinel Events That are Nonreviewable Under the Joint Commission's Sentinel Event Policy

Any "near miss."

Full or expected return of limb or bodily function to the same level as prior to the adverse event by discharge or within two weeks of the initial loss of said function.

Any sentinel event that has not affected a recipient of care (patient, client, resident).

Medication errors that do not result in death or major permanent loss of function.

Suicide other than in an around-the-clock care setting or following elopement from such a setting.

A death or loss of function following a discharge "against medical advice (AMA)."

Unsuccessful suicide attempts unless resulting in major permanent loss of function.

Minor degrees of hemolysis not caused by a major blood group incompatibility and with no clinical sequelae.

Note: In the context of its performance improvement activities, an organization may choose to conduct intensive assessment, for example, root cause analysis, for some nonreviewable events.[†] Please refer to the "Improving Organization Performance" chapter of this Joint Commission accreditation manual.

* **Note:** This list may not apply to all settings.

Table 2. Minimum Scope of Root Cause Analysis for Specific Types of Sentinel Events

Detailed inquiry into these areas is expected when conducting a root cause analysis for the specified type of sentinel event. Inquiry into areas not checked (or listed) should be conducted as appropriate to the specific event under review.

	<i>Suicide (24-Hour Care)</i>	<i>Medication Error</i>	<i>Procedural Complication</i>	<i>Wrong Site Surgery</i>	<i>Treatment Delay</i>	<i>Restraint Death</i>	<i>Elopement Death</i>	<i>Assault/Rape/Homicide</i>	<i>Transfusion Death</i>	<i>Patient Abduction</i>	<i>Unanticipated Death of Full-Term Infant</i>	<i>Unintended Retention of Foreign Body</i>	<i>Fall Related</i>
Behavioral assessment process*	X					X	X	X					
Physical assessment process†	X	X	X	X	X	X	X			X			X
Patient identification process		X		X					X				
Patient observation procedures	X				X	X	X	X	X	X			X
Care planning process	X		X			X	X			X			X
Continuum of care	X	X			X	X							X
Staffing levels	X	X	X	X	X	X	X	X	X	X		X	X
Orientation and training of staff	X	X	X	X	X	X	X	X	X	X	X	X	X
Competency assessment/ credentialing	X	X	X	X	X	X	X	X	X	X	X	X	X
Supervision of staff‡	X	X	X		X	X			X			X	
Communication with patient/family	X	X		X	X	X	X			X			X
Communication among staff members	X	X	X	X	X	X	X	X	X	X	X	X	X
Availability of information	X	X	X	X	X	X			X		X		X
Adequacy of technological support		X	X										
Equipment maintenance/ management		X	X		X	X					X		X
Physical environment§	X	X	X	X		X	X	X	X	X			X
Security systems and processes	X						X	X		X			
Medication management#		X	X		X				X		X		X

* Includes the process for assessing patient's risk to self (and to others, in cases of assault, rape, or homicide where a patient is the assailant).

† Includes search for contraband.

‡ Includes supervision of physicians-in-training.

§ Includes furnishings; hardware (for example, bars, hooks, rods); lighting; distractions.

Includes selection and procurement; storage; ordering and transcribing; preparing and dispensing; administration; and monitoring.