Outlining Changes in the Joint Commission's Sentinel Event Policy

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In April 1998, the Joint Commission on Accreditation of Healthcare Organizations' Board of Commissioners approved a more detailed definition of sentinel event occurrences that are reportable to the Joint Commission on a voluntary basis and adopted procedural revisions to assist organizations in complying with the policy. The intent of these revisions is to minimize the risk of additional liability exposure. The more precise definition will provide a framework for education in healthcare organizations and for scientific research on the demographics, epidemiology, and prevention of sentinel events.

Revised Sentinel Event Definition

The board approved revised criteria to define the subset of sentinel events that are reportable to the Joint Commission on a voluntary basis under the Sentinel Event Policy. Only those sentinel events that effect recipients of care (patients, clients, and residents) and that meet the following criteria fall into this category.

If the event has resulted in an unanticipated death or major permanent loss of function, unrelated to the natural course of the patient's illness or underlying condition; or if the event is one of the following[1]:

- Suicide of a patient in a setting where the patient receives 24-hour care
- Infant abduction or discharge to the wrong family
- Rape
- Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities
- Surgery on the wrong patient or wrong body part

The healthcare facility does not have to report an adverse outcome related to the natural progression of a patient's illness or condition. However, the Joint Commission wants the facility to voluntarily report adverse outcomes associated with the treatment, or lack of treatment, of that condition.

The Joint Commission defines a major permanent loss of function as sensory, motor, physiologic, or intellectual impairment not present on admission that requires continued treatment or lifestyle change. When a facility cannot immediately determine major permanent loss of function, the Joint Commission does not expect the facility to report the incident until the facility discharges the patient with continued major loss of function, or two weeks have elapsed and the patient has persistent major loss of function, whichever occurs first.

The Joint Commission maintains that facilities must determine a rape based on its own organization's definition, consistent with applicable law and regulation. It does not expect facilities to report an allegation of rape. The five-day time frame for voluntary reporting of the incident begins when the facility determines that a rape occurred. In addition, the Joint Commission does not expect a facility to report a rape when state law prohibits such reporting.

All events of surgery on the wrong patient or wrong body part are reportable, regardless of the magnitude of the procedure.

Examples of Sentinel Events that are Voluntarily Reportable under the Joint Commission's Sentinel Event Policy[1]

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

- Any suicide of a patient in a setting where the patient is housed around the clock, including suicides following elopement from such a setting
- Any elopement (i.e., unauthorized departure) of a patient from an around-the-clock care setting resulting in a temporally related death (suicide or homicide) or major permanent loss of function
- Any procedure on the wrong patient, wrong side of the body, or wrong organ
- 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 2500 grams
- 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

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

Examples of Events that are Not Reportable to the Joint Commission[3]

- Any "near miss"
- Full 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"
- Unsuccessful suicide attempts
- Unintentionally retained foreign body without major permanent loss of function
- Minor degrees of hemolysis with no clinical sequelae

Note: In the context of its performance improvement activities, an organization may choose to conduct intensive assessment (e.g., root cause analysis) for some non-reportable events. Please refer to the "Improving Organization Performance" chapter of the Joint Commission Standards Manual.

Other Sentinel Event Changes

The Joint Commission has initiated a number of procedures to protect the confidentiality of sentinel event information that is shared by the Joint Commission and accredited organizations.

- The Joint Commission advises healthcare organizations not to provide patient or caregiver identifiers when reporting sentinel events
- An organization that experiences a sentinel event should submit two separate documents to the Joint Commission: (a) the root cause analysis and (b) the resulting action plan. The root cause analysis will be returned to the organization once abstracted information is entered into the Joint Commission database. If copies have been made for internal review, they will be destroyed after the review. Also, once the action plan has been implemented to the satisfaction of the Joint Commission, it will be returned to the organization
- The Joint Commission's Board of Commissioners authorized the onsite review of root cause analyses for sentinel events or onsite interviews with review of relevant documentation to verify the appropriate analysis of the sentinel event. These options, which became available July 1, 1998, are viewed as interim measures until acceptable legal protections for root cause analyses are in place. The Joint Commis-sion will charge $2300 to cover the direct costs of the one-day reviews. If an organization declines to share any information regarding a sentinel event with the Joint Commission, the organization will be placed on accreditation watch. The organization ultimately risks the loss of accreditation
- As a strategy to protect the confidentiality of sentinel event-related information at the healthcare organization, the Joint Commission will include language in future contracts between the Joint Commission and accredited organizations that will formally recognize the Joint Commission as a participating entity in the organization's quality monitoring and improvement activities. In this context, the Joint Commission will be explicitly portrayed as part of, not separate from,

the organization in working to reduce the risk of future sentinel events. Until this contract revision is fully in place, the Joint Commission will, upon request, provide written documentation to organizations that articulate the Joint Commission's role in quality improvement activities

In addition, the board also approved a modification to the procedures that allows an organization to complete an acceptable root cause analysis without the risk of being placed on accreditation watch, if it has not voluntarily self-reported within 30 days from the date of a reportable sentinel event or of its becoming aware of the event.

The Legal Issue: Potential Waiver of Confidentiality Privilege

The Joint Commission's Sentinel Events Legal Issues Task Force addressed potential corrective strategies that could minimize the risk of discovering specific information pertaining to a sentinel event. The task force intends to assist the Joint Commission in pursuing federal legislation and developing model state legislation to reinforce existing protections for sentinel event-related information that healthcare organizations may share with the Joint Commission. The task force will also continue to explore mechanisms for closing unresolved gaps in confidentiality protection.

State statutes vary regarding confidentiality protections for healthcare organizations' peer review activity. In some states, root cause analysis information falls into the category of peer review, so the information is protected. In other states, it is less clear whether the Joint Commission is a third party or an "agent" of the healthcare organization. If the Joint Commission is considered a third party, there may be a potential waiver of privilege and confidentiality protections.

The Sentinel Events Legal Issues Task Force has surveyed the states regarding state statutes. The results are as follows (44 state responses)[4]:

- 84 percent indicate that sharing root cause analysis with the Joint Commission will jeopardize confidentiality
- 84 percent indicate surveyor review on site with retention of copy of root cause analysis will jeopardize confidentiality
- 45 percent indicate surveyor review on site without taking copy of root cause analysis will jeopardize confidentiality
- 40 percent indicate that state statutes permit healthcare organizations to enter a contract with Joint Commission (party to peer review)

Some potential remedies to discoverability that are under consideration by the Joint Commission are[5]:

- Modify language of contract to Terms of Agreement
- Special onsite review with copy of root cause analysis
- Special onsite review without copy of root cause analysis
- Special onsite review without seeing root cause analysis
- Visit Joint Commission with root cause analysis
- Triennial survey review of root cause analysis
- State legislative protections
- Federal legislative protections

Notes

1. Sentinel Event Alert. Available online at http://www.jcaho.org/about+us/news+letters/sentinel+event+alert/sea_3.htm.
2. "JCAHO Attempts to Clarify What it Means by a Reportable Sentinel Event," *Briefings on Joint Commission on Accreditation of Healthcare Organizations* 9, no. 6 (1998): 7-8.
3. *Ibid.*
4. Croteau, Richard J. "Sentinel Events in Health Care Organizations." Paper presented at the Joint Commission on Accreditation of Healthcare Organizations' Sixth Annual Invitational Forum for Liaison Network Organizations, Oakbrook Terrace, IL, June 1998.
5. *Ibid.*

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