1029 Sentinel Events Policy (HIPAA)

Definition of Sentinel Events
A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, which occurs in the course of a patient receiving behavioral health or mental health treatment or the risk thereof. 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.

An adverse event is a serious incident, therapeutic misadventures, iatrogenic injuries or other adverse occurrences directly associated with care or services provided. Adverse events may result from acts of omission or commission (e.g. administration of wrong medication, failure to make a timely diagnosis or institute the appropriate therapeutic intervention, or adverse of negative outcomes of a treatment. Examples would include patient falls, medication errors, and procedural complaints/complications, completed or attempted suicides on the premises, missing client events. Sentinel events can also be categorized as ‘near misses’.

Near misses are close calls, an event or situation that could have resulted in an accident, injury or illness, but did not. This may happen by chance or a timely intervention. Near Misses are opportunities for learning and afford the change to develop preventative strategies and actions. Near misses will receive the same level of scrutiny as adverse events that result in actual injury.

Goals of the Sentinel Event Policy
The policy has three goals:
1. To have a positive impact in improving patient care, treatment, and services and preventing sentinel events
2. To increase the general knowledge about sentinel events, their causes, and strategies for prevention
3. To maintain the confidence of the public and accredited organizations in the credentialing and accreditation process

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 underlies 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.

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. 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):

1. Suicide of any patient receiving care, treatment and services or within 72 hours of discharge
2. Serious physical or psychological injury
3. Abduction of any patient receiving care, treatment, and services
4. Rape

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 Minnewaska Area Schools becomes aware of a sentinel event that meets the above criteria, the organization is expected to do the following (If the Joint Commission becomes aware of a sentinel event that meets the above criteria the following is encouraged):

• 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 day (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 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
- 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 (MAS administration including principals and superintendent) 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 Minnewaska Area School and 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).

**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
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 SEMOS 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 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 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 oversight committee at Minnewaska Schools will include administrative staff and one delegate from each program and employee level. Others may be included at administrative authority. 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.

** “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