Sentinel Events

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A sentinel event is defined as a patient safety event that reaches a patient and results in any of the following:

- Death
- Permanent harm
- Severe temporary harm and requires intervention to sustain life

An event can also be considered a sentinel event even if the result is not one of those listed but is something that should "never" occur.

The Joint Commission adopted a formal policy on sentinel events in 1996. This was an effort by The Joint Commission to help hospitals to react to these events, learn from these events, and create patient safety processes to prevent future sentinel events. Any sentinel event must be reported to The Joint Commission and often to the state's department of health.

The Joint Commission defines the following as sentinel events:

- Intrapartum maternal death
- Any unexpected severe maternal morbidity
- Unanticipated death of a full-term infant
- Discharge of an infant to the wrong family
- Suicide of a patient within 72 hours of discharge from a hospital or emergency department setting
- Abduction of any patient receiving care, treatment, or services
- Elopement of a patient from a staffed setting leading to the death, permanent harm, or severe temporary harm of the patient
- Administration of blood or blood products resulting in unintended ABO or non-ABO incompatibility leading to transfusion reaction that causes death, permanent harm, or severe temporary harm
- Rape or assault of a patient, visitor, or health care worker within the organization
- Wrong-site surgery
- Retained foreign object
- Severe neonatal hyperbilirubinemia
- Prolonged fluoroscopy resulting in >1500 rad exposure
- Any wrong–body region radiotherapy
- Fire
- Fall that results in casting, surgery, injury, or death

Once a sentinel event is identified, the following actions should occur:

- If possible, the patient's condition should be stabilized
- The event should be disclosed to the patient and/or family
- Organization leadership must be informed
- The organization should provide support to the patient, family, and staff involved
- Immediate investigation should be conducted, using a comprehensive systematic analysis to identify factors that led to the event (failed process, staffing, equipment, communication error, etc.)
- Corrective actions should be developed to prevent further recurrences; this process should include due dates for deliverables and measurable outcomes to monitor success

A sentinel event is one example of a patient safety event. Other patient safety events include adverse events, no-harm events, close calls, and hazardous conditions.

- Adverse event: a patient safety event that results in harm to the patient
- No-harm event: a patient safety event that reaches the patient but does not result in harm to the patient
- Close call (near miss): a patient safety event that does not reach the patient
- Hazardous conditions: circumstances that increase the probability of an adverse event (e.g., inadequate staffing)

No-harm events, close calls, and hazardous conditions are institutional opportunities to redesign processes and systems to mitigate future patient safety events that result in harm.

Additional Reading

The Joint Commission. Sentinel Event Policy and Procedures. Available at: https://www.jointcommission.org/resources/sentinel-event/sentinel-event-policy-and-procedures/. Accessed November 2022.